AGENDA ITEM EXECUTIVE SUMMARY

Agenda Item:	Consider Resolution No. 2020-66 Authorizing Acceptance of the 2020 Employee Benefit Plan Renewal Effective November 1, 2020 for the City of Geneva, IL.
Presenter & Title:	Benjamin McCready, ACA/DOAS
Date:	September 8, 2020

Please Check Appropriate Box:

X	Committee of the Whole Meeting		Special Committee of the Whole Meeting
X	City Council Meeting		Special City Council Meeting
	Public Hearing		Other -

Associated Strategic Plan Goal/Objective: N/A

Estimated Cost: $2,177,070	Budgeted? X **YES** **NO**

*If **NO**, please explain how the item will be funded:*

Executive Summary:

The employee health, dental, vision, and life insurance coverages are due for renewal on November 1, 2020. The City currently utilizes Blue Cross Blue Shield (BCBSIL) for four options for health coverage (two HMO plans, a PPO plan, and a High Deductible PPO plan). The City also offers employees a PPO self-funded dental plan through Delta Dental of Illinois and a DHMO Dental Plan through Blue Cross Blue Shield (BCBSIL). The City offers a voluntary VSP Vision insurance option paid for by the employee. Finally, the City provides a life and AD&D policy through Standard Life Insurance at no cost to the employee. The City's estimated contributions for the renewal of all group health plans is $2,177,070. Open enrollment for employees, retirees, and those on or eligible for COBRA is set to occur mid-September 2020.

The initial BCBSIL renewal was sent to Lundstrom (the City's insurance broker) and through their efforts they were able to secure a reduced rate increase of 4.64% for the 2020/2021 plan year. The increase is consistent with projections and may be accommodated within the existing budget.

For comparison purposes, the following chart depicts the City's renewal rates for the past five (5) years (including this renewal):

Renewal Year	Percent Change
2016	4.50%
2017	3.80%
2018	(4.50%)
2019	1.16%
2020	4.64%
Average	***1.92%***

The dental plans renew on November 1, 2020. The BCBSIL DHMO dental plan will see a 0% increase for the 2020-2021 plan year. There are currently seven participants in the DHMO dental plan. Delta Dental's renewal returned a 1.58% increase in administrative fees and Delta is projecting an overall 4.46% decrease in claims. It is recommended to maintain current funding levels for the 2020-2021 benefit year.

The Standard Insurance Company provides the City with life, accidental death and dismemberment insurance. The City obtained a two-year rate guarantee for a period to end October 31, 2022. The renewal reflects no changes in rates to this benefit.

This is the second year of a four-year rate guarantee for the VSP voluntary vision program. Employees who wish to participate in the plan fund the full cost. There is no additional cost to the City to provide this voluntary benefit.

Representatives of Lundstrom Insurance will be present to answer questions.

Attachments: *(please list)*

- Resolution

Voting Requirements:

This motion requires 6 affirmative votes for passage.

The Mayor may vote on three occasions: (a) when the vote of the aldermen or trustees has resulted in a tie; (b) when one half of the aldermen or trustees elected have voted in favor of an ordinance, resolution, or motion even though there is no tie votes; or (c) when a vote greater than a majority of the corporate authorities is required by state statute or local ordinance to adopt an ordinance, resolution, or motion.

Recommendation / Suggested Action: *(briefly explain)*

Recommend Resolution No. 2020-66 authorizing acceptance of the 2020 Employee Benefit Program plan renewal effective November 1, 2020 for the City of Geneva, Illinois.

RESOLUTION NO. 2020-66

RESOLUTION AUTHORIZING ACCEPTANCE OF THE 2020 EMPLOYEE BENEFIT PROGRAM PLAN RENEWAL EFFECTIVE NOVEMBER 1, 2020 FOR THE CITY OF GENEVA, ILLINOIS.

BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF GENEVA, KANE COUNTY, ILLINOIS, as follows:

SECTION 1: That the City Administrator is hereby authorized to accept and execute plan documents for the 2020 Employee Benefit Program plan renewal (Exhibit A) effective November 1, 2020.

SECTION 2: This Resolution shall become effective from and after its passage as in accordance with law.

PASSED by the City Council of the City of Geneva, Kane County, Illinois, this ____ day of September 2020.

AYES: _ NAYS: _ ABSENT: _ ABSTAINING: _ HOLDING OFFICE: _

Approved by me this 21st day of September 2020.

_____
Mayor

ATTEST:

_____
City Clerk

Exhibit A

City of Geneva
2020 Employee Benefit Program Plan Renewal

	Total Monthly Premium (Employer + Employee Contribution)		
Medical (BCBSIL)	**Employee**	**Employee + 1**	**Family**
PPO	$ 675.21	$ 1,640.01	$ 1,989.56
HSA	$ 651.50	$ 1,582.35	$ 1,919.71
HMOI	$ 632.78	$ 1,536.93	$ 1,864.61
BlueAdv HMO	$ 588.48	$ 1,428.90	$ 1,734.12
Dental			
BCBS DHMO	$ 36.85		$ 98.60
Delta Dental (Self-Funded)	$ 37.92		$ 100.70
Vision			
VSP	$ 8.57		$ 18.42
Life/AD&D			
The Standard	$ 0.17 per $1,000 of salary up to $150,000		

BlueCross BlueShield of Illinois

BlueCare® Dental HMO
Benefit Program Application ("BPA")

Employer Account Number: 769669

BlueCare Dental HMO Employer Group Number(s): D02533

Section Number(s): 0001

Blue Cross Health Employer Group Number(s): H56633, B56633, P74397, PE1181
(Must be provided if the Employer has any other health coverage provided by HCSC.)

Employer's Legal Name: City of Geneva
(Specify the Employer, the employee trust or the association applying for coverage. Names of subsidiary or affiliated companies to be covered must also be included below. An employee benefit plan may not be named.)

Address: 22 South First Street
City: Geneva State: IL Zip Code: 60134

Billing Address (if different from above): _____

Employer Identification Number ("EIN"): 36-6005893 SIC: 8990

City: _____ State: _____ Zip Code: _____

Subsidiaries to be covered: _____

Affiliated Companies to be Covered: _____

(Affiliated Companies must be required or permitted to be aggregated per IRS guidelines. Employer hereby confirms that Employer, Subsidiaries and Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), or (c), or (m), or (o), or under applicable law.)

Administrative Contact: Benjamin McCready Phone: 630-938-4540 Fax: _____ Email: bmccready@geneva.il.us

Billing Contact Benjamin McCready Phone: 630-938-4540 Fax: _____

Blue Access for Employers (BAE) contact: Benjamin McCready

(The BAE Contact is the employee of the account authorized by the Employer to access and maintain its account via BAE.)

Title: Asst. City Administrator Phone: 630-938-4540 Fax: _____ Email: bmccready@geneva.il.us

Policy Effective Date: 11/01/2020
(Must be the first day of the month)

Policy Anniversary Date: 11/01/2021
(Must be the first day of the month)

ERISA Plan: ☐ Yes ☒ No If Yes, specify ERISA Plan Year: _____

ERISA Plan Administrator: _____

ERISA Plan Administrator's Address: _____

City: _____ State: _____ Zip Code: _____

ERISA Plan Administrator's Email: _____

1. **Eligible Person:**

Employer has decided that Eligible Person means a Full-time Employee of the Employer. Part-time and Seasonal Employees are not eligible. Full-time Employee means a person who is regularly scheduled to work a minimum of thirty (30) hours per week and who is on the permanent payroll of the Employer.

Total number of eligible employees (full and part-time) employed by the Employer: 151.

2. **Civil Union Partner Coverage:**

A Civil Union Partner and his or her dependents are automatically eligible to enroll for coverage and, once enrolled, eligible for continuation of coverage as described in the Certificate Booklet. The Employer as Policyholder is responsible for providing notice of possible tax implications to those Insureds with coverage for Civil Union Partners.

3. **Domestic Partner Coverage**: ☐ Yes ☒ No

If yes, a Domestic Partner, as defined in the Certificate Booklet, shall be considered eligible for coverage. The Policyholder is responsible for providing notice of possible tax implications to those Enrollees with Domestic Partner Coverage.

Domestic Partner Coverage Continuation: (only available if Domestic Partners are covered.) ☐ Yes ☐ No

4. **Retiree Coverage:** ☒ Yes ☐ No

If yes, complete the following, as applicable:

A. Retiree means those persons covered as retirees under the Employer's health care or dental care plan prior to the date the Employer initially purchased coverage from Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"): ☐ Yes ☐ No

If yes, indicate the retiree name(s) below:

Name of Retiree	Name of Retiree

B. Retiree means those persons who retire on or after the effective date of this Benefit Program Application: ☒ Yes ☐ No

If yes, such retirees must be at least IMRF Guidelines years of age on the date of retirement with _____ years of continuous full-time employment with the Employer. Note: Minimum years of age is fifty-five (55); minimum years of continuous full-time employment is ten (10).

For existing groups, former employees who retired after the date the Employer initially purchased coverage from HCSC and prior to the initial effective date of the retiree coverage specified in item 3.B. above are not eligible. An Employer may only elect or change retiree coverage on the Policy Effective Date or Policy Anniversary Date.

5. **Eligibility Date:** All current and new employees must satisfy the required waiting period indicated below before coverage will become effective. The waiting period means the waiting period an Employee must satisfy in order for coverage to become effective. Covered family members do not have to satisfy a waiting period to become effective.

☐ The first day of the month following the date of employment.

☒ The first day of the month following _____ month(s) or 15 days of employment.

Note: For multiple classes with different eligibility dates, use the Additional Provisions section below to specify each class and eligibility date.

6. **Limiting Age for covered children is twenty-six (26) years.** Hereafter, covered children means a natural child, a stepchild, an adopted child (including a child involved in a suit for adoption,), a child for whom the Insured is the legal guardian, under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status (if applicable under the Policy), marital status, or any combination of those factors. If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet. Coverage will terminate at the end of the period for which premium has been accepted. However, coverage shall be extended due to a leave of absence in accordance with any applicable federal or state law.

7. **Termination Date:** The effective date of termination for a person who ceases to meet the definition of an Eligible Person, Domestic Partner or Retiree is the last day of the calendar month in which such person no longer meets the definition and for which premium has been accepted.

8. **Extension of Benefits:** An Extension of Benefits will be provided for a period of thirty (30) days in the event of Temporary Layoff, Disability or Leave of Absence. However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law.

9. **Employer Contribution:**

☒ 90% for Employee Coverage

☐ _____% for Employee plus Spouse Coverage

☐ _____% for Employee plus Child(ren) Coverage (i.e. Employee plus one or more children)

☒ 50% for Family Coverage

☐ 100% of the Employee Coverage Premium will be applied toward the Family Coverage Premium.

Employee Participation Requirement: If an Employee contribution is required, then at least 75% of all Eligible Employees must select coverage and the Employer agrees to arrange payroll deductions for any Employee contribution.

10. **BlueCare Dental HMO Benefit Plan Purchased**:

☐ Plan 710

☐ Plan 730

☐ Plan 810

☐ Plan 830

☒ Other (For 151+ custom plans only.) Please specify plan number: Plan 630

11. **Schedule of Premium Rates:**

1. Employee only	$36.85
2. Employee and one dependent (i.e. Employee plus one spouse or one child)	$
3. Employee and two or more dependents	$
4. Spouse	$
5. Child(ren) (i.e. one or more children)	$
6. Family	$98.60
Single Tier rate structure – complete item 1.	
Two Tier rate structure – complete items 1. and 6.	
Three Tier rate structure – complete items 1., 2., and 3.	
Four Tier rate structure – complete items 1., 4., 5., and 6.	

12. **Premium Period**: The first day of each calendar month through the last day of each calendar month. (If the Employer has BlueCare Dental HMO coverage, the premium period for all coverages must be the first day of each calendar month through the last day of each calendar month.)

13. **Electronic Issuance**: The Employer consents to receive, via an electronic file or access to an electronic file, a Certificate Booklet and SBC provided by HCSC to the Employer for delivery to each Employee. The Employer further agrees that it is solely responsible for providing each Employee access, to the most current version of any E-file Certificate Booklet, SBC, amendment, or other revised form provided by HCSC, or to provide a paper copy of the same to an Employee upon request. The Employer is solely responsible and hold HCSC harmless from any misuse of the E-file provided by HCSC. By providing your consent, you agree to the electronic delivery of your insurance documents. You can go back to paper delivery at any time with no penalty. Your consent will be valid until it is withdrawn up to and including through policy renewals. To change your preferences, contact your Account Executive. Your documents can be viewed or printed using your computer or mobile device that supports most versions of Internet Explorer, Chrome and Firefox.

☒ **Accept** – Employer consents to receive electronic versions of Certificate Booklets and SBC's for covered Employees. Employer may withdraw this consent at any time and request receipt of hard copy versions by contacting their HCSC Account Executive.

☐ **Decline** – Employer does not consent to receive electronic versions of Certificate Booklets and desires HCSC to print and distribute hard copy versions.

Authorized Company Official's Initials: SW Date: 9/22/2020

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage. The undersigned representative is authorized and responsible for purchasing dental insurance on behalf of the Employer, has provided the information requested in this Benefit Program Application ("BPA") and on behalf of the Employer offers to purchase the benefit program as specified in item number 9 of this BPA. It is understood and agreed that the actual terms and conditions of coverage are those contained in the BlueCare Dental HMO Group Administration Document and the BlueCare Dental HMO Certificate Booklet. It is further understood that this BPA constitutes an offer by the Employer to purchase dental coverage from Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") and that said offer is subject to acceptance by HCSC. Upon acceptance, HCSC shall issue a Policy to the Employer and this BPA shall be incorporated and made a part of the Policy. Upon acceptance of this BPA and issuance of the Policy, the Employer shall be referred to as the Policyholder.

The undersigned representative acknowledges that any producer is acting on behalf of the Employer for purposes of purchasing the Employer's insurance, and that if HCSC accepts this BPA and issues a Policy to the Employer, HCSC may pay the Employer's producer a commission and/or other compensation in connection with the issuance of such Policy. The undersigned representative further acknowledges that if the Employer desires additional information regarding any commissions or other compensation paid to the producer by HCSC in connection with the issuance of a Policy, the Employer should contact its producer.

The undersigned representative hereby acknowledges that the Employee Retirement Income Security Act of 1974, as amended, ("ERISA"), establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term "employee welfare benefit plan" includes any plan, fund or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, dental, medical, surgical or hospital benefits, or benefits in the event of sickness, accident or disability. The undersigned representative further acknowledges that: (i) an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and that (ii) an employee welfare benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the employee welfare benefit plan document of the Employer (or any group member if the group is an association), the Employer agrees that no allocation or delegation of any fiduciary or non-fiduciary responsibilities under the employee welfare benefit plan of the Employer (or any group member if the group is an association) is effective with respect to or accepted by HCSC except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by HCSC.

ADDITIONAL PROVISIONS:

Effective 11/01/2020: Group is renewing with no changes.

Boomer Whipple

Producer Agency Representative

Signature of Producer Agency Representative

AssuredPartners of IL, LLC (DBA Lundstrom Insurance Agency)

Producer Agency Name

2205 Point Boulevward, Suite 200 Elgin, IL 60123

Producer Address

847-741-1000

Producer Phone Number

107816942

Producer Number

38-3970092

Producer Tax ID Number

Dee Roberts

HCSC Sales Representative

822/153

District/Cluster

Signature of Authorized Purchaser

City Administrator

Title

09/22/2020

Date

Witness

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members is scheduled to be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice provided to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

HCSC pays indemnification or advances to directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

Group No(s).: D02533

By: Stephanie K. Dawkins

Print Signer's Name Here

➡ Stephanie K City Admin.

Signature and Title

Group Name: City of Geneva
Address: 22 South First Street
City: Geneva

State: IL Zip Code: 60134

Dated this: 22 day of September, 2020
Month Year

Cut along dotted lines

BlueCross BlueShield of Illinois

BENEFIT PROGRAM APPLICATION ("BPA")

(All items are applicable to 151-Plus Grandfathered and Non-Grandfathered Insured Group Accounts unless otherwise specified.)
(All items are applicable to the HMO plan and the Non-HMO plan unless otherwise specified.)

Employer Account Number:	769669
HMO Illinois Employer Group Number(s):	H56633
HMO Illinois Section Number(s):	0000, 0100, 0500
BlueAdvantage® HMO Employer Group Number(s):	B56633
BlueAdvantage® HMO Section Number(s):	0000, 0500
Non-HMO Plan Employer Group Number(s):	P74397, PE1181
Non-HMO Plan Section Number(s):	0000, 0500

Employer' Legal Name: City of Geneva
(Specify the employer, the employee trust or the association applying for coverage. List subsidiary or affiliated companies to be covered below. An employee benefit plan may not be named.)

Physical Address: 22 South First Street City: Geneva State: IL Zip Code: 60134
Billing Address (if different from above): _____ City: _____ State: _____ Zip Code: _____

Employer Identification Number ("EIN"): 36-6005893

Wholly Owned Subsidiaries to be Covered: _____

Affiliated Companies to be Covered: _____

(Affiliated Companies must be required or permitted to be aggregated per IRS guidelines. Employer hereby confirms that Employer, Subsidiaries and Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), or (c), or (m), or (o), or under applicable law.)

Administrative Contact: Benjamin McCready Phone: 630-938-4540 Fax: _____ Email: bmccready@geneva.il.us

Blue Access for Employers ("BAE") Contact: Benjamin McCready
(The BAE Contact is the employee of the account authorized by the Employer to access and maintain its account via BAE.)

Title: Asst. City Administrator Phone: 630-938-4540 Fax: _____ Email: bmccready@geneva.il.us

Policy Effective Date: 11/01/2020 Policy Anniversary Date: 11 / 01 / 2021 (Month / Day / Year)

The **Employee Retirement Income Security Act of 1974 (ERISA)** is a federal law that sets minimum standards for employee benefit plans in the private industry. In general, **all** employer groups, insured or ASO, are subject to ERISA provisions except for governmental entities, such as municipalities and public school districts, and "church plans" as defined by the Internal Revenue Code.

ERISA Regulated Group Health Plan*: Yes ☐ No ☒
If **Yes**, specify ERISA Plan Year*: Beginning Date: __/__/__ End Date: __/__/__ (month/day/year)

ERISA Plan Sponsor*: _____
ERISA Plan Administrator*: _____
ERISA Plan Administrator's Address: _____
City: _____ State: _____ Zip Code: _____
ERISA Plan Administrator's Email: _____

If you contend ERISA is inapplicable to your group health plan, please give legal reason for exemption*:

- ☐ Federal Governmental Plan (e.g., the government of the United States or agency of the United States)
- ☒ Non-Federal Governmental Plan (e.g., the government of the State, an agency of the State, or the government of a political subdivision, such as a county or agency of the State)
- ☐ Church Plan (complete and attach a Medical Loss Ratio Assurance form)
- ☐ Other, please specify: _____

For more information regarding ERISA, contact your Legal Advisor.
*All as defined by ERISA and/or other applicable law/regulations.

ELIGIBILITY

1. Eligible Person:

Employer has decided that Eligible Person means: (For the HMO plan, an eligible person must reside in the Service Area of a Participating IPA.)

- ☒ A Full-Time Employee of the Employer.
- ☐ A Full-Time Employee who is a member of: _____ (name of union or association).
- ☐ Other (please specify): _____.

Full-Time Employee means:

- ☒ An Employee of the Employer who is regularly scheduled to work a minimum of 30 hours per week
- ☐ Other (please specify): _____
- ☒ An Eligible Person may also include a retiree of the Employer. Please specify: IMRF Guidelines.

The term "Employee" shall have the meaning set forth under ERISA and applicable law. HCSC reserve the right to audit Employer's initial and ongoing eligibility determinations.

2. Civil Union Partner Coverage:

A Civil Union partner, as defined in the Policy, and his or her dependents are automatically eligible to enroll for coverage and, once enrolled, eligible for continuation of coverage as described in the Certificate Booklet. The Employer as Policyholder is responsible for providing notice of possible tax implications to those Insureds with coverage for Civil Union partners.

3. Domestic Partner Coverage: ☐ Yes ☒ No

If Employer elects "**Yes**", a Domestic Partner, as defined in the Policy, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those Insureds with Domestic Partner Coverage.

Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, Domestic Partners are not eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), but Employer may elect to offer continuation coverage to Domestic Partners similar to that available to spouses under COBRA continuation.

Domestic Partner Coverage Continuation (only available if Domestic Partners are covered) ☐ Yes ☐ No

4. The Limiting Age for covered children:

Hereafter, covered children means a natural child, a stepchild, an eligible foster child, an adopted child (including a child involved in a suit for adoption), a child for whom the Insured is the legal guardian, under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status (if applicable under the Policy), marital status, or any combination of those factors. Unless Policyholder elects a Limiting Age over twenty-six (26), coverage will terminate at the end of the month in which the covered child turns age twenty-six (26). If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

To cover children age twenty-six (26) or over, you may select option (a) or (b) below:

(a) ☐ Limiting Age for covered children age twenty-six (26) or over, ☐ who are married ☐ who are unmarried ☐ regardless of marital status, is _____ years (twenty-seven (27) – thirty (30) are the available options). If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

(b) ☐ Limiting Age for covered children who are full-time students and age twenty-six (26) or over, ☐ who are married ☐ who unmarried ☐ regardless of marital status, is _____ years (twenty-seven (27) – thirty (30) are the available options). If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

For a covered child who reaches a Limiting Age over twenty-six (26), coverage will terminate at the end of the period for which premium has been accepted. However, coverage shall be extended due to a leave of absence in accordance with any applicable federal or state law.

5. **Eligibility Date:** All current and new employees must satisfy the substantive eligibility criteria and required waiting period indicated below before coverage will become effective. No waiting period may result in an effective date that exceeds ninety-one (91) calendar days from the date that an employee becomes eligible for coverage, unless otherwise permitted by applicable law.

   If a person is added to the Policy and it is later determined that the Policyholder reported a Coverage Date earlier than what would apply to the Employee or dependent, based on the Waiting Period and eligibility conditions the Policyholder provided to the Plan, the Plan reserves the right to retroactively adjust the Coverage Date for such person.

   ☐ The date of employment.
   ☒ The 31st day of employment. **Note:** This may not exceed ninety-one (91) calendar days.
   ☐ The _____ day (select 1st or 15th) of the month following _____ month(s) (option of 1 or 2 months) of employment.
   ☐ The _____ day (select 1st or 15th) of the month following _____ days (option of up to 60 days) of employment.
   ☐ The _____ day of the month following the date of employment.
   ☐ Other (please specify): _____. **Note:** This may not exceed ninety-one (91) calendar days.
   ☐ This election applies only to the HMO plan: A full month's premium will be charged for the first (1st) month of coverage for those employees whose Coverage Dates fall between the first (1st) and fifteenth (15th) day of the Premium period. No premium will be charged for the first month of coverage for those employees whose Coverage Dates fall between the sixteenth (16th) day and the end of the Premium Period.

   Substantive eligibility criteria.
   Provide a representation below regarding the terms of any eligibility conditions (other than any applicable waiting period already reflected above) imposed before an individual is eligible to become covered under the terms of the plan. If any of these eligibility conditions change, Employer is required to submit a new BPA to reflect that new information.

   Check all that apply:
   ☒ An Orientation Period that:
      1) Does not exceed one month (calculated by adding one calendar month and subtracting one calendar day from an employee's start date); and
      2) If used in conjunction with a waiting period, the waiting period begins on the first day after the orientation period.
   ☐ A Cumulative hours of service requirement that does not exceed 1200 hours
   ☐ An hours-of-service per period (or full-time status) requirement for which a Measurement period is used to determine the status of variable-hour employees, where the measurement period:
      1) Starts between the employee's date of hire and the first day of the following month;
      2) Does not exceed 12 months; and
      3) Taken together with other eligibility conditions does not result in coverage becoming effective later than 13 months from the employee's start date plus the number of days between a start date and the first day of the next calendar month (if start day is not the first day of the month).
   ☐ Other substantive eligibility criteria not described above; please describe: _____

6. **Special Enrollment**: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a Special Enrollment event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so. Such person's Coverage Date, Family Coverage Date, and /or dependent's Coverage Date will be effective on the date of the Special Enrollment event or, in the event of Special Enrollment due to termination of previous coverage, the date of application for coverage. In the case of a Special Enrollment event due to loss of coverage under Medicaid or a state children's health insurance program, however, this enrollment opportunity is not available unless the Eligible Person requests enrollment within sixty (60) days after such coverage ends.

   This election applies only to the Non-HMO plan: Annual Open Enrollment: ☐ Yes ☒ No

   Annual Open Enrollment: Specify Annual Open Enrollment Period: September 15 to October 15 for a November 1st effective date. An Eligible Person may apply for coverage, Family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Annual Open Enrollment Period. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") and the Employer. Such date shall be subsequent to the annual open enrollment period.

7. **This Section applies only to the HMO plan**: The Effective Date of Termination for a person who ceases to meet the definition of an Eligible Person:

☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
☐ Other (please specify): _____.

8. **Extension of benefits due to Temporary Layoff, Disability or Leave of Absence**:
Temporary Layoff: 30 days Disability: 30 days Leave of Absence: 30 days
☐ Other: (please specify): _____
However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law.
In the event of Total Disability at the time the group policy is terminated, an Extension of Benefits will be provided for a period of no more than twelve (12) months from the date of termination, to the extent required, and in accordance, with any applicable federal or state law.

9. **For the HMO Plan**:
Total Number of Employees (Please indicate the total number of actual employees, not enrollees):
Of the Employer: _____ Illinois employees: _____ National employees: _____

10. **FUNDING ARRANGEMENT:** ☒ Standard Premium – Prospective ☐ Cost Plus Program

11. **STANDARD PREMIUM INFORMATION:**
The following elections apply to both Grandfathered and Non-Grandfathered Groups:
Premium Period:
☒ The first (1st) day of each calendar month through the last day of each calendar month. (This option applies to all coverages if the Employer has BlueCare® Dental HMO coverage.)
☐ The _____ day of each calendar month through the _____ day of the next calendar month. (This option is not available for any coverage if the Employer has BlueCare Dental HMO coverage.)

12. **MINIMUM PARTICIPATION AND EMPLOYER CONTRIBUTION INFORMATION:**

(a) **The following elections apply to both Grandfathered and Non-Grandfathered Groups:**
Employer contribution:
☐ One hundred percent (100%) of the Individual Coverage Premium and an amount equal to one hundred percent (100%) of the Individual Coverage Premium will be contributed toward the Family Coverage Premium.
☒ 90% of the Individual Coverage Premium and 50% of the Family Coverage Premium.
☐ Other (please specify): _____.

(b) **The following applies to both Grandfathered and Non-Grandfathered Groups:**
HCSC reserves the right to change premium rates when a substantial change occurs in the number or composition of subscribers covered. A substantial change will be deemed to have occurred when the number of subscribers covered changes by ten percent (10%) or more over a thirty (30) day period or twenty-five percent (25%) or more over a ninety (90) day period.

(c) **The following applies to Non-Grandfathered Groups:**
HCSC reserves the right to take any or all of the following actions: 1) initial rates will be finalized for the effective date of the policy based on the enrolled participation and employer contribution levels; 2) after the policy effective date the group will be required to maintain a minimum Employer contribution of 25%, and at least a 70% participation of eligible employees (less valid waivers). In the event the group is unable to maintain the contribution and participation requirements, then the rates will be adjusted accordingly; and/or 3) non-renew or discontinue coverage unless the 25% minimum employer contribution is met and at least 70% of eligible employees (less valid waivers) have enrolled for coverage. Employer will promptly notify HCSC of any change in participation and Employer contribution.

(d) **The following applies to Grandfathered Groups:**
It is understood that no Policy will be issued or renewed on a contributory basis unless at least 25% of the Eligible Persons, and for Family Coverage 75% of the Eligible Persons with eligible dependents, have enrolled for coverage.

13. **Essential Health Benefits ("EHB") Definition Election:**
Employer elects EHBs based on the following:
1. ☒ EHBs based on a HCSC state benchmark:
☒ Illinois ("IL") ☐ Oklahoma ("OK") ☐ Montana ("MT") ☐ Texas ("TX") ☐ New Mexico ("NM")
2. ☐ EHBs based on benchmark of a state other than IL, MT, NM, OK and TX

In the absence of an affirmative selection by Employer of its EHBs, then Employer is deemed to have elected the EHBs based on the IL benchmark plan.

STANDARD PREMIUM RATES ☒ Yes ☐ No						
	For Internal Use Only - BlueStar Ben.Agree#: ***0001*** **P74397**	*For Internal Use Only - BlueStar Ben.Agree#:* ***0012*** H56633	*For Internal Use Only - BlueStar Ben.Agree#:* ***0013*** **B56633**	*For Internal Use Only - BlueStar Ben.Agree#:* ***0014*** **PE1181**	*For Internal Use Only - BlueStar Ben.Agree#:* _____ _____	**Total**
1. Employee only:	$675.21	$632.78	$588.48	$651.50	$_____	$_____
2. Employee plus one Dependent (i.e. Employee plus one spouse or one child):	$1,640.01	$1,536.93	$1,428.90	$1,582.35	$_____	$_____
3. Employee plus two or more Dependents:	$_____	$_____	$_____	$_____	$_____	$_____
4. Employee plus Spouse:	$_____	$_____	$_____	$_____	$_____	$_____
5. Employee plus Child(ren) (i.e. Employee plus one or more children):	$_____	$_____	$_____	$_____	$_____	$_____
6. Employee plus Family / Family:	$1,989.56	$1,864.61	$1,734.12	$1,919.71	$_____	$_____
7. Other: _____	$_____	$_____	$_____	$_____	$_____	$_____
Single Tier Rate structure - Complete item 1.						
Two Tier Rate structure - Complete items 1. and 6.						
Three Tier Rate structure - Complete items 1., 2., and 3.						
Four Tier Rate Structure - Complete items 1., 4., 5., and 6.						
Indicate "N/A" in any rate field that does not apply.						
Medicare Eligible Rates (When HCSC is Secondary Payer)						
Single Coverage:	$453.23	$424.89	$395.15	$437.45	$_____	$_____
Family Coverage:	$906.75	$849.74	$790.27	$874.85	$_____	$_____

COST PLUS PROGRAM

☐ Yes ☒ No

Service Charges:

For the HMO Plan:

a) Service Charges for Claim Payments:

☐ HMO Illinois: _____% of Claim Payments; or $_____ per Enrollee per month for health Claim Payments.

☐ BlueAdvantage® HMO: _____% of Claim Payments; or $_____ per Enrollee per month for health Claim Payments.

b) Physician's Services Fees:

☐ HMO Illinois: $_____ per month per single Enrollee; or $_____ per Month per Enrollee with one or more dependents.

☐ BlueAdvantage® HMO: $_____ Per month per single Enrollee; or $_____ Per Month per Enrollee with one or more dependents.

c) ☐ HMO Managed Care Fee: $_____ per HMO enrollee per month.

For the Non-HMO Plan:

☐ _____% of Net Claim Payments or $_____ per employee per month.

☐ Applies to all coverage(s).

☐ Different percentage(s) or amount(s) for the following types of coverage. Please specify below:

For _____ Coverage: _____% of _____ Claim Payments or $_____ per employee per month.

For _____ Coverage: _____% of _____ Claim Payments or $_____ per employee per month.

Other (please specify): _____.

☐ Virtual Visits Program (Non-HMO Plan only) ☐ Fee: $_____ per covered employee per month for administration of the program.

☐ Fee is included in the Service Charges.

Ancillary Program:

☐ Health Dialog **(may select one)** Health Dialog Fee: **$**_____ per covered employee per month

- ☐ Health Coach Line (In bound)
- ☐ Health Coach Line (In and out bound)
- ☐ Health Coach Line (With Disease Management)
- ☐ Not applicable

☐ American Healthways **(may select one)**

- ☐ Package A
- ☐ Package B
- ☐ Package C
- ☐ Not applicable

American Healthways Program Fees, per participating Covered Person per month: month."

Conditions:	Package A - Fees	Package B - Fees	Package C - Fees
Diabetes:	$_____	$_____	$_____
Chronic Heart Disease:	$_____	$_____	$_____
Chronic Obstructive Pulmonary Disease	$_____	$_____	Not Applicable
Asthma:	$_____	$_____	Not Applicable
Impact Conditions:	$_____	Not Applicable	Not Applicable

Payment Method: ☐ Transfer Payment ☐ Post Payment

If Transfer Payment, Method of Transfer Payment:

☐ Wire Transfer ☐ Draft ☐ Electronic Fund Transfer ☐ Other (please specify): _____

Payment Period:
☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other (please specify): _____

Claim Settlement Period: ☐ Monthly ☐ Quarterly ☐ Other (please specify): _____

If Transfer Payment, Tentative Final Settlement Period:
Transfer Payments to be made for the following time period after termination:
☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other (please specify): _____

Excess Loss – Run Off Period: _____ Months
Standard is twelve (12) months.

Final Settlement: Final Settlement is to be made within _____ days after end of Excess Loss Run-Off Period.
Standard is sixty (60) days.

Employer Payments are to be made past the run-off period for all claims and adjustments.

For Cost Plus plans, Effective Date of Termination for a person who ceases to meet the definition of Eligible Person:
☐ The date such person ceases to meet the definition of Eligible Person.
☐ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
☐ Other (please specify): _____

Prescription Drug Program:
☐ HMO (If selected, the Pharmacy Benefit Manager(s) ("PBM") Fee Schedule Exhibit must be attached and is part of this BPA.)
☐ PPO (If selected, the PBM Fee Schedule Exhibit must be attached and is part of this BPA.)

Rebate Credit for Drugs covered under the Pharmacy Benefit:
PPO: $_____ per Covered Employee per month
HMO: $_____ per Enrollee per month

HMO Pharmacy Network (Select one):
☐ Traditional Select Network
☐ Network shown on PBM Fee Schedule Exhibit

PPO Pharmacy Network (Select one):
☐ Advantage Network
☐ Preferred Network
☐ Network shown on PBM Fee Schedule Exhibit

PPO Drug List: [Select Drug List]; **Other (please specify):** _____

Prescription Drug Program Clinical Management Programs

☐ Medication Therapy Management (MTM) (Retrospective) (HMO) ☐ Fee: $_____ per member per month for administration of the program.
☐ Medication Therapy Management (MTM) (Retrospective) (PPO) ☐ Fee: $_____ per member per month for administration of the program.

Termination Administrative Charge

As applies to the Run-Off Period indicated in the Payment Specifications section below:

i. ***For service charges (including, but not limited to, access fees) billed on a per Covered Employee basis at the time of termination of the Policy or partial termination of Covered Employees,*** the Termination Administrative Charge will be the amount equal to ten percent (10%) of the annualized charges based on the service charges in effect as of the termination date or date of partial termination and the Policy participation of the two (2) months immediately preceding the termination date or date of partial termination. Such aggregate amount will be due the Plan within ten (10) days of the Plan's notification to the Policyholder of the Termination Administrative Charge described herein.

ii. ***For service charges (including, but not limited to, access fees) billed on a basis other than per Covered Employee at the time of termination of the Policy or partial termination of Covered Employees,*** the Termination Administrative Charge will be such service charges in effect at the time of termination of the Policy or partial termination of Covered Employees to be applied and billed by the Plan, and paid by the Policyholder, in the same manner as prior to termination of the Policy or partial termination of Covered Employees.

Termination Administrative Charges assume the continuation of the Policy benefit program(s) and the administrative services in effect prior to termination. Should such Policy benefit program(s) and/or administrative services change, or in

the event the average Policy enrollment during the three (3) months immediately preceding termination varies by ten percent (10%) or more from the enrollment used to determine the service charges in effect at the time of termination, the Plan reserves the right to adjust the rates for service charges (including, but not limited to, access fees) to be used to compute the Termination Administrative Charge.

FOR NON-HMO COST-PLUS PROGRAMS ONLY:
PLAN PROVIDER ACCESS FEE(S)
☐ **Yes** ☒ **No**

Group Number(s): _____
☐ % of ADP Savings: _____%
☐ $ Per Employee per Month: $_____

Please complete for groups with multiple products (for example, Comprehensive Major Medical and PPO) with separate access fees:
Group Number(s): _____
☐ % of ADP Savings: _____%
☐ $ Per Employee per Month: $_____

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Employer, has provided the information requested in this BPA and, on behalf of the Employer, offers to purchase the benefit program as outlined in the Request For Proposal ("RFP") or, in the case of an HMO Plan, the proposal document submitted to the Employer by the Sales Representative. Any changes to the RFP are specified below. It is understood and agreed that the actual terms and conditions of the benefit program are those contained in the Policy. This BPA is subject to acceptance by HCSC. Upon acceptance, HCSC shall issue a Policy to the Employer and this BPA shall be incorporated and made a part of the Policy. Upon acceptance of this BPA and issuance of the Policy, the Employer shall be referred to as the Policyholder. In the event of any conflict between the RFP and the Policy, the provisions of the Policy shall prevail. No coverage will begin until receipt of the first (1st) premium by HCSC.

The undersigned representative acknowledges that any producer is acting on behalf of the Employer for purposes of purchasing the Employer's insurance, and that if HCSC accepts this BPA and issues a Policy to the Employer, HCSC may pay the Employer's producer a commission and/or other compensation in connection with the issuance of such Policy. The undersigned representative further acknowledges that if the Employer desires additional information regarding any commissions or other compensation paid the producer by HCSC in connection with the issuance of a Policy, the Employer should contact its producer.

The undersigned representative acknowledges that the Employee Retirement Income Security Act of 1974, as amended, ("ERISA") establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term "employee welfare benefit plan" includes any plan, fund or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital benefits, or benefits in the event of sickness, accident or disability. The undersigned representative further acknowledges that: (i) an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and that (ii) an employee welfare benefit plan document may provide for the allocation or delegation of responsibilities thereunder. However, notwithstanding anything contained in the employee welfare benefit plan document of the Employer (or any group member if the group is an association), the Employer agrees that no allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Employer (or, for Non-HMO Plans, any group member if the group is an association) is effective with respect to or accepted by HCSC except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by HCSC.

The Rebate Credit is a per Covered Employee per month (or, for the HMO plan, per Enrollee per month) credit applied to the monthly billing statement. Rebate Credits shall not continue after termination of the Prescription Drug Program, except as otherwise set forth in this BPA or the PBM Fee Schedule Exhibit. (Further information about rebates, the Pharmacy Benefit Manager and the Rebate Credit is included in the governing Group Administration Document to which this BPA is attached under the section titled "The Plan's Separate Financial Arrangements Regarding Prescription Drugs.").

OTHER PROVISIONS:

(a) **Reimbursement**: It is understood and agreed that in the event BCBSIL makes a recovery on a third-party liability claim, BCBSIL will retain twenty five (25%) of any recovered amounts, other than recovery amounts received as a result of, or associated with, any Workers' Compensation Law.

(b) **Third Party Recovery Vendors and Law Firms Provisions (other than Reimbursement Services)**: Employer will pay no more than 25% of any recovered amount made by the BCBSIL's Third Party Recovery Vendor or up to 25% of any recovered amount will be deducted from the amount distributed according to established allocation processes. Employer will pay no more than 35% of any recovered amount made by BCBSIL's third party law firm or up to 35% of any recovered amount will be deducted from the amount distributed according to established allocation processes.

(c) **Summary of Benefits and Coverage ("SBC")**: The SBC Addendum is attached and made a part of the Policy. BCBSIL will create the SBC (only for benefits BCBSIL insures under the Policy) and provide the SBC to the Policyholder in electronic format. If the Policyholder approves of the content, Policyholder will then distribute the SBC to participants and beneficiaries (or hire a third party to distribute) as required by law. If the Policyholder would like changes to the SBC, it will promptly notify BCBSIL. BCBSIL will also distribute the SBC to participants and beneficiaries via regular hardcopy mail or electronically in response to occasional requests received directly from individuals. All other distribution is the responsibility of the Policyholder.

(d) **BlueEdge FSA (Vendor: Select Vendor) purchased**: ☐ Yes ☒ No

(e) **BlueCare® Dental HMO Coverage purchased**: ☒ Yes ☐ No (If yes, complete separate application.)

(f) **Life or Disability purchased**: ☐ Yes ☒ No (If yes, complete separate application.)

(g) **Excess Loss Coverage purchased**: ☐ Yes ☒ No (If yes, complete separate application.)

(h) **Blue Directions for Large Business purchased**: ☐ Yes ☒ No (if yes, The Blue Directions Addendum is attached and made a part of the Policy.)

(i) **For the Non-HMO Plan**:
Case Management: ☒ Yes ☐ No
If Yes: The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons in accordance with the provisions of the Policy.

(j) **Electronic Issuance**: The Employer consents to receive, via an electronic file or access to an electronic file, a Certificate Booklet and SBC provided by BCBSIL to the Employer for delivery to each Employee. The Employer further agrees that it is solely responsible for providing each Employee access, to the most current version of any E-file Certificate Booklet, SBC, amendment, or other revised form provided by BCBSIL, or to provide a paper copy of the same to an Employee upon request. The Employer is solely responsible and hold BCBSIL harmless from any misuse of the E-file provided by BCBSIL. HMO members will continue to receive paper copies of their HMO certificates. By providing your consent, you agree to the electronic delivery of your insurance documents. You can go back to paper delivery at any time with no penalty. Your consent will be valid until it is withdrawn up to and including through policy renewals. To change your preferences, contact your Account Executive. Your documents can be viewed or printed using your computer or mobile device that supports most versions of Internet Explorer, Chrome and Firefox.

☒ **Accept** – Employer consents to receive electronic versions of Certificate Booklets and SBC's for covered Employees. Employer may withdraw this consent at any time and request receipt of hard copy versions by contacting their BCBSIL Account Executive.

☐ **Decline** – Employer does not consent to receive electronic versions of Certificate Booklets and SBC's for covered Employees or the Contract and desires BCBSIL to print and distribute hard copy versions.

Authorized Company Official's Initials: [illegible] Date: 9/22/2020

(k) **Massachusetts Health Care Reform Act:** Notwithstanding anything to the contrary in this BPA, with respect to the Employer's employees who live in Massachusetts (if any) the Employer represents that it offers the health insurance benefits provided for herein to all full-time employees, and the Employer will not make a smaller premium contribution percentage to a full-time employee living in Massachusetts than to any other full-time employee living in Massachusetts who receives an equal or greater total hourly or annual salary. For purposes of this representation, a "full-time employee" is defined by Massachusetts law, generally an employee who is scheduled or expected to work at least the equivalent of an average of thirty-five (35) hours per week.

(l) ☒ **Wellbeing Management:** The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons in accordance with the provisions of the Policy.

Blue Care Connection® ("BCC") Program (For the Non-HMO Plan):

BCC Package (may select one):

☐ Standard
☐ Enhanced
☐ Unbundled
☐ Selective In/Out
☐ Unique Package Design
☐ Stand-Alone

☐ Fee: **$**_____ per covered employee per month for administration of the program.
☐ Fee is included in the Premium Charge/Service Charge

BCC Package Upgrade(s):

☐ Description: _____
☐ Fee: $ _____ per covered employee per month for administration of the package upgrade.

☐ Description: _____
☐ Fee: $ _____ per covered employee per month for administration of the package upgrade.

ADDITIONAL PROVISIONS:

A. Grandfathered Health Plans: Policyholder shall provide HCSC with written notice prior to renewal (and during the plan year, at least sixty (60) days advance written notice) of any changes in its Contribution Rate Based on Cost of Coverage or Contribution Rate Based on a Formula towards the cost of any tier of coverage for any class of Similarly Situated Individuals as such terms are described in applicable regulations. Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by HCSC to the terms and conditions of coverage. In no event shall HCSC be responsible for any legal, tax or other ramifications related to any benefit package of any group health insurance coverage (each hereafter a "plan") qualifying as a "grandfathered health plan" under the Affordable Care Act and applicable regulations or any representation regarding any plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference and part of the BPA and Group Policy, and Policyholder represents and warrants that such Form is true, complete and accurate. If Policyholder fails to timely provide HCSC with any requested grandfathered health plan information, HCSC may make retroactive and/or prospective changes to the terms and conditions of coverage, including changes for compliance with state or federal laws or regulations or interpretations thereof.

B. Retiree Only Plans and/or Excepted Benefits: If the BPA includes any retiree only plans and/or excepted benefits, then Policyholder represents and warrants that one or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by HCSC to the terms and conditions of coverage. In no event shall HCSC be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's past, present and future exempt plan status.

C. Policyholder shall indemnify and hold harmless HCSC and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) or other costs or obligations resulting from or arising out of any claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought or asserted against HCSC in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any directions, actions and interpretations of the Policyholder, (d) any provision of inaccurate information, (e) the SBC, (f) any plan's design (including but not limited to any directions, actions and interpretations of the Policyholder, and/or (g) Employer's selection of EHB definition for the purpose of the Patient Protection and Affordable Care Act ("ACA"). Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

The provisions of paragraphs A-C (directly above) shall be in addition to (and do not take the place of) the other terms and conditions of coverage and/or administrative services between the parties.

ACA FEE NOTICE: ACA established a number of taxes and fees that will affect our customers and their benefit plans. One of those fees is: the Annual Fee on Health Insurers or "Health Insurer Fee."

Section 9010(a) of ACA requires that "covered entities" providing health insurance ("health insurers") pay an annual fee to the federal government, commonly referred to as the Health Insurer Fee. The amount of this fee for a given calendar year will be determined by the federal government and may use a formula based in part on a health insurer's net premiums written with respect to health insurance on certain health risk during the preceding calendar year. This fee may be used to

help fund premium tax credits and cost-sharing subsidies offered to certain individuals who purchase coverage on health insurance exchanges.

In addition, ACA Section 1341 and/or other applicable laws may provide for the establishment of a temporary reinsurance program(s) that may be funded by reinsurance contributions or other amounts (collectively, the "Reinsurance Fees or Amounts") collected from health insurance issuers and/or self-funded group health plans. Federal and/or state governments may provide information as to how these Reinsurance Fees or Amounts are calculated. Federal regulations may establish a flat, per member, per month fee. The temporary reinsurance programs funded by these Reinsurance Fees or Amounts may be used to help stabilize premiums in the individual or other markets.

Except for the Cost Plus Program, your premium, which already accounts for current applicable federal and state taxes, includes the effects of the Health Insurer Fees and Reinsurance Fees or Amounts, if any. These rates may be adjusted on an annual basis for any incremental changes in Health Insurer Fees and Reinsurance Fees or Amounts, if any.

Notwithstanding anything in the Policy or Renewal(s) to the contrary, HCSC reserves the right to revise our charge for the cost of coverage (premium or other amounts) at any time if any local, state or federal legislation, regulation, rule or guidance (or amendment or clarification thereto) is enacted or becomes effective/implemented, which would require HCSC to pay, submit or forward, on its own behalf or on the Policyholder's behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts).

Renewals Only: If this BPA is blank, it is intentional, and this BPA is an addendum to the existing BPA. In such case, all terms of the existing BPA as amended from time to time shall remain in force and effect. However, beginning with the Policyholder's first renewal date on or after September 23, 2010, the provisions of paragraphs A-C (above) shall be part of (and be in addition to) the terms of the existing BPA as amended from time to time.

Any reference in this BPA to eligible dependents may include Domestic Partners or Civil Union partners but will include dependent covered children under the Limiting Age of twenty-six (26), or election made above.

Any reference in this BPA to the Limiting Age for covered children means twenty-six (26) years, or election made above, regardless of presence or absence of a child's financial dependency, residency, student status, employment, marital status or any combination of those factors. If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the certificate booklet.

Any reference in this BPA to the "Employee plus one dependent" rate structure means "Employee plus one spouse (includes Civil Union partner and/or, if elected, Domestic Partner) or one child."

Any reference in this BPA to the "Employee plus Child(ren)" rate structure means "Employee plus one or more children."

Effective 11/01/2020: Group is renewing with no benefit changes.

Dee Roberts	Stephanie M
Sales Representative	Signature of Authorized Purchaser
822	City Administrator
District	Title
Boomer Whipple	09/22/2020
Producer Representative	Date
	Maryann McCready
Signature of Producer Representative	Witness
Assurance Partners of IL, LLC (DBA Lundstrom Insurance Agency)	
Producer Firm	
2205 Point Blvd Ste 200 Elgin, IL 60123	
Producer Address	$_____ Amount Submitted
107816942	
Producer Number	
38-3970092	
Producer Tax ID No.	

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members is scheduled to be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice provided to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

HCSC pays indemnification or advances expenses to directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

Group No(s): B56633, H56633, P74397, PE1181

By: Stephanie K. Dawkins
Print Signer's Name Here

➡ Stephanie K, City Admin.
Signature and Title

Group Name: City of Geneva

Address: 22 South First Street

City: Geneva State: IL Zip Code: 60134

Dated this 22 day of September, 2020
Month Year