

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				

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.

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

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

Supplemental Accident Benefit Rider

SECTION 5. BENEFIT 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 in the Policyholder falls to contribute the percentage of Employees' premium specified above.			
Lifetime Maximum:			
Deductible □ \$200 □ \$250 □ \$300 □ \$750 □ \$1,000 □ Other:			
Coinsurance □ 90%/70% ⊠ 80%/60% □ 70%/50% □ Other:			
In-Network Calendar Year Coinsurance Max			
Out-of-Network Calendar Year Coinsurance Max None 2X 4X Other:			
Family Deductible Max (Max # / family)			
Family Calendar Year Coinsurance Max (Max # / family)			
PPO Optional Benefits:			
☐ Air Ambulance Benefit Rider ☐\$1,000 ☐\$2,000 ☐\$3,000 ☐\$4,000 ☐\$5,000			
PCP/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:			
\$10/\$30/\$50 Other:			
3 Tier Copay + Coin. Plan* [[\$10/\$20/\$30 + 20%] [[\$10/\$30/\$50+20%]			
☐ Deductible + Coin. Plan			
Coin. PPO: (Medical - 90/70 or 80/60) 20% (Medical - 70/50) 30%			
Coin. CMM: (Medical Coinsurance %) %			

SECTION 5. BENEFIT SELECTION	N (CONTIN	UED)				
BLUE~BY~DESIGN HSA (Che	ck Selected Bene	efit)				
EMPLOYER CONTRIBUTION - HEALTH/LIFE:	Employer (Contribution:	Employee:	%	Dependent:	%
Annual HSA contribution by tier:						
Employee Only: Employe	e/Spouse:	<u> </u>	Employee/C	hild:	Fami	ly:
HSA Contribution Frequency: A	nnually [Monthly	Semi-Moi	nthly		
NOTE: The Employer must pay a mini						nated by the
Company if the Policyholder fails to contri	ibute the perc	entage of Em	ployees' prem	ium specified	above.	
BENEFITS	611	612	613	614	615	616
DEDUCTIBLE						
Aggregate Individual In-Network	[\$1,200*]	\$2,000	\$3,000	\$4,000	\$5,000	\$2,000
Aggregate Family In-Network	[\$2,400*]	\$4,000	\$6,000	\$8,000	\$10,000	\$4,000
Aggregate Individual Out-of-Network	\$2,400	\$4,000	\$6,000	\$8,000	\$10,000	\$4,000
Aggregate Family Out-of-Network	\$4,800	\$8,000	\$12,000	\$16,000	\$20,000	\$8,000
COINSURANCE				· _		
In-Network	80%	80%	100%	100%	100%	100%
Out-of-Network	60%	60%	80%	80%	80%	80%
CALENDAR YEAR COINSURANCE MAX	_					
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 States of America as amended]	1, in accordanc	e with the prov	visions of §223 (of the Internal F	Revenue Code (of the United
LIFETIME MAXIMUM	\$2,000	,000 🔲 \$	5,000,000			
WELLNESS	Yes/	No				
AIR AMBULANCE Yes/ No						
MATERNITY (OPTIONAL UNDER 15 EMPLOYEES) Yes/ No						
DRUG COVERAGE						
☐ Option 1 (Standard Formulary) Subject to Deductible & Coinsurance						
Option 2 (Essential Care Subject to Deductible & Coinsurance Formulary)*						
☐ Option 3 (No Coverage)	No Covera	ige				
*Based on actuarial review, this drug benefit o		<u> </u>	standard Medica	are Part D pres	cription coverage	je.
SECTION 6. ARKANSAS MANDAT	ED OFFER	BENEFIT F	RIDERS			· ·
			t Each Rid	er		
					Floot	Poinst
Type of Benefit Rider		_			Elect	Reject
Mammography:						$ \boxtimes$
Psychiatric Conditions:						
тмј						$oxed{\boxtimes}_{-}$
Rejection of the TMJ Benefit Rider mean temporomandibular joint disorders (TMJ)	s covered ber or cranioman	nefits provided dibular disord	d to Covered F ders.	Persons will <u>no</u>	<u>ot</u> include	

SECTION 7. EMPLOYEE INFORMATION, MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQUIREMENTS. Full-Time means an active employee with a minimum of 30 hrs/week & 48 weeks/year ENROLLING WAIVING TOTAL 1. Full-Time Employees (In-State) 2. Full-Time Employees (Out-of-State): 3. COBRA Continuees 4. Total of lines 1, 2 & 3 (Enrolling & Waiving) 5. Part Time / Seasonal / Temporary Employees 6. Total # of Employees (add 4 & 5) Minimum Number of Insured Employees. To meet large group enrollment guidelines a group must have at least fifty-one Full-Time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal. Groups dropping below two Full-Time employees will no longer be eligible for group insurance. Minimum Participation Requirements. If an employer pays 100% of the employee-only premium, 100% of all Full-Time employees must be insured. If an employer pays less than 100% of the premium, employees covered through other comprehensive major medical-type coverage may be waived from the eligibility count. 75% of all eligible employees without waivers must be insured, and no less than 55% of the Full-Time employees must enroll. This Policy may be terminated by the Company if the number of insured Employees falls below the minimum number of insured Employees specified above or if the percentage of eligible Employees of the Policyholder covered by the Policy becomes less than the percentage of Employee participation specified above. SECTION 8. WAITING PERIOD & OPEN ENROLLMENT PERIOD & EFFECTIVE/RENEWAL DATE OF COVERAGE Class A: FULL TIME EMPLOYEES Class B: (Description) (Description) Waiting Period for New Hires -Waiting Period for New Hires -☐ No waiting period No waiting period 1 month 2 months 2 months 3 months ☐3 months 4 months 74 months 5 months 5 months 6 months 6 months Open Enrollment Period 12-11-12/31/08 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.)

STUDENT AGE 23

RATE CHANGE

Rates and benefits are effective: 1/1/09

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

Section 9. Signatures
This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the United States of America. This Application is incorporated in and made a part of the Group Policy and Reposit Contisions.
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 Ak, this 4th day of Dec. 2008
Signed at Jonesboro Ak, this 4th day of Dec. 2008
1.2 Agent
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.

Insurance License #/Agency Fed. Tax ID#

12-4-09

Agent Signature C

Agent Printed Name

Rates'

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



New Group	⊠Renewal Group			
APPLICATION by: CITY OF JONESBORO - PKG 06 - MEDI-PAK				
for a Group Policy covering the employees of the employees. The Policyholder intends hereby to es	ed "Policyholder") Policyholder and the eligible dependents of such stablish and maintain an employee benefit plan (the dependents, to contribute to the cost of the Plan, and loyees.			
SECTION 1. GROUP INFORMATION				
Legal Name of Business: 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			
SECTION 2. PROXY	2			

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 Commonly known as COBRA. 1. The Policyholder will contract with Ceridian, Inc. to		· ·		tion Act of 1985, Yes \sum No
2. If "No" who will handle COBRA administration for	you?			
The Policyholder agrees to indemnify ABCBS for action, litigation, suit, or claim brought by any Policyholder's COBRA administrator's failure to p	individual	arising out of th	e Policyhol	
SECTION 5. BENEFIT SELECTION				
Term Life and AD&D throu	igh USAbl	e Life NOT provid	ed	
CARVE-OUT HSA				
Employers may select a Blue~by~Design HSA benefit benefit option for the other class of employees. Select in Section 8.				
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contri	ibution:	PPO Employee:		ependent: %
NOTE The French and the second and t	<u> </u>	HSA Employee:		ependent: %
NOTE: The Employer must pay a minimum of 50% of the Company if the Policyholder fails to contribute the percentage.				terminated by the
BLUE~BY~DESIGN HRA (Check Selected Benefits)				
HRA Contribution Frequency: Annually Month	nly 🗌 Ser	mi-Monthly		
Annual HRA contribution by tier:				
Employee Only: Employee/Spouse:		Employee/Child:		Family:
COMPREHENSIVE MAJOR MEDICAL (CMM	M) (Check Sele	ected Benefits)		,
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Cont		<u> </u>	Depend	
NOTE: The Employer must pay a minimum of 50% of the Company if the Policyholder fails to contribute the percenta		-		terminated by the
Lifetime Maximum: \$1,000,000	\$2,000,0	000 🗆 \$	000,000	
Deductible	\$500		§1,000 [Other:
Coinsurance □ 90% □ 80% □ 70%	<u></u> 60%	☐ 50% ☐ Oth		
Calendar Year Coinsurance Max: \$2,5	500	\$5,000	\$10,000	Other:
Family Deductible (Max # / family)			Accumulated	Fulfillment
Family Calendar Year Coinsurance Max (Max # / family)	2X	3X Basis:	Accumulated	Fulfillment
CMM Optional Benefits:				
☐ Air Ambulance Benefit Rider ☐ \$1,000	\$2,00	0 \$3,000	\$4,000	\$5,000
Supplemental Accident Benefit Rider				_

SECTION 5. BENEFIT SELEC	TION (CONTINUED)			
PREFERRED PROVIDER ORGANIZATION (PPO) (Check Selected Benefits)				
EMPLOYER CONTRIBUTION - HEALTH/L	IFE: Employer Contribution: Employee: 66% Dependent: 66%			
	minimum of 50% of the Employee premium. This Policy may be terminated by the ontribute the percentage of Employees' premium specified above.			
Lifetime Maximum:	,000,000			
Deductible ☐ \$200 ☐ \$250	☐ \$300 ☐ \$500 ☐ \$750 ☐ \$1,000 ☐ Other:			
Coinsurance 90%/70				
In-Network Calendar Year Coinsuranc	e Max \$2,500 \$5,000 \$10,000 Other:			
Out-of-Network Calendar Year Coinsu				
Family Deductible Max (Max # / family)				
Family Calendar Year Coinsurance Ma	x (Max # / family)			
PPO Optional Benefits:				
Air Ambulance Benefit Rider	□\$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:			
	☐ \$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	N (CONTIN	IUED)				
BLUE~BY~DESIGN HSA (Check Selected Benefit)						
EMPLOYER CONTRIBUTION - HEALTH/LIFE:		Contribution:	Employee:	%	Dependent:	%
Annual HSA contribution by tier:						
Employee Only: Employee	e/Spouse:		Employee/C	Child:	Fam	
	nnually	Monthly	Semi-Mo			
NOTE: The Employer must pay a mini	mum of 50%	of the Emplo	ovee premium	This Policy	may he term	inated by the
Company if the Policyholder fails to contri	ibute the perc	entage of Em	ployees' prem	ium specified	above.	mateu by the
BENEFITS	611	612	613	C4.4		
DEDUCTIBLE		012	013	614	615	<u></u> 616
Aggregate Individual In-Network	[\$1,200*]	\$2,000	\$3,000	\$4,000	\$5,000	\$2,000
Aggregate Family In-Network	[\$2,400*]	\$4,000	\$6,000	\$8,000	\$10,000	\$4,000
Aggregate Individual Out-of-Network	\$2,400	\$4,000	\$6,000	\$8,000	\$10,000	\$4,000
Aggregate Family Out-of-Network	\$4,800	\$8,000	\$12,000	\$16,000	\$20,000	\$8,000
COINSURANCE						+0,000
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 a States of America as amended]				of the internal F	Revenue Code (of the United
LIFETIME MAXIMUM	\$2,000,		5,000,000			
WELLNESS						
AIR AMBULANCE	Yes/ No					
MATERNITY (OPTIONAL UNDER 15 EMPLOYEES) Yes/ No						
Drug Coverage	Coulci at to 1	D	<u> </u>			
☐ Option 1 (Standard Formulary) Subject to Deductible & Coinsurance						
Option 2 (Essential Care Formulary)* Subject to Deductible & Coinsurance						
☐ Option 3 (No Coverage)	No Covera	ge				
*Based on actuarial review, this drug benefit of	otion is non-cre	ditable to the s	tandard Medica	are Part D pres	cription coverag	<u>je</u> .
SECTION 6. ARKANSAS MANDATE	ED OFFER	BENEFIT R	IDERS			
You Must Elect Or Reject Each Rider						
Type of Benefit Rider					Elect	Reject
Mammography:			_			\boxtimes
Psychiatric Conditions:						\boxtimes
Substance Abuse:						
TMJ						\boxtimes
Rejection of the TMJ Benefit Rider means covered benefits provided to Covered Persons will <u>not</u> include temporomandibular joint disorders (TMJ) or craniomandibular disorders.					<u>t</u> include	

SECTION 7. EMPLOYEE INFORMATION, MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQUIREMENTS. Full-Time means an active employee with a minimum of 30 hrs/week & 48 weeks/year ENROLLING WAIVING TOTAL 1. Full-Time Employees (In-State) 2. Full-Time Employees (Out-of-State): 3. COBRA Continuees Total of lines 1, 2 & 3 (Enrolling & Waiving) 5. Part Time / Seasonal / Temporary Employees 6. Total # of Employees (add 4 & 5) Minimum Number of Insured Employees. To meet large group enrollment guidelines a group must have at least fifty-one Full-Time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal. Groups dropping below two Full-Time employees will no longer be eligible for group insurance. Minimum Participation Requirements. If an employer pays 100% of the employee-only premium, 100% of all Full-Time employees must be insured. If an employer pays less than 100% of the premium, employees covered through other comprehensive major medical-type coverage may be waived from the eligibility count. 75% of all eligible employees without waivers must be insured, and no less than 55% of the Full-Time employees must enroll. This Policy may be terminated by the Company if the number of insured Employees falls below the minimum number of insured Employees specified above or if the percentage of eligible Employees of the Policyholder covered by the Policy becomes less than the percentage of Employee participation specified above. SECTION 8. WAITING PERIOD & OPEN ENROLLMENT PERIOD & EFFECTIVE/RENEWAL DATE OF **COVERAGE** Class B: Class A: FULL TIME EMPLOYEES (Description) (Description) Waiting Period for New Hires -Waiting Period for New Hires -No waiting period No waiting period 1 month □ 1 month 2 months 2 months 3 months ☐ 3 months 4 months 4 months 5 months 5 months 6 months 6 months £31 108 Open Enrollment Period 12 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.)

STUDENT AGE 23

RATE CHANGE

Rates and benefits are effective: 1/1/09

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

SECTION 9. SIGNATURES
This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the United States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate. I hereby apply for the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies applied for, will take effect as of the next available effective date after approval, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. I also understand that my signature below represents my agreement and acceptance of the attached premium rate schedule.
Any person who knowingly property of the
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 Jones boro Ale, this 4th day of Dee 20 08
i
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.

Insurance License #/Agency Fed. Tax ID#

12-4-08

Agent Signature /

Agent Printed Name

Rates'

Tier	Product	Rate
EE	PPO	\$80.64

¹ The agent(s) or broker(s) involved in this insurance transaction may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

Tier	Product	Rate
EE	PPO	\$80.49
,		

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.



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

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 Commonly known as COBRA.	Consolidate	ed Omnibus Budg	et Reconcilia	ation Act of	1985,
1. The Policyholder will contract with Ceridian, Inc. to	provide it	COBRA administr	ration: 🛚 🖂	Yes [No
2. If "No" who will handle COBRA administration for	you?				
The Policyholder agrees to indemnify ABCBS for action, litigation, suit, or claim brought by any Policyholder's COBRA administrator's failure to p	individual	arising out of t	he Policyho		
SECTION 5. BENEFIT SELECTION					
Term Life and AD&D throu	ugh USAbi	le Life NOT provi	ded.		
CARVE-OUT HSA					
Employers may select a Blue~by~Design HSA benefit benefit option for the other class of employees. Select in Section 8.					isted
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contri	ribution:	PPO Employee:		ependent:	%
		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 Monti	hly 🗌 Se	———————— mi-Monthly			
Annual HRA contribution by tier:		<u> </u>			
Employee Only: Employee/Spouse:	_	Employee/Child:		Family:	
COMPREHENSIVE MAJOR MEDICAL (CMI	M) (Check Se	lected Benefits)			
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Cont		<u> </u>	Depen		%
NOTE: The Employer must pay a minimum of 50% of the Company if the Policyholder fails to contribute the percentage.				terminated i	by the
Lifetime Maximum: \$1,000,000	\$2,000,	000 🔲 S	\$5,000,000		
Deductible □\$200 □\$250 □\$300	\$500	\$750	\$1,000	Other:	
Coinsurance □ 90% □ 80% □ 70%	<u> </u>		her:		
Calendar Year Coinsurance Max: \$2,5	500] \$10,000	Other:	
Family Deductible (Max # / family)	☐ 2X ☐	3X Basis:	Accumulated	Fulfilli	
Family Calendar Year Coinsurance Max (Max # / family)	☐ 2X ☐	3X Basis:	Accumulated	Fulfilli	ment
CMM Optional Benefits:					
☐ Air Ambulance Benefit Rider ☐ \$1,000		00	\$4,000		00
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)				
Family Calendar Year Coinsurance Max (Max # / family)				
PPO Optional Benefits:				
☐ Air Ambulance Benefit Rider ☐\$1,000 ☐\$2,000 ☐\$3,000 ☐\$4,000 ☐\$5,000				
PCP Benefit Rider Office Visit Fee □\$10 PCP □\$20 PCP ☑ \$30 PCP □Other:				
PCP/SCP Benefit Rider Office Visit Fee \$20 PCP/\$40 SCP \$30 PCP/\$50 SCP				
Supplemental Accident Benefit Rider				
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:				
\$10/\$30/\$50 Uther:				
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%				
Cont. 11 C. (Modisal Cont.)				
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 SELECTIO	N (CONTIN	IUED)				
BLUE~BY~DESIGN HSA (Check Selected Benefit)						
EMPLOYER CONTRIBUTION - HEALTH/LIFE:		Contribution:	Employee:	%	Dependent:	%
Annual HSA contribution by tier:						
Employee Only: Employe	e/Spouse:		Employee/0		Fam	sib.e
HSA Contribution Frequency: A	nnually	Monthly	Semi-Mo		Fam	<u></u>
NOTE: The Employer must pay a mini	mum of 50%	of the Empl	ovee premium	This Policy	may ha tarm	imp4==1 t 11
Company if the Policyholder fails to contri	bute the perc	entage of Em	iployees' prem	ium specified	may be term 'above.	mated by the
BENEFITS						
DEDUCTIBLE	611	612	<u></u> 613	<u></u> 614	615	616
Aggregate Individual In-Network	[\$1,200*]	\$2,000	\$3,000	\$4,000	\$5.000	<u> </u>
Aggregate Family In-Network	[\$2,400*]	\$4,000	\$6,000	\$8,000	\$5,000 \$10,000	\$2,000
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	\$4,000
COINSURANCE		\$5,500	Ψ12,000	Ψ10,000	\$20,000	\$8,000
in-Network	80%	80%	100%	100%	100%	100%
Out-of-Network	60%	60%	80%	80%	80%	80%
CALENDAR YEAR COINSURANCE MAX					0070	
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						
WELLNESS	☐ Yes/ ☐ No					
AIR AMBULANCE	Yes/ No					
MATERNITY (OPTIONAL UNDER 15 EMPLOYEES)	Yes/	No				
Drug Coverage Drug Coverage						
☐ Option 1 (Standard Formulary)	Subject to i	Deductible &	Coinsurance			
Option 2 (Essential Care Subject to Deductible & Coinsurance Formulary)*						
☐ Option 3 (No Coverage)	No Covera	ge				
*Based on actuarial review, this drug benefit option is non-creditable to the standard Medicare Part D prescription coverage.						
SECTION 6. ARKANSAS MANDATE	D OFFER	BENEFIT R	IDERS		41	in the state of th
You	Must Elec	t Or Rejec	t Each Ride	er		
Type of Benefit Rider Elect Reject						
Mammography:			\boxtimes			
Psychiatric Conditions:						\boxtimes
Substance Abuse:			\boxtimes			
TMJ			-			\boxtimes
Rejection of the TMJ Benefit Rider means covered benefits provided to Covered Persons will <u>not</u> include temporomandibular joint disorders (TMJ) or craniomandibular disorders.						

SECTION 7. EMPLOYEE INFORMATION, MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQUIREMENTS. Full-Time means an active employee with a minimum of 30 hrs/week & 48 weeks/vear WAIVING ENROLLING TOTAL Full-Time Employees (In-State) 2. Full-Time Employees (Out-of-State): 3. COBRA Continuees Total of lines 1, 2 & 3 (Enrolling & Waiving) Part Time / Seasonal / Temporary Employees 6. Total # of Employees (add 4 & 5) Minimum Number of Insured Employees. To meet large group enrollment guidelines a group must have at least fifty-one Full-Time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal. Groups dropping below two Full-Time employees will no longer be eligible for group insurance. Minimum Participation Requirements. If an employer pays 100% of the employee-only premium, 100% of all Full-Time employees must be insured. If an employer pays less than 100% of the premium, employees covered through other comprehensive major medical-type coverage may be waived from the eligibility count. 75% of all eligible employees without waivers must be insured, and no less than 55% of the Full-Time employees must enroll. This Policy may be terminated by the Company if the number of insured Employees falls below the minimum number of insured Employees specified above or if the percentage of eligible Employees of the Policyholder covered by the Policy becomes less than the percentage of Employee participation specified above. SECTION 8. WAITING PERIOD & OPEN ENROLLMENT PERIOD & EFFECTIVE/RENEWAL DATE OF COVERAGE Class B: Class A: FULL TIME EMPLOYEES (Description) (Description) Waiting Period for New Hires -Waiting Period for New Hires -No waiting period No waiting period] 1 month □ 1 month 2 months 2 months 3 months 3 months ☐ 4 months 4 months 5 months 5 months ☐ 6 months 6 months oδ Open Enrollment Period 72/31 If a period is not specified, the Group's Open Enrollment Period will be the month prior to the Group's renewal date. ls 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.)

STUDENT AGE 23

RATE CHANGE

Rates and benefits are effective: 1/1/09

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

SECTION 9. SIGNATURES This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the United States of America. This Application is incorporated in and made a part of the Group Policy and 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 Jones boro Ah, 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

Insurance License #/Agency Fed. Tax ID#

12-4-08

application has been approved and the premium is received.

Agent Printed Name

Rates'

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.



New 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 CRAIGHE	EAD 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			
xec. Contact: DOUG FORMON E-Mail:				
roup 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:	s
· · · · · · · · · · · · · · · · · · ·	, [] 140
2. If "No" who will handle COBRA administration for you?	
The Policyholder agrees to indemnify ABCBS for any damage, claim or loss ABCBS may s action, litigation, suit, or claim brought by any individual arising out of the Policyholder 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 benefit option for the other class of employees. Select options for this employer below. Class description in Section 8.	
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: PPO Employee: % Depen	ndent: %
	ndent: %
NOTE: The Employer must pay a minimum of 50% of the Employee premium. This Policy may be term Company if the Policyholder fails to contribute the percentage of Employees' premium specified above.	ninated by the
BLUE~BY~DESIGN HRA (Check Selected Benefits)	
HRA Contribution Frequency: Annually Monthly Semi-Monthly	
Annual HRA contribution by tier:	
Employee Only: Employee/Spouse: Employee/Child: Fa	mily:
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 term Company if the Policyholder fails to contribute the percentage of Employees' premium specified above.	ninated by the
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)	Fulfillment
Family Calendar Year Coinsurance Max (Max # / family)	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 □ \$10,000 □ Other:				
Out-of-Network Calendar Year Coinsurance Max None 2X 4X Other:				
Family Deductible Max (Max # / family) □ 2X □ 3X □ 3X □ 3X □ 3X □ Accumulated □ Fulfillment				
Family Calendar Year Coinsurance Max (Max # / family)				
PPO Optional Benefits:				
☐ Air Ambulance Benefit Rider ☐\$1,000 ☐ \$2,000 ☐ \$3,000 ☐ \$4,000 ☐ \$5,000				
PCP/SCP Benefit Rider Office Visit Fee □\$20 PCP/\$40 SCP □\$30 PCP/\$50 SCP				
Supplemental Accident Benefit Rider				
Wellness Benefit Rider				
Special Group Considerations Form Number: 23-2186 Description: NO DEDUCTIBLE CARRYOVER				
Any special group considerations must be listed here (e.g. alternate eligibility, retirees, etc.)				
Prescription Drug Riders Available with CMM or PPO				
(Check Selected Benefit)				
☐ 2 Tier Copay Plan ☐ \$3/\$10 ☐ \$7/\$15 ☐ \$10/\$20 ☐ Other:				
3 Tier Copay + Coin. Plan* [\$10/\$20/\$30 + 20%] [\$10/\$30/\$50+20%] Other:				
□ Deductible + Coin. Plan Ded.: □ \$25 □ \$50 □ \$75 □ \$100 □ Other: ○ 20 □ PRO: (Modicel PRO: (Modice				
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	(CONTIN	UED)				
BLUE~BY~DESIGN HSA (Check Selected Benefit)						
EMPLOYER CONTRIBUTION - HEALTH/LIFE:		Contribution:	Employee:	%	Dependent:	%
Annual HSA contribution by tier:						
Employee Only: Employee	e/Spouse:		Employee/C	hild:	Fami	 ily:
HSA Contribution Frequency: An	nually	Monthly	Semi-Mor	nthly		
NOTE: The Employer must pay a minin	num of 50%	of the Empl	oyee premium	. This Policy	may be termi	nated by the
Company if the Policyholder fails to contrib	oute the perce	entage of Em	iployees' prem	ium specified	<u>above.</u>	
Benefits	611	<u>612</u>	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,		5,000,000			
WELLNESS	Yes/	No				
AIR AMBULANCE	Yes/ No					
ATERNITY (OPTIONAL UNDER 15 EMPLOYEES) Yes/ No						
Drug Coverage						
☐ Option 1 (Standard Formulary) Subject to Deductible & Coinsurance						
☐ Option 2 (Essential Care Subject to Deductible & Coinsurance Formulary)*						
☐ Option 3 (No Coverage) No Coverage						
*Based on actuarial review, this drug benefit option is non-creditable to the standard Medicare Part D prescription coverage.						
SECTION 6. ARKANSAS MANDATE	D OFFER	BENEFIT F	RIDERS			
You Must Elect Or Reject Each Rider						
Type of Benefit Rider					Elect	Reject
Mammography:						\boxtimes
Psychiatric Conditions:						\boxtimes
Substance Abuse:						\boxtimes
тмл						\boxtimes
Rejection of the TMJ Benefit Rider means covered benefits provided to Covered Persons will <u>not</u> include temporomandibular joint disorders (TMJ) or craniomandibular disorders.						

SECTION 7. EMPLOYEE INFORMATION, MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQUIREMENTS. Full-Time means an active employee with a minimum of 30 hrs/week & 48 weeks/year WAIVING ENROLLING TOTAL 1. Full-Time Employees (In-State) 2. Full-Time Employees (Out-of-State): 3. COBRA Continuees 4. Total of lines 1, 2 & 3 (Enrolling & Waiving) 5. Part Time / Seasonal / Temporary Employees 6. Total # of Employees (add 4 & 5) Minimum Number of Insured Employees. To meet large group enrollment guidelines a group must have at least fifty-one Full-Time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal. Groups dropping below two Full-Time employees will no longer be eligible for group insurance. Minimum Participation Requirements. If an employer pays 100% of the employee-only premium, 100% of all Full-Time employees must be insured. If an employer pays less than 100% of the premium, employees covered through other comprehensive major medical-type coverage may be waived from the eligibility count. 75% of all eligible employees without waivers must be insured, and no less than 55% of the Full-Time employees must enroll. This Policy may be terminated by the Company if the number of insured Employees falls below the minimum number of insured Employees specified above or if the percentage of eligible Employees of the Policyholder covered by the Policy becomes less than the percentage of Employee participation specified above. SECTION 8. WAITING PERIOD & OPEN ENROLLMENT PERIOD & EFFECTIVE/RENEWAL DATE OF COVERAGE Class B: Class A: FULL TIME EMPLOYEES (Description) (Description) Waiting Period for New Hires -Waiting Period for New Hires -No waiting period No waiting period 1 month 1 month 2 months 2 months 3 months 3 months 4 months 4 months ☐ 5 months 5 months 6 months 6 months 12/31/08 Open Enrollment Period If a period is not specified, the Group's Open Enrollment Period will be the month prior to the Group's renewal date. Is Waiting Period for Initial Enrollment Waived? 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.)

STUDENT AGE 23

RATE CHANGE

Rates and benefits are effective: 1/1/09

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

SECTION 9. SIGNATURES
This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the United States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate. I hereby apply for the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies applied for, will take effect as of the next available effective date after approval, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. I also understand that my signature below represents my agreement and acceptance of the attached premium rate schedule.
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in connection with an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
1. Policyholder Signed at Jones Doro Ab, this 4th day of Doe 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

Insurance License #/Agency Fed. Tax ID#

/2 - 4 - 0 8

Date

application has been approved and the premium is received.

Agent Printed Name

Rates'

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.



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 & H	OUSING				
D/B/A: URBAN RENEWAL & HOUSING					
Street Address: 330 UNION STREET					
Mailing Address: (if different from Street)					
City, State, Zip JONESBORO, AR 72401	County: CRAIGHEAD				
Telephone #: 870-935-9800					
Fax #:					
Fed. Tax I.D. #: 71-6013749	Group #: 024703				
Exec. Contact: DOUG FORMON	E-Mail:				
Group Administrator: GLORIA ROARK E-Mail:					
Primary SIC Code: 9199 SIC Description:					
Business Type: Sole Proprietorship Legal	Partnership				
SECTION 2. PROXY					

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

SECTION 3. POLICYHOLDER AS PLAN ADMINISTRATOR

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

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

SECTION 5. BENEFIT SELECTION (CONTINUED)					
PREFERRED PROVIDER ORGANIZATION (PPO) (Check Selected Benefits)					
EMPLOYER CONTRIBUTION - HEALTH/LIFE: Employer Contribution: Employee: 66% Dependent: 66%					
NOTE: The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the					
Company if the Policyholder fails to contribute the percentage of Employees' premium specified above.					
Lifetime Maximum: \$\infty\$ \$1,000,000					
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) Samily Deductible Max (Max # / family) Samily Deductible Max (Max # / family Deductible M					
Family Calendar Year Coinsurance Max (Max # / family) Solution Solution					
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 Tier Copay + Coin. Plan* [\$10/\$20/\$30 + 20%] [\$10/\$30/\$50+20%] Other:					
□ Deductible + Coin. Plan					
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.					
10-101BE R1/07					

SECTION 5. BENEFIT SELECTION	N (CONTIN	UED)				
BLUE~BY~DESIGN HSA (Che	ck Selected Bene	efit)				
EMPLOYER CONTRIBUTION - HEALTH/LIFE:	Employer (Contribution:	Employee:	%	Dependent:	%
Annual HSA contribution by tier:		 -				
Employee Only: Employe	e/Spouse:		Employee/C	hild:	Fami	ily:
HSA Contribution Frequency: A	nnually [Monthly	Semi-Mor			<u></u>
NOTE: The Employer must pay a mini		_ •		_ * -	may be termi	nated by the
Company if the Policyholder fails to contri						
BENEFITS	611	612	613	614	615	616
DEDUCTIBLE			 13	014	015	
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	\$1,000	45,000	1 4.2,000	\$10,000	420,000	Ψ0,000
In-Network	80%	80%	100%	100%	100%	100%
Out-of-Network	60%	60%	80%	80%	80%	80%
CALENDAR YEAR COINSURANCE MAX			1			
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 States of America as amended]	1, in accordanc	e with the prov	risions of §223 o	of the Internal F	Revenue Code	of the United
LIFETIME MAXIMUM	\$2,000	,000 🔲 \$	5,000,000			
WELLNESS	Yes/	No				
AIR AMBULANCE	Yes/	No				
MATERNITY (OPTIONAL UNDER 15 EMPLOYEES)	Yes/	No				
DRUG COVERAGE						
☐ Option 1 (Standard Formulary)	Subject to	Deductible &	Coinsurance			
Option 2 (Essential Care Formulary)*	Subject to	Deductible &	Coinsurance			
☐ Option 3 (No Coverage)	No Covera	ige				
*Based on actuarial review, this drug benefit o		<u> </u>	standard Medica	are Part D pres	cription coverag	_ ge.
SECTION 6. ARKANSAS MANDAT	ED OFFER	BENEFIT F	RIDERS			
			t Each Rid	er		
Type of Benefit Rider					Elect	Reject
, ··· 					Flect	
Mammography:						
Psychiatric Conditions:						
Substance Abuse:						
TMJ			11- O 17	Damana will	4 :- 01:-1:	
Rejection of the TMJ Benefit Rider means temporomandibular joint disorders (TMJ)	s covered ben or cranioman	ients provided <u>idibular disord</u>	i to Covered F ders	ersons Will <u>no</u>	<u>or</u> incinae	

SECTION 7. EMPLOYEE INFORMATION, MINIMUN	NUMBER OF	INSURED EN	PLOYEES &	MINIMUM
PARTICIPATION REQUIREMENTS. Full-Time means an active employee with a minimum of 30 hrs/week 8	18 wookshoor		100	
	40 Weeks/year	ENROLLING	WAIVING	TOTAL
1. Full-Time Employees (In-State)				
Full-Time Employees (Out-of-State):				
3. COBRA Continuees				
4. Total of lines 1, 2 & 3 (Enrolling & Waiving)				ļ
5. Part Time / Seasonal / Temporary Employees				
6. Total # of Employees (add 4 & 5)				
Minimum Number of Insured Employees. To meet large graph Time enrolled employees. Groups whose enrollment subsequently renewal. Groups dropping below two Full-Time employees will no lo	drops below fifty-o	one enrolled must		
Minimum Participation Requirements. If an employer pays 100 must be insured. If an employer pays less than 100% of the periodical-type coverage may be waived from the eligibility count. 75 less than 55% of the Full-Time employees must enroll.	remium, employee	es covered throug	gh other compret	nensive major (
This Policy may be terminated by the Company if the numbinsured Employees specified above or if the percentage of ebecomes less than the percentage of Employee participation s	eligible Employee			
SECTION 8. WAITING PERIOD & OPEN ENROLLI	MENT PERIOD	& EFFECTIV	E/RENEWAL	DATE OF
COVERAGE				
Class A: FULL TIME EMPLOYEES	Class B:			
(Description)		(Descript	tion)	į
Waiting Period for New Hires -	Waiting Period	d for New Hires	3 -	· ·
☐ No waiting period	☐ No waiting	period		}
⊠ 1 month	1 month			į
2 months	2 months			{
3 months	3 months			
4 months	☐ 4 months			Ì
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 rea	newal date.	
Is Waiting Period for Initial Enrollment Waived? 🗌 Yes	☐ No			
Requested effective date, pending approval is				
(Please Note: If a complete group enrollment packet	t is not received tin	nely, the group, if	approved, will be	
assigned the next ava	ailable effective dat	e.)		
Rates and benefits are effective: 1/1/09				
STUDENT AGE 23				
BENEFIT CHANGES: RX TO \$7/\$30/\$50				

10-101BE R1/07

RATE CHANGE

CTIO			
	SIGN		

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 Jenesh	oro AR	this 4 th _day of	Dre	20 08
	Cit.	State)			

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

Agent Printed Name

Insurance License #/Agency Fed. Tax ID#

/2-4-08

Date

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.



New Group	⊠Renewal Group
APPLICATION by: CITY OF JONESBORO MUNIC	
for a Group Policy covering the employees of the employees. The Policyholder intends hereby to es	ed "Policyholder") Policyholder and the eligible dependents of such tablish and maintain an employee benefit plan (the dependents, to contribute to the cost of the Plan, and oyees.
SECTION 1. GROUP INFORMATION	
Legal Name of Business: CITY OF JONESBORO	MUNICIPAL AIRPORT
D/B/A: CITY OF JONESBORO MUNICIPAL AIRPO	DRT
Street Address: 4116 LINBERGH DRIVE	
Mailing Address: (if different from Street) P.O. BOX 129	3, 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 I	Partnership
SECTION 2. PROXY	
as its proxy to act on its behalf at all meetings of members of the Board may designate by resolution to act on its behalf, vote for the Policyholder on all matters that may be voted held each year at the home office of ABCBS located at Monday of March, at 1:00 p.m. If the third Monday of Martime and place on the next day after, which is not a legal hout less than ten (10) or more than sixty (60) days prior to effect during the Policyholder's membership in ABCBS. The	doard") of Arkansas Blue Cross and Blue Shield ("ABCBS"), of ABCBS. This appointment shall include such persons as This proxy gives the Board, or its designee, full power to upon at any meeting. The annual meeting of Members is 601 S. Gaines Street, Little Rock, Arkansas, on the third ch is a legal holiday, then the meeting will be at the same bliday. A special meeting may be called upon notice mailed such meeting. This proxy, unless revoked, shall remain in e Policyholder may revoke this proxy in writing by advising ys prior any meeting. The Policyholder may also revoke its setting.

SECTION 3. POLICYHOLDER AS PLAN ADMINISTRATOR

The Policyholder, as Plan Administrator, assumes 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.

SECTION 4. COBRA ADMINISTRATION
The Policyholder is subject to the provisions of the Consolidated Omnibus Budget Respectively.
1 main ab OOD(V),
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.
FINDLOVED CONTRIBUTION MEAL THILLIEF, Family of Contribution of the Contribution of th
100 5
NOTE: The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the
Company if the Policyholder falls 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:
Deductible □\$200 □\$250 □\$300 □\$500 □\$750 □\$1,000 □ Other:
Coinsurance □ 90% □ 80% □ 70% □ 60% □ 50% □ Other:
Calendar Year Coinsurance Max: \$2,500 \$5,000 \$10,000 Other:
Family Deductible (Max # / family)
Family Calendar Year Coinsurance Max (Max # / family)
CMM Optional Benefits:
☐ Air 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 □ \$5,000,000 □ \$1,000,000 □ \$2,000,0000 □ \$2,0000,0000 □ \$2,0000,0000 □ \$2,0000,0000 □ \$2,0000,0000 □ \$2,0000,00000 □ \$2,0					
Deductible □ \$200 □ \$250 □ \$300 □ \$750 □ \$1,000 □ Other:					
Coinsurance □ 90%/70% ⊠ 80%/60% □ 70%/50% □ Other:					
In-Network Calendar Year Coinsurance Max □ \$2,500 □ \$5,000 □ \$10,000 □ Other:					
Out-of-Network Calendar Year Coinsurance Max None 2X 4X Other:					
Family Deductible Max (Max # / family)					
Family Calendar Year Coinsurance Max (Max # / family)					
PPO Optional Benefits:					
☐ Air Ambulance Benefit Rider ☐\$1,000 ☐\$2,000 ☐\$3,000 ☐\$4,000 ☐\$5,000					
✓ PCP Benefit Rider Office Visit Fee □\$10 PCP □\$20 PCP ☑ \$30 PCP □Other:					
PCP/SCP Benefit Rider Office Visit Fee ☐\$20 PCP/\$40 SCP ☐\$30 PCP/\$50 SCP					
Supplemental Accident Benefit Rider					
Wellness Benefit Rider					
Special Group Considerations Form Number: 23-2186 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:					
\$10/\$30/\$50 Other:					
3 Tier Copay + Coin. Plan* [\$10/\$20/\$30 + 20%] [\$10/\$30/\$50+20%] Other:					
Deductible + Coin. Plan Ded.: \$25 \$50 \$75 \$100 Other:					
Coin. PPO: (Medical - 90/70 or 80/60) 20% (Medical - 70/50) 30%					
Coin. CMM: (Medical Coinsurance %) %					
*Based on actuarial review, this drug benefit option is non-creditable to the standard Medicare Part D prescription coverage.					

SECTION 5. BENEFIT SELECTION	N (CONTIN	IUED)				
BLUE~BY~DESIGN HSA (Che	eck Selected Ben	efit)			· · · · · ·	
EMPLOYER CONTRIBUTION - HEALTH/LIFE:		Contribution:	Employee:	%	Dependent:	0/0
Annual HSA contribution by tier:						
Employee Only: Employee/Spouse: Employee/Child: Family:						
	nnually	Monthly	Semi-Mo		ran	11y.
NOTE: The Employer must pay a mini	mum of 50%	of the Empl	ovee premium	This Policy	may be down	Secretary of the second
Company if the Policyholder fails to contri	ibute the perc	entage of Em	ployees' premium	i. This Folicy nium specifiea	may be term. 'above.	nated by the
Benefits	611			_		
DEDUCTIBLE		<u></u> 612	613	614	615	616
Aggregate Individual In-Network	[\$1,200*]	\$2,000	\$3,000	\$4,000	¢5 000	60.000
Aggregate Family In-Network	[\$2,400*]	\$4,000	\$6,000	\$8,000	\$5,000 \$10,000	\$2,000
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	\$4,000 \$8,000
COINSURANCE	7.1,200	\$5,555	Ψ12,000	\$10,000	\$20,000	\$8,000
In-Network	80%	80%	100%	100%	100%	100%
Out-of-Network	60%	60%	80%	80%	80%	80%
CALENDAR YEAR COINSURANCE MAX					1	0070
Aggregate Individual In-Network	[\$2,000*]	\$2,000	\$0	\$0	\$0	\$0
Aggregate Family In-Network	[\$4,000*]	\$4,000	\$0	\$0	\$0	\$0
Aggregate Individual Out-of-Network	\$8,000	\$8,000	Unlimited	Unlimited	Unlimited	Unlimited
Aggregate Family Out-of-Network	\$16,000	\$16,000	Unlimited	Unlimited	Unlimited	Unlimited
[*adjusted annually for inflation each January a States of America as amended]	I, in accordanc	e with the prov	isions of §223 c	of the Internal F	Revenue Code d	of the United
LIFETIME MAXIMUM	\$2,000,	000 \$	5,000,000			
Wellness	Yes/	No				
AIR AMBULANCE	Yes/	No				
MATERNITY (OPTIONAL UNDER 15 EMPLOYEES)	Yes/	No				
DRUG COVERAGE						
Option 1 (Standard Formulary)	Subject to	Deductible &	Coinsurance			
Option 2 (Essential Care Formulary)*	Subject to i	Deductible &	Coinsurance			
☐ Option 3 (No Coverage)	No Covera	ge				
*Based on actuarial review, this drug benefit op	otion is non-cre	ditable to the s	tandard Medica	re Part D pres	cription coverag	ie.
SECTION 6. ARKANSAS MANDATE	D OFFER	BENEFIT R	IDERS			en en la la
You	Must Elec	t Or Rejec	t Each Ride	e <i>r</i>	_	
Type of Benefit Rider Elect Reject						
Mammography:						
Psychiatric Conditions:						
Substance Abuse:						
TMJ						\boxtimes
Rejection of the TMJ Benefit Rider means temporomandibular joint disorders (TMJ)				ersons will <u>no</u>	<u>t</u> include	

Note: Land				
SECTION 7. EMPLOYEE INFORMATION, MINIMUM	NUMBER OF I	NSURED EM	PLOYEES &	MINIMUM
PARTICIPATION REQUIREMENTS.				
Full-Time means an active employee with a minimum of 30 hrs/week & 4	18 weeks/year	ENROLLING	WAIVING	TOTAL
Full-Time Employees (In-State)				
2. Full-Time Employees (Out-of-State):				
3. COBRA Continuees				
4. Total of lines 1, 2 & 3 (Enrolling & Waiving)				
5. Part Time / Seasonal / Temporary Employees				
6. Total # of Employees (add 4 & 5)				
Minimum Number of Insured Employees. To meet large group enrollment guidelines a group must have at least fifty-one Full-Time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal. Groups dropping below two Full-Time employees will no longer be eligible for group insurance. Minimum Participation Requirements. If an employer pays 100% of the employee-only premium, 100% of all Full-Time employees				
must be insured. If an employer pays less than 100% of the premedical-type coverage may be waived from the eligibility count. 75% less than 55% of the Full-Time employees must enroll.	emium, employees	covered through	h other compret	nensive major
This Policy may be terminated by the Company if the number insured Employees specified above or if the percentage of elibecomes less than the percentage of Employee participation specified.	gible Employees			
SECTION 8. WAITING PERIOD & OPEN ENROLLM	ENT PERIOD	& EFFECTIV	E/RENEWAL	DATE OF
COVERAGE				
Class A: FULL TIME EMPLOYEES	Class B:			
(Description)	(Description)			
Waiting Period for New Hires -	Waiting Period for New Hires -			

CECTION O. TRAITING I ENGEL & CI EN ENROLE	MENT I ENOUGH ENTENEMAL BATE 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 12-14-12-131/08			
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	<u>-</u>		

SECTION 9. SIGNATURES

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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 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	,	10		
Signed at	nes boro Akthis	€ day of	Dee	20 08
ÿ Q	(City, State)			

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#

/2-4-08

Agent Printed Name

Date

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