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

EMPLOYER APPLICATION
Blues Enroll

Renewal APPLICATION by: City of Jonesboro Urban Renewal & Housin

(hereinafter called "Policyholder")

for a Group Policy covering the employees of the Policyholder and the eligible dependents of such employees. The Policyholder intends hereby to establish and maintain an employee benefit plan (the "Plan") for the Policyholder's employees and eligible dependents, to contribute to the cost of the Plan, and to actively promote the Plan to the Policyholder's employees.

GROUP INFORMATION

Legal Name of Business: CITY OF JONESBORO

D/B/A: City of Jonesboro Urban Renewal & Housin

Street Address: 330 Union Street

City, State, Zip: Jonesboro , AR , 72401 | County: Craighead

Mailing Address: (if different from Street) 330 Union Street

City, State, Zip: Jonesboro , AR , 72401

Telephone #: 870-935-9800

Fax #: -

Fed. Tax I.D #: 71-0024703

Exec. Contact: | E-Mail:

Group Administrator: Janice Grissum | E-Mail:

Primary SIC Code: 9199 SIC Description: General Government, NEC

Business Type: Government Entity

Agent: | Agent's Lic #:

Agent's Company: Agent's Tax Id:

POLICYHOLDER AS PLAN ADMINISTRATOR

The Policyholder, as Plan Administrator, assumes responsibility for the accuracy of information presented to Arkansas Blue Cross and Blue Shield ("ABCBS"), including all information on the employment status and eligibility of individuals to be covered under the Plan, as well as medical information provided with respect to each such individual. The Policyholder agrees that if misrepresentations are made in any of the information provided for rating or in this Group Application or any of the materials submitted with it, including, but not limited to, individual applications and medical information, then ABCBS may cancel or rescind this Group Policy. The Policyholder further agrees that if misrepresentations or false or misleading information is presented in filing of any claims hereunder ("improper claims"), ABCBS may cancel or rescind the coverage of any individual involved in presenting such a claim. Further, ABCBS may cancel or rescind the entire Group Policy if the Policyholder or any representative of the Policyholder knew or should have known of the improper claims, or if the Policyholder's action or inaction contributed to presentation of improper claims.

PROXY

The Policyholder hereby appoints the Board of Directors ("Board") of Arkansas Blue Cross and Blue Shield ("ABCBS"), as its proxy to act on its behalf at all meetings of members of ABCBS. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for the Policyholder on all matters that may be voted upon at any meeting. The annual meeting of Members is held each year at the home office of ABCBS located at 601 S. Gaines Street, Little Rock, Arkansas, on the third Monday of March, at 1:00 p.m. If the third Monday of March is a legal holiday, then the meeting will be at the same time and place on the next day after, which is not a legal holiday. A special meeting may be called upon notice mailed not less than ten (10) or more than sixty (60) days prior to such meeting. This proxy, unless revoked, shall remain in effect during the Policyholder's membership in ABCBS. The Policyholder may revoke this proxy in writing by advising ABCBS, attention Legal Division, of such at least five (5) days prior to any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Member's meeting.

BENEFIT SELECTION

PREFERRED PROVIDER ORGANIZATION (PPO) - PPO XXX - 1

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2011
Waiting Period Note: Effective Date is first of the month following the Waiting Period.
Date of Open Enrollment December
If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.

Class	Class Description	Waiting Period	Contribution
1	Full Time	1 Month	Employee 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.*

Maximum Dependent Age 26

Mandated Mental Health Parity: Yes

Please Indicate whether a HRA, or mechanisms utilized to reduce the employee's portion of health plan costs, is either in place or planned to be purchased. **No**
Rates offered for this plan are contingent on assertions submitted by the insurance applicant (or its agent) that there is no HRA or other funding mechanism in place, nor intent to purchase such an arrangement. Upon evidence to the contrary, the group health plan is subject to termination.

Deductible:	$500	**Deductible Carryover:** No
Family Deductible:	3	**Basis:** Fulfillment
Coinsurance:	80%/60%	
In-Network Calendar Year Coinsurance Max:	$2000	
Family Calendar Year Coinsurance Max:	3	**Basis:** Fulfillment
Out-of-Network Calendar Year Coinsurance Max:	None	
Lifetime Maximum:	Unlimited	
Traditional Wellness		

Prescription Drug Rider Plan: $10/$30/$50, Mail Order Drug - 2x Copay (90 days)

Based on actuarial review, this drug benefit option is creditable to the standard Medicare Part D prescription coverage.

PPO Optional Benefits:

Inpatient Copay - None	
Office Visit Copayment - $30	Maternity - Elected
Blue Card	Supplemental Accidental Endorsement - Declined
	ER Copayment - $100

Arkansas Mandated Offer Benefit Riders:

You Must Elect or Reject Each Rider:

Mammography - Reject	Substance Abuse - Reject
Psychiatric Condition - Reject	TMJ* - Reject
Hearing Aid - Reject	

*Rejection of the TMJ Benefit Rider means covered benefits provided to Covered Persons will not include temporomandibular Joint disorders (TMJ) or craniomandibular disorders.

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

RATES - PPO XXX - 1

Two Tier Composite	**Total Premium**
Employee	$316.43
Family	$679.82

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.

ATTESTATIONS

COBRA

Group health plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, "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.

(Yes__) (No__) Under the governmental guidelines the group health plan is subject to Cobra, meeting the criteria for 20 or more employees.

(Yes__)(No__) If yes, do you wish to use the services of Ceridian?

If no, who will administer Cobra for you? _____

Grandfather Status - Our records indicate that your health plan continues to be grandfathered under the Patient Protection and Affordable Care Act (PPACA) due to the benefit plan you have selected for renewal. However, there may be other reasons why you could lose grandfathered status, including reducing the amount of contribution made to the plan on behalf of employees as defined by the Interim Final Rule, an excerpt from which follows below:

"A group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate towards the costs of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate on March 23, 2010."

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

___Yes, I agree with the status as shown.

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

EMPLOYEE INFORMATION
MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQUIREMENTS.

Under the Medicare Secondary Payer Rules, it is the Employer's responsibility to annually inform Arkansas Blue Cross of proper employee counts for the purpose of determining payment priority between Medicare and Arkansas Blue Cross. Arkansas Blue Cross is required to furnish these counts to the Centers for Medicare and Medicaid Services (CMS).

Full-Time = means an active employee with a minimum of 30 hrs/week & 48 weeks/year

	In State	Out of State	Total
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):			
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):			
COBRA Continuees (Enrolling):			
Life ONLY Contracts:			
Total Enrolling and Waiving:			
Part Time/Seasonal/Temporary Employees :			
Total # of Employees:			

Minimum Number of Insured Employees. To meet large group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal.

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 50% of the full-time employees must enroll.

This Policy may be terminated by the Company if the number of insured Employees falls below the minimum number of insured Employees specified above or if the percentage of eligible Employees of the Policyholder covered by the Policy becomes less than the percentage of Employee participation specified above.

Special Group Considerations Form# 23-2546, Description alternate elgiblity hours(40/week)

Special Group Considerations Form# 23-2186, Description No Deductible Carryover

SIGNATURES

This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the United States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate.

I hereby renew the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies renewed, will take effect as of the renewal date, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. **I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in connection with an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

1. Policyholder

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

_____ [full legal name of Policyholder]

By: _____ _____
Authorized Signature Printed Name

_____
Title or Position

2. Agent

I hereby certify that all of the information contained in this employer application is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual proposed for coverage (except as noted on the employee applications). I have complied with the underwriting rules and regulations and have explained in detail the coverage to the member firm and its employees including the preexisting condition limitations and the qualifications of the effective date provisions. I understand that Arkansas Blue Cross and Blue Shield will have no liability until this application has been approved and the premium is received.

_____ 23908
Agent Signature Insurance License # / Agency Fed. Tax ID #

DAVID C. FERGUSON _____
Agent Printed Name Date