

BLUESENROLL LARGE EMPLOYER APPLICATION

New Group	⊠Renewal Group			
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.				
SECTION 1. GROUP INFORMATION				
Legal Name of Business: CITY OF JONESBORO				
D/B/A: CITY OF JONESBORO				
Street Address: P.O. BOX 1845				
Mailing Address: (if different from Street)				
City, State, Zip JONESBORO, AR 72403	County: CRAIGHEAD			
Telephone #: 870-933-4640				
Fax #:				
Fed. Tax I.D. #: 71-6013749	Group #: 011649			
Exec. Contact: DOUG FORMON	E-Mail:			
Group Administrator: GLORIA ROARK	E-Mail:			
Primary SIC Code: 9199	SIC Description:			
Business Type: Sole Proprietorship Legal I	Partnership			
SECTION 2. 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 any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Members' meeting.				
SECTION 3. 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 4. COBRA ADMINISTRATION			
The Policyholder is subject to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985,			
commonly known as COBRA.			
1. The Policyholder will contract with Ceridian, Inc. to provide it COBRA administration: Yes No			
2. If "No" who will handle COBRA administration for you?			
The Policyholder agrees to indemnify ABCBS for any damage, claim or loss ABCBS may suffer by any action, litigation, suit, or claim brought by any individual arising out of the Policyholder's failure or Policyholder's COBRA administrator's failure to perform duties under COBRA.			
Section 5. Benefit Selection			
Term Life and AD&D through USAble Life NOT provided.			
CARVE-OUT HSA			
Employers may select a Blue~by~Design HSA benefit option for one class of employees and pair it with a PPO benefit option for the other class of employees. Select options for this employer below. Class descriptions are listed in Section 8.			
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: PPO Employee: % Dependent: %			
HSA Employee: % Dependent: %			
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.			
BLUE~BY~DESIGN HRA (Check Selected Benefits)			
HRA Contribution Frequency: Annually Monthly Semi-Monthly			
Annual HRA contribution by tier:			
Employee Only: Employee/Spouse: Employee/Child: Family:			
COMPREHENSIVE MAJOR MEDICAL (CMM) (Check Selected Benefits)			
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: Employee: % Dependent: %			
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.			
Lifetime Maximum: \$1,000,000 \$2,000,000 \$5,000,000			
Deductible \$200 \$250 \$300 \$500 \$750 \$1,000 Other:			
Coinsurance 90% 80% 70% 60% 50% Other:			
Calendar Year Coinsurance Max: \$2,500 \$5,000 \$10,000 Other:			
Family Deductible (Max # / family) 2X 3X Basis: Accumulated Fulfillment			
Family Calendar Year Coinsurance Max (Max # / family) 2X 3X Basis: Accumulated Fulfillment			
CMM Optional Benefits:			
☐ Air Ambulance Benefit Rider ☐ \$1,000 ☐ \$2,000 ☐ \$3,000 ☐ \$4,000 ☐ \$5,000			

Supplemental Accident Benefit Rider

SECTION 5. BENEFIT SELECTION (CONTINUED)			
PREFERRED PROVIDER ORGANIZATION (PPO) (Check Selected Benefits)			
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: Employee: 66% Dependent: 66%			
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. Lifetime Maximum: \$\infty\$ \$1,000,000 \$\infty\$ \$5,000,000 \$\infty\$ \$5,000,000			
In-Network Calendar Year Coinsurance Max \$2,500 \$\infty\$ \$5,000 \$\infty\$ \$10,000 \$\infty\$ Other:			
Out-of-Network Calendar Year Coinsurance Max None 2X 4X Other:			
Family Deductible Max (Max # / family) \[\text{\text{2X}} \text{\text{3X}} \] Basis: \[\text{\text{\text{Accumulated}}} \text{\text{Fulfillment}} \]			
Family Calendar Year Coinsurance Max (Max # / family)			
PPO Optional Benefits: Air Ambulance Benefit Rider \$1,000 \$2,000 \$3,000 \$4,000 \$5,000			
✓ PCP Benefit Rider Office Visit Fee □\$10 PCP □\$20 PCP ☑ \$30 PCP □ Other:			
Supplemental Accident Benefit Rider			
Wellness Benefit Rider			
Special Group Considerations Form Number: 23-2186 Description: NO DEDUCTIBLE CARRYOVER			
Any special group considerations must be listed here (e.g. alternate eligibility, retirees, etc.)			
Prescription Drug Riders Available with CMM or PPO (Check Selected Benefit)			
2 Tier Copay Plan			
□ 3 Tier Copay Plan □ \$7/\$15/\$25 □ \$7/\$25/\$50 □ \$10/\$20/\$30 □ \$7/\$30/\$50 □ \$7/\$40/\$50 □			
\$10/\$30/\$50 Other:			
☐ 3 Tier Copay + Coin. Plan* ☐ [\$10/\$20/\$30 + 20%] ☐ [\$10/\$30/\$50+20%] ☐ Other:			
Deductible + Coin. Plan Ded.: \$25 \$50 \$75 \$100 Other:			
Coin. PPO: (Medical - 90/70 or 80/60) 20% (Medical - 70/50) 30%			
Coin. CMM: (Medical Coinsurance %) %			
*Based on actuarial review, this drug benefit option is non-creditable to the standard Medicare Part D prescription coverage.			

SECTION 5. BENEFIT SELECTION	N (CONTIN	UED)				
BLUE~BY~DESIGN HSA (Che		efit)				
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: Employee: % Dependent: %				%		
Annual HSA contribution by tier:						
Employee Only: Employee/Spouse: Employee/Child: Family:				ilv:		
HSA Contribution Frequency: Annually Monthly Semi-Monthly						
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.						
ENEFITS 611 612 613 614 615 616						T [C4 C
DEDUCTIBLE				014	1 013	<u>DIO</u>
Aggregate Individual In-Network	[\$1,200*]	\$2,000	\$3,000	\$4,000	\$5,000	\$2,000
Aggregate Family In-Network	[\$2,400*]	\$4,000	\$6,000	\$8,000	\$10,000	\$4,000
Aggregate Individual Out-of-Network	\$2,400	\$4,000	\$6,000	\$8,000	\$10,000	\$4,000
Aggregate Family Out-of-Network	\$4,800	\$8,000	\$12,000	\$16,000	\$20,000	\$8,000
COINSURANCE						
In-Network	80%	80%	100%	100%	100%	100%
Out-of-Network	60%	60%	80%_	80%	80%	80%
CALENDAR YEAR COINSURANCE MAX	140.001	<u> </u>	-			
Aggregate Individual In-Network	[\$2,000*]	\$2,000	\$0	\$0	\$0	\$0
Aggregate Family In-Network Aggregate Individual Out-of-Network	[\$4,000*] \$8,000	\$4,000	\$0 Unlimited	\$0	\$0	\$0
Aggregate Family Out-of-Network	\$16,000	\$8,000 \$16,000	Unlimited	Unlimited Unlimited	Unlimited Unlimited	Unlimited Unlimited
adjusted annually for inflation each January 1, in accordance with the provisions of §223 of the Internal Revenue Code of the United						
	States of America as amended]					
LIFETIME MAXIMUM						
WELLNESS	Yes/	No				
AIR AMBULANCE						
MATERNITY (OPTIONAL UNDER 15 EMPLOYEES) Yes/ No						
	ORUG COVERAGE					
Option 1 (Standard Formulary)	Subject to Deductible & Coinsurance					
Formulary)*	Formulary)*					
Option 3 (No Coverage)	No Covera					_
*Based on actuarial review, this drug benefit op				re Part D pres	cription coverag	je.
SECTION 6. ARKANSAS MANDATE	ED OFFER	BENEFIT R	IDERS			
You	ı <u>Must</u> Elec	ct Or Rejec	t Each Ride	er		
Type of Benefit Rider					Elect	Reject
Mammography:						\boxtimes
Psychiatric Conditions:						
Substance Abuse:				\boxtimes		
TMJ [*]						\boxtimes
Rejection of the TMJ Benefit Rider means temporomandibular joint disorders (TMJ)				ersons will <u>no</u>	<u>t</u> include	

SECTION 7. 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 ENROLLING WAIVING TOTAL 1. Full-Time Employees (In-State) 2. Full-Time Employees (Out-of-State): 3. COBRA Continuees 4. Total of lines 1, 2 & 3 (Enrolling & Waiving) 5. Part Time / Seasonal / Temporary Employees 6. Total # of Employees (add 4 & 5) Minimum Number of Insured Employees. To meet large group enrollment guidelines a group must have at least fifty-one Full-Time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal. Groups dropping below two Full-Time employees will no longer be eligible for group insurance. Minimum Participation Requirements. If an employer pays 100% of the employee-only premium, 100% of all Full-Time employees must be insured. If an employer pays less than 100% of the premium, 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 55% 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. SECTION 8. WAITING PERIOD & OPEN ENROLLMENT PERIOD & EFFECTIVE/RENEWAL DATE OF COVERAGE Class A: FULL TIME EMPLOYEES Class B: (Description) (Description) Waiting Period for New Hires -Waiting Period for New Hires -No waiting period No waiting period 1 month 1 month 2 months 2 months 3 months 3 months 4 months 4 months ີ 5 months ☐ 5 months 6 months ceil 6 months 12/31/08 Open Enrollment Period If a period is not specified, the Group's Open Enrollment Period will be the month prior to the Group's renewal date. Is Waiting Period for Initial Enrollment Waived? Tyes Tyes No Requested effective date, pending approval is (Please Note: If a complete group enrollment packet is not received timely, the group, if approved, will be assigned the next available effective date.) Rates and benefits are effective: 1/1/09

STUDENT AGE 23

RATE CHANGE

BENEFIT CHANGES: RX TO \$7/\$30/\$50

SECTION 9. 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 attached premium rate schedule.

Any person who kno benefit or knowing insurance is guilty	y presents fal	lse informati	on in connec	ction with an	application for
					
		· ·			

Tier	Product	Rate
EE	PPO	\$326.22
ESC	PPO	\$700.85

¹ The agent(s) or broker(s) involved in this insurance transaction 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 insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.



BLUESENROLL LARGE EMPLOYER APPLICATION

New Group Renewal Group		
APPLICATION by: CITY OF JONESBORO - PKG 06 - MEDI-PAK		
for a Group Policy covering the employees of the employees. The Policyholder intends hereby to es	ed "Policyholder") Policyholder and the eligible dependents of such tablish and maintain an employee benefit plan (the dependents, to contribute to the cost of the Plan, and loyees.	
SECTION 1. GROUP INFORMATION		
Legal Name of Business: CITY OF JONESBORO		
D/B/A: CITY OF JONESBORO		
Street Address: P.O. BOX 1845		
Mailing Address: (if different from Street)		
City, State, Zip JONESBORO, AR 72403	County: CRAIGHEAD	
Telephone #: 870-933-4640		
Fax #:		
Fed. Tax I.D. #: 71-6013749	Group #: 011649	
Exec. Contact: DOUG FORMON	E-Mail:	
Group Administrator: GLORIA ROARK	E-Mail:	
Primary SIC Code: 9199	SIC Description:	
Business Type: Sole Proprietorship Legal	Partnership	
as its proxy to act on its behalf at all meetings of members the Board may designate by resolution to act on its behalf vote for the Policyholder on all matters that may be voted held each year at the home office of ABCBS located at Monday of March, at 1:00 p.m. If the third Monday of Martime and place on the next day after, which is not a legal honot less than ten (10) or more than sixty (60) days prior to effect during the Policyholder's membership in ABCBS. The	Board") of Arkansas Blue Cross and Blue Shield ("ABCBS"), of ABCBS. This appointment shall include such persons as This proxy gives the Board, or its designee, full power to upon at any meeting. The annual meeting of Members is 601 S. Gaines Street, Little Rock, Arkansas, on the third rich is a legal holiday, then the meeting will be at the same bliday. A special meeting may be called upon notice mailed such meeting. This proxy, unless revoked, shall remain in e Policyholder may revoke this proxy in writing by advising ys prior any meeting. The Policyholder may also revoke its setting.	
SECTION 3. POLICYHOLDER AS PLAN ADMINISTRATOR		
The Policyholder, as Plan Administrator, assumes responsi Blue Cross and Blue Shield ("ABCBS"), including all inform to be covered under the Plan, as well as medical inform Policyholder agrees that if misrepresentations are made in Application or any of the materials submitted with it, includinformation, then ABCBS may cancel or rescind this misrepresentations or false or misleading information is presented as a cancel or rescind the coverage of any individual may cancel or rescind the entire Group Policy if the Police	bility for the accuracy of information presented to Arkansas ation on the employment status and eligibility of individuals ation provided with respect to each such individual. The any of the information provided for rating or in this Group ling, but not limited to, individual applications and medical Group Policy. The Policyholder further agrees that if sented in filing of any claims hereunder ("improper claims"), that involved in presenting such a claim. Further, ABCBS sybolder or any representative of the Policyholder knew or exholder's action or inaction contributed to presentation of	

SECTION 4. COBRA ADMINISTRATION				
The Policyholder is subject to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 19 commonly known as COBRA. 1. The Policyholder will contract with Ceridian, Inc. to provide it COBRA administration: Yes I	985, No			
2. If "No" who will handle COBRA administration for you?				
The Policyholder agrees to indemnify ABCBS for any damage, claim or loss ABCBS may suffer by any action, litigation, suit, or claim brought by any individual arising out of the Policyholder's failure or Policyholder's COBRA administrator's failure to perform duties under COBRA.				
SECTION 5. BENEFIT SELECTION				
Term Life and AD&D through USAble Life NOT provided.				
CARVE-OUT HSA				
Employers may select a Blue~by~Design HSA benefit option for one class of employees and pair it with a PPO benefit option for the other class of employees. Select options for this employer below. Class descriptions are list in Section 8.	ed			
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: PPO Employee: % Dependent:	%			
HSA Employee: % Dependent:	%			
NOTE: The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by Company if the Policyholder fails to contribute the percentage of Employees' premium specified above.	the			
BLUE~BY~DESIGN HRA (Check Selected Benefits)				
HRA Contribution Frequency: Annually Monthly Semi-Monthly				
Annual HRA contribution by tier:				
Employee Only: Employee/Spouse: Employee/Child: Family:				
COMPREHENSIVE MAJOR MEDICAL (CMM) (Check Selected Benefits)				
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: Employee: % Dependent: %				
NOTE: The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by Company if the Policyholder fails to contribute the percentage of Employees' premium specified above.	the			
Company if the Policyholder fails to contribute the percentage of Employees' premium specified above. Lifetime Maximum: \$1,000,000 \$2,000,000 \$5,000,000	the			
Company if the Policyholder fails to contribute the percentage of Employees' premium specified above.	the			
Company if the Policyholder fails to contribute the percentage of Employees' premium specified above. Lifetime Maximum: \$1,000,000 \$2,000,000 \$5,000,000 Deductible \$200 \$250 \$300 \$500 \$750 \$1,000 Other: Coinsurance 90% 80% 70% 60% 50% Other:	the			
Company if the Policyholder fails to contribute the percentage of Employees' premium specified above. Lifetime Maximum: \$1,000,000 \$2,000,000 \$5,000,000 Deductible \$200 \$250 \$300 \$500 \$1,000 Other: Coinsurance 90% 80% 70% 60% 50% Other: Calendar Year Coinsurance Max: \$2,500 \$5,000 \$10,000 Other:				
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Company if the Policyholder fails to contribute the percentage of Employees' premium specified above. Lifetime Maximum: \$1,000,000 \$2,000,000 \$5,000,000 Deductible \$200 \$250 \$300 \$500 \$750 \$1,000 Other: Coinsurance \$90\% \$80\% 70\% 60\% 50\% Other: Calendar Year Coinsurance Max: \$2,500 \$5,000 \$10,000 Other:	ent			
Company if the Policyholder fails to contribute the percentage of Employees' premium specified above. Lifetime Maximum: \$1,000,000 \$2,000,000 \$5,000,000 Deductible \$200 \$250 \$300 \$500 \$750 \$1,000 Other: Coinsurance 90% 80% 70% 60% 50% Other: Calendar Year Coinsurance Max: \$2,500 \$5,000 \$10,000 Other: Family Deductible (Max # / family) \$2X 3X Basis: Accumulated Fulfillme Family Calendar Year Coinsurance Max (Max # / family) 2X 3X Basis: Accumulated Fulfillme CMM Optional Benefits:	ent			
Company if the Policyholder fails to contribute the percentage of Employees' premium specified above. Lifetime Maximum: \$1,000,000 \$2,000,000 \$5,000,000 Deductible \$200 \$250 \$300 \$500 \$750 \$1,000 Other: Coinsurance 90% 80% 70% 60% 50% Other: Calendar Year Coinsurance Max: \$2,500 \$5,000 \$10,000 Other: Family Deductible (Max # / family) 2X 3X Basis: Accumulated Fulfillments Family Calendar Year Coinsurance Max (Max # / family) 2X 3X Basis: Accumulated Fulfillments	ent			

SECTION 5. BENEFIT SELECTION (CONTINUED)			
PREFERRED PROVIDER ORGANIZATION (PPO) (Check Selected Benefits)			
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: Employee: 66% Dependent: 66%			
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.			
Lifetime Maximum: \$1,000,000 \$2,000,000 \$5,000,000			
Deductible \$250 \$300 \$500 \$750 \$1,000 Other:			
Coinsurance 90%/70% 80%/60% 70%/50% Other:			
In-Network Calendar Year Coinsurance Max \$2,500 \$5,000 \$10,000 Other:			
Out-of-Network Calendar Year Coinsurance Max None 2X 4X Other:			
Family Deductible Max (Max # / family)			
Family Calendar Year Coinsurance Max (Max # / family)			
PPO Optional Benefits:			
☐ Air Ambulance Benefit Rider ☐\$1,000 ☐\$2,000 ☐\$3,000 ☐\$4,000 ☐\$5,000			
PCP Benefit Rider Office Visit Fee \$10 PCP \$20 PCP \$30 PCP Other:			
☐ PCP/SCP Benefit Rider Office Visit Fee ☐\$20 PCP/\$40 SCP ☐\$30 PCP/\$50 SCP			
Supplemental Accident Benefit Rider			
Wellness Benefit Rider			
Special Group Considerations Form Number: 23- Description:			
Any special group considerations must be listed here (e.g. alternate eligibility, retirees, etc.)			
Prescription Drug Riders Available with CMM or PPO			
(Check Selected Benefit)			
2 Tier Copay Plan \$3/\$10 \$7/\$15 \$10/\$20 Other:			
3 Tier Copay + Coin. Plan* [\$10/\$20/\$30 + 20%] [\$10/\$30/\$50+20%] Other:			
Deductible + Coin. Plan Ded.: \$25 \\$50 \\$75 \\$100 \Other:			
Deductible + Com. Plan			
Coin. CMM: (Medical Coinsurance %) (%			
*Based on actuarial review, this drug benefit option is non-creditable to the standard Medicare Part D prescription coverage.			

SECTION 7. EMPLOYEE INFORMATION, MINIMUN	NUMBER OF	INSURED EN	PLOYEES &	MINIMUM	
PARTICIPATION REQUIREMENTS.					
Full-Time means an active employee with a minimum of 30 hrs/week &	48 weeks/year	ENROLLING	WAIVING	TOTAL	
Full-Time Employees (In-State)					
2. Full-Time Employees (Out-of-State):					
3. COBRA Continuees					
4. Total of lines 1, 2 & 3 (Enrolling & Waiving)					
5. Part Time / Seasonal / Temporary Employees					
6. Total # of Employees (add 4 & 5)					
Minimum Number of Insured Employees. To meet large gr Time enrolled employees. Groups whose enrollment subsequently renewal. Groups dropping below two Full-Time employees will no lo	drops below fifty-o nger be eligible for	ne enrolled must l group insurance.	oe rated as a sm	nall group upon	
must be insured. If an employer pays less than 100% of the p	Minimum Participation Requirements. If an employer pays 100% of the employee-only premium, 100% of all Full-Time employees must be insured. If an employer pays less than 100% of the premium, 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 55% of the Full-Time employees must enroll.				
This Policy may be terminated by the Company if the number insured Employees specified above or if the percentage of electromes less than the percentage of Employee participation specified above.	ligible Employee				
SECTION 8. WAITING PERIOD & OPEN ENROLL	MENT PERIOD	& EFFECTIV	E/RENEWAL	DATE OF	
COVERAGE				to the second	
Class A: FULL TIME EMPLOYEES	Class B:				
(Description)		(Descript	ion)	Ì	
Waiting Period for New Hires - Waiting Period for New Hires -				1	
☐ No waiting period				}	
☑ 1 month ☐ 1 month			ļ		
2 months	2 months			j	
3 months	3 months			}	
4 months	4 months			{	
5 months 5 months			}		
6 months 6 months					
Open Enrollment Period 12/1 - 12/31/08					
If a period is not specified, the Group's Open Enrollment Period will be the month prior to the Group's renewal date.					
Is Waiting Period for Initial Enrollment Waived? Tyes No					
Requested effective date, pending approval is					
(Please Note: If a complete group enrollment packet is not received timely, the group, if approved, will be					
assigned the next available effective date.)					
Rates and benefits are effective: 1/1/09					
STUDENT AGE 23					
BENEFIT CHANGES: RX TO \$7/\$30/\$50				1	

RATE CHANGE

1

SECTION 9. 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 attached 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.

Tier	Product	Rate
EE	PPO	\$80.64
	_	

¹ The agent(s) or broker(s) involved in this insurance transaction 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 insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

Tier	Product	Rate
EE	PPO	\$80.49
,		
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BLUESENROLL LARGE EMPLOYER APPLICATION

New Group	⊠Renewal Group
APPLICATION by: CITY OF JONESBORO - PKG	05 RETIREES AND/OR DEPENDENTS
for a Group Policy covering the employees of the employees. The Policyholder intends hereby to es	ed "Policyholder") Policyholder and the eligible dependents of such tablish and maintain an employee benefit plan (the dependents, to contribute to the cost of the Plan, and loyees.
SECTION 1. GROUP INFORMATION	
Legal Name of Business: CITY OF JONESBORO	
D/B/A: CITY OF JONESBORO	
Street Address: P.O. BOX 1845	
Mailing Address: (if different from Street)	
City, State, Zip JONESBORO, AR 72403	County: CRAIGHEAD
Telephone #: 870-933-4640	
Fax #:	
Fed. Tax I.D. #: 71-6013749	Group #: 011649
Exec. Contact: DOUG FORMON	E-Mail:
Group Administrator: GLORIA ROARK	E-Mail:
Primary SIC Code: 9199	SIC Description:
Business Type: Sole Proprietorship Legal I	Partnership
as its proxy to act on its behalf at all meetings of members of the Board may designate by resolution to act on its behalf, vote for the Policyholder on all matters that may be voted held each year at the home office of ABCBS located at Monday of March, at 1:00 p.m. If the third Monday of Martime and place on the next day after, which is not a legal honot less than ten (10) or more than sixty (60) days prior to effect during the Policyholder's membership in ABCBS. Th	doard") of Arkansas Blue Cross and Blue Shield ("ABCBS"), of ABCBS. This appointment shall include such persons as This proxy gives the Board, or its designee, full power to upon at any meeting. The annual meeting of Members is 601 S. Gaines Street, Little Rock, Arkansas, on the third rich is a legal holiday, then the meeting will be at the same sliday. A special meeting may be called upon notice mailed such meeting. This proxy, unless revoked, shall remain in e Policyholder may revoke this proxy in writing by advising ys prior any meeting. The Policyholder may also revoke its setting.
SECTION 3. POLICYHOLDER AS PLAN ADMINIST	RATOR
Blue Cross and Blue Shield ("ABCBS"), including all information be covered under the Plan, as well as medical informations agrees that if misrepresentations are made in Application or any of the materials submitted with it, including	bility for the accuracy of information presented to Arkansas ation on the employment status and eligibility of individuals ation provided with respect to each such individual. The any of the information provided for rating or in this Group ling, but not limited to, individual applications and medical 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 4. COBRA ADMINISTRATION
The Policyholder is subject to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985,
commonly known as COBRA. 1. The Policyholder will contract with Ceridian, Inc. to provide it COBRA administration: Yes No
2. If "No" who will handle COBRA administration for you?
The Policyholder agrees to indemnify ABCBS for any damage, claim or loss ABCBS may suffer by any
action, litigation, suit, or claim brought by any individual arising out of the Policyholder's failure or Policyholder's COBRA administrator's failure to perform duties under COBRA.
SECTION 5. BENEFIT SELECTION
Term Life and AD&D through USAble Life NOT provided.
CARVE-OUT HSA
Employers may select a Blue~by~Design HSA benefit option for one class of employees and pair it with a PPO benefit option for the other class of employees. Select options for this employer below. Class descriptions are listed in Section 8.
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: PPO Employee: % Dependent: %
HSA Employee: % Dependent: %
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.
BLUE~BY~DESIGN HRA (Check Selected Benefits)
HRA Contribution Frequency: Annually Monthly Semi-Monthly
Annual HRA contribution by tier:
Employee Only: Employee/Spouse: Employee/Child: Family:
COMPREHENSIVE MAJOR MEDICAL (CMM) (Check Selected Benefits)
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: Employee: % Dependent: %
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.
Lifetime Maximum: \$1,000,000 \$2,000,000 \$5,000,000
Deductible □\$200 □\$250 □\$300 □\$500 □\$750 □\$1,000 □ Other:
Coinsurance □ 90% □ 80% □ 70% □ 60% □ 50% □ 0ther:
Calendar Year Coinsurance Max: \$2,500 \$5,000 \$10,000 Other:
Family Deductible (Max # / family)
Family Calendar Year Coinsurance Max (Max # / family) 2X 3X Basis: Accumulated Fulfillment
CMM Optional Benefits:
☐ Air Ambulance Benefit Rider ☐ \$1,000 ☐ \$2,000 ☐ \$3,000 ☐ \$4,000 ☐ \$5,000

Supplemental Accident Benefit Rider

SECTION 5. BENEFIT SELECTION (CONTINUED)
PREFERRED PROVIDER ORGANIZATION (PPO) (Check Selected Benefits)
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: Employee: 66% Dependent: 66%
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.
Lifetime Maximum: □ \$1,000,000 □ \$5,000,000
Deductible □ \$200 □ \$250 □ \$300 □ \$750 □ \$1,000 □ Other:
Coinsurance □ 90%/70% ⊠ 80%/60% □ 70%/50% □ Other:
In-Network Calendar Year Coinsurance Max \$2,500 \$5,000 \$10,000 \$0 Other:
Out-of-Network Calendar Year Coinsurance Max None 2X 4X Other:
Family Deductible Max (Max # / family)
Family Calendar Year Coinsurance Max (Max # / family)
PPO Optional Benefits:
☐ Air Ambulance Benefit Rider ☐\$1,000 ☐\$2,000 ☐\$3,000 ☐\$4,000 ☐\$5,000
Name Name
PCP/SCP Benefit Rider Office Visit Fee \$20 PCP/\$40 SCP \$30 PCP/\$50 SCP
Supplemental Accident Benefit Rider
Wellness Benefit Rider
Special Group Considerations Form Number: 23-2186 Description: NO DEDUCTIBLE CARRYOVER
Any special group considerations must be listed here (e.g. alternate eligibility, retirees, etc.)
Prescription Drug Riders Available with CMM or PPO (Check Selected Benefit)
☐ 2 Tier Copay Plan ☐ \$3/\$10 ☐ \$7/\$15 ☐ \$10/\$20 ☐ Other:
☐ 3 Tier Copay + Coin. Plan* ☐ [\$10/\$20/\$30 + 20%] ☐ [\$10/\$30/\$50+20%] ☐ Other:
Deductible + Coin. Plan Ded.: \$25 \$50 \$75 \$100 Other: Coin. PPO: (Medical - 90/70 or 80/60) 20% (Medical - 70/50) 30%
Coin. CMM: (Medical Coinsurance %)
*Based on actuarial review this drug benefit ontion is non-creditable to the standard Medicare Part D prescription coverage.

SECTION 5. BENEFIT SELECTION	(CONTIN	UED)				
BLUE~BY~DESIGN HSA (Chec	ck Selected Bene	efit)				
EMPLOYER CONTRIBUTION - HEALTH/LIFE:		Contribution:	Employee:	%	Dependent:	%
Annual HSA contribution by tier:						
Employee Only: Employee			Employee/C	Child:	Fam	ilv
	nually	Monthly	Semi-Moi			
NOTE: The Employer must pay a minim					may he termi	inated by the
Company if the Policyholder fails to contrib	oute the perc	entage of Em	ployees' prem	ium specified	above.	-
BENEFITS	611	612	1 1042	C44	1 1045	T-7010
DEDUCTIBLE		012	613	614	615	<u></u> 616
Aggregate Individual In-Network	[\$1,200*]	\$2,000	\$3,000	\$4,000	\$5,000	\$2,000
Aggregate Family In-Network	[\$2,400*]	\$4,000	\$6,000	\$8,000	\$10,000	\$4,000
Aggregate Individual Out-of-Network	\$2,400	\$4,000	\$6,000	\$8,000	\$10,000	\$4,000
Aggregate Family Out-of-Network	\$4,800	\$8,000	\$12,000	\$16,000	\$20,000	\$8,000
COINSURANCE	_			,	4==,=	45,555
In-Network	80%	80%	100%	100%	100%	100%
Out-of-Network	60%	60%	80%	80%	80%	80%
CALENDAR YEAR COINSURANCE MAX						
Aggregate Individual In-Network	[\$2,000*]	\$2,000	\$0	\$0	\$0	\$0
Aggregate Family In-Network	[\$4,000*]	\$4,000	\$0	\$0	\$0	\$0
Aggregate Individual Out-of-Network	\$8,000	\$8,000	Unlimited	Unlimited	Unlimited	Unlimited
Aggregate Family Out-of-Network	\$16,000	\$16,000	Unlimited	Unlimited	Unlimited	Unlimited
[*adjusted annually for inflation each January 1, in accordance with the provisions of §223 of the Internal Revenue Code of the United States of America as amended]						
LIFETIME MAXIMUM	\$2,000,		5,000,000			
Wellness	Yes/	No				
AIR AMBULANCE	Yes/	No				
MATERNITY (OPTIONAL UNDER 15 EMPLOYEES)	Yes/] No				
DRUG COVERAGE	<u> </u>					
☐ Option 1 (Standard Formulary)	<u> </u>	Deductible &				
Option 2 (Essential Care Formulary)*	Subject to	Deductible &	Coinsurance		_	
☐ Option 3 (No Coverage)	No Covera	ge		_		
*Based on actuarial review, this drug benefit op	tion is non-cre	editable to the s	standard Medica	re Part D pres	cription coverag	je
SECTION 6. ARKANSAS MANDATE	D OFFER	BENEFIT R	RIDERS			
You	Must Elec	t Or Rejec	t Each Ride	er		
Type of Benefit Rider					Elect	Reject
Mammography:						\square
Psychiatric Conditions:						\boxtimes
Substance Abuse:		_				\boxtimes
TMJ						\boxtimes
Rejection of the TMJ Benefit Rider means temporomandibular joint disorders (TMJ) of	covered ben or cranioman	efits provided dibular disord	I to Covered P Iers.	ersons will <u>no</u>	ot include	

SECTION 7. 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 ENROLLING WAIVING TOTAL 1. Full-Time Employees (In-State) 2. Full-Time Employees (Out-of-State): 3. COBRA Continuees 4. Total of lines 1, 2 & 3 (Enrolling & Waiving) 5. Part Time / Seasonal / Temporary Employees 6. Total # of Employees (add 4 & 5) Minimum Number of Insured Employees. To meet large group enrollment guidelines a group must have at least fifty-one Full-Time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal. Groups dropping below two Full-Time employees will no longer be eligible for group insurance. Minimum Participation Requirements. If an employer pays 100% of the employee-only premium, 100% of all Full-Time employees must be insured. If an employer pays less than 100% of the premium, 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 55% 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. SECTION 8. WAITING PERIOD & OPEN ENROLLMENT PERIOD & EFFECTIVE/RENEWAL DATE OF **COVERAGE** Class B: Class A: FULL TIME EMPLOYEES (Description) (Description) Waiting Period for New Hires -Waiting Period for New Hires -No waiting period No waiting period ☐ 1 month 1 month 2 months 2 months ☐ 3 months ☐ 3 months ☐ 4 months 4 months 5 months 5 months 6 months 6 months 108 Open Enrollment Period If a period is not specified, the Group's Open Enrollment Period will be the month prior to the Group's renewal date. Is Waiting Period for Initial Enrollment Waived? Yes No Requested effective date, pending approval is (Please Note: If a complete group enrollment packet is not received timely, the group, if approved, will be assigned the next available effective date.) Rates and benefits are effective: 1/1/09 STUDENT AGE 23

RATE CHANGE

BENEFIT CHANGES: RX TO \$7/\$30/\$50

SECTION 9. 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 attached 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.

Tier	Product	Rate
EE	PPO	\$326.22
ESC	PPO	\$700.85

¹ The agent(s) or broker(s) involved in this insurance transaction 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 insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.



BLUESENROLL LARGE EMPLOYER APPLICATION

New Group	⊠Renewal Group
APPLICATION by: CITY OF JONESBORO	
for a Group Policy covering the employees of the employees. The Policyholder intends hereby to es	ed "Policyholder") Policyholder and the eligible dependents of such stablish and maintain an employee benefit plan (the dependents, to contribute to the cost of the Plan, and loyees.
SECTION 1. GROUP INFORMATION	
Legal Name of Business: JONESBORO CRAIGHE	AD LIBRARY
D/B/A: JONESBORO CRAIGHEAD LIBRARY	
Street Address: 315 W OAK	
Mailing Address: (if different from Street)	
City, State, Zip JONESBORO, AR 72401	County: CRAIGHEAD
Telephone #: 870-935-5133	
Fax #:	
Fed. Tax I.D. #: 71-6013749	Group #: 023849
Exec. Contact: DOUG FORMON	E-Mail:
Group Administrator: GLORIA ROARK	E-Mail:
Primary SIC Code: 8231	SIC Description:
Business Type: Sole Proprietorship Legal	Partnership
as its proxy to act on its behalf at all meetings of members the Board may designate by resolution to act on its behalf.	Board") of Arkansas Blue Cross and Blue Shield ("ABCBS"), of ABCBS. This appointment shall include such persons as This proxy gives the Board, or its designee, full power to upon at any meeting. The annual meeting of Members is

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 any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Members' meeting.

SECTION 3. 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 4. COBRA ADMINISTRATION
The Policyholder is subject to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985,
commonly known as COBRA. 1. The Policyholder will contract with Ceridian, Inc. to provide it COBRA administration: Yes No
2. If "No" who will handle COBRA administration for you?
The Policyholder agrees to indemnify ABCBS for any damage, claim or loss ABCBS may suffer by any action, litigation, suit, or claim brought by any individual arising out of the Policyholder's failure or Policyholder's COBRA administrator's failure to perform duties under COBRA.
Section 5. Benefit Selection
Term Life and AD&D through USAble Life NOT provided.
CARVE-OUT HSA
Employers may select a Blue~by~Design HSA benefit option for one class of employees and pair it with a PPO benefit option for the other class of employees. Select options for this employer below. Class descriptions are listed in Section 8.
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: PPO Employee: % Dependent: %
HSA Employee: % Dependent: %
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.
BLUE~BY~DESIGN HRA (Check Selected Benefits)
HRA Contribution Frequency: Annually Monthly Semi-Monthly
Annual HRA contribution by tier:
Employee Only: Employee/Spouse: Employee/Child: Family:
COMPREHENSIVE MAJOR MEDICAL (CMM) (Check Selected Benefits)
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: Employee: % Dependent: %
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.
Lifetime Maximum: \$1,000,000 \$2,000,000 \$5,000,000
Deductible □\$200 □\$250 □\$300 □\$500 □\$750 □\$1,000 □ Other:
Coinsurance 90% 80% 70% 60% 50% Other:
Calendar Year Coinsurance Max: \$2,500 \$5,000 \$10,000 Other:
Family Deductible (Max # / family)
Family Calendar Year Coinsurance Max (Max # / family)
CMM Optional Benefits:
☐ Air Amhulanca Banefit Pider ☐ \$1,000 ☐ \$2,000 ☐ \$3,000 ☐ \$4,000 ☐ \$5,000

Supplemental Accident Benefit Rider

SECTION 5. BENEFIT SELECTION (CONTINUED)	
PREFERRED PROVIDER ORGANIZATION (PPO) (Check Selected Benefits)	
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: Employee: 66% Dependent: 66%)
NOTE: The Employer must pay a minimum of 50% of the Employee premium. This Policy may be termine Company if the Policyholder fails to contribute the percentage of Employees' premium specified above.	nated by the
Lifetime Maximum: □ \$1,000,000 □ \$2,000,000 □ \$5,000,000	
Deductible □ \$200 □ \$250 □ \$300 ⋈ \$500 □ \$750 □ \$1,000 □ Other:	
Coinsurance □ 90%/70% ☑ 80%/60% □ 70%/50% □ Other:	
In-Network Calendar Year Coinsurance Max	r:
Out-of-Network Calendar Year Coinsurance Max None 2X 4X Other	r:
Family Deductible Max (Max # / family)	Fulfillment
Family Calendar Year Coinsurance Max (Max # / family)	Fulfillment
PPO Optional Benefits:	
☐ Air Ambulance Benefit Rider ☐\$1,000 ☐\$2,000 ☐\$3,000 ☐\$4,000 ☐\$5,000	
✓ PCP Benefit Rider Office Visit Fee □\$10 PCP □\$20 PCP ☑\$30 PCP □0	ther:
PCP/SCP Benefit Rider Office Visit Fee □\$20 PCP/\$40 SCP □\$30 PCP/\$50 SCF	
Supplemental Accident Benefit Rider	
Wellness Benefit Rider	
Special Group Considerations Form Number: 23-2186 Description: NO DEDUCTIBLE CARRYOVE	ER
Any special group considerations must be listed here (e.g. alternate eligibility, retirees, etc.)	
Prescription Drug Riders Available with CMM or PPO (Check Selected Benefit)	
☐ 2 Tier Copay Plan ☐ \$3/\$10 ☐ \$7/\$15 ☐ \$10/\$20 ☐ Other:	
☐ 3 Tier Copay + Coin. Plan* ☐ [\$10/\$20/\$30 + 20%] ☐ [\$10/\$30/\$50+20%] ☐ Other:	
Deductible + Coin. Plan Ded.: \$25 \$50 \$75 \$100 Other:	
Coin. PPO: (Medical - 90/70 or 80/60) 20% (Medical - 70/50) [] 30%
Coin. CMM: (Medical Coinsurance %) %	
*Based on actuarial review, this drug benefit option is non-creditable to the standard Medicare Part D prescription coverage	je.

SECTION 5. BENEFIT SELECT	ON (CONTIN	UED)				
BLUE~BY~DESIGN HSA	Check Selected Bene	efit)				
EMPLOYER CONTRIBUTION - HEALTH/LIF		Contribution:	Employee:	%	Dependent:	%
Annual HSA contribution by tier:						
Employee Only: Emplo	yee/Spouse:		Employee/C	Child:	Fam	ly:
HSA Contribution Frequency:	Annually [Monthly	Semi-Mo	nthly		
NOTE: The Employer must pay a m						nated by the
Company if the Policyholder fails to co.	ntribute the perc	entage of Em	ployees' prem	nium specified	above.	
BENEFITS	<u></u> 611	612	613	614	615	616
DEDUCTIBLE					1	
Aggregate Individual In-Network	[\$1,200*]	\$2,000	\$3,000	\$4,000	\$5,000	\$2,000
Aggregate Family In-Network	[\$2,400*]	\$4,000	\$6,000	\$8,000	\$10,000	\$4,000
Aggregate Individual Out-of-Networ		\$4,000	\$6,000	\$8,000	\$10,000	\$4,000
Aggregate Family Out-of-Network	\$4,800	\$8,000	\$12,000	\$16,000	\$20,000	\$8,000
COINSURANCE			 	1	,,,,,,,	73,000
In-Network	80%	80%	100%	100%	100%	100%
Out-of-Network	60%	60%	80%	80%	80%	80%
CALENDAR YEAR COINSURANCE MAX			 		<u> </u>	
Aggregate Individual In-Network	[\$2,000*]	\$2,000	\$0	\$0	\$0	\$0
Aggregate Family In-Network	[\$4,000*]	\$4,000	\$0	\$0	\$0	\$0
Aggregate Individual Out-of-Networ	\$8,000	\$8,000	Unlimited	Unlimited	Unlimited	Unlimited
Aggregate Family Out-of-Network	\$16,000	\$16,000	Unlimited	Unlimited	Unlimited	Unlimited
[*adjusted annually for inflation each Janua States of America as amended]	ry 1, in accordanc	e with the prov	visions of §223 (of the Internal F	Revenue Code o	of the United
LIFETIME MAXIMUM	\$2,000	,000 🔲 \$	5,000,000			
Wellness	Yes/	No				
AIR AMBULANCE	Yes/	No				
MATERNITY (OPTIONAL UNDER 15 EMPLOYEES)	Yes/	No				
DRUG COVERAGE						
☐ Option 1 (Standard Formulary)	Subject to	Deductible &	Coinsurance			
Option 2 (Essential Care Formulary)*	Subject to	Deductible &	Coinsurance			
☐ Option 3 (No Coverage)	No Covera	ige				
*Based on actuarial review, this drug benefit	t option is non-cre	editable to the	standard Medica	are Part D pres	cription coverag	ge.
SECTION 6. ARKANSAS MANDA	TED OFFER	BENEFIT F	RIDERS			
Υ	ou <u>Must</u> Ele	ct Or Rejec	t Each Rid	er		
Type of Benefit Rider					Elect	Reject
Mammography:						\boxtimes
Psychiatric Conditions:						\boxtimes
Substance Abuse:						\boxtimes
TMJ						\boxtimes
Rejection of the TMJ Benefit Rider mea				Persons will <u>no</u>	t include	

SECTION 7. 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/vear **ENROLLING** WAIVING TOTAL 1. Full-Time Employees (In-State) 2. Full-Time Employees (Out-of-State): 3. COBRA Continuees 4. Total of lines 1, 2 & 3 (Enrolling & Waiving) 5. Part Time / Seasonal / Temporary Employees 6. Total # of Employees (add 4 & 5) Minimum Number of Insured Employees. To meet large group enrollment quidelines a group must have at least fifty-one Full-Time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal. Groups dropping below two Full-Time employees will no longer be eligible for group insurance. Minimum Participation Requirements. If an employer pays 100% of the employee-only premium, 100% of all Full-Time employees must be insured. If an employer pays less than 100% of the premium, 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 55% 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. SECTION 8. WAITING PERIOD & OPEN ENROLLMENT PERIOD & EFFECTIVE/RENEWAL DATE OF **COVERAGE** Class A: FULL TIME EMPLOYEES Class B: (Description) (Description) Waiting Period for New Hires -Waiting Period for New Hires -No waiting period No waiting period X 1 month 1 month 2 months 2 months 3 months 3 months 4 months 4 months ☐ 5 months ☐ 5 months 6 months 6 months Open Enrollment Period If a period is not specified, the Group's Open Enrollment Period will be the month prior to the Group's renewal date. Is Waiting Period for Initial Enrollment Waived? Tyes No Requested effective date, pending approval is (Please Note: If a complete group enrollment packet is not received timely, the group, if approved, will be assigned the next available effective date.) Rates and benefits are effective: 1/1/09 STUDENT AGE 23

RATE CHANGE

BENEFIT CHANGES: RX TO \$7/\$30/\$50

SECTION 9. 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 attached 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.

Tier	Product	Rate
EE	PPO	\$326.22
ESC	PPO	\$700.85

¹ The agent(s) or broker(s) involved in this insurance transaction 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 insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.



BLUESENROLL LARGE EMPLOYER APPLICATION

New Group	⊠Renewal Group
APPLICATION by: CITY OF JONESBORO	
for a Group Policy covering the employees of the employees. The Policyholder intends hereby to es	ed "Policyholder") Policyholder and the eligible dependents of such stablish and maintain an employee benefit plan (the dependents, to contribute to the cost of the Plan, and loyees.
SECTION 1. GROUP INFORMATION	
Legal Name of Business: URBAN RENEWAL & H	OUSING
D/B/A: URBAN RENEWAL & HOUSING	
Street Address: 330 UNION STREET	_
Mailing Address: (if different from Street)	
City, State, Zip JONESBORO, AR 72401	County: CRAIGHEAD
Telephone #: 870-935-9800	
Fax #:	
Fed. Tax I.D. #: 71-6013749	Group #: 024703
Exec. Contact: DOUG FORMON	E-Mail:
Group Administrator: GLORIA ROARK	E-Mail:
Primary SIC Code: 9199	SIC Description:
Business Type: Sole Proprietorship Legal I	Partnership
SECTION 2. PROXY	
as its proxy to act on its behalf at all meetings of members the Board may designate by resolution to act on its behalf, vote for the Policyholder on all matters that may be voted held each year at the home office of ABCBS located at Monday of March, at 1:00 p.m. If the third Monday of Martime and place on the next day after, which is not a legal honot less than ten (10) or more than sixty (60) days prior to effect during the Policyholder's membership in ABCBS. The ABCBS, attention Legal Division, of such at least five (5) days proxy by attending and voting in person at any Members' membership in ABCBS.	TRATOR
The Policyholder, as Plan Administrator, assumes responsi Blue Cross and Blue Shield ("ABCBS"), including all inform	bility for the accuracy of information presented to Arkansas ation 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 4. COBRA ADMINISTRATION
The Policyholder is subject to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA.
1. The Policyholder will contract with Ceridian, Inc. to provide it COBRA administration: Yes No
2. If "No" who will handle COBRA administration for you?
The Policyholder agrees to indemnify ABCBS for any damage, claim or loss ABCBS may suffer by any action, litigation, suit, or claim brought by any individual arising out of the Policyholder's failure or Policyholder's COBRA administrator's failure to perform duties under COBRA.
SECTION 5. BENEFIT SELECTION
Term Life and AD&D through USAble Life NOT provided.
CARVE-OUT HSA
Employers may select a Blue~by~Design HSA benefit option for one class of employees and pair it with a PPO benefit option for the other class of employees. Select options for this employer below. Class descriptions are listed in Section 8.
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: PPO Employee: % Dependent: %
HSA Employee: % Dependent: %
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.
BLUE~BY~DESIGN HRA (Check Selected Benefits)
HRA Contribution Frequency: Annually Monthly Semi-Monthly
Annual HRA contribution by tier:
Employee Only: Employee/Spouse: Employee/Child: Family:
COMPREHENSIVE MAJOR MEDICAL (CMM) (Check Selected Benefits)
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: Employee: % Dependent: %
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.
Lifetime Maximum: \$1,000,000 \$2,000,000 \$5,000,000
Deductible \$200 \$250 \$300 \$500 \$750 \$1,000 ○ Other:
Coinsurance □ 90% □ 80% □ 70% □ 60% □ 50% □ Other:
Calendar Year Coinsurance Max: \$2,500 \$5,000 \$10,000 Other:
Family Deductible (Max # / family)
Family Calendar Year Coinsurance Max (Max # / family) 2X 3X Basis: Accumulated Fulfillment
CMM Optional Benefits:
☐ Air Ambulance Benefit Rider ☐ \$1,000 ☐ \$2,000 ☐ \$3,000 ☐ \$4,000 ☐ \$5,000

Supplemental Accident Benefit Rider

SECTION 5. BENEFIT SELECT	TION (CONTINUED)			
PREFERRED PROVIDER ORGANIZATION (PPO) (Check Selected Benefits)				
EMPLOYER CONTRIBUTION - HEALTH/L	IFE: Employer Contribution: Employee: 66% Dependent: 66%			
	minimum of 50% of the Employee premium. This Policy may be terminated by the ontribute the percentage of Employees' premium specified above.			
Lifetime Maximum: \$1	,000,000			
Deductible ☐ \$200 ☐ \$250	☐ \$300 \$500 ☐ \$750 ☐ \$1,000 ☐ Other:			
Coinsurance 90%/70°				
In-Network Calendar Year Coinsurance				
Out-of-Network Calendar Year Coinsu	·			
Family Deductible Max (Max # / family)				
Family Calendar Year Coinsurance Ma	x (Max # / family)			
PPO Optional Benefits:				
Air Ambulance Benefit Rider				
PCP Benefit Rider	Office Visit Fee ☐\$10 PCP ☐\$20 PCP ☐\$30 PCP ☐Other:			
PCP/SCP Benefit Rider Office Visit Fee □\$20 PCP/\$40 SCP □\$30 PCP/\$50 SCP				
Supplemental Accident Benefit Rider				
Wellness Benefit Rider				
Special Group Considerations Form Number: 23-2186 Description: NO DEDUCTIBLE CARRYOVER				
Any special group considerations must be listed here (e.g. alternate eligibility, retirees, etc.)				
Prescription Drug Riders Available with CMM or PPO (Check Selected Benefit)				
2 Tier Copay Plan	☐ \$3/\$10 ☐ \$7/\$15 ☐ \$10/\$20 ☐ Other:			
	\$7/\$15/\$25 \$7/\$25/\$50 \$10/\$20/\$30 \$7/\$30/\$50 \$10/\$30/\$50 Other:			
3 Tier Copay + Coin. Plan* [\$10/\$20/\$30 + 20%] [\$10/\$30/\$50+20%] Other:				
□ Deductible + Coin. Plan Ded.: □ \$25 □ \$50 □ \$75 □ \$100 □ Other:				
	Coin. PPO: (Medical - 90/70 or 80/60) _ 20% (Medical - 70/50) _ 30%			
Coin. CMM: (Medical Coinsurance %) \(\bigcup \) \(\text{\text{\text{\text{\text{Coin.}}}} \text{Coin.} \text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{Coin.}}}} \text{\tin}\text{\tetx{\text{\text{\text{\text{\texi}\text{\text{\text{\text{\texi\text{\text{\text{\text{\text{\text{\text{\text{\text{\texit{				
*Based on actuarial review, this drug benefit option is non-creditable to the standard Medicare Part D prescription coverage.				

SECTION 5. BENEFIT SELECTION (CONTINUED)						
BLUE~BY~DESIGN HSA (Check Selected Benefit)						
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: Employee: % Dependent: %						
Annual HSA contribution by tier:						
Employee Only: Employee/Spouse: Employee/Child: Family:			ily:			
HSA Contribution Frequency: Annually Monthly Semi-Monthly						
NOTE: The Employer must pay a minir Company if the Policyholder fails to contrib	num of 50% bute the perce	of the Emplo entage of Em	oyee premium. ployees' premi	. This Policy ium specified	may be termi above.	nated by the
BENEFITS	611	612	<u></u> 613	<u>614</u>	<u>615</u>	616
DEDUCTIBLE						
Aggregate Individual In-Network	[\$1,200*]	\$2,000	\$3,000	\$4,000	\$5,000	\$2,000
Aggregate Family In-Network	[\$2,400*]	\$4,000	\$6,000	\$8,000	\$10,000	\$4,000
Aggregate Individual Out-of-Network	\$2,400	\$4,000	\$6,000	\$8,000	\$10,000	\$4,000
Aggregate Family Out-of-Network	\$4 ,800	\$8,000	\$12,000	\$16,000	\$20,000	\$8,000
COINSURANCE In-Network	80%	80%	100%	100%	1000/	4000/
Out-of-Network	60%	60%	100% 80%	80%	100% 80%	100% 80%
CALENDAR YEAR COINSURANCE MAX	0070	- 00 //	00 /0	0078	00 78	00 /6
Aggregate Individual In-Network	[\$2,000*]	\$2,000	\$0	\$0	\$0	\$0
Aggregate Family In-Network	[\$4,000*]	\$4,000	\$0	\$0	\$0	\$0
Aggregate Individual Out-of-Network	\$8,000	\$8,000	Unlimited	Unlimited	Unlimited	Unlimited
Aggregate Family Out-of-Network	\$16,000	\$16,000	Unlimited	Unlimited	Unlimited	Unlimited
[*adjusted annually for inflation each January 1 States of America as amended]				of the Internal F	Revenue Code o	of the United
LIFETIME MAXIMUM	LIFETIME MAXIMUM \$2,000,000 \$5,000,000					
WELLNESS	☐ Yes/ ☐ No					
AIR AMBULANCE	Yes/ No					
MATERNITY (OPTIONAL UNDER 15 EMPLOYEES)	Yes/	No				
DRUG COVERAGE ☐ Option 1 (Standard Formulary) Subject to Deductible & Coinsurance						
☐ Option 1 (Standard Formulary) ☐ Option 2 (Essential Care	-	Deductible &		-		-
Formulary)*						
Option 3 (No Coverage)	No Covera	-	-4 dod & do .dio .	Dod D		
*Based on actuarial review, this drug benefit op	_			are Part D pres	cription coverag	je
SECTION 6. ARKANSAS MANDATE				· ·		
You <u>Must</u> Elect Or Reject Each Rider						
Type of Benefit Rider Elect Reject				Reject		
Mammography:						\square
Psychiatric Conditions:						
Substance Abuse:						
TMJ						\boxtimes
Rejection of the TMJ Benefit Rider means covered benefits provided to Covered Persons will <u>not</u> include temporomandibular joint disorders (TMJ) or craniomandibular disorders.						

SECTION 7. EMPLOYEE INFORMATION, MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQUIREMENTS.

PARTICIPATION REQUIREMENTS.			
Full-Time means an active employee with a minimum of 30 hrs/week & 48 weeks/year	ENROLLING	WAIVING	TOTAL
Full-Time Employees (In-State)			
2. Full-Time Employees (Out-of-State):			
3. COBRA Continuees			
4. Total of lines 1, 2 & 3 (Enrolling & Waiving)			
5. Part Time / Seasonal / Temporary Employees			
6. Total # of Employees (add 4 & 5)			

Minimum Number of Insured Employees. To meet large group enrollment guidelines a group must have at least fifty-one Full-Time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal. Groups dropping below two Full-Time employees will no longer be eligible for group insurance.

Minimum Participation Requirements. If an employer pays 100% of the employee-only premium, 100% of all Full-Time employees must be insured. If an employer pays less than 100% of the premium, 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 55% 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.

SECTION 8. WAITING PERIOD & OPEN ENROLLMENT PERIOD & EFFECTIVE/RENEWAL DATE OF COVERAGE

Class A: FULL TIME EMPLOYEES	Class B:		
(Description)	(Description)		
Waiting Period for New Hires -	Waiting Period for New Hires -		
☐ No waiting period	☐ No waiting period		
☐ 1 month	1 month		
2 months	2 months		
3 months	3 months		
4 months	4 months		
5 months	5 months		
6 months	6 months		
Open Enrollment Period 12/1 - 12/31 08			
If a period is not specified, the Group's Open Enrollment Period will	be the month prior to the Group's renewal date.		
Is Waiting Period for Initial Enrollment Waived? Yes No			
Requested effective date, pending approval is			
(Please Note: If a complete group enrollment packe	t is not received timely, the group, if approved, will be		
assigned the next av	ailable effective date.)		
Rates and benefits are effective: 1/1/09			
STUDENT AGE 23			
BENEFIT CHANGES: RX TO \$7/\$30/\$50			
RATE CHANGE			

SECTION 9. 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 attached 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.

Tier	Product	Rate
EE	PPO	\$326.22
ESC	PPO	\$700.85

¹ The agent(s) or broker(s) involved in this insurance transaction 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 insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.



BLUESENROLL LARGE EMPLOYER APPLICATION

New Group	⊠Renewal Group			
APPLICATION by: CITY OF JONESBORO MUNICIPAL AIRPORT				
(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: CITY OF JONESBORO	MUNICIPAL AIRPORT			
D/B/A: CITY OF JONESBORO MUNICIPAL AIRP	ORT			
Street Address: 4116 LINBERGH DRIVE				
Mailing Address: (if different from Street) P.O. BOX 129	93, JONESBORO, AR 72403			
City, State, Zip JONESBORO, AR 72401	County: CRAIGHEAD			
Telephone #: 870-933-4640				
Fax #: 870-933-4640				
Fed. Tax I.D. #: 71-6013749	Group #: 028290			
Exec. Contact: DOUG FORMON	E-Mail:			
Group Administrator: GLORIA ROARK	E-Mail:			
Primary SIC Code: 4581	SIC Description:			
Business Type: Sole Proprietorship Legal Partnership Corporation Sovernment Entity				
Section 2. 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 any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Members' meeting.				

SECTION 3. 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 4. COBRA ADMINISTRATION The Policyholder is subject to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA. 1. The Policyholder will contract with Ceridian, Inc. to provide it COBRA administration: X Yes 2. If "No" who will handle COBRA administration for you? The Policyholder agrees to indemnify ABCBS for any damage, claim or loss ABCBS may suffer by any action, litigation, suit, or claim brought by any individual arising out of the Policyholder's failure or Policyholder's COBRA administrator's failure to perform duties under COBRA. SECTION 5. BENEFIT SELECTION Term Life and AD&D through USAble Life NOT provided. **CARVE-OUT HSA** Employers may select a Blue~by~Design HSA benefit option for one class of employees and pair it with a PPO benefit option for the other class of employees. Select options for this employer below. Class descriptions are listed in Section 8. EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: PPO Employee: % % Dependent: **HSA** Employee: % Dependent: % 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. BLUE~BY~DESIGN HRA (Check Selected Benefits) **HRA Contribution Frequency:** Annually ☐ Monthly Semi-Monthly Annual HRA contribution by tier: Employee Only: Employee/Spouse: Employee/Child: Family: COMPREHENSIVE MAJOR MEDICAL (CMM) (Check Selected Benefits) EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: Employee: % Dependent: 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. Lifetime Maximum: \$1,000,000 \$2,000,000 \$5,000,000 Deductible \$200 \$250 \$300 \$500 **\$750** \$1,000 Other: ☐ 70% 50% Other: 90% **80%** 60% Coinsurance **\$10,000** Other: Calendar Year Coinsurance Max: **\$2,500** \$5,000 ☐ 2X 3X Accumulated **Fulfillment** Family Deductible (Max # / family) Basis: Family Calendar Year Coinsurance Max (Max # / family) ☐ 2X □ 3X Basis: Accumulated **Fulfillment CMM Optional Benefits:** \$1,000 \$2,000 \$3,000 \$4,000 \$5,000 Air Ambulance Benefit Rider

Supplemental Accident Benefit Rider

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SECTION 5. BENEFIT SELEC	TION (CONTINUED)			
PREFERRED PROVIDER ORGANIZATION (PPO) (Check Selected Benefits)				
EMPLOYER CONTRIBUTION - HEALTH/L	IFE: Employer Contribution: Employee: 66% Dependent: 66%			
	minimum of 50% of the Employee premium. This Policy may be terminated by the			
	contribute the percentage of Employees' premium specified above.			
	,000,000			
Deductible				
Coinsurance 90%/70°	% ⊠ 80%/60% □ 70%/50% □ Other:			
In-Network Calendar Year Coinsuranc	e Max			
Out-of-Network Calendar Year Coinsu	rance Max None 2X 4X Other:			
Family Deductible Max (Max # / family)	∑2X ☐ 3X Basis: ☐ Accumulated ☐ Fulfillment			
Family Calendar Year Coinsurance Ma	ax (Max#/family)			
PPO Optional Benefits:				
Air Ambulance Benefit Rider	□\$1,000 □ \$2,000 □ \$3,000 □ \$4,000 □ \$5,000			
	Office Visit Fee ☐\$10 PCP ☐\$20 PCP ☐ \$30 PCP ☐Other:			
PCP/SCP Benefit Rider	Office Visit Fee \$20 PCP/\$40 SCP \$30 PCP/\$50 SCP			
Supplemental Accident Bene	fit Rider			
Wellness Benefit Rider				
Special Group Considerations Form Number: 23-2186 Description: NO DEDUCTIBLE CARRYOVER				
Any special group considerations must be listed here (e.g. alternate eligibility, retirees, etc.)				
Prescription Drug Riders Available with CMM or PPO				
(Check Selected Benefit)				
2 Tier Copay Plan	☐ \$3/\$10 ☐ \$7/\$15 ☐ \$10/\$20 ☐ Other:			
	\$7/\$15/\$25 \$7/\$25/\$50 \$10/\$20/\$30 \$7/\$30/\$50			
	\$10/\$30/\$50 Other:			
3 Tier Copay + Coin. Plan*	[\$10/\$20/\$30 + 20%] [\$10/\$30/\$50+20%] [Other:			
☐ Deductible + Coin. Plan	Ded.:			
	Coin. PPO: (Medical - 90/70 or 80/60) 20% (Medical - 70/50) 30%			
Coin. CMM: (Medical Coinsurance %) %				
*Based on actuarial review, this drug benefit option is non-creditable to the standard Medicare Part D prescription coverage.				

SECTION 5. BENEFIT SELECTION	V (CONTIN	UED)				
BLUE~BY~DESIGN HSA (Check Selected Benefit)						
EMPLOYER CONTRIBUTION - HEALTH/LIFE:	Employer (Contribution:	Employee:	%	Dependent:	%
Annual HSA contribution by tier:						
Employee Only: Employee/Spouse: Employee/Child:			hild:	Fami	 ily:	
HSA Contribution Frequency: Ar	nually	Monthly	Semi-Mor	nthly		
NOTE: The Employer must pay a minir						nated by the
Company if the Policyholder fails to contri	bute the perc	entage of Em	ployees' prem	ium specified	above.	
BENEFITS	611	612	613	614	615	616
DEDUCTIBLE						
Aggregate Individual In-Network	[\$1,200*]	\$2,000	\$3,000	\$4,000	\$5,000	\$2,000
Aggregate Family In-Network	[\$2,400*]	\$4,000	\$6,000	\$8,000	\$10,000	\$4,000
Aggregate Individual Out-of-Network	\$2,400	\$4,000	\$6,000	\$8,000	\$10,000	\$4,000
Aggregate Family Out-of-Network	\$4,800	\$8,000	\$12,000	\$16,000	\$20,000	\$8,000
COINSURANCE				_		
In-Network	80%	80%	100%	100%	100%	100%
Out-of-Network	60%	60%	80%	80%	80%	80%
CALENDAR YEAR COINSURANCE MAX				<u> </u>		
Aggregate Individual In-Network	[\$2,000*]	\$2,000	\$0	\$0	\$0	\$0
Aggregate Family In-Network	[\$4,000*]	\$4,000	\$0	\$0	\$0	\$0
Aggregate Individual Out-of-Network	\$8,000	\$8,000	Unlimited	Unlimited	Unlimited	Unlimited
Aggregate Family Out-of-Network \$16,000 \$16,000 Unlimited Unlimited Unlimited Unlimited						
[*adjusted annually for inflation each January a States of America as amended]	l, in accordanc	e with the prov	risions of §223 c	of the Internal I	Revenue Code (of the United
LIFETIME MAXIMUM ☐ \$2,000,000 ☐ \$5,000,000						
WELLNESS						
AIR AMBULANCE	Yes/	No				
MATERNITY (OPTIONAL UNDER 15 EMPLOYEES) Yes/ No						
DRUG COVERAGE						
Option 1 (Standard Formulary) Subject to Deductible & Coinsurance						
Option 2 (Essential Care Subject to Deductible & Coinsurance Formulary)*						
☐ Option 3 (No Coverage) No Coverage						
*Based on actuarial review, this drug benefit of	otion is non-cre	editable to the s	standard Medica	re Part D pres	scription coverag	је.
SECTION 6. ARKANSAS MANDATED OFFER BENEFIT RIDERS						
You Must Elect Or Reject Each Rider						
Type of Benefit Rider		Ĭ			Elect	Reject
Mammography:						\boxtimes
Psychiatric Conditions:	-					\boxtimes
Substance Abuse:						\square
TMJ						\boxtimes
	covered hen	efits provided	to Covered P	ersons will n	ot include	K'A
Rejection of the TMJ Benefit Rider means covered benefits provided to Covered Persons will <u>not</u> include temporomandibular joint disorders (TMJ) or craniomandibular disorders.						

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SECTION 7. 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 ENROLLING WAIVING TOTAL 1. Full-Time Employees (In-State) 2. Full-Time Employees (Out-of-State): 3. COBRA Continuees 4. Total of lines 1, 2 & 3 (Enrolling & Waiving) 5. Part Time / Seasonal / Temporary Employees 6. Total # of Employees (add 4 & 5) Minimum Number of Insured Employees. To meet large group enrollment guidelines a group must have at least fifty-one Full-Time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal. Groups dropping below two Full-Time employees will no longer be eligible for group insurance. Minimum Participation Requirements. If an employer pays 100% of the employee-only premium, 100% of all Full-Time employees must be insured. If an employer pays less than 100% of the premium, 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 55% 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. SECTION 8. WAITING PERIOD & OPEN ENROLLMENT PERIOD & EFFECTIVE/RENEWAL DATE OF **COVERAGE** Class A: FULL TIME EMPLOYEES Class B: (Description) (Description) Waiting Period for New Hires -Waiting Period for New Hires -No waiting period No waiting period 1 month 1 month 2 months 2 months ☐3 months 3 months 4 months 4 months ☐ 5 months 5 months 6 months 6 months Open Enrollment Period If a period is not specified, the Group's Open Enrollment Period will be the month prior to the Group's renewal date. Is Waiting Period for Initial Enrollment Waived? Yes Requested effective date, pending approval is (Please Note: If a complete group enrollment packet is not received timely, the group, if approved, will be assigned the next available effective date.)

STUDENT AGE 23

RATE CHANGE

Rates and benefits are effective: 1/1/09

BENEFIT CHANGES: RX TO \$7/\$30/\$50

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SECTION 9. 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 attached 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.

Tier	Product	Rate
EE	PPO	\$326.22
ESC	PPO	\$700.85

¹ The agent(s) or broker(s) involved in this insurance transaction 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 insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.