City of Benson
City Council Communication

Regular Meeting **June 9, 2014**

To: Mayor and Council Agenda Item # 4

From: William Stephens, City Manager
Megan Moreno, Finance Director

Subject:

Discussion and possible action regarding a Health Insurance contract with Blue Cross Blue Shield for the Employee Benefits for Fiscal Year 2014-2015, and authorization for the City Manager to sign the health insurance contract

Discussion:

This item is requesting approval of switching our employee health insurance provider from HealthNet to Blue Cross Blue Shield (BCBS) and to give authorization for the City Manager to sign the health insurance contract. Employee Solutions Group (ESG) worked to get the City the best renewal rate it could with HealthNet. Unfortunately, HealthNet's best offer was a substantial increase over the prior year. ESG solicited six additional offers from competing companies and brought these proposals before Finance, HR, and the City Manager for our review. After analyzing all offers, staff concluded that BCBS was the best offer. Staff feels confident that through BCBS, the City can continue to offer the same level of health insurance coverage without substantial increases in premiums. With BCBS, the City will offer a PPO and a Health Savings Account (HSA) plan option.

Staff Recommendation:

Approval of the health insurance contract with Blue Cross Blue Shield for the Employee Benefits for Fiscal Year 2014-2015, and authorization for the City Manager to sign the health insurance contract

BlueCross BlueShield of Arizona

Group Rate Proposal

Bid Acceptance & Benefit Selection Form

Legal Company Name: CITY OF BENSON
Name of Group Health Plan: CITY OF BENSON Group Health Plan

Proposal Number: 20140506031-3
Policy Period: 7/1/2014 - 6/30/2015
Group Rating Area: Cochise

Broker: INSIGHT RISK ADVISORS INC
Group HQ: Arizona
Group INC: Arizona

BDE: Barbra Heintz - D
BDE Phone: 520-745-7332
AHP Eligible: 84
Health Enrolling: 75

Health Plan Selections effective 7/1/2014

- [ ] * BlueAlliance $5,000/$20/$50 (70%/50%) - 2014
- [ ] * BlueAlliance $3,000/$20/$50 (70%/50%) - 2014
- [ ] * BlueAlliance $1,500/$20/$50 (70%/50%) - 2014
- [X] HSA Plus $5,000 (100%/50%) - 2014
- [ ] HSA Plus $4,000 (70%/50%) - 2014
- [ ] HSA Plus $4,000 (80%/50%) - 2014
- [ ] HSA Plus $4,000 (90%/50%) - 2014
- [ ] HSA Plus $4,000 (100%/50%) - 2014
- [ ] HSA Plus $3,000 (70%/50%) - 2014
- [ ] HSA Plus $3,000 (80%/50%) - 2014
- [ ] HSA Plus $3,000 (90%/50%) - 2014
- [ ] HSA Plus $3,000 (100%/50%) - 2014
- [ ] HSA Plus $2,600 (70%/50%) - 2014
- [ ] HSA Plus $2,600 (80%/50%) - 2014
- [ ] HSA Plus $2,600 (90%/50%) - 2014
- [ ] HSA Plus $2,600 (100%/50%) - 2014
- [ ] PPO $5,000/$25/$40 (70%/50%) - 2014
- [ ] PPO $4,000/$25/$40 (70%/50%) - 2014
- [ ] PPO $3,000/$25/$40 (70%/50%) - 2014
- [ ] PPO $2,500/$25/$40 (70%/50%) - 2014
- [ ] PPO $2,000/$25/$40 (70%/50%) - 2014
- [ ] PPO $1,500/$25/$40 (70%/50%) - 2014
- [ ] PPO $1,000/$25/$40 (70%/50%) - 2014
- [ ] PPO $500/$25/$40 (70%/50%) - 2014
- [ ] PPO $250/$25/$40 (70%/50%) - 2014
- [ ] PPO $5,000/$25/$40 (80%/60%) - 2014
- [ ] PPO $4,000/$25/$40 (80%/60%) - 2014
- [ ] PPO $3,000/$25/$40 (80%/60%) - 2014
- [ ] PPO $2,500/$25/$40 (80%/60%) - 2014
- [ ] PPO $2,000/$25/$40 (80%/60%) - 2014
- [ ] PPO $1,500/$25/$40 (80%/60%) - 2014
- [ ] PPO $1,000/$25/$40 (80%/60%) - 2014
- [ ] PPO $500/$25/$40 (80%/60%) - 2014
- [ ] PPO $250/$25/$40 (80%/60%) - 2014
- [ ] PPO $5,000/$25/$40 (90%/70%) - 2014
- [ ] PPO $4,000/$25/$40 (90%/70%) - 2014
- [ ] PPO $3,000/$25/$40 (90%/70%) - 2014
- [ ] PPO $2,500/$25/$40 (90%/70%) - 2014
- [ ] PPO $2,000/$25/$40 (90%/70%) - 2014
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- [ ] PPO $1,000/$25/$40 (90%/70%) - 2014
- [ ] PPO $500/$25/$40 (90%/70%) - 2014
- [ ] PPO $250/$25/$40 (90%/70%) - 2014
- [X] PPO $5,000/$25/$40 (100%/50%) - 2014
- [ ] PPO $4,000/$25/$40 (100%/50%) - 2014
- [ ] PPO $3,000/$25/$40 (100%/50%) - 2014
- [ ] PPO $2,500/$25/$40 (100%/50%) - 2014
- [ ] PPO $2,000/$25/$40 (100%/50%) - 2014
- [ ] PPO $1,500/$25/$40 (100%/50%) - 2014
- [ ] PPO $1,000/$25/$40 (100%/50%) - 2014
- [ ] PPO $500/$25/$40 (100%/50%) - 2014
- [ ] PPO $250/$25/$40 (100%/50%) - 2014
- [ ] HMO Plus $25/$40 - 2014

* The Alliance network covers Maricopa County, with only a few providers located outside Maricopa County. Please ask for more details.

Waiting Period Verification: The ACA prohibits waiting periods in excess of 90 days. By signing below you represent that you do not impose a waiting period which is longer than 90 days and that you have made all necessary changes to bring all waiting periods for your plan into compliance with the ACA requirements. You agree to promptly advise BCBSAZ of any change which may impact the accuracy of this representation. You agree to provide BCBSAZ with timely and accurate information regarding enrollee effective dates and shall ensure such effective dates comply with applicable laws.

- [ ] **I want to add BluePreferred Eyewear, BluePreferred Dental, and/or HealthEquity Integration** No

Health Plans	Plan Description	**Add HealthEquity Integration*** HSA	HRA	FSA	**Add Blue Preferred Eyewear (choose up to 1 plan per Health Plan)** Plan	**Add BluePreferred Dental**	
Plan 1	N/A					Plan 1	
Plan 2						Plan 2	
Plan 3						Ortho	
Plan 4							

The benefit and rates available must change if you are a small employer for purposes of the Affordable Care Act (ACA) or Arizona law. The rates and benefits in this proposal are not intended for groups considered small under the ACA or Arizona law and do not meet requirements necessary for that market.

THESE ARE PROPOSED RATES. Rates are subject to change based upon actual enrollment, employer contribution rates, employee participation, final and complete census information, coverage effective date, or review of medical information. Insurance brokers have no authority to bind coverage, guarantee rates or assign effective dates. BCBSAZ reserves the right to retroactively adjust final rates if information received after the effective date of coverage indicates that the enrollment information is inaccurate or a material misrepresentation was made in any of the enrollment material. BCBSAZ rates are proprietary and should not be shared with any other broker, agent or individual.

EMPLOYER PAID DENTAL ONLY: If BluePreferred Dental is selected, health rates will be reduced by approximately 1% while BluePreferred Dental remains in effect. If BluePreferred Dental is terminated during the contract period, health rates will revert to the rates shown above effective the date BluePreferred Dental is terminated. There is no reduction for Voluntary dental.

Authorized Signature | Please Print | Date

IMPORTANT NOTICE: BCBSAZ has made benefit modifications effective 1/1/2014. Please see Benefit Change Sheet.

* Groups selecting HealthEquity administration (including integration) services for HSA, HRA and/or FSA products hereby direct BCBSAZ to collect the HealthEquity administration fees and forward those fees to HealthEquity, along with the required personal health information. BCBSAZ is collecting the HealthEquity administration fees as a courtesy and is not responsible for any reconciliation, recoupment or adjustments to payments received and forwarded to HealthEquity on behalf of Employer. If Employer and HealthEquity negotiate alternative fees, Employer shall notify BCBSAZ. For a copy of the rates please contact your Client Service Manager. Employer agrees to pay charges for HealthEquity administration services. For HSAs and HRAs, those charges apply to all employees enrolled in a health plan the group has paired with a HealthEquity account. For FSAs, those charges apply to any employee for whom an FSA election has been sent to BCBSAZ by the employer.

BlueCross BlueShield of Arizona

Group Rate Proposal

Legal Company Name: CITY OF BENSON

Name of Group Health Plan: CITY OF BENSON Group Health Plan

Proposal Number:	20140506031-3	Broker:	INSIGHT RISK ADVISORS INC		
Policy Period:	7/1/2014 - 6/30/2015	Grp HQ:	Arizona	BDE:	Barbra Heintz - D
Group Rating Area:	Cochise	Grp Inc:	Arizona	BDE Phone #:	520-745-7332
				AHP Eligible:	84
				Health Enrolling:	75

These plans are considered non-grandfathered for the purposes of the Health Care Reform Law.

	Monthly Premium Rates ($'s)					
	EE Only	EE+Sp	EE+Ch	EE+Chren	Family	Total Premium
☐ PPO $5,000/$25/$40 (90%/70%) - 2014	$421.93	$729.94	$616.02	$616.02	$881.83	$45,036.80
☐ PPO $4,000/$25/$40 (90%/70%) - 2014	$451.86	$781.72	$659.72	$659.72	$944.39	$48,231.67
☐ PPO $3,000/$25/$40 (90%/70%) - 2014	$461.91	$799.10	$674.39	$674.39	$965.39	$49,304.22
☐ PPO $2,500/$25/$40 (90%/70%) - 2014	$489.08	$846.11	$714.06	$714.06	$1,022.18	$52,204.51
☐ PPO $2,000/$25/$40 (90%/70%) - 2014	$506.28	$875.86	$739.17	$739.17	$1,058.13	$54,040.37
☐ PPO $1,500/$25/$40 (90%/70%) - 2014	$526.16	$910.26	$768.19	$768.19	$1,099.67	$56,162.23
☐ PPO $1,000/$25/$40 (90%/70%) - 2014	$547.83	$947.75	$799.83	$799.83	$1,144.96	$58,475.32
☐ PPO $500/$25/$40 (90%/70%) - 2014	$589.97	$1,020.65	$861.36	$861.36	$1,233.04	$62,973.52
☐ PPO $250/$25/$40 (90%/70%) - 2014	$608.86	$1,053.33	$888.94	$888.94	$1,272.52	$64,989.85
☐ **PPO $5,000/$25/$40 (100%/50%) - 2014**	**$425.57**	**$736.24**	**$621.33**	**$621.33**	**$889.44**	**$45,425.33**
☐ PPO $4,000/$25/$40 (100%/50%) - 2014	$460.18	$796.11	$671.86	$671.86	$961.78	$49,119.61
☐ PPO $3,000/$25/$40 (100%/50%) - 2014	$489.34	$846.56	$714.44	$714.44	$1,022.72	$52,232.22
☐ PPO $2,500/$25/$40 (100%/50%) - 2014	$500.43	$865.74	$730.63	$730.63	$1,045.90	$53,415.91
☐ PPO $2,000/$25/$40 (100%/50%) - 2014	$523.79	$906.16	$764.73	$764.73	$1,094.72	$55,909.31
☐ PPO $1,500/$25/$40 (100%/50%) - 2014	$543.13	$939.61	$792.97	$792.97	$1,135.14	$57,973.62
☐ PPO $1,000/$25/$40 (100%/50%) - 2014	$565.47	$978.26	$825.59	$825.59	$1,181.83	$60,358.26
☐ PPO $500/$25/$40 (100%/50%) - 2014	$610.96	$1,056.96	$892.00	$892.00	$1,276.91	$65,213.89
☐ PPO $250/$25/$40 (100%/50%) - 2014	$622.44	$1,076.82	$908.76	$908.76	$1,300.90	$66,439.20
BlueSelect HMO Plus						
☐ HMO Plus $25/$40 - 2014	$611.31	$1,057.57	$892.51	$892.51	$1,277.64	$65,251.26
Total Contracts:	**EE Only: 33**	**EE+Sp: 11**	**EE+Ch: 8**	**EE+Chren: 8**	**Family: 15**	**Total: 75**

Small Businesses with at least 10 enrolled employees may offer any three plans to their employees.

EMPLOYER PAID DENTAL ONLY: If BluePreferred Dental is selected, health rates will be reduced by approximately 1% while BluePreferred Dental remains in effect. If BluePreferred Dental is terminated during the contract period, health rates will revert to the rates shown above effective the date BluePreferred Dental is terminated. There is no reduction for Voluntary dental.

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Group Rating Area:	Cochise	Grp Inc:	Arizona	AHP Eligible:	84
				Health Enrolling:	75

These plans are considered non-grandfathered for the purposes of the Health Care Reform Law.

	Monthly Premium Rates ($'s)					
	EE Only	EE+Sp	EE+Ch	EE+Chren	Family	Total Premium
BlueAlliance - Narrow Network Option*						
BlueAlliance $5,000/$20/$50 (70%/50%) - 2014	$299.26	$517.72	$436.92	$436.92	$625.45	$31,942.97
BlueAlliance $3,000/$20/$50 (70%/50%) - 2014	$330.17	$571.19	$482.05	$482.05	$690.06	$35,242.40
BlueAlliance $1,500/$20/$50 (70%/50%) - 2014	$372.82	$644.98	$544.32	$544.32	$779.19	$39,794.81

* The Alliance network covers Maricopa County, with only a few providers located outside Maricopa County. Please ask for more details.

HSA Plans as Standalone Option						
HSA Plus $4,000 (70%/50%) - 2014	$309.46	$535.37	$451.81	$451.81	$646.77	$33,031.76
HSA Plus $3,000 (70%/50%) - 2014	$320.01	$553.62	$467.21	$467.21	$668.82	$34,157.81
HSA Plus $2,600 (70%/50%) - 2014	$338.40	$585.43	$494.06	$494.06	$707.26	$36,120.79
HSA Plus $4,000 (80%/50%) - 2014	$313.25	$541.92	$457.35	$457.35	$654.69	$33,436.32
HSA Plus $3,000 (80%/50%) - 2014	$328.52	$568.34	$479.64	$479.64	$686.61	$35,066.29
HSA Plus $2,600 (80%/50%) - 2014	$349.57	$604.76	$510.37	$510.37	$730.60	$37,313.09
HSA Plus $4,000 (90%/50%) - 2014	$321.51	$556.21	$469.40	$469.40	$671.96	$34,317.94
HSA Plus $3,000 (90%/50%) - 2014	$341.38	$590.59	$498.41	$498.41	$713.48	$36,438.79
HSA Plus $2,600 (90%/50%) - 2014	$365.50	$632.32	$533.63	$533.63	$763.90	$39,013.60
HSA Plans As Multiple Option						
HSA Plus $4,000 (70%/50%) - 2014	$335.94	$581.18	$490.47	$490.47	$702.11	$35,858.17
HSA Plus $3,000 (70%/50%) - 2014	$347.61	$601.37	$507.51	$507.51	$726.50	$37,103.86
HSA Plus $2,600 (70%/50%) - 2014	$367.96	$636.57	$537.22	$537.22	$769.04	$39,276.07
HSA Plus $4,000 (80%/50%) - 2014	$340.13	$588.42	$496.59	$496.59	$710.87	$36,305.40
HSA Plus $3,000 (80%/50%) - 2014	$357.01	$617.63	$521.23	$521.23	$746.15	$38,107.19
HSA Plus $2,600 (80%/50%) - 2014	$380.32	$657.95	$555.27	$555.27	$794.87	$40,595.38
HSA Plus $4,000 (90%/50%) - 2014	$349.26	$604.22	$509.92	$509.92	$729.95	$37,279.97
HSA Plus $3,000 (90%/50%) - 2014	$371.25	$642.26	$542.03	$542.03	$775.91	$39,627.24
HSA Plus $2,600 (90%/50%) - 2014	$397.93	$688.42	$580.98	$580.98	$831.67	$42,475.04
HSA Plans As Standalone or Multiple Option						
HSA Plus $5,000 (100%/50%) - 2014	$350.88	$607.02	$512.28	$512.28	$733.34	$37,452.84
HSA Plus $4,000 (100%/50%) - 2014	$369.35	$638.98	$539.25	$539.25	$771.94	$39,424.43
HSA Plus $3,000 (100%/50%) - 2014	$398.36	$689.16	$581.61	$581.61	$832.57	$42,520.95
HSA Plus $2,600 (100%/50%) - 2014	$433.35	$749.70	$632.69	$632.69	$905.70	$46,255.79
Total Contracts:	EE Only: 33	EE+Sp: 11	EE+Ch: 8	EE+Chren: 8	Family: 15	Total: 75

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REQUESTED EFFECTIVE DATE (MM/DD/YYYY)

(NO RETROACTIVE CHANGES)

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

2-99 EMPLOYER APPLICATION
Exhibit B

CHECK SECTIONS TO BE CHANGED: ☐ I ☐ II ☐ III

PLEASE FULLY COMPLETE ALL SECTIONS OF THIS APPLICATION EVEN WHERE SPECIFIC PROVISIONS REMAIN UNCHANGED.

◯ NEW

◯ Change to existing group: GROUP #

SECTION I - EMPLOYER GROUP INFORMATION

LEGAL COMPANY NAME

DBA | PLAN YEAR ANNIVERSARY MONTH

ARIZONA LOCATION STREET ADDRESS | CITY | STATE AZ | ZIP CODE

ARIZONA BILLING ADDRESS | CITY | STATE AZ | ZIP CODE

COUNTY | FEDERAL TAX ID NUMBER | ARIZONA STATE TAX ID NUMBER

SUBSIDIARY OR AFFILIATE INFORMATION

DOES THE GROUP HAVE A PARENT COMPANY OR ANY SUBSIDIARY/SUBSIDIARIES OR AFFILIATE(S) FOR WHICH IT REQUESTS COVERAGE? ◯ YES ◯ NO

HEADQUARTERS LOCATION - STREET ADDRESS | CITY | STATE | ZIP CODE

TYPE OF BUSINESS | STATE INCORPORATED IN | CONTACT PHONE NUMBER | FAX

EXECUTIVE NAME | TITLE | E-MAIL

GROUP ADMINISTRATOR | TITLE | E-MAIL

LEGAL ENTITY

◯ CORP. ◯ LLC ◯ PARTNERSHIP ◯ POLITICAL SUBDIVISION/ MUNICIPALITY ◯ NON ARIZONA BASED ENTITY WHICH MEETS BCBSAZ UNDERWRITING GUIDELINES ◯ OTHER

SECTION II - PLAN INFORMATION - INDICATE HEALTH / DENTAL PLAN SELECTED AND HEALTH ACCOUNT ADMINISTRATION FROM HEALTH EQUITY*, IF ANY, SELECTED

	PPO	PPO HSA-QUALIFIED	HMO	OTHER	HSA INTEGRATION	HRA INTEGRATION	FSA INTEGRATION
HEALTH PLAN OPTION: _____	◯	◯	◯	◯	◯	◯	◯
HEALTH PLAN OPTION: _____	◯	◯	◯	◯	◯	◯	◯
HEALTH PLAN OPTION: _____	◯	◯	◯	◯	◯	◯	◯

◯ BluePreferred Dental OPTION:_____

◯ with ortho, child only

◯ with ortho, adult and child

LIFETIME ORTHO MAXIMUM

◯ $1,000 ◯ $1,500 ◯ $2,000

Waived 12 month waiting period for Type III benefits? ◯ YES ◯ NO

◯ OTHER

SECTION III - UNDERWRITING, ENROLLMENT, ELIGIBILITY, MANAGEMENT CONTINUATION AND PARTICIPATION

DOES THE EMPLOYER OFFER AN ENROLLMENT PERIOD OF AT LEAST 31 DAYS? ◯ YES ◯ NO (STANDARD RATES APPLY ONLY IF "YES")

1) EMPLOYER AGREES TO CONTRIBUTE TO PREMIUM COST FOR ELIGIBLE EMPLOYEES AS SPECIFIED IN BCBSAZ UNDERWRITING GUIDELINES. PLEASE REFER TO UNDERWRITING GUIDELINES FOR COMPLETE ELIGIBILITY, CONTRIBUTION AND PARTICIPATION REQUIREMENTS. (IF ELIGIBLE FOR RETIREE COVERAGE, SEE SECTION VI.)

DEFINE EMPLOYEE CLASSIFICATION AND INDICATE EMPLOYER CONTRIBUTION BY DOLLAR AMOUNT OR PERCENTAGE

CLASS 1 DEFINITION	ER HEALTH CONTRIBUTION →	EMPLOYEE	DEPENDENT	ER DENTAL CONTRIBUTION →	EMPLOYEE / DEPENDENT
CLASS 2 DEFINITION		EMPLOYEE	DEPENDENT		EMPLOYEE / DEPENDENT

2) EMPLOYEES ARE ELIGIBLE UPON COMPLETION OF THE FOLLOWING SPECIFIED EMPLOYEE'S ENROLLMENT WAITING PERIOD: CLASS 1 ◯ DAYS ◯ MONTHS; CLASS 2 ◯ DAYS ◯ MONTHS

3) NEW GROUP ENROLLMENT REGULATIONS

EMPLOYER'S HEALTH ENROLLMENT WAITING PERIODS WILL BE WAIVED AT THE NEW GROUP'S INITIAL ENROLLMENT ◯ YES ◯ NO

4) EMPLOYEE EFFECTIVE / TERMINATION DATE

◯ FIRST DAY OF THE BILLING MONTH FOLLOWING COMPLETION OF ENROLLMENT WAITING PERIOD / LAST DAY OF THE BILLING MONTH FOLLOWING LOSS OF ELIGIBILITY

OTHER ◯

5) DOMESTIC PARTNERS TO BE COVERED? ◯ YES ◯ NO

IF YES, GROUP ACCEPTS BCBSAZ DOMESTIC PARTNER CRITERIA AS DEFINED IN THE DECLARATION OF DOMESTIC PARTNERSHIP.

6) ELIGIBLE EMPLOYEES ARE DEFINED AS THOSE WORKING:

◯ A MINIMUM OF 25 HOURS PER WEEK ◯ OTHER

7) TOTAL NUMBER OF EMPLOYEES

TOTAL ELIGIBLE EMPLOYEES: | TOTAL NON-ELIGIBLE EMPLOYEES: | TOTAL NUMBER OF EMPLOYEES:

8) BANKRUPTCY

A) IN THE PAST 36 MONTHS, HAS THE COMPANY OR ANY AFFILIATED ENTITY FILED FOR PROTECTION OR OPERATED UNDER FEDERAL / STATE BANKRUPTCY LAWS? ◯ YES ◯ NO

B) IN THE PAST 36 MONTHS, HAS ANY CREDITOR FILED OR THREATENED TO FILE A PETITION REQUESTING THE COMPANY OR ANY AFFILIATED ENTITY TO BE PUT INTO BANKRUPTCY? ◯ YES ◯ NO

9) WORKER'S COMPENSATION **A)** DOES THE EMPLOYER PROVIDE WORKER'S COMPENSATION FOR ALL EMPLOYEES INCLUDING THE OWNER ◯ YES ◯ NO

B) IF NO, LIST THE EMPLOYEES NOT COVERED AND INDICATE REASON FOR NO COVERAGE BELOW IN BOXES 9-1 AND 9-2.

10) HOW MANY PREVIOUS GROUP HEALTH CARRIERS HAS THE GROUP HAD IN THE LAST FIVE YEARS?

11) LIST OTHER CO-EXISTING CARRIERS

9-1 NAME OF PERSON NOT COVERED:

REASON NOT COVERED:

9-2 NAME OF PERSON NOT COVERED:

REASON NOT COVERED:

SECTION IV - BROKER INFORMATION

LAST NAME | FIRST NAME | MI

AGENCY NAME

SUITE NO. | STREET ADDRESS

CITY | STATE | ZIP + FOUR

PHONE NUMBER (INCLUDE AREA CODE) | FAX NUMBER (INCLUDE AREA CODE) | E-MAIL

BROKER TAX ID NUMBER | BCBS BROKER NUMBER | ARIZONA DEPARTMENT OF INSURANCE LICENSE NUMBER

*HealthEquity is an independent company, contracted with BCBSAZ to administer HSAs, HRAs and FSAs for group benefit plans.

SECTION V - THIS SECTION APPLIES ONLY TO GROUPS OF 26 OR MORE ELIGIBLE EMPLOYEES

PLEASE COMPLETE THE FOLLOWING QUESTIONS WHEN APPLYING FOR NEW GROUP COVERAGE TO THE BEST OF YOUR KNOWLEDGE. THIS INFORMATION IS NECESSARY TO EVALUATE YOUR GROUP'S APPLICATION BY BLUE CROSS BLUE SHIELD OF ARIZONA. IN ORDER TO PROTECT THE INDIVIDUALS INVOLVED, DO NOT DISCLOSE THE NAME OF ANY EMPLOYEE OR DEPENDENT.

Are you aware of any employee, dependent, or COBRA employee who:

a) is currently disabled? _____ ◯ YES ◯ NO

b) incurred expenses of $5,000 or more in the last 18 months? _____ ◯ YES ◯ NO

c) has been advised that necessary surgery or hospitalization is required (including pregnancy)? _____ ◯ YES ◯ NO

d) has had an organ transplant such as kidney, liver, heart or lung? _____ ◯ YES ◯ NO

e) is currently being treated or diagnosed as having cancer, heart/lung disease, high blood pressure, diabetes, muscular skeletal condition? _____ ◯ YES ◯ NO

f) is currently taking medication? _____ ◯ YES ◯ NO

g) has been diagnosed or is being treated for any other known medical condition? _____ ◯ YES ◯ NO

h) has any other known medical conditions? _____ ◯ YES ◯ NO

If yes to any of the questions above, please explain: _____

_____

SECTION VI - RETIREE COVERAGE IS ONLY AVAILABLE AS SPECIFIED IN THE BCBSAZ UNDERWRITING GUIDELINES.

RETIREMENT ELIGIBILITY	RETIREES TO BE COVERED? ◯ YES ◯ NO	IF YES: ◯ UNDER 65 ◯ 65 AND OLDER	RETIREES DEPENDENTS TO BE COVERED? ◯ YES ◯ NO	OTHER THAN NEWBORNS, ETC. FOR WHICH COVERAGE MAY BE MANDATED UNDER APPLICABLE ARIZONA LAW

RETIREMENT PARTICIPATION REQUIREMENTS

A) RETIREE MUST COMPLETE YEARS OF SERVICE PRIOR TO RETIREMENT | B) RETIREE IS ELIGIBLE FOR COVERAGE ONLY THROUGH END OF BILLING PERIOD IN WHICH RETIREE REACHES AGE

C) OTHER:

SECTION VII - IMPORTANT - READ CAREFULLY

As the authorized representative of Company, I certify that the Company is the sole employer of the employees to be enrolled under this proposed contract for health insurance. I also certify that the information provided on this 2-99 Employer Application and all other applicable documents submitted in connection with this Application, is complete and accurate. I agree that Company shall promptly notify Blue Cross Blue Shield of Arizona (BCBSAZ) of any changes in this information that may affect the eligibility of employees or their dependents, including the hire date of any new eligible employees, addition of dependents, and the termination date of any enrolled employee or dependent. I understand and agree that BCBSAZ may, in its sole discretion, verify Health/Medical and all other information with or through outside sources, including third party investigative firms, as BCBSAZ deems necessary or appropriate for finalizing its decision on this Application. I agree that if the information (including medical information) contained in this Application or other supporting documentation is incomplete, inaccurate, materially misleading, false, or fraudulent, that BCBSAZ has the right to (a) retroactively adjust the Company's rates if such information would have affected the rate calculation; and (b) invalidate, or withdraw any rate proposal or terminate any group, to the extent permitted by law.

I understand and agree that this Application is not accepted until approved by BCBSAZ and that BCBSAZ's acceptance shall be based on information supplied by the group, the requested benefits, and any other information obtained from outside sources which BCBSAZ deems appropriate. BCBSAZ's acceptance shall be evidenced by the execution of this Application by an authorized representative of BCBSAZ, at which time this Application shall become binding upon BCBSAZ and the group. Upon acceptance, this Application shall be attached to and shall become a part of the Group Master Contract (the "Contract"). To the extent permitted by applicable law, BCBSAZ may terminate the Contract in accordance with the Contract terms, including the Group's failure to meet certain obligations under the Contract, such as failure to pay premium; failure to maintain Group contribution rates and percentages; and failure to maintain employee and/or dependent participation levels.

The Company agrees that it is solely responsible for ensuring that its classifications of employees for purposes of defining eligibility for benefits and the specific benefits available comply with applicable laws, including those which prohibit discrimination based upon salary. Company understands and agrees that federal law requires Company to provide dependent coverage for children under age 26, and prohibits Company from imposing pre-existing condition waiting periods for children under age 19.

By including my e-mail address on the reverse side, I authorize BCBSAZ to send me information via e-mail. I also understand I may change my e-mail address or rescind this permission at any time by contacting BCBSAZ through azblue.com.

Company Authorized Officer / Owner / Partner

X _____

SIGNATURE DATE

_____

TITLE LOCATION (CITY, STATE)

X _____

BCBSAZ Authorized Signature: DATE TITLE

To be completed by BCBSAZ

Team Code _____

GROUP # _____