BlueCross BlueShield
of Illinois

Account Name:	SECONDARY SCHOOL COOPERATIVE RISK MANAGEMENT	Account Number:	021648	Renewal Date:	07/01/2012

Grandfathered Health Plan Form

The Affordable Care Act (ACA) provides that a group health plan in which an individual was enrolled on March 23, 2010, (ACA's date of enactment) may be a "grandfathered health plan." Grandfathered health plans are not subject to certain ACA provisions.

By default, our group renewal offer(s) reflect a non-grandfathered health plan design. **This Grandfathered Health Plan Form must be signed by the group representative and returned to our offices at least 10 days prior to your renewal effective date in order to change your renewal(s) to a grandfathered health plan design.** If a plan is modified to a non-grandfathered health plan design on its effective date, it cannot later revert back to a grandfathered health plan design.

Complete the information on page 2 of this form to indicate whether your existing plan(s) qualify as grandfathered health plan(s) under the Affordable Care Act and related regulations. **Check all that apply** for *only* the benefit plan(s) in effect that qualify for and that you wish to be administered with a grandfathered health plan design. This information needs to be provided for all benefit plans in effect.

For more information on grandfathered health plans and what changes or events may cause a plan to lose grandfathered health plan status, go online to: bcbsil.com/affordable_care_act. If you have questions regarding this worksheet, contact your insurance broker (if applicable) or your BCBSIL account representative. The rules related to grandfathered health plans are complex. We recommend that you seek the advice and guidance of your legal counsel regarding ACA and grandfathered health plans. If you believe a plan or policy has lost or will lose grandfathered status, contact your insurance broker (if applicable) or BCBSIL representative immediately for available benefit plan options.

TO BE SIGNED BY THE GROUP REPRESENTATIVE:

I, the undersigned, a duly authorized representative of the plan sponsor named above ("Plan Sponsor"), hereby represent that I am knowledgeable as to standards associated with a "grandfathered health plan" as set forth in the Affordable Care Act and applicable regulations, and that the information contained in this Form and any subsequent updates to such Form, are true, accurate and complete; and (ii) agree that the Plan Sponsor will immediately provide BCBSIL with written notice prior to renewal (and during the plan year, with at least 60 days advance written notice) of any changes that would cause the Plan Sponsor's group health plan(s), including any benefit packages, to not qualify as a grandfathered health plan under ACA and applicable regulations.

Hillaire Siena
Signature

Asst. Supt. for Business Affairs
Title

Hillarie Siena
Print Name

6-19-12
Date

BlueCross BlueShield of Illinois

Account Name:	SECONDARY SCHOOL COOPERATIVE RISK MANAGEMENT	Account Number:	021648	Renewal Date:	07/01/2012

Grandfathered Health Plan Form

Group Number	Plan/Benefit Agreement Name/Number	Grandfathered
B21648	CAU10 MET ST - BLUEH / 0019	☒ Yes ☐ No
B21650	BSE10 MET ST - BLUEH / 0017	☒ Yes ☐ No
B21651	YRE05 MET ST - BLUEH / 0021	☒ Yes ☐ No
H21648	CAU10 MET ST - HMO / 0018	☒ Yes ☐ No
H21649	6QE05 MET ST - HMO / 0011	☒ Yes ☐ No
H21650	BSE10 MET ST - HMO / 0016	☒ Yes ☐ No
P21648	PPO PLUS - PPO+ / 0001	☒ Yes ☐ No
P21649	PPO PLUS - PPO+ / 0002	☒ Yes ☐ No
P21649	PPO PLUS - PPO+ / 0020	☒ Yes ☐ No
P21650	PPO PLUS - PPO+ / 0003	☒ Yes ☐ No
P21650	PPO PLUS - PPO+ / 0009	☒ Yes ☐ No
P22679	PPO PLUS - PPO+ / 0022	☐ Yes ☒ No

Add additional details as needed by copying this page. Make sure you return the signature and table page(s) together.

BlueCross BlueShield of Illinois

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

Customer Number:	021648
Employer Group Name:	Secondary School Cooperative Risk Management Program - Glenbrook High School District #225
Employer Group Address:	3801 West Lake Avenue, Suite 301 Glenview IL 60026
Employer Group Number(s):	H21650, B21650
Effective Date of Policy:	07/01/2012

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 _____ to _____

2. Aggregate Excess Loss Coverage shall apply to:

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

   ☐ ____

3. Average Claim Value: $ (per employee).

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

5. Aggregate Excess Loss Limit Claim Value: $
   (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 $, as specified in Section III of the Policy.

7. Excess Loss Premium

   ☐ Monthly: $ each month

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

8. The premium is based upon a current membership of 120 Individual Coverage Units and 181 Family Coverage Units.

Individual Excess Loss Coverage: ☒ Yes ☐ No

If yes, complete items 1 through 5 below.

1. Excess Loss Coverage Period:

   From 07/01/2012 to 06/30/2013

2. Individual Excess Loss Coverage shall apply to:

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

   ☐

3. Individual Excess Loss Coverage Limit: $125,000 per Covered Person during the Excess Loss Coverage Period

4. Excess Loss Premium (select one):

   ☒ Monthly: $ each month or $33.74 per Enrollee each month

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

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

Additional Provisions:

Renewal Effective 07/01/2012: renewal with rate changes only; no benefit changes.

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."

Chris Shillestad	Hillaire Sieg
Sales Representative	Signature of Authorized Purchaser
Dan Stanger	Asst. Supt. for Business Affairs
Printed Name of Underwriter	Title of Authorized Purchaser
	6-19-12
Signature of Underwriter	Date

BlueCross BlueShield of Illinois

The HMOs of Blue Cross and Blue Shield of Illinois

Benefit Program Application ("BPA")

Employer Account Number: 021648
HMO Illinois Employer Group Number(s): H21650
HMO Illinois Section Number(s): 1000, 2000, 4000, 8888
BlueAdvantage® HMO Employer Group Number(s): B21650
BlueAdvantage HMO Section Number(s): 1000, 2000, 4000, 8888

Employer Name: Secondary School Cooperative Risk Management Program - Glenbrook High School District #225

(Specify the Employer, the employee trust or the association applying for coverage. Names of subsidiary or affiliated companies to be covered must also be included below. An employee benefit plan may not be named.)

Address: 3801 West Lake Avenue, Suite 301

City: Glenveiw State: IL Zip Code: 60026

Billing Address (if different from above): _____

Employer Identification Number ("EIN"): 36-6004414

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: Ms. Hillarie Siena Phone: 847-486-4720 Fax : 847-486-4734 Email: hsiena@glenbrook225.org

Blue Access for Employers (BAE) Contact: Ms. Rhonda Sanders

(The BAE Contact is the employee of the account authorized by the Employer to access and maintain its account via BAE.)

Title: Broker Phone: 847-390-5663 Fax : 847-745-0453 Email: rsanders@cbcin.com

Policy Effective Date: 07/01/2012 Policy Anniversary Date: 07/01/2013

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: _____

1. Eligible Person means a person who resides in the Service Area of a Participating IPA and is:

   ☒ A full-time employee of the Employer.

   ☐ A member of (name of union or association): _____

   ☒ Other (please specify): All certified teachers covered under the Glenbrook Education Association agreement; all full-time administrators and educational support staff who work a minimum of 30 hours per week on a continuous basis, all instructional supervisors currently fulfilling their employment contract for the current year, and/or all eligible retirees to age 65. (For support staff, retirees are defined as employees with 10 years of service, working 30 hours per week, age 55 or older. Retirees

pay 100% of the premium. Certified teachers are eligible for retiree coverage if they satisfy the following requirments: 1) have 10 years of service immediately preceeding their retirement, or for a minimum of 15 years, of which a minimum of 5 years immediately preceeding their retirement @ will be at least 55 years of age by June 30 of the school year preceding the school year for which benefits are requested. 2) A teacher who is eligible to receive retirement pension of at least 74.6% of average salary and will attain age 55 on or before December 31 during the school year which commences on July 1 shall be deemed to attain age 55 on the preceeding June 1.

2. Full-Time Employee means:

☒ A person who is regularly scheduled to work a minimum of 30 hours per week and is on the payroll of the Employer.

☐ Other (please specify): _____

3. **The Limiting Age for covered children is twenty-six (26) years.** Hereafter, covered children means a natural child, a stepchild, an adopted child (including a child involved in a suit for adoption,) a child for whom the Insured is the legal guardian, under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status (if applicable under the Policy), marital status, or any combination of those factors. If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

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

(a) ☐ Limiting Age for covered children age twenty-six (26) or over, ☐ who are married ☐ who are unmarried ☐ regardless of marital status, is years. (twenty-seven (27) – thirty (30) are the available options.) If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

(b) ☐ Limiting Age for covered children who are full-time students and age twenty-six (26 or over, ☐ who are married ☐ who unmarried ☐ regardless of marital status, is years. (twenty-seven (27) – thirty (30) are the available options.) If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

Coverage will terminate:

☐ At the end of the period for which premium has been accepted.

☒ At the end of the month in which the Limiting Age is reached.

☐ At the end of the calendar year in which the Limiting Age is reached.

☐ On the Limiting Age Birthday.

☐ Other (please specify): _____.

However, coverage shall be extended due to a leave of absence in accordance with any applicable federal or state law.

4. Total number of employees: (indicate the total number of actual employees, not enrollees)
Of the Employer _____ Illinois employees _____ National employees 0

5. 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): _____

☐ 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.

6. 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 the effective date of the Special Enrollment event or, in the event of Special Enrollment due to termination of previous coverage, the date of application for coverage. In the case of a Special Enrollment event due to loss of coverage under Medicaid or a state children's health insurance program, however, this enrollment opportunity is not available unless the Eligible Person requests enrollment within sixty (60) days after such coverage ends.

   Open Enrollment: Specify Open Enrollment Period: May for a July 1st effective date. An Eligible Person may apply for coverage, Family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's 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 open enrollment period.

7. Effective Date of Termination for a person who ceases to meet the definition of an 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): See Addendum.

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

   Temporary Layoff: 0 days; Disability: The longer of the fiscal year or 6 months days; Leave of Absence: 0 days

   ☒ Other (please specify): See Addendum

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

9. Funding Arrangement: ☐ Premium Prospective (complete section 10.) ☒ Cost Plus (complete section 12.)

10. Employer Contribution:

    ☒ HMO Illinois: 95% of the Individual Coverage Premium, and 88% of the Family Coverage Premium. ☐ BlueAdvantage HMO: 95% of the Individual Coverage Premium, and 88% of the Family Coverage Premium.

    ☐ Other (please specify): _____.

11. Premium Period:

    ☐ The first day of each calendar month through the last day of each calendar month. (This option applies to all coverages if the Employer has BlueCare® Dental HMO Coverage.)

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

Premium Rates: (*Indicate "N/A" in any rate field that does not apply*)		
Health Coverage		
1. Employee only	HMO Illinois $	BlueAdvantage HMO $
2. Employee plus one dependent (i.e. Employee plus one spouse or one child)	HMO Illinois $	BlueAdvantage HMO $
3. Employee plus two or more dependents	HMO Illinois $	BlueAdvantage HMO $
4. Employee plus Spouse	HMO Illinois $	BlueAdvantage HMO $
5. Employee plus Child(ren) (i.e. Employee plus one or more children)	HMO Illinois $	BlueAdvantage HMO $
6. Family	HMO Illinois $	BlueAdvantage HMO $
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.		
Medicare Eligible Rates (When HCSC is Secondary Payer)		
Single Coverage	HMO Illinois $	BlueAdvantage HMO $
Family Coverage	HMO Illinois $	BlueAdvantage HMO $

12.Cost Plus Program:

a) Service Charges for Claim Payments:

☒ HMO Illinois: _____% of Claim Payments; $34.95 per Enrollee per month for health Claim Payments.

☒ BlueAdvantage HMO: _____% of Claim Payments; $34.95 per Enrollee per month for health Claim Payments.

b) Physician's Services Fees:

☒ HMO Illinois: $179.56 per month per single Enrollee; $542.15per month per Enrollee with one or more Dependents.

☒ BlueAdvantage HMO: $159.81 per month per single Enrollee; $482.50per month per Enrollee with one or more Dependents.

c) ☒ Transfer Payment Method:

☒ Wire Transfer ☐ Draft ☐ Electronic Fund Transfer ☐ Other (please specify): _____

Tentative Final Settlement Period - Transfer payments required after termination for:

☐ 3 months ☐ 6 months ☐ 9 months ☒ 12 months ☐ Other (please specify): _____

d) ☐ Post Payment Method

e) Payment Period:

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

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

g) Prescription Drug Rebate:
$10.14 per Enrollee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit.

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

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 proposal document submitted to the Employer by the Sales Representative. The benefit program and funding arrangements are as outlined in this BPA. 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 proposal document 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 to the broker/producer by HCSC in connection with the issuance of a Policy, the Employer should contact its broker/producer.

The undersigned representative hereby 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 and 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 non-fiduciary responsibilities under the employee welfare benefit plan of the Employer (or 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:

1. Certificate of Creditable Coverage: ☒ Yes ☐ No (The "yes/no" option is applicable to 100 plus only; A Certificate of Creditable Coverage is issued automatically under 100 lives.)

   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.

2. It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will retain 25% of any recovered amounts (under cost-plus funding) or deduct 25% of any recovered amounts from the amount credited to the group's experience (under premium funding), other than recovery amounts received as a result of, or associated with, any Workers' Compensation Law.

3. 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 Enrollees with Domestic Partners.

Domestic Partner Coverage Continuation: (only available if Domestic Partners are covered) ☐ Yes ☒ No

4. Excess Loss Coverage purchased: ☒ Yes ☐ No

   If yes: Complete separate Application for Excess Loss Coverage.

ADDITIONAL PROVISIONS:

A. **Grandfathered Health Plans: Policyholder shall provide HCSC with written notice prior to renewal (and during the plan year, at least 60 days advance written notice) of any changes in its Contribution Rate Based on Cost of Coverage or Contribution Rate Based on a Formula towards the cost of any tier of coverage for any class of Similarly Situated Individuals as such terms are described in applicable regulations.** Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by HCSC to the terms and conditions of coverage. In no event shall HCSC be responsible for any legal, tax or other ramifications related to any benefit package of any group health insurance coverage (each hereafter a "plan") qualifying as a "grandfathered health plan" under the Affordable Care Act and applicable regulations or any representation regarding any plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference and part of the BPA and Group Policy, and Policyholder represents and warrants that such Form is true, complete and accurate. If Policyholder fails to timely provide HCSC with any requested grandfathered health plan information, HCSC may make retroactive and/or prospective changes to the terms and conditions of coverage, including changes for compliance with state or federal laws or regulations or interpretations thereof.

B. **Retiree Only Plans and/or Excepted Benefits:** If the BPA includes any retiree only plans and/or excepted benefits, then Policyholder represents and warrants that one or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by HCSC to the terms and conditions of coverage. In no event shall HCSC be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's past, present and future exempt plan status.

C. Policyholder shall indemnify and hold harmless HCSC and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) or other costs or obligations resulting from or arising out of any claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought or asserted against HCSC in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any directions, actions and interpretations of the Policyholder, and/or (d) any provision of inaccurate information. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

The provisions of paragraphs A-C (directly above) shall be in addition to (and do not take the place of) the other terms and conditions of coverage and/or administrative services between the parties.

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

Any reference in this Benefit Program Application to eligible dependents may include Domestic Partners, but will include dependent covered children under the Limiting Age of twenty-six (26).

Any reference in this Benefit Program Application to the "Employee plus one dependent" rate structure means "Employee plus one spouse or one child."

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

Renewal Effective 07/01/2012: renewal with rate changes; no benefit changes for this period.

Effective 07/01/2012: HMO Managed Care Fee - $9.44 per enrollee per month for HMO Illinois and Blue Advantage HMO.

Chris Shillestad
Sales Representative

890 630-824-5172
District Phone No.

Mr. Ted Reese / Ms. Rhonda Sanders Rhonda Sanders
Producer Representative

Corporate Benefit Consultants
Producer Firm

2800 South River Road
Suite 130
Des Plaines, IL 60018
Producer Address

~~36-4004403~~ 36-4024403
Producer Tax ID No.

Hillaire Sisson
Signature of Authorized Purchaser

Asst. Supt. for Business Affairs
Title

6-19-12
Date

Vicki R. Jarvey
Witness

$_____ Amount Submitted (not required for renewals)

INTERNAL USE ONLY	UNDERWRITING AUTHORIZATION
	Date BPA approved by Underwriting: _____
	Printed Name and 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(s).: H21650, B21650

By:

Print Signer's Name Here

Group Name: Secondary School Cooperative Risk Management Program / Glenbrook High School District #225

Asst. Supt. for Business Affairs

Hillaire Sieg

Signature and Title

Address: 3801 West Lake Avenue, Suite 301

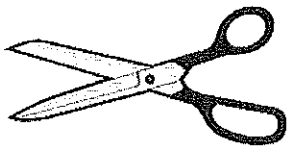
City: Glenview

State: IL Zip Code: 60026

Dated this: 19th day of June, 2012

Month Year

Cut along dotted lines



ASO

Benefit Program Application ("ASO BPA")

Applicable to Administrative Services Only (ASO) Group Accounts

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

Employer Account Number (6-digits): 021648

Employer Group Number(s): P21650, P21651

Section Number(s): 0000, 1000, 2000, 4000, 8888

Employer Name: Secondary School Cooperative Risk Management Program / Glenbrook High School District #225

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

Address: 3801 West Lake Avenue, Suite 301

City: Glenview State: IL Zip: 60026

Standard Industry Code (SIC): 8200 Employer Identification Number (EIN): 36-6004414

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 Benefit Program Application.)

Administrative Contact: Ms. Hilarie Siena Phone Number: 847-486-4720 Fax Number: 847-486-4734

Title: Assistant Superintendent Business Email Address: hsiena@glenbrook225.org

Blue Access for Employers (BAE) Contact: Ms. Rhonda Sanders Phone Number: 847-390-5663 Fax Number: 847-745-0453

(The BAE Contact is the Employee of the Account authorized by the Employer to access and maintain its account via BAE.) Email Address: rsanders@cbcin.com

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

ERISA Plan Administrator: Plan Administrator's address:

Effective Date of Coverage: 07/01/2012 Anniversary Date: 07/01/2013

SCHEDULE OF ELIGIBILITY

1. Eligible Person means:
   - ☒ A full-time employee of the Employer.
   - ☐ A full-time employee who is a member of:

     (name of union)

   - ☒ Other: All certified teachers covered under the Glenbrook Educational Association agreement, all active full time administrators and educational support staff who work a minimum of 30 hours per week on a continuous basis, all instructional supervisors currently fulfilling their employment contract for the current year and all eligible retirees to age 65.
2. Full-Time Employee means:
   - ☒ A person who is regularly scheduled to work a minimum of 30 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: See Addendum

4. Domestic Partners covered: ☒ Yes ☐ No

   If yes: A Domestic Partner, as defined in the Plan, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those Covered Employees with Domestic Partners.

   If yes, are Domestic Partners eligible to continue coverage under COBRA? ☐ Yes ☒ No

   If yes, are dependents of Domestic Partners eligible for coverage? ☐ Yes ☒ No If yes, the Limiting Age for covered children of Domestic Partners means twenty-six (26) years, regardless of presence or absence of a child's financial dependency, residency, student status, employment, marital status or any combination of those factors.

5. The Limiting Age for covered children is **Twenty-six (26) years,** regardless of presence or absence of a child's financial dependency, residency, student status, employment, marital status or any combination of those factors. For plan years beginning before January 1, 2014, an ASO grandfathered group health plan may exclude an adult child under 26 from coverage only if the child is eligible to enroll in an eligible employer sponsored health plan (as defined in Section 5000A(f)(2) of the Internal Revenue Code) other than a group health plan of a parent.

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

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

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

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

   ii. ☐ The Limiting Age for covered children **who are full-time students** and age twenty-six (26) or over,
      - ☐ who are unmarried
      - ☐ regardless of marital status,

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

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

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

6. The 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:

7. Enrollment:

   Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a qualifying event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to termination of previous coverage, the date of application of coverage. In the case of a qualifying event due to loss of coverage under Medicaid or a state children's health

insurance program, however, this enrollment opportunity is not available unless the Eligible Person requests enrollment within sixty (60) days after such coverage ends.

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

Open Enrollment: ☒ Yes ☐ No

An Eligible Person may apply for coverage, Family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Open Enrollment Period.

- Specify Open Enrollment Period: August for a September 1st effective date

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

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

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

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

9. COBRA Auto Cancel? ☐ Yes ☒ No

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

ASO STATUS

1. Group Status: Renewing ASO Account
2. If a former HCSC Insured Group is converting to ASO, on what basis?

   Basis: Select from Pull Down

LINES OF BUSINESS

(Check all applicable products)	
☒ Participating Provider Option	☐ Outpatient Prescription Drugs:
☐ Point of Service (BlueChoice)	☐ Outpatient Prescription Drug Program
☐ Blue Choice Select	☐ Covered under the medical benefit
☐ Comprehensive Major Medical	☒ Dental
☐ Base Plus	☒ Blue Care Connection®

FEE SCHEDULE

Fee Schedule Period

To begin on Effective Date of Coverage and continue for:

☒ **12 Months** ☐ **Other (please specify):** **Months**

Administrative Charge(s)

% of Claim Payments or $ per Covered Employee per month

☐ Applies to all coverages

☒ Different percentage(s) or amount(s) for the following types of coverages. Please specify: 5.3% for medical claims and 4.5% for Dental claims.

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

Claim Administrator Provider Access Fee(s)

Group Number(s): P21650, P21651

☒ % of ADP Savings: **0.7%**

☐ $ per Covered Employee per month: $

Complete for Groups with multiple Provider Access Fees by products (i.e., CMM, PPO and/or POS plans):
Group Number(s):

☐ % of ADP Savings: %

☐ $ per Covered Employee per month: $

BlueCard Program/Network access fees: Available upon request.

Other Service and/or Program Fee(s)

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

Not applicable to Grandfathered Plans

External Review Coordination:

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

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

Reimbursement Provision: ☒ Yes ☐ No
If yes: It is understood and agreed that in the event the Claim Administrator makes a recovery on a third-party liability

claim, the Claim Administrator will retain 25% of any recovered amounts other than recovered amounts received as a result of or associated with any Workers' Compensation Law.

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

Blue Care Connection ("BCC") Program

BCC Package:

Enhanced

Fee: $0 per Covered Employee per month for administration of the program package.

BCC Package Buy Up(s):

Description:

Fee: $ per Covered Employee per month for administration of the package upgrade.

Description:

Fee: $ per Covered Employee per month for administration of the package upgrade.

Ancillary Program:

Select from Pull Down

Termination Administrative Charge

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

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

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

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

Payment Specifications

Employer Payment Method:	☐ **Online Bill Pay**	☒ **Electronic**	☐ **Check**
Employer Payment Period:	☐ **Weekly *(cannot be selected if Check is selected as payment method above)***		
☐ **Twice-Monthly**	☒ **Monthly**	☐ **Other (please specify):**	
Claim Settlement Period:	☒ **Monthly**	☐ **Other (please specify):**	

Run-Off Period

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

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

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

HCSC COBRA ADMINISTRATIVE SERVICES

HCSC COBRA Administrative Services Purchased: ☐ Yes ☒ No

If yes, please complete the COBRA sections below. If no, the COBRA sections below do not apply.

☐ RENEWAL - NO CHANGES COBRA Services	
COBRA Administrative Billing Services Only:	☐ Yes ☐ No
COBRA Administrative Full Services:	☐ Yes ☐ No
Notification Services included: (Full Services):	☐ Yes ☐ No
Conversion Rights included: (Full Services):	☐ Yes ☐ No
Monthly Reports* included: **Paper reports provided by mail/electronic reports via email*	☐ Yes ☐ No *If Yes,* Email Address:
Effective date(s) of services if different from ASO Effective Date of Coverage:	
COBRA Service Charges	
Billing Services Fee per Participant per month:	$10.00
If Notification Services included (Full Services) Notification Fee (per Participant for each notice):	$10.00
Monthly Administrative Fee:	$75.00
The Employer will pay HCSC a sum of One Hundred Dollars *($100.00)* per hour for any system programming costs associated with non-standard administration services.	$100.00
COBRA Membership	
Number of Active Members*:	
Number of current COBRA participants/members*:	
Number of current COBRA retiree participants/members*:	
**Full Service Unit (FSU) set-up of participants/members in BlueStar required*	
FSU Location:	
FSU Contact:	Phone Number:
Email Address:	Fax Number:
Is all COBRA participant census information attached?	☐ Yes ☐ No
Is all COBRA participant coverage(s) and level elected information attached?	☐ Yes ☐ No
Is all dependent census information attached?	☐ Yes ☐ No

COBRA Coverage

Are rates (SINGLE/FAMILY or TIERED) for all coverages attached?	☐ Yes ☐ No
Is 2% included in attached rates?	☐ Yes ☐ No
Does Employer have any non-HCSC coverage?	☐ Yes ☐ No
If Yes, Other Carrier(s):	
Name:	
Address:	
City: State: Zip:	
Administrative Contact: Phone Number: Fax Number: Email Address:	
Name:	
Address:	
City: State: Zip:	
Administrative Contact: Phone Number: Fax Number: Email Address:	
COBRA coverage begins:	☐ On date of Qualifying Event ☐ First of month following date of Qualifying Event
Should 150% of the COBRA premium be charged to participants eligible for disability extension for the remaining 11 months of COBRA? *(Extension is from 18 months to 29 months when deemed disabled by Social Security)*	☐ Yes ☐ No
Is contract provided and signed?	☐ Yes ☐ No
Prior COBRA administrator info:	
Name:	
Address:	
City: State: Zip:	
Administrative Contact: Phone Number: Fax Number: Email Address:	

OTHER PROVISIONS

1. Certificate of Creditable Coverage: ☒ Yes ☐ No

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

2. Case Management Program/Medical Services Advisory: ☒ Yes ☐ No

   If yes: The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons in accordance with the provisions of the Administrative Services Agreement to which this ASO BPA is attached and the Employer's plan document.

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

4. The Massachusetts Health Care Reform Act requires employers to provide, or contract with another entity to provide, a written statement to individuals residing in Massachusetts who had "creditable coverage" at any time during the prior calendar year through the employer's group health plan and to file a separate electronic report to the Massachusetts Department of Revenue verifying information in the individual written statements.

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

      ☒ Yes ☐ No

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

5. Stop Loss Coverage purchased: ☐ Yes ☒ No *(If yes, complete a separate Exhibit to the Stop Loss Coverage Policy)*

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

7. Health Care Account (HCA) Administrative Services purchased: ☐ Yes ☒ No *(If yes, complete separate HCA application)*

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

ADDITIONAL PROVISIONS:

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

B. Retiree Only Plans, Excepted Benefits and/or Self-Insured Nonfederal Governmental Plans: If the BPA includes any retiree only plans, excepted benefits and/or self-insured nonfederal governmental plans (with an exemption election), then Employer represents and warrants that one or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of administrative services. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's exempt plan status.

C. Employer shall indemnify and hold harmless Claim Administrator and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) or other costs or obligations resulting from or arising out of any claims, lawsuits, demands, governmental inquires or actions, settlements or judgments brought or asserted against Claim Administrator in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any plan's design (including but not limited to any directions, actions and interpretations of the Employer), and/or (d) any provision of inaccurate information. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of administrative services.

The provisions of paragraphs A-C (directly above) shall be in addition to (and do not take the place of) the other terms and conditions of administrative services between the parties.

Renewal effective 07/01/2012: renewal with rate changes only; no benefit changes. Group carving out Stop Loss coverage to outside reinsurer.

Chris Shillestad
Sales Representative

890 630-824-5172
District Phone & FAX Numbers

Mr. Ted Reese / Ms. Rhonda Sanders
Producer Representative

Corporate Benefit Consultants
Producer Firm

2800 South River Road
Suite 130
Des Plaines, IL 60018
Producer Address

847-390-5663
Producer Phone & FAX Numbers

rsanders@cbcin.com
Producer Email Address

36-4024403
Tax I.D. No.

Hillaire Sieg
Signature of Authorized Purchaser

Asst. Supt. for Business Affairs
Title

6-19-12
Date

PROXY

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

Group No.: P21650, P21651

By: Hilloric Siena
Print Signer's Name Here

➡ Hillaire Siena Asst. Supt. for Business Affairs
Signature and Title

Group Name: Secondary School Cooperative Risk Management Program / Glenbrook High School District #225

Address: 3801 West Lake Avenue, Suite 301

City: Glenview State: IL Zip Code: 60026

Dated this 19th day of June 2012
Month Year