Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

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 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 : Harold Perrin	E-Mail :
Group Administrator : NANCY DOBBINS	E-Mail : nancy@libraryinjonesboro.org
Primary SIC Code : 8231	SIC Description:Libraries
Business Type : Government	
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 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 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.

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 $600 Deductible

Requested Effective Date,Pending approval is : **1/1/2018**
Waiting Period Note : Effective Date is the first day 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 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 : $600	Deductible CarryOver : No
Family Deductible : 3	Basis : Fulfillment
CoInsurance : 80%/60%	In-Network Calendar Year Coinsurance Max: $2,000/$6,000
Family Calendar Year Coinsurance Max: 3	Basis : Fulfillment

Out-of-Network Calendar Year Coinsurance Max:None/None

Lifetime Maximum: Unlimited	Traditional Wellness

Prescription Drug Rider Plan: $15/$35/$55 Standard Formulary With Step Therapy

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:	
Office Visit Copayment - $35	Maternity - Elected
Supplemental Accidental Endorsement - Declined	ER Copayment -$100
Blue Card	Inpatient Copay - None

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 not include temporomandibular Joint disorders (TMJ) or craniomandibular disorders.

Term Life and AD&D through USAble Life is not Provided

RATES - PPO $600 Deductible

Two Tier Composite	Total Premium
Employee	$429.56
Family	$922.87

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

Grandfather Status - Our records indicate that your health plan is grandfathered.

Please confirm if you agree with the grandfathered status as indicated above.

✓ Yes, I agree with the status as shown.

____ No, I disagree with the status as shown because _____

ATTESTATIONS

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, "WageWorks", 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.[1]

(Yes✓) (No__) As an employer, are you currently obligated by law to comply with COBRA?

(Yes✓) (No__) Do you want to use the services of WageWorks?

(Yes__) (No✓) If yes, are you currently contracting directly with WageWorks?

1 COBRA Handbook 2009, ¶4.03[E][2]; 26 CFR §54.4980B-2 Q/A 5(e).
2 42 CFR §411.170.

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 preceding 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 1 employee 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 employee on the first day of the plan year.

The policyholder is a :
Small Employer _____
Large Employer ____✓____ (if selected please check one of the following)
51-100 Employees _____ 101+ Employees ____✓____

L Policyholder to Distribute and Account for Premium Rebates

In the event federal or state law requires the Company to rebate a portion of an annual premium payment, Company will pay the Policyholder the total rebate applicable to the Policy, and Policyholder shall handle the rebate payment in accordance with the applicable provisions of Employee Retirement Income Security Act of 1974 (ERISA).Policyholder will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Policyholder's failure to carry out its obligations under this Section L of the Group Policy.

EMPLOYEE INFORMATION
MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQUIREMENTS

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):			
COBRA Continuees (Enrolling):			
Life ONLY Contracts			
Total Enrolling and Waiving:			
Part Time/Seasonal/Temporary Employees :			
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 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 25% 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# 23-2186	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 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.

1. Policyholder

Signed at _____, this _____ day of _____ 20___
(City, State)

_____ [full legal name of Policyholder]

By: _____ _____
Authorized Signature Printed Name

_____
Title or Position

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.

__✓__ I will provide the applicant with a signed copy of this application.

_____ I have emailed the applicant a signed copy of this application.

_____ 23908
Agent Signature Insurance License # / Agency Fed. TaxID #

David C. Ferguson 10-19-2017
Agent Printed Name Date

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

10/19/2017

Group Name: CITY OF JONESBORO CRAIGHEAD LIBRARY

315 W Oak
Jonesboro , AR 72401

Group Number: Proposal-ID : 31780

Dear Group Administrator:

Please be advised that the current benefit you offer (PPO Custom), meets the minimum essential coverage requirements as defined in § 5000A of the Internal Revenue Code (employer-sponsored plan), and provides minimum value within the meaning of § 36B(c)(2)(C)(ii).
Effective 1/1/2018, employers are required by law to inform their employees of coverage options under the new health care law. You will find the compliant notification document at this link: **http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf**. Please distribute copies of this notice to all your employees.

If you have any questions or concerns, please contact your agent or an Arkansas Blue Cross representative. We are happy to help you through the implementation of this new requirement.

SBC

The Patient Protection and Affordable Care Act (PPACA) mandates a Summary of Benefits and Coverage (SBC) document be created for every health insurance plan. An SBC that applies to this plan(s) can be found online at www.arkansasbluecross.com/esbc.After we receive and process your signed contract, you may access the SBC(s) for this plan by going to our SBC locator tool and entering the following unique identifier(s) into the SBC locator:

61767

Groups with more than one plan type may have more than one link. You may download an electronic copy (PDF) of the appropriate SBC(s) to fulfill distribution requirements as mandated by the Patient Protection and Affordable Care Act (PPACA).Copies of your SBC will also be available on Blueprint for Employers. A printed version is available by calling your group service representative.

Arkansas BlueCross BlueShield

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 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 :Harold Perrin	E-Mail :
Group Administrator : NANCY DOBBINS	E-Mail : nancy@libraryinjonesboro.org
Primary SIC Code : 8231	SIC Description:Libraries
Business Type : Government	
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 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 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.

COBRA ADMINISTRATION

COBRA - Group vision 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, "WageWorks", 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__)As an employer, are you currently obligated by law to comply with COBRA?

(Yes✓)(No__) Do you want to use the services of WageWorks?

(Yes__)(No✓) If yes, are you currently contracting directly with WageWorks?

BENEFIT SELECTION

VOLUNTARY VISION Voluntary VSP Choice Plan Gold-

Customized Plan : No

Requested Effective Date,Pending approval is : 01/01/2018

Waiting Period Note :Effective Date is the first day 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	ALL FULL TIME EMPLOYEES	1 Month	Employee 0% Dependent 0%	

Note: *Employer contribution is 0% to 49%.*

Eye Health Examination inclusive of Dialation: 12 Months

Spectacle Lens: 12 Months | **Frames:** 24 Months

Contact Lens Evaluation,Fitting & Follow-up Care: 12 Months

Contact Lens(in lieu of eyeglasses): 12 Months

Eye Health Examination Copayment: $10 | **Spectacle Lens Copayment:** $20

Contact Lens Evaluation, Fitting & Follow-Up Care Copayment: 15% discount/$60 max

Elective Contact Lenses :$150

Out-Of-Network Coverage

Eye Examination: Once every 12 Months, $45 | **Frames:** Once every 24 Months, $70

Spectacle Lens:

Single Vision Lens: Once every 12 Months , $30 | **Bifocal/Progressive Lens:** Once every 12 Months, $50

Trifocal Lens: Once every 12 Months, $65 | **Lenticular Lens:** Once every 12 Months, $100

Elective Contact Lens: Once every 12 Months, $105

Medically Necessary Contact Lens(with prior approval): $210

Minimum Participation Requirements and Minimum Number of Insured Employees: This policy may be terminated by the Company if the number of insured Employees falls below five (5) insured Employees.

RATES - Voluntary VSP Choice Plan Gold-

Two Tier Composite	Total Premium
Employee	$9.00
Family	$21.06

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

EMPLOYEE INFORMATION
MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQUIREMENTS

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):			
COBRA Continuees (Enrolling):			
Total Enrolling and Waiving:			
Part Time/Seasonal/Temporary Employees :			
Total # of Employees:			

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.

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."

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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.

1. Policyholder

Signed at _____, this _____ day of _____ 20___
(City, State)

_____ [full legal name of Policyholder]

By: _____ _____
Authorized Signature Printed Name

_____
Title or Position

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.

_✓_ I will provide the applicant with a signed copy of this application.

_____ I have emailed the applicant a signed copy of this application.

_____ 23908
Agent Signature Insurance License # / Agency Fed. TaxID #

David C. Ferguson 10-19-2017
Agent Printed Name Date