

Renewal 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.

GROUP INFORMATION

Legal Name of Business: CITY OF JONESBORO

D/B/A: CITY OF JONESBORO

Street Address: 515 W Washigton

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

Mailing Address: (if different from Street) P O BOX 1845

City, State, Zip: Jonesboro, AR, 72403

Telephone #: 870-933-4640

Fax #: -

Fed. Tax I.D #: 71-6013749

Exec. Contact: Harold Perrin E-Mail:

Group Administrator: GLORIA ROARK E-Mail:

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

Business Type: Government Entity

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.

PREFERRED PROVIDER ORGANIZATION (PPO) - PPO XXX - 1

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2010

Effective Date is first of the month following the Waiting Period.

Date of Open Enrollment December - 2010

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 23

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: | \$1,000,000 | |

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: | |
|-------------------------------|--|
| Wellness - Elected | Inpatient Copay - None |
| Office Visit Copayment - \$30 | Maternity - Elected |
| Air Ambulance - Declined | Supplemental Accidental Endorsement - Declined |
| Blue Card | 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 | |
| ALL DIST | | |

Hearing Aid - Reject

*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.

RATES - PPO XXX - 1

| Two Tier Composite | Total Premium |
|--------------------|---------------|
| Employee | \$316.43 |
| Family | \$679.82 |

MEDIPAK

MEDIPAK F Plan

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.

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|----|--------------------|---------------|--|
| | One Tier Composite | Total Premium | |
| | Employee | \$ 251.88 | |

| ATTESTATIONS | CHORES MANUAL CONTROL | | process to the control of the control |
|--|--|--|---------------------------------------|
| Group health plans for employers with 20 or more employees on more than 50% of the calendar year are subject to Cobra. Employers are required to provide qualified beneficial which the beneficiary can elect to continue coverage under the guidelines. We offer the 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 0 employee counts as a fraction of an employee, with the fraction equal to the number of number of hours used to determine full time status. | aries an e services d Cobra. Ea hours wor | lection period of a vendor, " ch part-time ked divided b | d during Ceridian", by the |
| (Yes_v) (No_) Under the governmental guidelines the group health plan is subjectiteria for 20 or more employees. | ect to Co | obra, meetin | g the |
| (Yes_√)(No) If yes, do you wish to use the services of Ceridian? | | | |
| If no, who will administer Cobra for you? | | | |
| EMPLOYEE INFORMATION MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQU | IREMENT | S. | 0.000 A LUNE BURNER |
| Under the Medicare Secondary Payer Rules, it is the Employer's responsibility to Blue Cross of proper employee counts for the purpose of determining payment and Arkansas Blue Cross. Arkansas Blue Cross is required to furnish these coun Medicare and Medicaid Services (CMS). | priority | between Me | |
| Full-Time = means an active employee with a minimum of 30 hrs/week & 48 weeks/year | | ademany () — () TTTL - TdT-T- page page () — | |
| Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date): | In State | Out of State | Total |
| Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date): | | A Southern State of S | |
| COBRA Continuees (Enrolling): | | | |
| Life ONLY Contracts: | | | |
| Total Enrolling and Waiving: | | | - P |
| Part Time/Seasonal/Temporary Employees : | | | |
| Total # of Employees: | | · · · · · · · · · · · · · · · · · · · | |
| Minimum Number of Insured Employees. To meet large group enrollment guidelines one full-time enrolled employees. Groups whose enrollment subsequently drops below fit a small group upon renewal. Minimum Participation Requirements. If an employer pays 100% of the employee-or employees must be insured. If an employer pays less than 100% of the premium, employements are major medical-type coverage may be waived from the eligibility count. 75 without waivers must be insured, and no less than 50% of the full-time employees must | fty-one en nly premic yees cove 5% of all e | nrolled must b im, 100% of a ered through | be rated as all full-time other |
| This Policy may be terminated by the Company if the number of insured Employnumber of insured Employees specified above or if the percentage of eligible Encovered by the Policy becomes less than the percentage of Employee participat | nployees | s of the Poli | cyholder |
| Special Group Considerations Form# 23-2170, Description Continuation for Municipal E | mps 55+ | | |
| Special Group Considerations Form# 23-2186, Description No Deductible Carryover | A Maria | | |
| Special Group Considerations Form# 23-2232, Description Continuation of RX for Retired | es | . The Manifest consequence recognition of | |
| Special Group Considerations Form# 23-2432, Description Contin for City Cnsl Mbrs & | Elect Offic | cials | |

| SIGNATURES | |
|--|---|
| This Application is made and delivered in the State of Arkans States of America. This Application is incorporated in and ma | |
| I hereby renew the above referenced coverage and agree the policies renewed, will take effect as of the renewal date, provereceived by the home office of Arkansas Blue Cross and Blu represents my agreement and acceptance of the premi | rided this application is approved and the premium is e Shield. I also understand that my signature below |
| Any person who knowingly presents a false or fraudule presents false information in connection with an application subject to fines and control of the subject to fine sub | lication for insurance is guilty of a crime and may be |
| 1. Policyholder | |
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| 2. Agent | |
| I hereby certify that all of the information contained in this er | mployer application is correct to the best of my knowledge, |
| and I know nothing unfavorable about this firm or any individual | ual proposed for coverage (except as noted on the employee |
| applications). I have complied with the underwriting rules and the member firm and its employees including the preexisting | d regulations and have explained in detail the coverage to |
| 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. | • |
| Bul Rogen | |
| Agent Signature | Insurance License # / Agency Fed. Tax ID # |
| | 11-30-09 |
| Agent Printed Name | Date |
| , 490.1 | |



| Renewal APPLICATION by: City of Jonesboro C | Craighead Library | | |
|--|--|--|--|
| (her | einafter called "Policyholder") | | |
| Policyholder intends hereby to establish and maint | Policyholder and the eligible dependents of such employees. The tain an employee benefit plan (the "Plan") for the Policyholder's employees if the Plan, and to actively promote the Plan to the Policyholder's employees. | | |
| GROUP INFORMATION | | | |
| Legal Name of Business: CITY OF JONESBOR | 20 | | |
| D/B/A: City of Jonesboro Craighead Library | | | |
| Street Address: 315 W. Oak | | | |
| City, State, Zip: Jonesboro , AR , 72401 County: Craighead | | | |
| Mailing Address: (if different from Street) 315 W | V. Oak | | |
| City, State, Zip: Jonesboro , AR , 72401 | | | |
| Telephone #: 870-933-4640 | | | |
| Fax #: - | | | |
| Fed. Tax I.D #: 71-0023849 | | | |
| Exec. Contact: | E-Mail: | | |
| Group Administrator: Nancy Dobbins | E-Mail: | | |
| Primary SIC Code: 9199 SIC Description: | General Government, NEC | | |
| Business Type: Government Entity | | | |
| Agent: | gent: Agent's Lic #: | | |

POLICYHOLDER AS PLAN ADMINISTRATOR

Agent's Tax Id:

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PROXY

Agent's Company:

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If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.

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|---|-------|-------------------|----------------|---------------|--|
| | 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 23

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.

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|---|-------------|--------------------------|
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| In-Network Calendar Year Coinsurance Max: | \$2000 | |
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| Out-of-Network Calendar Year Coinsurance Max: | None | |
| Lifetime Maximum: | \$1,000,000 | |

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| PPO Optional Benefits: | |
|-------------------------------|--|
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| Office Visit Copayment - \$30 | Maternity - Elected |
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Arkansas Mandated Offer Benefit Riders:

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| Psychiatric Condition - Reject | TMJ* - Reject | |

Hearing Aid - Reject

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| | RATES - PPO XXX - 1 |
|--------------------|---------------------|
| Two Tier Composite | Total Premium |
| Employee | \$316.43 |
| Family | \$679.82 |

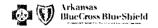
| | u ann a sain na sain | | |
|--|--|--|-------------------------|
| ATTESTATIONS | | | |
| COBRA Group health plans for employers with 20 or more employees on more than 50% of the calendar year are subject to Cobra. Employers are required to provide qualified benefici which the beneficiary can elect to continue coverage under the guidelines. We offer the 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 employee counts as a fraction of an employee, with the fraction equal to the number of number of hours used to determine full time status. | aries an e services (Cobra. Ea | election period of a vendor, " ach part-time | d during 'Ceridian", |
| (Yes $\sqrt{}$) (No) Under the governmental guidelines the group health plan is subcriteria for 20 or more employees. | ject to Co | obra, meetin | g the |
| $(Yes \sqrt{)}(No_{})$ If yes, do you wish to use the services of Ceridian? | | | |
| If no, who will administer Cobra for you? | | | |
| EMPLOYEE INFORMATION MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQU | IREMENT | rs. | |
| Under the Medicare Secondary Payer Rules, it is the Employer's responsibility Blue Cross of proper employee counts for the purpose of determining payment and Arkansas Blue Cross. Arkansas Blue Cross is required to furnish these cour Medicare and Medicaid Services (CMS). | t priority | between Me | rkansas edicare |
| 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: | THE CONTRACTOR OF THE CONTRACT | | |
| Part Time/Seasonal/Temporary Employees : | | | |
| Total # of Employees: | | ter en | |
| | | | |

Minimum Number of Insured Employees. To meet large group enrollment guidelines a group must have at least fiftyone 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.

| SIGNATURES • | |
|---|---|
| This Application is made and delivered in the State of Arka States of America. This Application is incorporated in and | nsas and is governed by the laws of Arkansas and the United made a part of the Group Policy and Benefit Certificate. |
| I hereby renew the above referenced coverage and agree to policies renewed, will take effect as of the renewal date, proceived by the home office of Arkansas Blue Cross and Brepresents my agreement and acceptance of the presents. | lue Shield. I also understand that my signature below |
| presents false information in connection with an ap | lent claim for payment of a loss or benefit or knowingly plication for insurance is guilty of a crime and may be confinement in prison. |
| 1. Policyholder | |
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| | |
| 2. Agent I hereby certify that all of the information contained in this | employer application is correct to the best of my knowledge, |
| | dual proposed for coverage (except as noted on the employee |
| | nd regulations and have explained in detail the coverage to |
| | ng condition limitations and the qualifications of the effective and Blue Shield will have no liability until this application has |
| been approved and the premium is received. | id blue official will have no liability diffil this application has |
| 2 5 | |
| Bill Rosem | |
| | Incurrence Lineage # / Amengy Ford Toy ID # |
| Agent Signature | Insurance License # / Agency Fed. Tax ID # |
| | 11-30-07 |
| Agent Printed Name | Date |
| - consistency of the control of the | |



Renewal 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.

GROUP INFORMATION

Legal Name of Business: CITY OF JONESBORO

D/B/A: City of Jonesboro Municipal Airport

Street Address: 4116 Linbergh Drive

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

Mailing Address: (if different from Street) P.O. Box 17116

City, State, Zip: Jonesboro, AR, 72403

Telephone #: 870-933-4640

Fax #: -

Fed. Tax I.D #: 71-0028290

Exec. Contact:

Group Administrator: Gloria Roark

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

Business Type: Government Entity

Agent:

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E-Mail:

E-Mail:

Agent's Lic #:

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| Illandia Aid Diant | | |

Hearing Aid - Reject

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| RATES - PPO XXX - 1 | | |
|---------------------|---------------|--|
| Two Tier Composite | Total Premium | |
| Employee | \$316.43 | |
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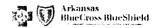
| ATTESTATIONS | | | |
|---|---|--|--|
| Group health plans for employers with 20 or more employees on more than 50% of the calendar year are subject to Cobra. Employers are required to provide qualified benefic which the beneficiary can elect to continue coverage under the guidelines. We offer the to 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 employee counts as a fraction of an employee, with the fraction equal to the number of number of hours used to determine full time status. | iaries an e e services Cobra. Ea | election period of a vendor, " ach part-time | d during 'Ceridian", |
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| If no, who will administer Cobra for you? | | | |
| EMPLOYEE INFORMATION | | | amaanamaanameeatu.antee |
| MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQL | | | aha., an other here a real and a second se |
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| The same an active employee with a minimal of earlies week a 10 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): | | And the second s | |
| Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date): | | 1 1,911 | |
| 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 one full-time enrolled employees. Groups whose enrollment subsequently drops below a small group upon renewal. Minimum Participation Requirements. If an employer pays 100% of the employee-comployees must be insured. If an employer pays less than 100% of the premium, employees must be insured. | fifty-one e only premi loyees cov | enrolled must um, 100% of vered through | be rated a all full-time other |
| comprehensive major medical-type coverage may be waived from the eligibility count. 7 without waivers must be insured, and no less than 50% of the full-time employees mus | | eligible emplo | oyees |
| This Policy may be terminated by the Company if the number of insured Emplonumber of insured Employees specified above or if the percentage of eligible Ecovered by the Policy becomes less than the percentage of Employee participa | Employee | s of the Poli | icyholder |
| Special Group Considerations Form# 23-2186, Description No Deductible Carryover | | The same of the sa | |

Special Group Considerations Form# 23-2232, Description Continuation of RX for Retirees

| SIGNATURES | <u></u> | |
|--|---|--|
| | | e of Arkansas and is governed by the laws of Arkansas and the United I in and made a part of the Group Policy and Benefit Certificate. |
| policies renewed, will tak received by the home off | e effect as of the renewal ice of Arkansas Blue Cros | d agree the group insurance, subject to the terms and conditions of the date, provided this application is approved and the premium is as and Blue Shield. I also understand that my signature below the premium rate schedule. |
| | ation in connection wit | r fraudulent claim for payment of a loss or benefit or knowingly th an application for insurance is guilty of a crime and may be nes and confinement in prison. |
| and I know nothing unfavapplications). I have com the member firm and its | rorable about this firm or a plied with the underwriting employees including the p tand that Arkansas Blue (| d in this employer application is correct to the best of my knowledge, any individual proposed for coverage (except as noted on the employee grules and regulations and have explained in detail the coverage to preexisting condition limitations and the qualifications of the effective Cross and Blue Shield will have no liability until this application has |
| Bie | Roger | Incurrence Licenses # / Agency Ford Toy ID # |
| Age | ent Signatu ll é | Insurance License # / Agency Fed. Tax ID # |

/1-30-05 Date

Agent Printed Name



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:

Group Administrator: Gloria Roark

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

Business Type: Government Entity

Agent:

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 filling 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.

E-Mail:

E-Mail:

Agent's Lic #:

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.

PREFERRED PROVIDER ORGANIZATION (PPO) - PPO XXX - 1

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2010

Effective Date is first of the month following the Waiting Period.

Date of Open Enrollment December - 2010

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 23

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.

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: | \$1,000,000 | |

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: | | | | |
|-------------------------------|--|--|--|--|
| Wellness - Elected | Inpatient Copay - None | | | |
| Office Visit Copayment - \$30 | Maternity - Elected | | | |
| Air Ambulance - Declined | Supplemental Accidental Endorsement - Declined | | | |
| Blue Card | 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 - Rejec | 1 | | | | |

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.

RATES - PPO XXX - 1

| Two Tier Composite | Total Premium | | |
|--------------------|---------------|--|--|
| Employee | \$316.43 | | |
| Family | \$679.82 | | |

| ATTECTATIONS | | Charles and the second | water w |
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| ATTESTATIONS | | A Harpender C - Margaritan Al | |
| Group health plans for employers with 20 or more employees on more than 50% of the calendar year are subject to Cobra. Employers are required to provide qualified benefic which the beneficiary can elect to continue coverage under the guidelines. We offer the 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 employee counts as a fraction of an employee, with the fraction equal to the number of number of hours used to determine full time status. (Yes) (No) Under the governmental guidelines the group health plan is subcriteria for 20 or more employees. | iaries an de services Cobra. Edition | election perion of a vendor, ' ach part-time orked divided | d during 'Ceridia by the |
| (Yes <u>√</u>)(No) If yes, do you wish to use the services of Ceridian? | | | |
| If no, who will administer Cobra for you? | | | |
| | THE CONTRACT OF THE PERSON NAMED IN | The same of the sa | |
| EMPLOYEE INFORMATION | HOEMEN | te | |
| MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQU Under the Medicare Secondary Payer Rules, it is the Employer's responsibility Blue Cross of proper employee counts for the purpose of determining paymen and Arkansas Blue Cross. Arkansas Blue Cross is required to furnish these counts | to annua t priority | illy inform A between Me | |
| Under the Medicare Secondary Payer Rules, it is the Employer's responsibility Blue Cross of proper employee counts for the purpose of determining paymen | to annua t priority nts to the | illy inform A between Me | |
| Under the Medicare Secondary Payer Rules, it is the Employer's responsibility Blue Cross of proper employee counts for the purpose of determining paymen and Arkansas Blue Cross. Arkansas Blue Cross is required to furnish these could Medicare and Medicaid Services (CMS). | to annua t priority nts to the | illy inform A between Me | |
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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# 23-2186, Description No Deductible Carryover

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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

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.

Agent Printed Name

Agent Signature

Insurance License # / Agency Fed. Tax ID #

Date