Resolution # 15-1

WHEREAS, Sangamon County employees are covered by various benefits which require the County to enter into agreements with benefit providers, and

WHEREAS, with assistance of the County's benefit providers, the Human Resource office reviews the cost of providing these benefits and, on a contract-by-contract basis, either recommends renewal of existing contracts, re-negotiates contracts, or solicits new contracts from competing providers, and

WHEREAS, the Human Resource office works with the Board of Managers of the Sangamon County Employee's Health Insurance Plan to select cost-effective providers of quality services for the employee health insurance plans, and contracts for a third party claims administrator, physician networks, stop-loss insurance, and prescription drug program administration have been negotiated in the best interests of Sangamon County and its employees for the upcoming year.

NOW, THEREFORE, BE IT RESOLVED that the Sangamon County Board, in session this 10th day of September 2019, approves the attached list of contracts for employee benefits for 2020 and furthermore authorizes the Director of Human Resources to sign said contracts.

_____
DEPARTMENT HEAD/ELECTED OFFICIAL

Employee Services Committee

_____, Chairman _____, Member

_____, Member _____, Member

_____, Member _____, Member

_____, Member _____, Member

FILED
SEP 04 2019
Sangamon County Clerk

RECEIVED
2660
AUG 28 2019
Andy Goleman
SANGAMON COUNTY AUDITOR

Sangamon County
Fringe Benefit Contracts Approval
Attachment to Resolution for September 10, 2019 Board Meeting

Fringe Benefit	Vendor	Contract Term
Health Insurance Plan (Third Party Administrator, Physician Provider Network, and Stop-loss Insurance) and Prescription Drug Program	Blue Cross/Blue Shield of IL	01/01/20 thru 12/31/20

153

Benefit Program Application ("ASO BPA")

Applicable to Administrative Services Only (ASO) Group Accounts

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

Group Status: Renewing ASO Account

Section Number(s): 0001, 0004, 0005, 0006, 0007, 0008, 0009, 0010, 0011, 0014, 0015, 0017, 0018, 0019, 0023, 0024, 0025, 0026, 0027, 0028, 0029, 0030, 0031, 0034, 0035, 0040, 0041, 0043, 0045, 0046, 0054, 0100, 0500, 0911, 7000, 7011, 8000, 8001, 8011, 8888

Employer Account Number (6-digits): 014688 Group Number(s): P14688

Legal Employer Name: Sangamon Coungty

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

ERISA Regulated Group Health Plan*: ☐ Yes ☒ No

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

ERISA Plan Administrator*: Plan Administrator's Address:

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

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

For more information regarding ERISA, contact your Legal Advisor.

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

Effective Date of Coverage: (Month/Day/Year) 12 / 01 / 2019

Anniversary Date: (Month/Day/Year) 12 / 01 / 2020

Account Information ☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Standard Industry Code (SIC): 9111 Employer Identification Number (EIN): 376002039

Address: 200 South Ninth Street, Room 205

City: Springfield State: IL ZIP: 62701-1965

Administrative Contact: Charlie Stratton Title: Human Resources Director

Email Address: charlies@co.sangamon.il.us Phone Number: 217-535-3130 Fax Number: 217-535-3131

Wholly Owned Subsidiaries:

Affiliated Companies:

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

Blue Access for Employers (BAE) Contact: Denise McCrady

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

Email Address: denisem@co.sangamon.il.us Phone Number: 217-747-5195 Fax Number: 217-535-3130

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

Schedule of Eligibility ☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Employer has made the following eligibility decisions:

1. Eligible Person means:

☒ A full-time employee of the Employer.
☐ A full-time employee of the Employer who is a member of: *(name of union)*
☐ A part-time employee of the Employer.
☐ A retiree of the Employer. Define criteria: _____
☒ Other: "Retiree" pursuant to the Empoyer's personnel practices and/or Union Contract.
Are any classes of employees to be excluded from coverage? ☐ Yes ☒ No
If yes, please identify the classes and describe the exclusion: _____

2. Employee Definitions

Full-Time Employee means:
☐ A person who is regularly scheduled to work a minimum of _____ hours per week and who is on the permanent payroll of the Employer.
☒ Other: "Full-time Employee" pursuant to the Employer's personnel practices and/or Union Contract.

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

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

4. Select an effective `date rule for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan (The effective date must not be later than the 91st calendar day after the date that a newly eligible person becomes eligible for coverage, unless otherwise permitted by applicable law).
☒ The date of employment.
☐ The day of employment.
☐ The day of the month following month(s) of employment.
☐ The day of the month following days of employment.
☐ The day of the month following the date of employment.
☐ Other:
Is the waiting period requirement to be waived on initial group enrollment? ☐ Yes ☐ No
Are there multiple new hire waiting periods? ☐ Yes ☒ No
If yes, please attach eligibility and contribution details for each section.

5. Domestic Partners covered: ☐ Yes ☒ No
If yes: a Domestic Partner is eligible to enroll for coverage.
If yes, are Domestic Partners eligible for continuation of coverage? ☐ Yes ☐ No
If yes, are dependents of Domestic Partners eligible to enroll for coverage? ☐ Yes ☐ No
If yes, are dependents of Domestic Partners eligible for continuation of coverage? ☐ Yes ☐ No

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

6. Civil Union Partners covered:
i. ☒ The Employer is an Illinois county, municipality, the State of Illinois, subject to the Illinois School Code, a church plan or other non-ERISA plan. For such Employers, a Civil Union Partner and his or her dependents are automatically eligible to enroll for coverage and, once enrolled, eligible for continuation of coverage as described in the Employer's Plan.
ii. For all other Employers, ☐Yes ☐ No

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

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

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

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

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

8. Termination of coverage upon reaching the Limiting Age:
   - ☒ The last day of coverage is the day prior to the birthday.
   - ☐ The last day of coverage is the last day of the month in which the limiting age is reached.
   - ☐ The last day of coverage is the last day of the billing month.
   - ☐ The last day of coverage is the last day of the year (12/31) in which the limiting age is reached.
   - ☐ The last day of coverage is the day prior to the Employer's Anniversary Date.

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

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

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

   ☒ Yes (specify number of days below) ☐ No

   Temporary Layoff: 0 days Disability: 365 days Leave of Absence: 365 days

   However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with an applicable federal or state law. The Employer will notify HCSC of such requirements.

10. Enrollment:

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

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

    Late Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer.

    Open Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Open Enrollment Period. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer. Such date shall be subsequent to the Open Enrollment Period.

    Specify Open Enrollment Period: November 1 through November 30 with an effective date of January 1 of the following year.

11. * Does COBRA Auto Cancel apply? ☒ Yes ☐ No
Member's COBRA/Continuation of Coverage will be automatically cancelled at the end of the member's eligibility period.
** Not recommended for accounts with automated eligibility.*

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

FEE SCHEDULE

Payment Specifications ☐ NO CHANGES ☐ SEE ADDITIONALPROVISIONS

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

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

Claim Settlement Period: ☒ **Monthly**

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

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

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

	PPO			
Administrative Fee	$50.27	$____	$____	$____
Dental	$____	$____	$____	$____
Limited Fiduciary Services	$____	$____	$____	$____
Health Advocacy Solutions	$____	$____	$____	$____
Wellbeing Management	$____	$____	$____	$____
Management of the Virtual Visits Program	$____	$____	$____	$____
*Rebate Credit for the Prescription Drug Program	$-39.89	$____	$____	$____
MTM (Retrospective) **(No cost if both HAS and Prescription Drug Program are elected)**	$____	$____	$____	$____
Commissions	$____	$____	$____	$____
Other: Select Service Category List Service: ____	$____	$____	$____	$____
Other: Select Service Category List Service:	$	$	$	$
Other: Select Service Category List Service:	$	$	$	$
Other: Select Service Category List Service:	$	$	$	$
Miscellaneous:	$	$	$	$
Miscellaneous:	$	$	$	$
Total	$10.38	$	$	$

*The Rebate Credit is a per Covered Employee per month credit applied to the monthly billing statement. The Employer and Claim Administrator have agreed to the Rebate Credit and Employer agrees that it and its group health plan have no right to, or legal interest in, any portion of the rebates, either under the pharmacy benefit or the medical benefit, actually provided by the Pharmacy Benefit Manager (PBM) to Claim Administrator and consents to Claim Administrator's retention of all such rebates. The Rebate Credit will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates actually provided to Claim Administrator by the PBM or expected to be provided. Rebate

Credits shall not continue after termination of the Prescription Drug Program. Employer agrees that any provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

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

Claim Administrator Provider Access Fee(s) ☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS
Group Number(s): P14688
☒ % of ADP Savings: **1.57%**
☐ $ per Covered Employee per month: $
☐ ***Group with multiple Provider Access Fees by services (e.g., CMM, and/or PPO plans):*** **Group Number(s):**
☐ % of ADP Savings: %
☐ $ per Covered Employee per month: $
BlueCard Program/Network access fees: Available upon request.

Other Service and/or Program Fee(s) ☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS
External Review Coordination: ☐ Yes ☒ No If yes, coordination fee: $700 for each external review requested by a Covered Person that the Claim Administrator coordinates for the Employer in relation to the Employer's Plan. Employer elects the following process: ☒ State of Illinois External Review Process ☐ Federal Affordable Care Act Process
Reimbursement Service: ☒ Yes ☐ No If yes: The Employer has elected to utilize the reimbursement service offered by the Claim Administrator, the Corporate Reimbursement Subrogation department. It is understood and agreed that in the event the Claim Administrator makes a recovery on a third-party liability claim, the Claim Administrator will retain 25% of any recovered amounts other than recovered amounts received as a result of or associated with any Workers' Compensation Law.
Claim Administrator's Third Party Recovery Vendors and Law Firms (other than Reimbursement Services): Employer will pay no more than 25% of any recovered amount made by Claim Administrator's Third Party Recovery Vendor. Employer will pay no more than 35% of any recovered amount made by Claim Administrator's third party law firm.
Alternative Compensation Arrangements: Employer acknowledges and agrees that Claim Administrator has Alternative Compensation Arrangements with contracted Providers, including but not limited to Accountable Care Organizations and other Value Based Programs. Further information concerning Employer's payment for covered services under such Arrangements is described in the Administrative Services Agreement.

Virtual Visits Program: ☐ Yes ☒ No If yes, Covered Persons would be able to obtain certain Covered Services remotely via video or audio only (where available) capability from Providers participating in the Virtual Visit program.

Termination Administrative Charge

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

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

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

Other Provisions ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

1. Summary of Benefits & Coverage:

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

      ☒ Yes. Please answer question b. The SBC Addendum is attached.
      ☐ No. If No, then skip question b and refer to the Administrative Services Agreement for further information.

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

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

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

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

2. Massachusetts Health Care Reform Act:

   Does the Employer direct Claim Administrator to provide written statements of creditable coverage to its Covered Employees who reside, or have enrolled dependents who reside, in Massachusetts and file electronic reports to the Massachusetts Department of Revenue in a manner consistent with the requirements under the Massachusetts Health Care Reform Act? ☐ Yes ☒ No

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

3. Case Management Program: ☒ Yes ☐ No *The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons for Utilization Management, Case Management, and other health care management programs.*

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

5. Essential Health Benefits ("EHB") Election:

   Employer elects EHBs based on the following:

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

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

   ☐ 3. Other EHB, as determined by Employer

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

6. This ASO BPA is binding on both parties and is incorporated into and made a part of the Administrative Services Agreement with both such documents to be referred to collectively as the "Agreement" unless specified otherwise.

7. Producer/Consultant Compensation

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

Additional Provisions: Effective 12/1/19 - Group will change from Blue Care Connection to Well Being Management Enable. PA penalty is None.

"Section 1557 . Employer has informed Claim Administrator that neither Employer nor Employer's benefit plan is regulated by Section 1557 of the Affordable Care Act, including but not limited to the related Final Rule. Employer has also informed Claim Administrator that Employer's benefit plan is not required to cover gender reassignment(i) under applicable law, or (ii) under the terms of Employer's plan documents. Employer acknowledges that Employer, and not Claim Administrator, is responsible for providing members with proper notice of Employer's benefit decisions and changes.

Employer has directed BCBSIL to process claims with dates of services on or after 12/1/2019 to exclude coverage of the above items and services. In no event shall Claim Administrator be responsible or liable for any legal, tax or other ramifications related to or arising from Employer's decisions or its interpretations or application of applicable law. Employer confirms that it has consulted with its own legal advisors with respect to any of the matters described in this Section, including, but not limited to, discrimination laws. Employer will promptly notify Claim Administrator if the legal basis for Employer's coverage exclusion in this Section changes.

Employer shall indemnify and hold harmless Claim Administrator and any of its directors, officers, affiliates and employees ("Claim Administrator Parties") against any and all claims, losses, liability, damages, fines, penalties, taxes, expenses (including attorney's' fees and costs) and/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 Claim Administrator Parties in connection with any of the matters described in this Section, including, but not limited to, Employer's interpretation and application of applicable laws and any directives to Claim Administrator regarding same. Employer agrees to defend Claim Administrator Parties, using counsel acceptable to Claim Administrator, in any claim, lawsuit, demand, governmental inquiry or action, settlement or judgment to which this Section applies. Moreover, Claim Administrator, at its sole discretion, may elect to participate in the defense of its own interests in any such action for which it is entitled to indemnification hereunder, using attorneys selected by Claim Administrator, at Employer's expense.

If there is a change in the laws, rules, regulations, guidance (whether formal or informal) or interpretations related to applicable laws or which otherwise impacts the Employer's application or interpretation thereof, the parties agree that the provisions of this Section may be revisited and are subject to amendment upon mutual agreement of the parties. Employer's obligations under this Section shall survive termination or expiration of this BPA and Agreement. The Employer's obligations in this Section are in addition to and do not supersede or take the place of Employer's obligations in the governing Agreement. Employer's obligations under this Section shall survive termination or expiration of this BPA and Agreement."

Signature

Erin Bickers

Sales Representative

848 217-637-1800

District Phone & FAX Numbers

Maripat Cline

Producer Representative

BPA - Troxell

Producer Firm

214 S. Grand Avenue West, Springfield, IL 62704

Producer Address

217-528-7533 (P) 217-528-1041 (F)

Producer Phone & FAX Numbers

mcline@troxellins.com

Producer Email Address

37-0902741

Tax I.D. No.

Signature of Authorized Purchaser

Print Name

Title

Date

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members is scheduled to be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice provided to the member not less

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

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

Group No.: P14688 By: _____
Print Signer's Name Here

➡ _____
Signature and Title

Group Name: Sangamon County

Address: 200 South Ninth Street, Room 205

City: Springfield State: IL ZIP: 62701-1965

Dated this _____ day of _____
Month Year

BlueCross BlueShield of Illinois

EXHIBIT TO THE STOP LOSS COVERAGE POLICY

Employer Group Name: Sangamon County
Employer Group Address: 200 South Ninth Street
City: Springfield **State of Situs:** IL **Zip Code:** 62701
Account Number: 014688
Employer Group Number(s): P14688
Current Effective Date of Policy 12/01/2019
Current Policy Period: These specifications are for the Policy Period commencing on 12/01/2019 and ending on 11/30/2020

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

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

1. ☐ New Coverage ☒ Renewal of Existing Coverage
2. Stop Loss Coverage during the current Policy Period:

☐ New Coverage (Select one from below):

☐ Incurred and paid during the Policy Period: Claims incurred and paid from to

☐ Run-in coverage: Claims incurred from to
and Claims paid from to

If coverage is for claims incurred prior to the effective date of the Policy and paid by Policyholder's prior claim administrator, then such claims must be reported by the Policyholder to the Company (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid by the Policyholder's prior claim administrator by the end of the current Policy Period.

☒ Renewal of Existing Coverage:

☒ Claim Administrator's Claims: Claims incurred on or after the original Effective Date of Policy and paid during the Policy Period.

3. Aggregate Stop Loss Coverage shall apply to:

☒ Medical Claims ☒ Vision Claims
☒ Outpatient Prescription Drug Claims with Company's Pharmacy Benefit Manager ☐ Dental Claims

☐ Outpatient Prescription Drug Claims with Policyholder's Pharmacy Benefit Manager: _____

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

☐ Other (please specify): _____

4. Average Claim Value: $1,002.57 (per Employee per month)

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

Attachment Factor: 115% of the Average Claim Value

5. Aggregate Attachment Claim Liability:

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

$1,152.96 for each Coverage Unit

$n/a for each Family Coverage Unit

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

Run-Off Attachment Claim Liability Factors:

Employer's Run-Off Claim Liability shall be an amount equal to 15% of the annualized Employer Claim Liability based on the participation of the two (2) calendar months immediately preceding termination. Settlement for the final accounting period will be described in the section of the Policy entitled SETTLEMENTS.

7. Aggregate Stop Loss Claims:

a. The amount of Paid Claims during the current Policy Period, less Individual (Specific) Stop Loss Claims if any, that exceeds the Aggregate Point of Attachment. The Aggregate Point of Attachment shall equal the sum of the Employer's Claim Liability amounts calculated Monthly as described in item A.5. above for the current Policy Period. However, for the current Policy Period the minimum Aggregate Point of Attachment shall be $7,695,319.

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

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

c. The amount of "Run-in" Claims that is excluded from Individual (Specific) Stop Loss Coverage in item B.2. is also not eligible for Aggregate Stop Loss coverage.

8. Stop Loss Premium (Select one):

☒ Annual Premium (Due on the first day of the current Policy Period): $69,890.

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

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

$_____ for each Coverage Unit

$_____ for each Family Coverage Unit

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

In the event of termination at the end of the current Policy Period, an additional Premium amount equal to 15% of the annualized Premium based on the participation of the two (2) months immediately preceding termination will be due within ten (10) calendar days of receipt of the billing.

9. The premium is based upon a current membership of 409 Individual Coverage Units and 209 Family Coverage Units.

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

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

1. ☐ New Coverage ☒ Renewal of Existing Coverage
2. Stop Loss Coverage during the current Policy Period:

☐ New Coverage (Select one from below):

☐ Incurred and paid during the Policy Period: Claims incurred and paid from to

☐ Run-in coverage: Claims incurred from to
and Claims paid from to

If coverage is for claims incurred prior to the effective date of the Policy and paid by Policyholder's prior claim administrator, then such claims must be reported by the Policyholder to the Company (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) paid by the Policyholder's prior claim administrator by the end of the current Policy Period.

☒ Renewal of Existing Coverage:

☒ Claim Administrator's Claims: Claims incurred on or after the original Effective Date of Policy and paid during the Policy Period.

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

☒ Medical Claims ☒ Vision Claims

☒ Outpatient Prescription Drug Claims with Company's Pharmacy Benefit Manager ☐ Dental Claims

☐ Outpatient Prescription Drug Claims with Policyholder's Pharmacy Benefit Manager:

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

☐ Other (please specify): _____

4. Individual (Specific) Stop Loss Claims

For each other Covered Person:

a. Individual (Specific) Stop Loss Coverage equals the amount of Paid Claims for a Covered Person during the current Policy Period in excess of the Individual Point of Attachment of $125,000 per Covered Person. Such amount shall apply for the current Policy Period.

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

☐ Excludes Claim Administrator's Provider Access Fee

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

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

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

a. In the event of termination at the end of the current Policy Period, Individual (Specific) Stop Loss Coverage shall equal the amount of Final Settlement Paid Claims that exceed the Point of Attachment specified in B.4. above. Final Settlement Paid Claims shall equal the sum of Paid Claims for a Covered Person during the Final Policy Period and the Run-Off Period (beginning on 12/1/2020 and ending on 11/30/2021.

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

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

6. Stop Loss Premium (select one):

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

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

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

$111.12 for each Coverage Unit

$n/a for each Family Coverage Unit

The following applies if the answer to item B.5. above is "Yes" (Individual (Specific) Stop Loss Coverage includes coverage of Run-Off Paid Claims): In the event of termination at the end of the current Policy Period, an additional premium amount equal to 20% of the annualized Premium based on the participation of the two (2) months immediately preceding termination will be due within ten (10) calendar days of receipt of the billing.

7. The premium is based upon a current membership of 409 Individual Coverage Units and 209 Family Coverage Units.

Additional Provisions:
Retirees Covered: Yes ☐ No ☐

No changes at the renewal

The undersigned person represents that he/she is authorized and responsible for purchasing stop loss coverage on behalf of the Employer. It is understood that the actual terms and conditions of coverage are those contained in this Exhibit and the Stop Loss Coverage Policy into which this Exhibit shall be incorporated at the time of acceptance by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"). Upon acceptance, HCSC shall issue a Stop Loss Coverage Policy to the Employer. Upon acceptance of this Exhibit and issuance of the Stop Loss Coverage Policy, the Employer shall be referred to as the "Policyholder."

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Erin Bickers Sales Representative	Signature of Authorized Purchaser
Erica Rocque Name of Underwriter	Title of Authorized Purchaser
Signature of Underwriter	Date

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

PBM Fee Schedule Addendum to the Benefit Program Application

Sangamon County	
Term: 12/01/2019-11/30/20	Employees: 618
Guaranteed Traditional Aggregate Pricing Arrangement C[1]*	
Traditional Select Network and Basic Drug List	
RETAIL	
Brand	**Generic**
AWP minus	**AWP minus**
19.25%	82.55%
DISPENSING FEE	
Brand	**Generic**
$1.05	$1.05
MAIL	
Brand	**Generic**
AWP minus	**AWP minus**
22.25%	82.85%
DISPENSING FEE:	$0.00
EXTENDED SUPPLY NETWORK ("ESN") (If Applicable)	
Brand	**Generic**
AWP minus	**AWP minus**
21.05%	81.95%
DISPENSING FEE:	$0.00
Aggregate Specialty Discount	
Pricing based on Employer's use of the Prime Specialty network	AWP minus: 18.00%
DISPENSING FEE:	$0.00

Rebate Credits to Employer:	
PEPM Rebate Credits to Employer:	$39.89

Employer Administration Fees:	
PBM Administration Fees PEPM:	$0.00

Additional Provisions:

[1] Employer will be billed for retail brand and retail generic prescriptions, mail brand and mail generic prescriptions, ESN brand and ESN generic, and Specialty pharmacy claims (excluding compound prescriptions) based on the lesser of (a) U&C or (b) PBM's adjudication rate schedule(s) that is/are intended to achieve, on an aggregate calendar-year basis, the AWP discounts and Dispensing Fees shown above for all of Claim Administrator's group customers that have purchased the above specific pricing arrangement ("Groups with the Pricing Arrangement") and use the above Network (the "Employer's Contract Rates").

For purposes of setting Employer's Contract Rates and calculating whether the AWP discounts and Dispensing Fees have been achieved:

a. "Brand" products include "Brand Drugs" as defined in the PBM Exhibit and also include generic products that are available from no greater than three (3) generic manufacturers; and

b. "Generic" products include all products not defined in (a), above, as "Brand" products.

Employer acknowledges and agrees that Employer's Contract Rates may vary based on market influences and as necessary to achieve the AWP discounts and Dispensing Fees shown above, on an aggregate calendar year basis, for Groups with the Pricing Arrangement that use the above Network. However, such variation for Brand products in each of the Retail, Mail, and ESN categories (on an aggregate annual basis) may only vary by +/-3% from the applicable AWP discount shown above.

Employer will be billed the above Dispensing Fee (such Fee may be included in the amount billed to Employer) unless the Employer is billed based on the U&C price. If the Employer is billed based on the U&C price, then the Dispensing Fee is included in such U&C price.

Employer will be billed for Compound Drug claims based on the applicable discounted rate in the Network Contract.

Employer will be billed for Foreign Claims based on an amount equal to the amount billed by the pharmacy.

Employer will be billed for out-of-network claims based on the pricing set forth in the Administrative Services Agreement and/or PBM Exhibit, as applicable.

If the AWP discounts and Dispensing Fees shown above are not achieved for a particular calendar year, for Groups with the Pricing Arrangement that use the above Network, then Employer will be credited, no later than 180 days after the end of each calendar year during the Term, an amount calculated as follows:

- First, the total aggregate shortfall dollar amount for the calendar year for Groups with the Pricing Arrangement that use the above Network will be calculated by comparing the actual performance of each of the above categories (Retail, Mail, ESN, and Specialty) with the corresponding AWP discounts and Dispensing Fees shown above for each category. The amount of any performance in any category that exceeds the above AWP discounts and Dispensing Fees will be used to offset any and all shortfall(s) in any or all categories. The above aggregate shortfall, if any, is then divided by total claims for Groups with the Pricing Arrangement that use the above Network, and did not terminate their Addendum prior to their anniversary date, for the calendar year ("Per Claim Amount"). Then the Per Claim Amount will be multiplied by Employer's total claims for that calendar year to calculate the reconciliation credit. However, if Employer terminates this Addendum prior to its anniversary date and the above Guaranteed Traditional Aggregate Pricing Arrangement is not achieved, then Employer will not be eligible to receive such credit.

- For purposes of determining if a shortfall exists, claims billed to Employer based on the U&C price will be considered to have $0.00 Dispensing Fees.

- Compound Drug claims, Foreign Claims, reversed claims, and out-of-network claims are excluded from the calculation of whether the AWP discounts and Dispensing Fees shown above have been achieved and also are excluded from the calculation of any shortfall credit for Employer.

- If the AWP discounts and Dispensing Fees shown above are exceeded for Groups with the Pricing Arrangement that use the above Network, then Employer will not receive any credit, and there will not be a year-end settlement.

- Under the Guaranteed Traditional Aggregate Pricing Arrangement any particular group customer's experience relative to the pricing guarantees will not determine its eligibility for a credit. Group customer's eligibility for a credit is determined based on the aggregate experience of all group customers that have purchased the Pricing Arrangement and use the above Network. As such, an individual group customer may have experience that does not meet, or exceeds, the AWP discounts and Dispensing Fees shown above. In addition, when there is a reconciliation credit, it is allocated in a manner described above and not based on any particular group's experience (other than number of claims).

PBM uses Medi-Span as the pricing source to establish AWP, for purposes of calculating whether the above AWP discounts have been achieved.

Members' cost share is the applicable copayment, deductible, and/or coinsurance, which coinsurance is calculated based on the Employer's Contract Rate or the applicable out-of-network pricing. Zero balance logic is not employed.

AWP discounts are based on the actual NDC-11 dispensed.

AWP discounts do not include savings from drug utilization review or other clinical or medical management programs.

The above Guaranteed Traditional Aggregate Pricing Arrangement, Rebate Credits and Administrative Fees may be subject to change if the Employer's claims include 340B pricing.

In addition to the rights of the parties under the PBM Exhibit, if changes occur within the pharmacy benefit management marketplace which lead to a significant deviation from the current economic environment, both parties agree to engage in good faith negotiations to amend this Addendum to make impact on both parties commercially reasonably economically neutral. If the parties cannot agree on the terms of the amendment, either party shall be allowed to (a) proceed to dispute resolution, as set forth in the Administrative Services Agreement or (b) terminate this Addendum with 90 days' prior written notice to the other party. Failure to reach agreement on the amendment shall not be a breach of contract.

The above Guaranteed Traditional Aggregate Pricing Arrangement, Rebate Credits and Administrative Fees are based on the Network and Drug List shown above.

Unless otherwise specified in this Addendum, capitalized terms used in this Addendum shall have the meanings set forth in the Administrative Services Agreement or the PBM Exhibit, as applicable.

* Employer Payments to Claim Administrator for Covered Services provided by Network Participants are calculated based on the pricing terms set forth in this Addendum which shall remain in effect for the term of this Addendum to the extent described in the Administrative Services Agreement. Such pricing may or may not equal the amounts actually paid to the Network Participants or received from drug manufacturers (e.g., rebates), or the amounts paid or received between Claim Administrator and the PBM. As a result, the PBM or Claim Administrator may realize positive margin on prescriptions filled at retail, mail order, ESN or specialty pharmacies or prescription drug rebates. Employer acknowledges that it has negotiated for the specific traditional pricing terms set forth in this Addendum, and that it and its group health plan have no right to, or legal interest in, any portion of any positive margin retained by Claim Administrator or PBM and consents to Claim Administrator's and PBM's retention of all such amounts.

_____

Signature of Authorized Purchaser

_____

Print Name

_____

Title

_____

Date