Blue Cross of Idaho®

Employer Group Application and Questionnaire ASC

(This form to be completed when sale is final)

Group Number: _____ Requested Effective Date: 9/1/2024

Beginning of Open Enrollment Period: 08/15 End Date: 09/30

Group Information

Legal Name of Business			Telephone
Lapwai School District #341			208-843-2622
Mailing Address	**City**	**State**	**ZIP Code**
404 S Main St	Lapwai	ID	83540
Billing Address	**City**	**State**	**ZIP Code**
Physical Address (No PO Box)	**City**	**State**	**ZIP Code**

Tax Identification Number (TIN)	SIC Code
82-6000843	

Nature of Business	Type of Business
K-12 Public School	❑ Sole Proprietor ❑ Partnership ❑ Corporation ■ Other Local Gov't

Is the business affiliated with any other business? ❑ Yes ■ No If yes, which one? _____

Does this business file a separate or joint state tax return?	In which state is the company's headquarters located?
❑ Separate ❑ Joint	
Does this business have warehouses, stores, offices, etc. located outside of Idaho? ❑ Yes ❑ No If yes, where? _____	How many eligible employees are located at each location outside of Idaho?

Does this business have union negotiated benefits? ■ Yes ❑ No If YES, next scheduled negotiation date next May/June

Does this business have 500 or more enrolling employees? ❑ Yes ■ No
If YES, do 25% or more of the enrolled employees reside outside of Idaho? ❑ Yes ❑ No

Is this business subject to ERISA? ❑ Yes ■ No If YES, ERISA plan year _____

Contact Information

Executive Contact[1]

Name[1]	Title[1]
■ Mr. ❑ Mrs. ❑ Ms. David Aiken	Superintendent

Email Address[1]	Phone Number	Fax Number
daiken@lapwai.org	208-843-2622	

Management or Other Contact

Name[1]	Title[1]
❑ Mr. ❑ Mrs. ■ Ms. Connie Desjarlais	District Office Manager

Email Address	Phone Number	Fax Number
cdesjarlais@lapwai.org	208-843-2622	

Group Administrator[1]

Name[1]	Title[1]
■ Mr. ❑ Mrs. ❑ Ms. Nathan Weeks	Business Manager

Email Address[1]	Phone Number	Fax Number
nweeks@lapwai.org	208-843-2622	208-843-7746

Primary Billing Contact

Name[1]	Title[1]
❑ Mr. ❑ Mrs. ❑ Ms. Nathan Weeks	Business Manager

Email Address	Phone Number	Fax Number

Current Carrier Information

Name of medical carrier	Regence
Name of dental carrier	Delta Dental

([1] required fields)

3000 E. Pine Ave. • Meridian, Idaho 83642 • 208-345-4550
Mailing Address: P.O. Box 7408 • Boise, ID 83707-1408

Do you currently have an employee(s) who, by National Medical Support Order (NMSO) or Qualified Medical Child Support Order (QMCSO), must provide medical coverage for a dependent(s)? ❑ Yes ■ No

If YES, please attach a copy of the court order(s). These documents should already be on file with your Human Resources Department.

ASC Administrative Information

Agreement Period: From 9/1/2024 Through 8/31/2025

Administrative Services Contract (ASC)	❑ Self Funded – Conventional (available to groups with 100 or more enrolled employees) ❑ Self Funded – Balanced Funding (available to groups with 51–250 enrolled employees)
Policy Type (check all that apply)	Traditional or PPO ❑ ASC ***(local)*** ❑ NTA ***(National ASC Group: Blue Cross of Idaho is the host plan)*** ❑ NCA ***(National ASC Group: Blue Cross of Idaho is the home plan)***
Total Administrative Fee	See attached Quote/Rating Sheet
Claims Reimbursement	❑ ACH Draft[2] (preferred) Blue Cross of Idaho drafts groups account ❑ Check ❑ ACH Transfer (special instructions from Accounting) – Group wires payment to Blue Cross of Idaho ***[2]Normally when funds are drafted directly from a bank account, the group does not receive an invoice. Unless otherwise requested, the ACH groups receive only the claims report.***

The group agrees to pay out-of-area processing, access, surcharge and/or other fees, if any, as outlined in the Group's Administrative Agreement. The group is self-funding its health benefit plan(s) and agrees to set up the appropriate trust agreement and to comply with ERISA, HIPAA, and/or any other applicable Federal or state requirements.

Employer Requirements

Eligibility — *The Group agrees to cover employees with the following eligibility parameters.*

❑ **Mid-Sized Group (51-99)**

❑ Employee, Spouse and Children (Standard) ❑ Employee only coverage ❑ Employee and Spouse only ❑ Employee and Children only Domestic Partner ❑ Yes ❑ No

■ **Large Group (100+)**

■ Employee, Spouse and Children (Standard) ❑ Employee and Children only Domestic Partner ❑ Yes ❑ No

A. Employees working 30 or more hours per week on average OR ❑ Yes ❑ No

B. Employees working 20 or more hours per week (for groups with at least three (3) active enrollees and by agreement between Blue Cross of Idaho and the Group) ■ Yes ❑ No

C. Public officers and public employees regardless of the number of hours worked (City or County Employees Only) ❑ Yes ❑ No

Participation — *The Group understands that it will be the Group's responsibility to maintain a minimum of 75% participation of eligible employees as enrolled with Blue Cross of Idaho.*

1. The Group certifies that it is not contributing to any other group or individual health/dental program that an employee or dependent may be participating in. At the time of this application, the Group represents that it has:

Determining Group Size (D is 50 or fewer = small group, D is 51+ = large group)

A. Total number of employees including owners 130 (A)

B. Total part-time employees (Not eligible employees) 25 (B)

C. Number of full-time employees in probationary period (Not eligible employees) 0 (C)

D. Subtotal of B + C then subtract from A. (this determines group size) 105 (D)

Determining Participation

A. Number of waivers from eligible employees with qualifying existing coverage 34 (A)

B. Number of employees from D of "Determining Group Size" minus A of this section 105 (B)

C. Number of waivers from eligible employees without qualifying existing coverage 0 (C)

D. Number of employees applying for enrollment under the contract (B minus C) 71 (D)

E. D divided by B – participation percentage 67 %(E)

Contribution — *The Group agrees to make the following employer contribution toward premiums:*

The Group agrees to make the following employer contribution toward premiums:

100 % per employee 0 % per dependent

Employers are required to contribute at least 50% of the monthly premium rate for employees. Contribution toward monthly premium for dependents is recommended.

Probationary Period

The probationary period to be served by new employees will be: 0 days (Under ACA this cannot exceed 90 days. Blue Cross of Idaho standard is 60 days).
If the probationary period varies by class of employee, please explain:_____

Are you waiving the pro-period for the initial set-up of this group? ■ Yes ❑ No

Miscellaneous Information

Will this coverage be offered to employees as the sole health insurance option? ■ Yes ❑ No
If **NO**, what other carriers will be offered and how many employees are enrolled with each?

Carrier	Number of Employees	Carrier	Number of Employees

See Attached Quote Sheet

Benefit Options (continued)

Dental

Dental: ❑ Yes ❑ No
If **YES**, indicate desired program.

Dual:
❑ Yes ❑ No

Employee Enrollment:
❑ Identical/Integrated
❑ Standard/Non-integrated
❑ Non-standard/Dental Only

Dental Carryover:
❑ Yes ❑ No
(Not available on Dental Blue Connect or Voluntary)

Waive Waiting Periods for Initial Enrollment:
❑ Yes ❑ No

Healthy Rewards Dental
❑ Traditional Network ❑ PPO Network
Annual Maximum
❑ $1,000 ❑ $1,250 ❑ $1,500
Waiting periods:
❑ Yes ❑ No

Preferred Dental
❑ $25 Deductible ❑ $50 Deductible
Annual Maximum
❑ $1,000 ❑ $1,250 ❑ $1,500
Waiting periods:
❑ Yes ❑ No

Dental Blue Connect
❑ Valley
❑ Hills
❑ Highland

Optimal Dental
❑ Yes ❑ No
Waiting periods:
❑ Yes ❑ No

Expanded Preferred Dental
❑ $25 Deductible ❑ $50 Deductible
Annual Maximum
❑ $1,000 ❑ $1,250 ❑ $1,500
Waiting periods:
❑ Yes ❑ No

Orthodontia ❑ Yes ❑ No
❑ Child only ❑ Adult and child
Lifetime Maximum:
❑ $1,000 lifetime maximum
❑ $1,250 lifetime maximum
❑ $1,500 lifetime maximum
Waiting periods:
❑ No waiting period
❑ 12-month waiting period not available for Voluntary Dental
❑ 24-month waiting period
Orthodontia is available for groups with 20 or more enrolled contracts.

Voluntary Dental (No choice of closed list)
Deductible
❑ $25 in-network / $50 out-of-network
❑ $50 in-network / $75 out-of-network

Orthodontia (optional)
❑ Child Only
❑ Child and Adult

Annual Maximum
❑ $1,000 ❑ $1,250 ❑ $1,500
Waiting periods apply

Vision (VSP) *(Issued separately for HSA Blue℠ PPO)*

Standard	Voluntary
❑ Plan CI (12/12/12) ❑ Plan CII (12/12/12) ❑ Plan CIII (12/12/12)	❑ Plan V1 $10/$25 (12/12/12) ❑ Plan V2 $20/$25 (12/12/12) ❑ Plan V3 $10/$25 (12/12/24) ❑ Plan V4 $20/$25 (12/12/24)

Ancillary Products (Consumer Driven Health Plans)

Health Reimbursement Arrangement (HRA)	Flexible Spending Account (FSA)
❑ No ■ Yes	■ No ❑ Yes If YES, choose one or more below:
Health Savings Account	**Ways to Save**
❑ No ■ Yes	■ No ❑ Yes

Employee Assistance Program

■ Yes ❑ No If Yes, number of visits 4

Does Blue Cross of Idaho bill for EAP? ■ Yes ❑ No

Letter of Record

This is to certify that _____

(Insurance Agent)

If more than one agent, please indicate:

Primary Agent _____ Split % _____

Secondary Agent _____ Split % _____

Split percentage must equal 100% has been appointed as Agent of Record for the company named below, for matters relating to group accident and health care coverage.

This appointment is continuous until:

a. another agent is appointed,
b. the above-named agent is terminated by the group, or
c. the above-named agent no longer has a "company appointment" with Blue Cross of Idaho.

At its discretion, Blue Cross of Idaho may accept the requested change of agent and notify the prior agent of record, the group, and the newly appointed agent of record that commissions will be payable to the new agent of record on the first day of the month following receipt of confirmation of the new appointment from a duly authorized officer of the group.

Blue Cross Broker Number: _____

Idaho License Number: _____

Agent Email Address: _____

Mailing Address: _____

City, State, Zip Code: _____

Business Telephone: _____

We certify that the information provided is accurate to the best of our knowledge.

Authorized Group Representative (Print name) Nathan Weeks	Title Business Manager
Authorized Group Representative's Signature Nathan Weeks	Date 6/14/2024
Independent Producer (Print name)	Blue Cross of Idaho Number
Independent Producer's Signature	Date