VILLAGE OF DOWNERS GROVE
REPORT FOR THE VILLAGE COUNCIL MEETING
OCTOBER 8, 2013 AGENDA

SUBJECT:	TYPE:	SUBMITTED BY:
Employee Benefits Renewal Contracts and Medical Plan Amendments for FY2014	✓ Resolution Ordinance Motion Discussion Only	Dennis Burke Director of Human Resources

SYNOPSIS
Resolutions have been prepared to authorize approval of employee benefits renewal contracts and plan amendments for 2014.

STRATEGIC PLAN ALIGNMENT
The goals for 2011-2018 included *Steward of Financial Sustainability*.

FISCAL IMPACT
The FY14 health insurance budget includes $965,000 for claims administration and stop loss contracts. The vendors and contract amounts for FY2013 and FY2014 are itemized below:

Vendor	Contract Item	FY2013 Amount	FY2014 Amount
Blue Cross/Blue Shield	Medical Claim Administration	$311,992	$309,707
Blue Cross/Blue Shield	Specific and Aggregate Stop Loss	$400,086	$328,054
Delta Dental	Dental Program Claim Administration	$18,734	$19,522
TruAssure	Vision Program Claim Administration	$45,000	$44,271
Subtotal		**$775,812**	**$701,554**
Humana – Retiree Premiums	Medicare Advantage Program for Retirees over 65 (new contract in 2014–explained below)	N/A	$206,856
Total			**$908,410**

RECOMMENDATION
Approval on the October 8, 2013 consent agenda.

BACKGROUND
The recommended contracts provide the necessary administration and support for the Village's Health Insurance program, which has a total budget of $6.8 million as shown in the FY2014 Recommended Budget. The budget also describes how the Village has positioned itself well to effectively control health insurance costs and respond to the requirements of the Patient Protection Affordable Care Act.

A summary of the 2014 employee benefits contracts is provided below:

- *Medical Claim Administration* – The Village has a self-funded medical plan and contracts with an outside vendor to provide claim administration on behalf of the Village. Claim administration includes medical and prescription drug claim adjudication, pre-certification and medical case management services. On an annual basis, staff reviews the claim administration services received from the vendor. Also reviewed is the relationship the vendor has with preferred provider organizations (PPO) to ensure the discounts received through the PPO contracts are cost effective to both the employee and the Village. The Village has contracted with Blue Cross/Blue Shield of

Illinois for these services since 2011. Blue Cross has provided a renewal quote for 2014 for claims administration at $45.61 per employee/per month. Blue Cross also charges a fee to access their PPO network and for 2014 this fee is estimated at $89,685. This fee is offset by the significant savings the Village realizes through the Blue Cross PPO discounts. Total annual costs for medical claims administration for 2014 which includes the PPO access fee are $309,707.

- *Stop Loss Coverage* - The Village purchases stop loss coverage to limit its financial exposure. Stop loss coverage provides insurance for catastrophic medical claims of participants in the Village's group health care plan. There are two types of stop loss coverage, specific and aggregate. Specific stop loss insurance provides a point at which time the insurance company becomes responsible for any claims after an individual insured reaches a pre-determined limit in the contract year. As part of the annual review, staff directs the Village's consultant, the Horton Group, to recommend to the Village the most appropriate attachment point for specific stop loss coverage. The consultant reviews specific claim data on the Village's group and determines if it is cost effective for the Village to take on additional claim exposure. For 2014 the consultant determined that the Village should remain at the current $150,000 specific stop loss level. The Village does obtain alternative quotes on stop loss coverage on an annual basis. Blue Cross's quote for stop loss totals $328,054 annually.

- Dental – The Village provides employees a dental program administered by Delta Dental Plan of Illinois. Under this program, employees utilize PPO network providers where services are received at discounted rates and benefits are primarily paid in full. Employees also have the flexibility of going out-of-network; however, they would receive coverage that is less comprehensive. Fees for administration of the Delta Dental program for 2014 are $19,522.

- Vision - The Village obtains it vision coverage from TruAssure (a subsidiary of Delta Dental Plan of Illinois and is included in the same contract with Delta Dental) for vision services. Employees use providers within the EyeMed PPO network and by doing so pay a modest co-payment or receive discounted rates on various services. Employees also have the flexibility to go outside of the EyeMed network, but by doing so, receive a less comprehensive benefit. Premium costs for 2014 did not change and total costs for 2014 are estimated to be $44,271.

- *Humana Retiree Premiums* – Medicare Advantage Program for Retirees Over 65 – State law requires that the Village offer health insurance to retirees which the Village does currently through the Blue Cross policy. Retirees who select to continue and pay for coverage through the Village's Health Insurance Plan are required to enroll in Medicare as primary insurance provider once they reach Medicare-eligible age, but are then also eligible to continue on the Village's Health Insurance plan as secondary coverage. Currently all retirees pay the full premium for coverage under the Village's plan; however, employees who retired before September 2009 were eligible for a 50% premium discount once they reached Medicare age. Currently, there are 51 retirees on the Village plan who are over the age of 65. This year the Village's broker (Horton Group) submitted a fully insured carve-out plan for retirees over 65 through Humana. The premium for each retiree is $338 per month which is significantly lower then any of the Village's plans. Additionally, the prescription plan is enhanced and there is no deductible. This change will save the Village's self-insured Health Plan an estimated $150,000 annually in premiums while still providing quality health insurance coverage to retirees. Total anticipated costs for this program are $206,856 annually.

ATTACHMENTS
Contract Documents
Resolutions

RESOLUTION NO. ____

A RESOLUTION AUTHORIZING EXECUTION OF AN AGREEMENT BETWEEN THE VILLAGE OF DOWNERS GROVE AND BLUE CROSS/BLUE SHIELD OF ILLINOIS

BE IT RESOLVED by the Village Council of the Village of Downers Grove, DuPage County, Illinois, as follows:

1. That the form and substance of a certain Administrative Services and Claim Administrator Agreement (the "Agreement"), between the Village of Downers Grove (the "Employer") and Blue Cross/Blue Shield of Illinois (the "Claim Administrator"), for medical claim administration services, effective January 1, 2014 through December 31, 2014, as set forth in the form of the Agreement submitted to this meeting with the recommendation of the Village Manager, is hereby approved.

2. That the Village Manager and Village Clerk are hereby respectively authorized and directed for and on behalf of the Village to execute, attest, seal and deliver the Agreement, substantially in the form approved in the foregoing paragraph of this Resolution, together with such changes as the Manager shall deem necessary.

3. That the proper officials, agents and employees of the Village are hereby authorized and directed to take such further action as they may deem necessary or appropriate to perform all obligations and commitments of the Village in accordance with the provisions of the Agreement.

4. That all resolutions or parts of resolutions in conflict with the provisions of this Resolution are hereby repealed.

5. That this Resolution shall be in full force and effect from and after its passage as provided by law.

_____
Mayor

Passed:
Attest: _____
Village Clerk

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ASO

Benefit Program Application ("ASO BPA")

Applicable to Administrative Services Only (ASO) Group Accounts

administered by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, hereinafter referred to as "Claim Administrator" or "HCSC"

Group Status: Renewing ASO Account

If former HCSC Insured Group converting to ASO, on what basis? Not applicable

Employer Account Number (6-digits): 365058

Group Number(s): P65059, P65060, P65061

Section Number(s): 0100,0102,0103,0200,0202,0203,0300,0302,0303,0400,0402,0403,0500,0502,0503,0600,0602,0603,0700,0702,0703,0800,0802,0803,0902,0903,8881,8882,8883,8884,8885,8886,8887,8888

Legal Employer Name: Village of Downers Grove

(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.)

ERISA Regulated Group Health* Plan: ☐ Yes ☒ No

If Yes, is your ERISA Plan Year a period of 12 months beginning on the Anniversary Date specified below? ☐Yes ☐ No
If no, please specify your ERISA Plan Year*: Beginning Date __/__/__ End Date __/__/__ (month/day/year)

ERISA Plan Administrator*: N/A

Plan Administrator's Address:

If you maintain that ERISA is not applicable to your group health plan, please give legal reason for exemption:
Select legal reason ; if applicable, specify other: _____

Is your Non-ERISA Plan Year a period of 12 months beginning on the Anniversary Date specified below? ☐Yes ☐No
If no, please specify your Non-ERISA Plan Year: Beginning Date __/__/__ End Date __/__/__ (month/day/year)

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

Effective Date of Coverage: 01/01/2014

Anniversary Date: Month/Year 01 / 2015

ACCOUNT INFORMATION

☒ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

Standard Industry Code (SIC): 9111

Employer Identification Number (EIN): 366005857

Address: 801 Burlington Avenue

City: Downers Grove

State: IL

Zip: 60515

Administrative Contact: Dennis Burke

Title: Human Resource Director

Email Address: dburke@downers.us

Phone Number: 630-434-5537

Fax Number: 630-434-5484

Subsidiaries: N/A

Affiliated Companies: n/a

(If Affiliated Companies listed above are to be covered, 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 Benefit Program Application.)

Blue Access for Employers (BAE) Contact: Mary Weisenburn

(The BAE Contact is the Employee of the Account authorized by the Employer to access and maintain its account in BAE.)

Email Address: mweisenburn@downers.us

Fax Number: 630-434-5484

Phone Number: 630-434-5538

SCHEDULE OF ELIGIBILITY

☐ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

1. Eligible Person means:
   - ☒ A full-time employee of the Employer.
   - ☐ A full-time employee who is a member of: *(name of union)*
   - ☒ Other: Retiree

2. 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: Other: Part-Time employees budgeted to work 1000 hours or more per year

3. The Effective Date of termination for a person who ceases to meet the definition of Eligible Person:
   - ☐ The date such person ceases to meet the definition of Eligible Person.
   - ☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
   - ☐ Other:

4. Civil Union Partners covered:
   - i. ☒Yes. Check "Yes" if Employer is an Illinois county, municipality, the State of Illinois, subject to the Illinois School Code, a church plan or other non-ERISA plan. For such Employers, 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 Employer's Plan. Skip to item 5 below.
   - ii. For all other Employers, ☐Yes ☐ No

   If yes: A Civil Union Partner and his or her dependents are eligible to enroll for coverage.

   If yes, are Civil Union Partners and his or her dependents eligible for continuation of coverage? ☐ Yes ☐ No

   The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for Civil Union Partners.

5. Domestic Partners covered: ☐ Yes ☒ No (skip to Question 6)

   If yes: A Domestic Partner is eligible to enroll for coverage.

   If yes, are Domestic Partners eligible for continuation of coverage? ☐ Yes ☐ No

   If yes, are dependents of Domestic Partners eligible to enroll for coverage? ☐ Yes ☐ No

   If yes, are dependents of Domestic Partners eligible for continuation of coverage? ☐ Yes ☐ No

   The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for Domestic Partners.

6. The Limiting Age for covered children is **Twenty-six (26) years,** regardless of presence or absence of a child's financial dependency, residency, student status, employment, marital status or any combination of those factors.

   If Employer is an Illinois county, municipality, the State of Illinois, or subject to the Illinois School Code, this Limiting Age is extended to **thirty (30) years**, for unmarried eligible military personnel as described in the Employer's Plan.

   To cover dependent children age twenty-six (26) and over other than unmarried eligible military personnel described above, you may select and complete option i. or ii. below:

   - i. ☐ The Limiting Age for covered children age twenty-six (26) or over,
     - ☐ who are unmarried
     - ☐ regardless of marital status,

     is _____ years. (Twenty-seven (27) through thirty (30) are the available options.)
   - ii. ☐ The Limiting Age for covered children **who are full-time students** and age twenty-six (26) or over,
     - ☐ who are unmarried
     - ☐ regardless of marital status,

     is _____ years (Twenty-seven (27) through thirty (30) are the available options.)

   Coverage based on the Limiting Age(s) elected above terminates on:
   - ☐ The birthday on which the Limiting Age is reached.
   - ☒ The last day of the calendar month in which the Limiting Age is reached.

However, such coverage shall be extended in accordance with any applicable federal or state law.

7. **Select an effective date rule for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan** (The effective date must not exceed 90 calendar days from the date that a newly eligible person becomes eligible for coverage, unless otherwise permitted by applicable law.)

   ☐ The date of employment.
   ☐ The day of employment.
   ☒ The 1st day of the month following 1 month(s) of employment.
   ☐ The day of the month following days of employment.
   ☐ The day of the month following the date of employment.
   ☐ Other:

8. Enrollment:

   Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a qualifying 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 the effective date of the qualifying event or, in the event of Special Enrollment due to termination of previous coverage, the date of application of coverage. In the case of a qualifying 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.

   Late Enrollment: 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. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer.

   Open Enrollment: ☒ Yes ☐ No

   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 Open Enrollment Period.

   - Specify Open Enrollment Period: November 15th to December 15th for a January 1st effective date

   Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer. Such date shall be subsequent to the Open Enrollment Period.

9. Will extension of benefits due to temporary layoff, disability or leave of absence apply? ☒ Yes (specify number of days below) ☐ No (skip to question 10)

   Temporary Layoff: 365 days Disability: 365 days Leave of Absence: 365 days

   However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law.

10. ** Does COBRA Auto Cancel apply? ☒ Yes ☐ No

    Member's COBRA/Continuation of Coverage will be automatically cancelled at the end of the member's eligibility period.

    *** Not recommended for accounts with automated eligibility.*

LINES OF BUSINESS **(Check all applicable products)** ☒ **NO CHANGES** ☐ ***See Additional Comments***
Managed Care Coverage:
☒ Participating Provider Option (PPO)
☐ Point of Service (POS) (BlueChoice)
☐ BlueChoice Select
☐ Comprehensive Major Medical
☐ Base Plus
Consumer Driven Health Plan: ☐ Health Care Account (HCA) Administrative Services *(if purchased, complete separate HCA BPA)* ☐ BlueEdge FSA (Vendor: ConnectYourCare)
Outpatient Prescription Drugs: ☒ Outpatient Prescription Drug Program ☐ Covered under the medical benefit
☐ **Dental Coverage** ☒ **Blue Care Connection®** ☒ **Stop Loss** *(if purchased, complete separate Exhibit to the Stop Loss Coverage Policy)* ☐ **Dearborn National Life Insurance** *(if purchased, complete separate Life application)* ☐ **HCSC COBRA Administrative Services** *(if purchased, complete separate COBRA Administrative Services Addendum to the BPA)* ☐ **Blue Directions** (Private Exchange)

Additional Comments: _____

FEE SCHEDULE

Payment Specifications

☒ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

Employer Payment Method: ☐ **Online Bill Pay** ☐ **Electronic** ☒ **Check**

Employer Payment Period: ☐ **Weekly** (cannot be selected if Check is selected as payment method above)
☐ **Twice-Monthly**
☒ **Monthly**
☐ **Other** (please specify)

Claim Settlement Period: ☒ **Monthly** ☐ **Other** (please specify)

Run-Off Period: Employer Payments are to be made for **12** months following end of Fee Schedule Period.
Standard is twelve (12) months.

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

Fee Schedule Period

To begin on Effective Date of Coverage and continue for:
☒ 12 Months ☐ Other (please specify): Months

Administrative Charge(s)

☐ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

☒ Applies to all coverages
☐ Different percentage(s) or amount(s) for the following types of coverages. Please specify:

Subscriber Share Methodology for Illinois Network Provider Claims Applies*:* ☒ Yes ☐ No
(If no, a letter declining Subscriber Share Methodology for Claims processing must be attached to this Benefit Program Application.)

Administrative Charge Chart:
Each column can be used to differentiate rates between product types or employee tiers. All columns do not need to be used. All fees listed are per employee per month.

Administrative Per Employee per Month (PEPM) Charges

Product / Service	**MEDICAL**			
Administrative Fee	**$57.89**	$	$	$
Commissions	$	$	$	$
Dental	$	$	$	$
Fiduciary	$	$	$	$
Rx Administrative Fee	$	$	$	$
*Prescription Drug Rebate Credit	**$12.28**	$	$	$
Other: Select Service Category List Service: _____	$	$	$	$

Other: Select Service Category List Service: _____	**$**_____	**$**_____	**$**_____	**$**_____
Other: Select Service Category List Service: _____	**$**_____	**$**_____	**$**_____	**$**_____
Other: Select Service Category List Service: _____	**$**_____	**$**_____	**$**_____	**$**_____
Miscellaneous: _____	**$**_____	**$**_____	**$**_____	**$**_____
Miscellaneous: _____	**$**_____	**$**_____	**$**_____	**$**_____
Total	**$**_____	**$**_____	**$**_____	**$**_____

*Prescription Drug Rebate Credit per Covered Employee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit. Expected rebate amounts to be received by the Claim Administrator are passed back to the Employer with one hundred percent (100%) of the expected amount applied as a credit on the monthly billing statement on a per Covered Employee per month basis. Rebate credits are paid prospectively to the Employer and shall not continue after termination of the Prescription Drug Program. (Further information concerning this credit is included in the governing Administrative Services Agreement to which this ASO BPA is attached under the section titled "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS.")

Administrative Line Item Charges	**Frequency**	**Amount**
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	**$**_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	**$**_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	**$**_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	**$**_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	**$**_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	**$**_____
	Total:	**$**_____

Note: Additional services and/or fees may be itemized in the "Miscellaneous" fields above or in the Additional Comments section below.

Legacy Carve Out Disease Management: Not applicable

Additional Comments (Provide any additional details regarding the fee structure): _____

Claim Administrator Provider Access Fee(s) **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**
Group Number(s): P65059, P65060, P65061
☒ % of ADP Savings: **2.51**%
☐ $ per Covered Employee per month: $
Complete for Groups with multiple Provider Access Fees by products (i.e., CMM, PPO and/or POS plans): **Group Number(s):**
☐ % of ADP Savings: %
☐ $ per Covered Employee per month: $
BlueCard Program/Network access fees: Available upon request.

Other Service and/or Program Fee(s)

☒ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

Not applicable to Grandfathered Plans

External Review Coordination:

If selected, Employer acknowledges and agrees: (i) to a fee of $700 for each external review requested by a Covered Person that the Claim Administrator coordinates for the Employer in relation to the Employer's Plan; (ii) that the Claim Administrator's coordination shall include reviewing external review requests to ensure that they meet eligibility requirements, referring requests to accredited external independent review organizations, and reversing the Plan's determinations if so indicated by external independent review organizations; and (iii) that the external reviews shall be performed by an independent third party entity or organization and not the Claim Administrator. Amounts received by Claim Administrator and external independent review organizations may be revised from time to time and may be paid each time an external review is undertaken. Further, Employer elects for external reviews to be performed under the process selected below (select one):

☒ State of Illinois External Review Process ☐ Federal Affordable Care Act Process

Reimbursement Provision: ☒ Yes ☐ No

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

Conversion Privilege: ☐ Yes ☒ No *If yes,* conversion fee: $6,000 per conversion.

Claim Administrator's Third Party Recovery Vendor:

It is understood and agreed that in the event the Claim Administrator's Third Party Recovery Vendor makes a recovery on a claim, the Employer will pay no more than 25% of any recovered amount.

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,*** 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 and the Plan participation of the two (2) months immediately preceding the termination date. Such aggregate amount will be due the Claim Administrator within ten (10) days of the Claim Administrator's notification to the Employer of the Termination Administrative Charge described herein.

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

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

Broker/Consultant Compensation

The Employer acknowledges that if any broker/consultant acts on its behalf for purposes of purchasing services in connection with the Employer's Plan under the Administrative Services Agreement to which this ASO BPA is attached, the Claim Administrator may pay the Employer's broker/consultant a commission and/or other compensation in connection with such services under the Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid the broker/consultant by the Claim Administrator in connection with services under the Agreement, the Employer should contact its broker/consultant.

OTHER PROVISIONS

☒ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

1. **Will Claim Administrator Issue Certificate of Creditable Coverage**: ☒ Yes ☐ No

   If yes: The Employer directs the Claim Administrator to issue to individuals, whose coverage under the Plan terminates during the term of the Administrative Services Agreement to which this ASO BPA is attached, a Certificate of Creditable Coverage, if required by applicable law. The Certificate of Creditable Coverage shall be based upon information required for issuance of a Certificate of Creditable Coverage to be provided to the Claim Administrator by the Employer and coverage under the Plan during the term of the Administrative Services Agreement.

2. **Summary of Benefits & Coverage**:

   a. Will Claim Administrator create Summary of Benefits & Coverage (SBC)?

   ☒ Yes. Please answer question b. The SBC Addendum is attached.

   ☐ No. If No, then the Employer acknowledges and agrees that the Employer 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 the Claim Administrator have any responsibility or obligation with respect to the SBC. The Claim Administrator is not obligated to respond to or forward misrouted calls, but may, at its option, provide participants and beneficiaries with Employer's contact information. A new clause (e) is added to Subsection C. in the Additional Provisions as follows: "(e) the SBC". (Skip question b.)

   b. Will Claim Administrator distribute the Summary of Benefits & Coverage (SBC) to participants and beneficiaries?

   ☐ No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law.

   ☒ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute to participants and beneficiaries as required by law, except that Claim Administrator will send the SBC in response to the occasional request received directly from individuals.

   ☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and distribute SBC to participants and beneficiaries via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is $1.50 per package. The distribution fee will not apply to SBCs that Claim Administrator sends in response to the occasional request received directly from individuals.

3. **Case Management Program/Medical Services Advisory**: ☒ 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 Administrative Services Agreement to which this ASO BPA is attached and the Employer's plan document.

4. **Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which pre-certification is required**: ☒ Yes ☐ No If no, Employer authorizes Claim Administrator to post Employer's pre-certification requirements on Claim Administrator's Website: ☒ Yes ☐ No

5. **Does Employer have any Employees that reside in Massachusetts?** ☒ Yes ☐ No

   The Massachusetts Health Care Reform Act requires employers to provide, or contract with another entity to provide, a written statement to individuals residing in Massachusetts who had "creditable coverage" at any time during the

prior calendar year through the employer's group health plan and to file a separate electronic report to the Massachusetts Department of Revenue verifying information in the individual written statements.

a. Does the Employer direct Claim Administrator to provide written statements of creditable coverage to its Covered Employees who reside, or have enrolled dependents who reside, in Massachusetts and file electronic reports to the Massachusetts Department of Revenue in a manner consistent with the requirements under the Massachusetts Health Care Reform Act. Such written statements and electronic reporting shall be based on information provided to the Claim Administrator by the Employer and coverage under the Plan during the term of the Administrative Services Agreement. The Employer hereby certifies that, to the best of its knowledge, such coverage under the Plan is "creditable coverage" in accordance with the Massachusetts Health Care Reform Act. The Employer acknowledges that the Claim Administrator is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this service. The Employer or its Covered Employees should seek advice from their legal or tax advisors as necessary.

☒ Yes ☐ No

b. If no: The Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

6. **EHB Election:**

Employer elects EHBs based on the following:

☒ 1. EHBs based on a HCSC state benchmark:
- ☒ Illinois
- ☐ Oklahoma
- ☐ Montana
- ☐ Texas
- ☐ New Mexico

☐ 2. EHBs based on benchmark of a state other than IL, MT, NM, OK and TX
If so, indicate the state's benchmark that Employer elects: ___

☐ 3. Other EHB, as determined by Employer

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

7. **This ASO Benefit Program Application (ASO BPA) is incorporated into and made a part of the Administrative Services Agreement with both such documents to be referred to collectively as the "Agreement" unless specified otherwise.**

ADDITIONAL PROVISIONS:

A. **Grandfathered Health Plans:** Employer shall provide Claim Administrator with written notice prior to renewal (and during the plan year, at least 60 days advance written notice) of any changes that would cause any benefit package of its group health plan(s) (each hereafter a "plan") to not qualify as a "grandfathered health plan" under the Affordable Care Act and applicable regulations. Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of administrative services. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any plan's grandfathered health plan status 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 Agreement, and Employer represents and warrants that such Form is true, complete and accurate.

B. **Retiree Only Plans, Excepted Benefits and/or Self-Insured Nonfederal Governmental Plans:** If the BPA includes any retiree only plans, excepted benefits and/or self-insured nonfederal governmental plans (with an exemption election), then Employer 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 Claim Administrator to the terms and conditions of administrative services. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's exempt plan status.

C. Employer shall indemnify and hold harmless Claim Administrator 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 inquires or actions, settlements or judgments brought or asserted against Claim Administrator in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any plan's design (including but not limited to any directions, actions and interpretations of the Employer), (d) any provision of inaccurate information, (e) the SBC, and/or (f) selection of employer's EHB benchmark for the purpose of ACA. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of administrative services.

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 administrative services between the parties.

1/1/14 Deductible now included in the OPX.
1/1/14 OPX includes all Medical and ER copays.
1/1/14 Pre-X is excluded.
1/1/14 tests and x-rays are not charged an additional copay if done on the same day as a part of the physical.

Dee Mastro-Holzkopf

Sales Representative

890 630-824-5558

District Phone & FAX Numbers

Producer Representative

The Horton Group

Producer Firm

10320 Orland Parkway, Orland Park, IL

Producer Address

708-845-3126, 708-845-4126 - fax

Producer Phone & FAX Numbers

Producer Email Address

36-3672171

Tax I.D. No.

Signature of Authorized Purchaser

Title

Date

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 thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least twenty (20) days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Group No.: P65058, P65059, P65060, P65061

By: _____

Print Signer's Name Here

➡ _____

Signature and Title

Group Name: Village of Downers Grove

Address: 801Burlington Ave

City: Downers Grove State: IL Zip Code: 60515

Dated this _____ day of _____
Month Year

RESOLUTION NO. ____

A RESOLUTION AUTHORIZING EXECUTION OF AN AGREEMENT BETWEEN THE VILLAGE OF DOWNERS GROVE AND BLUE CROSS/BLUE SHIELD OF ILLINOIS FOR STOP LOSS COVERAGE

BE IT RESOLVED by the Village Council of the Village of Downers Grove, DuPage County, Illinois, as follows:

1. That the form and substance of a certain Stop Loss Coverage Policy (the "Agreement"), between the Village of Downers Grove (the "Policyholder") and Blue Cross/Blue Shield of Illinois, (the "Company"), for stop loss insurance coverage effective January 1, 2014 through December 31, 2014, as set forth in the form of the Agreement submitted to this meeting with the recommendation of the Village Manager, is hereby approved.

2. That the Village Manager and Village Clerk are hereby respectively authorized and directed for and on behalf of the Village to execute, attest, seal and deliver the Agreement, substantially in the form approved in the foregoing paragraph of this Resolution, together with such changes as the Manager shall deem necessary.

3. That the proper officials, agents and employees of the Village are hereby authorized and directed to take such further action as they may deem necessary or appropriate to perform all obligations and commitments of the Village in accordance with the provisions of the Agreement.

4. That all resolutions or parts of resolutions in conflict with the provisions of this Resolution are hereby repealed.

5. That this Resolution shall be in full force and effect from and after its passage as provided by law.

_____
Mayor

Passed:
Attest: _____
Village Clerk

1\wp8\res.14\Insurance\StopLossIns-2014

BlueCross BlueShield of Illinois

[redacted]

EXHIBIT TO THE STOP LOSS COVERAGE POLICY

(ASO Accounts Only)

Employer Group Name: Village of Downers Grove
Employer Group Address: 801 Burlington Ave
City: Downers Grove **State of Situs:** IL **Zip Code:** 60515
Account Number: 365058
Employer Group Number(s): P65058.P65059,P65060,P65061
Effective Date of Policy January 1, 2014
Policy Period: These specifications are for the Policy Period commencing on January 1, 2014 and ending on December 31, 2014

The specifications below shall become effective on the first day of the Policy Period specified above and shall continue in full force and effect until the earliest of the following dates: (1) The last day of the Policy Period; (2) The date the Policy terminates; or (3) The date this Exhibit is superseded in whole or in part by a later executed Exhibit.

A. Aggregate Stop Loss Insurance: ☒ Yes ☐ No
If yes, complete items 1. through 9. below.

1. ☐ New Coverage ☒ Renewal of Existing Coverage
2. Stop Loss Coverage Period:
   ☐ New Coverage (Select one from below):
      ☐ Standard: Claims incurred and paid during the Policy Period.
      ☐ Standard with "Run-in" included: Claims incurred on or after _____ and paid during the Policy Period.
      "Run-in" includes claims paid by Policyholder's prior claim administrator: Yes ☐ No ☐
      If yes, such claims must be reported by the Policyholder to the Company (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) within 12 months of the Effective Date of Policy and paid by the Policyholder's prior claim administrator within 6 months after the Effective Date of Policy.
   ☒ Renewal of Existing Coverage:
      Claims incurred on or after the original Effective Date of Policy and paid during the Policy Period.
3. Aggregate Stop Loss Insurance shall apply to:
   ☒ Medical Claims ☐ Vision Claims
   ☒ Outpatient Prescription Drug Claims ☐ Dental Claims

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

☐ Other (please specify): _____

4. Average Claim Value: $940.30 (per employee per month)

   ☒ Includes Claim Administrator's Provider Access Fee
   ☐ Excludes Claim Administrator's Provider Access Fee

   Attachment Factor: 125% of the Average Claim Value

5. Aggregate Attachment Claim Liability:

   Employer's Claim Liability for each Policy Period shall be the sum of the Monthly amounts obtained by multiplying the number of Individual and Family Coverage Units for each Month by the following factor:

   $1175.38for each Coverage Unit

6. Aggregate Stop Loss Coverage includes coverage of Run-Off Paid Claims: ☒ Yes ☐ No

   Run-Off Attachment Claim Liability Factors:

   Employer's Run-Off Claim Liability shall be an amount equal to 15% of the annualized Employer Claim Liability based on the participation of the two calendar months immediately preceding termination. Settlement for the final accounting period will be described in the section of the Policy entitled SETTLEMENTS.

7. Aggregate Stop Loss Coverage:

   a. The amount of Paid Claims during the current Policy Period, less Individual (Specific) Stop Loss Claims, if any, that exceed the Point of Attachment. The Point of Attachment shall equal the sum of the Employer's Claim Liability amounts calculated Monthly as described in Item 5. above for the indicated Policy Period. However, for the indicated Policy Period the minimum Point of Attachment shall be $5,750,967.

   b. The following applies if the answer to item 6. above is "Yes." (Aggregate Stop Loss Coverage includes coverage of Run-Off Paid Claims):
   In the event of termination at the end of a Policy Period, Aggregate Stop Loss Coverage shall equal the amount of Final Settlement Paid Claims that exceed the Final Settlement Point of Attachment. Final Settlement Paid Claims shall equal the sum of the Paid Claims during the Final Policy Period and the Paid Claims during the Run-Off Period, less Individual (Specific) Stop Loss Claims, if any. The Final Settlement Point of Attachment shall equal the sum of the Employer's Claim Liability amount for the Final Policy Period and the Employer's Run-Off Claim Liability calculated as described in items 5. and 6. above. However, for the Final Settlement Period the minimum Point of Attachment shall be the minimum Point of Attachment in item 7.a. above increased by 15%.

8. Premium (Select one):

   ☒ Annual Premium (Due on the first day of the Policy Period): $14,494.

   The following applies if the answer to item 6. above is "Yes." (Aggregate Stop Loss Coverage includes coverage of Run-Off Paid Claims): In the event of termination at the end of a Policy Period, an additional premium amount equal to 15% of the Annual Premium will be due within 10 calendar days of receipt of the billing.

   ☐ Monthly Premium shall be equal to the amounts obtained by multiplying the number of Individual and Family Coverage Units for a particular Month by:

   $_____ for each Coverage Unit

   The following applies if the answer to item 6. above is "Yes." (Aggregate Stop Loss Coverage includes coverage of Run-Off Paid Claims):

   In the event of termination at the end of a Policy Period, an additional premium amount equal to 15% of the annualized Premium based on the participation of the two months immediately preceding termination will be due within 10 calendar days of receipt of the billing.

9. The premium is based upon a current membership of 134 Individual Coverage Units and 268 Family Coverage Units.

B. Individual (Specific) Stop Loss Insurance: ☒ Yes ☐ No

If yes, complete items 1. through 6. below.

1. ☐ New Coverage ☒ Renewal of Existing Coverage

2. Stop Loss Coverage Period:

☐ New Coverage (Select one from below):

☐ Standard: Claims incurred and paid during the Policy Period.

☐ Standard with "Run-in" included: Claims incurred on or after _____and paid during the Policy Period.

"Run-in" includes claims paid by Policyholder's prior claim administrator: Yes ☐ No ☐

If yes, such claims must be reported by the Policyholder to the Company (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) within 12 months of the Effective Date of Policy and paid by the Policyholder's prior claim administrator within 6 months after the Effective Date of Policy.

☒ Renewal of Existing Coverage:

Claims incurred on or after the original Effective Date of Policy and paid during the Policy Period.

3. Individual (Specific) Stop Loss Insurance shall apply to:

☒ Medical Claims ☐ Vision Claims

☒ Outpatient Prescription Drug Claims ☐ Dental Claims

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

☐ Other (please specify): _____

4. Individual (Specific) Stop Loss Coverage

a. Individual Stop Loss Coverage equals the amount of Paid Claims for a Covered Person during the current Policy Period in excess of the Point of Attachment of $150,000 per Covered Person. Such amount shall apply for the Policy Period.

Point of Attachment ☒ Includes Claim Administrator's Provider Access Fee

☐ Excludes Claim Administrator's Provider Access Fee

b. Employer's Claim Liability equals the sum of Paid Claims for a Covered Person during the Policy Period up to the Point of Attachment specified in 4.a. above.

5. Individual Stop Loss Coverage includes coverage of Run-Off Paid Claims: ☒ Yes ☐ No

The following applies if the answer to item 5. above is "Yes" (Individual Stop Loss Coverage includes coverage of Run-Off Paid Claims):

a. In the event of termination at the end of the Policy Period, Individual Stop Loss Coverage shall equal the amount of Final Settlement Paid Claims that exceed the Point of Attachment specified in 4.a. above. Final Settlement Paid Claims shall equal the sum of Paid Claims for a Covered Person during the Final Policy Period and the Run-Off Period.

b. In the event of termination at the end of the Policy Period, Employer's Final Settlement Claim Liability equals the sum of Paid Claims for a Covered Person during the Final Policy Period and Run-Off Period up to the Point of Attachment specified in Item 4.a. above.

Settlement for the final accounting period will be described in the section of the Policy entitled SETTLEMENTS.

6. Premium (select one):

   ☐ Annual Premium (Due on the first day of the Policy Period): $_____.

   The following applies if the answer to item B.5. is “Yes” (Individual Stop Loss Coverage includes coverage of Run-Off Paid Claims): In the event of termination at the end of a Policy Period, an additional premium amount equal to 20% of the Annual Premium will due within 10 calendar days of receipt of the billing.

   ☒ Monthly Premium shall be equal to the amounts obtained by multiplying the number of Individual and Family Coverage Units for a particular Month by:

   $65.00 for each Coverage Unit

   The following applies if the answer to item B.5. above is “Yes” (Individual Stop Loss Coverage includes coverage of Run-Off Paid Claims): In the event of termination at the end of a Policy Period, an additional premium amount equal to 20% of the annualized Premium based on the participation of the two months immediately preceding termination will be due within 10 calendar days of receipt of the billing.

7. The premium is based upon a current membership of 134 Individual Coverage Units and 268 Family Coverage Units.

Additional Provisions:

_____

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

Dee Mastro-Holzkopf
Sales Representative

Signature of Authorized Purchaser

Lucy Oakwood
Name of Underwriter

Title of Authorized Purchaser

Date

INTERNAL USE ONLY	Date Application approved by Underwriting: Name of Underwriter:

RESOLUTION NO. ____

A RESOLUTION AUTHORIZING EXECUTION OF AN AGREEMENT BETWEEN THE VILLAGE OF DOWNERS GROVE AND HUMANA

BE IT RESOLVED by the Village Council of the Village of Downers Grove, DuPage County, Illinois, as follows:

1. That the form and substance of a certain Medicare Advantage Insurance Policy (the "Agreement"), between the Village of Downers Grove (the "Policy Holder") and Humana (the "Company"), for Medicare Advantage insurance for retirees over 65, effective January 1, 2014 through December 31, 2014, as set forth in the form of the Application submitted to this meeting with the recommendation of the Village Manager, is hereby approved.

2. That the Village Manager and Village Clerk are hereby respectively authorized and directed for and on behalf of the Village to execute, attest, seal and deliver the Agreement, substantially in the form approved in the foregoing paragraph of this Resolution, together with such changes as the Manager shall deem necessary.

3. That the proper officials, agents and employees of the Village are hereby authorized and directed to take such further action as they may deem necessary or appropriate to perform all obligations and commitments of the Village in accordance with the provisions of the Agreement.

4. That all resolutions or parts of resolutions in conflict with the provisions of this Resolution are hereby repealed.

5. That this Resolution shall be in full force and effect from and after its passage as provided by law.

_____
Mayor

Passed:
Attest: _____
Village Clerk

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HUMANA
Guidance when you need it most

Internal Use Only
Group Number:

Group Sponsored Medicare Advantage Application

Please refer to your proposal to complete this document.
Print clearly in black ink, and answer all questions or indicate "not applicable."

Your Business Profile

Business Name: Village of Downers Grove
Federal Tax ID Number: 36-6005857

Location address (not a P.O. Box): 801 Burlington Avenue

City: Downers Grove State: IL Zip: 60515-4776 County: DuPage

Do you have more than one location? Yes: X No:

Billing address (if different): 801 Burlington Avenue

City: Downers Grove State: IL Zip: 60515-4776 County: DuPage

Nature of business or SIC number: 9199
Date company established: 1832

Business Status: Corporation: Partnership: Sole Proprietorship: Other: X

Business Phone Number: 630-434-5500
Fax Number: 630-434-5571

Management Contact: Dennis Burke
Administrative Contact: Mary Weisenburn

Management Contact e-mail address: dburke@downers.us
Administrative Contact e-mail address: mweisenburn@downers.us

Effective Date

Requested Effective Date: 1-Jan-14

Plan Selection

Plan:	LPPO 079 066	Option:	LPPO 079 066	Rx Option:	Rx 66
Plan:		Option:		Rx Option:	

Group Information

Are any affiliations or subsidiaries to be covered? No: X Yes:

If yes,: Affiliation: Subsidiary:
Affiliation/subsidiary information: Name:
Address:

Eligibility

Total number of Medicare eligible retirees: 51
Number of Medicare eligible spouses: n/a

Number of Medicare retirees to be covered: 51
Number of Medicare eligible spouses to be covered:

How much will the plan sponsor contribute to premium?
Retiree (% or $): 50%
Spouse of Retiree (% or $): n/a

For the plan to remain in effect, the eligibility, underwriting, and participation requirements must be maintained. Failure to maintain the plan eligibility, underwriting, and participation requirements will terminate the group coverage.

Plan Sponsor Agreement

You the plan sponsor, understand, agree and represent that

- You have read this document and the information you provided is accurate and complete to the best of your knowledge and belief.
- You have received and reviewed a proposal and the applicable regulatory information.
- Neither you nor the agent/broker/producer has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind us by making any promise or representation, or waive any of our other rights or requirements.
- Only individuals who meet the eligibility requirements of the plan are eligible to maintain coverage.
- Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the plan coverage.
- The employer/union sponsor can subsidize different amounts for different classes of enrollees in a plan provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly). Different classes cannot be based on eligibility for the Part D Low-Income Subsidy.
- The premium cannot vary for individuals within a given class of enrollees. With regard to the Part D premium, an employer/union cannot charge an enrollee for prescription drug coverage provided under the MA plan more than the sum of his or her monthly beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part D benefits (if any).
- The employer/union must pass through any direct subsidy payments received from CMS to reduce the amount that the beneficiary pays (or in those instances where the subscriber to or participant in the employer/union-only plan pays premiums on behalf of a Medicare eligible spouse or dependent, the amount the subscriber or participant pays).

Dated on: _____ By: _____

(month, date, year) (plan sponsor signature)

Dated at: _____ Title: _____

(city and state) (plan sponsor title)

Business Name: Village of Downers Grove

Agent/Producer Information

Agency of Record

Name (print) The Horton Group
Tax ID 36-3672171
Address 10320 Orland Parkway
City/State/Zip: Orland Park, IL 60467

Writing Agent/Agent of Record

Name (print) Michael E. Wojcik

Social Security Number _____

As the Writing Agent/Producer, I acknowledge that I am responsible to meet with the group submitting this application in order to fully and accurately represent the terms and conditions of the benefits and services offered by the plan.

Writing Agent's Signature: _____ Date: _____

RESOLUTION NO. ____

A RESOLUTION AUTHORIZING RENEWAL OF A GROUP DENTAL AND VISION CONTRACT BETWEEN THE VILLAGE OF DOWNERS GROVE AND DELTA DENTAL OF ILLINOIS

BE IT RESOLVED by the Village Council of the Village of Downers Grove, DuPage County, Illinois, as follows:

1. That the form and substance of a certain Proposed Renewal (the "Renewal"), between the Village of Downers Grove (the "Village") and Delta Dental of Illinois ("DDIL"), for renewal of the employee dental and vision insurance program effective January 1, 2014, as set forth in the form of the Renewal submitted to this meeting with the recommendation of the Village Manager, is hereby approved.

2. That the Village Manager and Village Clerk are hereby respectively authorized and directed for and on behalf of the Village to execute, attest, seal and deliver the Renewal, substantially in the form approved in the foregoing paragraph of this Resolution, together with such changes as the Manager shall deem necessary.

3. That the proper officials, agents and employees of the Village are hereby authorized and directed to take such further action as they may deem necessary or appropriate to perform all obligations and commitments of the Village in accordance with the provisions of the Renewal.

4. That all resolutions or parts of resolutions in conflict with the provisions of this Resolution are hereby repealed.

5. That this Resolution shall be in full force and effect from and after its passage as provided by law.

_____
Mayor

Passed:
Attest: _____
Village Clerk

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DELTA DENTAL

www.deltadentalil.com

July 8, 2013

Mary Weisenburn
VILLAGE OF DOWNERS GROVE
801 Burlington Avenue
Downers Grove, IL 60515

RE: VILLAGE OF DOWNERS GROVE, Contract # 08338
Renewal Notification January 1, 2014

Dear Mary:

Enclosed is Delta Dental of Illinois' renewal package for VILLAGE OF DOWNERS GROVE. It includes your group's renewal rates and underwriting assumptions.

Network Savings and Utilization

Listed below are the annual savings and network utilization realized by your group due to Delta Dental of Illinois' PPO Plus network services and administration.

Delta Dental PPO Network Dentist Fee Savings	**$182,146**
Delta Dental Premier Network Dentist Fee Savings	**$26,321**
Total PPO Plus Premier Network Savings	**$208,467**
In Network Penetration	**91.5%**

We are pleased to inform you that your dental benefit renewal administration fee reflects a multi-line discount based on the inclusion of a DeltaVision® or TruAssure product in your benefit package. Because the multi-line discounts are based on cost efficiencies associated with the administration of more than one product, the proposed dental benefit renewal rates are subject to change if you choose to terminate your DeltaVision or TruAssure plan. If you would like additional information about DeltaVision or TruAssure products, please contact your broker or consultant.

I welcome the opportunity to meet with you to review this information. If you have any questions or would like to schedule a meeting to discuss your renewal, please contact me. After you have reviewed the enclosed information, please indicate your acceptance of this renewal by signing and returning a copy of the signature page to us.

The entire Delta Dental of Illinois team values your business. We are honored that you selected us as your dental benefits carrier and we look forward to continuing our relationship for many years to come.

Sincerely,

Stacy Beitzel
Senior Account Manager
630-718-4742
sbeitzel@deltadentalil.com

cc: Horton Insurance Agency

DeltaVision® is provided by TruAssure Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks

Renewal Package

for

VILLAGE OF DOWNERS GROVE

Presented By:
Delta Dental of Illinois (DDIL) / TruAssure Insurance Company (TAIC)

Stacy Beitzel
Senior Account Manager
Delta Dental of Illinois
111 Shuman Boulevard
Naperville, IL 60563
Phone 630-718-4742
Fax 630-983-4242
Email sbeitzel@deltadentalil.com

This renewal is for January 1, 2014 to December 31, 2014.

Confidentiality Agreement

By accepting this renewal, you agree that all information is confidential and has been provided by Delta Dental of Illinois for your use or that of the specified client only. Therefore, you agree not to disclose any information (except to the specified client, broker, consultant or agent) without the express written permission of Delta Dental of Illinois. It is acknowledged that information to be furnished in this renewal is in all respects confidential in nature, other than information that is available in the public domain through other means. Use or disclosure of information contained in this plan is strictly forbidden without obtaining written consent of Delta Dental of Illinois.

Upon request, this document is to be immediately returned to Delta Dental of Illinois, 111 Shuman Boulevard, Naperville, IL 60563.

Proposed Renewal
Self Insured

Delta Dental PPO With Delta Dental Premier "Safety Net"			
	Current Rate	**Proposed Rate**	**Rate Change**
Administration Fee	**$4.13**	**$4.27**	**3.5%**
	Current Premium Equivalent	**Recommended Premium Equivalent**	**% Change**
Employee	**$40.48**	**$39.06**	**-3.5%**
Family	**$124.95**	**$120.58**	**-3.5%**

DeltaVision-Current Plan			
	Current Rate	**Proposed Rate**	**Rate Change**
Employee	**$4.50**	**$4.50**	**0%**
Family	**$12.59**	**$12.59**	**0%**

Underwriting Assumptions

1. The proposed renewal ASO fees will be in effect from: January 1, 2014 to December 31, 2014.

2. The projection is based on 119 employees and 262 families.

Projected Annual Incurred Claims:	$415,341
Projected Annual Administration Fee:	$19,543
Projected Annual Total Cost:	$434,884

3. All of our standard processing policies, limitations and exclusions apply.

4. During the current experience period of January 1, 2013 to December 31, 2013, VILLAGE OF DOWNERS GROVE averaged 381 enrollees. If enrollment changes by more than 10% we reserve the right to revise our ASO fees.

5. Please acknowledge your acceptance of these terms and rates by signing below and returning this page. **You can fax this letter to 630-983-4242, or mail attn: Stacy Beitzel, Delta Dental of Illinois, 111 Shuman Boulevard, Naperville, IL 60563.**

   If we do not receive notification from you by December 1, 2013, Delta Dental of Illinois will assume you agree to the proposed ASO fees and renew your current dental benefit plan.

AGREED AND ACCEPTED:
VILLAGE OF DOWNERS GROVE, Contract #08338

By: _____Date: _____

Title: _____

Delta Dental of Illinois
111 Shuman Boulevard
Naperville, IL 60563

Contact Sheet

For questions about your renewal, please contact:

Stacy Beitzel, Senior Account Manager
630-718-4742
fax 630-983-4242
sbeitzel@deltadentalil.com

Your Accounts Specialist will be able to assist you with any account-related questions you may have, as well as enrollment activities and fulfillment. **For questions about ongoing account administration, claims and other account inquiries, please contact:**

Erma McGahee
630-718-4768
fax 630-983-4568
emcgahee@deltadentalil.com

Your enrollees can reach Delta Dental of Illinois' Customer Service department by calling 1-800-323-1743.