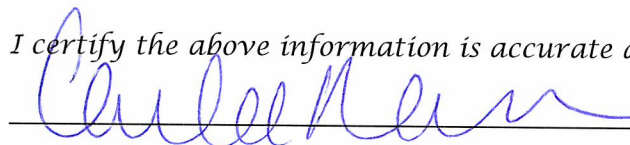


Agenda Summary Report (ASR)

Franklin County Board of Commissioners

DATE SUBMITTED: 10/7/2019	PREPARED BY: Carlee Nave
Meeting Date Requested: 10/15/2019	PRESENTED BY: Carlee Nave
ITEM: (Select One) <input checked="" type="checkbox"/> Consent Agenda <input type="checkbox"/> Brought Before the Board Time needed:	
SUBJECT: Premera Blue Cross Group Verification Report	
FISCAL IMPACT: Budgeted Expense	
BACKGROUND: On 10/1/2019, the Board gave consensus approval to move forward with Premera Blue Cross plans for 2020 employee medical and dental insurance. The Group Master Verification Report is an administrative document required for these plans and will ultimately become part of the Premera Health Care Contract for 2020.	
RECOMMENDATION: Approve the resolution authorizing the Chair to sign the Report as the Group's Representative.	
COORDINATION: The Report was completed by C Hanks at Conover insurance, in partnership with Carlee Nave, HR Director. Because the document will become part of the contract, legal review was requested, and the Report has been approved as to form by J. Johnson, Chief Civil Deputy Prosecuting Attorney/Risk Manager.	
ATTACHMENTS: (Documents you are submitting to the Board) <ul style="list-style-type: none"> 1. Resolution 2. Premera Blue Cross Group Verification Report 	
HANDLING / ROUTING: (Once document is fully executed it will be imported into Document Manager. Please list <u>name(s)</u> of parties that will need a pdf) n/a	

I certify the above information is accurate and complete.


 Carlee Nave, HR Director

FRANKLIN COUNTY RESOLUTION _____

BEFORE THE BOARD OF COMMISSIONERS
FRANKLIN COUNTY, WASHINGTON

2020 PREMIERA BLUE CROSS GROUP VERIFICATION REPORT

WHEREAS, the Board of Franklin County Commissioners has selected Premera Blue Cross plans for 2020 employee medical and dental insurance; and

WHEREAS, Premera Blue Cross requires a Group Verification Report for new plans; and

WHEREAS, the Group Verification Report will become part of the 2020 Premera Blue Cross contract to provide health care coverage; and

WHEREAS, the Board of Franklin County Commissioners constitutes the legislative authority of Franklin County.

NOW, THEREFORE, BE IT RESOLVED the Premera Blue Cross Group Verification Report is approved by the Board of Franklin County Commissioners.

AND, BE IT FURTHER RESOLVED the Board of Franklin County Commissioners authorizes the Chair of the Board to sign the Premera Blue Cross Group Verification Report as the Group's Representative.

APPROVED this ____ day of _____, 2019.

BOARD OF COUNTY COMMISSIONERS
FRANKLIN COUNTY, WASHINGTON

Chair

Chair Pro Tem

Member

ATTEST:

Clerk to the Board

Group Verification Report (Application)

Please review and note any changes in the Revisions / Additions column.

Group Number: 4012688

Effective Date From: 01/01/2020

To: 12/31/2020

Group Information		Revisions / Additions
A. Legal Name Common Name Physical Address City, State, Zip	Franklin County Franklin County 1016 N 4TH AVE, PASCO, WA, 99301	
B. Mailing Address City, State, Zip	1016 N 4TH AVE, PASCO, WA, 99301	
C. Sub Group Name Billing Address City, State, Zip Billing Contact Name Billing Contact Phone Billing Contact Email Billing Contact Fax	Franklin County - Franklin County 1016 N 4TH AVE, PASCO, WA, 99301 ROSA GOMEZ 5095453505 Ext 6096 rgomez@co.franklin.wa.us	Peter Gadowskiy 509-545-3556 pgadowskiy@co.franklin.wa.us
Sub Group Name Billing Address City, State, Zip Billing Contact Name Billing Contact Phone Billing Contact Email Billing Contact Fax	Franklin County - LEOFF 1 Retirees 1016 N 4TH AVE, PASCO, WA, 99301 DONNA CRISP 5095465813 dsorisp@co.franklin.wa.us	Human Resources hr@co.franklin.wa.us
Sub Group Name Billing Address City, State, Zip Billing Contact Name Billing Contact Phone Billing Contact Email Billing Contact Fax	Franklin County - Retirees PO BOX 10088, YAKIMA, WA, 98909 TERESA HARPER 5099727417 teresah@verdeservices.com	
Sub Group Name Billing Address City, State, Zip Billing Contact Name Billing Contact Phone Billing Contact Email Billing Contact Fax	Franklin County - COBRA PO BOX 10088, YAKIMA, WA, 98909 TERESA HARPER 5099727417 teresah@verdeservices.com	
D. Benefit Administrator Information Billing Address City, State, Zip Benefit Administrator Contact Name Benefit Administrator Phone Benefit Administrator Email Benefit Administrator Fax	1016 N 4TH AVE PASCO, WA 99301 CARLEE NAVE 5095465817 cnave@co.franklin.wa.us	
E. Other Contact Person Name Other Contact Person Phone Other Contact Person Email Other Contact Person Fax	ISABEL BAHENA 5095465813 ibahena@co.franklin.wa.us	
Other Contact Person Name Other Contact Person Phone Other Contact Person Email Other Contact Person Fax	DONNA CRISP 5095465813 dsorisp@co.franklin.wa.us	

Other Contact Person Name Other Contact Person Phone Other Contact Person Email Other Contact Person Fax	RAUL RAMIREZ-HERNANDEZ 5095453355 rramirez@co.franklin.wa.us	
Other Contact Person Name Other Contact Person Phone Other Contact Person Email Other Contact Person Fax	ERIC WYANT 5095465813 ewyant@co.franklin.wa.us	
F. COBRA Administrator Information (bill will be sent to this address) Billing Address City, State, Zip COBRA Administrator Contact Name COBRA Administrator Phone COBRA Administrator Email COBRA Administrator Fax	None on file	Verde Services Teresa Harper PO Box 10088, Yakima, WA 98909 509-972-7417 teresah@verdeservices.com
G. Employer Identification Number Type of Business SIC # NAICS #	916001315 General Government, NEC 9199 921190	

Class Information

Employee Eligibility Requirements		
A. All employees who work a minimum of:	20.77 Hour(s) per Week	
Specific class or classes:	Appraisers	
B. Employee probationary period - all eligible employees are effective on the:	First day of the Month following Date of Hire	
C. Coverage will end:	<input checked="" type="checkbox"/> Last day of the month for which subscription is paid <input type="checkbox"/> Other	

- D. Domestic partners coverage is standard for all fully insured groups with 51 or more employees. All domestic partners, including same sex, opposite sex, and state registered will be considered eligible dependents. Domestic partner eligibility will include eligibility for COBRA continuation of coverage.

If you would like to limit domestic partner coverage to state-registered domestic partners and/or choose not to extend COBRA coverage for domestic partners please contact your sales representative. If your group is self-funded please contact your sales representative for your options.

Group Notes: Only state registered domestic partners are eligible .

Employee Participation and Employer Contribution Requirements	Revisions / Additions					
A. The minimum eligible employee participation requirement is:	100					
The minimum eligible dependent participation requirement is:	0					
B. Effective date of contribution: (month/day/year)	01/01/2020					
C. The employer will contribute the following percentage or dollar amount toward the cost of eligible employee coverage:	Medical 100%	Dental 100%	Vision 0%	Medical	Dental	Vision
The employer will contribute the following percentage or dollar amount toward the cost of spouse / domestic partner coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or more) coverage:	0%	0%	0%			

Please Note: If you differentiate contributions by class of employee, those same classes must be represented here.

D. Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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Note: If the Employer contribution towards the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010, the plan ceases to be grandfathered.

Class Information		
Employee Eligibility Requirements		
A. All employees who work a minimum of:	0 Hour(s) per Week	
Specific class or classes:	Under Age 65	Under Age 65 Retiree
B. Employee probationary period - all eligible employees are effective on the:	First day of the Month following Date of Hire	
C. Coverage will end:	<input checked="" type="checkbox"/> Last day of the month for which subscription is paid <input type="checkbox"/> Other	
D. Domestic partners coverage is standard for all fully insured groups with 51 or more employees. All domestic partners, including same sex, opposite sex, and state registered will be considered eligible dependents. Domestic partner eligibility will include eligibility for COBRA continuation of coverage. If you would like to limit domestic partner coverage to state-registered domestic partners and/or choose not to extend COBRA coverage for domestic partners please contact your sales representative. If your group is self-funded please contact your sales representative for your options.		

Group Notes: Only state registered domestic partners are eligible .

Employee Participation and Employer Contribution Requirements				Revisions / Additions		
A. The minimum eligible employee participation requirement is:				0		
The minimum eligible dependent participation requirement is:				0		
B. Effective date of contribution: (month/day/year)				01/01/2020		
C. The employer will contribute the following percentage or dollar amount toward the cost of eligible employee coverage:				Medical	Dental	Vision
				0%	0%	0%
The employer will contribute the following percentage or dollar amount toward the cost of spouse / domestic partner coverage:						
				0%	0%	0%
The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:						
				0%	0%	0%
The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or more) coverage:						
				0%	0%	0%

Please Note: If you differentiate contributions by class of employee, those same classes must be represented here.

D. Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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Note: If the Employer contribution towards the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010, the plan ceases to be grandfathered.

Class Information	
Employee Eligibility Requirements	
A. All employees who work a minimum of:	0 Hour(s) per Week
Specific class or classes:	LEOFF 1 Retirees
B. Employee probationary period - all eligible employees are effective on the:	First day of the Month following Date of Hire
C. Coverage will end:	<input checked="" type="checkbox"/> Last day of the month for which subscription is paid <input type="checkbox"/> Other
D. Domestic partners coverage is standard for all fully insured groups with 51 or more employees. All domestic partners, including same sex, opposite sex, and state registered will be considered eligible dependents. Domestic partner eligibility will include eligibility for COBRA continuation of coverage.	
If you would like to limit domestic partner coverage to state-registered domestic partners and/or choose not to extend COBRA coverage for domestic partners please contact your sales representative. If your group is self-funded please contact your sales representative for your options.	

Group Notes: Only state registered domestic partners are eligible .

Employee Participation and Employer Contribution Requirements				Revisions / Additions		
A. The minimum eligible employee participation requirement is:	100					
The minimum eligible dependent participation requirement is:	0					
B. Effective date of contribution: (month/day/year)	01/01/2020					
C. The employer will contribute the following percentage or dollar amount toward the cost of eligible employee coverage:	Medical	Dental	Vision	Medical	Dental	Vision
	100%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of spouse / domestic partner coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or more) coverage:	0%	0%	0%			

Please Note: If you differentiate contributions by class of employee, those same classes must be represented here.

D. Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
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Note: If the Employer contribution towards the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010, the plan ceases to be grandfathered.

Class Information		
Employee Eligibility Requirements		
A. All employees who work a minimum of:	40 Hour(s) per Week	30 hours per week
Specific class or classes:	Corrections	
B. Employee probationary period - all eligible employees are effective on the:	First day of the Month following Date of Hire	
C. Coverage will end:	<input checked="" type="checkbox"/> Last day of the month for which subscription is paid <input type="checkbox"/> Other	
D. Domestic partners coverage is standard for all fully insured groups with 51 or more employees. All domestic partners, including same sex, opposite sex, and state registered will be considered eligible dependents. Domestic partner eligibility will include eligibility for COBRA continuation of coverage. If you would like to limit domestic partner coverage to state-registered domestic partners and/or choose not to extend COBRA coverage for domestic partners please contact your sales representative. If your group is self-funded please contact your sales representative for your options.		

Group Notes: Only state registered domestic partners are eligible.

Employee Participation and Employer Contribution Requirements				Revisions / Additions		
A. The minimum eligible employee participation requirement is:	100					
The minimum eligible dependent participation requirement is:	0					
B. Effective date of contribution: (month/day/year)	01/01/2020					
C. The employer will contribute the following percentage or dollar amount toward the cost of eligible employee coverage:	Medical 100%	Dental 100%	Vision 0%	Medical	Dental	Vision
The employer will contribute the following percentage or dollar amount toward the cost of spouse / domestic partner coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or more) coverage:	0%	0%	0%			
Please Note: If you differentiate contributions by class of employee, those same classes must be represented here.						
D. Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					

Note: If the Employer contribution towards the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010, the plan ceases to be grandfathered.

Class Information		
Employee Eligibility Requirements		
A. All employees who work a minimum of:	20.77 Hour(s) per Week	
Specific class or classes:	Courthouse	
B. Employee probationary period - all eligible employees are effective on the:	First day of the Month following Date of Hire	
C. Coverage will end:	<input checked="" type="checkbox"/> Last day of the month for which subscription is paid <input type="checkbox"/> Other	
<p>D. Domestic partners coverage is standard for all fully insured groups with 51 or more employees. All domestic partners, including same sex, opposite sex, and state registered will be considered eligible dependents. Domestic partner eligibility will include eligibility for COBRA continuation of coverage.</p> <p>If you would like to limit domestic partner coverage to state-registered domestic partners and/or choose not to extend COBRA coverage for domestic partners please contact your sales representative. If your group is self-funded please contact your sales representative for your options.</p>		

Group Notes: Only state registered domestic partners are eligible.

Employee Participation and Employer Contribution Requirements	Revisions / Additions					
A. The minimum eligible employee participation requirement is:	100					
The minimum eligible dependent participation requirement is:	0					
B. Effective date of contribution: (month/day/year)	01/01/2020					
C. The employer will contribute the following percentage or dollar amount toward the cost of eligible employee coverage:	Medical 100%	Dental 100%	Vision 0%	Medical	Dental	Vision
The employer will contribute the following percentage or dollar amount toward the cost of spouse / domestic partner coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or more) coverage:	0%	0%	0%			

Please Note: If you differentiate contributions by class of employee, those same classes must be represented here.

D. Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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Note: If the Employer contribution towards the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010, the plan ceases to be grandfathered.

Class Information		
Employee Eligibility Requirements		
A. All employees who work a minimum of:	20.77 Hour(s) per Week	
Specific class or classes:	Public Works (Courthouse)	This class will be move to the Courthouse class.
B. Employee probationary period - all eligible employees are effective on the:	First day of the Month following Date of Hire	
C. Coverage will end:	<input checked="" type="checkbox"/> Last day of the month for which subscription is paid <input type="checkbox"/> Other	
D. Domestic partners coverage is standard for all fully insured groups with 51 or more employees. All domestic partners, including same sex, opposite sex, and state registered will be considered eligible dependents. Domestic partner eligibility will include eligibility for COBRA continuation of coverage. If you would like to limit domestic partner coverage to state-registered domestic partners and/or choose not to extend COBRA coverage for domestic partners please contact your sales representative. If your group is self-funded please contact your sales representative for your options.		

Group Notes: Only state registered domestic partners are eligible .

Employee Participation and Employer Contribution Requirements				Revisions / Additions		
A. The minimum eligible employee participation requirement is:	100					
The minimum eligible dependent participation requirement is:	0					
B. Effective date of contribution: (month/day/year)	01/01/2020					
C. The employer will contribute the following percentage or dollar amount toward the cost of eligible employee coverage:	Medical 100%	Dental 100%	Vision 0%	Medical	Dental	Vision
The employer will contribute the following percentage or dollar amount toward the cost of spouse / domestic partner coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or more) coverage:	0%	0%	0%			
Please Note: If you differentiate contributions by class of employee, those same classes must be represented here.						
D. Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					

Note: If the Employer contribution towards the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010, the plan ceases to be grandfathered.

Class Information		
Employee Eligibility Requirements		
A. All employees who work a minimum of:	40 Hour(s) per Week	30 hours per week
Specific class or classes:	Deputies	
B. Employee probationary period - all eligible employees are effective on the:	First day of the Month following Date of Hire	
C. Coverage will end:	<input checked="" type="checkbox"/> Last day of the month for which subscription is paid <input type="checkbox"/> Other	
<p>D. Domestic partners coverage is standard for all fully insured groups with 51 or more employees. All domestic partners, including same sex, opposite sex, and state registered will be considered eligible dependents. Domestic partner eligibility will include eligibility for COBRA continuation of coverage.</p> <p>If you would like to limit domestic partner coverage to state-registered domestic partners and/or choose not to extend COBRA coverage for domestic partners please contact your sales representative. If your group is self-funded please contact your sales representative for your options.</p>		

Group Notes: Only state registered domestic partners are eligible .

Employee Participation and Employer Contribution Requirements	Revisions / Additions					
A. The minimum eligible employee participation requirement is:	100					
The minimum eligible dependent participation requirement is:	0					
B. Effective date of contribution: (month/day/year)	01/01/2020					
C. The employer will contribute the following percentage or dollar amount toward the cost of eligible employee coverage:	Medical 100%	Dental 100%	Vision 0%	Medical	Dental	Vision
The employer will contribute the following percentage or dollar amount toward the cost of spouse / domestic partner coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or more) coverage:	0%	0%	0%			
Please Note: If you differentiate contributions by class of employee, those same classes must be represented here.						
D. Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					

Note: If the Employer contribution towards the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010, the plan ceases to be grandfathered.

Class Information		
Employee Eligibility Requirements		
A. All employees who work a minimum of:	40 Hour(s) per Week	30 hours per week
Specific class or classes:	Elected	
B. Employee probationary period - all eligible employees are effective on the:	First day of the Month following Date of Hire	
C. Coverage will end:	<input checked="" type="checkbox"/> Last day of the month for which subscription is paid <input type="checkbox"/> Other	
D. Domestic partners coverage is standard for all fully insured groups with 51 or more employees. All domestic partners, including same sex, opposite sex, and state registered will be considered eligible dependents. Domestic partner eligibility will include eligibility for COBRA continuation of coverage. If you would like to limit domestic partner coverage to state-registered domestic partners and/or choose not to extend COBRA coverage for domestic partners please contact your sales representative. If your group is self-funded please contact your sales representative for your options.		

Group Notes: Only state registered domestic partners are eligible.

Employee Participation and Employer Contribution Requirements				Revisions / Additions		
A. The minimum eligible employee participation requirement is:	100					
The minimum eligible dependent participation requirement is:	0					
B. Effective date of contribution: (month/day/year)	01/01/2020					
C. The employer will contribute the following percentage or dollar amount toward the cost of eligible employee coverage:	Medical 100%	Dental 100%	Vision 0%	Medical	Dental	Vision
The employer will contribute the following percentage or dollar amount toward the cost of spouse / domestic partner coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or more) coverage:	0%	0%	0%			
Please Note: If you differentiate contributions by class of employee, those same classes must be represented here.						
D. Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					

Note: If the Employer contribution towards the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010, the plan ceases to be grandfathered.

Class Information		
Employee Eligibility Requirements		
A. All employees who work a minimum of:	20 Hour(s) per Week	
Specific class or classes:	Non-Bargs	
B. Employee probationary period - all eligible employees are effective on the:	First day of the Month following Date of Hire	
C. Coverage will end:	<input checked="" type="checkbox"/> Last day of the month for which subscription is paid <input type="checkbox"/> Other	
<p>D. Domestic partners coverage is standard for all fully insured groups with 51 or more employees. All domestic partners, including same sex, opposite sex, and state registered will be considered eligible dependents. Domestic partner eligibility will include eligibility for COBRA continuation of coverage.</p> <p>If you would like to limit domestic partner coverage to state-registered domestic partners and/or choose not to extend COBRA coverage for domestic partners please contact your sales representative. If your group is self-funded please contact your sales representative for your options.</p>		

Group Notes: Only state registered domestic partners are eligible .

Employee Participation and Employer Contribution Requirements	Revisions / Additions					
A. The minimum eligible employee participation requirement is:	100					
The minimum eligible dependent participation requirement is:	0					
B. Effective date of contribution: (month/day/year)	01/01/2020					
C. The employer will contribute the following percentage or dollar amount toward the cost of eligible employee coverage:	Medical 100%	Dental 100%	Vision 0%	Medical	Dental	Vision
The employer will contribute the following percentage or dollar amount toward the cost of spouse / domestic partner coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or more) coverage:	0%	0%	0%			
Please Note: If you differentiate contributions by class of employee, those same classes must be represented here.						
D. Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					

Note: If the Employer contribution towards the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010, the plan ceases to be grandfathered.

Class Information		
Employee Eligibility Requirements		
A. All employees who work a minimum of:	20 Hour(s) per Week	
Specific class or classes:	Sherrif's Clerical	Sheriff's Support
B. Employee probationary period - all eligible employees are effective on the:	First day of the Month following Date of Hire	
C. Coverage will end:	<input checked="" type="checkbox"/> Last day of the month for which subscription is paid <input type="checkbox"/> Other	
<p>D. Domestic partners coverage is standard for all fully insured groups with 51 or more employees. All domestic partners, including same sex, opposite sex, and state registered will be considered eligible dependents. Domestic partner eligibility will include eligibility for COBRA continuation of coverage.</p> <p>If you would like to limit domestic partner coverage to state-registered domestic partners and/or choose not to extend COBRA coverage for domestic partners please contact your sales representative. If your group is self-funded please contact your sales representative for your options.</p>		

Group Notes: Only state registered domestic partners are eligible.

Employee Participation and Employer Contribution Requirements				Revisions / Additions		
A. The minimum eligible employee participation requirement is:	100					
The minimum eligible dependent participation requirement is:	0					
B. Effective date of contribution: (month/day/year)	01/01/2020					
C. The employer will contribute the following percentage or dollar amount toward the cost of eligible employee coverage:	Medical	Dental	Vision	Medical	Dental	Vision
	100%	100%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of spouse / domestic partner coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or more) coverage:	0%	0%	0%			

Please Note: If you differentiate contributions by class of employee, those same classes must be represented here.

D. Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
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Note: If the Employer contribution towards the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010, the plan ceases to be grandfathered.

Class Information		
Employee Eligibility Requirements		
A. All employees who work a minimum of:	20 Hour(s) per Week	
Specific class or classes:	Public Works (Non-Barge)	
B. Employee probationary period - all eligible employees are effective on the:	First day of the Month following Date of Hire	
C. Coverage will end:	<input checked="" type="checkbox"/> Last day of the month for which subscription is paid <input type="checkbox"/> Other	
<p>D. Domestic partners coverage is standard for all fully insured groups with 51 or more employees. All domestic partners, including same sex, opposite sex, and state registered will be considered eligible dependents. Domestic partner eligibility will include eligibility for COBRA continuation of coverage.</p> <p>If you would like to limit domestic partner coverage to state-registered domestic partners and/or choose not to extend COBRA coverage for domestic partners please contact your sales representative. If your group is self-funded please contact your sales representative for your options.</p>		

Group Notes: Only state registered domestic partners are eligible .

Employee Participation and Employer Contribution Requirements				Revisions / Additions		
A. The minimum eligible employee participation requirement is:	100					
The minimum eligible dependent participation requirement is:	0					
B. Effective date of contribution: (month/day/year)	01/01/2020					
C. The employer will contribute the following percentage or dollar amount toward the cost of eligible employee coverage:	Medical 100%	Dental 100%	Vision 0%	Medical	Dental	Vision
The employer will contribute the following percentage or dollar amount toward the cost of spouse / domestic partner coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or more) coverage:	0%	0%	0%			

Please Note: If you differentiate contributions by class of employee, those same classes must be represented here.

D. Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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Note: If the Employer contribution towards the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010, the plan ceases to be grandfathered.

Class Information	
Employee Eligibility Requirements	
A. All employees who work a minimum of:	0 Hour(s) per Week
Specific class or classes:	Retiree
B. Employee probationary period - all eligible employees are effective on the:	First day of the Month following Date of Hire
C. Coverage will end:	<input checked="" type="checkbox"/> Last day of the month for which subscription is paid <input type="checkbox"/> Other
<p>D. Domestic partners coverage is standard for all fully insured groups with 51 or more employees. All domestic partners, including same sex, opposite sex, and state registered will be considered eligible dependents. Domestic partner eligibility will include eligibility for COBRA continuation of coverage.</p> <p>If you would like to limit domestic partner coverage to state-registered domestic partners and/or choose not to extend COBRA coverage for domestic partners please contact your sales representative. If your group is self-funded please contact your sales representative for your options.</p>	

Group Notes: Only state registered domestic partners are eligible .

Employee Participation and Employer Contribution Requirements	Revisions / Additions					
A. The minimum eligible employee participation requirement is:	0					
The minimum eligible dependent participation requirement is:	0					
B. Effective date of contribution: (month/day/year)	01/01/2020					
C. The employer will contribute the following percentage or dollar amount toward the cost of eligible employee coverage:	Medical 0%	Dental 0%	Vision 0%	Medical	Dental	Vision
The employer will contribute the following percentage or dollar amount toward the cost of spouse / domestic partner coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or more) coverage:	0%	0%	0%			
Please Note: If you differentiate contributions by class of employee, those same classes must be represented here.						
D. Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					

Note: If the Employer contribution towards the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010, the plan ceases to be grandfathered.

Class Information		
Employee Eligibility Requirements		
A. All employees who work a minimum of:	18.46 Hour(s) per Week	
Specific class or classes:	Public Works (Local 874)	Roads (Local 874)
B. Employee probationary period - all eligible employees are effective on the:	First day of the Month following Date of Hire	
C. Coverage will end:	<input checked="" type="checkbox"/> Last day of the month for which subscription is paid <input type="checkbox"/> Other	
<p>D. Domestic partners coverage is standard for all fully insured groups with 51 or more employees. All domestic partners, including same sex, opposite sex, and state registered will be considered eligible dependents. Domestic partner eligibility will include eligibility for COBRA continuation of coverage.</p> <p>If you would like to limit domestic partner coverage to state-registered domestic partners and/or choose not to extend COBRA coverage for domestic partners please contact your sales representative. If your group is self-funded please contact your sales representative for your options.</p>		

Group Notes: Only state registered domestic partners are eligible.

Employee Participation and Employer Contribution Requirements				Revisions / Additions		
A. The minimum eligible employee participation requirement is:	100					
The minimum eligible dependent participation requirement is:	0					
B. Effective date of contribution: (month/day/year)	01/01/2020					
C. The employer will contribute the following percentage or dollar amount toward the cost of eligible employee coverage:	Medical 100%	Dental 100%	Vision 0%	Medical	Dental	Vision
The employer will contribute the following percentage or dollar amount toward the cost of spouse / domestic partner coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:	0%	0%	0%			
The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or more) coverage:	0%	0%	0%			
Please Note: If you differentiate contributions by class of employee, those same classes must be represented here.						
D. Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					

Note: If the Employer contribution towards the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010, the plan ceases to be grandfathered.

Producer		Revisions / Additions	
A. Producer of record name:	DAVE GUYLL		
Producer number:	5095436420		
Firm / Agency name:	Conover Insurance Services LLC		
Effective Date of the Producer Appointment:	01/01/2018		
Producer email address:	daveg@conoverinsurance.com		
Commission:	\$12.00 PEPM Medical / \$3.21 PEPM Dental		
B. Split Commission:			
Producer of record name:			
Producer number:			
Commission:			

Complete/Verify the sections below

Employee Enrollment	
A. Total number of employees on payroll in the prior calendar year:	302
B. Total number of eligible employees enrolling:	274

Federal Requirements

Helpful Hint: We strongly urge you to consult legal counsel in answering the questions below. The summaries below are not intended to be or to replace legal advice on your particular group. It is the group's responsibility to inform Premera Blue Cross immediately if facts change which would cause the group's answers below to change.

- A. Is the group subject to the federal Medicare Secondary Payer (MSP) laws that prohibit discrimination against individuals with group coverage based on their (or a spouse's) current employment status who have Medicare due to age?

1. ☒ Yes. This plan will pay primary to Medicare as required by federal law. ☐ No. Under 20 employees.
2. Please also provide the number of employees who now meet Medicare's definition of "employee." 302

Helpful Hint: These laws do not apply to any employer who did not employ 20 employees or more for each working day in each of 20 or more calendar weeks in either the current or preceding calendar year. For these small group plans, Medicare pays primary to the group plan.

"Employees" include all full-time and part-time employees as well as those employees on disability and subject to FICA taxes. Also count leased employees if they would be counted as employees under §414(n)(2) of the Internal Revenue Code (IRC), and count employees employed by an "affiliated service group" under IRC §414(m) or by employers considered to be a "single employer" under IRC §52(a) or (b).

- B. Is the group subject to COBRA?

- ☒ Yes ☐ No, give the legal reason for exemption: _____

Helpful Hint: Generally, these laws apply to any non-church employer that employed 20 or more employees on at least 50% of its working days in the preceding calendar year.

"Employees" are full-time and part-time common-law employees. Self-employed workers as defined in IRC §401(c)(1), corporate directors, or independent contractors should not be counted unless they qualify as common-law employees. "Employees" may also include leased employees who qualify as common-law employees. Please see COBRA regulations at 26 CFR § 54.4980B-2 Q/A 5 for guidance on counting a part-time employee as a fraction of a full-time employee.

- C. Is the group subject to the federal Medicare Secondary Payer (MSP) laws that prohibit discrimination against individuals with group coverage based on their (or a family member's) current employment status who have Medicare due to disability?

1. ☒ Yes. This plan will pay primary to Medicare as required by federal law. ☐ No. Under 100 employees.
2. Please also provide the number of employees who now meet Medicare's definition of "employee." 302

Helpful Hint: Generally, these laws apply to any employer that employed at least 100 employees on 50% or more of its working days in the preceding calendar year. See the helpful hint in A above for a definition of "employee" for this purpose.

- D. Is this group subject to ERISA?

- ☐ Yes, Enter the month the ERISA plan year ends: Month

- ☒ No. Give the legal reason for exemption: ☒ Government or Public Plan ☐ Church Plan
☐ Other, please specify: _____

Helpful Hint: Generally, ERISA applies to all employer health plans except governmental, public or church plans. Non-profit status alone does not exempt an employer from ERISA.

Group Materials

Important Note: Electronic copies of benefit booklets are available online at www.premera.com.

Producer Agreement to Contract

You, the producer(s), certify that you have met with the group submitting this agreement and that you have fully explained its contents. You have discussed coverage, eligibility, the effect of misrepresentations, termination provisions and subscription charge billing administration.

Producer Signature

David A. Bynell

Date

10/4/19

Group Agreement to Contract

You, the group named in the Group Information section of this application, understand and agree to the following.

A. This application becomes part of the contract to provide health care coverage after:

- The application is signed by you;
- The application is received and approved by us; and
- We receive the initial month's subscription charges

You may not assign this contract without our written consent. Any attempt to do so will not have any binding effect on us. You agree to promptly deliver materials and notifications, including benefit booklets, received from us to all covered employees. You attest to have read this application, and certify that all statements are true and complete. You agree to the terms and obligations stated in this application. It is understood that provisions of the Health Care Contract, including subscription charges, may be amended or changed from time to time, upon our notice to you. All prior applications, to the extent that you have not made changes to them in this application, remain in full force and effect. The agent/broker listed in The Producer section will remain effective until written notice is given by either party. We are authorized to pay, on your behalf, commission, if any, for which you are liable to the above named agent/broker.

B. You may elect to allow the producer listed above to act as a group benefit administrator beginning on the group's first effective date. This means that the producer/administrator will be able to access membership and billing functions, and obtain information about group members via the Web on behalf of the group. These functions may include, but are not limited to:

- Reinstate Terminated Members
- Request Invoice
- View Benefit Detail
- Search for a member
- Inquire on Invoice
- Inquire on Eligibility
- Enroll a Member
- Order ID Cards for an Individual or Whole Family
- View Group Demographic Information
- Cancel a Member

Do you elect and authorize Premera Blue Cross to provide such information to the producer?
(Producer authorized as Group Benefits Administrator?)

☐ No ☒ Yes

C. I affirm that this Group has a physical location outside Clark County in the State of Washington, and I am authorized to sign on behalf of the group.

Signature of Group's Representative

Date

Group's Representative (Print Name)

Title

Please note: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Tracking Information - To be completed by Premera Blue Cross Washington

Date Received by Sales	Information Complete	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date Missing Information Received
Account Manager	Extension		Rep. Code

Approved as to form:
PROSECUTING ATTORNEY'S OFFICE