# Arkansas BlueCross BlueShield

# **EMPLOYER APPLICATION**

Blues Enroll

Renewal APPLICATION by: City of Jonesboro	Municipal Airport
(he	reinafter called "Policyholder")
Policyholder intends hereby to establish and main	Policyholder and the eligible dependents of such employees. The stain an employee benefit plan (the "Plan") for the Policyholder's employees of the Plan, and to actively promote the Plan to the Policyholder's employees
GROUP INFORMATION	
Legal Name of Business: CITY OF JONESBOR	RO
D/B/A: City of Jonesboro Municipal Airport	
Street Address: 4116 Linbergh Drive	
City, State, Zip: Jonesboro , AR , 72403	County: Craighead
Mailing Address: (if different from Street) P.O. &	Box 1293
City, State, Zip: Jonesboro , AR , 72403	
Telephone #: 870-933-4640	
Fax #: -	en e
Fed. Tax I.D #: 71-0028290	
Exec. Contact:	E-Mail:
Group Administrator: Gloria Roark	E-Mail:
Primary SIC Code: 9199 SIC Description:	General Government, NEC
Business Type: Government Entity	

# POLICYHOLDER AS PLAN ADMINISTRATOR

Agent's Tax Id:

The Policyholder, as Plan Administrator, assumes responsibility for the accuracy of information presented to Arkansas Blue Cross and Blue Shield ("ABCBS"), including all information on the employment status and eligibility of individuals to be covered under the Plan, as well as medical information provided with respect to each such individual. The Policyholder agrees that if misrepresentations are made in any of the information provided for rating or in this Group Application or any of the materials is submitted with it, including, but not limited to, individual applications and medical information, then ABCBS may cancel or rescind this Group Policy. The Policyholder further agrees that if misrepresentations or false or misleading information is inpresented in filing of any claims hereunder ("improper claims"), ABCBS may cancel or rescind the coverage of any individual involved in presenting such a claim. Further, ABCBS may cancel or rescind the entire Group Policy if the Policyholder or any representative of the Policyholder knew or should have known of the improper claims, or if the Policyholder's action or inaction contributed to presentation of improper claims.

Agent's Lic #:

#### **PROXY**

Agent:

Agent's Company:

The Policyholder hereby appoints the Board of Directors ("Board") of Arkansas Blue Cross and Blue Shield ("ABCBS"), as its proxy to act on its behalf at all meetings of members of ABCBS. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for the Policyholder on all matters that may be voted upon at any meeting. The annual meeting of Members is held each year at the home office of ABCBS located at 601 S. Gaines Street, Little Rock, Arkansas, on the third Monday of March, at 1:00 p.m. If the third Monday of March is a legal holiday, then the meeting will be at the same time and place on the next day after, which is not a legal holiday. A special meeting may be called upon notice mailed not less than ten (10) or more than sixty (60) days prior to such meeting. This proxy, unless revoked, shall remain in effect during the Policyholder's membership in ABCBS. The Policyholder may revoke this proxy in writing by advising ABCBS, attention Legal Division, of such at least five (5) days prior to any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Member's meeting.

#### BENEFIT SELECTION

PREFERRED PROVIDER ORGANIZATION (PPO) - PPO XXX - 1

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2012

Waiting Period Note: Effective Date is first of the month following the Waiting Period.

Date of Open Enrollment December

If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date

Class	Class Description	Waiting Period	Contribution		
1	Full Time	1 Month	Employee 71 %	Dependent 71 %	

Note: The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage of Employees' premium specified above.

#### Maximum Dependent Age 26

# Mandated Mental Health Parity: Yes

Please Indicate whether a HRA, or mechanisms utilized to reduce the employee's portion of health plan costs, is either in place or planned to be purchased. **No** 

Rates offered for this plan are contingent on assertions submitted by the insurance applicant (or its agent) that there is no HRA or other ifunding mechanism in place, nor intent to purchase such an arrangement. Upon evidence to the contrary, the group health plan is subject to termination.

!Deductible:	\$500	Deductible Carryover: No
Family Deductible:	3	Basis: Fulfillment
Coinsurance:	80%/60%	
In-Network Calendar Year Coinsurance Max:	\$2000	
Family Calendar Year Coinsurance Max:	[3	Basis: Fulfillment
Out-of-Network Calendar Year Coinsurance Max:	None	
Lifetime Maximum:	Unlimited	
Traditional Wellness		

Prescription Drug Rider Plan: \$10/\$30/\$50/100% Value Formulary

Mail Order Drug - 2x Copay (90 days)

Based on actuarial review, this drug benefit option is creditable to the standard Medicare Part D prescription coverage.

PPO Optional Benefits:	
Inpatient Copay - None	
Office Visit Copayment - \$30	Maternity - Elected
Blue Card	Supplemental Accidental
·	Endorsement - Declined
	ER Copayment - \$100

## Arkansas Mandated Offer Benefit Riders:

You Must Elect or Reject Each Rider:				
Mammography - Reject	Substance Abuse - Reject			
Psychiatric Condition - Reject	TMJ* - Reject			
Hearing Aid - Reject				

\*Rejection of the TMJ Benefit Rider means covered benefits provided to Covered Persons will <u>not</u> include temporomandibular Joint disorders (TMJ) or craniomandibular disorders.

RATES - PPO XXX - 1		
Two Tier Composite	Total Premium	
Employee	\$321.18	
Family	\$690.02	
compensation is included in the premium involved in this transaction, please direct	paid by the covered person. For more information on the compensation your inquiry to the agent or broker.	
Grandfather Status - Our records indica	le that your health plan is grandfathered.	
Please confirm if you agree with the g	randfathered status as indicated above.	
Yes, I agree with the status as shown		
No, I disagree with the status as show	n because	

	Company of the Compan
Group health plans for employers with 20 or more employees on more than 50% of the business days in calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vertex to assist you in administering Cobra (no additional cost).  Both full time and part time employees are counted to determine if a plan is subject to Cobra. Each partemployee counts as a fraction of an employee, with the fraction equal to the number of hours worked disnumber of hours used to determine full time status.  (Yes (No) Under the governmental guidelines the group health plan is subject to Cobra, in criteria for 20 or more employees.	period during ndor, "Ceridian", t-time vided by the
(Yes <u>√</u> )(No) If yes, do you wish to use the services of Ceridian?	
(res - )(NO) if yes, do you wish to use the services of Cendian?	
If no, who will administer Cobra for you?	
*Medical Loss Ratio - The determination of Large and Small Groups is based upon the average number semployed by the employer on business days during the proceeding calendar year. The Public Health See \$2791(e) provides	, ,
;(1) The term "large employer" means, in connection with a group health plan with respect to a calendar liyear, an employer who employed an average of at least 51 employees on business days during the preciper and who employs at least 2 employees on the first day of the plan year.	
(2) The term "small employer" means, in connection with a group health plan with respect to a calendar plan year, an employer who employed an average of at least 1 but not more than 50 employees on busi during the preceding calendar year and who employs at least 1 employees on the first day of the plan year.	iness days
The policyholder is a large employer small employer (check one).	

ATTESTATIONS

Under the Medicare Secondary Payer Rules, it is the Employer's responsibility to annually inform Arkansas Blue Cross of proper employee counts for the purpose of determining payment priority between Medicare and Arkansas Blue Cross. Arkansas Blue Cross is required to furnish these counts to the Centers for Medicare and Medicaid Services (CMS).

Full-Time = means an active employee with a minimum of 30 hrs/week & 48 weeks/year			
	in State	Out of State	Total
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):	/	,	/
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):			The manufacture of the second
COBRA Continuees (Enrolling):			[
Life ONLY Contracts:	,	··· [	
Total Enrolling and Waiving:	Programme and the second		
Part Time/Seasonal/Temporary Employees :	-		
Total # of Employees:	THE RESERVE		7

Minimum Number of Insured Employees. To meet large group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal.

Minimum Participation Requirements. Employees covered through other comprehensive major medical-type coverage may be waived from the eligibility count. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

This Policy may be terminated by the Company if the number of insured Employees falls below the minimum number of insured Employees specified above or if the percentage of eligible Employees of the Policyholder covered by the Policy becomes less than the percentage of Employee participation specified above.

Special Group Considerations Form# 23-2546, Description Alternate eligibility hours(40 hours/week)

Special Group Considerations Form# 23-2186, Description No Deductible Carryover

Special Group Considerations Form# 23-2242, Description \$100 ER co-pay

# SIGNATURES

This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the United States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate.

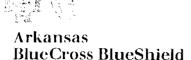
I hereby renew the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies renewed, will take effect as of the renewal date, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly

•	an application for insurance is guilty of a crime and may be s and confinement in prison.	Э
Signed at (City, State), this	7 day of <u>alse</u> 2011	
and I know nothing unfavorable about this firm or any applications). I have complied with the underwriting ruthe member firm and its employees including the pres	In this employer application is correct to the best of my knowledge individual proposed for coverage (except as noted on the employules and regulations and have explained in detail the coverage to existing condition limitations and the qualifications of the effectives and Blue Shield will have no liability until this application has	/ee
1212	23908	_
gent Signature	Insurance License # / Agency Fed. Tax ID #	
DAVID C. FERBUSON		_

Date

Agent Printed Name



# **EMPLOYER APPLICATION**

Blues Enroll

Renewal APPLICATION by: City of Jonesboro	Urban Renewal & Housin
(he	ereinafter called "Policyholder")
Policyholder intends hereby to establish and mai	Policyholder and the eligible dependents of such employees. The ntain an employee benefit plan (the "Plan") for the Policyholder's employees of the Plan, and to actively promote the Plan to the Policyholder's employees.
GROUP INFORMATION	
Legal Name of Business: CITY OF JONESBO	RO
D/B/A: City of Jonesboro Urban Renewal & Ho	pusin
Street Address: 330 Union Street	
City, State, Zip: Jonesboro , AR , 72401	County: Craighead
Mailing Address: (if different from Street) 330 U	Jnion Street
City, State, Zip: Jonesboro , AR , 72401	The second secon
Telephone #: 870-935-9800	
Fax #: -	THE SECOND SECON
Fed. Tax I.D #: 71-0024703	
Exec. Contact:	E-Mail:
Group Administrator: Janice Grissum	E-Mail:
Primary SIC Code: 9199 SIC Description	: General Government, NEC
Business Type: Government Entity	
Agent:	Agent's Lic #:
Agent's Company: Agent's Tax Id:	AND A SECOND CONTRACTOR OF THE PROPERTY OF THE

#### POLICYHOLDER AS PLAN ADMINISTRATOR

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# PROXY

The Policyholder hereby appoints the Board of Directors ("Board") of Arkansas Blue Cross and Blue Shield ("ABCBS"), as its proxy to act on its behalf at all meetings of members of ABCBS. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for the Policyholder on all matters that may be voted upon at any meeting. The annual meeting of Members is held each year at the home office of ABCBS located at 601 S. Gaines Street, Little Rock, Arkansas, on the third Monday of March, at 1:00 p.m. If the third Monday of March is a legal holiday, then the meeting will be at the same time and place on the next day after, which is not a legal holiday. A special meeting may be called upon notice mailed not less than ten (10) or more than sixty (60) days prior to such meeting. This proxy, unless revoked, shall remain in effect during the Policyholder's membership in ABCBS. The Policyholder may revoke this proxy in writing by advising ABCBS, attention Legal Division, of such at least five (5) days prior to any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Member's meeting.

#### BENEFIT SELECTION

PREFERRED PROVIDER ORGANIZATION (PPO) - PPO XXX - 1

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2012

Waiting Period Note: Effective Date is first of the month following the Waiting Period.

Date of Open Enrollment December

If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date

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Class	Class Description	Waiting Period	Contribution		-
1	Full Time	1 Month	Employee 71 %	Dependent 71 %	-

Note: The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage of Employees' premium specified above

#### Maximum Dependent Age 26

# Mandated Mental Health Parity: Yes

Please Indicate whether a HRA, or mechanisms utilized to reduce the employee's portion of health plan costs, is either in place or planned to be purchased.

Rates offered for this plan are contingent on assertions submitted by the insurance applicant (or its agent) that there is no HRA or other funding mechanism in place, nor intent to purchase such an arrangement. Upon evidence to the contrary, the group health plan is subject to termination.

Deductible:	\$500	Deductible Carryover: No
Family Deductible:	3	Basis: Fulfillment
Coinsurance:	80%/60%	
In-Network Calendar Year Coinsurance Max:	\$2000	
Family Calendar Year Coinsurance Max:	3	Basis: Fulfillment
Out-of-Network Calendar Year Coinsurance Max:	None	
Lifetime Maximum:	Unlimited	700 PE 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Traditional Wellness		many file college. All the file is many and college in the college in the college of a part of the temperature and the college of the college in the college

Prescription Drug Rider Plan: \$10/\$30/\$50/100% Value Formulary

Mail Order Drug - 2x Copay (90 days)

Based on actuarial review, this drug benefit option is creditable to the standard Medicare Part D prescription coverage

# PPO Optional Benefits:

Inpatient Copay - None

Office Visit Copayment - \$30

Blue Card

Maternity - Elected

Supplemental Accidental Endorsement - Declined

ER Copayment - \$100

# Arkansas Mandated Offer Benefit Riders:

# ************************************				
You Must Elect	or	Reject	Each	Rider:

'Mammography - Reject Substance Abuse - Reject TMJ\* - Reject Psychiatric Condition - Reject

Hearing Aid - Reject

\*Rejection of the TMJ Benefit Rider means covered benefits provided to Covered Persons will not include temporomandibular Joint disorders (TMJ) or craniomandibular disorders

	RATES - PPO XXX - 1
Two Tier Composite	Total Premium
Employee	\$321.18
Family	\$690.02
compensation is included in the premium paid involved in this transaction, pleasedirect your	by the covered person. For more information on the compensation inquiry to the agent or broker.
Grandfather Status - Our records indicate tha	at your health plan is grandfathered
Please confirm if you agree with the grand	stathered status as indicated above.
<b>V</b> es, I agree with the status as shown.	
No, I disagree with the status as shown be	cause

COBRA
Group health plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during
which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, "Ceridian", to assist you in administering Cobra (no additional cost).
Both full time and part time employees are counted to determine if a plan is subject to Cobra. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours worked divided by the number of hours used to determine full time status.
(Yes <u>v</u> ) (No_) Under the governmental guidelines the group health plan is subject to Cobra, meeting the criteria for 20 or more employees.
(Yes_)(No_) If yes, do you wish to use the services of Ceridian?
If no, who will administer Cobra for you?
Medical Loss Ratio - The determination of Large and Small Groups is based upon the average number of employees employed by the employer on business days during the proceeding calendar year. The Public Health Services Act §2791(e) provides
(1) The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.
(2) The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employees on the first day of the plan year.
The policyholder is a $\underline{\mathcal{V}}$ large employer $\underline{\hspace{1cm}}$ small employer (check one).

ATTESTATIONS

Under the Medicare Secondary Payer Rules, it is the Employer's responsibility to annually inform Arkansas Blue Cross of proper employee counts for the purpose of determining payment priority between Medicare and Arkansas Blue Cross. Arkansas Blue Cross is required to furnish these counts to the Centers for Medicare and Medicaid Services (CMS).

Full-Time = means an active employee with a minimum of 30 hrs/week & 48 weeks/year	ter 188. statistica en empeter protestiga e 27 gas	ren en relación de la constitución	AND MARKET AND
	In State	Out of State	Total
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):	38		38
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):	6		6
COBRA Continuees (Enrolling):			
Life ONLY Contracts:	gr. err. se næ noombritsse æ i	[	
Total Enrolling and Waiving:	- y- 1		
Part Time/Seasonal/Temporary Employees :		and the same of th	
Total # of Employees:		ageng gagger, ag shiff der 1990 ill salaming dien gengengen geb	38

Minimum Number of Insured Employees. To meet large group enrollment guidelines a group must have at least fiftyone full-time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal.

Minimum Participation Requirements. Employees covered through other comprehensive major medical-type coverage may be waived from the eligibility count. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

This Policy may be terminated by the Company if the number of insured Employees falls below the minimum number of insured Employees specified above or if the percentage of eligible Employees of the Policyholder covered by the Policy becomes less than the percentage of Employee participation specified above.

:Special Group Considerations Form# 23-2546, Description Alternate eligibility hours(40 hours/week)

Special Group Considerations Form# 23-2186, Description No Deductible Carryover

Special Group Considerations Form# 23-2242, Description \$100 ER co-pay

'States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate.				
I hereby renew the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies renewed, will take effect as of the renewal date, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.				
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in connection with an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.				
Signed at fourtherd act, this 7 day of loe 2011 (City, State)				
2. Agent I hereby certify that all of the information contained in this employer application is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual proposed for coverage (except as noted on the employed applications). I have complied with the underwriting rules and regulations and have explained in detail the coverage to the member firm and its employees including the preexisting condition limitations and the qualifications of the effective date provisions. I understand that Arkansas Blue Cross and Blue Shield will have no liability until this application has been approved and the premium is received.				

Insurance License # / Agency Fed. Tax ID #

Date

DAVID C. FERGUSON

# Arkansas BlueCross BlueShield

# **EMPLOYER APPLICATION**

Blues Enroll

Renewal APPLICATION by: City of Jonesboro Craighead Library	
(hereinafter called "Policyholder")	There is the second property of the second points o
for a Group Policy covering the employees of the Policyholder and the eligible dependents of such employees. Policyholder intends hereby to establish and maintain an employee benefit plan (the "Plan") for the Policyholder and eligible dependents, to contribute to the cost of the Plan, and to actively promote the Plan to the Policyholder.	r's employees
GROUP INFORMATION	

# Legal Name of Business: CITY OF JONESBORO D/B/A: City of Jonesboro Craighead Library Street Address: 315 W. Oak City, State, Zip: Jonesboro, AR, 72401 County: Craighead :Mailing Address: (if different from Street) 315 W. Oak City, State, Zip: Jonesboro , AR , 72401 Telephone #: 870-933-4640 Fax #: -Fed. Tax I.D #: 71-0023849 Exec. Contact: E-Mail: Group Administrator: Nancy Dobbins E-Mail: Primary SIC Code: 8231 SIC Description: Libraries Business Type: Government Entity Agent Agent's Lic #:

## POLICYHOLDER AS PLAN ADMINISTRATOR

contributed to presentation of improper claims

Agent's Tax Id:

The Policyholder, as Plan Administrator, assumes responsibility for the accuracy of information presented to Arkansas Blue. Cross and Blue Shield ("ABCBS"), including all information on the employment status and eligibility of individuals to be coverunder the Plan, as well as medical information provided with respect to each such individual. The Policyholder agrees that if misrepresentations are made in any of the information provided for rating or in this Group Application or any of the materials submitted with it, including, but not limited to, individual applications and medical information, then ABCBS may cancel or rescind this Group Policy. The Policyholder further agrees that if misrepresentations or false or misleading information is presented in filing of any claims hereunder ("improper claims"), ABCBS may cancel or rescind the coverage of any individual involved in presenting such a claim. Further, ABCBS may cancel or rescind the entire Group Policy if the Policyholder or any

#### PROXY

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10-102GRPAPP R07/11

#### BENEFIT SELECTION PREFERRED PROVIDER ORGANIZATION (PPO) - PPO XXX - 1 REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2012 Waiting Period Note: Effective Date is first of the month following the Waiting Period Date of Open Enrollment December If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date Class Class Description Waiting Period Contribution Full Time 1 Month Employee 71 % Dependent 71 % Note: The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage of Employees' premium specified above Maximum Dependent Age 26 Mandated Mental Health Parity: Yes Please Indicate whether a HRA, or mechanisms utilized to reduce the employee's portion of health plan costs, is either in place or planned to be purchased. Rates offered for this plan are contingent on assertions submitted by the insurance applicant (or its agent) that there is no HRA or other funding mechanism in place, nor intent to purchase such an arrangement. Upon evidence to the contrary, the group health plan is subject to termination Deductible: \$500 Deductible Carryover: No Family Deductible: 3 Basis: Fulfillment Coinsurance: 80%/60% In-Network Calendar Year Coinsurance Max: \$2000 Family Calendar Year Coinsurance Max: 3 Basis: Fulfillment Out-of-Network Calendar Year Coinsurance Max: None Lifetime Maximum: Unlimited Traditional Wellness Prescription Drug Rider Plan: \$10/\$30/\$50/100% Value Formulary Mail Order Drug - 2x Copay (90 days) Based on actuarial review, this drug benefit option is creditable to the standard Medicare Part D prescription coverage. PPO Optional Benefits: Inpatient Copay - None Office Visit Copayment - \$30 Matemity - Elected Supplemental Accidental Blue Card Endorsement - Declined ER Copayment - \$100

# Arkansas Mandated Offer Benefit Riders:

# You Must Elect or Reject Each Rider:

'Mammography - Reject	Substance Abuse - Reject		
Psychiatric Condition - Reject	TMJ* - Reject		
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RATES - PPO XXX - 1		
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Family	\$690.02	
Crandfathor Status Our records indicate that	your health plan is grandfathored	
Grandfather Status - Our records indicate that	your health plan is grandfathered.	
Please confirm if you agree with the grandf	athered status as indicated above.	
Please confirm if you agree with the grandf  Yes, I agree with the status as shown.	athered status as indicated above.	

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(Yes_) (No_) Under the governmental guidelines the group health plan is subject to Cobra, meeting the criteria for 20 or more employees.
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The policyholder is a large employer small employer (check one).

ATTESTATIONS

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Special Group Considerations Form# 23-2546, Description Alternate eligibility hours(40 hours/week)

Special Group Considerations Form# 23-2186, Description no deductible carryover

Special Group Considerations Form# 23-2242, Description \$100 ER co-pay

SIGNATURES
This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the Unite States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate.
If hereby renew the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies renewed, will take effect as of the renewal date, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in connection with an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Signed at City, State)  Signed at City, State)
2. Agent I hereby certify that all of the information contained in this employer application is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual proposed for coverage (except as noted on the employee applications). I have complied with the underwriting rules and regulations and have explained in detail the coverage to the member firm and its employees including the preexisting condition limitations and the qualifications of the effective date provisions. I understand that Arkansas Blue Cross and Blue Shield will have no liability until this application has been approved and the premium is received.

Insurance License # / Agency Fed. Tax ID #

Date

gent Signature

DAVID C. FERGUSON
Agent Printed Name



# **EMPLOYER APPLICATION**

Blues Enroll

Renewal APPLICATION by: CITY OF JONESBORO

(hereinafter called "Policyholder")

for a Group Policy covering the employees of the Policyholder and the eligible dependents of such employees. The Policyholder intends hereby to establish and maintain an employee benefit plan (the "Plan") for the Policyholder's employees and eligible dependents, to contribute to the cost of the Plan, and to actively promote the Plan to the Policyholder's employees.

# GROUP INFORMATION Legal Name of Business: CITY OF JONESBORO D/B/A: CITY OF JONESBORO Street Address: 515 W Washigton

City, State, Zip: Jonesboro , AR , 72401

Mailing Address: (if different from Street) P O BOX 1845

City, State, Zip: Jonesboro , AR , 72403

Telephone #: 870-933-4640

Fax #: -

Fed. Tax I.D #: 71-6013749

Exec. Contact: Harold Perrin

E-Mail:

Group Administrator: GLORIA ROARK

E-Mail:

Primary SIC Code: 9199 SIC

SIC Description: General Government, NEC

County: Craighead

Business Type: Government Entity

Agent:

Agent's Lic#:

Agent's Company:

Agent's Tax Id:

## POLICYHOLDER AS PLAN ADMINISTRATOR

The Policyholder, as Plan Administrator, assumes responsibility for the accuracy of information presented to Arkansas Blue Cross and Blue Shield ("ABCBS"), including all information on the employment status and eligibility of individuals to be constuded the Plan, as well as medical information provided with respect to each such individual. The Policyholder agrees that if misrepresentations are made in any of the information provided for rating or in this Group Application or any of the materials submitted with it, including, but not limited to, individual applications and medical information, then ABCBS may cancel or rescind this Group Policy. The Policyholder further agrees that if misrepresentations or false or misleading information is irresented in filing of any claims hereunder ("improper claims"), ABCBS may cancel or rescind the coverage of any individual involved in presenting such a claim. Further, ABCBS may cancel or rescind the entire Group Policy if the Policyholder or any representative of the Policyholder knew or should have known of the improper claims, or if the Policyholder's action or inaction contributed to presentation of improper claims.

#### PROXY

The Policyholder hereby appoints the Board of Directors ("Board") of Arkansas Blue Cross and Blue Shield ("ABCBS"), as its proxy to act on its behalf at all meetings of members of ABCBS. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for the Policyholder on all matters that may be voted upon at any meeting. The annual meeting of Members is held each year at the home office of ABCBS located at 601 S. Gaines Street, Little Rock, Arkansas, on the third Monday of March, at 1:00 p.m. If the third Monday of March is a legal holiday, then the meeting will be at the same time and place on the next day after, which is not a legal holiday. A special meeting may be called upon notice mailed not less than ten (10) or more than sixty (60) days prior to such meeting. This proxy, unless revoked, shall remain in effect during the Policyholder's membership in ABCBS. The Policyholder may revoke this proxy in writing by advising ABCBS, attention Legal Division, of such at least five (5) days prior to any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Member's meeting.

10-102GRPAPP R07/11

#### BENEFIT SELECTION

## PREFERRED PROVIDER ORGANIZATION (PPO) - PPO XXX - 1

## REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2012

Waiting Period Note: Effective Date is first of the month following the Waiting Period.

Date of Open Enrollment December

ill a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date

Class	Class Description	Waiting Period	Contribution		
1	Full Time	1 Month	Employee 71 %	Dependent 71 %	

Note: The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage of Employees' premium specified above.

## Maximum Dependent Age 26

## Mandated Mental Health Parity: Yes

Please Indicate whether a HRA, or mechanisms utilized to reduce the employee's portion of health plan costs, is either in place or planned to be purchased. **No** 

Rates offered for this plan are contingent on assertions submitted by the insurance applicant (or its agent) that there is no HRA or other ifunding mechanism in place, nor intent to purchase such an arrangement. Upon evidence to the contrary, the group health plan is subject to itermination.

Deductible:	\$500	Deductible Carryover: No	
Family Deductible:	3	Basis: Fulfillment	
Coinsurance:	80%/60%		
In-Network Calendar Year Coinsurance Max:	\$2000		
Family Calendar Year Coinsurance Max:	3	Basis: Fulfillment	
Out-of-Network Calendar Year Coinsurance Max:	None		
Lifetime Maximum:	Unlimited		
	1		

Traditional Wellness

## Prescription Drug Rider Plan: \$10/\$30/\$50/100% Value Formulary

Mail Order Drug - 2x Copay (90 days)

Based on actuarial review, this drug benefit option is creditable to the standard Medicare Part Deprescription coverage.

## PPO Optional Benefits:

Inpatient Copay - None

Office Visit Copayment - \$30 Maternity - Elected

Blue Card

Supplemental Accidental Endorsement - Declined

ER Copayment - \$100

# Arkansas Mandated Offer Benefit Riders:

# You Must Elect or Reject Each Rider:

Mammography - Reject Substance Abuse - Reject
Psychiatric Condition - Reject TMJ\* - Reject

Hearing Aid - Reject

\*Rejection of the TMJ Benefit Rider means covered benefits provided to Covered Persons will <u>not</u> include temporomandibular. Joint disorders (TMJ) or craniomandibular disorders.

<u>RATES</u> - PPO XXX - 1		
Two Tier Composite	Total Premium	
Employee	\$321.18	-
Family	\$690.02	-!
involved in this transaction, pleasedirect	paid by the covered person. For more information on the compensation your inquiry to the agent or broker.  ate that your health plan is grandfathered.	
•	grandfathered status as indicated above.	
Yes, I agree with the status as shown	1.	
No, I disagree with the status as show	vn because	

#### BENEFIT SELECTION

PREFERRED PROVIDER ORGANIZATION (PPO) - PPO XXX - 1

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2012

Waiting Period Note: Effective Date is first of the month following the Waiting Period.

Date of Open Enrollment December

If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.

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Class	Class Description	Waiting Period	Contribution		,
2	Retirees	0 Months	Employee 0 %	Dependent 0 %	

Note. The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage of Employees' premium specified above.

## Maximum Dependent Age 26

Mandated Mental Health Parity: Yes

Please Indicate whether a HRA, or mechanisms utilized to reduce the employee's portion of health plan costs, is either in place or planned to be purchased. **No** 

Rates offered for this plan are contingent on assertions submitted by the insurance applicant (or its agent) that there is no HRA or other funding mechanism in place, nor intent to purchase such an arrangement. Upon evidence to the contrary, the group health plan is subject to itermination.

Deductible:	\$500	Deductible Carryover: No	
Family Deductible:	3	Basis: Fulfillment	
Coinsurance:	80%/60%		
In-Network Calendar Year Coinsurance Max:	\$2000		
Family Calendar Year Coinsurance Max:	3 Basis: Fulfillment		
Out-of-Network Calendar Year Coinsurance Max:	None		
Lifetime Maximum:	Unlimited		
Traditional Wellness	APT. No. of programmer of the contract of the		

Prescription Drug Rider Plan: \$10/\$30/\$50/100% Value Formulary

Mail Order Drug - 2x Copay (90 days)

Based on actuarial review, this drug benefit option is creditable to the standard Medicare Part Diprescription coverage.

PPO Optional Benefits:	The state of the s
Inpatient Copay - None	
Office Visit Copayment - \$30	Maternity - Elected
Blue Card	Supplemental Accidental Endorsement - Declined
	FR Consyment - \$100

#### Arkansas Mandated Offer Benefit Riders:

You Must	Elect or	Reject	Each	Rider:
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Mammography - Reject	Substance Abuse - Reject
Psychiatric Condition - Reject	TMJ* - Reject
Hearing Aid - Reject	HILL TO THE PROPERTY OF THE PR

\*Rejection of the TMJ Benefit Rider means covered benefits provided to Covered Persons will <u>not</u> include temporomandibular Joint disorders (TMJ) or craniomandibular disorders

B	RATES - PPO XXX - 1
Two Tier Composite	Total Premium
Employee	\$321.18
Family	\$690.02
•	or her services related to the placement of this coverage. Any such e covered person. For more information on the compensation y to the agent or broker.
Grandfather Status - Our records indicate that you	r health plan is grandfathered.
Please confirm if you agree with the grandfathe  Yes, I agree with the status as shown.	,
No, I disagree with the status as shown because	;

COBRA
Group health plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, "Ceridian" to assist you in administering Cobra (no additional cost).
Both full time and part time employees are counted to determine if a plan is subject to Cobra. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours worked divided by the number of hours used to determine full time status.
(Yes <u>/</u> ) (No) Under the governmental guidelines the group health plan is subject to Cobra, meeting the criteria for 20 or more employees.
Yes☑)(No) If yes, do you wish to use the services of Ceridian?
f no, who will administer Cobra for you?
Medical Loss Ratio - The determination of Large and Small Groups is based upon the average number of employees employed by the employer on business days during the proceeding calendar year. The Public Health Services Act §2791(e) provides
1) The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan rear, an employer who employed an average of at least 51 employees on business days during the preceding calendar rear and who employs at least 2 employees on the first day of the plan year.
2) The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employees on the first day of the plan year.
The policyholder is a $\sqrt{}$ large employer $\underline{}$ small employer (check one).

Under the Medicare Secondary Payer Rules, it is the Employer's responsibility to annually inform Arkansas Blue Cross of proper employee counts for the purpose of determining payment priority between Medicare and Arkansas Blue Cross. Arkansas Blue Cross is required to furnish these counts to the Centers for Medicare and Medicaid Services (CMS).

Full-Time = means an active employee with a minimum of 30 hrs/week & 48 weeks/year	-	Marine	
	In State	Out of State	Total
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):	486		486
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):	: :		f
COBRA Continuees (Enrolling):		yer yer retained the second of	
Life ONLY Contracts:	;		
Total Enrolling and Waiving:	33	, to take	35
Part Time/Seasonal/Temporary Employees :		F 1700 - 10 SOOT-ABBIEGE FANKENSON, 1854 IN VIOLEN	!
Total # of Employees:			521

Minimum Number of Insured Employees. To meet large group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal.

Minimum Participation Requirements. Employees covered through other comprehensive major medical-type coverage may be waived from the eligibility count. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

This Policy may be terminated by the Company if the number of insured Employees falls below the minimum number of insured Employees specified above or if the percentage of eligible Employees of the Policyholder covered by the Policy becomes less than the percentage of Employee participation specified above.

Special Group Considerations Form# 23-2232, Description retiree elected officals Rx

Special Group Considerations Form# 23-2170, Description Continuation for Municipal Emps 55+

Special Group Considerations Form# 23-2186, Description No Deductible Carryover

Special Group Considerations Form# 23-2432, Description Contin for City Cnsl Mbrs & Elect Officials

Special Group Considerations Form# 23-2546, Description alternate eligibility hours(40/week)

Special Group Considerations Form# 23-2242, Description \$100 ER co-pay

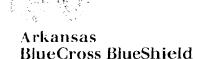
SIGNATURES			
This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the Unite States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate.			
I hereby renew the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies renewed, will take effect as of the renewal date, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.			
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in connection with an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.			
Signed at Journal Whis 7 day of 20 11 (City, State)			
2. Agent			
I hereby certify that all of the information contained in this employer application is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual proposed for coverage (except as noted on the employer applications). I have complied with the underwriting rules and regulations and have explained in detail the coverage to the member firm and its employees including the preexisting condition limitations and the qualifications of the effective date provisions. I understand that Arkansas Blue Cross and Blue Shield will have no liability until this application has been approved and the premium is received.			

Insurance License # / Agency Fed. Tax ID #

Date

DAVID C. FERBUSON

Agent Printed Name



# **EMPLOYER APPLICATION**

Blues Enroll

Renewal APPLICATION by: CITY OF JONESBORO

(hereinafter called "Policyholder")

for a Group Policy covering the employees of the Policyholder and the eligible dependents of such employees. The Policyholder intends hereby to establish and maintain an employee benefit plan (the "Plan") for the Policyholder's employees and eligible dependents, to contribute to the cost of the Plan, and to actively promote the Plan to the Policyholder's employees

# GROUP INFORMATION Legal Name of Business: CITY OF JONESBORO D/B/A: CITY OF JONESBORO Street Address: 515 W Washigton City, State, Zip: Jonesboro, AR, 72401 County: Craighead Mailing Address: (if different from Street) P O BOX 1845 City, State, Zip: Jonesboro, AR, 72403 Telephone #: 870-933-4640 Fax #: -Fed. Tax I.D #: 71-6013749 Exec. Contact: Harold Perrin E-Mail: Group Administrator: GLORIA ROARK E-Mail: Primary SIC Code: 9199 SIC Description: General Government, NEC Business Type: Government Entity

Agent's Company: Agent's Tax Id:

#### POLICYHOLDER AS PLAN ADMINISTRATOR

The Policyholder, as Plan Administrator, assumes responsibility for the accuracy of information presented to Arkansas Plan Cross and Blue Shield ("ABCBS"), including all information on the employment status and eligibility of individuals to be consumed the Plan, as well as medical information provided with respect to each such individual. The Policyholder agrees that if misrepresentations are made in any of the information provided for rating or in this Group Application or any of the materials submitted with it, including, but not limited to, individual applications and medical information, then ABCBS may cancel or rescind this Group Policy. The Policyholder further agrees that if misrepresentations or false or misleading information is presented in filing of any claims hereunder ("improper claims"), ABCBS may cancel or rescind the coverage of any individual involved in presenting such a claim. Further, ABCBS may cancel or rescind the entire Group Policy if the Policyholder or any representative of the Policyholder knew or should have known of the improper claims, or if the Policyholder's action or inaction contributed to presentation of improper claims.

Agent's Lic #:

#### PROXY

The Policyholder hereby appoints the Board of Directors ("Board") of Arkansas Blue Cross and Blue Shield ("ABCBS"), as its proxy to act on its behalf at all meetings of members of ABCBS. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for the Policyholder on all matters that may be voted upon at any meeting. The annual meeting of Members is held each year at the home office of ABCBS located at 601 S. Gaines Street, Little Rock, Arkansas, on the third Monday of March, at 1:00 p.m. If the Ithird Monday of March is a legal holiday, then the meeting will be at the same time and place on the next day after, which is not a legal holiday. A special meeting may be called upon notice mailed not less than ten (10) or more than sixty (60) days prior to such meeting. This proxy, unless revoked, shall remain in effect during the Policyholder's membership in ABCBS. The Policyholder may revoke this proxy in writing by advising ABCBS, attention Legal Division, of such at least five (5) days prior to any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Member's meeting.

# Benefit Selection

RX ONLY - MEDIPAK SUPPLEMENT RX

# REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2012

Waiting Period Note: Effective Date is the first of the month following the Waiting Period.

Date of Open Enrollment December

If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.

Class	Class Description	Waiting Period	Contribution		
4	Med supp elctd offices w 20 yrs cnt sc-rx	0 Months	Employee 25%	Dependent 0%	

Note: The Employer must pay a minimum of 50% of the Employee premium. This policy may be terminated by the company if the Policyholder fails to contribute the percentage of the Employees' premium specified above.

Maximum Dependent Age: 26

Mandated Mental Health Parity: Yes

**RX ONLY** 

Prescription Drug Rider Plan: \$10/\$30/\$50,100% Value Formulary Mail Order Drug – 2x Copay (90 days)

Based on actuarial review, this drug benefit option is creditable to the standard Medicare Part D prescription coverage.

RA	ATES - MEDIPAK SUPPLEMENT RX
One Tier Composite	Total Premium
Employee	\$79.25
Cross and Blue Shield, or one of its affiliates,	for his or her services related to the placement of this coverage. Any such d by the covered person. For more information on the compensation inquiry to the agent or broker.
Grandfather Status - Our records indicate th	at your health plan is grandfathered.
Please confirm if you agree with the grand	dfathered status as indicated above.
Yes, Lagree with the status as shown.	
No, I disagree with the status as shown be	ecause
	10 August 1 10 10 10 10 10 10 10 10 10 10 10 10 1

ATTESTATIONS
Group health plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, "Ceridian" to assist you in administering Cobra (no additional cost).  Both full time and part time employees are counted to determine if a plan is subject to Cobra. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours worked divided by the number of hours used to determine full time status.  (Yes ) (No_) Under the governmental guidelines the group health plan is subject to Cobra, meeting the criteria for 20 or more employees.
(Yes)(No) If yes, do you wish to use the services of Ceridian?
If no, who will administer Cobra for you?
Medical Loss Ratio - The determination of Large and Small Groups is based upon the average number of employees employed by the employer on business days during the proceeding calendar year. The Public Health Services Act
§2791(e) provides  (1) The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.
(2) The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employees on the first day of the plan year.
The policyholder is a large employer small employer (check one).

<u>10-102GRPAPP R07/11</u>

Under the Medicare Secondary Payer Rules, it is the Employer's responsibility to annually inform Arkansas Blue Cross of proper employee counts for the purpose of determining payment priority between Medicare and Arkansas Blue Cross. Arkansas Blue Cross is required to furnish these counts to the Centers for Medicare and Medicaid Services (CMS).

	In State	Out of State	Total
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):	1		, ,
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):			
COBRA Continuees (Enrolling):			
Life ONLY Contracts:			
Total Enrolling and Waiving:			- ;
Part Time/Seasonal/Temporary Employees :	n'i Allen Allen Marie Marie de La Cale de La		- [
Total # of Employees:			

Minimum Number of Insured Employees. To meet large group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal.

Minimum Participation Requirements. Employees covered through other comprehensive major medical-type coverage may be waived from the eligibility count. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

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Special Group Considerations Form# 23-2186, Description No Deductible Carryover

Special Group Considerations Form# 23-2432, Description Contin for City Cnsl Mbrs & Elect Officials

Special Group Considerations Form# 23-2546, Description alternate eligibilty hours(40/week)

Special Group Considerations Form# 23-2242, Description \$100 ER co-pay

SIGNATURES	
This Application is made and delivered in the State of Arkansas and States of America. This Application is incorporated in and made a p	
I hereby renew the above referenced coverage and agree the group policies renewed, will take effect as of the renewal date, provided this received by the home office of Arkansas Blue Cross and Blue Shield represents my agreement and acceptance of the premium rate	is application is approved and the premium is d. I also understand that my signature below
Any person who knowingly presents a false or fraudulent clai presents false information in connection with an application subject to fines and confinen	for insurance is guilty of a crime and may be
1. Policyholder  Signed at  (City, State)  (City, State)	of <u>Oe</u> 20//
2. Agent I hereby certify that all of the information contained in this employer and I know nothing unfavorable about this firm or any individual proper applications). I have complied with the underwriting rules and regulate the member firm and its employees including the preexisting condition date provisions. I understand that Arkansas Blue Cross and Blue Shibeen approved and the premium is received.	osed for coverage (except as noted on the employer ions and have explained in detail the coverage to on limitations and the qualifications of the effective ield will have no liability until this application has
AU VV	23908

Insurance License # / Agency Fed Tax 40 \*

Date

DAVID C. FERBUSON
Agent Printed Name