City of Jonesboro

900 West Monroe
Jonesboro, AR 72401

Meeting Agenda

Finance & Administration Council Committee

Tuesday, November 6, 2012 | **5:20 PM** | **Huntington Building**

Special Called Meeting

1. Call To Order

2. New Business

Resolutions To Be Introduced

RES-12:198 A RESOLUTION TO ACCEPT INSURANCE CONTRACTS FROM ARKANSAS BLUE CROSS & BLUE SHIELD TO PROVIDE INSURANCE COVERAGE FOR CITY EMPLOYEES FOR 2013

Sponsors: Mayor's Office and Human Resources

Attachments: Airport
COJ
Library
JURH
COJ Medipac Supp

RES-12:200 A RESOLUTION TO ACCEPT DENTAL INSURANCE PROPOSAL FROM DELTA DENTAL TO PROVIDE DENTAL INSURANCE COVERAGE FOR CITY EMPLOYEES

Sponsors: Mayor's Office and Human Resources

Attachments: Delta Dental contract

RES-12:202 A RESOLUTION TO ACCEPT LIFE INSURANCE PROPOSAL FROM USABLE TO PROVIDE BASIC LIFE INSURANCE COVERAGE FOR CITY EMPLOYEES AND DEPENDENTS,

Sponsors: Mayor's Office and Human Resources

Attachments: USAble contract

3. Public Comments

4. Adjournment

City of Jonesboro

515 West Washington
Jonesboro, AR 72401

Legislation Details (With Text)

File #:	RES-12:198	**Version:**	1	**Name:**	Contract with BlueCross Blue Shield for city employee health insurance coverage
Type:	Resolution			**Status:**	To Be Introduced
File created:	10/31/2012			**In control:**	Finance & Administration Council Committee
On agenda:				**Final action:**	
Title:	A RESOLUTION TO ACCEPT INSURANCE CONTRACTS FROM ARKANSAS BLUE CROSS & BLUE SHIELD TO PROVIDE INSURANCE COVERAGE FOR CITY EMPLOYEES FOR 2013				
Sponsors:	Mayor's Office, Human Resources				
Indexes:	Contract, Employee benefits				
Code sections:					
Attachments:	Airport COJ Library JURH COJ Medipac Supp				

Date	Ver.	Action By	Action	Result

title
A RESOLUTION TO ACCEPT INSURANCE CONTRACTS FROM ARKANSAS BLUE CROSS & BLUE SHIELD TO PROVIDE INSURANCE COVERAGE FOR CITY EMPLOYEES FOR 2013
body
WHEREAS, The City of Jonesboro offers Medical Insurance for employees; and

WHEREAS, The City of Jonesboro bid out health insurance for 2011

WHEREAS, The City of Jonesboro has the authority to renew these policies with the current carriers for a period of up to two years following the bid year

NOW THEREFORE, BE IT RESOLVED, by the City Council of the City of Jonesboro, that

SECTION 1. The Arkansas Blue Cross & Blue Shield contract shall be renewed with a 2% increase in premiums. Single coverage will be $327.60 per month and $703.82 for family coverage. The city will pay 73.5% of the premium for both single and family coverage.

SECTION 2: The Mayor is hereby authorized to execute such documents as are necessary to effectuate these contracts between the City of Jonesboro and Arkansas Blue Cross & Blue Shield.

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

EMPLOYER APPLICATION
Blues Enroll

Renewal APPLICATION by: City of Jonesboro Municipal Airport

(hereinafter called "Policyholder")

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

GROUP INFORMATION

Legal Name of Business: CITY OF JONESBORO

D/B/A: City of Jonesboro Municipal Airport

Street Address: 4116 Linbergh Drive

City, State, Zip: Jonesboro , AR , 72403 | County: Craighead

Mailing Address: (if different from Street) P.O. Box 1293

City, State, Zip: Jonesboro , AR , 72403

Telephone #: 870-933-4640

Fax #: -

Fed. Tax I.D #: 71-0028290

Exec. Contact: | E-Mail:

Group Administrator: Gloria Roark | E-Mail:

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

Business Type: Government Entity

Agent: | Agent's Lic #:

Agent's Company: Agent's Tax Id:

POLICYHOLDER AS PLAN ADMINISTRATOR

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

PROXY

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

BENEFIT SELECTION

PREFERRED PROVIDER ORGANIZATION (PPO) - PPO XXX - 1

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2013
Waiting Period Note: Effective Date is first of the month following the Waiting Period.
Date of Open Enrollment December
If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.

Class	Class Description	Waiting Period	Contribution
1	Full Time	1 Month	Employee 71 % Dependent 71 %

Note: *The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage of Employees' premium specified above.*

Maximum Dependent Age 26

Mandated Mental Health Parity: Yes

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

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

Prescription Drug Rider Plan: $10/$30/$50/100% Value Formulary

Mail Order Drug - 2x Copay (90 days)

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

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

Arkansas Mandated Offer Benefit Riders:

You Must Elect or Reject Each Rider:	
Mammography - Reject	Substance Abuse - Reject
Psychiatric Condition - Reject	TMJ* - Reject
Hearing Aid - Reject	

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

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

RATES - PPO XXX - 1

Two Tier Composite	**Total Premium**
Employee	$327.60
Family	$703.82

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

Grandfather Status - Our records indicate that your health plan is grandfathered.

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

✓

___Yes, I agree with the status as shown.

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

ATTESTATIONS

COBRA

Group health plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, "Ceridian", to assist you in administering Cobra (no additional cost).

Both full time and part time employees are counted to determine if a plan is subject to Cobra. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours worked divided by the number of hours used to determine full time status.

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

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

If no, who will administer Cobra for you? _____

Medical Loss Ratio - The determination of Large and Small Groups is based upon the average number of employees employed by the employer on business days during the proceeding calendar year. The Public Health Services Act §2791(e) provides

(1) The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(2) The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

The policyholder is a ____ large employer ✓ small employer (check one).

L. Policyholder to Distribute and Account for Premium Rebates

In the event federal or state law requires the Company to rebate a portion of an annual premium payment, Company will pay the Policyholder the total rebate applicable to the Policy, and Policyholder shall use the amount of the rebate that is proportionate to the total amount of premium paid by all Employees under the policy for the benefit of Employees in one of the following ways, at the option of the Policyholder:

1. For all Employees covered under any option offered under the policyholder's group health plan at the time the rebate is received by the policyholder, to reduce the Employees' portion of premium for the subsequent policy year;
2. For Employees covered, at the time the rebate is received by the policyholder, under the group health plan option for which the Company is providing a rebate, to reduce the Employees' portion of premium for the subsequent policy year;
3. A cash refund to Employees enrolled in the group health plan option, at the time the rebate is received by the policyholder, for which the Company is providing a rebate; and
4. The reduction in future premium or the cash refund provided under paragraphs 1, 2 or 3 of this section may, at the option of the policyholder, be: divided evenly among such Employees; divided based on each Employee's actual contributions to premium; or apportioned in a manner that reasonably reflects each Employee's contributions to premium.
5. The portion of a rebate based upon former Employees' contributions to premium must be aggregated and used for the benefit of current Employees in the group health plan in any manner permitted by this section.

Policyholder will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Policyholder's failure to carry out its obligations under this Section L of the Group Policy.

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

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

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

	In State	Out of State	Total
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):	1		1
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):			
COBRA Continuees (Enrolling):			
Life ONLY Contracts:			
Total Enrolling and Waiving:			
Part Time/Seasonal/Temporary Employees :			
Total # of Employees:			1

Minimum Number of Insured Employees. To meet large group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal.
Minimum Participation Requirements. Employees covered through other comprehensive major medical-type coverage may be waived from the eligibility count. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

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

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

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

Special Group Considerations Form# 23-2242, Description $100 ER co-pay

SIGNATURES

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

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

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

1. Policyholder

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

_____ [full legal name of Policyholder]

By: _____ _____
Authorized Signature Printed Name

_____
Title or Position

2. Agent

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

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

DAVID C. FERGUSON _____
Agent Printed Name Date

The Patient Protection and Affordable Care Act (PPACA) mandates a Summary of Benefits and Coverage (SBC) document be created for every health insurance plan. An SBC that applies to this plan(s) can be found online at www.arkansasbluecross.com/esbc. After we receive and process your signed contract, you may access the SBC(s) for this plan by going to our SBC locator tool and entering the following unique identifier(s) into the SBC locator:

10051209044602

Groups with more than one plan type may have more than one link. You may download and electronic copy (PDF) of the appropriate SBC(s) to fulfill distribution requirements as mandated by the Patient Protection and Affordable Care Act (PPACA). A printed version is available by calling your group service representative.

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

EMPLOYER APPLICATION
Blues Enroll

Renewal APPLICATION by: CITY OF JONESBORO

(hereinafter called "Policyholder")

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

GROUP INFORMATION

Legal Name of Business: CITY OF JONESBORO

D/B/A: CITY OF JONESBORO

Street Address: 515 W Washigton

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

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

City, State, Zip: Jonesboro , AR , 72403

Telephone #: 870-933-4640

Fax #: -

Fed. Tax I.D #: 71-6013749

Exec. Contact: Harold Perrin | E-Mail: hperrin@jonesboro.org

Group Administrator: GLORIA ROARK | E-Mail: groark@jonesboro.org

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

Business Type: Government Entity

Agent: | Agent's Lic #:

Agent's Company: Agent's Tax Id:

POLICYHOLDER AS PLAN ADMINISTRATOR

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

PROXY

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

BENEFIT SELECTION

PREFERRED PROVIDER ORGANIZATION (PPO) - PPO XXX - 1

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2013
Waiting Period Note: Effective Date is first of the month following the Waiting Period.
Date of Open Enrollment December
If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.

Class	Class Description	Waiting Period	Contribution
1	Full Time	1 Month	Employee 71 % Dependent 71 %

Note: *The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage of Employees' premium specified above.*

Maximum Dependent Age 26

Mandated Mental Health Parity: Yes

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

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

Prescription Drug Rider Plan: $10/$30/$50/100% Value Formulary

Mail Order Drug - 2x Copay (90 days)

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

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

Arkansas Mandated Offer Benefit Riders:

You Must Elect or Reject Each Rider:

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

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

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

RATES - PPO XXX - 1

Two Tier Composite	**Total Premium**
Employee	$327.60
Family	$703.82

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

Grandfather Status - Our records indicate that your health plan is grandfathered.

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

✓ Yes, I agree with the status as shown.

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

BENEFIT SELECTION

PREFERRED PROVIDER ORGANIZATION (PPO) - PPO XXX - 1

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2013
Waiting Period Note: Effective Date is first of the month following the Waiting Period.
Date of Open Enrollment December
If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.

Class	Class Description	Waiting Period	Contribution
2	Retirees	0 Months	Employee 0 % Dependent 0 %

Note: *The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage of Employees' premium specified above.*

Maximum Dependent Age 26

Mandated Mental Health Parity: Yes

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

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

Prescription Drug Rider Plan: $10/$30/$50/100% Value Formulary

Mail Order Drug - 2x Copay (90 days)

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

PPO Optional Benefits:

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

Arkansas Mandated Offer Benefit Riders:

You Must Elect or Reject Each Rider:

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

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

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

RATES - PPO XXX - 1

Two Tier Composite	**Total Premium**
Employee	$327.60
Family	$703.82

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

Grandfather Status - Our records indicate that your health plan is grandfathered.

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

✓ Yes, I agree with the status as shown.

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

ATTESTATIONS

COBRA

Group health plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, "Ceridian", to assist you in administering Cobra (no additional cost).
Both full time and part time employees are counted to determine if a plan is subject to Cobra. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours worked divided by the number of hours used to determine full time status.

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

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

If no, who will administer Cobra for you? _____

Medical Loss Ratio - The determination of Large and Small Groups is based upon the average number of employees employed by the employer on business days during the proceeding calendar year. The Public Health Services Act §2791(e) provides

(1) The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(2) The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

The policyholder is a ✓ large employer ____ small employer (check one).

L. Policyholder to Distribute and Account for Premium Rebates

In the event federal or state law requires the Company to rebate a portion of an annual premium payment, Company will pay the Policyholder the total rebate applicable to the Policy, and Policyholder shall use the amount of the rebate that is proportionate to the total amount of premium paid by all Employees under the policy for the benefit of Employees in one of the following ways, at the option of the Policyholder:
1. For all Employees covered under any option offered under the policyholder's group health plan at the time the rebate is received by the policyholder, to reduce the Employees' portion of premium for the subsequent policy year;
2. For Employees covered, at the time the rebate is received by the policyholder, under the group health plan option for which the Company is providing a rebate, to reduce the Employees' portion of premium for the subsequent policy year;
3. A cash refund to Employees enrolled in the group health plan option, at the time the rebate is received by the policyholder, for which the Company is providing a rebate; and
4. The reduction in future premium or the cash refund provided under paragraphs 1, 2 or 3 of this section may, at the option of the policyholder, be: divided evenly among such Employees; divided based on each Employee's actual contributions to premium; or apportioned in a manner that reasonably reflects each Employee's contributions to premium.
5. The portion of a rebate based upon former Employees' contributions to premium must be aggregated and used for the benefit of current Employees in the group health plan in any manner permitted by this section.
Policyholder will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Policyholder's failure to carry out its obligations under this Section L of the Group Policy.

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

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

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

	In State	Out of State	Total
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):	496		496
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):			
COBRA Continuees (Enrolling):			
Life ONLY Contracts:			
Total Enrolling and Waiving:			
Part Time/Seasonal/Temporary Employees :			44
Total # of Employees:			540

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

Minimum Participation Requirements. Employees covered through other comprehensive major medical-type coverage may be waived from the eligibility count. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

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

Special Group Considerations Form# 23-2170, Description Continuation for Municipal Emps 55+

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

Special Group Considerations Form# 23-2432, Description Contin for City Cnsl Mbrs & Elect Officials

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

Special Group Considerations Form# 23-2242, Description $100 ER co-pay

SIGNATURES

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

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

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

1. Policyholder

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

_____ [full legal name of Policyholder]

By: _____ _____
Authorized Signature Printed Name

_____
Title or Position

2. Agent

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

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

DAVID C. FERGUSON _____
Agent Printed Name Date

The Patient Protection and Affordable Care Act (PPACA) mandates a Summary of Benefits and Coverage (SBC) document be created for every health insurance plan. An SBC that applies to this plan(s) can be found online at www.arkansasbluecross.com/esbc. After we receive and process your signed contract, you may access the SBC(s) for this plan by going to our SBC locator tool and entering the following unique identifier(s) into the SBC locator:

10051209044592
10051209044639

Groups with more than one plan type may have more than one link. You may download and electronic copy (PDF) of the appropriate SBC(s) to fulfill distribution requirements as mandated by the Patient Protection and Affordable Care Act (PPACA). A printed version is available by calling your group service representative.

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

EMPLOYER APPLICATION
Blues Enroll

Renewal APPLICATION by: City of Jonesboro Craighead Library

(hereinafter called "Policyholder")

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

GROUP INFORMATION

Legal Name of Business: CITY OF JONESBORO

D/B/A: City of Jonesboro Craighead Library

Street Address: 315 W. Oak

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

Mailing Address: (if different from Street) 315 W. Oak

City, State, Zip: Jonesboro , AR , 72401

Telephone #: 870-933-4640

Fax #: -

Fed. Tax I.D #: 71-0023849

Exec. Contact: | E-Mail:

Group Administrator: Nancy Dobbins | E-Mail:

Primary SIC Code: 8231 SIC Description: Libraries

Business Type: Government Entity

Agent: | Agent's Lic #:

Agent's Company: Agent's Tax Id:

POLICYHOLDER AS PLAN ADMINISTRATOR

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

PROXY

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

BENEFIT SELECTION

PREFERRED PROVIDER ORGANIZATION (PPO) - PPO XXX - 1

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2013
Waiting Period Note: Effective Date is first of the month following the Waiting Period.
Date of Open Enrollment December
If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.

Class	Class Description	Waiting Period	Contribution
1	Full Time	1 Month	Employee 71 % Dependent 71 %

Note: *The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage of Employees' premium specified above.*

Maximum Dependent Age 26

Mandated Mental Health Parity: Yes

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

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

Prescription Drug Rider Plan: $10/$30/$50/100% Value Formulary

Mail Order Drug - 2x Copay (90 days)

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

PPO Optional Benefits:

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

Arkansas Mandated Offer Benefit Riders:

You Must Elect or Reject Each Rider:

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

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

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

RATES - PPO XXX - 1

Two Tier Composite	**Total Premium**
Employee	$327.60
Family	$703.82

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

Grandfather Status - Our records indicate that your health plan is grandfathered.

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

✓ Yes, I agree with the status as shown.

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

ATTESTATIONS

COBRA

Group health plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, "Ceridian", to assist you in administering Cobra (no additional cost).

Both full time and part time employees are counted to determine if a plan is subject to Cobra. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours worked divided by the number of hours used to determine full time status.

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

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

If no, who will administer Cobra for you? _____

Medical Loss Ratio - The determination of Large and Small Groups is based upon the average number of employees employed by the employer on business days during the proceeding calendar year. The Public Health Services Act §2791(e) provides

(1) The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(2) The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

The policyholder is a ____ large employer ✓ small employer (check one).

L. Policyholder to Distribute and Account for Premium Rebates

In the event federal or state law requires the Company to rebate a portion of an annual premium payment, Company will pay the Policyholder the total rebate applicable to the Policy, and Policyholder shall use the amount of the rebate that is proportionate to the total amount of premium paid by all Employees under the policy for the benefit of Employees in one of the following ways, at the option of the Policyholder:

1. For all Employees covered under any option offered under the policyholder's group health plan at the time the rebate is received by the policyholder, to reduce the Employees' portion of premium for the subsequent policy year;
2. For Employees covered, at the time the rebate is received by the policyholder, under the group health plan option for which the Company is providing a rebate, to reduce the Employees' portion of premium for the subsequent policy year;
3. A cash refund to Employees enrolled in the group health plan option, at the time the rebate is received by the policyholder, for which the Company is providing a rebate; and
4. The reduction in future premium or the cash refund provided under paragraphs 1, 2 or 3 of this section may, at the option of the policyholder, be: divided evenly among such Employees; divided based on each Employee's actual contributions to premium; or apportioned in a manner that reasonably reflects each Employee's contributions to premium.
5. The portion of a rebate based upon former Employees' contributions to premium must be aggregated and used for the benefit of current Employees in the group health plan in any manner permitted by this section.

Policyholder will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Policyholder's failure to carry out its obligations under this Section L of the Group Policy.

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

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

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

	In State	Out of State	Total
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):	29		29
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):	1		1
COBRA Continuees (Enrolling):			
Life ONLY Contracts:			
Total Enrolling and Waiving:			
Part Time/Seasonal/Temporary Employees :			
Total # of Employees:			29

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

Minimum Participation Requirements. Employees covered through other comprehensive major medical-type coverage may be waived from the eligibility count. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

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

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

Special Group Considerations Form# 23-2186, Description no deductible carryover

Special Group Considerations Form# 23-2242, Description $100 ER co-pay

SIGNATURES

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

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

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

1. Policyholder

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

_____ [full legal name of Policyholder]

By: _____ _____
Authorized Signature Printed Name

_____
Title or Position

2. Agent

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

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

DAVID C. FERGUSON _____
Agent Printed Name Date

The Patient Protection and Affordable Care Act (PPACA) mandates a Summary of Benefits and Coverage (SBC) document be created for every health insurance plan. An SBC that applies to this plan(s) can be found online at www.arkansasbluecross.com/esbc. After we receive and process your signed contract, you may access the SBC(s) for this plan by going to our SBC locator tool and entering the following unique identifier(s) into the SBC locator:

10051209044632

Groups with more than one plan type may have more than one link. You may download and electronic copy (PDF) of the appropriate SBC(s) to fulfill distribution requirements as mandated by the Patient Protection and Affordable Care Act (PPACA). A printed version is available by calling your group service representative.

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

EMPLOYER APPLICATION
Blues Enroll

Renewal APPLICATION by: City of Jonesboro Urban Renewal & Housin

(hereinafter called "Policyholder")

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

GROUP INFORMATION

Legal Name of Business: CITY OF JONESBORO

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

Street Address: 330 Union Street

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

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

City, State, Zip: Jonesboro , AR , 72401

Telephone #: 870-935-9800

Fax #: -

Fed. Tax I.D #: 71-0024703

Exec. Contact: | E-Mail:

Group Administrator: Janice Grissum | E-Mail:

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

Business Type: Government Entity

Agent: | Agent's Lic #:

Agent's Company: Agent's Tax Id:

POLICYHOLDER AS PLAN ADMINISTRATOR

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

PROXY

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

BENEFIT SELECTION

PREFERRED PROVIDER ORGANIZATION (PPO) - PPO XXX - 1

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2013
Waiting Period Note: Effective Date is first of the month following the Waiting Period.
Date of Open Enrollment December
If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.

Class	Class Description	Waiting Period	Contribution
1	Full Time	1 Month	Employee 71 % Dependent 71 %

Note: *The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage of Employees' premium specified above.*

Maximum Dependent Age 26

Mandated Mental Health Parity: Yes

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

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

Prescription Drug Rider Plan: $10/$30/$50/100% Value Formulary

Mail Order Drug - 2x Copay (90 days)

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

PPO Optional Benefits:

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

Arkansas Mandated Offer Benefit Riders:

You Must Elect or Reject Each Rider:

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

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

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

RATES - PPO XXX - 1

Two Tier Composite	**Total Premium**
Employee	$327.60
Family	$703.82

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

Grandfather Status - Our records indicate that your health plan is grandfathered.

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

✓ Yes, I agree with the status as shown.

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

ATTESTATIONS

COBRA

Group health plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, "Ceridian", to assist you in administering Cobra (no additional cost).

Both full time and part time employees are counted to determine if a plan is subject to Cobra. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours worked divided by the number of hours used to determine full time status.

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

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

If no, who will administer Cobra for you? _____

Medical Loss Ratio - The determination of Large and Small Groups is based upon the average number of employees employed by the employer on business days during the proceeding calendar year. The Public Health Services Act §2791(e) provides

(1) The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(2) The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

The policyholder is a ____ large employer ✓ small employer (check one).

L. Policyholder to Distribute and Account for Premium Rebates

In the event federal or state law requires the Company to rebate a portion of an annual premium payment, Company will pay the Policyholder the total rebate applicable to the Policy, and Policyholder shall use the amount of the rebate that is proportionate to the total amount of premium paid by all Employees under the policy for the benefit of Employees in one of the following ways, at the option of the Policyholder:

1. For all Employees covered under any option offered under the policyholder's group health plan at the time the rebate is received by the policyholder, to reduce the Employees' portion of premium for the subsequent policy year;
2. For Employees covered, at the time the rebate is received by the policyholder, under the group health plan option for which the Company is providing a rebate, to reduce the Employees' portion of premium for the subsequent policy year;
3. A cash refund to Employees enrolled in the group health plan option, at the time the rebate is received by the policyholder, for which the Company is providing a rebate; and
4. The reduction in future premium or the cash refund provided under paragraphs 1, 2 or 3 of this section may, at the option of the policyholder, be: divided evenly among such Employees; divided based on each Employee's actual contributions to premium; or apportioned in a manner that reasonably reflects each Employee's contributions to premium.
5. The portion of a rebate based upon former Employees' contributions to premium must be aggregated and used for the benefit of current Employees in the group health plan in any manner permitted by this section.

Policyholder will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Policyholder's failure to carry out its obligations under this Section L of the Group Policy.

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

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

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

	In State	Out of State	Total
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):	38		38
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):	6		6
COBRA Continuees (Enrolling):			
Life ONLY Contracts:			
Total Enrolling and Waiving:			
Part Time/Seasonal/Temporary Employees :			
Total # of Employees:			38

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

Minimum Participation Requirements. Employees covered through other comprehensive major medical-type coverage may be waived from the eligibility count. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

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

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

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

Special Group Considerations Form# 23-2242, Description $100 ER co-pay

SIGNATURES

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

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

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1. Policyholder

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

_____ [full legal name of Policyholder]

By: _____ _____
Authorized Signature Printed Name

_____
Title or Position

2. Agent

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

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

DAVID C. FERGUSON _____
Agent Printed Name Date

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10051209044625

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

EMPLOYER APPLICATION
Blues Enroll

Renewal APPLICATION by: CITY OF JONESBORO

(hereinafter called "Policyholder")

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

GROUP INFORMATION

Legal Name of Business: CITY OF JONESBORO

D/B/A: CITY OF JONESBORO

Street Address: 515 W Washigton

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

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

City, State, Zip: Jonesboro , AR , 72403

Telephone #: 870-933-4640

Fax #: -

Fed. Tax I.D #: 71-6013749

Exec. Contact: Harold Perrin | E-Mail: hperrin@jonesboro.org

Group Administrator: GLORIA ROARK | E-Mail: groark@jonesboro.org

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

Business Type: Government Entity

Agent: | Agent's Lic #:

Agent's Company: Agent's Tax Id:

POLICYHOLDER AS PLAN ADMINISTRATOR

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

PROXY

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

BENEFIT SELECTION

RX ONLY - MEDIPAK SUPPLEMENT RX

REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2013
Waiting Period Note: Effective Date is first of the month following the Waiting Period.
Date of Open Enrollment December
If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.

Class	Class Description	Waiting Period	Contribution
4	Med supp elctd offics w20 Yrs cnt sc-rx	0 Months	Employee 25 % Dependent 0 %

Note: *The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage of Employees' premium specified above.*

Maximum Dependent Age: 26

Mandated Mental Health Parity: Yes

Prescription Drug Rider Plan: $10/$30/$50 /100% Value Formulary, Mail Order Drug - 2x Copay (90 days)

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

RATES - MEDIPAK SUPPLEMENT RX

One Tier Composite	**Total Premium**
Employee	$80.84

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

Grandfather Status - Our records indicate that your health plan is grandfathered.

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

✓ Yes, I agree with the status as shown.

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

ATTESTATIONS

COBRA

Group health plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, "Ceridian", to assist you in administering Cobra (no additional cost).

Both full time and part time employees are counted to determine if a plan is subject to Cobra. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours worked divided by the number of hours used to determine full time status.

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

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

If no, who will administer Cobra for you? _____

Medical Loss Ratio - The determination of Large and Small Groups is based upon the average number of employees employed by the employer on business days during the proceeding calendar year. The Public Health Services Act §2791(e) provides

(1) The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(2) The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

The policyholder is a ✓ large employer ____ small employer (check one).

L. Policyholder to Distribute and Account for Premium Rebates

In the event federal or state law requires the Company to rebate a portion of an annual premium payment, Company will pay the Policyholder the total rebate applicable to the Policy, and Policyholder shall use the amount of the rebate that is proportionate to the total amount of premium paid by all Employees under the policy for the benefit of Employees in one of the following ways, at the option of the Policyholder:

1. For all Employees covered under any option offered under the policyholder's group health plan at the time the rebate is received by the policyholder, to reduce the Employees' portion of premium for the subsequent policy year;
2. For Employees covered, at the time the rebate is received by the policyholder, under the group health plan option for which the Company is providing a rebate, to reduce the Employees' portion of premium for the subsequent policy year;
3. A cash refund to Employees enrolled in the group health plan option, at the time the rebate is received by the policyholder, for which the Company is providing a rebate; and
4. The reduction in future premium or the cash refund provided under paragraphs 1, 2 or 3 of this section may, at the option of the policyholder, be: divided evenly among such Employees; divided based on each Employee's actual contributions to premium; or apportioned in a manner that reasonably reflects each Employee's contributions to premium.
5. The portion of a rebate based upon former Employees' contributions to premium must be aggregated and used for the benefit of current Employees in the group health plan in any manner permitted by this section.

Policyholder will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Policyholder's failure to carry out its obligations under this Section L of the Group Policy.

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

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

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

	In State	Out of State	Total
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):	1		1
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):			
COBRA Continuees (Enrolling):			
Life ONLY Contracts:			
Total Enrolling and Waiving:			
Part Time/Seasonal/Temporary Employees :			
Total # of Employees:			1

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

Minimum Participation Requirements. Employees covered through other comprehensive major medical-type coverage may be waived from the eligibility count. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

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

Special Group Considerations Form# 23-2170, Description Continuation for Municipal Emps 55+

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

Special Group Considerations Form# 23-2432, Description Contin for City Cnsl Mbrs & Elect Officials

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

Special Group Considerations Form# 23-2242, Description $100 ER co-pay

SIGNATURES

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

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

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

1. Policyholder

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

_____ [full legal name of Policyholder]

By: _____ _____
Authorized Signature Printed Name

_____
Title or Position

2. Agent

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

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

DAVID C. FERGUSON _____
Agent Printed Name Date

The Patient Protection and Affordable Care Act (PPACA) mandates a Summary of Benefits and Coverage (SBC) document be created for every health insurance plan. An SBC that applies to this plan(s) can be found online at www.arkansasbluecross.com/esbc. After we receive and process your signed contract, you may access the SBC(s) for this plan by going to our SBC locator tool and entering the following unique identifier(s) into the SBC locator:

10051209044646

Groups with more than one plan type may have more than one link. You may download and electronic copy (PDF) of the appropriate SBC(s) to fulfill distribution requirements as mandated by the Patient Protection and Affordable Care Act (PPACA). A printed version is available by calling your group service representative.

515 West Washington
Jonesboro, AR 72401

City of Jonesboro

Legislation Details (With Text)

File #:	RES-12:200	**Version:**	1	**Name:**	Contract with Delta Dental for city employee dental insurance coverage
Type:	Resolution			**Status:**	To Be Introduced
File created:	11/1/2012			**In control:**	Finance & Administration Council Committee
On agenda:				**Final action:**	
Title:	A RESOLUTION TO ACCEPT DENTAL INSURANCE PROPOSAL FROM DELTA DENTAL TO PROVIDE DENTAL INSURANCE COVERAGE FOR CITY EMPLOYEES				
Sponsors:	Mayor's Office, Human Resources				
Indexes:	Contract, Employee benefits				
Code sections:					
Attachments:	Delta Dental contract				

Date	Ver.	Action By	Action	Result

title
A RESOLUTION TO ACCEPT DENTAL INSURANCE PROPOSAL FROM DELTA DENTAL TO PROVIDE DENTAL INSURANCE COVERAGE FOR CITY EMPLOYEES
body
WHEREAS, The City of Jonesboro offers Dental Insurance for employees; and

WHEREAS, The City of Jonesboro has the authority to renew these policies with the current carriers for a period of up to two years following the bid year;

WHEREAS, The City of Jonesboro bid out the dental insurance for 2011;

NOW THEREFORE BE IT RESOLVED BY THE CITY COUNCIL FOR THE CITY OF JONESBORO; ARKANSAS THAT:

SECTION 1: The Delta Dental contract shall be renewed without an increase in premiums. Single coverage remain $26.14 per month and $83.22 for family coverage. The city will provide single coverage for all full time employees and elected officials and if family coverage is desired the employee will pay $57.08

SECTION 2: The Mayor is hereby authorized to execute such documents as are necessary to effectuate this contract between the City of Jonesboro and Delta Dental.

City Of Jonesboro

Dental Benefit Renewal

September 20, 2012

City Of Jonesboro
Group Number 9448
Monthly Rates

	Current Rates	New Rates (Effective 01/01/2013 - 12/31/2013)
	12 Month Rates	12 Month Rates
City Of Jonesboro		
Subscriber	$26.14	$26.14
Subscriber-Spouse	$83.22	$83.22
Subscriber-Child	$83.22	$83.22
Subscriber-Children	$83.22	$83.22
Family	$83.22	$83.22

Date: July 6, 2012
Account Executive: Large
Underwriter:

EXPERIENCE-RATED
RENEWAL ACCOUNT INFORMATION

Group Name: **City Of Jonesboro** Group Number: **9448**
Address: **P O Box 1845, Jonesboro, AR 72403**
Contact Person/Telephone #: **Gloria Roark**
Effective Date: **January 1, 2013 - December 31, 2013**
External Agent: **Town & Country Ins Agency**

Current Plan Design:

Type of Contract: [**X**] Risk [ ] ASO
ASO funding arrangement: Escrow Deposit Amount $__ Other
Reimbursement Method: [ ] UCR [ ] TOA [ ] RTOA [**X**] Other
USA Account: [**X**] Yes [ ] No

Product: **Delta Dental PPO**		Apply Ded	Ben W/Per	Wv Init	Late Entrnt	Prorate
Diagnostic & Preventive	**100/100/90**%	**No**		**No**		**No**
Sealants	**100/100/90**%	**No**		**No**		**No**
Oral Surgery	**80/80/72**%	**Yes**		**No**		**No**
Emergency Palliative	**80/80/72**%	**Yes**		**No**		**No**
Space Maintainers	**80/80/72**%	**Yes**		**No**		**No**
Endodontics	**80/80/72**%	**Yes**		**No**		**No**
Simple Extractions	**80/80/72**%	**Yes**		**No**		**No**
Prosthodontics	**50/50/45**%	**Yes**		**No**	**12**	**No**
Orthodontic Device to Aid	**50/50/45**%	**No**		**No**	**12**	**No**
Minor Restorative	**80/80/72**%	**Yes**		**No**		**No**
Relines, Rebases & Repairs	**50/50/45**%	**Yes**		**No**	**12**	**No**
Major Restorative	**50/50/45**%	**Yes**		**No**	**12**	**No**
Non-Surgical Periodontics	**80/80/72**%	**Yes**		**No**		**No**
Surgical Periodontics	**50/50/45**%	**Yes**		**No**	**12**	**No**
Orthodontics	**50/50/45**%	**No**		**No**	**12**	**No**

Deductible: Individual coverage amount **$50**
Family coverage amount **$50x3**

Maximums: All covered classes (excluding Ortho, TMJ) Individual coverage amount $**1000**
Individual lifetime - ortho $**1000**

Deductible/Maximum Benefit Period: [ ] Contract [**X**] Calendar

Benefit Limitation Period: **DUSA Cal Yr**

Are adults eligible for orthodontic coverage, if applicable? [ ] Yes [**X**] No

Dependent Coverage: Dependent **26** End of **Month**

New Hire Waiting Period:

Executive Cost Management

Group Name **CITY OF JONESBORO**

Group Number(s) **9448**

Experience Period **06/01/2011 - 05/31/2012**

Billed Charges	$587,274	
Paid Claims	$289,739	
Claims as a Percent of Billed Charges	49.34%	
Average Number of Employees	542	
Delta Difference Savings (Non-Billable)	**Dollars Saved**	**% of Billed Charges**
Non-Billable Procedures	$3,977	0.68%
Duplicate Claims	$68,533	11.67%
Delta Dental PPO Dentist Fee Reductions	$17,120	2.92%
Delta Dental Premier Dentist Fee Reductions	$52,032	8.86%
Delta Difference Savings Total	**$141,662**	**24.12%**
Network Savings Per Employee Per Month	**$10.63**	
Contract Savings (May Be Billable)	**Dollars Saved**	**% of Billed Charges**
Non-Participating Dentist Maximum	$2,283	0.39%
Contract Exclusions	$8,813	1.50%
Consultant Review	$1,959	0.33%
Contract Limitations	$11,437	1.95%
Alternate Treatment	$713	0.12%
Coordination of Benefits	$10,657	1.81%
Contract Savings Total	**$35,862**	**6.11%**
Total Savings	**$177,524**	
Patient Responsibility	**Dollars Saved**	**% of Billed Charges**
Coinsurance Savings	$93,361	15.90%
Deductible Savings	$12,545	2.14%
Plan Maximum Savings	$12,690	2.16%
Eligibility Verification	$1,415	0.24%
Patient Responsibility Total	**$120,011**	**20.44%**

DELTA DENTAL

CITY OF JONESBORO
Claims Summary Report
Group Number: 9448
06/01/2011 to 05/31/2012
Comparison

Group #9448	Claim Count	Submitted Fee	Approved Amount	Allowed fee	Deductible Amount	Net Plan Pay	Average Enrollment	Average Cost/Claim	Average Cost/Employee
06/01/2011 - 05/31/2012									
Total Time Period	2,086	$587,274.16	$477,287.86	$418,992.27	$12,545.30	$289,739.25	542	$138.90	$534.57
06/01/2010 - 05/31/2011									
Total Time Period	2,151	$564,439.94	$460,819.74	$419,372.82	$13,483.90	$294,338.63	536	$136.84	$549.14
% Change									
TOTAL	**-3.02%**	**4.05%**	**3.57%**	**-0.09%**	**-6.96%**	**-1.56%**	**1.12%**	**1.50%**	**-2.65%**

DELTA DENTAL

CITY OF JONESBORO
CLAIMS ANALYSIS COMPARISON
Group Number: 9448

Claims Analysis

	06/01/2010 - 05/31/2011				06/01/2011 - 05/31/2012				Percent Change Year to Year			
Type of Services	**Claims Paid**	**Percent of Total Paid**	**# Proc**	**Average Cost Per Employee**	**Claims Paid**	**Percent of Total Paid**	**# Proc**	**Average Cost Per Employee**	**Claims Paid**	**# of Procedures**	**Average Cost Per Employee**	**DD CO-Wide % of Total Paid 2010**
Diagnostic	$83,978.70	28.53%	2,719	$156.68	$83,867.90	28.95%	2,771	$154.74	-0.13%	1.91%	-1.24%	20.76%
Perio Prophy	$495.00	0.17%	6	$0.92	$180.00	0.06%	3	$0.33	-63.64%	-50.00%	-64.04%	0.06%
Preventive	$59,117.82	20.08%	1,546	$110.29	$57,686.10	19.91%	1,459	$106.43	-2.42%	-5.63%	-3.50%	15.14%
Sealant	$2,845.40	0.97%	96	$5.31	$1,857.00	0.64%	62	$3.43	-34.74%	-35.42%	-35.46%	0.74%
Space Maintainers	$0.00	0.00%	0	$0.00	$408.00	0.14%	2	$0.75	0.00%	0.00%	0.00%	0.16%
Endodontics	$23,104.70	7.85%	75	$43.11	$28,268.02	9.76%	94	$52.16	22.35%	25.33%	20.99%	8.21%
Extractions	$5,808.10	1.97%	128	$10.84	$6,190.20	2.14%	119	$11.42	6.58%	-7.03%	5.40%	3.49%
Oral and Maxillofacial Surgery	$13,477.00	4.58%	107	$25.14	$12,530.38	4.32%	98	$23.12	-7.02%	-8.41%	-8.05%	4.89%
Perio Maintenance	$716.00	0.24%	24	$1.34	$821.60	0.28%	29	$1.52	14.75%	20.83%	13.48%	0.57%
Periodontics - Nonsurgical	$2,322.40	0.79%	33	$4.33	$5,079.68	1.75%	62	$9.37	118.73%	87.88%	116.30%	3.17%
Periodontics - Surgical	$35.50	0.01%	3	$0.07	$379.00	0.13%	4	$0.70	967.61%	33.33%	955.79%	0.69%
Restorative Basic	$38,972.51	13.24%	595	$72.71	$32,935.43	11.37%	469	$60.77	-15.49%	-21.18%	-16.43%	15.54%
Implants	$3,991.50	1.36%	8	$7.45	$2,251.30	0.78%	15	$4.15	-43.60%	87.50%	-44.22%	1.50%
Prosthetic Repair	$50.50	0.02%	6	$0.09	$95.50	0.03%	2	$0.18	89.11%	-66.67%	87.02%	0.28%
Prosthodontics Fixed	$5,438.10	1.85%	19	$10.15	$3,166.70	1.09%	16	$5.84	-41.77%	-15.79%	-42.41%	2.34%
Prosthodontics Removable	$2,930.00	1.00%	8	$5.47	$3,085.50	1.06%	10	$5.69	5.31%	25.00%	4.14%	3.75%
Restorative Major	$36,099.60	12.26%	191	$67.35	$35,282.90	12.18%	189	$65.10	-2.26%	-1.05%	-3.34%	12.65%
Orthodontics	$10,814.40	3.67%	238	$20.18	$12,036.52	4.15%	208	$22.21	11.30%	-12.61%	10.07%	4.21%
Adjunctive General Services	$4,141.40	1.41%	171	$7.73	$3,617.52	1.25%	164	$6.67	-12.65%	-4.09%	-13.62%	1.74%
	$294,338.63	100.00%	5,973	$549.14	$289,739.25	100.00%	5,776	$534.57	-1.56%	-3.30%	-2.65%	99.89%
Average Enrollment	**536**				**542**				**1.12%**			

City of Jonesboro

515 West Washington
Jonesboro, AR 72401

Legislation Details (With Text)

File #:	RES-12:202	**Version:**	1	**Name:**	Contract with USAble for city employee life insurance coverage
Type:	Resolution			**Status:**	To Be Introduced
File created:	11/1/2012			**In control:**	Finance & Administration Council Committee
On agenda:				**Final action:**	
Title:	A RESOLUTION TO ACCEPT LIFE INSURANCE PROPOSAL FROM USABLE TO PROVIDE BASIC LIFE INSURANCE COVERAGE FOR CITY EMPLOYEES AND DEPENDENTS,				
Sponsors:	Mayor's Office, Human Resources				
Indexes:	Contract, Employee benefits				
Code sections:					
Attachments:	USAble contract				

Date	Ver.	Action By	Action	Result

title
A RESOLUTION TO ACCEPT LIFE INSURANCE PROPOSAL FROM USABLE TO PROVIDE BASIC LIFE INSURANCE COVERAGE FOR CITY EMPLOYEES AND DEPENDENTS,
body
WHEREAS, The City of Jonesboro offers Basic Life Insurance for employees and dependents; and

WHEREAS, USAble has had an increase of basic life insurance of $.17 per 1000 to $.18 per 1000;

NOW THEREFORE, BE IT RESOLVED, by the City Council of the City of Jonesboro, Arkansas that the Mayor is hereby authorized to execute such documents as are necessary to effectuate this contract between the City of Jonesboro and USAble.

USAble Life

November 1, 2012

City of Jonesboro
515 W WASHINGTON
PO BOX 1845
JONESBORO AR 72401

RE: Policy Number: 50001517

Dear Group Administrator

Your group life insurance plan with USAble Life renews **1/1/2013**. We have completed the review of the rates for your plan. Based on this analysis, we have determined that a rate adjustment is indicated. The new rates will be effective 1/1/2013,with a **2-year rate guarantee**. The new rates are as follows:

Benefit	Current Rate	Renewal Rate
Basic Life	$0.17 per 1,000	$0.18 per 1,000
AD&D	$0.03 per 1,000	$0.03 per 1,000
Dependent Life	$0.24 per 1,000	$0.24 per 1,000

*Rates on all Voluntary Group products will remain the same through 1/1/2015.

Thank you for giving us the opportunity to serve your employees' insurance needs.
Please feel free to contact our office (501-375-7200 or 800-648-0271) or your local insurance representative whenever we can be of assistance.

Sincerely,

Henry W. Reed,
VP, Group Underwriting