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12/3/24

Wellmark

Wellmark Blue Cross and Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association.

Self Funded FINAL Renewal Rates

Group Name: *Woodbury County*

Account Key: *00017570*

Renewal Period: *01/01/2025 to 12/31/2025*

Current Benefit Offerings	Current Enrollment	Stop Loss Terms
OBS #189438-127 / 189438-128 (MV3)	19 Single	Contract: 96/12
Wellmark Blue HMO	22 Family	Monthly Aggregate Option: No
Deductible: $250 / $500		Payment Terms: Actual Weekly
Coinsurance: 10%		
OPM: $750/$1,250	41 Total	
Office Visit Copay: See OBS		
BlueRx Value Plus		
Deductible: $250/$500		
Copay: $6/$25/$50		
Coinsurance: 20%/20%/20%		

	Level	Fee/Contract	Estimated Annual Premium Based on Current Enrollment
Individual Stop Loss	$100,000	$226.51	$111,443
Aggregate Stop Loss	125%	$4.86	$2,391
Administrative Fees - Health	w/weekly settlement	$49.69	$24,447
Administrative Fees - PBM		$1.10	$541
Consultant Fee		$0.00	$0
Total Administrative Fees		$282.16	$138,823
Network Access Fee		$11.26	$5,540

	Single	Family	Annual Projection
Expected Claims	$777.86	$1,944.65	$690,740
Admin, NAF & Stop Loss Fees	$140.37	$350.93	$124,650
Estimated Suggested Rates*	$918.23	$2,295.58	$815,390
Attachment Points	$972.32	$2,430.80	$863,420
Admin, NAF & Stop Loss Fees	$140.37	$350.93	$124,650
Estimated Max Liability to Fund*	$1,112.69	$2,781.73	$988,070

*Actual results may vary. Also, rates provided include administrative costs based on the entire group population.
Individual Stop Loss includes coverage for Health and Drug and is based on a lifetime maximum of unlimited.
Aggregate Stop Loss includes coverage for Health and Drug. The maximum Aggregate reimbursement is unlimited.

Employer Signature: _____ Date: 12-3-24

Comments:

Wellmark

Independent Licensee of the Blue Cross and Blue Shield Association

Self Funded FINAL Renewal Rates

Group Name: *Woodbury County*

Account Key: *00017570*

Renewal Period: *01/01/2025 to 12/31/2025*

Current/Renewal Benefits

OBS #189438-125 / 189438-126 (MV3)
Alliance Select
Deductible: $250 / $500
Coinsurance: 10% / 20%
OPM: $750/$1,250
Office Visit Copay: $20
BlueRx Complete
Deductible: $250/$500
Copay: $6/$25/$50
Coinsurance: 20%/20%/20%

Current Enrollment

87 Single
260 Family

347 Total

Stop Loss Terms

Contract: 96/12
Monthly Aggregate Option: No
Payment Terms: Actual Weekly

	Level	Fee/Contract	Estimated Annual Premium Based on Current Enrollment
Individual Stop Loss	$100,000	$226.51	$943,188
Aggregate Stop Loss	125%	$4.86	$20,237
Administrative Fees - Health	w/weekly settlement	$49.69	$206,909
Administrative Fees - PBM		$1.10	$4,580
Consultant Fee		$0.00	$0
Total Administrative Fees		$282.16	$1,174,914
Network Access Fee		$11.26	$46,887

	Single	Family	Annual Projection
Expected Claims	$880.43	$2,201.08	$7,786,539
Admin, NAF & Stop Loss Fees	$140.38	$350.95	$1,241,520
Estimated Suggested Rates*	$1,020.81	$2,552.03	$9,028,059
Attachment Points	$1,100.54	$2,751.35	$9,733,176
Admin, NAF & Stop Loss Fees	$140.38	$350.95	$1,241,520
Estimated Max Liability to Fund*	$1,240.92	$3,102.30	$10,974,696

*Actual results may vary. Also, rates provided include administrative costs based on the entire group population.
Individual Stop Loss includes coverage for Health and Drug and is based on a lifetime maximum of unlimited.
Aggregate Stop Loss includes coverage for Health and Drug. The maximum Aggregate reimbursement is unlimited.

Employer Signature: _____ Date: 12-3-24

Comments:

ACCOUNT INFORMATION AND BINDER AGREEMENT

WOODBURY COUNTY	1/1/2025	00017570	0000XA117
Account Legal Name	Effective Date	Account Key	Group Number

Physical Address

620 DOUGLAS ST RM 701		
Address Line 1	Address Line 2	
SIOUX CITY	IA	51101
City	State	Zip

Billing Address (if different than physical address)

☐ Alternate Location ☐ 3rd Party Billing Service *(If checked, account acknowledges the Wellmark Group Statement or premium invoice, delivered periodically to any third party service provider, can be viewed by account, by registering for electronic billing at Wellmark.com.)*

Address Line 1	Address Line 2	
City	State	Zip

Authorized Health Plan Representatives

An authorized health plan representative is an employee of the **Account** (not the Producer) who is authorized to request and receive the minimum necessary protected health plan information about the group health plan's members in order to perform their day-to-day job functions of administering benefits for participants of the plan. The following individual employees are authorized health plan representatives.

1/1/25
Effective Date

Name	Title	Email	Phone
LISA ANDERSON	HR SECRETARY	lisaanderson@woodburycou	

Authorized Health Plan Representatives (continued)

Name	Title	Email	Phone
Melissa Thomas	HR Director	melissathomas@woodbury	712-279-6470

Producer Designation

No Consultant Designated

Account requests that Wellmark recognize the following individual and firm as the designated employee benefits and insurance producer.

Designation of Producer Effective Date

Primary Producer Name | Producer Firm Name | Producer Number

Producer Firm Address 1 | City | Zip

State

Primary Contact Name | Email | Phone

Authorization to Release Group Health Plan Information and Protected Health Information to Consultant

By signing below, the Employer hereby authorizes and directs Wellmark, Inc. to disclose to the above, designated Consultant certain group health plan information and Protected Health Information regarding participants in the employer-sponsored group health plan for the purpose of the Consultant's administration of the Employer's group health plan. The Employer authorizes Wellmark to disclose such information via secure online access through Wellmark's website, including the following website applications which contain information the Employer considers necessary to provide to the Consultant in order to conduct operations of the Employer's group health plan:

- Member Maintenance/Update Member Information
- Employer Reports
- Update Other Insurance Information/Coordination of Benefits
- Check Claims Status
- eBilling Services
- Eligibility Verification Benefits Information (EVBI)

☐ Yes, I authorize my Consultant to access this information.

By signing below, the Employer authorizes Wellmark to provide the Consultant access to this information on an ongoing basis without further authorization. The Employer represents and agrees that 1) The Consultant is considered a Business Associate of the Employer, not Wellmark, Inc., 2) The information to be disclosed is considered confidential, 3) The Consultant has provided satisfactory assurance to the Employer that the Consultant will properly safeguard and not further disclose the information, 4) Wellmark shall not be liable or responsible for any misuse or wrongful disclosure of such information by the Employer or its Consultant, 5) The Employer agrees to indemnify and hold Wellmark harmless from and against any claim, cause of action, liability, damage, cost or expense, including attorney's fees and court or proceeding costs, arising out of, or in connection with, any misuse or wrongful disclosure of the information by the Employer, or its Consultant. The Employer acknowledges that the Consultant will be required to agree to Wellmark's website terms and conditions upon registering for access to such information.

Producer Designation (continued)

☒ No, I do not authorize my Consultant to access this information.

Secondary Consultant

Secondary Consultant Name	Email Address	Phone

Authorization to Release Protected Health Information for Third-Party Explanation of Benefits

Not Applicable

General Account Information

Wellmark Account Manager	Rep ID#
MICHELLE L MOON	00000146

Contact Month	Plan Year Month	Unique Alpha Prefix
August	July	WCX

Employer Plan Type

- ☐ ERISA
- ☐ Church Plan
- ☐ Non-Federal Government Plan

Association

Form 5500 Plan Number

Wellmark **IS** the Exclusive Carrier

Enrollment Method: Blues Enroll; Paper

Open Enrollment Period*

**Enrollment Period is the period in which employees can enroll within a plan or plans, and/or when written application materials are provided to employees, if sooner.*

The account will hold an open enrollment: ☒ YES ☐ NO

If YES, fill in open enrollment period dates:

Starting date	Ending date
11/01/2025	11/30/2025

General Account Information (continued)

Funding Arrangement

☐ This self-funded account will be developing our own SBCs to distribute. (*If you modify or opt out of using the standard, Wellmark-provided SBCs, please be aware that Wellmark will not be able to retain or distribute your customized SBCs to your employees.*)

Self Funded	Wellmark	Actual Weekly Claims with Month-end Settlement
Funding Arrangement	Stop Loss Carrier	Self-Funded Payment Method

Terminal Rider applies: ☐ YES ☒ NO (If yes, Signed exhibit page attached.)

Value Based Program elected: ☐ YES ☒ NO

Carveout Rx Vendor

Product

☒ Health ☒ Pharmacy ☐ Dental

A group health plan may designate a state benchmark plan other than Iowa or South Dakota for purpose of determining compliance with essential health benefit (EHB) requirements.

Benchmark Exception for EHB? ☒ YES ☐ NO If yes, list State UTAH

Guarantees

See Attached Exhibit(s)

Not Applicable

Health Care Management Services

Not Applicable

Representation of Grandfathered Status under the Affordable Care Act

Not Applicable

Plan Year Designation

Your group health plan's designated plan year is significant for the implementation of ERISA, HIPAA, and ACA-provisions and guidelines. If no Plan Year Start Date is indicated, the plan year will default to the benefit year used under the plan, typically Jan. 1.

Plan Year Designation (continued)

ACA Plan Year Start Date	Document Source*

** Provide Document Source if Plan Year does not begin on the effective date of the annual renewal period.*

Common Credible Document Sources:

** 5500 Form (5500 Form must be filed for Health Plan)*
** 509 (a) Certificate filed by self-funded public bodies*
** Summary Plan Document (SPD) if Plan Year is defined*
** CMS Disclosure Form (if there is no contradictory Plan Year information within other Plan documents)*

COBRA

Not Applicable

This Large Group Account Information and Binder Agreement ("Binder Agreement") serves solely as evidence of Wellmark's agreement to provide the health insurance coverage or administrative services and to provide services for any applicable stop loss insurance coverage indicated above. The Account agrees to the terms and payment obligations stated herein and agrees to pay Wellmark the applicable rates, administrative fees, and/or stop loss premium stated in the attached documentation. Execution of the Binder Agreement by the Account authorizes Wellmark to implement the administration of this coverage including the processing and settlement of claims for members of the Account's group health plan incurred within the Rating Period stated in the attached Rating Exhibit. On or about the effective date of coverage, Wellmark shall issue and execute a definitive agreement which may be a Group Insurance Policy, Administrative Services Agreement and or Stop Loss Policy, depending on the nature of the group health plan. The definitive Agreement will set forth the rights and responsibilities of Wellmark and the Account. Account's payment to Wellmark of the applicable fees as of the effective date is evidence of Account's agreement to the terms specified in the definitive agreement.

Signatures on this Binder Agreement confirm that the Binder Agreement and the subsequent definitive agreement are issued for delivery in either Iowa or South Dakota, as applicable. Account understands and agrees that Wellmark defines a National Account as any company headquartered in Wellmark's service area of Iowa or South Dakota but which also has employees working at locations in other states whose claims are processed through the Blue Cross and Blue Shield Association's Blue Card program. If the Account is not headquartered in Wellmark's service area, coverage may be limited to employees associated with Account locations in Wellmark's service, and coverage will be void for any persons associated with Account locations outside Wellmark's Service Area unless express consent is obtained from the local Blue Cross or Blue Shield licensee.

Account acknowledges and agrees that it has reviewed and approved this Binder Agreement and all attachments. Account acknowledges Wellmark will rely on the information contained in this Binder Agreement, and all of the attachments hereto, including but not limited to the SBC Employer Data Form, Medicare Secondary Payer Addendum, Rate Exhibits, Health and Care Management rates, Online Benefit Summary (OBS), COBRA Agreements, representations of grandfathered status and any performance guarantee information. Account represents to Wellmark that the information contained herein is correct.

This Binder Agreement shall expire upon Wellmark's issuance and execution of the definitive agreement (either the Group Insurance Policy, or Administrative Services Agreement and Stop Loss Policy, if applicable), EXCEPT that any COBRA Agreements, Health and Care Management Programs/Services Rating Exhibit, will remain in effect and become a part of the definitive agreement. It is understood that the Wellmark may continue to rely on the designations of individuals and authorizations made herein until the Account withdraws such designations or authorizations or provides updated designations and authorizations. It is understood and agreed that the terms and conditions of the definitive agreement and benefits document(s) issued by Wellmark to the Account, and the terms and conditions of the definitive stop loss policy issued by stop loss carrier, if any, shall govern and control the terms stated in this Binder. Any inconsistency between this Binder Agreement, including attachments, and any subsequently issued definitive agreement(s) shall be construed in favor of the subsequently issued definitive agreement. This Binder Agreement shall be governed in accordance with Iowa Law.

ACCOUNT:

By (sign here)	Printed Name: Matthew Ulm
Title: Board Chairman	Date: 12-3-24

For Internal Use Only

Renewal-No Benefit Change

Notes

Wellmark.

Wellmark Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

FOR ADMINISTRATIVE USE ONLY
New Group: Group # _____
Coverage Effective Date: ____/____/____

CONFIRMATION OF MSP ADDENDUM

ALL NEW AND RENEWAL GROUPS ARE REQUIRED TO SUBMIT A COMPLETED FORM. FAILURE TO SUBMIT A COMPLETED FORM WILL DELAY THE INITIAL ENROLLMENT OR RENEWAL PROCESS UNTIL THIS FORM IS SUBMITTED.

Part A - Employer Information

Please complete a separate confirmation form for each Employer Tax Identification Number you use to report employee earnings to the Internal Revenue Service (IRS). See the Medicare Secondary Payer Definitions page (M-1756) for more information on terms shown in italics.

Employer Tax Identification Number: 4 2 6 0 0 5 2 2 1

Group Number (Renewing Groups Only): 0000XA117-0003;0000XA117-0011;0000XA117-0013;+Various

Employer Name: WOODBURY COUNTY

Employer Address: 620 DOUGLAS ST RM 701

City: SIOUX CITY State: IA Zip: 51101

Contact Person: _____

Telephone Number: _____ E-mail Address (optional): _____

1. Did your organization make contributions on behalf of any employee who was covered under a *collectively bargained Health and Welfare Fund* (i.e., union plan) during the previous calendar year? ☐ Yes ☒ No
2. Did you have 20 or more *employees* for 20 or more calendar weeks (this includes all full-time, *part-time,* intermittent, *leased* and/or seasonal employees, not just those eligible or enrolled employees) during the previous or current calendar year? If no, in the event you experience a change, you must notify Wellmark when this change occurs. ☒ Yes ☐ No
3. Did you have 100 or more *employees* during 50 percent of your business days (this includes all full-time, *part-time,* intermittent, *leased* and/or seasonal employees, not just those eligible or enrolled employees) during the previous calendar year? ☒ Yes ☐ No
4. Did your organization participate in a *multi* or *multiple employer group health plan* (more than one employer in group, i.e., Multiple Employer Welfare Association) during the previous calendar year? ☐ Yes ☒ No
   If yes, what is the name and address of the *multi* or *multiple employer plan?*
   Name: _____
   Address: _____
   City: _____ State: _____ Zip: _____
5. Was your organization part of a commonly owned or commonly controlled group of organizations during the previous calendar year? ☐ Yes ☐ No
   If yes, what is the name and address of the *commonly owned/controlled entity?*

Name: _____ Name: _____
Address: _____ Address: _____
City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Part B - Employer Certification

I certify that the information provided is accurate and truthful. All information will be used to identify the *Medicare Secondary Payer* status of *Medicare*-enrolled *employees.*

_____ 12 3 24
Signature Date

Send completed MSP form based on following:			
IA & SD Large Groups (new or renewal)	IA & SD Small Groups (new or renewing with benefit changes)	IA Small Groups renewing with no benefit change - send this form to:	SD Small Groups renewing with no benefit change
Submit this completed MSP form with group's health plan new or renewal paperwork	Submit this completed MSP form with group's health plan new or renewal paperwork	Fax: (515) 376-9044 or Wellmark, Inc. PO Box 9232 – Mail Station 3W396 Des Moines, IA 50306-9232	Send this completed MSP form to: Wellmark, Inc. PO Box 5023 – Station 338 Sioux Falls, SD 57117-5023