THE VILLAGE OF TINLEY PARK
Cook County, Illinois
Will County, Illinois

RESOLUTION
NO. 2022-R-093

A RESOLUTION AUTHORIZING THE EXECUTION OF APPLICABLE BENEFIT AGREEMENTS FOR A 15-MONTH TERM FOR THE PURCHASE OF MEDICAL, DENTAL, VISION, AND LIFE INSURANCE BENEFITS FOR THE BENEFIT PLAN YEAR OCTOBER 2022 THROUGH DECEMBER 2023

MICHAEL W. GLOTZ, PRESIDENT
NANCY M. O'CONNOR, VILLAGE CLERK

WILLIAM P. BRADY
WILLIAM A. BRENNAN
DIANE M. GALANTE
DENNIS P. MAHONEY
MICHAEL G. MUELLER
COLLEEN M. SULLIVAN
Board of Trustees

Published in pamphlet form by authority of the President and Board of Trustees of the Village of Tinley Park

RESOLUTION NO. 2022-R-093

A RESOLUTION AUTHORIZING THE EXECUTION OF APPLICABLE BENEFIT AGREEMENTS FOR A 15-MONTH TERM FOR THE PURCHASE OF MEDICAL, DENTAL, VISION, AND LIFE INSURANCE BENEFITS FORTHE BENEFIT PLAN YEAR OCTOBER 2022 THROUGH DECEMBER 2023

WHEREAS, the Village of Tinley Park, Cook and Will Counties, Illinois, is a Home Rule Unit pursuant to the Illinois Constitution of 1970; and

WHEREAS, the Corporate Authorities of the Village of Tinley Park, Cook and Will Counties, Illinois, have considered entering into an Agreement with BlueCross BlueShield of Illinois, MetLife and VSP for a 15-month term; and

WHEREAS, the Corporate Authorities of the Village of Tinley Park, Cook and Will Counties, Illinois, have determined that it is in the best interests of said Village of Tinley Park that said Agreement be entered into by the Village of Tinley Park;

NOW, THEREFORE, Be It Resolved by the President and Board of Trustees of the Village of Tinley Park, Cook and Will Counties, Illinois, as follows:

Section 1: The Preambles hereto are hereby made a part of, and operative provisions of, this Resolution as fully as if completely repeated at length herein.

Section 2: That this President and Board of Trustees of the Village of Tinley Park hereby find that it is in the best interests of the Village of Tinley Park and its residents that the aforesaid Agreements be entered into and executed by said Village of Tinley Park, with said Agreement shall reflect the attached Marketing Proposal rates for such benefits being attached hereto and made a part hereof as **EXHIBIT 1**.

Section 3: That the President and Clerk of the Village of Tinley Park, Cook and Will Counties, Illinois are hereby authorized to execute for and on behalf of said Village of Tinley Park the aforesaid Agreement.

Section 4: That this Resolution shall take effect from and after its adoption and approval.

ADOPTED this 16th day of August, 2022, by the Corporate Authorities of the Village of Tinley Park on a roll call vote as follows:

AYES: Brady, Brennan, MAhoney, Mueller, Sullivan

NAYS: None

ABSENT: Galante

APPROVED this 16th day of August, 2022, by the President of the Village of Tinley Park.

Michael W. Glotz
Village President

ATTEST:

Nancy M. O'Connor
Village Clerk

EXHIBIT 1

AGREEMENTS REFLECTING

THE HORTON GROUP MARKETING PROPOSAL

BlueCross BlueShield of Illinois

Benefit Program Application (BPA)

BlueCross BlueShield of Illinois

BENEFIT PROGRAM APPLICATION ("BPA")

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

Employer Account Number:	271855
HMO Illinois Employer Group Number(s):	H57096
HMO Illinois Section Number(s):	0000, 0101, 0104, 0105, 0106, 0107, 0110, 0111, 0112, 2001, 2002, 2003, 2004,8888
Blue Advantage HMO℠ Employer Group Number(s):	B57096
Blue Advantage HMO Section Number(s):	0000, 0101, 0104, 0105,0106 0107, 0110,0111, 0112, 2001, 2002, 2003, 2004,8888
Non-HMO Plan Employer Group Number(s):	P71855
Non-HMO Plan Section Number(s):	0000, 0101, 0104,0105,0106 0107, 0110,0111, 0112, 2001, 2002, 2003, 2004,8888

Employer's Legal Name: Village of Tinley Park
(Specify the employer, the employee trust or the association applying for coverage. List subsidiary or affiliated companies to be covered below. An employee benefit plan may not be named.)

Physical Address: 16250 South Oak Park Avenue
City: Tinley Park State: IL Zip Code: 60477

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

Employer Identification Number ("EIN"): 36-6006127 Standard Industry Code (SIC): _____

Wholly Owned Subsidiaries to be covered (if additional space is needed, use the Additional Provisions section):

_____

Affiliated Companies to be covered (if additional space is needed, use the Additional Provisions section):

_____

(Affiliated Companies must be required or permitted to be aggregated per IRS guidelines. Employer hereby confirms that Employer, Subsidiaries and Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), or (c), or (m), or (o), or under applicable law.)

Administrative Contact: Angela Arrigo Email: aarrigo@tinleypark.org
Phone: 708-444-5091 Fax: _____

Blue Access for Employers℠ ("BAE℠") Contact: Angela Arrigo
(The BAE contact is the employee of the account authorized by the Employer to access and maintain its account via BAE.)

Title: Human Resources Director Email: aarrigo@tinleypark.org
Phone: 708-444-5091 Fax: _____

Policy Effective Date: 10/01/2022 Policy Anniversary Date (month/day/year): 01/01/2024

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

ERISA Regulated Group Health Plan*: ☐ Yes ☒ No

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

ERISA Plan Sponsor*: _____

ERISA Plan Administrator*: _____

ERISA Plan Administrator's Address: _____

City: _____ State: _____ Zip Code: _____

ERISA Plan Administrator's Email: _____

Please provide your Non-ERISA Plan Month/Year: 10/2022

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

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

For more information regarding ERISA, contact your Legal Advisor.

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

ELIGIBILITY

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

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

   Full-Time Employee means:

   ☒ An Employee of the Employer who is regularly scheduled to work a minimum of 30 hours per week
   ☐ Other (please specify): _____
   ☒ An Eligible Person may also include a retiree of the Employer. Please specify: A police retiree must be at least 50 years of age and with a minimum of 20 years of service. An IMRF employee must be at least 55 years of age with a minimum of 8 years of service. Retiree and eligible dependents must be covered on the date immediately prior to the date of retirement. Retiree and/or eligible spouse may stay on the plan until Medicare entitlement (at which time Medicare becomes primary and BCBSIL becomes secondary), the retiree coverage is terminated, or otherwise required by state statute. If the retiree coverage is terminated, the eligible covered spouse may continue on the plan under their own unique identification number until Medicare entitlement (at which time Medicare becomes primary and BCBSIL becomes secondary), the retiree spouse's coverage is terminated, or otherwise required by state statute. The eligible dependent child(ren) may stay on the plan until reaching the dependent age limit at which time dependent is terminated and qualifies for COBRA. This eligibility language only applies to those early retired employees, their spouses, and their eligible dependents.

   Employees that are deemed full-time using the 12 month measurement period will be eligible for medical and

dental coverage for the subsequent 12 month stability period.

The term "Employee" shall have the meaning set forth under ERISA and applicable law. Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("BCBSIL") reserves the right to audit Employer's initial and ongoing eligibility determinations.

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

3. **Domestic Partner Coverage:** ☐ Yes ☒ No

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

Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, Domestic Partners are not eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as a spouse, but Employer may elect to offer continuation coverage to Domestic Partners similar to that available to spouses under COBRA continuation. Employer shall determine eligibility for COBRA continuation for Domestic Partners, if any. Please indicate your election below:

☐ Yes, Employer elects to offer continuation coverage to Domestic Partners, as defined in the Certificate Booklet

☐ No, Employer does not elect to offer continuation coverage to Domestic Partners (Domestic Partners are not eligible for continuation coverage)

☐ Other: _____

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

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

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

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

For a covered child who reaches a Limiting Age over twenty-six (26), coverage will terminate:

☐ 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. **Disabled Dependent**: Disabled Dependent means a child who is medically certified as disabled and dependent upon the Employee or his/her spouse (or Civil Union partner and/or Domestic Partner if Domestic Partner coverage is elected). To administer medical certification of disabled dependents, you may select option (a) standard rules or (b) custom rules. If (b) is selected there are additional selections regarding age, proof of prior coverage, certification review, forms, and previous medical certification approvals.

(a) ☒ Disabled Dependent Administration will follow **standard rules.**

A disabled dependent may continue coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26). A disabled dependent may add coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26), and proof of coverage as a disabled dependent is provided.

Certification Review is administered by BCBSIL; a Disabled Dependent Certification Form must be submitted to BCBSIL.

(b) ☐ Disabled Dependent Administration will follow **custom rules**. Please make the following selections:

Age: Please select one (1) option regarding age of when the disability began.

☐ The disability must have begun before the child attained the age of twenty-six (26).

☐ All disabled dependents are covered regardless of when the disability began.

Proof of Prior Coverage: Please select required or not required below:

When adding coverage, proof of prior coverage as a disabled dependent is ☐ required ☐ not required.

Certification Review: Please select one (1) option regarding administration of Certification Review.

☐ Certification Review is administered by BCBSIL; a Disabled Dependent Certification Form must be submitted to BCBSIL.

☐ Certification Review is administered by the Employer; there are no Disabled Dependent Certification Form requirements.

If Certification Review is administered by BCBSIL, please select one (1) option regarding forms:

☒ BCBSIL's Disabled Dependent Certification Form will be utilized.

☐ A custom/other Disabled Dependent Certification Form will be utilized.

If Certification Review is administered by BCBSIL, please select allowed or not allowed below:

An approved disabled dependent medical certification from a prior carrier is ☐ allowed ☐ not allowed.

An approved disabled dependent medical certification from a prior BCBS policy is ☐ allowed ☐ not allowed.

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

If a person is added to the Policy and it is later determined that the Employer reported a Coverage Date earlier than what would apply to the Employee or dependent, based on the waiting period and eligibility conditions the Employer provided to BCBSIL, BCBSIL reserves the right to retroactively adjust the Coverage Date for such person.

☒ The date of employment.

☐ The _____ day of employment. **Note:** This may not exceed ninety-one (91) calendar days.

☐ The select one day of the month following select one month(s) of employment.

☐ The select one day of the month following _____ days (option of up to sixty (60) days) of employment.

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

☐ Other (please specify): _____. **Note:** This may not exceed ninety-one (91) calendar days.

☐ This election applies only to the HMO plan: A full month's premium will be charged for the first (1st) month of coverage for those Employees whose Coverage Dates fall between the first (1st) and fifteenth (15th) day of the Premium period. No premium will be charged for the first month of coverage for those Employees whose Coverage Dates fall between the sixteenth (16th) day and the end of the Premium Period.

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

Check all that apply:

☐ An Orientation Period that:

1) Does not exceed one (1) month (calculated by adding one (1) calendar month and subtracting one (1) calendar day from an Employee's start date); and

2) If used in conjunction with a waiting period, the waiting period begins on the first (1st) day after the orientation period.

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

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

1) Starts between the Employee's date of hire and the first (1st) day of the following month;

2) Does not exceed twelve (12) months; and

3) Taken together with other eligibility conditions does not result in coverage becoming effective later than thirteen (13) months from the Employee's start date plus the number of days between a start date and the first (1st) day of the next calendar month (if start day is not the first (1st) day of the month).

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

7. Enrollment

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: The 2022 open enrollment will occur the month of August for an October 1st effective date, and then again November for a January, 2023 effective date. Moving forward open enrollment will be held in November 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 BCBSIL and the Employer. Such date shall be subsequent to the annual open enrollment period.

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

Temporary Layoff: 30 days Disability: 365 days Leave of Absence: 30 days

☐ Other: (please specify): _____

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

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

9. FUNDING ARRANGEMENT: ☒ Standard Premium – Prospective ☐ Cost Plus Program

10. STANDARD PREMIUM INFORMATION

The following elections apply to both Grandfathered and Non-Grandfathered Groups:

Premium Period:

☒ The first (1st) day of each calendar month through the last day of each calendar month. (This option applies to all coverages if the Employer has BlueCare Dental HMO℠ coverage.)

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

11. MINIMUM PARTICIPATION AND EMPLOYER CONTRIBUTION INFORMATION:

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

Employer contribution:

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

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

☒ Other (please specify): Varies based on group. Minimum 10% employee contribution.

(b) The following applies to both Grandfathered and Non-Grandfathered Groups: BCBSIL reserves the right to change premium rates when a substantial change occurs in the number or composition of Subscribers covered. A substantial change will be deemed to have occurred when the number of Subscribers covered changes by ten percent (10%) or more over a thirty (30) day period or twenty-five percent (25%) or more over a ninety (90) day period.

(c) The following applies to Non-Grandfathered Groups: BCBSIL reserves the right to take any or all of the following actions:

1) Initial rates will be finalized for the effective date of the policy based on the enrolled participation and Employer contribution levels;

2) After the policy effective date, the group will be required to maintain a minimum Employer contribution of twenty-five percent (25%), and at least a seventy percent (70%) participation of Eligible Employees (less valid waivers). In the event the group is unable to maintain the contribution and participation requirements, then the rates will be adjusted accordingly; and/or

3) Non-renew or discontinue coverage unless the twenty-five percent (25%) minimum Employer contribution is met and at least seventy percent (70%) of Eligible Employees (less valid waivers) have enrolled for coverage. Employer will promptly notify BCBSIL of any change in participation and Employer contribution.

(d) The following applies to Grandfathered Groups: It is understood that no Policy will be issued or renewed on a contributory basis unless at least twenty-five percent (25%) of the Eligible Persons, and for Family Coverage seventy-five percent (75%) of the Eligible Persons with eligible dependents, have enrolled for coverage.

12. Essential Health Benefits ("EHB") Definition Election: Employer elects EHBs based on the Illinois benchmark.

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

☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.

☐ Other (please specify): _____.

CURRENT ELIGIBILITY INFORMATION

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

1. On payroll _____
2. On COBRA continuation coverage _____

3. With retiree coverage (if applicable) _____
4. Who work part-time _____
5. Serving the new hire waiting period _____
6. Declining because of other **group** coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) _____
7. Declining coverage (not covered elsewhere) _____

STANDARD PREMIUM RATES ☒ Yes ☐ No						
	For Internal Use Only - Blue Star℠ Ben.Agree#: ***0018*** **P71855**	*For Internal Use Only* - Blue Star Ben.Agree#: ***0019*** B57096	*For Internal Use Only* - Blue Star Ben.Agree#: ***0020*** **H57096**	*For Internal Use Only* - Blue Star Ben.Agree#: _____ _____	*For Internal Use Only* - Blue Star Ben.Agree#: _____ _____	**Total**
1. Employee only:	$889.05	$675.69	$684.58	$_____	$_____	$_____
2. Employee plus one (1) dependent (i.e. Employee plus one (1) spouse or one (1) child):	$_____	$_____	$_____	$_____	$_____	$_____
3. Employee plus two (2) or more dependents:	$_____	$_____	$_____	$_____	$_____	$_____
4. Employee plus Spouse:	$1,817.69	$1,381.44	$1,399.63	$_____	$_____	$_____
5. Employee plus Child(ren) (i.e. Employee plus one (1) or more children):	$1,744.29	$1,325.67	$1,343.12	$_____	$_____	$_____
6. Employee plus Family / Family:	$2,698.76	$2,051.06	$2,078.04	$_____	$_____	$_____
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 BCBSIL is Secondary Payer)						
Single Coverage:	$755.55	$574.22	$581.79	$_____	$_____	$_____
Family Coverage:	$1,511.12	$1,148.46	$1,163.56	$_____	$_____	$_____

COST PLUS PROGRAM

☐ Yes ☒ No

Service Charges:

For the HMO Plan:

a) Service Charges for Claim Payments:

- ☐ HMO Illinois: _____% of Claim Payments; or $_____ per Enrollee per month for health Claim Payments.
- ☐ Blue Advantage HMO: _____% of Claim Payments; or $_____ per Enrollee per month for health Claim Payments.

b) Physician's Services Fees:

- ☐ HMO Illinois: $_____ per month per single Enrollee; or $_____ per month per Enrollee with one (1) or more dependents.
- ☐ Blue Advantage HMO: $_____ per month per single Enrollee; or $_____ per month per Enrollee with one (1) or more dependents.

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

For the Non-HMO Plan:

- ☐ _____% of Net Claim Payments or $_____ per Employee per month.
- ☐ Applies to all coverage(s).
- ☐ Different percentage(s) or amount(s) for the following types of coverage. Please specify below:
  - For _____ coverage: _____% of _____ Claim Payments or $_____ per Employee per month.
  - For _____ coverage: _____% of _____ Claim Payments or $_____ per Employee per month.
  - Other (please specify): _____.

☐ **Virtual Visits Program** (Non-HMO Plan only)

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

☐ **Ancillary Program:**

- ☐ Health Dialog (may select one (1)) Health Dialog Fee: **$**_____ per covered Employee per month
  - ☐ Health Coach Line (In bound)
  - ☐ Health Coach Line (In and out bound)
  - ☐ Health Coach Line (With Disease Management)
  - ☐ Not applicable

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:
☐ Three (3) months ☐ Six (6) months ☐ Nine (9) months ☐ Twelve (12) months
☐ Other (please specify): _____

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

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

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

(PPO Only) Advanced Payment Review (APR): APR is a suite of payment integrity offerings. Refer to the ABS. Reimbursement Services are included for the Cost-Plus program. BCBSIL will retain twenty-five percent (25%) of any recovered amounts made on third-party liability claims other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

Does Employer elect additional APR capabilities? ☐ Yes ☐ No If **yes**, indicate APR Savings Program or PEPM below:

☐ APR Savings Program

☐ PEPM

For APR capabilities other than Reimbursement Services: If Employer elects APR Savings Program, BCBSIL will invoice twenty-five percent (25%) of any recovered amounts identified by BCBSIL or third-party vendor other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

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 Drugs covered under the Medical Benefit:

Medical Drug Rebate Credit

PPO: $_____ per covered Employee per month.

Prescription Drug Program:

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

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

Rebate Credit for Drugs covered under the Pharmacy Benefit:

PPO: $_____ per covered Employee per month.

HMO: $_____ per Enrollee per month.

HMO Pharmacy Network (Select one (1)):

☐ Traditional Select Network

☐ Network shown on PBM Fee Schedule Exhibit

PPO Pharmacy Network (Select one (1)):

☐ Advantage Network

☐ Preferred Network

☐ Network shown on PBM Fee Schedule Exhibit

PPO Drug List: Select Drug List; **Other (please specify):** _____

Prescription Drug Program Clinical Management Programs

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

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

Termination Administrative Charge

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

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

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

FOR NON-HMO COST-PLUS PROGRAMS ONLY:
PLAN PROVIDER ACCESS FEE(S)
☐ Yes ☒ No

Group Number(s): _____

☐ % of Average Discount Percentage ("ADP") savings: _____%

☐ $ per Employee per month: $_____

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

☐ % of ADP savings: _____%

☐ $ per Employee per month: $_____

EMPLOYER STATEMENTS:

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

2. The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Employer, has provided the information requested in this BPA and, on behalf of the Employer, offers to purchase the benefit program as outlined in the Request For Proposal ("RFP") or, in the case of an HMO Plan, the proposal document submitted to the Employer by the Sales Representative. Any changes to the RFP are specified below. It is understood and agreed that the actual terms and conditions of the benefit program are those contained in the Policy.

3. This BPA is subject to acceptance by BCBSIL. Upon acceptance, BCBSIL shall issue a Policy to the Employer and this BPA shall be incorporated and made a part of the Policy. Upon acceptance of this BPA and issuance of the Policy, the Employer shall be referred to as the Policyholder. In the event of any conflict between the RFP and the Policy, the provisions of the Policy shall prevail. No coverage will begin until receipt of the first (1st) premium by BCBSIL.

4. The undersigned representative acknowledges that any producer is acting on behalf of the Employer for purposes of purchasing the Employer's insurance, and that if BCBSIL accepts this BPA and issues a Policy to the Employer, BCBSIL may pay the Employer's 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 producer by BCBSIL in connection with the issuance of a Policy, the Employer should contact its producer.

5. The undersigned representative acknowledges that the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 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 BCBSIL except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by BCBSIL.

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

OTHER PROVISIONS:

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

2. **Third-Party Recovery Vendors (other than Reimbursement Services):** BCBSIL engages with third-party recovery vendors on a post-pay basis to identify and/or recover any potential overpayments that may have been made to Providers. This provision does not apply to the Cost-Plus PPO Program.

3. **Third-Party Law Firms Provisions (other than Reimbursement Services)**: BCBSIL engages with third-party law firms on a post-pay basis to identify and/or recover any potential overpayments that may have been made to Providers.

4. **Summary of Benefits and Coverage ("SBC")**: The SBC Addendum is attached and made a part of the Policy. BCBSIL will create the SBC (only for benefits BCBSIL insures under the Policy) and provide the SBC to the Employer in electronic format. If the Employer approves of the content, Employer will then distribute the SBC to participants and beneficiaries (or hire a third party to distribute) as required by law. If the Employer would like changes to the SBC, it will promptly notify BCBSIL. BCBSIL will also distribute the 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 Employer.

5. **FSA purchased**: ☐ Yes ☒ No (If yes, select vendor)
   (Vendor: Select Vendor)

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

7. **Life or Disability purchased**: ☒ Yes ☐ No (If yes, complete separate application.)

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

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

10. **(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.

11. **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.

12. ☒ **Wellbeing Management (WBM)**

ADDITIONAL PROVISIONS:

A. **Grandfathered Health Plans:** Employer shall provide BCBSIL with written notice prior to renewal (and during the plan year, at least sixty (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 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 BCBSIL to the terms and conditions of coverage. In no event shall BCBSIL 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 made part of the BPA and Group Policy, and Employer represents and warrants that such Form is true, complete, and accurate. If Employer fails to timely provide BCBSIL with any requested grandfathered health plan information, BCBSIL 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 Employer represents and warrants that one (1) 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 ERISA) (an "exempt plan status"). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by BCBSIL to the terms and conditions of coverage. In no event shall BCBSIL 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. Employer 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 (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any directions, actions and interpretations of the Employer, (d) any provision of inaccurate information, (e) the SBC, (f) any plan's design (including but not limited to any directions, actions and interpretations of the Employer, and/or (g) Employer's selection of EHB definition for the purpose of the Patient Protection and Affordable Care Act ("ACA"). 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.

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

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

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

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

Any reference in this BPA to the "Employee plus one (1) dependent" rate structure means "Employee plus one (1) spouse (includes Civil Union partner and/or, if elected, Domestic Partner) or one (1) child."

Any reference in this BPA to the "Employee plus Child(ren)" rate structure means "Employee plus one (1) or more children."

Effective 10/01/2022:

1.) Medical Contract moving to 10/01/2022 - 12/31/2023.

2.) PPO Plan is moving to the Performance Drug List per BCBSIL Mandate for Fully Insured PPO plans. No other plan changes.

3.) Dental moved to Metlife & Life Insurance is remaining with BCBSIL/Dearborn.

4.) Updating the extension of benefits due to Disability from: 30 days, to: 365 days.

5.Cancel timing rule: End of month

6.) The following sections on the account structure to be renamed:
0101 to Non-Union
0107 to ACA
0110 to ACA-Fire Suppression

Rename 2001, 2003 to remove "-NONMED"

Rename 2002, 2004 to remove "-MED" and replace with "-POST 65"

7.) The following sections on the account structure will be ended:
0102, 0103, 0108, 0109

8.) The 2022 open enrollment will occur the month of August for an October 1st effective date, and then again November for a January, 2023 effective date. Moving forward open enrollment will be held in November for a January 1st effective date.

Ben Coleman
Sales Representative

890 630-824-5399
District Phone No.

Mike Wojcik
Producer Representative

Signature of Producer Representative

The Horton Group
Producer Firm

10320 Orland Parkway, Orland Park, IL 60467
Producer Address

000607220
Producer Number

36-3672171
Producer Tax ID No.

Signature of Authorized Purchaser

Village Manager
Title

8 Sept. 2022
Date

Witness

$_____ Amount Submitted (not required for renewals)

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 HCSC 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 either 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.

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

Group No(s):
H57096
B57096
P71855

By: Patrick J. Carr
Print Signer's Name Here

Signature and Title → Village Manager

Group Name: Village of Tinley Park

Address: 16250 South Oak Park Avenue

City: Tinley Park State: IL Zip Code: 60477

Dated this _____ day of _____, ____
Month Year

MetLife

Application for Group Insurance (Dental)

MetLife

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York

APPLICATION FOR GROUP INSURANCE

The applicant named below is applying for Group Insurance to provide coverage for the class(es) of persons specified below.

APPLICANT DATA

1. Full legal name of Applicant: Village Of Tinley Park (the "Policyholder")

2. Address: 16250 S Oak Park Ave City Tinley Park State IL Zip 60477

EFFECTIVE DATE

The effective date of the applied for group insurance will be 10/01/2022, subject to MetLife's acceptance of this application and the Applicant's payment of the Premium due on or before such date.

SITUS

Group Policy forms will be issued for delivery in and governed by the laws of **Illinois**.

COVERAGE DATA

Employees / Members	Dependents
Dental	Dental

PREMIUM DATA

Premiums will be paid: ☒ Monthly ☐ Quarterly ☐ Annually ☐ Other _____

Attached is an advance payment of: $ 0

AGREEMENT

The Applicant signing below agrees to accept the terms and provisions of all Group Policy forms issued pursuant to this application; including all Exhibits, amendments and endorsements, if any.

Fraud Warning. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Applicant's Authorized Representative

Signed at: City TINLEY PARK, State IL Date: 9-1-2022

Name of Authorized Representative Pat Carr

Title of Authorized Representative VILLAGE MANAGER

Applicant's Signature [signature]

Signature of Licensed MetLife Agent or Resident Agent as required by law

Agent's State License No. _____

Date: 08/18/2022

Name of Agent: Anthony Manfrin

Agent's Signature Anthony Manfrin

HIPAA Request

If you wish to include in your booklet certificate the HIPAA privacy language shown on the specimen "Sample Dental and/or Vision Booklet Certificate/SPD Language" provided to you by MetLife, please answer the following questions, sign, and return this form to your MetLife Sales Office.

A. Are there employees of the Plan Sponsor that may access PHI (Protected Health Information) provided by the Plan? If there are, please provide their title(s) or other identifiers below.

PLEASE DO NOT PROVIDE THEIR NAMES; ONLY TITLE OR OTHER IDENTIFIER.

Title **Client Executive** Title **Assistant Client Manager** Title **Client Manager**

Title **Human Resources Director** Title Title

B. Should the term "Privacy Officer" be included in Section III. (c) "Sharing of PHI with the Plan Sponsor" of the Dental and/or Vision Plan Document?

☐ Yes ☒ No

C. Should Section IV. "Participant's Rights" be included in the Dental and/or Vision Plan Document? (This is an optional section.)

☒ Yes ☐ No

D. Should Section V. "Privacy Complaints/Issues" be included in the Dental and/or Vision Plan Document? (This is an optional section.)

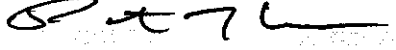
☒ Yes ☐ No

As a duly authorized representative of the Customer named below and its group dental and/or vision plan, and consistent with such Customer's decision to amend its plan document to incorporate HIPAA privacy provisions, I hereby request that MetLife include in Customer's booklet certificate HIPAA privacy language reflecting Customer's choices on this form.

Customer Name **Village Of Tinley Park**

Name of Authorized Representative **Pat Carr**

Title of Authorized Representative VILLAGE MANAGER

Signature of Authorized Representative  Date 9-1-2022

Group, Voluntary & Worksite Benefits
Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166

MetLife

Statement of Responsibility

MetLife will be responsible to the group policyholder for the performance of its administrative obligations under the group policy, this agreement and any other written agreement between MetLife and the group policyholder. If MetLife uses a third party in connection with any of MetLife's administrative obligations, MetLife will remain responsible to the group policyholder for the performance by the third party of those administrative obligations. The third party will work under the control and direction of Metlife and Metlife will be solely responsible for the acts, errors and omissions of the third party.

The group policyholder will be responsible to MetLife for the performance of its administrative obligations under the group policy, this agreement and any other written agreement between MetLife and the group policyholder. If the group policyholder uses a third party in connection with any of the group policyholder's administrative obligations, the group policyholder will remain responsible to MetLife for the performance by the third party of those administrative obligations. The third party will work under the control and the direction of the group policyholder and the group policyholder will be solely responsible for the acts, errors and omissions of the third party.

To be completed by Policyholder:

Pat Carr
(Name of Authorized Representative)

VILLAGE MANAGER
(Title of Authorized Representative)

(Signature of Policyholder Authorized Representative)

Village Of Tinley Park
(Group Policyholder Name)

Signed at:
TINLEY PARK
(City)

IL
(State)

9-1-2022
Date(MM/DD/YYYY)

To be completed by Metropolitan Life Insurance Company:

James W. Reid
Executive Vice President
Group, Voluntary & Worksite Benefits

Date(MM/DD/YYYY)

Village Of Tinley Park

Employer Sponsored Dental

Proposal produced on August 17, 2022
This quote is valid for 90 days from date of proposal

Village Of Tinley Park
Rate Summary

Coverage	Participating Lives	Covered Volume	Rates	Annual Premium
Dental Option - 1.3 8/10 6762526				
Employer Sponsored Dental *(per Employee Per Month)*	311			$258,022
▪ Employee Only	113		$32.32	
▪ Employee + Spouse	61		$71.33	
▪ Employee + Child(ren)	27		$68.46	
▪ Employee + Family	110		$105.91	
Rates are guaranteed from October 1, 2022 - December 31, 2023				
2nd year Rate Cap: The first year's renewal rates will not be increased by more than 6.0% above the current rates. 3rd year Rate Cap: The second year's renewal rates will not be increased by more than 7.0% above the prior plan year's rates.				

Summary of Benefits
Dental Insurance - Dental Option - 1.3 8/10

Employer Sponsored Dental				
Class Description	All Active Full Time Employees (30 Hours)		Retirees (Current & Future Retirees) (30 Hours)	
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***
Reimbursement	Negotiated Fee Schedule	R&C 90th Percentile	Negotiated Fee Schedule	R&C 90th Percentile
Type A – Preventive	100%	100%	100%	100%
Type B – Basic	80%	80%	80%	80%
Type C – Major	50%	50%	50%	50%
Calendar Year Deductible applies to: ▪ **Individual** ▪ **Family**	B & C $50 $150 Aggregate	B & C $50 $150 Aggregate	B & C $50 $150 Aggregate	B & C $50 $150 Aggregate
Calendar Year Maximum ***(applies to A,B,C services)***	$1,000	$1,000	$1,000	$1,000
Orthodontia	50%	50%	50%	50%
Orthodontia Lifetime Maximum	$1,250	$1,250	$1,250	$1,250

* Out of Network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of (1) the dentist's actual charge (the 'Actual Charge'), (2) the dentist's usual charge for the same or similar services (the 'Usual Charge') or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.

Employer Sponsored Dental	Rate per Employee	Lives	Est Monthly Premium	Est Annual Premium
▪ Employee Only	$32.32	113	$21,502	$258,022
▪ Employee + Spouse	$71.33	61		
▪ Employee + Child(ren)	$68.46	27		
▪ Employee + Family	$105.91	110		
▪ Total		311		
Rates are guaranteed from October 1, 2022 - December 31, 2023 (15 months)				
2nd year Rate Cap: The first year's renewal rates will not be increased by more than 6.0% above the current rates. 3rd year Rate Cap: The second year's renewal rates will not be increased by more than 7.0% above the prior plan year's rates.				

Frequency & Allocations / Exclusions

(Custom Primary (Flex) - Custom Lower Cost (Flex))

Class Description: All Active Full Time Employees	
TYPE A ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Examinations	▪ 2 times in 1 calendar year
▪ Examinations – Problem Focused	▪ Combined with Examinations Limit
▪ Prophylaxis: Cleanings	▪ 2 times in 1 calendar year
▪ Fluoride	▪ 2 times in 1 calendar year for a dependent child under age 19
▪ Full Mouth X-Rays	▪ Once in 36 months
▪ Bitewing X-Rays	▪ For a child under 14: 1 time in 12 months ▪ Adult: 1 time in 12 months
▪ Periapical X-Rays	
▪ Other X-Rays	
TYPE B ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Sealants	▪ 1 per molar in 60 months for a child under age 19
▪ Space Maintainers	▪ No Limit for a child under age 19
▪ Amalgam Fillings	▪ 1 replacement per surface in 24 Months
▪ Root Canal	▪ 1 in 24 months
▪ Periodontal Maintenance	▪ 2 perio. Treatments in 1 calendar yr, includes 2 cleanings (total comb: 2)
▪ Periodontal Surgery	▪ 1 per quadrant in any 36 month period
▪ Scaling & Root Planing	▪ 1 per quadrant in any 24 month period
▪ Prefabricated Crowns	▪ 1 per tooth in 5 calendar years
▪ Labs & Other Tests	
▪ Emergency Palliative Treatment	
▪ General Anesthesia	
▪ Resin Composite Fillings(includes coverage for composite fillings on molars)	
▪ Pulpotomy	
▪ Pulp Capping	
▪ Pulp Therapy	
▪ Apexification & Recalcification	
▪ Periodontal Surgery – Soft & Connective Tissue Grafts	
▪ Periodontics – Non-Surgical	
▪ Oral Surgery: Simple Extractions	
▪ Oral Surgery: Surgical Extractions	
▪ Other Oral Surgery	
▪ General Services	
TYPE C ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Consultations	▪ 1 in 12 months
▪ Crown Buildups / Post Core	▪ 1 per tooth in 5 calendar years
▪ Repairs	▪ 1 in 12 months
▪ Recementations	▪ 1 in 12 months
▪ Dentures	▪ 1 in 5 calendar years

▪ Immediate Temporary Dentures – Complete / Partial	▪ 1 replacement in 12 months
▪ Dentures – Rebases / Relines	▪ 1 in 36 months
▪ Denture Adjustments	▪ 1 in 12 months
▪ Fixed Bridges	▪ 1 in 5 calendar years
▪ Inlays / Onlays /Crowns	▪ 1 replacement per tooth in 5 calendar years
▪ Tissue Conditioning	▪ 1 in 36 months
▪ Occlusal Adjustments	▪ 1 in 12 months
Orthodontics ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Orthodontic Diagnostics	
▪ Orthodontic Treatment	

Exclusions

All Active Full Time Employees

- Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature.
- Services for which a covered person would not be required to pay in the absence of dental insurance.
- Services or supplies received by a covered person before the insurance starts for that person.
- Services which are neither performed nor prescribed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for scaling or polishing of teeth or fluoride treatment.
- Services which are primarily cosmetic. (For residents of Texas: Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child).
- Services or appliances which restore or alter occlusion or vertical dimension.
- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease.
- Restorations or appliances used for the purpose of periodontal splinting.
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
- Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
- Initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
- Decoration or inscription of any tooth, device, appliance, crown or other dental work.
- Missed appointments.
- Services covered under any workers' compensation or occupational disease law.
- Services covered under any employer liability law.
- Services for which the employer of the person receiving such services is not required to pay.
- Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.
- Services covered under other coverage provided by the Policyholder.
- Temporary or provisional restorations.
- Temporary or provisional appliances.
- Prescription drugs.
- Services for which the submitted documentation indicates a poor prognosis.
- Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first.
- The following when charged by the dentist on a separate basis - Claim form completion; infection control such as gloves, masks, and sterilization of supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing and biting of food.

- Caries susceptibility tests.
- Precision attachments associated with fixed and removable prostheses.
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, cast restoration or denture.
- Intra and extraoral photographic images.
- Fixed and removable appliances for correction of harmful habits.
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
- Implantology, including repairs.
- Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.
- Implant Supported Prosthetics.

Frequency & Allocations / Exclusions

(Custom Primary (Flex) - Custom Lower Cost (Flex))

Class Description: Retirees (Current & Future Retirees)	
TYPE A ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Examinations	▪ 2 times in 1 calendar year
▪ Examinations – Problem Focused	▪ Combined with Examinations Limit
▪ Prophylaxis: Cleanings	▪ 2 times in 1 calendar year
▪ Fluoride	▪ 2 times in 1 calendar year for a dependent child under age 19
▪ Full Mouth X-Rays	▪ Once in 36 months
▪ Bitewing X-Rays	▪ For a child under 14: 1 time in 12 months ▪ Adult: 1 time in 12 months
▪ Periapical X-Rays	
▪ Other X-Rays	
TYPE B ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Sealants	▪ 1 per molar in 60 months for a child under age 19
▪ Space Maintainers	▪ No Limit for a child under age 19
▪ Amalgam Fillings	▪ 1 replacement per surface in 24 Months
▪ Root Canal	▪ 1 in 24 months
▪ Periodontal Maintenance	▪ 2 perio. Treatments in 1 calendar yr, includes 2 cleanings (total comb: 2)
▪ Periodontal Surgery	▪ 1 per quadrant in any 36 month period
▪ Scaling & Root Planing	▪ 1 per quadrant in any 24 month period
▪ Prefabricated Crowns	▪ 1 per tooth in 5 calendar years
▪ Labs & Other Tests	
▪ Emergency Palliative Treatment	
▪ General Anesthesia	
▪ Resin Composite Fillings(includes coverage for composite fillings on molars)	
▪ Pulpotomy	
▪ Pulp Capping	
▪ Pulp Therapy	
▪ Apexification & Recalcification	

▪ Periodontal Surgery – Soft & Connective Tissue Grafts	
▪ Periodontics – Non-Surgical	
▪ Oral Surgery: Simple Extractions	
▪ Oral Surgery: Surgical Extractions	
▪ Other Oral Surgery	
▪ General Services	
TYPE C ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Consultations	▪ 1 in 12 months
▪ Crown Buildups / Post Core	▪ 1 per tooth in 5 calendar years
▪ Repairs	▪ 1 in 12 months
▪ Recementations	▪ 1 in 12 months
▪ Dentures	▪ 1 in 5 calendar years
▪ Immediate Temporary Dentures – Complete / Partial	▪ 1 replacement in 12 months
▪ Dentures – Rebases / Relines	▪ 1 in 36 months
▪ Denture Adjustments	▪ 1 in 12 months
▪ Fixed Bridges	▪ 1 in 5 calendar years
▪ Inlays / Onlays /Crowns	▪ 1 replacement per tooth in 5 calendar years
▪ Tissue Conditioning	▪ 1 in 36 months
▪ Occlusal Adjustments	▪ 1 in 12 months
Orthodontics ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Orthodontic Diagnostics	
▪ Orthodontic Treatment	

Exclusions
Retirees (Current & Future Retirees)
▪ Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature. ▪ Services for which a covered person would not be required to pay in the absence of dental insurance. ▪ Services or supplies received by a covered person before the insurance starts for that person. ▪ Services which are neither performed nor prescribed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for scaling or polishing of teeth or fluoride treatment. ▪ Services which are primarily cosmetic. (For residents of Texas: Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child). ▪ Services or appliances which restore or alter occlusion or vertical dimension. ▪ Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease. ▪ Restorations or appliances used for the purpose of periodontal splinting. ▪ Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco. ▪ Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss. ▪ Initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth. ▪ Decoration or inscription of any tooth, device, appliance, crown or other dental work. ▪ Missed appointments. ▪ Services covered under any workers' compensation or occupational disease law. ▪ Services covered under any employer liability law. ▪ Services for which the employer of the person receiving such services is not required to pay. ▪ Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or

VA hospital.
- Services covered under other coverage provided by the Policyholder.
- Temporary or provisional restorations.
- Temporary or provisional appliances.
- Prescription drugs.
- Services for which the submitted documentation indicates a poor prognosis.
- Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first.
- The following when charged by the dentist on a separate basis - Claim form completion; infection control such as gloves, masks, and sterilization of supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing and biting of food.
- Caries susceptibility tests.
- Precision attachments associated with fixed and removable prostheses.
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, cast restoration or denture.
- Intra and extraoral photographic images.
- Fixed and removable appliances for correction of harmful habits.
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
- Implantology, including repairs.
- Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.
- Implant Supported Prosthetics.

Highlights
Broker Commissions included in the rate: Flat 2.00%
Third Party Entity Service/Platform fees in the rate: Employer Sponsored Dental: 3.00%
Expected Participation: 89% and at least 10 covered lives.
Employee Contributions: 25%
Financial Arrangement: Non-retrospectively Experience Rated
Situs is ILLINOIS
Only those residing in the United States are eligible for benefits
Dependent Child Definition: A Child is covered up to age 26, A student is covered up to age 26.
Ortho coverage applies to: Child Only. Children are covered to the dependent age limit.
This quote assumes the plan is a Section 125 plan.
An Open Enrollment period occurring annually is included.

Underwriting Assumptions
WillsCenter.com: Online will prep service offered through SmartLegalForms, Inc., available to all customers at no charge.
If insurance coverage is provided, it will be governed by the terms and conditions of the insurance policy and applicable law. If administrative services are provided, they are governed by the terms and condition of the administrative services agreement and by applicable law.
If MetLife is requested to duplicate contractual provisions from the prior carrier, such provisions must be compatible with all MetLife's standards.
The quoted rates and or fees are based upon the request received. If new or additional information in connection with this request is provided, MetLife reserves the right to change its quote at any time before the effective date. After the effective date, rate and or fees are subject to the terms and conditions of the policy and or administrative services agreement.
Only those eligible persons residing in the United States may be covered. Any others must be approved by MetLife.
NOTICE REGARDING NON-US COVERAGE When providing you with information concerning a group insurance policy issued or proposed to your affiliate or subsidiary outside the United States by a Metropolitan Life Insurance Company (MLIC) affiliate or by other locally licensed insurers that are members of the MAXIS Global Benefits Network (MAXIS GBN), New York insurance law requires the person providing the information to be licensed as an insurance broker. In this capacity, the information provided to you will only be on behalf of such insurers and not on behalf of MLIC or any other insurer that is not a member of MAXIS GBN. Please note that while MLIC is a member of MAXIS GBN and is licensed to transact insurance business in New York, the other MAXIS GBN member insurers are not licensed or authorized to do business in New York. The group insurance policies they issue are for coverage outside the United States and are governed by the laws of the country they were issued in. These policies have not been approved by the New York Superintendent of Financial Services, are not subject to all of the laws of New York, and are not protected by the New York State Guaranty Fund.
Some services in connection with the coverage may be performed by our affiliate, MetLife Services and Solutions, LLC. These service arrangements in no way alter Metropolitan Life Insurance Company's obligations. Coverage will continue to be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.
SIC Code: 9111

U.S. Business Intermediary and Producer Compensation Notice

Metropolitan Life Insurance Company, Metropolitan Tower Life Insurance Company, and Metropolitan General Insurance Company (collectively herein called "MetLife"), enters into arrangements concerning the sale, servicing and/or renewal of MetLife group insurance and certain other group-related products *("Products")* with brokers, agents, consultants, third party administrators, general agents, associations, and other parties that may participate in the sale, servicing and/or renewal of such products *(each an "Intermediary")*. MetLife may pay your Intermediary compensation, which may include, among other things, base compensation, supplemental compensation and/or a service fee. MetLife may pay compensation for the sale, servicing and/or renewal of products, or remit compensation to an Intermediary on your behalf. Your Intermediary may also be owned by, controlled by or affiliated with another person or party, which may also be an Intermediary and who may also perform marketing and/or administration services in connection with your products and be paid compensation by MetLife.

Base compensation, which may vary from case to case and may change if you renew your products with MetLife, may be payable to your Intermediary as a percentage of premium or a fixed dollar amount. MetLife may also pay your Intermediary compensation that is based upon your Intermediary placing and/or retaining a certain volume of business *(number of products sold or dollar value of premium)* with MetLife. In addition, supplemental compensation may be payable to your Intermediary for eligible Products. Under MetLife's current supplemental compensation plan (SCP), the amount payable as supplemental compensation may range from 0% to 8% of premium. The supplemental compensation percentage may be based on one or more of: (1) the number of products sold through your Intermediary during a one-year period, or other defined period; (2) the amount of premium or fees with respect to products sold through your Intermediary during a one-year period; (3) the persistency percentage of products inforce through your Intermediary during a one-year period; (4) the block growth of the products inforce through your Intermediary during a one-year period; (5) premium growth during a one-year period; or (6) a flat amount, fixed percentage or sliding scale of the premium for products as set by MetLife. The supplemental compensation percentage will be set by MetLife based on the achievement of the outlined qualification criteria and it may not be changed until the following SCP plan year. As such, the supplemental compensation percentage may vary from year to year, but will not exceed 8% under the current supplemental compensation plan.

The cost of supplemental compensation is not directly charged to the price of our products except as an allocation of overhead expense, which is applied to all eligible group insurance products, whether or not supplemental compensation is paid in relation to a particular sale or renewal. As a result, your rates will not differ by whether or not your Intermediary receives supplemental compensation. If your Intermediary collects the premium from you in relation to your products, your Intermediary may earn a return on such amounts. Additionally, MetLife may have a variety of other relationships with your Intermediary or its affiliates, or with other parties, that involve the payment of compensation and benefits that may or may not be related to your relationship with MetLife *(e.g., insurance and employee benefits exchanges, enrollment firms and platforms, sales contests, consulting agreements, participation in an insurer panel, or reinsurance arrangements)*.

More information about the eligibility criteria, limitations, payment calculations and other terms and conditions under MetLife's base compensation and supplemental compensation plans can be found on MetLife's Website at www.metlife.com/business-and-brokers/broker-resources/broker-compensation. Questions regarding Intermediary compensation can be directed to ask4met@metlifeservice.com, or if you would like to speak to someone about Intermediary compensation, please call (800) ASK 4MET. In addition to the compensation paid to an Intermediary, MetLife may also pay compensation to your representative. Compensation paid to your representative is for participating in the sale, servicing, and/or renewal of products, and the compensation paid may vary based on a number of factors including the type of product(s) and volume of business sold. If you are the person or entity to be charged under an insurance policy or annuity contract, you may request additional information about the compensation your representative expects to receive as a result of the sale or concerning compensation for any alternative quotes presented, by contacting your representative or calling (866) 796-1800.

Non-U.S. Coverage

When providing you with information concerning an eligible group insurance policy issued or proposed to your affiliate or subsidiary outside the United States by a MetLife affiliate or by other locally licensed insurers that are members of the MAXIS Global Benefits Network (MAXIS GBN), New York insurance law requires the person providing the information to be licensed as an insurance broker. In this capacity, the information provided to you will only be on behalf of such insurers and not on behalf of MetLife or any other insurer that is not a member of MAXIS GBN. Please note that while MetLife is a member of MAXISGBN and is licensed to transact insurance business in New York, the other MAXIS GBN member insurers are not licensed or authorized to do business in New York. The group insurance policies they issue are for coverage outside the United States and are governed by the laws of the country they were issued in. These policies have not been approved by the New York Superintendent of Financial Services, are not subject to all of the laws of New York, and are not protected by the New York State Guaranty Fund.

THE HORTON GROUP

MARKETING PROPOSAL

Insurance Risk Advisory Employee Benefits

HORTON

The Horton Group's

Marketing Proposal

Prepared for: **Village of Tinley Park**
October 2022

Presented By:
Michael E. Wojcik
mike.wojcik@thehortongroup.com
Phone: 708-845-3126 / Cell: 708-650-1557

HORTON

Village of Tinley Park

October 1, 2022

The following Medical markets were approached:	
Carrier	***Status***
Aetna	Declined
Blue Cross Blue Shield of IL	Quoted
Cigna	Declined
Humana	Declined
United Healthcare	Declined

The following Voluntary Dental markets were approached:	
Carrier	***Status***
Aetna	Quoted
BCBS	Incumbent
MetLife	Quoted
UHC	Quoted

HORTON

Village of Tinley Park
Health Review
October 1, 2022

Taken from Renewal

	EE	ES	EC	FAM	Med	Med + 1	Total
BA HMO	11	2	4	9	0	0	26
HMOI	14	5	2	14	0	0	35
PPO	79	50	22	86	3	1	241
Total	104	57	28	109	3	1	302

Presented by: Mike Wojcik

				12 Month Policy			15 Month Policy		
Carriers:	**CURRENT BCBS**			**RENEWAL BCBS**			**RENEWAL BCBS**		
Type of Plan	**BA HMO**	**HMO I**	**PPO**	**BA HMO**	**HMO I**	**PPO**	**BA HMO**	**HMO I**	**PPO**
In Network Benefits									
Individual Deductible	n/a	n/a	$500	n/a	n/a	$500	n/a	n/a	$500
Family Deductible	n/a	n/a	$1,500	n/a	n/a	$1,500	n/a	n/a	$1,500
Co-Insurance	100%	100%	80%	100%	100%	80%	100%	100%	80%
Individual Out of Pocket	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500
Family Out of Pocket	$3,000	$3,000	$4,500	$3,000	$3,000	$4,500	$3,000	$3,000	$4,500
Emergency Room Co-pay	$150	$150	$250	$150	$150	$250	$150	$150	$250
Hospital Co-pay	100%	100%	80% After Ded	100%	100%	80% After Ded	100%	100%	80% After Ded
Retail Rx Co-pay	$10/40/60	$10/40/60	$15/40/60	$10/40/60	$10/40/60	$15/40/60	$10/40/60	$10/40/60	$15/40/60
Mail Order Rx Co-pay	2 x Retail	2 x Retail	2 x Retail	2 x Retail	2 x Retail	2 x Retail	2 x Retail	2 x Retail	2 x Retail
Individual Rx OOPM includes copays	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000
Family Rx OOPM includes copays	$2,000	$2,000	$3,000	$2,000	$2,000	$3,000	$2,000	$2,000	$3,000
Primary Physician Office Visit Co-pay	$20	$30	$25	$20	$30	$25	$20	$30	$25
Specialists Office Visit Co-pay	$40	$50	$50	$40	$50	$50	$40	$50	$50
Telemedicine	N/A	N/A	$25	N/A	N/A	$25	N/A	N/A	$25
Preventative Services	100%	100%	100%	100%	100%	100%	100%	100%	100%
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Out of Network Benefits									
Individual Deductible			$1,500			$1,500			$1,500
Family Deductible			$4,500			$4,500			$4,500
Co-Insurance			60%			60%			60%
Individual Out of Pocket			$4,500			$4,500			$4,500
Family Out of Pocket			$10,500			$10,500			$10,500
Emergency Co-pay			80% After Ded			80% After Ded			80% After Ded
Hospital Co-pay			$300, then 80% After Ded			$300, then 80% After Ded			$300, then 80% After Ded
Physician Office Visit Services			60% After Ded			60% After Ded			60% After Ded
Preventative Services			60% After Ded			60% After Ded			60% After Ded
Lifetime Maximum			Unlimited			Unlimited			Unlimited
Medical Premium									
Employee	$589.09	$596.84	$775.11	$716.92	$726.35	$943.31	$735.77	$745.45	$968.11
Employee + Spouse	$1,204.39	$1,220.25	$1,584.73	$1,465.74	$1,485.04	$1,928.62	$1,504.28	$1,524.09	$1,979.33
Employee +Children	$1,155.77	$1,170.98	$1,520.74	$1,406.57	$1,425.08	$1,850.74	$1,443.56	$1,462.55	$1,899.40
Family	$1,788.19	$1,811.72	$2,352.88	$2,176.23	$2,204.86	$2,863.45	$2,233.45	$2,262.84	$2,938.75
Medicare Primary	$500.63	$507.23	$658.72	$609.27	$617.30	$801.66	$625.29	$633.53	$822.74
Medicare + 1	$1,001.27	$1,014.44	$1,317.45	$1,218.55	$1,234.57	$1,603.34	$1,250.59	$1,267.04	$1,645.50
Monthly Premium	**$29,605.56**	**$42,163.05**	**$379,567.76**	**$36,029.95**	**$51,312.30**	**$461,933.79**	**$36,977.32**	**$52,661.61**	**$474,080.21**
Total Monthly Premium		**$451,336.37**			**$549,276.04**			**$563,719.14**	
Total Annual Premium		**$5,416,036.44**			**$6,591,312.48**			**$6,764,629.68**	
Premium Change					**$1,175,276.04**			**$1,348,593.24**	
Percent Change					**21.70%**			**24.90%**	

*Out of Pocket Maximum includes all member costs: deductible, coinsurance, office visit copayments, emergency room copayments and prescription drug copayments.

HORTON

Village of Tinley Park
Health Review
October 1, 2022

Taken from Renewal

	EE	ES	EC	FAM	Med	Med + 1	Total
BA HMO	11	2	4	9	0	0	26
HMOI	14	5	2	14	0	0	35
PPO	79	50	22	86	3	1	241
Total	104	57	28	109	3	1	302

Presented by: Mike Wojcik

Carriers:	CURRENT BCBS			Renegotiated 7.21 12 Month Policy RENEWAL BCBS			Renegotiated 7.21 15 Month Policy RENEWAL BCBS		
Type of Plan	**BA HMO**	**HMO I**	**PPO**	**BA HMO**	**HMO I**	**PPO**	**BA HMO**	**HMO I**	**PPO**
In Network Benefits									
Individual Deductible	n/a	n/a	$500	n/a	n/a	$500	n/a	n/a	$500
Family Deductible	n/a	n/a	$1,500	n/a	n/a	$1,500	n/a	n/a	$1,500
Co-Insurance	100%	100%	80%	100%	100%	80%	100%	100%	80%
Individual Out of Pocket	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500
Family Out of Pocket	$3,000	$3,000	$4,500	$3,000	$3,000	$4,500	$3,000	$3,000	$4,500
Emergency Room Co-pay	$150	$150	$250	$150	$150	$250	$150	$150	$250
Hospital Co-pay	100%	100%	80% After Ded	100%	100%	80% After Ded	100%	100%	80% After Ded
Retail Rx Co-pay	$10/40/60	$10/40/60	$15/40/60	$10/40/60	$10/40/60	$15/40/60	$10/40/60	$10/40/60	$15/40/60
Mail Order Rx Co-pay	2 x Retail	2 x Retail	2 x Retail	2 x Retail	2 x Retail	2 x Retail	2 x Retail	2 x Retail	2 x Retail
Individual Rx OOPM includes copays	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000
Family Rx OOPM includes copays	$2,000	$2,000	$3,000	$2,000	$2,000	$3,000	$2,000	$2,000	$3,000
Primary Physician Office Visit Co-pay	$20	$30	$25	$20	$30	$25	$20	$30	$25
Specialists Office Visit Co-pay	$40	$50	$50	$40	$50	$50	$40	$50	$50
Telemedicine	N/A	N/A	$25	N/A	N/A	$25	N/A	N/A	$25
Preventative Services	100%	100%	100%	100%	100%	100%	100%	100%	100%
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Out of Network Benefits									
Individual Deductible			$1,500			$1,500			$1,500
Family Deductible			$4,500			$4,500			$4,500
Co-Insurance			60%			60%			60%
Individual Out of Pocket			$4,500			$4,500			$4,500
Family Out of Pocket			$10,500			$10,500			$10,500
Emergency Co-pay			80% After Ded			80% After Ded			80% After Ded
Hospital Co-pay			$300, then 60% After Ded			$300, then 60% After Ded			$300, then 60% After Ded
Physician Office Visit Services			60% After Ded			60% After Ded			60% After Ded
Preventative Services			60% After Ded			60% After Ded			60% After Ded
Lifetime Maximum			Unlimited			Unlimited			Unlimited
Medical Premium									
Employee	$589.99	$596.84	$775.11	$663.90	$672.64	$873.55	$675.69	$684.58	$888.05
Employee + Spouse	$1,204.38	$1,220.25	$1,584.73	$1,357.35	$1,375.22	$1,785.99	$1,381.44	$1,399.63	$1,817.69
Employee +Children	$1,155.77	$1,170.98	$1,520.74	$1,302.65	$1,319.89	$1,713.67	$1,325.67	$1,343.12	$1,744.29
Family	$1,788.19	$1,811.72	$2,352.88	$2,015.29	$2,041.81	$2,651.70	$2,051.06	$2,078.04	$2,698.76
Medicare Primary	$500.63	$507.23	$658.72	$564.21	$571.65	$742.38	$574.22	$581.79	$755.55
Medicare + 1	$1,001.27	$1,014.44	$1,317.45	$1,128.43	$1,143.27	$1,484.77	$1,148.46	$1,163.56	$1,511.12
Monthly Premium	**$29,605.56**	**$42,163.05**	**$379,567.76**	**$33,365.41**	**$47,517.78**	**$427,773.20**	**$33,957.69**	**$48,361.07**	**$435,364.98**
Total Monthly Premium		**$451,336.37**			**$508,656.39**			**$517,683.72**	
Total Annual Premium		**$5,416,036.44**			**$6,103,876.68**			**$6,212,204.64**	
Premium Change					**$687,840.24**			**$796,168.20**	
Percent Change					**12.70%**			**14.70%**	

*Out of Pocket Maximum includes all member costs: deductible, coinsurance, office visit copayments, emergency room copayments and prescription drug copayments.

HORTON

Village of Tinley Park
Health Review
October 1, 2022

Taken from Renewal

	EE	ES	EC	FAM	Med	Med + 1	Total
BA HMO	11	2	4	9	0	0	26
HMOI	14	5	2	14	0	0	35
PPO	79	50	22	86	3	1	241
Total	104	57	28	109	3	1	302

Renegotiated 7.21
15 Month Policy
Plan change necessitates rebalancing of HMO rates

Presented by: Mike Wojcik

Carriers:	CURRENT BCBS			RENEWAL BCBS			
Type of Plan	BA HMO	HMO I	PPO	BA HMO	HMO I	Blue Choice Options PPO	
						Tier 1	Tier 2
In Network Benefits							
Individual Deductible	n/a	n/a	$500	n/a	n/a	$500	$1,000
Family Deductible	n/a	n/a	$1,500	n/a	n/a	$1,500	$3,000
Co-Insurance	100%	100%	80%	100%	100%	80%	60%
Individual Out of Pocket	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$3,000
Family Out of Pocket	$3,000	$3,000	$4,500	$3,000	$3,000	$4,500	$9,000
Emergency Room Co-pay	$150	$150	$250	$150	$150	$250	$250
Hospital Co-pay	100%	100%	80% After Ded	100%	100%	80% After Ded	60% After Ded
Retail Rx Co-pay	$10/40/60	$10/40/60	$15/40/60	$10/40/60	$10/40/60	$15/40/60	
Mail Order Rx Co-pay	2 x Retail	2 x Retail	2 x Retail	2 x Retail	2 x Retail	2 x Retail	
Individual Rx OOPM includes copays	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	
Family Rx OOPM includes copays	$2,000	$2,000	$3,000	$2,000	$2,000	$3,000	
Primary Physician Office Visit Co-pay	$20	$30	$25	$20	$30	$25	$35
Specialists Office Visit Co-pay	$40	$50	$50	$40	$50	$50	$60
Telemedicine	N/A	N/A	$25	N/A	N/A	$25	
Preventative Services	100%	100%	100%	100%	100%	100%	
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	
Out of Network Benefits							
Individual Deductible			$1,500			$2,000	
Family Deductible			$4,500			$6,000	
Co-Insurance			60%			50%	
Individual Out of Pocket			$4,500			$6,000	
Family Out of Pocket			$10,500			$18,000	
Emergency Co-pay			60% After Ded			80% After Ded	
Hospital Co-pay			$300, then 60% After Ded			$300, then 50% After Ded	
Physician Office Visit Services			60% After Ded			50% After Ded	
Preventative Services			60% After Ded			50% After Ded	
Lifetime Maximum			Unlimited			Unlimited	
Medical Premium							
Employee	$588.09	$596.84	$775.11	$673.80	$725.40	$852.62	
Employee + Spouse	$1,204.39	$1,220.25	$1,584.73	$1,377.58	$1,483.09	$1,743.20	
Employee +Children	$1,155.77	$1,170.98	$1,520.74	$1,321.97	$1,423.21	$1,672.81	
Family	$1,768.19	$1,811.72	$2,352.88	$2,045.33	$2,201.96	$2,588.17	
Medicare Primary	$500.83	$507.23	$658.72	$572.62	$616.49	$724.59	
Medicare + 1	$1,001.27	$1,014.44	$1,317.45	$1,145.25	$1,232.95	$1,449.20	
Monthly Premium	**$29,605.56**	**$42,163.05**	**$379,567.76**	**$33,862.81**	**$51,244.91**	**$417,524.39**	
Total Monthly Premium		**$451,336.37**			**$502,632.11**		
Total Annual Premium		**$5,416,036.44**			**$6,031,585.32**		
Premium Change					**$615,548.88**		
Percent Change					**11.37%**		

*Out of Pocket Maximum includes all member costs: deductible, coinsurance, office visit copayments, emergency room copayments and prescription drug copayments.

Insurance · Risk Advisory · Employee Benefits

HORTON

The Horton Group's

Marketing Proposal
Additional Lines Coverage

Prepared for: **Village of Tinley Park**
October 2022

Presented By:
Michael E. Wojcik
mike.wojcik@thehortongroup.com
Phone: 708-845-3126 / Cell: 708-650-1557

HORTON

Village of Tinley Park
Dental Review
October 1, 2022

Based on Renewal

EE	115
ES	59
EC	26
FAM	110
Total	310

Presented by: Mike Wojcik

Carriers:	CURRENT BCBS	RENEWAL BCBS	RENEWAL BCBS	OPTION METLIFE*	OPTION METLIFE**	OPTION METLIFE**
Type of Plan	PPO	PPO	PPO	PPO	PPO	PPO
In Network Benefits						
Individual Deductible	$50	$50	$50	$50	$50	$50
Family Deductible	$150	$150	$150	$150	$150	$150
Preventative Co-Insurance	100%	100%	100%	100%	100%	100%
Deductible Waived on Preventative	Yes	Yes	Yes	Yes	Yes	Yes
Basic Co-Insurance	80%	80%	80%	80%	80%	80%
Major Co-Insurance	50%	50%	50%	50%	50%	50%
Orthodontia Co-Insurance	50%	50%	50%	50%	50%	50%
Deductible Waived on Ortho	Yes	Yes	Yes	Yes	Yes	Yes
Endodontics Co-Insurance	80%	80%	80%	80%	80%	80%
Periodontics Co-Insurance	80%	80%	80%	80%	80%	80%
Surgical Periodontics Co-Insurance	80%	80%	80%	80%	80%	80%
Annual Maximum	$1,000	$1,000	$1,000	$1,000	$1,000	$1,500
Orthodontia Lifetime Maximum	$1,250	$1,250	$1,250	$1,250	$1,250	$1,250
Out of Network Benefits						
Individual Deductible	$50	$50	$50	$50	$50	$50
Family Deductible	$150	$150	$150	$150	$150	$150
Preventative Co-Insurance	100%	100%	100%	100%	100%	100%
Deductible Waived on Preventative	Yes	Yes	Yes	Yes	Yes	Yes
Basic Co-Insurance	80%	80%	80%	80%	80%	80%
Major Co-Insurance	50%	50%	50%	50%	50%	50%
Orthodontia Co-Insurance	50%	50%	50%	50%	50%	50%
Deductible Waived on Ortho	Yes	Yes	Yes	Yes	Yes	Yes
Endodontics Co-Insurance	80%	80%	80%	80%	80%	80%
Periodontics Co-Insurance	80%	80%	80%	80%	80%	80%
Surgical Periodontics Co-Insurance	80%	80%	80%	80%	80%	80%
Annual Maximum	$1,000	$1,000	$1,000	$1,000	$1,000	$1,500
Orthodontia Lifetime Maximum	$1,250	$1,250	$1,250	$1,250	$1,250	$1,250
	90th U&C	*90th U&C*	*90th U&C*	*R&C 90th*	*R&C 90th*	*R&C 90th*
Dental Premium						
Employee	$39.61	$39.61	$39.61	$32.37	$32.32	$35.04
Employee +Spouse	$87.43	$87.43	$87.43	$71.45	$71.33	$77.34
Employee +Child	$83.91	$83.91	$83.91	$68.58	$68.46	$74.23
Family	$129.80	$129.80	$129.80	$106.08	$105.91	$114.82
Total PPO Monthly Premium	**$26,173.18**	**$26,173.18**	**$26,173.18**	**$21,389.98**	**$21,355.33**	**$23,152.84**
Total Dental Annual Premium	**$314,078.16**	**$314,078.16**	**$314,078.16**	**$256,679.76**	**$256,263.96**	**$277,834.08**
Percent Change		**0.00%**	**0.00%**	**-18.28%**	**-18.41%**	**-11.54%**
Rate Guarantee		**Until 9/30/23**	**Until 12/31/23**	**Until 12/31/23**	**Until 12/31/23**	**Until 12/31/23**
				2nd Yr Cap: 6%	**2nd Yr Cap: 6%**	**2nd Yr Cap: 6%**
				3rd Yr Cap: 7%	**3rd Yr Cap: 7%**	**3rd Yr Cap: 7%**

*** Certain benefits are limited to 1 per tooth in 10 calendar years**
**** Certain benefits are limited to 1 per tooth in 5 calendar years, matching current BCBS benefits**

Insurance / Risk Advisory / Employee Benefits
HORTON

Village of Tinley Park
Life Review
October 1, 2022

EE's
253

Presented by: Mike Wojcik

Carriers	CURRENT BCBS	RENEWAL BCBS	Renegotiated 8.2 RENEWAL BCBS
Benefit Amount			
Director & Assistant Director	**$65,000**	**$65,000**	**$65,000**
Senior Management	**$60,000**	**$60,000**	**$60,000**
Professional & Supervisory	**$55,000**	**$55,000**	**$55,000**
Elected & Appointed Officials	**$50,000**	**$50,000**	**$50,000**
Library Employees	**$50,000**	**$50,000**	**$50,000**
All Others	**$50,000**	**$50,000**	**$50,000**
% Benefit Amount Reduces to at Age 65	65%	65%	65%
% Benefit Amount Reduces to at Age 70	50%	50%	50%
% Benefit Amount Reduces to at Age 75	35%	35%	35%
% Benefit Amount Reduces to at Age 80	n/a	n/a	n/a
Medical Evacuation	Included	Included	Included
Life Premium			
Employee Life per $1000	$0.170	$0.170	$0.153
Employee AD&D per $1000	$0.025	$0.025	$0.023
Total for Life & AD&D	**$0.195**	**$0.195**	**$0.176**
Life Volume	**12,992,500**	**12,992,500**	**12,992,500**
Life Monthly Premium	**$2,533.54**	**$2,533.54**	**$2,286.68**
Life Annual Premium	**$30,402.45**	**$30,402.45**	**$27,440.16**
Percentage Change		**0.00%**	**-9.74%**
Rate Guarantee		**Until 11/30/23**	**Until 12/31/24**

***Pending Rate Adjustment 10/1/22 - Requested rate adjustment as of 10/1/22 with revised rates guaranteed to 1/1/24.**

Village of Tinley Park
Vision Review
October 1, 2022

Insurance / Risk Advisory / Employee Benefits
HORTON

EE	21	36
ES	11	27
EC	3	7
FAM	8	32
Total	43	102

Presented by: Mike Wojcik

Reduced Rates as of 10/1/2022 with Rate Guarantee until 1/1/2024

Carriers:	Current VSP				Renewal VSP			
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
	Standard Plan		Premium Plan		Standard Plan		Premium Plan	
Copayment Exam	$10		$10		$10		$10	
Copayment Materials	$25		$25		$25		$25	
Benefits								
Examination	$25	Reimbursed up to $45	$25	Reimbursed up to $45	$25	Reimbursed up to $45	$25	Reimbursed up to $45
Basic Lenses								
Single	Covered in Full	Reimbursed up to $30	Covered in Full	Reimbursed up to $30	Covered in Full	Reimbursed up to $30	Covered in Full	Reimbursed up to $30
Bifocal	Covered in Full	Reimbursed up to $50	Covered in Full	Reimbursed up to $50	Covered in Full	Reimbursed up to $50	Covered in Full	Reimbursed up to $50
Trifocal	Covered in Full	Reimbursed up to $65	Covered in Full	Reimbursed up to $65	Covered in Full	Reimbursed up to $65	Covered in Full	Reimbursed up to $65
Lens Options								
Ant-Reflective Coating	n/a		$0		n/a		$0	
Scratch-Resistance	n/a		$0		n/a		$0	
Tint	n/a		$0		n/a		$0	
Progressive	$0-175		$0		$0-175		$0	
Other	Average 30% savings		Average 30% savings		Average 30% savings		Average 30% savings	
Contact Lenses								
Elective Conventional Lenses	Covered in Full up to $130	Reimbursed up to $105	Covered in Full up to $180	Reimbursed up to $105	Covered in Full up to $130	Reimbursed up to $105	Covered in Full up to $180	Reimbursed up to $105
Elective Disposables	Covered in Full up to $130	Reimbursed up to $105	Covered in Full up to $180	Reimbursed up to $105	Covered in Full up to $130	Reimbursed up to $105	Covered in Full up to $180	Reimbursed up to $105
Necessary Contact Lenses	Covered in Full	Reimbursed up to $210	Covered in Full	Reimbursed up to $210	Covered in Full	Reimbursed up to $210	Covered in Full	Reimbursed up to $210
Frames	Covered in full up to $130 retail allowance; 20% off balance	Reimbursed up to $70	Covered in full up to $180 retail allowance; 20% off balance	Reimbursed up to $70	Covered in full up to $130 retail allowance; 20% off balance	Reimbursed up to $70	Covered in full up to $180 retail allowance; 20% off balance	Reimbursed up to $70
Availability								
Examination	Once Every 12 months		Once Every 12 months		Once Every 12 months		Once Every 12 months	
Lenses	Once Every 12 months		Once Every 12 months		Once Every 12 months		Once Every 12 months	
Frames	Once Every 12 months		Once Every 24 months		Once Every 12 months		Once Every 24 months	
Contacts	Once Every 12 months		Once Every 12 months		Once Every 12 months		Once Every 12 months	
Rates								
Employee	$8.47		$11.68		$8.20		$11.31	
Employee + One (EE + SP)	$13.55		$18.69		$13.12		$18.09	
(EE + CH)	$13.83		$19.08		$13.39		$18.47	
Family	$22.30		$30.77		$21.59		$29.78	
Monthly Premium	**$546.81**		**$2,043.31**		**$529.41**		**$1,977.84**	
Total Monthly Premium	**$2,590.12**				**$2,507.25**			
Total Annual Premium	**$31,081.44**				**$30,087.00**			
Percent Change					**-3.20%**			
Rate Guarantee	**10/1/2023**				**1/1/2024**			

Horton Benefit Solutions
Disclaimer Notice

Exposure Evaluation

All terms of this proposal are based on the evaluation of material provided by you or your employees. Horton expressly disclaims all liability for the content of such evaluation material, including but not limited to, any errors or omissions contained therein or arising therefrom. The terms of this proposal are subject to change if you provide new or revised evaluation material to Horton.

Coverage Terms & Conditions

All coverage terms and conditions in the preceding pages are intended as a reference only. Actual policies will contain full coverage exclusions or limitations, terms and conditions, and other wordings that are not summarized herein.

STATE OF ILLINOIS)
COUNTY OF COOK) SS
COUNTY OF WILL)

CERTIFICATE

I, Nancy M. O'Connor, Village Clerk of the Village of Tinley Park, Counties of Cook and Will and State of Illinois, DO HEREBY CERTIFY that the foregoing is a true and correct copy of Resolution No. 2022-R-093, "**A RESOLUTION AUTHORIZING THE EXECUTION OF APPLICABLE BENEFIT AGREEMENTS FOR A 15-MONTH TERM FOR THE PURCHASE OF MEDICAL, DENTAL, VISION, AND LIFE INSURANCE BENEFITS FOR THE BENEFIT PLAN YEAR OCTOBER 2022 THROUGH DECEMBER 2023**," which was adopted by the President and Board of Trustees of the Village of Tinley Park on 16th day of August, 2022.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the corporate seal of the Village of Tinley Park this 16th day of August, 2022.

_____
VILLAGE CLERK

Tinley Park

CONTRACT AND DOCUMENT APPROVAL CHECKLIST

Ordinance/Resolution No: 2022-R-093 Annual Benefit Renewal Horton Group

Exhibits Attached: Yes ☑ No ☐

Contracting Party/Vendor: _____

Contract Contact Info: _____

Bid Opening Date (If applicable): _____

Mylar (Rcvd by Clerk's Office): Y / N – Date Sent for Recording: _____ **Date Recorded:** _____

Certificates of Insurance Received: Yes ☐ No ☐

Contract Expiration: **Date:** December 2023

Signature of Contracting Party received: Yes ☑ **Date:** Sept. 8, 2022

Staff Review **Date:** _____ **Approved Via:** _____ **By:** _____

Attorney Review: **Date:** _____ **Approved Via:** _____ **By:** _____

Village Manager Review: **Date:** 8/12/2022 **Approved Via:** in person **By:** PC

Committee Review **Date:** 8/16/2022 **Committee Type:** COW

Committee Approval **Date:** 8/16/2022 **Committee Type:** COW

Village Board Meeting: **Date:** 8/16/2022

Village Board Approval: **Date:** 8/16/2022 **Approved:** X **Denied:** _____

Notes: