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

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 Partnership ☐ Corporation ☒ Government 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: ☒ 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:	☒ $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	☐ $2,500	☒ $5,000	☐ $10,000	☐ Other:		
Out-of-Network Calendar Year Coinsurance Max	☒ None	☐ 2X	☐ 4X	☐ Other:		
Family Deductible Max (Max # / family)	☒ 2X	☐ 3X	Basis: ☒ Accumulated	☐ Fulfillment		
Family Calendar Year Coinsurance Max (Max # / family)	☒ 2X	☐ 3X	Basis: ☒ Accumulated	☐ 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	☐ 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:
☒ **3 Tier Copay Plan**	☐ $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 %) ☐ %

**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:

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.

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						
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	☐ $2,000,000 ☐ $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 Coverage

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

SECTION 6. ARKANSAS MANDATED OFFER BENEFIT RIDERS

You Must Elect Or Reject Each Rider

Type of Benefit Rider	Elect	Reject
Mammography:	☐	☒
Psychiatric Conditions:	☐	☒
Substance Abuse:	☐	☒
TMJ*	☐	☒

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

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

(Description)

Waiting Period for New Hires -

- ☐ No waiting period
- ☒ 1 month
- ☐ 2 months
- ☐ 3 months
- ☐ 4 months
- ☐ 5 months
- ☐ 6 months

Class B:

(Description)

Waiting Period for New Hires -

- ☐ No waiting period
- ☐ 1 month
- ☐ 2 months
- ☐ 3 months
- ☐ 4 months
- ☐ 5 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 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
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.

1. Policyholder

Signed at Jonesboro AR (City, State), this 4th day of Dec. 20 08

2. Agent

I hereby certify that all of the information contained in this large 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 new 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 Signature	Insurance License #/Agency Fed. Tax ID#
Agent Printed Name	12-4-08 Date

Rates[1]

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.

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BLUESENROLL
LARGE EMPLOYER APPLICATION

☐ New Group ☒ Renewal Group

APPLICATION by: CITY OF JONESBORO - PKG 06 - MEDI-PAK

(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 Partnership ☐ Corporation ☒ Government Entity

SECTION 2. PROXY

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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:	☐ $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	☐ $2,500	☐ $5,000	☐ $10,000	☐ Other:		
Out-of-Network Calendar Year Coinsurance Max	☐ None	☐ 2X	☐ 4X	☐ Other:		
Family Deductible Max (Max # / family)	☐ 2X	☐ 3X	Basis: ☐ Accumulated	☐ Fulfillment		
Family Calendar Year Coinsurance Max (Max # / family)	☐ 2X	☐ 3X	Basis: ☐ Accumulated	☐ 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	☐ 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 Plan**	☐ $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 %) ☐ %

**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:

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.

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						
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	☐ $2,000,000 ☐ $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 Coverage

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

SECTION 6. ARKANSAS MANDATED OFFER BENEFIT RIDERS

You Must Elect Or Reject Each Rider

Type of Benefit Rider	Elect	Reject
Mammography:	☐	☒
Psychiatric Conditions:	☐	☒
Substance Abuse:	☐	☒
TMJ	☐	☒

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

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

(Description)

Waiting Period for New Hires -

- ☐ No waiting period
- ☒ 1 month
- ☐ 2 months
- ☐ 3 months
- ☐ 4 months
- ☐ 5 months
- ☐ 6 months

Class B:

(Description)

Waiting Period for New Hires -

- ☐ No waiting period
- ☐ 1 month
- ☐ 2 months
- ☐ 3 months
- ☐ 4 months
- ☐ 5 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 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
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.

1. Policyholder

Signed at Jonesboro AR (City, State), this 4th day of Dec 20 08

2. Agent

I hereby certify that all of the information contained in this large 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 new 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 Signature	Insurance License #/Agency Fed. Tax ID#
Agent Printed Name	Date: 12-4-08

Rates[1]

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.

Rates[1]

Tier	Product	Rate
EE	PPO	$80.49

[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.

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

BLUESENROLL
LARGE EMPLOYER APPLICATION

☐ New Group ☒ Renewal Group

APPLICATION by: CITY OF JONESBORO - PKG 05 RETIREES AND/OR DEPENDENTS

(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 Partnership ☐ Corporation ☒ Government 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: ☒ 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:	☒ $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	☐ $2,500	☒ $5,000	☐ $10,000	☐ Other:		
Out-of-Network Calendar Year Coinsurance Max	☒ None	☐ 2X	☐ 4X	☐ Other:		
Family Deductible Max (Max # / family)	☒ 2X	☐ 3X	Basis: ☒ Accumulated	☐ Fulfillment		
Family Calendar Year Coinsurance Max (Max # / family)	☒ 2X	☐ 3X	Basis: ☒ Accumulated	☐ 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	☐ 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:
☒ **3 Tier Copay Plan**	☐ $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 %) ☐ %

**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:

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.

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						
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	☐ $2,000,000 ☐ $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 Coverage

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

SECTION 6. ARKANSAS MANDATED OFFER BENEFIT RIDERS

You Must Elect Or Reject Each Rider

Type of Benefit Rider	Elect	Reject
Mammography:	☐	☒
Psychiatric Conditions:	☐	☒
Substance Abuse:	☐	☒
TMJ	☐	☒

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

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

(Description)

Waiting Period for New Hires -

- ☐ No waiting period
- ☒ 1 month
- ☐ 2 months
- ☐ 3 months
- ☐ 4 months
- ☐ 5 months
- ☐ 6 months

Class B:

(Description)

Waiting Period for New Hires -

- ☐ No waiting period
- ☐ 1 month
- ☐ 2 months
- ☐ 3 months
- ☐ 4 months
- ☐ 5 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 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
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.

1. Policyholder

Signed at Jonesboro AR (City, State), this 4th day of Dec 20 08

2. Agent

I hereby certify that all of the information contained in this large 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 new 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 Signature	Insurance License #/Agency Fed. Tax ID#
Agent Printed Name	12-4-08 Date

Rates[1]

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.

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

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: JONESBORO CRAIGHEAD 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 ☐ Corporation ☒ Government 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: ☒ 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:	☒ $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	☐ $2,500	☒ $5,000	☐ $10,000	☐ Other:		
Out-of-Network Calendar Year Coinsurance Max	☒ None	☐ 2X	☐ 4X	☐ Other:		
Family Deductible Max (Max # / family)	☒ 2X	☐ 3X	Basis: ☐ Accumulated	☐ Fulfillment		
Family Calendar Year Coinsurance Max (Max # / family)	☒ 2X	☐ 3X	Basis: ☐ Accumulated	☐ 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	☐ 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:
☒	**3 Tier Copay Plan**	☐ $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 %) ☐ %

**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:

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.

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						
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	☐ $2,000,000 ☐ $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 Coverage

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

SECTION 6. ARKANSAS MANDATED OFFER BENEFIT RIDERS

You Must Elect Or Reject Each Rider

Type of Benefit Rider	Elect	Reject
Mammography:	☐	☒
Psychiatric Conditions:	☐	☒
Substance Abuse:	☐	☒
TMJ	☐	☒

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

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 12/ – 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 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
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.

1. Policyholder

Signed at Jonesboro Ar (City, State), this 4th day of Dec 20 08

2. Agent

I hereby certify that all of the information contained in this large 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 new 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 Signature	Insurance License #/Agency Fed. Tax ID#
Agent Printed Name	12-4-08 Date

Rates[1]

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.

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

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: URBAN RENEWAL & HOUSING	
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 Partnership ☐ Corporation ☒ Government 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: ☒ 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:	☒ $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	☐ $2,500	☒ $5,000	☐ $10,000	☐ Other:		
Out-of-Network Calendar Year Coinsurance Max	☒ None	☐ 2X	☐ 4X	☐ Other:		
Family Deductible Max (Max # / family)	☒ 2X	☐ 3X	Basis: ☒ Accumulated	☐ Fulfillment		
Family Calendar Year Coinsurance Max (Max # / family)	☒ 2X	☐ 3X	Basis: ☒ Accumulated	☐ 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	☐ 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:
☒ **3 Tier Copay Plan**	☐ $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 %) ☐ %

**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:

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.

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						
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	☐ $2,000,000 ☐ $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 Coverage

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

SECTION 6. ARKANSAS MANDATED OFFER BENEFIT RIDERS

You Must Elect Or Reject Each Rider

Type of Benefit Rider	Elect	Reject
Mammography:	☐	☒
Psychiatric Conditions:	☐	☒
Substance Abuse:	☐	☒
TMJ*	☐	☒

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

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

(Description)

Waiting Period for New Hires -

- ☐ No waiting period
- ☒ 1 month
- ☐ 2 months
- ☐ 3 months
- ☐ 4 months
- ☐ 5 months
- ☐ 6 months

Class B:

(Description)

Waiting Period for New Hires -

- ☐ No waiting period
- ☐ 1 month
- ☐ 2 months
- ☐ 3 months
- ☐ 4 months
- ☐ 5 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 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
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.

1. Policyholder

Signed at Jonesboro AR (City, State), this 4th day of Dec 20 08

2. Agent

I hereby certify that all of the information contained in this large 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 new 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 Signature	Insurance License #/Agency Fed. Tax ID#
Agent Printed Name	12-4-08 Date

Rates[1]

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.

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

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 AIRPORT	
Street Address: 4116 LINBERGH DRIVE	
Mailing Address: (if different from Street) P.O. BOX 1293, 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 ☒ Government 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: ☒ 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:	☒ $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	☐ $2,500	☒ $5,000	☐ $10,000	☐ Other:		
Out-of-Network Calendar Year Coinsurance Max	☒ None	☐ 2X	☐ 4X	☐ Other:		
Family Deductible Max (Max # / family)	☒ 2X	☐ 3X	Basis: ☒ Accumulated	☐ Fulfillment		
Family Calendar Year Coinsurance Max (Max # / family)	☒ 2X	☐ 3X	Basis: ☒ Accumulated	☐ 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	☐ 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:
☒	**3 Tier Copay Plan**	☐ $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 %) ☐ %

**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:

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.

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						
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	☐ $2,000,000 ☐ $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 Coverage

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

SECTION 6. ARKANSAS MANDATED OFFER BENEFIT RIDERS

You Must Elect Or Reject Each Rider

Type of Benefit Rider	Elect	Reject
Mammography:	☐	☒
Psychiatric Conditions:	☐	☒
Substance Abuse:	☐	☒
TMJ	☐	☒

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

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 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 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
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.

1. Policyholder

Signed at Jonesboro AR (City, State), this 4th day of Dec 20 08

2. Agent

I hereby certify that all of the information contained in this large 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 new 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 Signature	Insurance License #/Agency Fed. Tax ID#
Agent Printed Name	12-4-08 Date

Rates[1]

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.