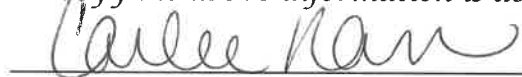


Agenda Summary Report (ASR)

Franklin County Board of Commissioners

DATE SUBMITTED: 10/12/2021	PREPARED BY: Carlee Nave
Meeting Date Requested: 10/19/2021	PRESENTED BY: Carlee Nave
ITEM: (Select One) <input checked="" type="checkbox"/> Consent Agenda <input type="checkbox"/> Brought Before the Board Time needed:	
SUBJECT: United Healthcare Group Membership Application	
FISCAL IMPACT: Budgeted expense for employee benefits, currently \$1,006.61/month for medical and dental coverage. This requested action does not have a fiscal impact, as it does not modify the County's contribution to employee benefits coverage.	
BACKGROUND: On 10/5/2021, the Board gave consensus approval to move forward with United Healthcare plans for 2022 employee medical and dental insurance. The Employer Application for Large Group is the document required to execute the group policy. The required disclosures indicated on page 3 of the Application will be attached before transmittal to United Healthcare as they contain Protected Health Information (PHI).	
RECOMMENDATION: Approve the resolution authorizing the Chair to sign the Employer Application as the Group's representative.	
COORDINATION: C Hanks at Conover insurance completed the Application in partnership with C Nave, HR Director. The Application has been reviewed and approved as to form by J Johnson, Chief Civil Deputy Prosecuting Attorney/Risk Manager	
ATTACHMENTS: (Documents you are submitting to the Board) <ol style="list-style-type: none">1. Resolution2. United Healthcare Employer Application for Large Group	
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

***UNITED HEALTHCARE GROUP MEMBERSHIP APPLICATION FOR 2022 EMPLOYEE
MEDICAL AND DENTAL INSURANCE***

WHEREAS, the Board of Franklin County Commissioners has selected United Healthcare plans for 2022 employee medical and dental insurance; and

WHEREAS, United Healthcare requires an Employer Application for new plans; and

WHEREAS, the Employer Application for Large Group is the required document to execute the plans as approved by the Board; and

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

NOW, THEREFORE, BE IT RESOLVED the United Healthcare Employer Application for Large Group 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 United Healthcare Employer Application for Large Group as the Group's Representative.

APPROVED this ____ day of _____, 2021.

BOARD OF COUNTY COMMISSIONERS
FRANKLIN COUNTY, WASHINGTON

Chair

Chair Pro Tem

Member

ATTEST:

Clerk to the Board

Employer Application for Large Group

Washington

To avoid processing delays, please make sure you:

1. Answer all questions completely and accurately.
2. **DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**
3. Include a deposit check in the amount of any required premiums; such amount will be returned in the event coverage does not become effective and will be applied against the first month's premium if coverage does become effective.



- UnitedHealthcare Insurance Company
- UnitedHealthcare of Washington, Inc.

Requested Effective Date 1/1/2022

General Information					
Group's/Company's Legal Name Franklin County					
Group name to appear on ID card (maximum 30 characters) F r a n k l i n C o u n t y					
Street Address 1016 North Fourth Avenue				Tax ID 91-6001315	
City Pasco	State WA	Zip Code 99301	Names of Owners/Partners (if applicable)		Internet Access? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Contact Person Carfee Nave		Email Address hr@franklin.co.us			# of Years in Business 137
Billing Address (if different)			Telephone (509) 546-5813	Fax (509) 546-5814	
Multi-location group/company?* <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	# of Locations	Address(es) (or list on additional sheet of paper)			
Organization Type <input type="checkbox"/> Partnership <input type="checkbox"/> C-Corp <input type="checkbox"/> S-Corp <input type="checkbox"/> LLC <input type="checkbox"/> LLP <input type="checkbox"/> Sole Proprietor <input checked="" type="checkbox"/> Other County	Nature of Business Governmental Agency			Industry Code 9199	
Waiting Period for new hires (Waiting period for medical coverage cannot exceed 90 days) <input checked="" type="checkbox"/> 1st of Policy Month following Date of Hire <input type="checkbox"/> 1st of Policy Month following _____ <input type="checkbox"/> months <input type="checkbox"/> days of employment <input type="checkbox"/> Date of Hire (no waiting period) <input type="checkbox"/> _____ <input type="checkbox"/> months <input type="checkbox"/> days of employment following Date of Hire			Waiting Period waived for initial enrollees <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Medical Benefit Plan Option <input checked="" type="checkbox"/> Calendar Year <input type="checkbox"/> Policy Year
Number of Persons currently on COBRA/Continuation and/or Short/Long Term Disability (employees/dependents) i-Cobra		Number of Employees Termined in last 12 Months 38		Classes Excluded: <input checked="" type="checkbox"/> None <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Non-Management <input type="checkbox"/> Salary	
Have Workers' Comp? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Name of Workers' Compensation Carrier State of Washington			Mandated offer for TMJ <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Names of Owners/Partners not covered by Workers' Compensation NA					

*If the majority of your employees are not located in your state of application, UnitedHealthcare policies and/or state law may require that your policy be written out of a different state and/or that your benefit plans vary.

Participation	# Employees Applying for:	# Employees Waiving for:	Contribution	Employer %	Employer % for Dep
# Eligible Employees	257	Medical 197	Medical 60	945.00/949.99	
# Ineligible Employees		Dental 229	Dental	61.61	
Total # Employees		Vision	Vision		
# Hours per week to be eligible		Basic EE Life/AD&D	Basic EE Life/AD&D	na	
		Basic Dep Life	Basic Dep Life	na	
# Hours per week to be eligible for Disability coverage if different from above **		Supp EE Life/AD&D	Supp EE Life/AD&D	na	
		Supp Dep Life/AD&D	Supp Dep Life/AD&D	na	
**For Disability products the minimum # of work hours per week to be eligible is 30 hours.		STD	STD	na	
		STD Buy Up***	STD Buy Up***	na	
		LTD	LTD	na	
*** Only available to Groups with 100+ Eligible Employees		LTD Buy Up***	LTD Buy Up***	na	
		Voluntary AD&D***	Voluntary AD&D***	na	
	Other	Other	Other		

Coverage provided by "UnitedHealthcare and Affiliates":
 Medical coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of Washington, Inc.
 Dental coverage provided by UnitedHealthcare Insurance Company.
 Life, Short-Term Disability (STD) and Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
 Vision coverage provided by UnitedHealthcare Insurance Company

UnitedHealthcare Insurance Company
 185 Asylum Street
 Hartford, Connecticut 06103-3408
 UnitedHealthcare of Washington, Inc.
 PO Box 6092
 Cypress, CA 90630-0092

General Information (continued)

Enter the Prior Calendar Year Average Total Number of Employees **302** Under Health Care Reform law, the number of employees means the average number of employees employed by the company during the preceding calendar year. An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage.

To calculate the annual average, add all the monthly employee totals together, then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the number of employees at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).

Enter the Prior Calendar Year Total Number of Eligible Employees **257** For purposes of determining your number of eligible employees, Eligible employees are those who are eligible to enroll in any medical plan you offer, even if they aren't eligible to enroll in a UnitedHealthcare plan. Here you may add COBRA and retirees.

Calculate your number of eligible employees from the preceding calendar year: (1) Count the total number of eligible employees at the end of each month (2) Add all the monthly eligible totals from line (1) and divide by 12. Use whole numbers only (no decimals, fractions or ranges and round down).

Enter the Prior Calendar Year Full Time Equivalent Total Number of Employees **257** For purposes of determining your number of full-time equivalent employee count, the number of employees means the average number of employees employed full-time (at least 30 hours/week in any given month), by the company on business days during the preceding calendar year.

In addition to the number of full-time employees noted above, for any month otherwise determined, include for such month the number of full-time employees divided by the aggregate number of hours of service of all employees who are not full-time employees for the month by 120. Employers should exclude employees who were seasonal workers who worked 120 days or fewer in the preceding calendar year.

Yes No Subject to ERISA? (Most private sector plans are ERISA plans)
 If No, please indicate appropriate category:
 Church (Additional information needed) Federal Government
 Indian Tribe – Commercial Business Non-Federal Government (State, Local or Tribal Gov.)
 Foreign Government/Foreign Embassy Non-ERISA Other

Yes No In the past 36 months, has the Group/Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)

Yes No In the past 36 months, has any creditor filed or threatened to file a petition requesting the Group/Company or any affiliated entity be placed voluntarily into bankruptcy?

Yes No Does your group sponsor a plan that covers employees of more than one employer?
 If you answered Yes, then indicate which of the following most closely describes your plan:
 Professional Employer Organization (PEO) Multiple Employer Welfare Arrangement (MEWA)
 Taft Hartley Union Governmental
 Church Employer Association

Yes No Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) or client-site employee(s)?
 If you answered Yes, then by signing this application you agree with the certification in this section.
 I hereby certify that my company is a PEO, ELC or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that UnitedHealthcare will not cover the co-employees under this group policy.

Yes No Do you currently utilize the services of a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), Staff Leasing Company, HR Outsourcing Organization (HRO), or Administrative Services Organization (ASO)?

Yes No Do you have common ownership with any other businesses? If you own multiple companies, or a parent-subsidiary relationship exists between your company and another, this may indicate common ownership of businesses.

UnitedHealthcare's Leave of Absence (LOA) Policy; Eligibility for Medical Coverage
 If the employee is on an employer approved leave of absence and the employer continues to pay required medical premiums, the coverage will remain in force for: (1) No longer than 13 consecutive weeks for non-medical leaves (i.e. temporarily laid-off). (2) No longer than 26 consecutive weeks for a medical leave. Coverage may be extended for a longer period of time, if required by local, state or federal rules.

If the employee's medical coverage terminates under this LOA policy, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage)?
 Yes, we continue medical coverage during an approved leave of absence for full time* employees (as defined on page 1).
 No, we do not offer medical coverage during a leave of absence.

HRA and Supplemental Insurance Information

Health Savings Account (if selected): Which bank will be used: OptumBank Other
Do you currently offer or intend to offer a Health Reimbursement Account (HRA) plan and/or comprehensive supplemental insurance policy or funding arrangement in addition to this UnitedHealthcare medical plan?

Answers must be accurate whether purchased from UnitedHealthcare or any other insurer or third party administrator.
 HRA Yes No
 If yes, please identify type: UnitedHealthcare HRA (any HRA design offered through UnitedHealthcare) Other Administrator HRA
 HRA plans administered by other insurers or third party administrators must comply with UnitedHealthcare HRA design standards.
 Comprehensive Supplemental Insurance Policy or Funding Arrangement Yes No

If you answered "Yes" to either question above, you must choose from the list of UnitedHealthcare HRA-eligible medical plans as shown to you by your broker or agent. Other plans are not eligible for pairing with these arrangements. Purchase of such arrangements at any point during the duration of this policy will require you to notify UnitedHealthcare.

Group Name Franklin County

HRA/HSA Employer Premium Contribution

	Option #1	Option #2	Option #3
Medical Plan			
Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA/HSA Employer Account Funding Amount

Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA / HSA Account Administrator:

Are there any other contributions or benefit reimbursements allowed? Yes No

Who will provide account balances to UnitedHealthcare?

Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare coverage in the last 12 months?
 Yes No If Yes, please provide policy number _____ and Coverage Begin Date ____/____/____ End Date ____/____/____

Has this group been covered for major dental services for the previous 12 consecutive months? Yes No

		Name of Carrier	Initial Coverage Begin Date	Coverage End Date
Current Medical Carrier	<input type="checkbox"/> None	Premera BlueCross	01/01/18	12/31/21
Current Dental Carrier	<input type="checkbox"/> None	Premera Blue Cross	01/01/18	12/31/21
Current Life Carrier	<input type="checkbox"/> None			
Current Disability Carrier	<input type="checkbox"/> None			
Current Vision Carrier	<input type="checkbox"/> None			

Disclosures

If you are applying for medical coverage, please answer the following questions to the best of your knowledge by referencing available employee records and other personnel documents for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses, and dependent children) to the extent permitted by applicable law. UnitedHealthcare is only seeking to collect information about the current health status of those employees and their dependents who are applying for coverage. In answering these questions, do not include any genetic information about your employees or their dependents, including requests for genetic services, genetic diseases for which they may be at risk or family medical history information.

Please provide details to "Yes" answers in the space provided.

IMPORTANT: Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

- Yes No 1. Within the past 3 years, has any employee or dependent filed a claim for short-term disability, long term disability, social security disability income, workers' compensation, Medicare, or Medicaid benefits or any other type of disability benefits on any policy?
- Yes No 2. During the past 3 years, has any employee or dependent had life, disability or health insurance declined; postponed, changed, cancelled or withdrawn?
- Yes No 3. Except for a maternity or paternity leave, within the past 3 years, has any employee applied for a family or medical leave of more than 2 weeks due to injury, disability or illness of the employee or dependent?
- Yes No 4. Within the past 3 years, has any employee been absent from work for more than 2 consecutive weeks due to injury, disability or illness?
- Yes No 5. Except for a mental health admission, during the past 3 years, has any employee or dependent had a hospital stay lasting more than 5 days or is any employee or dependent contemplating treatment that would require hospitalization for more than 5 days?
- Yes No 6. Is any employee or dependent currently hospitalized?
- Yes No 7. Within the past 3 years has any employee or dependent been diagnosed, treated for, or received prescription medication for one of the following conditions? *See Attached List*
- | | |
|---|--|
| <input type="checkbox"/> Cancer (any type) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Lung disease or respiratory problem (any type) | <input type="checkbox"/> Morbid obesity |
| <input type="checkbox"/> Heart disease or disorder (any type) | <input type="checkbox"/> Congenital abnormality |
| <input type="checkbox"/> Organ, tissue or cell transplant | <input type="checkbox"/> Vascular disease (any type) |
| <input type="checkbox"/> Liver disease (any type) | <input type="checkbox"/> Neurological disorder (any type) |
| <input type="checkbox"/> Kidney disease (any type) | <input type="checkbox"/> Immunological disorder (reportable types) |
| <input type="checkbox"/> Pancreatic disorder (any type) | <input type="checkbox"/> Alcohol or drug addiction or abuse |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia or Blood disorder (any type) |

If you have answered "Yes" to any of the questions above, please provide the requested information on the next page for each individual. If necessary, use additional sheets of paper.

Group Name Franklin County

Producer Information (if applicable)			
Producer Name Dave Guyll	Agency HUB International Northwest LLC	Agent Code/Tax ID Number 91-2036015	
Email Address dave.guyll@hubinternational.com		Social Security#	Phone Number (509) 543-6420
All Payments to: HUB International Northwest LLC		Producer Commission Schedule (if applicable) _____ Std Scale of _____ %	
Street Address 1804 W. Lewis Street	City Pasco	State WA	Zip Code 99301
Producer Signature <i>Dave A. Guyll</i>		Date 10/12/2021	
Rep Name		Rep #	

General Agent Information (if applicable)			
General Agent	Phone #	Franchise Code	
Street Address	City	State	ZIP Code