THE CITY OF BLUE ISLAND
COOK COUNTY, ILLINOIS

RESOLUTION
NUMBER 2018-029

A RESOLUTION APPROVING A BENEFIT PROGRAM APPLICATION ("BPA")WITH BLUE CROSS BLUE SHIELD OF ILLINOIS AND AUTHORIZING THE MAYOR AND CITY CLERK TO SUBMIT THE APPLICATION

DOMINGO F. VARGAS, Mayor
Randy Heuser, City Clerk

DEXTER JOHNSON
LETICIA VIEYRA
NANCY RITA
TOM HAWLEY
BILL FAHRENWALD
CANDACE CARR
KENNETH PITTMAN
GEORGE POULOS
FRED BILOTTO
KEVIN DONAHUE
ALECIA SLATTERY
JANICE OSTLING
JAIRO FRAUSTO
NANCY THOMPSON

Aldermen

RESOLUTION NO. 2018-029

A RESOLUTION APPROVING A BENEFIT PROGRAM APPLICATION ("BPA") WITH BLUE CROSS BLUE SHIELD OF ILLINOIS AND AUTHORIZING THE MAYOR AND CITY CLERK TO SUBMIT THE APPLICATION

WHEREAS, the City of Blue Island has the authority to contract and be contracted with pursuant to 65 ILCS 5/2-2-12;

WHEREAS, the City plans to submit a Benefit Program Application ("BPA") to Blue Cross Blue Shield of Illinois to provide health insurance benefit plans for current and former City employees, in accordance with the terms of the Benefit Program Application attached hereto as Exhibit A;

WHEREAS, the appropriate city officials have considered and reviewed the Benefit Program Application attached as Exhibit A and find the same to be in the best interests of the City;

NOW AND THEREFORE, BE IT RESOLVED by the City Council of the City of Blue Island, Cook County, Illinois, as follows:

SECTION 1: AGREEMENT FORM AND TERMS AUTHORIZED

The terms and conditions as shown in the Benefit Program Application, attached as Exhibit "A" to this Resolution, are hereby approved.

SECTION 2: AUTHORIZATION OF AGENT TO EXECUTE AND ACT IN ACCORDANCE WITH AGREEMENT

The City Council further authorizes the Mayor or his designee and the City Clerk to execute the Benefit Program Application and any and all documentation that may be necessary to carry out the intent of this Resolution. The officers, employees, and/or agents of the City shall take all action necessary or reasonably required by the City to carry out, give effect to, and consummate the intent of this Resolution.

SECTION 3: EFFECTIVE DATE

This resolution shall be in full force and effect upon its passage and approval as required by law.

(Intentionally left blank)

ADOPTED this **25th** day of **September, 2018**, pursuant to a roll call vote as follows:

	YES	NO	ABSENT	PRESENT	ABSTAIN
Alderman Hawley	X				
Alderman Poulos	X				
Alderman Vieyra	X				
Alderman Bilotto	X				
Alderman Rita	X				
Alderman Donahue	X				
Alderman Carr	X				
Alderman Slattery	X				
Alderman Ostling	X				
Alderman Pittman	X				
Alderman Johnson	X				
Alderman Frausto	X				
Alderman Thompson	X				
Alderman Fahrenwald	X				
Mayor Vargas					
TOTAL	14				

APPROVED by the Mayor on **September 25, 2018**.

Domingo F. Vargas

DOMINGO F. VARGAS
MAYOR OF THE CITY OF BLUE ISLAND,
COUNTY OF COOK AND STATE OF ILLINOIS

ATTESTED and **Filed** in my office this
25th day of **September, 2018**.

Randy Heuser

RANDY HEUSER
CITY CLERK

EXHIBIT "A"

BENEFIT PROGRAM APPLICATION

BlueCross BlueShield
of Illinois

BENEFIT PROGRAM APPLICATION ("BPA")

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

Employer Account Number: 120665

HMO Illinois Employer Group Number(s): _____

HMO Illinois Section Number(s): _____

BlueAdvantage® HMO Employer Group Number(s): B01243

BlueAdvantage® HMO Section Number(s): 0100 (Active Employees); 0200 (Retirees); 8888 (COBRA)

Non-HMO Plan Employer Group Number(s): P43670, P64430

Non-HMO Plan Section Number(s): 0100 (Active Employees); 0200 (Retirees); 8888 (COBRA)

Employer' Legal Name: City of Blue Island

(Specify the employer, the employee trust or the association applying for coverage. List subsidiary or affiliated companies to be covered below. An employee benefit plan may not be named.)

Physical Address: 13051 South Greenwood Avenue City: Blue Island State: IL Zip Code: 60406

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

Employer Identification Number ("EIN"): 36-6005798

Wholly Owned Subsidiaries to be Covered: N/A

Affiliated Companies to be Covered: N/A

(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: Mike Marzal Phone: 708-396-7066 Fax: _____ Email: mmarzal@cityofblueisland.org

Blue Access for Employers ("BAE") Contact: _____

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

Title: Primary Contact Admin Phone: 708-396-7066 Fax: _____ Email: mmarzal@cityofblueisland.org

Policy Effective Date: 01/01/2019

Policy Anniversary Date: 01 / 01 / 2020
Month Day Year

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

ERISA Regulated Group Health Plan*: Yes ☐ No ☒

If Yes, specify ERISA Plan Year*: Beginning Date: __/__/__ End Date: __/__/__ (month/day/year)

ERISA Plan Sponsor*: _____

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

Please provide your Non-ERISA Plan Month/Year: 01 /2019

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

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

For more information regarding ERISA, contact your Legal Advisor.

*All as defined by ERISA and/or other applicable law/regulations.

ELIGIBILITY

1. Eligible Person:

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

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

Full-Time Employee means:

- ☒ An Employee of the Employer who is regularly scheduled to work a minimum of 30 hours per week
- ☐ Other (please specify): _____

☒ An Eligible Person may also include a retiree of the Employer. Please specify: FOP/Police are the only employees currently eligible for future retiree coverage. They must have a minimum of 20 years of service and be at least 50 years old. Until eligibile for Medicare, Retirees will be covered on the same basis as Employees. Upon attaining eligibility for Medicare Part A and Medicare Part B (whether or not selected), Retiress will be eligible on a secondary basis to Medicare coverage.

All other currently enrolled Retirees are paer od a closed class. Those in the closed class were required to have a minimum of 20 years of service and be at least 55 years of age (for Fire/Police, the minimum age was only 50). Until eligibility for Medicare, Retirees will be covered on the same basis as Employees. Upon attaining eligibility for Medicare Part A and Medicare Part B (whether or not selected), Retirees will be eligible on a secondary basis for Medicare coverage.

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

2. Civil Union Partner Coverage:

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

3. Domestic Partner Coverage: ☐ Yes ☒ No

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

Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, Domestic Partners are not eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA),

but Employer may elect to offer continuation coverage to Domestic Partners similar to that available to spouses under COBRA continuation.

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

4.The Limiting Age for covered children:

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

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

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

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

Coverage will terminate at the end of the period for which premium has been accepted. However, coverage shall be extended due to a leave of absence in accordance with any applicable federal or state law.

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

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

☐ The date of employment.
☐ The _____ day of employment. **Note:** This may not exceed ninety-one (91) calendar days.
☐ The _____ day (select 1st or 15th) of the month following _____ month(s) (option of 1 or 2 months) of employment.
☒ The 1st day (select 1st or 15th) of the month following 30 days (option of up to 60 days) of employment.
☐ The _____ day of the month following the date of employment.
☐ Other (please specify): _____ **Note:** This may not exceed ninety-one (91) calendar days.
☐ This election applies only to the HMO plan: A full month's premium will be charged for the first (1st) month of coverage for those employees whose Coverage Dates fall between the first (1st) and fifteenth (15th) day of the Premium period. No premium will be charged for the first month of coverage for those employees whose Coverage Dates fall between the sixteenth (16th) day and the end of the Premium Period.

Substantive eligibility criteria.

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

Check all that apply:

☐ An Orientation Period that:

1)Does not exceed one month (calculated by adding one calendar month and subtracting one calendar day from an employee's start date); and
2)If used in conjunction with a waiting period the waiting period begins on the first day after the orientation period.

☐ A Cumulative hours of service requirement that does not exceed 1200 hours

☐ An hours of service per period (or full-time status) requirement for which a Measurement period is used to determine the status of variable-hour employees, where the measurement period:

1)Starts between the employee's date of hire and the first day of the following month;
2)Does not exceed 12 months; and
3)Taken together with other eligibility conditions does not result in coverage becoming effective later than 13 months from the employee's start date plus the number of days between a start date and the first day of the next calendar month (if start day is not the first day of the month).

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

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

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

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

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

   ☐ The 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): _____.

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

   Temporary Layoff: 0 days Disability: Follows rules of IMRF; Employees can also use accrued sick days per terms of contract and be elibigle for up to 365 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.

   In the event of Total Disability at the time the group policy is terminated, an Extension of Benefits will be provided for a period of no more than twelve (12) months from the date of termination, to the extent required, and in accordance, with any applicable federal or state law.

9. For the HMO Plan:

   Total Number of Employees (Please indicate the total number of actual employees, not enrollees):
   Of the Employer: 177 Illinois employees: 177 National employees: _____

10. **FUNDING ARRANGEMENT**

    ☒ Standard Premium – Prospective ☐ Cost Plus Program

11. **STANDARD PREMIUM INFORMATION:**

    The following elections apply to both Grandfathered and Non-Grandfathered Groups:
    Premium Period:
    ☒ The first (1st) day of each calendar month through the last day of each calendar month. (This option applies to all

coverages if the Employer has BlueCare® Dental HMO coverage.)

☐ The _____ day of each calendar month through the _____ day of the next calendar month. (This option is not available for any coverage if the Employer has BlueCare Dental HMO coverage.)

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

(a) **The following elections apply to both Grandfathered and Non-Grandfathered Groups:**

Employer contribution:

☐ One hundred percent (100%) of the Individual Coverage Premium and an amount equal to one hundred percent (100%) of the Individual Coverage Premium will be contributed toward the Family Coverage Premium.

☒ _____% of the Individual Coverage Premium and _____% of the Family Coverage Premium.

☒ Other (please specify): Employer pays 85% for EE and Family coverage for P43670 & P64430. For B01243, Employer pays 90% for EE and Family coverage.

(b) **The following applies to both Grandfathered and Non-Grandfathered Groups:**

HCSC reserves the right to change premium rates when a substantial change occurs in the number or composition of subscribers covered. A substantial change will be deemed to have occurred when the number of subscribers covered changes by ten percent (10%) or more over a thirty (30) day period or twenty five percent (25%) or more over a ninety (90) day period.

(c) **The following applies to Non-Grandfathered Groups:**

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

(d) **The following applies to Grandfathered Groups:**

It is understood that no Policy will be issued or renewed on a contributory basis unless at least 25% of the Eligible Persons, and for Family Coverage 75% of the Eligible Persons with eligible dependents, have enrolled for coverage.

13. Essential Health Benefits ("EHB") Definition Election:

Employer elects EHBs based on the following:

☒ a. EHBs based on a HCSC state benchmark:

☒ Illinois ("IL") ☐ Oklahoma ("OK")
☐ Montana ("MT") ☐ Texas ("TX")
☐ New Mexico ("NM")

☐ b. EHBs based on benchmark of a state other than IL, MT, NM, OK and TX

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

STANDARD PREMIUM RATES ☒ Yes ☐ No						
	For Internal Use Only - BlueStar Ben.Agree#: ***0002*** **P43670-$1500 deductible**	*For Internal Use Only - BlueStar Ben.Agree#:* ***0003*** P64430-HSA	*For Internal Use Only - BlueStar Ben.Agree#:* ***0007*** **BAHMO B01243**	*For Internal Use Only - BlueStar Ben.Agree#:* _____ _____	*For Internal Use Only - BlueStar Ben.Agree#:* _____ _____	**Total**
1. Employee only:	$667.20	$590.28	$573.31	$_____	$_____	$_____
2. Employee plus one Dependent (i.e. Employee plus one spouse or one child):	$_____	$_____	$_____	$_____	$_____	$_____
3. Employee plus two or more Dependents:	$_____	$_____	$_____	$_____	$_____	$_____
4. Employee plus Spouse:	$1,401.12	$1,336.69	$1,108.18	$_____	$_____	$_____
5. Employee plus Child(ren) (i.e. Employee plus one or more children):	$1,267.67	$1,209.37	$1,063.45	$_____	$_____	$_____
6. Employee plus Family / Family:	$2,001.58	$1,909.55	$1,645.35	$_____	$_____	$_____
7. Other: _____	$_____	$_____	$_____	$_____	$_____	$_____
Single Tier Rate structure - Complete item 1.						
Two Tier Rate structure - Complete items 1. and 6.						
Three Tier Rate structure - Complete items 1., 2., and 3.						
Four Tier Rate Structure - Complete items 1., 4., 5., and 6.						
Indicate "N/A" in any rate field that does not apply.						
Medicare Eligible Rates (When HCSC is Secondary Payer)						
Single Coverage:	$533.77	$472.22	$343.98	$_____	$_____	$_____
Family Coverage:	$1,067.55	$944.45	$687.95	$_____	$_____	$_____

COST PLUS PROGRAM
☐ Yes ☒ No

Service Charges:
For the HMO Plan:

a) Service Charges for Claim Payments:
☐ HMO Illinois: _____% of Claim Payments; or $_____ per Enrollee per month for health Claim Payments.
☐ BlueAdvantage® HMO: _____% of Claim Payments; or $_____ per Enrollee per month for health Claim Payments.

b) Physician's Services Fees:
☐ HMO Illinois: $_____ per month per single Enrollee; or $_____ per Month per Enrollee with one or more dependents.
☐ BlueAdvantage® HMO: $_____ Per month per single Enrollee; or $_____ Per Month per Enrollee with one or more dependents.

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

For the Non-HMO Plan:
☐ _____% of Net Claim Payments or $_____ per employee per month.
☐ Applies to all coverage(s).

☐ Different percentage(s) or amount(s) for the following types of coverage. Please specify below:
For _____ Coverage: _____% of _____ Claim Payments or $_____ per employee per month.
For _____ Coverage: _____% of _____ Claim Payments or $_____ per employee per month.
Other (please specify): _____.

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

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

BCC Package (may select one):
☐ Standard
☐ Enhanced
☐ Unbundled
☐ Selective In/Out
☐ Unique Package Design
☐ Stand-Alone

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

BCC Package Upgrade(s):
☐ Description: _____
☐ Fee: $ _____ per covered employee per month for administration of the package upgrade.

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

Ancillary Program:
☐ Health Dialog **(may select one)**
- ☐ Health Coach Line (In bound)
- ☐ Health Coach Line (In and out bound)
- ☐ Health Coach Line (With Disease Management)
- ☐ Not applicable

Health Dialog Fee: $_____ per covered employee per month

☐ 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): _____

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

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

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

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

Prescription Drug Program:

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

☐ PPO (If selected, the PBM Fee Schedule Exhibit must be attached and is part of this BPA.)

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

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

PPO Pharmacy Network (Select one):

☐ Advantage Network

☐ Preferred Network

☐ Network shown on PBM Fee Schedule Exhibit

PPO Drug List: Select Drug List

Other (please specify): _____

Prescription Drug Program Clinical Management Programs

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

Termination Administrative Charge

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

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

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

Termination Administrative Charges assume the continuation of the Policy benefit program(s) and the administrative services in effect prior to termination. Should such Policy benefit program(s) and/or administrative services change, or in the event the average Policy enrollment during the three (3) months immediately preceding termination varies by ten percent (10%) or more from the enrollment used to determine the service charges in effect at the time of termination, the Plan reserves the right to adjust the rates for service charges (including, but not limited to, access fees) to be used to compute the Termination Administrative Charge.

FOR NON-HMO COST-PLUS PROGRAMS ONLY:

PLAN PROVIDER ACCESS FEE(S)

☐ Yes ☒ No

Group Number(s): _____

☐% of ADP Savings: _____%

☐ $ Per Employee per Month: $_____

Please complete for groups with multiple products (for example, Comprehensive Major Medical and PPO) with separate access fees:

Group Number(s): _____

☐% of ADP Savings: _____%

☐ $ Per Employee per Month: $_____

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

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

The undersigned representative acknowledges that any 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.

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

OTHER PROVISIONS:

(a) Reimbursement 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 twenty five (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

(b) Summary of Benefits and Coverage ("SBC"): The SBC Addendum is attached and made a part of the Policy. BCBSIL will create SBC (only for benefits BCBSIL insures under the Contract) and provide SBC to the Employer in electronic format. If the Employer approves of the content, Employer will then distribute 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. The Plan will create SBC (only for benefits the Plan insures under the Policy) and distribute SBC to participants and beneficiaries via regular hardcopy mail or electronically in response to occasional requests received directly from individuals. All other distribution is the responsibility of the Policyholder.

(c) BlueEdge FSA (Vendor: **HSA Bank**) purchased: ☐ Yes ☒ No

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

(e) Dearborn National Life Insurance purchased: ☐ Yes ☒ No (If yes, complete separate application.)

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

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

(h) 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.

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

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

☐ Decline – Employer does not consent to receive electronic versions of Certificate Booklets and SBC's for covered Employees or the Contract and desires BCBSIL to print and distribute hard copy versions.
Authorized Company Official's Initials: _____ Date: _____

(j) 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.

(k) ☒ Wellbeing Management

ADDITIONAL PROVISIONS:

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

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

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

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

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

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

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

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

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

Katie Fox
Sales Representative
890
District
Adriana Duenas
Producer Representative

Signature of Producer Representative
Mesirow Financial
Producer Firm

Domingo F. Vargas
Signature of Authorized Purchaser
MAYOR
Title
9/26/18
Date
Witness

353 North Clark Street, Suite 1100
Chicago, Illinois 60654

Producer Address

$_____ Amount Submitted

Producer Number

36-3429604

Producer Tax ID No.

PROXY

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

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

Group No(s): P43670, P64430 B01243

By: DOMINGO F. VARGAS
Print Signer's Name Here

Signature and Title

Group Name: City of Blue Island

Address: 13051 South Greenwood Avenue

City: Blue Island State: IL Zip Code: 60406

Dated this 25th day of SEPTEMBER 2018
Month Year