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

Employer Account Number (6-digits): 992918

Group Number(s): P06548, OM2920, PD3006, PD3014, PD3018

Section Number(s): See account structure

Legal Employer Name: McLean County Unit District No. 5

(Specify the Employer or the employee trust applying for coverage. Names of subsidiary or affiliated companies to be covered must also be named below. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED.)

ERISA Regulated Group Health Plan*: ☐ Yes ☒ No

Is your ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☐ Yes
If not, please specify your ERISA Plan Year*: Beginning Date ___/___/___ End Date ___/___/___ (month/day/year)

ERISA Plan Administrator*: Plan Administrator's Address:

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

Is your Non-ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☒ Yes
If not, 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: (Month/Day/Year) 07 / 01 / 2020

Anniversary Date: (Month/Day/Year) 07 / 01 / 2021

Account Information

☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Standard Industry Code (SIC): 8210

Employer Identification Number (EIN): 376004011

Address: 1809 Hovey Ave.

City: Normal State: IL ZIP: 61761

Administrative Contact: Marty Hickman Title: Business Manager

Email Address: hickmanms@unit5.org Phone Number: 309-557-4043 Fax Number: 309-557-4057

Wholly Owned Subsidiaries to be covered:

Affiliated Companies to be covered: Employer Identification Number (EIN):

(If Subsidiaries or Affiliated Companies listed above are to be covered, Employer hereby confirms that Employer and the listed Subsidiaries and/or Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), (c) or (m).)

Blue Access for Employers (BAE) Contact: Marty Hickman

(The BAE Contact is the Employee authorized by the Employer to access and maintain the Employer's account in BAE.)

Email Address: hickmanms@unit5.org Phone Number: 309-557-4043 Fax Number: 309-557-4057

☒ The Employer or other company listed in this BPA is a public entity or governmental agency/contractor

Schedule of Eligibility ☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Employer has made the following eligibility decisions:

1. Eligible Person means:

- ☐ A full-time employee of the Employer.
- ☐ A full-time employee of the Employer who is a member of: *(name of union)*
- ☐ A part-time employee of the Employer.
- ☐ A retiree of the Employer. Define criteria: _____
- ☒ Other: All full-time employees except: union custodial and maintenance employees, noon hour supervisors, bus monitors, certain retired employees. Certain retired employees with at lest 10 years of service and who are at least 55 years of age or IMRF disabled or retired employees, all certified staff, secretaries, classified administrators, bus drivers, teacher assistants, and cafeteria personnel who work a minimum set hour per week are considered Eligible Persons.

Are any classes of employees to be excluded from coverage? ☐ Yes ☒ No

If yes, please identify the classes and describe the exclusion: _____

2. Employee Definitions:

Full-Time Employee means:

- ☐ A person who is regularly scheduled to work a minimum of _____ hours per week and who is on the permanent payroll of the Employer.
- ☒ Other: Meets definition in #1

Part-Time Employee means:

- ☐ A person who is regularly scheduled to work a minimum of _____ hours per week and who is on the permanent payroll of the Employer.
- ☐ Other:

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: When employment ceases prior to the end of the school year, health insurance continues for one month past the month in which the employee last works and earns a salary. When employment ceases on the last day of the current school year (resignation and retirements) insurance continues through August 31st of the next school year.

4. 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 be later than the 91st calendar day after 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 day of the month following month(s) of employment.
- ☐ The day of the month following days of employment.
- ☐ The day of the month following the date of employment.
- ☒ Other: Medical - date of employment /// Dental - can add children anytime up to age 5

Is the waiting period requirement to be waived on initial group enrollment? ☒ Yes ☐ No

Are there multiple new hire waiting periods? ☐ Yes ☒ No

If yes, please attach eligibility and contribution details for each section.

5. Domestic partners covered: ☐ Yes ☒ No

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. Civil Union Partners covered:

☒ The 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.

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.

7. Limiting Age for covered Children: Twenty-six (26) years, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. Other:

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.

8. Termination of coverage upon reaching the Limiting Age:

☐ The last day of coverage is the day prior to the birthday.
☒ The last day of coverage is the last day of the month in which the limiting age is reached.
☐ The last day of coverage is the last day of the billing month.
☐ The last day of coverage is the last day of the year (12/31) in which the limiting age is reached.
☐ The last day of coverage is the day prior to the Employer's Anniversary Date.

Will coverage for a child who is medically certified as disabled and dependent on the employee terminate upon reaching the limiting age even if the child continues to be both disabled and dependent on the employee? ☐ Yes ☒ No

However, such coverage shall be extended in accordance with any applicable federal or state law. *The Employer will notify HCSC of such requirements*.

9. Will extension of benefits due to temporary layoff, disability or leave of absence apply?

☒ Yes (specify number of days below) ☐ No

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 an applicable federal or state law. The Employer will notify HCSC of such requirements.

10. Enrollment:

***Special Enrollment**:* An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a Special Enrollment qualifying event if he/she did not previously apply prior to his/her Eligibility Date or when otherwise 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 marriage or termination of previous coverage, then no later than the first day of the Plan Month following the date of receipt of the person's application of coverage.

An Eligible Person may apply for coverage within sixty (60) days of a Special Enrollment qualifying event in the case either of a loss of coverage under Medicaid or a state Children's Health Insurance program, or eligibility for group coverage where the Eligible Person is deemed qualified for assistance under a state Medicaid or CHIP premium assistance program.

***Open 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, during the Employer's 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 the Claim Administrator and the Employer. Such date shall be subsequent to the Open Enrollment Period. Specify Open Enrollment Period: 11/10 - 12/15 with a 1/1 effective date

***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.

Select one of the provisions below:

☒ Open Enrollment – Late applicants may only apply during Open Enrollment.

☐ Late Entrant – Late applicants may apply at any time – coverage effective date is determined by the receipt date and the off cycle allowed rules.

11. * 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 services)	☒ **NO CHANGES** ☐ ***See Additional Provisions***
Medical Plan Services: ☒ Participating Provider Option (PPO) ☐ Blue Choice Select PPO ☐ Blue Choice Options **Additional Services:** ☐ Blue Care Connection® ☒ Wellbeing Management ☐ Wellness Incentives ☐ Health Advocacy Solutions ☐ Blue Directions (Private Exchange) *(If selected, the Blue Directions Addendum is attached and made a part of the Agreement.)* ☐ Limited Fiduciary Services for Claims and Appeals ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other ☐ Other	**Consumer Driven Health Plan:** ☐ Health Care Account (HCA) Administrative Services *(if purchased, complete separate HCA BPA)* ☐ BlueEdge℠ FSA (Vendor: Select Vendor) ☒ HSA Eligible Health Plan (Vendor: Select Vendor) **Prescription Drugs:** ☒ Covered under a pharmacy benefit *(If selected, the PBM Fee Schedule Addendum must be attached and is part of this BPA.)* ☒ Covered under the medical benefit or Blue Script **Pharmacy Network (Select one)**: ☐ Traditional Select Network ☒ Advantage Network ☐ Preferred Network (Not offered with Blue Script) ☐ Elite Network (Not offered with Blue Script) ☐ Network on PBM Fee Schedule Addendum PPO Drug List: Basic Drug List Other (please specify): **Prescription Drug Program Clinical Programs** ☐ MTM (Retrospective) (Included with HAS) **Ancillary Services:** ☒ Dental Plan Services ☒ Vision Plan Services ☒ Stop Loss *(if selected, complete separate Exhibit to the Stop Loss Coverage Policy)*

	☐ Life or Disability Insurance provided by separate carrier *(if selected, complete separate Life application)* ☒ COBRA Administrative Services *(if selected, complete separate COBRA Administrative Services Addendum to the BPA)*

FEE SCHEDULE

Payment Specifications ☒ **NO CHANGES** ☐ **SEE ADDITIONALPROVISIONS**

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

Employer Payment Period: ☒ **Weekly** (cannot be selected if Check is selected as payment method above)
☐ **Semi Monthly** ☐ **Monthly**

Claim Settlement Period: ☒ **Monthly**

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

Fee Schedule Period: To begin on Effective Date of Coverage and continue for 12 months. If other than 12 months, please specify: Months

Administrative Per Employee Per Month (PEPM) Charges ☐ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

	PPO			
Administrative Fee	**$54.02**	$_____	$_____	$_____
Dental	**$3.50**	$_____	$_____	$_____
Limited Fiduciary Services	$_____	$_____	$_____	$_____
Health Advocacy Solutions	$_____	$_____	$_____	$_____
Blue Care Connection®	$_____	$_____	$_____	$_____
Wellbeing Management	**$Included in admin fee**	$_____	$_____	$_____
Management of the Virtual Visits Program	**$0.52**	$_____	$_____	$_____
*Rebate Credit for the Prescription Drug Program	**$-35.59**	$_____	$_____	$_____
MTM (Retrospective) **(No cost if both HAS and Prescription Drug Program are elected)**	$_____	$_____	$_____	$_____]
Commissions	**$included in admin fee**	$_____	$_____	$_____
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	**$**	**$**	**$**	**$**

*The Rebate Credit is a per Covered Employee per month credit applied to the monthly billing statement. The Employer and Claim Administrator have agreed to the Rebate Credit and Employer agrees that it and its group health plan have no right to, or legal interest in, any portion of the rebates, either under the pharmacy benefit or the medical benefit, actually provided by the Pharmacy Benefit Manager ("PBM") or a pharmaceutical manufacturer to Claim Administrator and consents to Claim Administrator's retention of all such rebates. The Rebate Credit will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates actually provided to Claim Administrator or expected to be provided. Rebate Credits shall not continue after termination of the Prescription Drug Program. Employer agrees that any provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

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:	**$**_____

Claim Administrator Provider Access Fee(s) ☐ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

Group Number(s): P06548, OM2920, PD3006, PD3014, PD3018

☒ % of ADP Savings: **0.78**%

☐ $ per Covered Employee per month: $

☐ ***Group with multiple Provider Access Fees by services (e.g., CMM, and/or PPO 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**

External Review Coordination: ☒ Yes ☐ No

If yes, coordination fee: $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.

Employer elects the following process:

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

Reimbursement Service: ☒ Yes ☐ No

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

Third-Party Recovery Vendors and Law Firms Provisions (other than Reimbursement Services): Employer will pay no more than 25% of any recovered amount made by BCBSIL's Third-Party Recovery Vendor or up to 25% of any recovered amount will be deducted from the amount distributed according to established allocation processes. Employer will pay no more than 35% of any recovered amount made by BCBSIL's third-party law firm or up to 35% of any recovered amount will be deducted from the amount distributed according to established allocation processes.

Alternative Compensation Arrangements: Employer acknowledges and agrees that Claim Administrator has Alternative Compensation Arrangements with contracted Providers, including but not limited to Accountable Care Organizations and other Value Based Programs. Further information concerning Employer's payment for covered services under such Arrangements is described in the Administrative Services Agreement.

Virtual Visits Program: ☒ Yes ☐ No

If yes, Covered Persons would be able to obtain certain Covered Services remotely via interactive video and/or interactive audio/video (where available) capability from Providers participating in the Virtual Visit program.

Termination Administrative Charge

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

i. ***For service charges (including, but not limited to, access fees) billed on a per Covered Employee basis at the time of termination of the Agreement or partial termination of Covered Employees,*** the Termination Administrative Charge will be the amount equal to ten percent (10%) of the annualized charges based on the service charges in effect as of the termination date or date of partial termination and the Plan participation of the two (2) months immediately preceding the termination date or date of partial termination. 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 of the Agreement or partial termination of Covered Employees,*** the Termination Administrative Charge will be such service charges in effect at the time of termination of the Agreement or partial termination of Covered Employees to be applied and billed by the Claim Administrator, and paid by the Employer, in the same manner as prior to termination of the Agreement or partial termination of Covered Employees.

Other Provisions ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

1. 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 skip question b and refer to the Administrative Services Agreement for further information.

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.

2. Massachusetts Health Care Reform Act:

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? ☐ Yes ☒ No

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.

3. Alternative Care Management Program (this is a component of the purchased medical management program):
☒ Yes ☐ No

The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons for Utilization Management, Case Management, including but not limited to Behavioral Health, and other health care management programs.

4. Prior Authorization (this is a component of the purchased medical management program): Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which pre-notification or preauthorization is required: ☒ Yes ☐ No

If no, Employer authorizes Claim Administrator to post Employer's pre-notification or preauthorization requirements on Claim Administrator's Website: ☐ Yes ☐ No

5. Essential Health Benefits ("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.

6. This ASO BPA is binding on both parties and 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.

7. Producer/Consultant Compensation: The Employer acknowledges that if any producer/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 producer/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 producer/consultant by the Claim Administrator in connection with services under the Agreement, the Employer should contact its producer/consultant.

Additional Provisions: Effective 7/1/2020 - P.A. 101-393 (HB 3503) Hearing Aid Coverage for adults applies.

Signature

Erin Bickers

Sales Representative

848 217-637-1800

District Phone & FAX Numbers

David Underkoffler

Producer Representative

Clemens & Associates Life Agency

Producer Firm

2806 E Empire Dr, Bloomington, IL 61761

Producer Address

309-662-2100

Producer Phone & FAX Numbers

dunderkoffler@clemensins.com

Producer Email Address

37-1075738

Tax I.D. No.

Signature of Authorized Purchaser

Print Name

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 is scheduled to be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice provided to the member not less than 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.

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

Group No.: P06548, OM2920, PD3006, PD3014, PD3018

By:

Print Signer's Name Here

➡

Signature and Title

Group Name: Mclean County Unit District No. 5

Address: 1809 Hovey Ave.

City: Normal State: IL ZIP: 61761

Dated this _____ day of _____
Month Year