Clerk's Contract and Agreement Cover Page

Year:	2009	**Legistar File ID#:**	2008-0545
Multi Year:	☐	**Amount**	$68,750.00

Contract Type:	Professional Services
Contractor's Name:	The Horton Group
Contractor's AKA:	
Execution Date:	10/1/2008
Termination Date:	12/31/2009
Renewal Date:	
Department:	Administration/Village Manager
Originating Person:	Stephana Przybylski

Contract Description: 2008-2009 Employee Insurance Renewal and Consulting
BCBS, VSP, Delta

14700 S. Ravinia Ave.
Orland Park, IL 60462
(708) 403-6100

VILLAGE HALL

September 26, 2008

Mr. Michael E. Wojcik
The Horton Group
10320 Orland Parkway
Orland Park, Illinois 60467

RE: ***2008-2009 Employee Insurance Renewal and Consulting Services***

Dear Mr. Wojcik:

Enclosed are the signed agreements for the Blue Cross Blue Shield of Illinois Benefit Program and Excess Loss Coverage (HMO, PPO, and HSA), VSP and Delta Dental Applications for the period October 1, 2008 – December 31, 2009. Also enclosed is the signed Service Retainer Agreement with Horton Group, Inc. in the amount of Sixty-Eight Thousand Seven Hundred Fifty and No/100 ($68,750.00) Dollars.

Please call Stephana Przybylski at (708) 403-6166 or me at (708) 403-6173 if you have any questions.

Sincerely,

Denise Domalewski
Contract Administrator

cc: Stephana Przybylski
Annmarie Mampe

SERVICE RETAINER AGREEMENT

This Agreement is made this **1st** day of **October, 2008**, between **The Village of Orland Park** of **14700 Ravinia Avenue Orland Park, IL 60462-3167**, hereinafter referred to as **The Village of Orland Park**, and THE HORTON GROUP, INC. of 10320 Orland Parkway, Orland Park, IL 60467 hereinafter referred to as "Horton".

WHEREAS, Horton, together with its affiliated entities (its "Affiliates"), operates insurance agencies and related businesses which procure numerous lines and types of insurance products and provide various related services to accounts located throughout the areas of the United States in which Horton and such Affiliates may operate, from time to time; and

WHEREAS, **The Village of Orland Park** desires to engage Horton to provide certain benefit services in exchange for the fees as outlined in this Agreement.

NOW, THEREFORE, the parties hereto agree as follows:

1. The term of this Agreement shall commence as of **October 1, 2008**, and shall remain in effect for a period of **fifteen (15) months** thereafter ending on **December 31, 2009,** with the option to renew for an additional twelve (12) months at the same annual fee, unless earlier terminated as hereinafter provided.

2. Complete fee structure by service category is **illustrated in the attached Fee-Based Pricing Proposal**. The fee for the fifteen (15) month period October 1, 2008 through December 31, 2009 is $68,750.00; thereafter, the annual fee is $55,000.00.

3. The Service Retainer is in lieu of standard agent commissions normally paid to Horton by the insurance carriers involved. Any standard agent commissions received by Horton shall be credited by Horton against past due and future installments of the Service Retainer. The credits shall be reflected at the end of each calendar year.

   Horton may receive additional compensation from the insurance companies, in the forms of, including but not limited to, contingent commission or bonus commission. Upon request, Horton is pleased to disclose all compensation amounts as well as any other contingent or similar agreements that may be in place.

4. The Service Retainer shall be compensation for the services **illustrated in the attached Fee-Based Pricing Proposal.**

5. Agreed to and included services only apply to those coverages and policies included within the Broker appointment to Horton evidenced by a fully executed broker-of-record letter(s) and not otherwise excluded or offered as an option(s) to be separately negotiated. They include:

   a. **Medical**
   b. **RX**
   c. **Dental**
   d. **Vision**
   e. **Life/AD&D**
   f. **Flexible Spending Account**

6. It is understood that this Service Retainer Agreement is open to review at any time by either party. It is also understood that in the event Horton's retention is terminated by **The Village of Orland Park** within 90 days of the inception of the insurance policy or contract, all unearned amounts of the Service Retainer previously paid to Horton will be refunded to **The Village of Orland Park** based on a pro rata calculation on the effective date of termination. It is also understood that in the event Horton's retention is terminated by **The Village of Orland Park** after 90 days of the inception of the

applicable insurance policy or contract, all fees outlined in the Service Retainer Agreement are fully earned and shall become immediately due and payable.

7. The Service Retainer Agreement covers only those specifically listed services in the attached Fee-Based Pricing Proposal and only those operations currently insured by the insurance program to be serviced under this agreement. Fees for additional services requested or required by **The Village of Orland Park** shall be separately negotiated.

THE VILLAGE OF ORLAND PARK

By: _____

Name: Paul G. Grimes

Its: Village Manager

Date: 9/18/08

THE HORTON GROUP, INC.

By: _____

Name: Kenneth Olson

Its: Division President

Date: 9-5-08

The Horton Group is an Equal Employment Opportunity Employer

THE VILLAGE OF ORLAND PARK
Fee-Based Pricing Proposal

Our proposed service charges are as follows:

Core Services	
Benefit Consulting and Brokerage Support, Benefit Plan Marketing, Plan Installation, Local Enrollment Meetings, Document Review and Compliance, Ongoing Administrative Client and Employee Customer Service	***$55,000 Annual Fee*** ***Payable on a quarterly basis in four (4) equal installments***
Special Services	
Call Center Assistance (Claims, Billing, Eligibility) Benefit News Alerts	***Included in Core Services***
Financial	
Mid-Year Plan Performance -Benchmark Reporting and Reviews (with standard data provided by carriers)	***Included in Core Services***
Expanded Consulting	
Contribution Modeling	***Included in Core Services***
Wellness/Prevention/Education	
Health Fair Coordination (major locations) Includes preparation and coordination of carriers and vendors. Can be combined with consumer driven educational meetings.	***Included in Core Services. Outside vendor expenses to be discussed / considered at the time services arranged / performed. Travel expenses beyond 150 miles are covered by customer***
On-Site Health Assessments Flu Shots	***Direct cost from vendor.*** ***No additional Horton fee assessed.***
Annual Employee Benefit Statements	***Included in Core Services***
Monthly Wellness Newsletters supplied electronically	***Included in Core Services***
H.R. Connect (Employee Portal) My Wave (Employer Portal)	***Included in Core Services***
Open Enrollment	
Onsite Group Enrollment (major locations)	***Included in Core Services***
On-Line Enrollment Capabilities	Varies by vendor – bid solely on vendor capabilities and costs – no additional Horton fee assessed
Webinar and 1-800 Conference Call Based Enrollment Meetings	Employer provides Webcast

BlueCross BlueShield of Illinois

BENEFIT PROGRAM APPLICATION ("BPA")

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

Employer Account Number: 206338

HMO Illinois Employer Group Number(s): H06652

HMO Illinois Section Number(s): 0512,1510,2510,8510

BlueAdvantage® HMO Employer Group Number(s): _____

BlueAdvantage® HMO Section Number(s): _____

Non-HMO Plan Employer Group Number(s): P06652 - PPO P06870 - Blue Edge HSA

Non-HMO Plan Section Number(s): 0812,1812,2812,8812

Employer Name: Village of Orland 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)

Address: 14700 Ravinia Avenue City: Orland Park State: Illinois Zip Code: 60462

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

Subsidiaries: _____

Affiliated Companies: _____

(If Affiliated Companies to be covered are listed above, a separate "Addendum to the Benefit Program Application Regarding Affiliated Companies" must be completed, signed by the Employer's authorized representative, and attached to this BPA.)

Administrative Contact: Stephana Przybylski Phone: 708-403-6166 Fax: 708-349-4859 Email: sprzybylski@orland-park.il.us

Policy Effective Date: October 1, 2008 Policy Anniversary Date: January 1, 2010

ERISA Plan: ☐ Yes ☒ No If Yes, specify ERISA Plan Year: _____

ERISA Plan Administrator: _____

ERISA Plan Administrator's Address: _____

City: _____ State: _____ Zip Code: _____

ERISA Plan Administrator's Email: _____

ELIGIBILITY

1. Eligible Person means: (For the HMO plan, an eligible person must reside in the Service Area of a Participating IPA)

   ☐ A full-time employee of the Employer.

   ☐ A full-time employee who is a member of: _____ (name of union or association)

   ☒ Other (please specify): Full - time employees; retirees and disabled police officers; retired and disabled members of IMRF; elected officials

   Full-Time Employee means:

   ☒ A person who is regularly scheduled to work a minimum of 40 hours per week and who is on the permanent payroll of the Employer.

   ☐ Other (please specify): _____

   ☐ An Eligible Person may also include a retiree of the Employer. Please specify: _____.

2. Domestic Partner Coverage: ☐ Yes ☒ No

   If yes, a Domestic Partner, as defined in the Policy, shall be considered eligible for coverage. The Policyholder is responsible for providing notice of possible tax implications to those Insureds with Domestic Partner coverage.

3. Limiting Age for covered unmarried children is unmarried to age 19; part time students to age 23 years; 25 years if a full-time student.

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

For the Non-HMO Plan:

☐ On birthday.

☐ The month in which the limiting age is reached.

☐ The year in which the limiting age is reached

For the HMO Plan:

☐ The month in which the limiting age is reached.

☐ The year in which the limiting age is reached.

☐ Other (please specify): _____

For Cost Plus Funding, coverage will terminate at the end of the following period:

For the Non-HMO Plan:

☐ On birthday.

☒ The month in which the limiting age is reached.

☐ The year in which the limiting age is reached

For the HMO Plan:

☒ The month in which the limiting age is reached.

☐ The year in which the limiting age is reached.

☐ Other (please specify): _____

4. Eligibility Date for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan:

☒ The date of employment.

☐ The _____ day of employment.

☐ The _____ day of the month following _____ month(s) or _____ days of employment.

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

☐ Other (please specify): _____

☐ For the HMO plan: A full month's premium will be charged for the first month of coverage for those employees whose Coverage Dates fall between the first and fifteenth day of the Premium period. No premium will be charged for the first month of coverage for those employees whose Coverage Dates fall between the sixteenth day and the end of the Premium Period.

5. 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.

Annual Open Enrollment: Specify Annual Open Enrollment Period:September 1 - 30 for an October 1 effective date.. An Eligible Person may apply for coverage, Family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Annual Open Enrollment Period. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to

by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") and the Employer. Such date shall be subsequent to the annual open enrollment period.

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

   Temporary Layoff: 0 days Disability: 0 days Leave of Absence: 0 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.)

7. For the HMO Plan:

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

   Of the Employer: 350 Illinois employees: 350 National employees: 0

FUNDING ARRANGEMENT

☐ Standard Premium – Prospective ☒ Cost Plus Program

STANDARD PREMIUM INFORMATION:

(a) Premium Period:
- ☐ The first day of each calendar month through the last day of each calendar month.
- ☐ The _____ day of each calendar month through the _____ day of the next calendar month.
- ☐ Other (please specify): _____

(b) Employer contribution:

For the HMO Plan:
- ☐ HMO Illinois: _____% of the Individual Coverage Premium and _____% of Family Coverage Premium.
- ☐ BlueAdvantage® HMO: _____% of the Individual Coverage Premium and _____% of the Family Coverage Premium.
- ☐ Other (please specify): _____

For the Non-HMO Plan:
- ☐ 100% of the Individual Coverage Premium and an amount equal to 100% of the Individual Coverage Premium will be contributed toward the Family Coverage Premium.
- ☐ _____% of the Individual Coverage Premium and _____% of the Family Coverage Premium.
- ☐ Other (please specify): _____

(c) For the Non-HMO Plan:
It is understood that no Policy will be issued or renewed on a contributory basis unless at least _____% of the Eligible Persons and, for Family Coverage, _____% of the Eligible Persons with eligible dependents have enrolled for coverage.

STANDARD PREMIUM RATES ☐ Yes ☒ No						
	For Internal Use Only - BlueStar Ben.Agree#: _____ **HMO Illinois** _____	*For Internal Use Only - BlueStar Ben.Agree#:* _____ **Blue Advantage® HMO** _____	*For Internal Use Only - BlueStar Ben.Agree#:* _____ **Non-HMO Health Coverage:** _____	*For Internal Use Only - BlueStar Ben.Agree#:* _____ **Non-HMO Health Coverage:** _____	*For Internal Use Only - BlueStar Ben.Agree#:* _____ **Dental Coverage:** _____	**Total**
1. Employee only:	$	$	$	$	$	$
2. Employee plus one dependent:	$	$	$	$	$	$
3. Employee plus two or more dependents:	$	$	$	$	$	$
4. Employee plus Spouse:	$	$	$	$	$	$
5. Employee plus Child(ren):	$	$	$	$	$	$
6. Employee plus Family / Family:	$	$	$	$	$	$
7. Other: _____	$	$	$	$	$	$
Single Tier Rate structure - Complete item 1.						
Two Tier Rate structure - Complete items 1. and 6.						
Three Tier Rate structure - Complete items 1., 2., and 3.						
Four Tier Rate Structure - Complete items 1., 4., 5., and 6.						
Indicate "N/A" in any rate field that does not apply.						
Medicare Eligible Rates (When HCSC is Secondary Payer)						
Single Coverage:	$	$	$	$		$
Family Coverage:	$	$	$	$		$

COST PLUS PROGRAM

☒ Yes ☐ No

Service Charges:
For the HMO Plan:

a) Service Charges for Claim Payments:

☒ HMO Illinois: _____% of Claim Payments; or $55.44 per Enrollee per month for health Claim Payments
☐ BlueAdvantage® HMO: _____% of Claim Payments; or $_____ per Enrollee per month for health Claim Payments

b) Physician's Services Fees:

☒ HMO Illinois: $151.35 per month per single Enrollee; or $441.14 per Month per Enrollee with one or more dependents.
☐ BlueAdvantage® HMO: $_____ Per month per single Enrollee; or $_____ Per Month per Enrollee with one or more dependents.

For the Non-HMO Plan:

☒ _____% of Net Claim Payments or $55.44 per employee per month.
☒ Applies to all coverage(s)

☐ Different percentage(s) or amount(s) for the following types of coverage. Please specify below:
For _____ Coverage: _____% of _____ Claim Payments or $_____ per employee per month
For _____ Coverage: _____% of _____ Claim Payments or $_____ per employee per month
Other (please specify): _____

Blue Care Connection® ("BCC") (For the Non-HMO Plan):

BCC Program (may select one):
☒ Blue Care Advisor
☐ Please refer to Additional Provisions

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

Blue Care Custom

☐ Health Dialog **(may select one)** 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

☐ American Healthways **(may select one)**
- ☐ Package A
- ☐ Package B
- ☐ Package C
- ☐ Not applicable

American Healthways Program Fees, per participating Covered Person per month:

Conditions:	*Package A - Fees*	*Package B - Fees*	*Package C - Fees*
Diabetes:	$_____	$_____	$_____
Chronic Heart Disease:	$_____	$_____	$_____
Chronic Obstructive Pulmonary Disease	$_____	$_____	Not Applicable
Asthma:	$_____	$_____	Not Applicable
Impact Conditions:	$_____	Not Applicable	Not Applicable

Payment Method: ☐ Transfer Payment ☒ Post Payment

If Transfer Payment, Method of Transfer Payment:
☐ Wire Transfer ☐ Draft ☐ Electronic Fund Transfer ☐ Other (please specify):_____

Payment Period:
☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other (please specify): _____

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

If Transfer Payment, Tentative Final Settlement Period:
Transfer Payments to be made for the following time period after termination:
☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other (please specify): _____

For Cost Plus plans, Effective Date of Termination for a person who ceases to meet the definition of Eligible Person:

☐ The date such person ceases to meet the definition of Eligible Person.
☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
☐ Other (please specify): _____

Prescription Drug Rebate: $16.14 per Covered Employee per month or, for the HMO Plan, per Enrollee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit.

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

Group Number(s):

☒% of ADP Savings: 3.5%

☐ $ 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: $_____

The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Employer, has provided the information requested in this Benefit Program Application ("BPA") and, on behalf of the Employer, offers to purchase the benefit program as outlined in the Request For Proposal ("RFP") or, in the case of an HMO Plan, the proposal document submitted to the Employer by the Sales Representative. Any changes to the RFP are specified below. It is understood and agreed that the actual terms and conditions of the benefit program are those contained in the Policy. This BPA is subject to acceptance by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"). Upon acceptance, HCSC shall issue a Policy to the Employer and this BPA shall be incorporated and made a part of the Policy. Upon acceptance of this BPA and issuance of the Policy, the Employer shall be referred to as the Policyholder. In the event of any conflict between the RFP and the Policy, the provisions of the Policy shall prevail.

The undersigned representative acknowledges that any broker/producer is acting on behalf of the Employer for purposes of purchasing the Employer's insurance, and that if HCSC accepts this BPA and issues a Policy to the Employer, HCSC may pay the Employer's broker/producer a commission and/or other compensation in connection with the issuance of such Policy. The undersigned representative further acknowledges that if the Employer desires additional information regarding any commissions or other compensation paid the broker/producer by HCSC in connection with the issuance of a Policy, the Employer should contact its broker/producer.

The undersigned representative acknowledges that the Employee Retirement Income Security Act of 1974, as amended, ("ERISA") establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term "employee welfare benefit plan" includes any plan, fund or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital benefits, or benefits in the event of sickness, accident or disability. The undersigned representative further acknowledges that: (i) an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and that (ii) an employee welfare benefit plan document may provide for the allocation or delegation of responsibilities thereunder. However, notwithstanding anything contained in the employee welfare benefit plan document of the Employer (or any group member if the group is an association), the Employer agrees that no allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Employer (or, for Non-HMO Plans, any group member if the group is an association) is effective with respect to or accepted by HCSC except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by HCSC.

OTHER PROVISIONS:

(a) Reimbursement Provision for the HMO Plan: It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will deduct 25% of the net recovery from the amount credited to the group's experience after attorneys' fees, if any, have been paid.

Reimbursement Provision for the Non-HMO Plan: ☒ Yes ☐ No

If yes: It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will retain 25% of the net recovery (under cost-plus funding) or deduct 25% of the net recovery from the amount credited to the group's experience (under premium funding) after attorneys' fees, if any, have been paid.

(b) Certificate of Creditable Coverage: ☒ Yes ☐ No

If yes: It is understood and agreed that HCSC will issue a Certificate of Creditable Coverage consistent with the requirements under the Health Insurance Portability and Accountability Act of 1996. The Certificate of Creditable Coverage shall be based upon coverage under the Plan during the term of the Policy and information provided to HCSC by the Employer.

If no: The Certificate of Creditable Coverage Release and Indemnification letter is attached to this BPA and made part of the Policy.

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

(d) Fort Dearborn Life Insurance purchased: ☐ Yes ☒ No *(If yes, complete separate application.)*

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

(f) For the Non-HMO Plan:
Case Management: ☒ Yes ☐ No

If Yes: The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons in accordance with the provisions of the Policy.

(g) For the Non-HMO Plan: Electronic Issuance: The Policyholder consents to receive, via an electronic file or access to an electronic file, a Certificate Booklet provided by HCSC to the Policyholder for delivery to each Insured. The Policyholder further agrees that it is solely responsible for providing each Insured access, via the internet, intranet or otherwise, to the most current version of any electronic file provided by HCSC to the Policyholder and, upon the Insured's request, a paper copy of the Certificate Booklet.

(h) Massachusetts Health Care Reform Act: Notwithstanding anything to the contrary in this BPA, with respect to the Employer's employees who live in Massachusetts (if any) the Employer represents that it offers the health insurance benefits provided for herein to all full-time employees, and the Employer will not make a smaller premium contribution percentage to a full-time employee living in Massachusetts than to any other full-time employee living in Massachusetts who receives an equal or greater total hourly or annual salary. For purposes of this representation, a "full-time employee" is defined by Massachusetts law, generally an employee who is scheduled or expected to work at least the equivalent of an average of thirty-five (35) hours per week.

ADDITIONAL PROVISIONS:15 month renewal period 10/01/2008 - 12/31/2009.
Effective 10/01/2008: Adding mandated coverage of the HPV vaccine benefit under wellness, doesnot apply to the maximum.

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

Nancy Robertson

Sales Representative

Downers Grove 630-824-5178

District

Mike Wojcik

Producer Representative

The Horton Group

Producer Firm

10320 Orland Parkway, Orland Park, IL. 60467

Producer Address

36-3672171

Producer Tax I.D. No.

Ellen L. Baker

Signature of Authorized Purchaser

Asst. Village Manager

Title

9/26/08

Date

Witness

$_____ Amount Submitted

UNDERWRITING USE ONLY
Date BPA approved:
Signature of Underwriter

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Group No.: P06652, P06870, H06652

By: Ellen J Baer

For Paul G. Grimes
Print Signer's Name Here

Ellen J Baer Asst. Village Manager
Signature and Title

Group Name: Village of Orland Park

Address: 14700 Ravinia Avenue

City: Orland Park State: IL Zip Code: 60462

Dated this 26th day of September 2008
Month Year

BlueCross BlueShield of Illinois

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

Customer Number:	206338		
Employer Group Name:	Village of Orland Park		
Employer Group Address:	14700 Ravinia Avenue		
	Orland Park	Illinois	60462
Employer Group Number(s):	H06652		
Effective Date of Policy:	10/01/2008		

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

☒ Yes ☐ No

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

Aggregate Excess Loss Coverage: ☒ Yes ☐ No

If yes, complete items 1 through 8 below.

1. Excess Loss Coverage Period:

   From 10/01/2008 to 01/01/2010

2. Aggregate Excess Loss Coverage shall apply to:

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

   ☒ HMO claims and outpatient prescription drug claims

3. Average Claim Value: $6,885.15 (per employee).

4. Attachment Point: 125% of the Average Claim Value.

5. Aggregate Excess Loss Limit Claim Value: $8,606.40
   (equals the Average Claim Value multiplied by the Attachment Point)

6. Aggregate Excess Loss Coverage Limit:

   The Aggregate Excess Loss Coverage Limit shall equal the average number of employees during the Excess Loss Coverage Period multiplied by the Aggregate Excess Loss Limit Claim Value. In no event shall the Aggregate Excess Loss Coverage Limit be less than $697,118, as specified in Section III of the Policy.

7. Excess Loss Premium

   ☐ Monthly: $ each month

   ☒ Annual (Due on the Effective Date of Policy): $7,631

8. The premium is based upon a current membership of 32 Individual Coverage Units and 58 Family Coverage Units.

Individual Excess Loss Coverage: ☒ Yes ☐ No

If yes, complete items 1 through 5 below.

1. Excess Loss Coverage Period:

   From 10/01/2008 to 01/01/2010

2. Individual Excess Loss Coverage shall apply to:

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

   ☒ HMO claims and outpatient prescription drugs

3. Individual Excess Loss Coverage Limit: $100,000 per Covered Person during the Excess Loss Coverage Period

4. Excess Loss Premium (select one):

   ☒ Monthly: $ each month **or** $20.74 per Enrollee each month

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

5. The premium is based upon a current membership of 32 Individual Coverage Units and 58 Family Coverage Units.

Additional Provisions:

15 month renewal period.

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

Nancy Robertson	Ellen J. Baer
Sales Representative	Signature of Authorized Purchaser
	Assistant Village Manager
Printed Name of Underwriter	Title of Authorized Purchaser
	9/24/08
Signature of Underwriter	Date

BlueCross BlueShield of Illinois

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

Employer Group Name: Village of Orland Park
Employer Group Address: 14700 Ravinia Avenue
Orland Park, Illinois 60462
Account Number: 206338
Employer Group Number(s): P06652
Effective Date of Policy: 10/01/2008

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

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

1. ☐ New Coverage ☒ Renewal of Existing Coverage
2. Excess Loss Coverage Period:
   ☐ New Coverage (Select one from below):
      ☐ Standard: Claims incurred and paid from: _____ to _____
      ☐ "Run-in" included: Claims incurred from: _____ and paid on or after the Effective Date of Policy to: _____
   ☒ Renewal of Existing Coverage:
      Claims incurred on or after the effective date of the administration of the Group Policy by the Plan (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid on or after the Effective Date of Policy to: 01/01/2010
3. Aggregate Excess Loss Coverage shall apply to:
   ☒ Medical Claims ☐ Vision Claims
   ☒ Outpatient Prescription Drug Claims ☐ Dental Claims (Pre-Dent)
   ☐ For Hospital Employer Groups only: *Excludes* _____% of Home Hospital Medical claims
   ☐ Other (please specify): _____
4. Average Claim Value: $17,417.40 (per employee).
   ☒ Includes Plan's Provider Access Fee ☐ Excludes Plan's Provider Access Fee
5. Attachment Point: 125% of the Average Claim Value.
6. Aggregate Excess Loss Limit Claim Value: $21,771.75

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

7. Aggregate Excess Loss Coverage Limit:

   The Aggregate Excess Loss Coverage Limit shall equal the average number of employees during the Excess Loss Coverage Period multiplied by the Aggregate Excess Loss Limit Claim Value. In no event shall the Aggregate Excess Loss Coverage Limit be less than $4,683,103 as specified in Section III of the Policy.

8. Annual Premium

   (Due on the Effective Date of Policy): $51,178

9. The annual premium is based upon a current membership of 71 Individual Coverage Units and 168 Family Coverage Units.

Individual Excess Loss Coverage: ☒ Yes ☐ No

If yes, complete items 1 through 6 below.

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

   ☐ New Coverage (Select one from below):

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

   ☐ "Run-in"included: Claims incurred from: _____ and paid on or after the Effective Date of Policy to: _____

   ☒ Renewal of Existing Coverage:

   Claims incurred on or after the effective date of the administration of the Group Policy by the Plan (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid on or after the Effective Date of Policy to: 01/01/2010.

3. Individual Excess Loss Coverage shall apply to:

   ☒ Medical Claims ☐ Vision Claims

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

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

   ☐ Other (please specify): _____

4. Individual Excess Loss Coverage Limit: $100,000

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

5. Premium (select one):

   ☒ Monthly: $_____ each month **or** $65.17 per employee each month.

   ☐ Annual: $_____

6. The premium is based upon a current membership of 71 Individual Coverage Units and 168 Family Coverage Units.

Additional Provisions:

15 month renewal period

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

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

Nancy Robertson

Sales Representative

Carl Charvat

Name of Underwriter

Signature of Authorized Purchaser

Assistant Village Manager

Title of Authorized Purchaser

9/26/08

Date

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

BlueCross BlueShield of Illinois

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

Employer Group Name: Village of Orland Park
Employer Group Address: 14700 Ravinia Avenue
Orland Park, Illinois 60462
Account Number: 206338
Employer Group Number(s): P06870
Effective Date of Policy: 10/01/2008

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

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

1. ☐ New Coverage ☒ Renewal of Existing Coverage
2. Excess Loss Coverage Period:
   ☐ New Coverage (Select one from below):
      ☐ Standard: Claims incurred and paid from: _____ to _____
      ☐ "Run-in" included: Claims incurred from: _____ and paid on or after the Effective Date of Policy to: _____
   ☒ Renewal of Existing Coverage:
      Claims incurred on or after the effective date of the administration of the Group Policy by the Plan (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid on or after the Effective Date of Policy to: 01/01/2010
3. Aggregate Excess Loss Coverage shall apply to:
   ☒ Medical Claims ☐ Vision Claims
   ☒ Outpatient Prescription Drug Claims ☐ Dental Claims (Pre-Dent)
   ☐ For Hospital Employer Groups only: *Excludes* _____% of Home Hospital Medical claims
   ☐ Other (please specify): _____
4. Average Claim Value: $15,654.84 (per employee).
   ☒ Includes Plan's Provider Access Fee ☐ Excludes Plan's Provider Access Fee
5. Attachment Point: 125% of the Average Claim Value.
6. Aggregate Excess Loss Limit Claim Value: $19,568.55

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

7. Aggregate Excess Loss Coverage Limit:

   The Aggregate Excess Loss Coverage Limit shall equal the average number of employees during the Excess Loss Coverage Period multiplied by the Aggregate Excess Loss Limit Claim Value. In no event shall the Aggregate Excess Loss Coverage Limit be less than $176,117 as specified in Section III of the Policy.

8. Annual Premium

   (Due on the Effective Date of Policy): $0

9. The annual premium is based upon a current membership of 10 Individual Coverage Units and 0 Family Coverage Units.

Individual Excess Loss Coverage: ☒ Yes ☐ No

If yes, complete items 1 through 6 below.

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

   ☐ New Coverage (Select one from below):

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

   ☐ "Run-in"included: Claims incurred from: _____ and paid on or after the Effective Date of Policy to: _____

   ☒ Renewal of Existing Coverage:

   Claims incurred on or after the effective date of the administration of the Group Policy by the Plan (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid on or after the Effective Date of Policy to: 01/01/2010.

3. Individual Excess Loss Coverage shall apply to:

   ☒ Medical Claims ☐ Vision Claims

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

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

   ☐ Other (please specify): _____

4. Individual Excess Loss Coverage Limit: $100,000

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

5. Premium (select one):

   ☒ Monthly: $_____ each month **or** $65.17 per employee each month.

   ☐ Annual: $_____

6. The premium is based upon a current membership of 10 Individual Coverage Units and 0 Family Coverage Units.

Additional Provisions:

15 month renewal period

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

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

Nancy Robertson

Sales Representative

Carl Charvat

Name of Underwriter

Signature of Authorized Purchaser

Assistant Village Manager

Title of Authorized Purchaser

9/26/08

Date

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

VSP Vision care for life

July 17, 2008

Ms Stephana Przybylski
Village of Orland Park
14700 S Ravinia Avenue
Orland Park IL

Re: Village of Orland Park

Dear Stephana:

Village of Orland Park currently has VSP's Standard Plan C, with a $10 co-payment for exam and $25 co-payment for materials. This plan provides an exam, lenses and a frame once every 12 months for employees and dependents. VSP reviewed your experience and has determined that an increase is warranted at this time.

Your employees and dependents faithfully utilize the VSP provider network with a 97% in-network utilization rate. It is evident that they consider vision care and their relationship with VSP doctors to be an important component of their overall healthcare package.

If you have any questions, or if you would like to discuss additional plan alternatives, please give me a call.

Cordially,

Kal Sanghera
Senior Account Executive

Enclosures

Renewal Agreement
Village of Orland Park
12022165

VSP
Vision care for life

Current Plan Design

Frequency:	Based on Service Year Examination once every twelve (12) Months Lenses or Contacts once every twelve (12) Months Frames once every twelve (12) Months
Copays:	$10 Co-payment /Exam, $25 Co-payment/Materials
Allowances:	$46 Wholesale In Network Frame Allowance / $120 Retail Equivalent $120 Elective Contact Lens Allowance.
Current Rates;	$7.49/9.25/16.58
Renewal Rates;	$8.26/10.20/18.29

Renewal Options

☐ Option I. Renew current plan design with a 12 month contract term $8.14/10.06/18.02

☒ Option II. Renew current plan design with a 15 month contract term $8.17/10.09/18.09
10/1/08 – 12/31/09

To renew your contract and maintain continuous service, please choose the option that best meets your needs, sign and fax it to 916-463-3928 by September 30, 2008. VSP will produce your renewal contract when we have received the Signed Renewal Agreement. Please review the new contract carefully, since some of the provisions may have changed from your prior contract. Additionally, please keep a copy of this Renewal Agreement and accompanying letter, given that they serve as your Notice of Renewal.

By: Ellen Brandt Asst Village Manager
FOR
Title: Paul G. Grimes
Village Manager
Date: 9/26/08

DELTA DENTAL

www.deltadentalil.com

September 2, 2008

Stephana Przybylski
VILLAGE OF ORLAND PARK
14700 Ravinia Avenue
Orland Park, IL 60462

RE: VILLAGE OF ORLAND PARK, Contract # 8331
Renewal Notification October 1, 2008

Dear Stephana:

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

New Products

We are also expanding the products available to you. Delta Dental of Illinois is now offering **life and disability insurance** packages and **vision care plans** through TruAssure Insurance Company, a wholly owned subsidiary of Delta Dental of Illinois. A TruAssure vision care benefit gives enrollees access to a national, integrated network of both independent providers and leading optical retailers through EyeMed Vision Care's strong network. Enclosed is a TruAssure vision care plan quote for one of our most popular plans to give you an idea of how valuable the plan can be to your employees. **You can save up to 7% on your dental rate by adding qualifying TruAssure Vision, Life and Disability products.** If you would like additional information about TruAssure vision care plan or life and disability insurance plans, please do not hesitate to contact your broker or consultant.

Web Site

As a reminder, our web site, www.deltadentalil.com features the Subscriber Connection, where enrollees can:

- Find network dentists
- Check claim status
- Get contact information
- Retrieve benefit information
- Print EOBs (Explanation of Benefits)
- Print an ID card

I welcome the opportunity to meet with you to review this information. If you have any questions or would like to schedule a meeting to discuss your renewal, please do not hesitate to contact me. After you have reviewed the enclosed information, please indicate your acceptance of this renewal by signing and returning a copy of the signature page to us.

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

Sincerely,

Michelle Watkiss
Senior Account Executive
630-724-4055
mwatkiss@deltadentalil.com

cc: Horton Insurance Agency

DELTA DENTAL

Renewal Package

for

VILLAGE OF ORLAND PARK

Presented by:

Michelle Watkiss
Senior Account Executive
Delta Dental of Illinois
801 Ogden Avenue
Lisle, IL 60532

Phone 630-724-4055
Fax 630-724-4255
Email mwatkiss@deltadentalil.com

This renewal is for October 1, 2008 thru December 31, 2011.

Confidentiality Agreement

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

Upon request, this document is to be immediately returned to Delta Dental of Illinois, 801 Ogden Avenue, Lisle, IL 60532.

Proposed Renewal
Self Insured

Delta Dental PPO With Delta Dental Premie r "Safety Net"			
	Current Fee	Proposed Fee Guaranteed for 3 Years	Fee Change
Administration Fee	$3.71	$3.71	0%
Funding Factors			
	Current Funding Factors	Recommended Funding Factors	% Change
Single	$24.10	$29.04	20.3%
2-Party	$48.23	$58.12	20.3%
Family	$83.40	$100.50	20.3%

Underwriting Assumptions

1. The proposed renewal ASO fees will be in effect from: October 1, 2008 thru December 31, 2011.

2. The projection is based on 86 singles, 83 2-Party and 158 families.

Projected Annual Incurred Claims:	$264,103
Projected Annual Administration Fee:	$ 14,603
Projected Annual Total Cost:	$278,706

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

4. During the current experience period of October 1, 2007 thru September 30, 2008 averaged 327 enrollees. If enrollment changes by more than 10% we reserve the right to revise our ASO fees.

5. Please acknowledge your acceptance of these terms and rates by signing below and returning this page. **You can fax this letter to 630-724-4255, or mail attn: Michelle Watkiss, Delta Dental of Illinois, 801 Ogden Avenue, Lisle, IL 60532.**

   If we do not receive notification from you by September 1, 2008, Delta Dental of Illinois will assume you agree to the proposed ASO fees and renew your current dental benefit plan.

AGREED AND ACCEPTED:
VILLAGE OF ORLAND PARK, Contract #8331

By: _____ Date: 9/26/08

Title: ~~A~~ Village Manager

Delta Dental of Illinois
801 Ogden Avenue
Lisle, IL 60532

Contact Sheet

For questions about your renewal, please contact:
Michelle Watkiss, Senior Account Executive
630-724-4055
fax 630-724-4255
mwatkiss@deltadentalil.com

Our Operations Specialists work directly with our groups. Each Operations Specialist will be able to assist you with any account-related questions you may have, as well as enrollment activities and fulfillment. **For questions about ongoing account administration, claims and other account inquiries, please contact the following Operations Specialist:**

Leslie Cobb
630-724-4066
fax 630-724-4266
lcobb@deltadentalil.com

For supply requests, please go to our Web site at www.deltadentalil.com and select Supply Connection in the Employer section.

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

Delta Dental of Illinois
801 Ogden Avenue
Lisle, IL 60532