

State: Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield
TOI/Sub-TOI: MS08G Group Medicare Supplement - Standard Plans 2010/MS08G.005 Plan F (Basic) 2010
Product Name: Group Medipak Application
Project Name/Number: Application/10-103 GRPRET R11/12

Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield
Product Name: Group Medipak Application
State: Arkansas
TOI: MS08G Group Medicare Supplement - Standard Plans 2010
Sub-TOI: MS08G.005 Plan F (Basic) 2010
Filing Type: Form
Date Submitted: 11/28/2012
SERFF Tr Num: ARBB-128787172
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: 10-103 GRPRET R11/12

Implementation: 11/01/2012
Date Requested:
Author(s): Christi Kittler, Yvonne McNaughton, Frank Sewall, Rita Thatcher, Evelyn Laney
Reviewer(s): Stephanie Fowler (primary)
Disposition Date: 12/05/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

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TOI/Sub-TOI: MS08G Group Medicare Supplement - Standard Plans 2010/MS08G.005 Plan F (Basic) 2010
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Project Name/Number: Application/10-103 GRPRET R11/12

General Information

Project Name: Application	Status of Filing in Domicile: Pending
Project Number: 10-103 GRPRET R11/12	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Arkansas is state of domicile.
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 12/05/2012	Deemer Date:
State Status Changed: 12/05/2012	Submitted By: Evelyn Laney
Created By: Evelyn Laney	
Corresponding Filing Tracking Number:	

Filing Description:

Attached please find forms 10-103GRPRET R11/12 for your review and approval if indicated.

In Form 10-103GRPRET R11/12, we have changed the COBRA language on this application to be like all of our other applications.

Also attached is a Flesch Reading Ease score certification signed by an officer of the company as required by Arkansas Code Annotated §23-80-206(d).

I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19.

I certify that the Life and Health Guaranty Association Notices required by Arkansas Insurance Department Rule & Regulation 49 are incorporated in the benefit certificates to which this amendment will be attached.

I further certify that the Life and Health Guaranty Association Notices required by Arkansas Insurance Department Rule & Regulation 49 and the consumer information notice required by Arkansas Code Annotated §23-79-138 are incorporated in the policies to which this amendment is attached.

Please feel free to contact me at 378-2165 with any questions you may have.

Company and Contact

Filing Contact Information

Evelyn Laney, Senior Compliance Analyst exlaney@arkbluecross.com
 320 West Capitol, Ste 211 501-378-2165 [Phone]
 Little Rock, AR 72201 501-378-2975 [FAX]

Filing Company Information

Arkansas Blue Cross and Blue Shield	CoCode: 83470	State of Domicile: Arkansas
601 S. Gaines Street	Group Code:	Company Type:
Little Rock, AR 72201	Group Name:	State ID Number: N/A
(501) 378-2967 ext. [Phone]	FEIN Number: 71-0226428	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	\$50.00

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Per Company: No

Company	Amount	Date Processed	Transaction #
Arkansas Blue Cross and Blue Shield	\$50.00	11/28/2012	65260085

SERFF Tracking #:

ARBB-128787172

State Tracking #:

Company Tracking #:

10-103 GRPRET R11/12

State:

Arkansas

Filing Company:

Arkansas Blue Cross and Blue Shield

TOI/Sub-TOI:

MS08G Group Medicare Supplement - Standard Plans 2010/MS08G.005 Plan F (Basic) 2010

Product Name:

Group Medipak Application

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Application/10-103 GRPRET R11/12

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	12/05/2012	12/05/2012

SERFF Tracking #:

ARBB-128787172

State Tracking #:

Company Tracking #:

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Filing Company: Arkansas Blue Cross and Blue Shield

Disposition

Disposition Date: 12/05/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form	Application	Approved-Closed	Yes

State: Arkansas

Filing Company:

Arkansas Blue Cross and Blue Shield

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Form Schedule

Lead Form Number: 10-103 GRPRET R11/12

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1	Approved-Closed 12/05/2012	Application	10-103 GRPRET R11/12	AEF	Revised	Previous Filing Number:	10-103 GRPRET 1/10		10-103GRPRET_R11-12.pdf
						Replaced Form Number:	10-103 GRPRET R11/12		

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



APPLICATION by:

(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.

SECTION 1. GROUP INFORMATION

Legal Name of Business:

D/B/A:

Street Address:

City, State, Zip:

County:

Mailing Address: (if different from Street)

City, State, Zip:

Telephone #:

Fax #:

Fed. Tax I.D. #:

Business Type: [Sole Proprietorship] [Legal Partnership]
[Corporation] [Government Entity]

Exec. Contact:

E-Mail:

Group Administrator:

E-Mail:

Primary SIC Code:

SIC Description:

Agent:

Agent's Lic #:

Agent's Company:

Agent's Tax Id:

SECTION 2. 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.

SECTION 3. 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 Members' meeting.

SECTION 4. BENEFIT SELECTION

RETIREE MEDIPAK® GROUP BENEFITS

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: _____

Class	Class Description	Waiting Period	Contribution		
			Retiree	% Dependent	%

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

Medicare Extended Hospital Services

100% of Medicare Part A Inpatient Hospital Deductible
Part A Medicare Eligible Expenses for 61st through 90th day per Benefit Period
Part A Medicare Eligible Expenses for 91st through 150th day (Lifetime Reserve)
Part A Medicare Eligible Expenses for additional 365 days
Part A – Blood – Cost of first 3 pints of blood
Extended Care Services received at Participating Skilled Nursing Facility during 21st through the 100th day per Benefit Period

Medicare Part B Services

100% of Medicare Part B Deductible
Part B Coinsurance for Medicare Eligible Expenses
Part B – Blood – Cost of first 3 pints of blood
Part B Medicare Excess Charges

Medically Necessary Emergency Care in a Foreign Country

Fitness Program Rider

Rates

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.

SECTION 5. ATTESTATIONS

There are a number of federal regulations that impact small group business owners, either in requirements to provide health plan benefits or the types of benefits that must be offered. Our goal is to assist you in meeting these requirements, to help us accomplish this we ask that each small group business owner provide us with answers to the questions below.

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.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 Ceridian?

(Yes ___)(No ___) If yes, are you currently contracting directly with Ceridian?

Medicare Secondary Payer – If you have employees who are over 65 and enrolled in Medicare, Medicare will pay as “primary” if you have less than 20 employees (note that other criteria may apply as well). If Medicare is primary, we will offer lower “group health plan” rates to your employees who are over 65 and have their Medicare card, but not if Medicare is secondary. The count of employees is determined on whether or not you employed 20 or more full time and part time employees each working day of 20 or more calendar weeks during the current or the previous calendar year.

Under the governmental guidelines discussed above, the group health plan will result in Medicare being the secondary payer, due to meeting the criteria for 20 or more employees as defined above. (Yes ___) (No ___)²

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

² 42 CFR §411.170.

SECTION 6. RETIREE / DEPENDENT INFORMATION, MINIMUM NUMBER OF INSURED RETIREES / DEPENDENTS & 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).

	In State	OUT OF STATE	TOTAL
Total Number of Retirees and Dependents			

Minimum Number of Insured Retirees and Dependents. To meet group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. A group must maintain 25 enrolled Retirees and Dependents to remain active in the plan.
This Policy may be terminated by the Company if the number of insured Retirees and Dependents fall below the minimum number of insured Retirees and Dependents specified above.

SECTION 7. 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 apply for the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies applied for, will take effect as of the next available effective date after approval, 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 individual applications). I have complied with the underwriting rules and regulations and have explained in detail the coverage to the member firm and its retirees including 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.

_____ Agent Signature

_____ Insurance License #/Agency Fed. Tax ID#

_____ Agent Printed Name

_____ Date

SERFF Tracking #:

ARBB-128787172

State Tracking #:

Company Tracking #:

10-103 GRPRET R11/12

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification		
Bypass Reason:	Not required.		
		Item Status:	Status Date:
Bypassed - Item:	Application		
Bypass Reason:	Already attached.		
		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage		
Bypass Reason:	Not required.		