AGENDA ITEM EXECUTIVE SUMMARY

Agenda Item:	2025 Employee Benefit Plan Renewal
Presenter & Title:	Lauren Newton, HR Manager
Date:	August 18, 2025

Please Check Appropriate Box:

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

Associated Strategic Plan Goal/Objective: QIS-II

Estimated Cost: $2,705,933	Budgeted? ☒ Yes ☐ No	Other Funding? ☐ Yes ☐ No

If "Other Funding," please explain how the item will be funded:

Executive Summary:

The employee health, dental, vision, and life insurance coverages renew November 1, 2025. The City currently utilizes Blue Cross Blue Shield (BCBSIL) for three options for health coverage (an HMO, a PPO, and a High Deductible PPO plan). For dental coverage, the City 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 benefit plans is $2,705,933. This estimate may be accommodated within the existing budget. Open enrollment for employees, retirees, and those on or eligible for COBRA is set to occur mid-September 2025.

The BCBSIL renewal for the 2025/2026 plan year was sent to Assured Partners (the City's insurance broker) representing an increase of 6.83%. The plans are recommended for approval without any changes. 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
2021	7.69%
2022	4.00%
2023	4.77%
2024	-2.5%
2025	6.83%
Average	***4.16%***

The BCBSIL DHMO and Delta Dental renewals were sent to Assured Partners and there was no increase for either plan. Staff recommends no changes to the current funding levels for the new plan year.

The Standard Insurance Company provides the City with life, accidental death and dismemberment insurance. The City is entering its second year of a two-year rate guarantee with Standard. There are no changes to the current rates.

The VSP voluntary vision program is entering its third year of a four-year contract in which there is no rate increase. The plan is recommended for approval without any changes.

Representatives of Assured Partners will be present to answer questions.

Attachments: *(please list)*

- Resolution
- Exhibit

Voting Requirements:

This motion requires a simple majority of affirmative votes for passage. (City Council Only)

The Mayor may vote on three occasions: (a) when the vote of the alderpersons has resulted in a tie; (b) when one half of the alderpersons elected have voted in favor of an ordinance, resolution, or motion even though there is no tie vote; 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: *(how the item should be listed on agenda)*

Consider Approval of Resolution Authorizing Acceptance of the 2025 Employee Benefit Program Plan Renewal Effective November 1, 2025 for the City of Geneva, Illinois.

RESOLUTION NO. 2025-101

RESOLUTION AUTHORIZING ACCEPTANCE OF THE 2025 EMPLOYEE BENEFIT PROGRAM PLAN RENEWAL EFFECTIVE NOVEMBER 1, 2025 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 or designee is hereby authorized to accept and execute plan documents for the 2025 Employee Benefit Program plan renewal (Exhibit A) effective November 1, 2025.

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 2nd day of September 2025.

AYES: NAYS: ABSENT: ABSTAINING: HOLDING OFFICE:

Approved by me this 2nd day of September 2025.

_____
Mayor

ATTEST:

_____
City Clerk

Exhibit A

City of Geneva
2025 Employee Benefit Program Plan Renewal

	Total Monthly Premium (Employer + Employee Contribution)		
Medical (BCBSIL)	**Employee**	**Employee + 1**	**Family**
PPO	$864.83	$2,100.56	$2,548.23
HSA	$834.47	$2,026.72	$2,458.81
BlueAdv HMO	$753.76	$ 1,830.17	$2,221.12
Dental			
BCBS DHMO	$36.85		$98.60
Delta Dental (Self-Funded)	$37.09		$98.47
Vision			
VSP	$9.09		$19.54
Life/AD&D			
The Standard	$ 0.179 per $1,000 of salary up to $150,000		

BlueCross BlueShield of Illinois

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, 300 E Randolph, Chicago, IL 60601

BlueCare Dental HMO℠
Benefit Program Application ("BPA")
Blue Cross and Blue Shield of Illinois (herein called "BCBSIL")

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.)

Employer Account Number: 769669

BlueCare Dental HMO Employer Group Number(s): D02533

Section Number(s): See Account Structure

Blue Cross Health Employer Group Number(s): P74397, B56633, PE1181

(Must be provided if the Employer has any other health coverage provided by BCBSIL.)

Address: 22 South First Street

City: Geneva State: IL Zip Code: 60134

Billing Address (if different from above): _____

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

City: _____ State: _____ Zip Code: _____

Subsidiaries to be covered (if additional space is needed, use the Additional Provisions section):

_____

Affiliated Companies to be covered (if additional space is needed, use the Additional Provisions section):

_____

(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: Lauren Newton

Phone: (630)232-0867 Fax: _____

Email: lnewton@geneva.il.us

Billing Contact: Lauren Newton

Phone: (630)232-0867 Fax: _____

Blue Access for Employers℠ ("BAE℠") contact: Lauren Newton

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

Title: Human Resources Manager

Phone: (630)232-0867 Fax: _____

Email: lnewton@geneva.il.us

Policy Effective Date: 11.01.2025
(Must be the first day of the month)

Policy Anniversary Date: 11.01.2026
(Must be the first day of the month)

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 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: _____

ELIGIBILITY

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: 157.

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 Employer is responsible for providing notice of possible tax implications to those Insureds with Domestic Partner Coverage. An Employer may only elect or change Domestic Partner Coverage on the Policy Effective Date or Policy Anniversary Date.

   Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, a Domestic Partner is eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) if an eligible Employee elects COBRA coverage. Employer may also elect whether to provide continuation coverage for Domestic Partners on an independent basis from the Employee. Please indicate your election below:

   ☐ Yes, Employer elects to offer continuation coverage to Domestic Partners on an independent basis from an Employee's election of COBRA.

   ☐ No, Employer does not elect to offer continuation coverage to Domestic Partners on an independent basis from an Employee's election of COBRA (Domestic Partners are not independently eligible for continuation coverage)

   ☐ Other:

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 BCBSIL: ☐ Yes ☐ No

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

Name of Retiree	Name of Retiree
IMRF Guidelines	
IL Police and Fire Pension Code	

   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, IL Police and Fire Pension code 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 BCBSIL and prior to the initial effective date of the retiree coverage specified in item 4.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.

A full month's premium will be charged for the first 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.

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. Unless Employer 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 select one years. 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 are unmarried ☐ regardless of marital status, is select one years. 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
☒ At the end of the month in which the Limiting Age is reached.
☐ At the end of the calendar year in which the Limiting Age is reached.
☐ On the Limiting Age Birthday.
☐ Other (please specify): _____.

However, coverage shall be extended due to a leave of absence in accordance with any applicable federal or state law.

7. **Disabled Dependent**: Disabled Dependent means a child who is medically certified as disabled and dependent upon the Employee or his/her spouse (or Civil Union partner and/or Domestic Partner, if elected). Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered as a dependent under the Plan or as a dependent child under another employer plan and before the child attains the limiting age with no break in coverage. To administer medical certification of disabled Dependents, you may select option A. standard rules or B. custom rules. If B is selected there are additional selections regarding age, proof of prior coverage, certification review, forms, and previous medical certification approvals.

NOTE: Employers with fifty-one (51) to one hundred fifty (150) Employees must follow standard rules.

A. ☒ Disabled Dependent Administration will follow **standard rules.**

A disabled Dependent may continue coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26). A disabled Dependent may add coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26), and proof of coverage as a disabled Dependent is provided.

Certification Review is administered by BCBSIL; a Disabled Dependent Certification Form must be submitted to BCBSIL.

B. ☐ Disabled Dependent Administration will follow **custom rules**. Please make the following selections:

Age: Please select one (1) option regarding age of when the disability began.

☐ The disability must have begun before the child attained the age of twenty-six (26).

☐ All disabled Dependents are covered regardless of when the disability began.

Proof of Prior Coverage: Please select required or not required below:

When adding coverage, proof of prior coverage as a disabled Dependent is ☐ required ☐ not required.

Certification Review: Please select one (1) option regarding administration of Certification Review.

☐ Certification Review is administered by BCBSIL; a Disabled Dependent Certification Form must be submitted to BCBSIL.

☐ Certification Review is administered by the Employer; there are no Disabled Dependent Certification Form requirements.

If Certification Review is administered by BCBSIL, please select one (1) option regarding forms:

☐ BCBSIL's Disabled Dependent Certification Form will be utilized.

☐ A custom/other Disabled Dependent Certification Form will be utilized

If Certification Review is administered by BCBSIL, please select allowed or not allowed below:

An approved disabled Dependent medical certification from a prior carrier is ☐ allowed ☐ not allowed.

An approved disabled Dependent medical certification from a prior BCBS policy is ☐ allowed ☐ not allowed.

8. The 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 Eligible Person.

☐ Other (please specify): _____.

9. 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.

10. Current Eligibility Information. Total Number of Employees (Please indicate the total number of actual Employees, not Enrollees):

NOTE: if an Eligible Employee has been included in the total count for a medical plan with BCBSIL, the Employee should not be included in the count below.

A. On payroll 157

B. On COBRA continuation coverage 2

C. With retiree coverage (if applicable) 52

D. Who work part-time 0

E. Serving the new hire waiting period 2

F. Declining because of other **group** coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) 0

G. Declining coverage (not covered elsewhere) 0

11. Employer Contribution:

☒ 90% for Employee Coverage

☐ _____% for Employee plus Spouse Coverage

☐ _____% for Employee plus Child(ren) Coverage (i.e. Employee plus one (1) or more children)

☒ 50% for Family Coverage

☐ One hundred percent (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 seventy-five percent (75%) of all Eligible Employees must select coverage and the Employer agrees to arrange payroll deductions for any Employee contribution.

12. BlueCare Dental HMO Benefit Plan Purchased:

☐ Plan 710
☐ Plan 730
☐ Plan 810
☐ Plan 830
☒ Other (For 151+ custom plans only.) Please specify plan number: 630

13. Schedule of Premium Rates:

1. Employee only	$ 36.85
2. Employee and one (1) Dependent (i.e. Employee plus one (1) spouse or one (1) child)	$
3. Employee and two (2) or more Dependents	$
4. Spouse	$
5. Child(ren) (i.e. one (1) 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.	

14. 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 (1st) day of each calendar month through the last day of each calendar month.)

EMPLOYER STATEMENTS:

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

2. The undersigned representative is authorized and responsible for purchasing dental 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 specified in item number 12 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 BCBSIL and that said offer is subject to acceptance by BCBSIL. Upon

acceptance, BCBSIL 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.

3. 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 BCBSIL accepts this BPA and issues a Policy to the Employer, BCBSIL 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 BCBSIL in connection with the issuance of a Policy, the Employer should contact its producer.

4. The undersigned representative hereby acknowledges that the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 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 BCBSIL except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by BCBSIL.

ADDITIONAL PROVISIONS: Effective 11.01.2025 - No Dental Benefit changes.

Boomerer Whipple
Producer Agency Representative

Signature of Producer Agency Representative

Assured Partners of IL, LLC dba Lundstrom Insurance Agency
Producer Agency Name

2055 Point Blvd. Suite 200 Elgin, IL. 60123
Producer Address

837.741.1000
Producer Phone Number

107816942
Producer Number

383970092
Producer Tax ID Number

Lynn Reilly
BCBSIL Sales Representative

890/128
District/Cluster

Signature of Authorized Purchaser

Asst. City Administrator
Title

9/3/2025
Date

Witness

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"), or any successor thereof, 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 HCSC 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 thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until revoked either in writing by the undersigned at least twenty (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 its 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: Benjamin McCready
Print Signer's Name Here

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

Bryan McCready, Asst. City Administrator
Signature and Title

Dated this: _____ day of _____, _____
Month Year

Cut along dotted lines

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, 300 E Randolph, Chicago, IL 60601
Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148

BENEFIT PROGRAM APPLICATION ("BPA")

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (herein called "BCBSIL")

(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's 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.)

Employer Account Number:	769669
HMO Illinois Employer Group Number(s):	_____
HMO Illinois Section Number(s):	_____
Blue Advantage HMO℠ Employer Group Number(s):	B56633
Blue Advantage HMO Section Number(s):	See Account Structure
Non-HMO Plan Employer Group Number(s):	P74397,PE1181
Non-HMO Plan Section Number(s):	See Account Structure

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 Standard Industry Code (SIC): 8990

Wholly Owned Subsidiaries to be covered (if additional space is needed, use the Additional Provisions section):
_____

Affiliated Companies to be covered (if additional space is needed, use the Additional Provisions section):
_____

(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: Lauren Newton Email: lnewton@geneva.il.us
Phone: (630)232-0867 Fax: _____

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

Title: Human Resource Manager Email: lnewton@geneva.il.us

Phone: (630)232-0867 Fax: _____

Policy Effective Date: 11.01.2025 Policy Anniversary Date (month/day/year): 11/01/2026

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* (month/day/year): Beginning Date: _____/_____/_____ End Date: _____/_____/_____
ERISA Plan Sponsor*: _____
ERISA Plan Administrator*: _____
ERISA Plan Administrator's Address: _____
City: _____ State: _____ Zip Code: _____
ERISA Plan Administrator's Email: _____

Please provide your Non-ERISA Plan Month/Year: 11/2025
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
☐ 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 or work 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, IL Police and Fire Pension Code.

   The term "Employee" shall have the meaning set forth under ERISA and applicable law. BCBSIL reserves 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 Certificate Booklet, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those Insureds with Domestic Partner Coverage. An Employer may only elect or change Domestic Partner Coverage on the Policy Effective Date or Policy Anniversary Date.

Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, a Domestic Partner is eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) if an eligible Employee elects COBRA coverage. Employer may also elect whether to provide continuation coverage for Domestic Partners on an independent basis from the Employee. Please indicate your election below:

☐ Yes, Employer elects to offer continuation coverage to Domestic Partners on an independent basis from an Employee's election of COBRA.

☐ No, Employer does not elect to offer continuation coverage to Domestic Partners on an independent basis from an Employee's election of COBRA (Domestic Partners are not independently eligible for continuation coverage)

☐ Other: _____

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 Employer 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. 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 are unmarried ☐ regardless of marital status, is _____ years. 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.

☒ At the end of the month in which the Limiting Age is reached.

☐ At the end of the calendar year in which the Limiting Age is reached.

☐ On the Limiting Age birthday.

☐ Other (please specify): _____.

However, coverage shall be extended due to a leave of absence in accordance with any applicable federal or state law.

5. **Disabled Dependent**: Disabled Dependent means a child who is medically certified as disabled and dependent upon the Employee or his/her spouse (or Civil Union partner and/or Domestic Partner if Domestic Partner coverage is elected). Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered as a dependent under the Plan or as a dependent child under another employer plan and before the child attains the limiting age with no break in coverage. To administer medical certification of disabled dependents, you may select option (a) standard rules or (b) custom rules. If (b) is selected there are additional selections regarding age, proof of prior coverage, certification review, forms, and previous medical certification approvals.

(a) ☒ Disabled Dependent Administration will follow **standard rules.**

A disabled dependent may continue coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26). A disabled dependent may add coverage beyond

the limiting age, provided the disability began before the child attained the age of twenty-six (26), and proof of coverage as a disabled dependent is provided.

Certification Review is administered by BCBSIL; a Disabled Dependent Certification Form must be submitted to BCBSIL.

(b) ☐ Disabled Dependent Administration will follow **custom rules**. Please make the following selections:

Age: Please select one (1) option regarding age of when the disability began.

☐ The disability must have begun before the child attained the age of twenty-six (26).

☐ All disabled dependents are covered regardless of when the disability began.

Proof of Prior Coverage: Please select required or not required below:

When adding coverage, proof of prior coverage as a disabled dependent is ☐ required ☐ not required.

Certification Review: Please select one (1) option regarding administration of Certification Review.

☐ Certification Review is administered by BCBSIL; a Disabled Dependent Certification Form must be submitted to BCBSIL.

☐ Certification Review is administered by the Employer; there are no Disabled Dependent Certification Form requirements.

If Certification Review is administered by BCBSIL, please select one (1) option regarding forms:

☐ BCBSIL's Disabled Dependent Certification Form will be utilized.

☐ A custom/other Disabled Dependent Certification Form will be utilized.

If Certification Review is administered by BCBSIL, please select allowed or not allowed below:

An approved disabled dependent medical certification from a prior carrier is ☐ allowed ☐ not allowed.

An approved disabled dependent medical certification from a prior BCBS policy is ☐ allowed ☐ not allowed.

6. **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 Employer reported a Coverage Date earlier than what would apply to the Employee or dependent, based on the waiting period and eligibility conditions the Employer provided to BCBSIL, BCBSIL 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 of the month following _____ month(s) of employment.

☐ The _____ day of the month following _____ days (option of up to sixty (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.

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 (1) month (calculated by adding one (1) calendar month and subtracting one (1) 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 (1st) 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 (1st) day of the following month;

2) Does not exceed twelve (12) months; and

3) Taken together with other eligibility conditions does not result in coverage becoming effective later than thirteen (13) months from the Employee's start date plus the number of days between a start date and the first (1st) day of the next calendar month (if start day is not the first (1st) day of the month).

☐ Other substantive eligibility criteria not described above; please describe: _____

7. Enrollment

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.

Annual Open Enrollment: Specify annual open enrollment period:September 15th thru October 15th 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 BCBSIL and the Employer. Such date shall be subsequent to the annual open enrollment period.

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

10. **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.)

11. **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:** BCBSIL 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.** BCBSIL 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 twenty-five percent (25%), and at least a seventy percent (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 twenty-five percent (25%) minimum Employer contribution is met and at least seventy percent (70%) of Eligible Employees (less valid waivers) have enrolled for coverage. Employer will promptly notify BCBSIL 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 twenty-five percent (25%) of the Eligible Persons, and for Family Coverage seventy-five percent (75%) of the Eligible Persons with eligible dependents, have enrolled for coverage.

12. **Essential Health Benefits ("EHB") Definition Election**: Employer elects EHBs based on the Illinois benchmark.

13. **The Effective Date of Termination for a person who ceases to meet the definition of an 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 Eligible Person.

☐ Other (please specify): _____.

CURRENT ELIGIBILITY INFORMATION

Total Number of Employees (Please indicate the total number of actual Employees, not Enrollees):

1. On payroll 157

2. On COBRA continuation coverage __2__
3. With retiree coverage (if applicable) __35__
4. Who work part-time __0__
5. Serving the new hire waiting period __2__
6. Declining because of other **group** coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) __0__
7. Declining coverage (not covered elsewhere) __0__

STANDARD PREMIUM RATES ☒ Yes ☐ No						
	For Internal Use Only - Blue Star℠ Ben.Agree#: ***0001*** **PPO** **P74397**	*For Internal Use Only - Blue Star Ben.Agree#:* ***0013*** BaHMO B56633	*For Internal Use Only - Blue Star Ben.Agree#:* ***0014*** **HSA** **PE1181**	*For Internal Use Only - Blue Star Ben.Agree#:* _____ _____	*For Internal Use Only - Blue Star Ben.Agree#:* _____ _____	*For Internal Use Only - Blue Star Ben.Agree#:* _____ _____
1. Employee only:	$864.83	$753.76	$834.47	$_____	$_____	$_____
2. Employee plus one (1) dependent (i.e. Employee plus one (1) spouse or one (1) child):	$2,100.56	$1,830.17	$2,026.72	$_____	$_____	$_____
3. Employee plus two (2) or more dependents:	$_____	$_____	$_____	$_____	$_____	$_____
4. Employee plus Spouse:	$_____	$_____	$_____	$_____	$_____	$_____
5. Employee plus Child(ren) (i.e. Employee plus one (1) or more children):	$_____	$_____	$_____	$_____	$_____	$_____
6. Employee plus Family / Family:	$2,548.23	$2,221.12	$2,458.81	$_____	$_____	$_____
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 BCBSIL is Secondary Payer)						
Single Coverage:	$580.51	$506.12	$560.30	$_____	$_____	$_____
Family Coverage:	$1,161.39	$1,012.20	$1,120.53	$_____	$_____	$_____

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.
- ☐ Blue Advantage 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 (1) or more dependents.
- ☐ Blue Advantage HMO: $_____ per month per single Enrollee; or $_____ per month per Enrollee with one (1) or more dependents.

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

d) ☐ **Other administrative charges (list service):**

$ Select Fee/Billing Type
$ Select Fee/Billing Type
% Select Fee/Billing Type

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 (1)) 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

☐ **Other administrative charges (list service):**

$ Select Fee/Billing Type
$ Select Fee/Billing Type
% Select Fee/Billing Type

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:

☐ three (3) months ☐ six (6) months ☐ nine (9) months ☐ twelve (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.

Advanced Payment Review (APR): APR is a suite of payment integrity offerings. Refer to the Automated Benefit Summary ("ABS"). Reimbursement Services are included for the Cost-Plus program. BCBSIL will retain twenty-five percent (25%) of any recovered amounts made on third-party liability claims other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

Does Employer elect additional APR capabilities? ☐ Yes ☐ No If **yes**, indicate APR Savings Program or PEPM below:

☐ APR Savings Program

☐ PEPM

For APR capabilities other than Reimbursement Services: If Employer elects APR Savings Program, BCBSIL will invoice twenty-five percent (25%) of any savings amounts identified by BCBSIL or third-party vendor.

Prescription Drugs covered under the Medical Benefit:

Medical Drug Rebate Credit:

PPO: $_____ per covered Employee per month.

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 covered Employee per month.

HMO Pharmacy Network (Select one (1)):

☐ Traditional Select Network

☐ Network shown on PBM Fee Schedule Exhibit

PPO Pharmacy Network (Select one (1)):

☐ 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 BCBSIL within ten (10) days of BCBSIL's notification to the Employer 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 BCBSIL, and paid by the Employer, 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, BCBSIL 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 Average Discount Percentage ("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: $_____

EMPLOYER STATEMENTS:

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

2. 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.

3. This BPA is subject to acceptance by BCBSIL. Upon acceptance, BCBSIL 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 BCBSIL.

4. 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 BCBSIL accepts this BPA and issues a Policy to the Employer, BCBSIL 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 BCBSIL in connection with the issuance of a Policy, the Employer should contact its producer.

5. The undersigned representative acknowledges that the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 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 BCBSIL except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by BCBSIL.

6. The Rebate Credit (if applicable) is a per covered Employee per month (or, for the HMO plan, per covered Employee 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:

1. **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 percent (25%) of any recovered amounts, other than recovery amounts received as a result of, or associated with, any Workers' Compensation Law.

2. **Third-Party Recovery Vendors (other than Reimbursement Services):** BCBSIL engages with third-party recovery vendors on a post-pay basis to identify and/or recover any potential overpayments that may have been made to Providers. This provision does not apply to the Cost-Plus Program.

3. **Third-Party Law Firms Provisions (other than Reimbursement Services)**: BCBSIL engages with third-party law firms on a post-pay basis to identify and/or recover any potential overpayments that may have been made to Providers.

4. **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 Employer in electronic format. If the Employer approves of the content, Employer will then distribute the SBC to participants and beneficiaries (or hire a third party to distribute) as required by law. If the Employer 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 Employer.

5. **Preferred HSA purchased**: ☐ Yes ☒ No (If yes, select vendor) **(Vendor:Select Vendor)**
If HealthEquity, Inc. is selected, BCBSIL to send HSA enrollment to HealthEquity, Inc.: ☐ Yes ☐ No
Non-Preferred Vendor:

6. **Preferred FSA purchased**: ☐ Yes ☒ No (If yes, select vendor) **(Vendor: Select Vendor)**
Non-Preferred Vendor:

7. **HCA purchased:** ☐ Yes ☒ No (If yes, complete and attach a separate HCA Benefit Program Application)

8. **Preferred Health Reimbursement Account (HRA) purchased:** ☐ Yes ☒ No (if yes, select vendor) **(Vendor:Select Vendor)**
Non-Preferred Vendor:

   An HSA must be paired with a qualified high deductible health plan (HDHP) and follow strict requirements set forth by the Internal Revenue Service (IRS). Employer Groups should seek advice from their independent tax advisor, legal counsel, or other professional counselor, to ensure their proposed benefit strategy, with respect to HSAs, FSAs, HRAs, or other benefit arrangements, does not conflict with current IRS requirements.

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

10. **Life, Disability, Critical Illness, Accident, Hospital Indemnity or Vision Insurance purchased**: ☐ Yes ☒ No (If yes, complete separate application.)

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

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

13. **(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.

14. **Massachusetts Health Care Reform Act**: If elected below, BCBSIL will provide required written statements of Minimum Creditable Coverage ("MCC") to Covered Persons residing in Massachusetts and submit applicable electronic reporting to the Massachusetts Department of Revenue. Information transmitted will be exclusively based on information provided to BCBSIL by Employer and coverage under the Plan(s) during the term of the Policy. By electing to have BCBSIL transmit these creditable coverage reports on Employer's behalf, Employer hereby certifies that, to the best of its knowledge, such coverage under the Plan(s) is "creditable coverage" in accordance with the

Massachusetts Health Care Reform Act. Employer acknowledges that BCBSIL is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this service. Employer or its Covered Persons should seek advice from their legal or tax advisors as necessary. If not elected, Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

☒ Employer consents to BCBSIL transmitting MCC reports on its behalf. Further, Employer attests that the information submitted is true and compliant with all relevant MCC Regulations.

☐ Employer will transmit MCC reports, and any other documentation as may be required to comply with the Massachusetts Health Care Reform Act.

15. ☒ **Wellbeing Management (WBM)**

16. ☐ **Medical and Ancillary Package Pricing:** The rates shown in this Policy reflect a volume-based discount in an amount up to three percent (3%) of the medical premium for the twelve (12) month period beginning on the Policy Effective Date. If any of the qualifying ancillary coverage (BlueCare Dental, Basic Life, Short-Term Disability, Long-Term Disability, Accident, Critical Illness, Hospital Indemnity and/or Vision product(s)) lapses during this twelve (12) month period, BCBSIL reserves the right to remove the volume-based discount attributable to the lapsed product on medical premium. In such event, upon sixty (60) days prior written notice to Employer, the premium payment will be adjusted to reflect the removal of the discount attributable to the lapsed product.

ADDITIONAL PROVISIONS:

A. **Grandfathered Health Plans:** Employer shall provide BCBSIL 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 the Affordable Care Act and applicable regulations. Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by BCBSIL to the terms and conditions of coverage. In no event shall BCBSIL 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 made part of the BPA and Group Policy, and Employer represents and warrants that such Form is true, complete, and accurate. If Employer fails to timely provide BCBSIL with any requested grandfathered health plan information, BCBSIL 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 Employer represents and warrants that one (1) 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 ERISA) (an "exempt plan status"). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by BCBSIL to the terms and conditions of coverage. In no event shall BCBSIL 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. Employer shall indemnify and hold harmless BCBSIL 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 BCBSIL 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 Employer, (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 Employer, 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 does not take the place of) the other terms and conditions of coverage and/or administrative services between the parties.

Notwithstanding anything in the Policy or Renewal(s) to the contrary, BCBSIL 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 BCBSIL to pay, submit or forward, on its own behalf or on the Employer'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 Employer'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 (1) dependent" rate structure means "Employee plus one (1) spouse (includes Civil Union partner and/or, if elected, Domestic Partner) or one (1) child."

Any reference in this BPA to the "Employee plus Child(ren)" rate structure means "Employee plus one (1) or more children."

Effective 11.01.2025 - BCBSIL will provide a one-time wellness credit of $30,000 for the twelve-month period beginning on the Contract Effective Date, to be used to cover costs and expenses associated with implementation and/or operation of a wellness program.Employer is accepting the wellness credit on behalf of the wellness program, which is or is part of an ERISA plan.Employer hereby certifies that it will only use it for purposes consistent with the administration of the plan. If Employer cancels coverage before expiration of the policy period, Employer will be required to refund BCBSIL the full amount of the wellness credit. -
No Medical Benefit changes.

Lynn Reilly
Sales Representative

890 630.824.5644
District Phone No.

Bommer Whipple
Producer Representative

Signature of Producer Representative

Assured Partners of IL, LLC. (dba Lundstrom Insurance Agency)
Producer Firm

2205 Point Blvd. Suite 200 Elgin, IL 60123
Producer Address

847-741-1000
Producer Phone No.

107816942
Producer Number

383970092
Producer Tax ID No.

Signature of Authorized Purchaser

Asst. City Administrator
Title

09/03/2025
Date

Witness

$_____ Amount Submitted (not required for renewals)

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"), or any successor thereof, 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 HCSC 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 thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until revoked either in writing by the undersigned at least twenty (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 its directors, officers, employees, or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

Group No(s): P74397
B56633
PE1181

By: Benjamin McCready
Print Signer's Name Here

➡ Benjamin McCready Asst. City Administrator
Signature and Title

Group Name: City of Geneva

Address: 22 South First Street

City: Geneva State: IL Zip Code: 60134

Dated this _____ day of _____
Month Year