COUNTY OF KANE

Christopher J. Lauzen
Kane County Board Chairman

Kane County Government Center
719 South Batavia Avenue
Geneva, IL 60134
P: (630) 232-5930
F: (630) 232-9188
clauzen@kanecoboard.org
www.countyofkane.org

DOCUMENT VET SHEET
for
Christopher J. Lauzen
Chairman, Kane County Board

Name of Document: Benefit Program Application Resolution No.: 13-338

Submitted by: Sheila McCraven Dept. Head Signature: Sheila T McCraven

Date Submitted: December 12, 2013 Dept. Head Sign-off Date: 12/12/13

Examined by: Joseph LuLves
(Print name)
Joseph F. Lulves
(Signature)
12-12-13
(Date)

Post on the Web: YES ✓ NO _____ Atty. Initials VFL

Comments:
Document reviewed by Laurence Marx at Global Benefits, the County's health insurance broker.

Chairman signed: YES ✓ NO _____ 12/13/2013
(Date)

Document returned to: McCraven.
(Name/Department)

Rev. 05/2013

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: 014425

HMO Illinois Employer Group Number(s): H01737

HMO Illinois Section Number(s): 0100, 0200, 0300, 0400, 0600, 0700, 0800, 8888

BlueAdvantage® HMO Employer Group Number(s): B03214

BlueAdvantage® HMO Section Number(s): 0100, 0200, 0300, 0400, 0600, 0700, 0800, 8888

Non-HMO Plan Employer Group Number(s): P77122

Non-HMO Plan Section Number(s): 0100, 0200, 0300, 0400, 0600, 0700, 0800, 8888

Employer Name: Kane County

(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: 719 Batavia Avenue City: Geneva State: IL Zip Code: 60134

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

Employer Identification Number ("EIN"): 36-6006585

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: Sheila McCraven Phone: 630.232.5932 Fax: 630.208.0116 Email: mccravensheila@co.kane.il.us

Blue Access for Employers (BAE) Contact: Sheila McCraven

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

Title: Executive Director Phone: 630.232.5932 Fax: 630.208.0116 Email: mccravensheila@co.kane.il.us

Policy Effective Date: 01/01/2014 Policy Anniversary Date: 01/01/2015

ERISA Plan: ☐ Yes ☒ No If Yes, specify ERISA Plan Year: N/A

ERISA Plan Administrator: N/A

ERISA Plan Administrator's Address: N/A

City: N/A State: N/A Zip Code: N/A

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): Regular part-time employees who work at least 21 hours per week. Active Elected County Officials and County Board members .

Full-Time Employee means:

☒ A person who is regularly scheduled to work a minimum of 35 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: Qualified Retirees receiving IMRF pension.

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 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

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

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

(a) ☐ The 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) ☐ The 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. (twenty-seven (27) – thirty (30) are the available options.) If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

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

☐ 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. 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 61st 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): Date of hire for newly elected county board members and elected officials .

☐ 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.

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.

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

7. 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): _____.

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

   Temporary Layoff: 180 days Disability: 180 days Leave of Absence: 180 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.

9. For the HMO Plan:

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

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: 83% of the Individual Coverage Premium and 83% of Family Coverage Premium.
☒ BlueAdvantage® HMO: 83% of the Individual Coverage Premium and 83% of the Family Coverage Premium.
☐ Other (please specify): _____.

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.
☒ 83% of the Individual Coverage Premium and 83% 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 _____% of the Eligible Persons and, for Family Coverage, _____% of the Eligible Persons with eligible dependents have enrolled for coverage.

STANDARD PREMIUM RATES ☐ Yes ☒ No						
	For Internal Use Only - BlueStar Ben.Agree#: ____ **HMO Illinois** ____	*For Internal Use Only - BlueStar Ben.Agree#:* ____ **Blue Advantage® HMO** ____	*For Internal Use Only - BlueStar Ben.Agree#:* ____ **Non-HMO Health Coverage:** ____	*For Internal Use Only - BlueStar Ben.Agree#:* ____ **Non-HMO Health Coverage:** ____	*For Internal Use Only - BlueStar Ben.Agree#:* ____ **Non-HMO Dental Coverage:** ____	**Total**
1. Employee only:	$	$	$	$	$	$
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:	$	$	$	$	$	$
5. Employee plus Child(ren) (i.e. Employee plus one or more children):	$	$	$	$	$	$
6. Employee plus Family / Family:	$	$	$	$	$	$
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:	$	$	$	$		$
Family Coverage:	$	$	$	$		$

COST PLUS PROGRAM

☒ Yes ☐ No

Service Charges:
For the HMO Plan:

a) Service Charges for Claim Payments:

☐ HMO Illinois: _____% of Claim Payments; or $45.59 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: $146.76 per month per single Enrollee; or $407.17 per Month per Enrollee with one or more dependents.
☒ BlueAdvantage® HMO: $146.76 Per month per single Enrollee; or $407.17 Per Month per Enrollee with one or more dependents.

For the Non-HMO Plan:

☒ _____% of Net Claim Payments or $45.59 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") 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): _____

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: $12.84 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): P77122
☒ % of ADP Savings: 0.63%
☐ $ 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 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 any recovered amounts (under cost-plus funding) or deduct 25% of any recovered amounts from the amount credited to the group's experience (under premium funding), other than recovery amounts received as a result of, or associated with, any Workers' Compensation Law.

(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) Dearborn National 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:

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

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

C. Policyholder shall indemnify and hold harmless HCSC and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) or other costs or obligations resulting from or arising out of any claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought or asserted against HCSC in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any directions, actions and interpretations of the Policyholder, (d) any provision of inaccurate information, and/or (e) the SBC. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

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

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 Benefit Program Application 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).

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

Summary of Benefits & Coverage:

1). BCBSIL will create Summary of Benefits & Coverage (SBC)?

☒ Yes. If yes, please answer question #2. The SBC Addendum is attached.

☐ No. If No, then the Policyholder acknowledges and agrees that the Policyholder is responsible for the creation and distribution of the SBC as required by Section 2715 of the Public Health Service Act (42 USC 300gg-15) and SBC regulations (45 CFR 147.200), as supplemented and amended from time to time, and that in no event will BCBSIL have any responsibility or obligation with respect to the SBC. BCBSIL may, but is not required to, monitor Policyholder's performance of its SBC obligations, audit the Policyholder with respect to the SBC, request and receive information, documents and assurances from Policyholder with respect to the SBC, provide its own SBC (or SBC corrections) to participants and beneficiaries, communicate with participants and beneficiaries regarding the SBC, respond to SBC-related inquiries from participants and beneficiaries, and/or take steps to avoid or correct potential violations of applicable laws or regulations. BCBSIL is not obligated to respond to or forward misrouted calls, but may, at its option, provide participants and beneficiaries with Policyholder's contact information. A new clause (e) is added to Subsection C. in the Additional Provisions as follows: "(e) the SBC". (Skip question #2.)

2). BCBSIL will distribute Summary of Benefits & Coverage (SBC) to participants and beneficiaries?

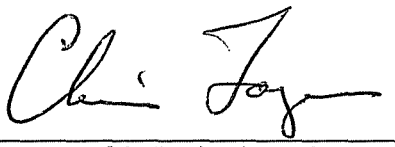
☒ No. BCBSIL will create SBC (only for benefits BCBSIL insures under the Policy) and provide SBC to the Policyholder in electronic format. Policyholder will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law.

☐ Yes. BCBSIL will create SBC (only for benefits BCBSIL 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.

01/01/2014- Plan is moving to Cost Plus funding. Group is Non Grandfathered all state and federal mandates apply.
Effective 1/1/12014 the following changes will apply
PPO
Deductible to $750 (3X Family)
$2750 Out of Pocket Maximum (3 X Family) In Network
Deductible included in OPM

PPO & HMO
$30 General & $50 Specialist OV Copays (both plans)
HMO Rx $10/$40/$60
HMO Allocated Taxes and Fees = $19.16 PEPM
HMO Managed care fee = $8.67 PEPM

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

Tisha Kosarek	
Sales Representative	Signature of Authorized Purchaser
822	
District	Title
Kurt Schmitke	
Producer Representative	Date
Signature of Producer Representative	Witness
Global Benefits, Inc	
Producer Firm	
1512 Artaius Pkwy, Libertyville IL 60048	
Producer Address	$_____ Amount Submitted
36-4254547	
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(s).: H01737; B03214; P77122

By: _____

Print Signer's Name Here

➡ _____

Signature and Title

Group Name: Kane County

Address: 719 Batavia Avenue

City: Geneva State: IL Zip Code: 60134

Dated this _____ day of _____, 2013

Month Year

Summary of Benefits and Coverage Addendum
To Benefit Program Application

Employer Name: Kane County | Account Number: 014425

Effective/ Renewal Date: 1/1/2014 | First Date of Employer's Open Enrollment Period for the next Plan Year (the "First Open Enrollment Date"): 11/1/2013

The Affordable Care Act ("ACA") requires group health plans and/or insurance issuers to create and distribute a Summary of Benefits and Coverage (or alternate format permitted by ACA) (the "SBC"), to participants and beneficiaries in certain specified situations (the "SBC Requirements"). In accordance with the Policyholder's election on the most current BPA, to have Blue Cross and Blue Shield of Illinois (BCBSIL) create and/or distribute the SBC, as of the First Open Enrollment Date, Policyholder acknowledges and agrees:

1. BCBSIL's SBC services do not include the creation or distribution of coverage information for benefits it does not insure under the Policy, unless otherwise agreed to in the BPA or this Addendum.

2. Policyholder is responsible for the proper synthesizing of information from its various insurers and administrative service providers it uses for its group health plan (or providing multiple partial SBCs if permitted by law).

3. The Policyholder is responsible for SBC services performed by Policyholder's third party vendors.

4. The Policyholder must review and approve the SBC prior to distribution and is responsible for the content of the SBC. Nothing in this Addendum or in the Policy relieves the Policyholder or its group health plan of their respective legal and regulatory obligations with respect to the SBC.

5. ACA and the SBC regulatory and sub-regulatory guidance (the "Guidance") are new (and subject to change) and the regulatory agencies and industry interpretations thereof are evolving; therefore, BCBSIL's operations shall not be considered to be in breach of this Addendum or the Policy to the extent BCBSIL has worked diligently and in good faith to provide the SBC services, based on a reasonable interpretation of then-current SBC-related ACA provisions and Guidance, in a manner consistent with the SBC Requirements.

6. Policyholder agrees to furnish to BCBSIL in a timely manner all information necessary for the timely distribution of SBCs, including but not limited to names and addresses for: (i) any person currently enrolled in any plan administered or insured by BCBSIL, and (ii) any person the employer tells us is eligible or may become eligible. Policyholder's failure to furnish such information, to agree to an implementation plan or to promptly review/approve SBCs may substantially delay and/or jeopardize BCBSIL's SBC services and BCBSIL is relieved of its SBC obligations.

7. BCBSIL may, but is not required to, monitor Policyholder's performance of its SBC obligations, audit the Policyholder with respect to the SBC, request and receive information, documents and assurances from Policyholder with respect to the SBC, provide its own SBC (or SBC corrections) to participants and beneficiaries, communicate with participants and beneficiaries regarding the SBC, respond to SBC-related inquiries from participants and beneficiaries, and/or take steps to avoid or correct potential violations of applicable laws or regulations.). Policyholder will notify BCBSIL of any actual or potential non-compliance with the SBC Requirements.

8. Policyholder 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 the SBC (and Policyholder's or its vendors' distribution of the SBC).

BlueCross BlueShield of Illinois

APPLICATION FOR EXCESS LOSS COVERAGE
(HMO Cost-Plus Accounts Only)

Customer Number: 014425
Employer Group Name: Kane County
Employer Group Address: 719 Batavia Avenue,
Geneva IL 60134
Employer Group Number(s): H01737, B03214
Effective Date of Policy: 1/1/14

Is this a Unified group (HMO Excess Loss Coverage and Indemnity Excess Loss Coverage)?

☒ Yes ☐ No

If yes, complete separate HMO and Indemnity Excess Loss Coverage Applications.

Aggregate Excess Loss Coverage: ☒ Yes ☐ No

If yes, complete items 1 through 8 below.

1. Excess Loss Coverage Period:

   From 01/01/2014 to 01/01/2015

2. Aggregate Excess Loss Coverage shall apply to:

   ☒ HMO Claims (not including fixed amounts paid to Participating IPAs)

   ☐ ____

3. Average Claim Value: $487.84 (per employee).

4. Attachment Point: 115% of the Average Claim Value.

5. Aggregate Excess Loss Limit Claim Value: $561.02
   (equals the Average Claim Value multiplied by the Attachment Point)

6. Aggregate Excess Loss Coverage Limit:

   The Aggregate Excess Loss Coverage Limit shall equal the average number of employees during the Excess Loss Coverage Period multiplied by the Aggregate Excess Loss Limit Claim Value. In no event shall the Aggregate Excess Loss Coverage Limit be less than $4,005,650, as specified in Section III of the Policy.

7. Excess Loss Premium

   ☐ Monthly: $ each month

   ☒ Annual (Due on the Effective Date of Policy): $5,922.00

8. The premium is based upon a current membership of 230 Individual Coverage Units and 365 Family Coverage Units.

Individual Excess Loss Coverage: ☒ Yes ☐ No

If yes, complete items 1 through 5 below.

1. Excess Loss Coverage Period:

   From 01/01/2014 to 01/01/2015

2. Individual Excess Loss Coverage shall apply to:

   ☒ HMO Claims (not including fixed amounts paid to Participating IPAs)

   ☐

3. Individual Excess Loss Coverage Limit: $205,000 per Covered Person during the Excess Loss Coverage Period

4. Excess Loss Premium (select one):

   ☒ Monthly: $ each month **or** $21.45 per Enrollee each month

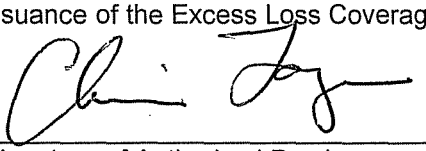
   ☐ Annual (Due on the Effective Date of Policy): $

5. The premium is based upon a current membership of 230 Individual Coverage Units and 365 Family Coverage Units.

Additional Provisions:

01/01/2014 Kane County moving to Unified Cost Plus Funding; including Stop Loss policy

The undersigned person represents that he/she is authorized and responsible for purchasing excess loss coverage on behalf of the Employer Group. It is understood that the actual terms and conditions of coverage are those contained in this Application and the Excess Loss Coverage Policy into which this Application for Excess Loss Coverage shall be incorporated at the time of 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 an Excess Loss Coverage Policy to the Employer Group. Upon acceptance of this Application and issuance of the Excess Loss Coverage Policy, the Employer Group shall be referred to as "The Policyholder."

Tisha Kosarek	
Sales Representative	Signature of Authorized Purchaser
David Whitman	
Printed Name of Underwriter	Title of Authorized Purchaser
Signature of Underwriter	Date

BlueCross BlueShield of Illinois

APPLICATION FOR EXCESS LOSS COVERAGE
(Cost-Plus Accounts Only)

Employer Group Name: Kane County
Employer Group Address: 719 Batavia Avenue, Geneva, IL. 60134

Account Number: 014425
Employer Group Number(s): P77122
Effective Date of Policy: 1/1/14

Is this a Unified group (Indemnity Excess Loss Coverage and HMO Excess Loss Coverage)? ☒ Yes ☐ No
If yes, please complete separate Indemnity and HMO Excess Loss Coverage Applications.

Aggregate Excess Loss Coverage: ☒ Yes ☐ No
If yes, complete items 1 through 9 below.

1. ☒ New Coverage ☐ Renewal of Existing Coverage
2. Excess Loss Coverage Period:
   - ☒ New Coverage (Select one from below):
     - ☐ Standard: Claims incurred and paid from: _____ to _____
     - ☒ "Run-in" included: Claims incurred from: 01/01/2013 and paid on or after the Effective Date of Policy to: 01/01/2015
   - ☐ Renewal of Existing Coverage:

     Claims incurred on or after the effective date of the administration of the Group Policy by the Plan (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid on or after the Effective Date of Policy to: _____
3. Aggregate Excess Loss Coverage shall apply to:
   - ☒ Medical Claims ☐ Vision Claims
   - ☒ Outpatient Prescription Drug Claims ☐ Dental Claims (Pre-Dent)
   - ☐ For Hospital Employer Groups only: *Excludes* _____% of Home Hospital Medical claims
   - ☐ Other (please specify): _____
4. Average Claim Value: $1039.48 (per employee).
   - ☒ Includes Plan's Provider Access Fee ☐ Excludes Plan's Provider Access Fee
5. Attachment Point: 115% of the Average Claim Value.
6. Aggregate Excess Loss Limit Claim Value: $1195.40

(equals the Average Claim Value multiplied by the Attachment Point)

7. Aggregate Excess Loss Coverage Limit:

   The Aggregate Excess Loss Coverage Limit shall equal the average number of employees during the Excess Loss Coverage Period multiplied by the Aggregate Excess Loss Limit Claim Value. In no event shall the Aggregate Excess Loss Coverage Limit be less than $7,681,485 as specified in Section III of the Policy.

8. Annual Premium

   (Due on the Effective Date of Policy): $11,355

9. The annual premium is based upon a current membership of 196 Individual Coverage Units and 343 Family Coverage Units.

Individual Excess Loss Coverage: ☒ Yes ☐ No

If yes, complete items 1 through 6 below.

1. ☒ New Coverage ☐ Renewal of Existing Coverage
2. Excess Loss Coverage Period:

   ☒ New Coverage (Select one from below):

   ☐ Standard: Claims incurred and paid from: _____ to: _____

   ☒ "Run-in"included: Claims incurred from: 01/01/2013 and paid on or after the Effective Date of Policy to: 01/01/2015

   ☐ Renewal of Existing Coverage:

   Claims incurred on or after the effective date of the administration of the Group Policy by the Plan (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid on or after the Effective Date of Policy to: _____.

3. Individual Excess Loss Coverage shall apply to:

   ☒ Medical Claims ☐ Vision Claims

   ☒ Outpatient Prescription Drug Claims ☐ Dental Claims (Pre-Dent)

   ☐ For Hospital Employer Groups only: *Excludes* _____% of Home Hospital Medical claims

   ☐ Other (please specify): _____

4. Individual Excess Loss Coverage Limit: $_____

   ☒ Includes Plan's Provider Access Fee ☐ Excludes Plan's Provider Access Fee

5. Premium (select one):

   ☒ Monthly: $_____ each month **or** $49.05 per employee each month.

   ☐ Annual: $_____

6. The premium is based upon a current membership of 196 Individual Coverage Units and 343 Family Coverage Units.

Additional Provisions:

01/01/14 renewal moving to Unified Cost Plus Funding; Purchasing Stop Loss Coverage

The undersigned person represents that he/she is authorized and responsible for purchasing excess loss coverage on behalf of the Employer Group. It is understood that the actual terms and conditions of coverage are those contained in this Application and the Excess Loss Coverage Policy into which this Application for Excess Loss Coverage shall be incorporated at the time of 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 Excess Loss Coverage

Policy to the Employer Group. Upon acceptance of this Application and issuance of the Excess Loss Coverage Policy, the Employer Group shall be referred to as the "The Policyholder."

Tisha Kosarek

Sales Representative

David Whitman

Name of Underwriter

Signature of Authorized Purchaser

Title of Authorized Purchaser

Date

	UNDERWRITING AUTHORIZATION
INTERNAL USE ONLY	Date Application approved by Underwriting: _____ Signature of Underwriter: _____