



**Blues Enroll**

Renewal APPLICATION by CITY OF JONESBORO ARKANSAS

(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 ARKANSAS

D/B/A : CITY OF JONESBORO ARKANSAS

Street Address: 300 South Church Street

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 : Dewayne Douglas

E-Mail : ddouglas@jonesboro.org

Primary SIC Code : 9199

SIC Description: General Government, NEC

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**

**RX ONLY** medi-pak Plan F w/RX

**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	
4	MED SUPP ELECTED OFFICIALS W20 YRS CNT SC-RX	0 Days	Employee 25% Dependent 0%	

**Maximum Dependent Age: 26**

**Mandated Mental Health Parity: True**

**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.*

**RATES - medi-pak Plan F w/RX**

One Tier Composite	Total Premium
Employee	\$106.00

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.<sup>1</sup>

(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 use the amount of the rebate that is proportionate to the total amount of premium paid by all Employees under the policy for the benefit of Employees in one of the following ways, at the option of the Policyholder:

1. For all Employees covered under any option offered under the policyholder's group health plan at the time the rebate is received by the policyholder, to reduce the Employees' portion of premium for the subsequent policy year;
2. For Employees covered, at the time the rebate is received by the policyholder, under the group health plan option for which the Company is providing a rebate, to reduce the Employees portion of premium for the subsequent policy year;
3. A cash refund to Employees enrolled in the group health plan option, at the time the rebate is received by the policyholder, for which the Company is providing a rebate; and
4. The reduction in future premium or the cash refund provided under paragraphs 1, 2 or 3 of this section may, at the option of the policyholder, be: divided evenly among such Employees divided based on each Employee's actual contributions to premium; or apportioned in a manner that reasonably reflects each Employee's contributions to premium.

5. The portion of a rebate based upon former Employees' contributions to premium must be aggregated and used for the benefit of current Employees in the group health plan in any manner permitted by this section. 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# 23-2232

Description: retiree elected officials RX

**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

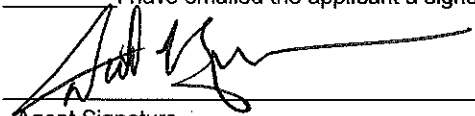
\_\_\_\_\_  
Title or Position

**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.

  
Agent Signature

23908  
Insurance License # / Agency Fed. TaxID #

David C. Ferguson  
Agent Printed Name

10-19-2017  
Date



**Blues Enroll**

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Group Administrator : Dewayne Douglas

E-Mail : ddouglas@jonesboro.org

Primary SIC Code : 9199

SIC Description: General Government, NEC

Business Type : Government

Agent :

Agent's Lic # :

Agent's Company :

Agent's Tax ID :

**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 \$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%
2	RETIREEES	0 Days	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 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&amp;D through USABLE Life is not Provided

**RATES - PPO \$600 deductible**

<b>Two Tier Composite</b>	<b>Total Premium</b>
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.<sup>1</sup>

(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 use the amount of the rebate that is proportionate to the total amount of premium paid by all Employees under the policy for the benefit of Employees in one of the following ways, at the option of the Policyholder:

1. For all Employees covered under any option offered under the policyholder's group health plan at the time the rebate is received by the policyholder, to reduce the Employees' portion of premium for the subsequent policy year;
2. For Employees covered, at the time the rebate is received by the policyholder, under the group health plan option for which the Company is providing a rebate, to reduce the Employees portion of premium for the subsequent policy year;
3. A cash refund to Employees enrolled in the group health plan option, at the time the rebate is received by the policyholder, for which the Company is providing a rebate; and
4. The reduction in future premium or the cash refund provided under paragraphs 1, 2 or 3 of this section may, at the option of the policyholder, be: divided evenly among such Employees divided based on each Employee's actual contributions to premium; or apportioned in a manner that reasonably reflects each Employee's contributions to premium.

5. The portion of a rebate based upon former Employees' contributions to premium must be aggregated and used for the benefit of current Employees in the group health plan in any manner permitted by this section. 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# 23-2432	Description: Contin for City Cnsl Mbrs & Elect Officials
Special Group Considerations Form# 23-2170	Description: Continuation for Municipal Emps 55+
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

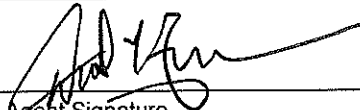
\_\_\_\_\_ Title or Position

**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.

  
Agent Signature

23908  
Insurance License # / Agency Fed. TaxID #

David C. Ferguson  
Agent Printed Name

10-19-2017  
Date



Arkansas  
**BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

10/19/2017

Group Name: CITY OF JONESBORO ARKANSAS

300 South Church Street  
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](http://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:

61769

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.



## EMPLOYER APPLICATION

### Blues Enroll

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(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%
2	RETIREEES	0 Days	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."

**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

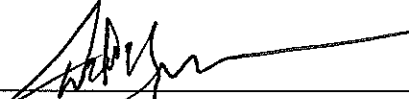
\_\_\_\_\_  
Title or Position

**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.

  
Agent Signature

23908  
Insurance License # / Agency Fed. TaxID #

David C. Ferguson  
Agent Printed Name

10-19-2017  
Date