#100147

VILLAGE OF LOMBARD
REQUEST FOR BOARD OF TRUSTEES ACTION

__X__ Resolution or Ordinance (Blue) *Waiver of First requested* __
_____ Recommendations of Boards, Commissions & Committees (Green)
_____ Other Business (Pink)

TO: PRESIDENT AND BOARD OF TRUSTEES

FROM: David A. Hulseberg, Village Manager

DATE: March 19, 2010 (B of T) Date: April 1, 2010

TITLE: A Resolution authorizing Approval of President & Clerk on an Agreement for Blue Cross/Blue Shield PPO Health Insurance, Blue Cross/Blue Shield PPO Plus, HMO Illinois Health Insurance and HMO Blue Advantage Insurance

SUBMITTED BY: Kathleen Dunne, Human Resource Administrator

BACKGROUND/POLICY IMPLICATIONS:

Please find attached a renewal benefit program application with BlueCross BlueShield of Illinois for Fiscal Year 2010/2011 Health Insurance Programs.

The attached resolution provides for new contracts between the Village of Lombard and Blue Cross/Blue Shield of Illinois. These contracts provide for two PPO options, and two HMO options. There will be an increase of 16.3%.

FISCAL IMPACT/FUNDING SOURCE:

Village Attorney _____ Date _____
Finance Director _____ Date _____
Village Manager _____ Date 3/24/10

DATE: March 23, 2010

TO: David Hulseberg
Village Manager

FROM: Kathleen Dunne
Human Resources Administrator

SUBJECT: Resolution on Health Insurance Contracts

The attached resolution provides for new contracts between the Village of Lombard and Blue Cross/Blue Shield of Illinois. These contracts provide for two PPO options, and two HMO choices. The two HMO options are HMO Illinois and Blue Advantage. The new PPO Plus option has the same network as our current PPO, but with a higher deductible. The PPO Plan for non-union will decrease the coinsurance from 80/60 to 90/70. This will minimize cost increases due to employees choosing either of these options.

RESOLUTION
R_____10

A RESOLUTION AUTHORIZING SIGNATURE OF PRESIDENT AND CLERK ON AN APPLICATION

WHEREAS, THE Corporate Authorities of the Village of Lombard have received an application for Blue Cross/Blue Shield PPO Health Insurance, Blue Cross/Blue Shield PPO Plus, HMO Illinois Health Insurance and HMO Blue Advantage Insurance; and

WHEREAS, THE Corporate Authorities deem it to be in the best interest of the Village of Lombard to approve the application as attached hereto and marked Exhibit "A".

NOW, THEREFORE, BE IT RESOLVED BY THE PRESIDENT AND BOARD OF TRUSTEES OF THE VILLAGE OF LOMBARD, DUPAGE COUNTY, ILLINOIS as follows:

SECTION I: That the Village President be and hereby is authorized to sign on behalf of the Village of Lombard said application as attached hereto.

SECTION 2: That the Village Clerk be and hereby is authorized to attest said application as attached hereto.

Adopted this _____day of _____,2010.

Ayes:_____

Nays:_____

Absent:_____

Approved this _____ day of _____,2010.

_____
William J. Mueller
Village President

ATTEST:

_____
Brigitte O'Brien
Village Clerk

APPROVAL AS TO FORM:

_____
Thomas P. Bayer
Village Attorney

Exhibit "A"

Health Care Account ("HCA") Plan
Benefit Program Application ("BPA")

Employer Group Number(s): P08641
Section Number(s):
Employer Name: Village of Lombard
(Specify the employer or the employee trust applying for coverage. Names of subsidiary or affiliated companies to be covered must also be included. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED)
Employer Identification Number (EIN): 366005975
Address: 255 East Wilson Ave.
Phone Number: 630-620-5918
City: Lombard
State: IL Zip: 60148
Subsidiaries: n/a
Affiliated Companies: n/a
Administrative Contact: Kathy Dunne
Title: Group Administrator
Phone Number: 630-620-5918 FAX: 630-620-8222
Email: dunnek@villageoflombard.org
Plan Administrator: Village of Lomard
ERISA Plan Year: n/a
Effective Date of Coverage: 06/01/2010
Anniversary Date: 06/01/2011

SCHEDULE OF ELIGIBILITY

Eligible Person, the Effective Date of termination for a person who ceases to meet the definition of Eligible Person, the Limiting Age for covered unmarried dependent children, the Eligibility Date for a person who becomes an Eligible Person after the Effective Date of the Employer's HCA Plan, HCA Plan enrollment options, and extension of benefits due to Temporary Layoff, Disability or Leave of Absence, shall be as specified under the Employer's HCA Plan.

IMPORTANT TAX NOTE: Please be reminded that Health Reimbursement Arrangements ("HRAs") – referred to herein as Health Care Accounts ("HCAs") – have tax and legal ramifications. I.R.S. Regulations require employers to comply with certain requirements, including those concerning participant eligibility, for HRAs (such as this HCA), particularly if HRA benefits are made available to self-employed individuals. In some circumstances HRA benefits might constitute income to such participants.

Blue Cross and Blue Shield of Illinois is not responsible for ensuring or verifying participant eligibility. Further, Blue Cross and Blue Shield of Illinois does not provide legal or tax advice, and nothing herein, nor in any materials incorporated into this document, should be construed as legal or tax advice. Any tax-related statements in the aforementioned materials are not intended nor written to be used, and cannot be used nor relied on, for the purpose of avoiding tax penalties.

Any tax-related statements, within associated materials, may have been written in connection with the promotion or marketing of the transaction(s) or matter(s) addressed within this and accompanying materials.

Employer should seek advice based on participants' particular circumstances from an independent tax advisor regarding the tax consequences of specific health insurance plans or products.

Health Care Account (HCA)

☒ BlueEdge HCA ☐ BlueEdge Direct HCA ☐ BlueEdge Wellness Rewards HCA

☐ BlueEdge Vitality HCA ☐ BlueEdge FSAFirst ☐ BlueEdge Limited Purpose HCA

HCA Account Structure

Employee Yes ☒ No ☐
Employee + Spouse Yes ☐ No ☒
Employee + Child(ren) Yes ☐ No ☒
Family Yes ☒ No ☐
Employee + 1 Dependent Yes ☐ No ☒
Employee + 2 or more Dependents Yes ☐ No ☒

Employer HCA Contribution Amounts: If funding is through incentives only, contribution amounts should remain blank. Please then check the box for incentives below.

Employee $500
Employee + Spouse $n/a
Employee + Child(ren) $n/a
Family $1,000
Employee + 1 Dependent $n/a
Employee + 2 or more Dependents $n/a

Direct HCA Only: Self Pay-Corridor

Employee $n/a
Employee + Spouse $n/a
Employee + Child(ren) $n/a
Family $n/a
Employee + 1 Dependent $n/a
Employee + 2 or more Dependents $n/a

HCA Maximum- HCA balance for contributions cannot exceed listed dollar amount

Employee $1,000
Employee + Spouse $n/a
Employee + Child(ren) $n/a
Family $2,000
Employee + 1 Dependent $n/a
Employee + 2 or more Dependents $n/a

HCA Roll Over Amount:
(The amount of participant's balance to be carried forward to the next 12-month plan period.)

☐ 0% ☒ 100% ☐ ____%

HCA Proration:
(Applies to initial funding, new membership and changes in coverage from single to family or family to single)

☒ Semi-Annual ☐ Quarterly ☐ Monthly ☐ None

HCA Contribution Frequency Options:

(Note: contribution frequency for variable contributions must match HCA proration. **The HCA contribution frequency selected by the employer could be monthly, quarterly, and semi-annual in addition to current annual basis. The default HCA funding benefit frequency will remain annual. This means that each month, quarter or semi-annual period, the portion of the contribution is available to the participants and only that portion. The portions accumulate according to selection if it is monthly, quarterly or semi-annual, up to the full contribution amount.**)

☒ Yes (if yes, select frequency below) ☐ No

☒ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

Incentive applied to HCA Yes ☐ No ☒
If yes, then please fill out the incentives on the Matrix.

Additional Spending Accounts paired with the product Yes ☐ No ☒ If yes, then another BPA must be completed for each additional spending account.

Do you have an existing HCA (HRA) that will require a credit of ending HCA balances? ☐ Yes ☒ No

Please indicate the date of the prior carrier credit: n/a

HCA Account Yearly Claims payment options:

☒ Multiple- Claims incurred in the current year may use current year contribution or rollover dollars from previous years. Current year contribution amounts will not be available for the prior year claims; only the rollover dollars are available for that prior year's claims.

☐ Single- All current funding and rollover dollars are available for claims incurred in any year.

By signing below, Employer acknowledges and agrees as follows:

- **Employer has reviewed and hereby accepts the benefits and other specifications, terms and conditions set out in the HCA Benefit Program Application and other applicable documentation (e.g., Group Administration Document (GAD) or the Matrix, etc.);**
- **Employer understands and agrees that the HCA is an employer-sponsored benefit plan and that, even though the HCA is offered as a companion to the Employer's medical benefit plan, the HCA itself is a health and welfare benefit plan under ERISA or similar federal or state employee benefit laws;**
- **Employer acknowledges and agrees that Employer is solely responsible for the creation, funding and maintenance of the HCA plan, including obligations under ERISA or similar federal or state employee benefit laws and that Blue Cross and Blue Shield of Illinois as the HCA Administrator provides only HCA administrative services for the Employer-established HCA Plan;**
- **Employer agrees that this HCA Benefit Program Application and the HCA Administrative Services Agreement ("HCA ASA" or "Agreement") and any exhibits, attachments, or amendments thereto constitute the entire agreement between the Employer and Blue Cross and Blue Shield of Illinois, serving as the HCA Administrator.**

ADDITIONAL PROVISIONS:

New HCA Plan added 6/1/2010

Nancy Chaidez
Sales Representative

Signature of Employer's Authorized Purchaser

Date

Title

BCBSIL
Address

Date

822 630-824-5406
District Phone No.

312-938-4576
FAX No.

Tom Schaffler
Producer Representative

Lockton Companies, LLC
Producer Firm

Chicago
Producer Address

312-669-6704
Producer Phone & FAX Numbers

Producer email Address

203354970
Tax I.D. No.

BlueCross BlueShield of Illinois

BENEFIT PROGRAM APPLICATION ("BPA")

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

Employer Account Number: 206522

HMO Illinois Employer Group Number(s): H56789

HMO Illinois Section Number(s): 0100, 0200, 0300, 0400, 0500, 0600, 8888, 8889

BlueAdvantage® HMO Employer Group Number(s): B56789

BlueAdvantage® HMO Section Number(s): 0100, 0200, 0300, 0400, 0500, 0600, 8888, 8889

Non-HMO Plan Employer Group Number(s): P06522 (Union Plan), P08644 NEW (NonUnion Plan), P08641 NEW (HCA Plan)

Non-HMO Plan Section Number(s): 0100 (non-union), 0200 (union), 0300 (union), 0400 (union), 0500 (retirees), 8880 (cobra union), 8888 (cobra non-union)

Employer Name: VILLAGE OF LOMBARD

(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)

Address: 255 EAST WILSON City: LOMBARD State: IL Zip Code: 60148

Billing Address *(if different from above)* : SAME City: _____ State: _____ Zip Code: _____

Employer Identification Number ("EIN"): 366005975

Subsidiaries: n/a

Affiliated Companies: n/a

(If Affiliated Companies to be covered are listed above, a separate "Addendum to the Benefit Program Application Regarding Affiliated Companies" must be completed, signed by the Employer's authorized representative, and attached to this BPA.)

Administrative Contact: KATHY DUNNE Phone: 630-620-5918 Fax: 630-620-8288 Email: dunnek@villageoflombard.org

Blue Access for Employers (BAE) Contact: KATHY DUNNE

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

Title: GROUP AMINISTRATOR Phone: 630-620-5918 Fax: 630-620-8222 Email: dunnek@villageoflombard.org

Policy Effective Date: 06/01/2010 Policy Anniversary Date: 06/01/2011

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

ERISA Plan Administrator: n/a

ERISA Plan Administrator's Address: n/a

City: _____ State: _____ Zip Code: _____

ERISA Plan Administrator's Email: n/a

ELIGIBILITY

1. 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): AActive elected officials who pay the fully applicable payment with no Village contribution per Village Board Policy 98-3. Retirees per IMRF guidelines.

Full-Time Employee means:

☒ A person who is regularly scheduled to work a minimum of 40 hours per week and who is on the permanent payroll of the Employer.

☐ Other (please specify): _____

☒ An Eligible Person may also include a retiree of the Employer. Please specify: PER IMRF GUIDELINES.

2. Domestic Partner Coverage: ☐ Yes ☒ No

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

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

3. Limiting Age for covered unmarried children is:

☒ twenty-six (26) years; thirty (30) years if eligible military personnel as described in the Certificate Booklet.

☐ years; years if eligible military personnel as described in the Certificate Booklet.

(The minimum allowable ages for this option are 26; 30 if eligible military personnel)

☐ years if a full-time student.

(The minimum allowable ages for this option are 26; 30 if eligible military personnel)

For Non-HMO plans, coverage will terminate at the end of the period for which premium has been accepted:

For HMO plans, coverage will terminate at the end of the following period for which premium has been accepted:

☒ The month in which the Limiting Age is reached.

☐ The year in which the Limiting Age is reached.

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

4. Eligibility Date for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan:

☒ The date of employment.

☐ The _____ day of employment.

☐ The _____ day of the month following _____ month(s) or _____ days of employment.

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

☐ Other (please specify): _____

☒ For the HMO plan: A full month's premium will be charged for the first month of coverage for those employees whose Coverage Dates fall between the first and fifteenth 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 day and the end of the Premium Period.

5. 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.

Annual Open Enrollment: Specify Annual Open Enrollment Period:MAY FOR A JUNE 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.

6. For the HMO plan: 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 an Eligible Person.

☐ Other (please specify):

7. Extension of benefits due to Temporary Layoff, Disability or Leave of Absence:

Temporary Layoff: 0 days Disability: 0 days Leave of Absence: 0 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.)

8. For the HMO Plan:

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

Of the Employer: 289 Illinois employees: 289 National employees: 0

FUNDING ARRANGEMENT

☒ Standard Premium – Prospective ☐ Cost Plus Program

STANDARD PREMIUM INFORMATION:

(a) Premium Period:

☒ The first 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.)

(b) Employer contribution:

For the HMO Plan:

☐ HMO Illinois: _____% of the Individual Coverage Premium and _____% of Family Coverage Premium.

☐ BlueAdvantage® HMO: _____% of the Individual Coverage Premium and _____% of the Family Coverage Premium.

☒ Other (please specify): both HMOI & BAHMO = 90-93% for single coverage, and 80-90% for families

For the Non-HMO Plan:

☐ 100% of the Individual Coverage Premium and an amount equal to 100% of the Individual Coverage Premium will be contributed toward the Family Coverage Premium.

☒ 90% of the Individual Coverage Premium and 70% of the Family Coverage Premium.

☐ Other (please specify): _____

(c) For the Non-HMO Plan:
It is understood that no Policy will be issued or renewed on a contributory basis unless at least 75% of the Eligible Persons and, for Family Coverage, 75% of the Eligible Persons with eligible dependents have enrolled for coverage.

STANDARD PREMIUM RATES ☒ Yes ☐ No						
	For Internal Use Only - BlueStar Ben.Agree#: ***0005*** **HMO Illinois H56789 ALL EE**	*For Internal Use Only - BlueStar Ben.Agree#:* ***0007*** **Blue Advantage® HMO** B56789 ALL EE	*For Internal Use Only - BlueStar Ben.Agree#:* ***0006 PPO*** **Non-HMO Health Coverage: P06522 UNION**	*For Internal Use Only - BlueStar Ben.Agree#:* ***0012 PPO*** **Non-HMO Health Coverage: P08644 NONUNION**	*For Internal Use Only - BlueStar Ben.Agree#:* ***0013 HCA*** **Non-HMO Dental Coverage: HCA Medical Plan P08641 ALL EE**	**Total**
1. Employee only:	$512.79	$460.76	$569.51	$555.27	$489.78	$
2. Employee plus one dependent:	$	$	$	$	$	$
3. Employee plus two or more dependents:	$	$	$	$	$	$
4. Employee plus Spouse:	$	$	$	$	$	$
5. Employee plus Child(ren):	$	$	$	$	$	$
6. Employee plus Family / Family:	$1407.10	$1266.80	$1615.08	$1574.71	$1388.98	$
7. Other: _____	$	$	$	$	$318.37 Medicare Single $636.73 Medicare Family	$
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:	$512.79	$460.76	$370.19	$360.94		$
Family Coverage:	$1025.57	$921.50	$740.39	$721.87		$

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.

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): _____

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

BCC Program (may select one):
☐ Blue Care Advisor
☐ Please refer to Additional Provisions

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

Blue Care Custom

☐ 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:

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): _____

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 Rebate: $_____ per Covered Employee per month or, for the HMO Plan, per Enrollee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit.

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: $_____

The undersigned representative is authorized and responsible for purchasing 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 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 Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("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.

The undersigned representative acknowledges that any broker/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 broker/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 broker/producer by HCSC in connection with the issuance of a Policy, the Employer should contact its broker/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.

OTHER PROVISIONS:

(a) Reimbursement Provision for the HMO Plan: It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will deduct 25% of the net recovery from the amount credited to the group's experience after attorneys' fees, if any, have been paid.

Reimbursement Provision for the Non-HMO Plan: ☒ Yes ☐ No

If yes: It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will retain 25% of the net recovery (under cost-plus funding) or deduct 25% of the net recovery from the amount credited to the group's experience (under premium funding) after attorneys' fees, if any, have been paid.

(b) Certificate of Creditable Coverage: ☒ Yes ☐ No

If yes: It is understood and agreed that HCSC will issue a Certificate of Creditable Coverage consistent with the requirements under the Health Insurance Portability and Accountability Act of 1996. The Certificate of Creditable Coverage shall be based upon coverage under the Plan during the term of the Policy and information provided to HCSC by the Employer.

If no: The Certificate of Creditable Coverage Release and Indemnification letter is attached to this BPA and made part of the Policy.

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

(d) Fort Dearborn Life Insurance purchased: ☐ Yes ☒ No *(If yes, complete separate application.)*

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

(f) 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.

(g) For the Non-HMO Plan: Electronic Issuance: The Policyholder consents to receive, via an electronic file or access to an electronic file, a Certificate Booklet provided by HCSC to the Policyholder for delivery to each Insured. The Policyholder further agrees that it is solely responsible for providing each Insured access, via the internet, intranet or otherwise, to the most current version of any electronic file provided by HCSC to the Policyholder and, upon the Insured's request, a paper copy of the Certificate Booklet.

(h) 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.

ADDITIONAL PROVISIONS: Renewal Effective 6/1/2010

PPO Plan P06522: this will only be offered to UNION employees, includes sections 0200 (union), 0300 (union), 0400 (union), and 8880 (cobra union)

Add New PPO Plan P08644 BA#0012: this plan will only be offered to NON-UNION members, includes sections 0100 (non-union), 0500 (retirees), and 8888 (cobra non-union). This plan will mapped from P06522 with the exception of the coinsurance. Coinsurance changes from 90/70 to 80/60.

Add HCA Plan P08641 BA#0013: this plan will be offered to all employees. The coinsurance is 90/70 with a $1,000 deductible. Refer to HCA BPA for HCA funding provisons.

Nested HMO Plans: this plan will be offerd to all employees. No plan chagnes with the exception of the mandated Federal and State laws.

The following legislative changes apply to all medical plans.

Federal Legislative Changes – Effective 6/1/2010
Mental Health Parity and Addiction Equity Act
This group must comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The group health plans are required to provide mental health or substance use disorder benefits that have similar deductibles, copays and day/visit limits as medical and surgical benefits.

Michelle's Law
The group health plans must allow college students insured under their parent's policies to remain covered if they are required to take a medical leave of absence from school for up to 12 months.

State Legislative Changes - Effective 6/1/2010

Enhance coverage per state mandate PA 95-1045 for coverage of in network routine mammograms and breast ultrasounds by requiring that these services be provided at no cost to the insured and not be applied to an annual maximum benefit or lifetime maximum, unless performed by an out-of-network provider.

Add coverage for Illinois Mandate – Eating Disorder Treatment (Anorexia Nervosa and Bulimia Nervosa). The new Public Act changes the definition of "Serious Mental Illness" (SMI) to include Anorexia Nervosa and Bulimia Nervosa.

Plan already includes coverage for Marriage and Family Therapists. Illinois Mandate requires coverage of treatment for mental, emotional and nervous disorders by a licensed marriage and family therapist.

Habilitative Services for Children - Effective April 7, 2009, health plans are required to cover the habilitative services for individuals under age 19 prescribed by a physician pursuant to a treatment plan to enhance the ability of a child to function with a congenital, genetic or early acquired disorder.

☐ Additional Provisions are specified in the Exhibit attached hereto and made a part of this BPA.

Nancy Chaidez	
Sales Representative	Signature of Authorized Purchaser
822	
District	Title
Tom Schaffler 312-669-6704	
Producer Representative	Date
Lockton Companies, LLC	
Producer Firm	Witness
Chicago, IL	
Producer Address	$_____ Amount Submitted
203354970	
Producer Tax I.D. No.	

UNDERWRITING USE ONLY
Date BPA approved:
Signature of Underwriter

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 shall 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 mailed 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.

Group No.: H56789
B56789
P06522
P08644
P08641

By: _____
Print Signer's Name Here

➡ _____
Signature and Title

Group Name: Village of Lomard

Address: 255 East Wilson Avenue

City: Lomard State: IL Zip Code: 60148

Dated this _____ day of _____, _____
Month Year