RESOLUTION NO. R17-24

A RESOLUTION OF THE CITY COUNCIL AUTHORIZING THE MAYOR TO SIGN RENEWAL AGREEMENTS WITH BLUE CROSS BLUE SHIELD OF MONTANA AND VSP FOR THE PROVISION OF THE EMPLOYEE HEALTH INSURANCE PROGRAM.

WHEREAS, the City Council approved agreements with Blue Cross Blue Shield of Montana and VSP ("Insurers") for the City employee health insurance program through Resolution No. R16-41 on June 7, 2016; and

WHEREAS, the Insurers have provided the City with their respective yearly renewal agreements for the City's review and consideration; and

WHEREAS, City staff reviewed the agreements and determined renewal of the same is in the best interests of the City and its employees.

NOW THEREFORE BE IT RESOLVED by the City Council of the City of Laurel, Montana, that the Mayor is authorized to sign renewal agreements with Blue Cross Blue Shield of Montana and VSP for the employee health insurance program, copies of which are attached hereto.

Introduced at a special meeting of the City Council on June 13, 2017, by Council Member Poehls.

PASSED and ADOPTED by the City Council of the City of Laurel, Montana, this 13th day of June, 2017.

APPROVED by the Mayor this 13th day of June, 2017.

CITY OF LAUREL

Mark A. Mace, Mayor

ATTEST:

Bethany Keeler, Clerk/Treasurer

Approved as to form:

Sam S. Painter, Civil City Attorney

BlueCross BlueShield of Montana

BENEFIT PROGRAM APPLICATION ("Application")

Blue Cross and Blue Shield of Montana ("BCBSMT")

51 OR MORE ELIGIBLE EMPLOYEES

560 N Park Avenue, P.O. Box 4309, Helena, MT 50604

Account Status: Existing with Changes

Employer Account Number (6-digits): 138674

Group Number(s): 138706, 199106

Section Number(s): 0001,0002,0003; 9901, 0003, 0004,0005,9903, 0006,0007,0008,9904

Contract Effective Date: 07/01/2017

Contract Anniversary Date (AD): 07/01/2018

Legal Employer Name: **City of Laurel**

(Specify the employer or the employee trust applying for coverage. An employee benefit plan *may not* be named.)

ERISA Regulated Group Health* Plan: ☐ Yes ☒ No

If Yes, is your ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified above? ☐Yes ☐No

If No, please specify your ERISA Plan Year (month/day/year): Beginning Date ____/____/____ End Date ___/____/____

ERISA Plan Administrator*: _____ ERISA Plan Address: ____

If you maintain that ERISA is not applicable to your group health plan, please give legal reason for exemption:

☐ Federal Governmental plan (e.g., the government of the United States or agency of the United States)

☒ Non-Federal Governmental plan (e.g., the government of the State, an agency of the state, or the government of a political subdivision, such as a county or agency of the State)

☐ Church plan

☐ Other; please specify: _____

Is your Non-ERISA Plan Year a period of 12 months beginning on the Anniversary Date specified above? ☒Yes ☐No

If No, please specify your Non-ERISA Plan Year (month/day/year): Beginning Date __/__/__ End Date __/__/__

For more information regarding ERISA, contact your legal advisor.

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

ACCOUNT INFORMATION

☐ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

Employer Identification Number: 81-6001283 SIC: 9910 Nature of Business: City Government

Primary Address: P.O. Box 10

City: Laurel State: MT Zip: 59044

Administrative Contact: Kelly Strecker Title: Clerk

Phone: (406) 628-7431 ext 1 Fax: (406) 628-2289 Email: kstrecker@laurel.mt.gov

Physical Address (if different from Primary): 115 West 1st Street

City: Laurel State: MT Zip: 59044

Administrative Contact: Kelly Strecker Title: Clerk

Phone: (406) 628-7431 ext 1 Fax: (406) 628-2289 Email: kstrecker@laurel.mt.gov

Billing Address (if different from Primary):

City: State: Zip:

Billing Contact: Kelly Strecker Title: Clerk

Phone: (406) 628-7431 ext 1 Fax: (406) 628-2289 Email: kstrecker@laurel.mt.gov

Blue Access for Employers (BAE) Contact: Kelly Streckerl Title: Clerk

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

Phone: (406) 628-7431 ext 1 Fax: (406) 628-2289 Email: kstrecker@laurel.mt.gov

Subsidiary/Affiliated Company:

If necessary, list additional subsidiary companies and subsidiary company addresses in the Additional Provisions section.

Contact: Title:

Subsidiary/Affiliated Companies Address:

City: State: Zip:

Phone: Fax: Email:

PRODUCER OF RECORD INFORMATION

☒ **NO CHANGES**

1.*Producer/Agency** name to whom commissions are to be paid: David Allen

Producer Number of ☒ Producer or ☐ Agency: 046274000

Street Address: 2048 Overland Ave. City: Bilings State: MT Zip: 59102

Phone: (406) 656-2324 Fax: (406) 294-0276 Email: davealleninsurance.com

Is Producer/Agency appointed with BCBSMT? ☒ Yes ☐ No

If commissions apply, check all active lines of business, list the commission rate and select the calculation method.

Line of Business	Commission Rate	Calculation Method
☒ Health	1.32%	% Premium
☐ Dental		Select from dropdown

2. *Producer/Agency** name to whom commissions are to be paid: _____

Producer Number of ☐ Producer or ☐ Agency: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Is Producer/Agency appointed with BCBSMT? ☐ Yes ☐ No

If commission split, designate percentage for each Producer/Agency. **Note**: total commissions paid must equal 100%.

Producer/Agency 1: _____% Producer/Agency 2: _____%

If applicable, effective _____, the named producer(s) or agency(ies) is/are recognized as Employer's Producer of Record (POR), to act as representative in negotiations with and to receive commissions from Blue Cross and Blue Shield of Montana, a division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and HCSC subsidiaries for employer's employee benefit programs. This statement rescinds any and all previous POR appointments for employer. The POR is authorized to perform membership transactions on behalf of employer. This appointment will remain in effect until withdrawn or superseded in writing by employer.

*The producer or agency name(s) above to whom commissions are to be paid must exactly match the name(s) on the appointment application(s).

** If commissions are split, please provide the information requested above on both producers/agencies. BOTH must be appointed to do business with BCBSMT.

SCHEDULE OF ELIGIBILITY

☐ **NO CHANGES**

1. **Employee Eligibility Provisions:** All employees working a minimum of 20 hours per week.
   Specify:
   ☒ Full-time employee of the employer.
   ☒ Part-time employee of the employer.
   ☒ COBRA
   ☒ Retiree of the employer. Define criteria: Public Employee Retiree Criteria (PERS)
   ☐ Other: _____
   Are any classes of employees to be excluded from coverage? ☐ Yes ☒ No
   If Yes, please identify the classes and describe the exclusion: _____

2. **Are Spouses eligible for coverage:** ☒ Yes ☐ No

3. **Are Domestic Partners eligible for coverage:** (If coverage for a spouse is not available, coverage for a Domestic Partner is not available.) ☒ Yes ☐ No (skip to question 4)
   A Domestic Partner means a person with whom the employee has entered into a domestic partnership in accordance with the employer's plan guidelines. The employer is responsible for providing notice of possible tax implications to those covered employees with Domestic Partners.
   Are Domestic Partners eligible for continued coverage equivalent to COBRA continuation? ☒ Yes ☐ No

4. **Probationary Waiting Period:** All current and new Employees must satisfy the substantive eligibility criteria and required waiting period in order for coverage to become effective. Covered eligible Dependents do not have to satisfy a probationary waiting period to become effective, but in no instance shall an eligible Dependent be covered prior to the Employee's effective date.

   The effective date of coverage for a newly Eligible Employee is: (Note: No probationary waiting period may result in an effective date that exceeds ninety-one (91) calendar days from the date that an individual becomes eligible for coverage):
   ☐ The date of employment (date of hire).
   ☐ The _____ day (standard is 1st or 15th) of the month following the date of employment
   ☐ The _____ day (standard is 1st or 15th) of the month following _____ days (select 0, 30 or 60 days) of employment.
   ☐ The _____ day (standard is 1st or 15th) of the month following _____ month(s) (select 1 or 2 months) of employment.
   ☒ The 1St of the month following date of hire: unless date of hire falls on the 1st -then eligible to enroll date of hire. day of employment (select any number of days less than or equal to 91; examples - 10th, 14th, or 21st day of employment).

   If a person is added to the Policy and it is later determined that the Policyholder reported a coverage date earlier than what would apply, based on the waiting period and eligibility conditions the Policyholder provided to the Plan, the Plan reserves the right to retroactively adjust the coverage date for such person.

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

   Check all that apply:

   ☐ An Orientation Period that:

   1) Does not exceed one month (calculated by adding one calendar month and subtracting one calendar day from an employee's start date); and
   2) If used in conjunction with a waiting period the waiting period begins on the first day after the orientation period.

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

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

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

2) Does not exceed 12 months; and
3) Taken together with other eligibility conditions does not result in coverage becoming effective later than 13 months from the employee's start date plus the number of days between a start date and the first day of the next calendar month (if start day is not the first day of the month).

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

_____

_____

_____

5. **Are there multiple new hire probationary waiting periods?** ☐ Yes ☒ No
(Note: No combined probationary waiting periods may result in an effective date that exceeds ninety-one (91) calendar days from the date that an individual becomes eligible for coverage.)

If Yes, attach eligibility and contribution details for each section.
New Groups Only - Is the probationary waiting period requirement to be waived on initial group enrollment?
Health: ☐ Yes ☐ No ☐ N/A Dental: ☐ Yes ☐ No ☐ N/A

6. **The date of termination for a person who ceases to meet the definition of Eligible Person will be:**

1st of the month group renewal and billing date
☒ Last day of the month in which the covered person(s) is (are) no longer eligible.
☐ Other (please specify): _____

15th of the month group renewal and billing date
☐ 14th of the month in which the covered person(s) Is (are) no longer eligible
☐ Other (please specify): _____

7. **The minimum standard limiting age for covered Dependent children is twenty-six (26) years.** Dependent children under age 26 are eligible for coverage until their 26th birthday. Dependent child, used hereafter, means a natural child, a stepchild, an eligible foster child, an adopted child or child placed for adoption (including a child for whom the Member or his/her spouse is a party in a legal action in which the adoption of the child is sought), under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. A child not listed above who is legally dependent upon the Member or spouse is also considered a Dependent child under the Group Health Plan, provided proof of dependency is provided with the child's application.

A Dependent child who is medically certified as intellectually disabled or physically disabled and dependent upon the Member or his/her spouse is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

8. Blue Directions (Private Exchange) purchased ☐ Yes ☒ No

CURRENT ELIGIBILITY INFORMATION

☐ **NO CHANGES**

Total number of Employees/Subscribers:

1. On payroll 66
2. On COBRA continuation coverage 0
3. With retiree coverage (if applicable) 2
4. Who work part-time 4
5. Serving the new hire probationary waiting period 0 1
6. Declining because of other **group** coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) NA
7. Declining coverage (not covered elsewhere) NA

☐ NO CHANGES

LINES OF BUSINESS
(Check all applicable products)

All benefits will be processed according to State and Federal mandates.

	Deductible (Individual/Family)	Coinsurance (In-network/Out-of-network)	Out-of-Pocket (Individual/Family)	Office Visit Copay (if applicable)
☒ Blue Dimensions (PPO)				
Plan: 80/20	$1,000 / $2,000	80/20%%/65/35%%	$2,500 / $5,000	$25
Plan: 70/30	$1,500 / $3,000	70%/30%/55%/45%	$3,500 / $7,000	$35
☐ Blue Edge HSA Plus ☐ PPO ☐ Traditional (Embedded Deductible)				
Plan:	$ / $	%/ %	$ / $	$
Plan:	$ / $	%/ %	$ / $	$
☐ Blue Edge HSA Standard ☐ PPO ☐ Traditional				
Plan:	$ / $	%/ %	$ / $	$
Plan:	$ / $	%/ %	$ / $	$
☐ Comprehensive Major Medical ☐ PPO ☐ Traditional				
Plan:	$ / $	%/ %	$ / $	$
Plan:	$ / $	%/ %	$ / $	$
☐ Health First ☐ PPO ☐ Traditional				
Plan:	$ / $	%/ %	$ / $	$
Plan:	$ / $	%/ %	$ / $	$
☐ BlueEdge HCA (PPO)				
Plan:	$ / $	%/ %	$ / $	$
Plan:	$ / $	%/ %	$ / $	$

	Deductible (In-Network/Out-of-Network)	Coinsurance (In-network/Out-of-network)	Out-of-Pocket (In-Network/Out-of-Network)	Office Visit Copay PCP/SPC (if applicable)
☒ Blue Choice (HSA) (PPO)				
Marketing ID Number: MBH3535D10	$3,500/$7,000 / $7,000/$14,000	$100/0 / $100/0	$3,500/$7,000 / $7,000/$14,000	$N/A
Marketing ID Number:	$ / $	$ / $	$ / $	$
☐ Blue Choice (PPO)				
Marketing ID Number:	$ / $	$ / $	$ / $	$ / $
Marketing ID Number:	$ / $	$ / $	$ / $	$ / $

Health Care Management Services

☐ **Total Health Management (THM)** (additional charges apply)

☐ **Employee Assistance Program (EAP)**

Dental Coverage
☐ Yes If Yes, please list plan:
☒ No

Vision Coverage
☐ Yes, Standard Coverage
☐ Yes, Custom Coverage
☒ No

☐ **Life & Disability** (if checked, attach separate Dearborn National application)

☒ **HCSC COBRA Administrative Services** - If selected, complete separate COBRA Administrative Services Addendum. If not selected, please provide name of entity administering COBRA: _____

COMMENTS: Group is renewing on Triple Option Benefits: Renewing current Blue Dimensions Plans with the following mandated benefit changes: Performance Formulary applies at renewal.
RX Changes: Value Pharmacy Retail: Standard RX Benefit - $100 Deductible $10/$40/60% up to $200 max per fill; 90 Day supply available at Value Pharmacies only – 3 copays apply.

Mail Order – 90 Day Supply - benefit remains the same - 2 copays apply.
Non-Value Pharmacy/Prime/OON - Benefit Differential applies: $100 Deductible $15/$50/60% up to max per fill of $250
OON Specialty RX – 50% co-insurance does not apply to OOP.

Adding New Benefit Plan: Blue Choice HSA compatible Plan – MBH3535D10 with the following mandated benefits at renewal: Performance Formulary applies at renewal for dispensing limits, non-covered drugs, step therapy and prior authorization programs.
HDHP Preventive Drug List - $0 copay benefit
OON Specialty RX – 50% co-insurance does not apply to OOP

MD Live – Virtual Visits – Medical/Behavioral effective at Renewal on all three plans.

Group does not utilize ACA Re-hire criteria. Group does not utilize substantive eligibility.

ACCOUNT EXPERIENCE – NEW GROUPS ONLY

Has there been a significant change in the claims experience previously provided?

☐ No – skip the rest of this (Account Experience) section

☐ Yes – Please answer the below questions to the best of your knowledge. Note: any changes indicated below may impact rates and will require Underwriter approval. "Member" means all Eligible Employees, Dependent children, Retirees and COBRA Continuants.

1. Has any Member received more than $20,000 in medical benefits during the last 12 months? ☐ Yes ☐ No
2. Is any Member expected to have claims in excess of $20,000 during the next 12 months? ☐ Yes ☐ No
3. Is any Member mentally or physically handicapped or disabled or not actively at work? ☐ Yes ☐ No
4. Has any Member been diagnosed as having a high risk condition? ☐ Yes ☐ No

If any question is answered "yes," details must be provided below:

Member Age	Diagnosis or Nature of the Disorder	Dates of Treatment	$ Amount of Claims	Prognosis/Current Treatment
			$	
			$	
			$	
			$	
			$	
			$	

RATES

For the current year's premium rate information, refer to the accepted finalized new group/renewal Option Sheet for complete details. The Option Sheet shall be incorporated by reference and made part of the Application and Group Contract.

SPECIAL FINANCIAL ARRANGEMENT

☒ **NO CHANGES**

Special financial arrangement: ☐ Yes ☒ No If yes, provide additional information below

	Definition of terms (e.g. 50/50)	
☐ Minimum Premium		Retention Factor: _____
☐ Modified Retention		Retention Factor: _____
☐ Full Retention		Retention Factor: _____
☐ Contingent Premium		
☐ Other		

☐ Aggregate Stop-Loss ☐ Yes ☐ No Attachment Point _____% of expected claims

☐ Specific Stop-Loss ☐ Yes ☐ No Terms (i.e. attachment point and monthly or annual accommodation): _____

☐ Premium Deferral ☐ Yes ☐ No If Yes, please specify months _____

Options: 100-199 Contracts = 2 Months
200+ Contracts = 3 Months

Additional Information:

STANDARD PREMIUM INFORMATION

1. **Premium Period:**
   - ☒ The first day of each calendar month through the last day of each calendar month.
   - ☐ The 15th day of each calendar month through the 14th day of the next calendar month.
   - ☐ 15/16 Day Rule – premiums will be billed for the entire month for Members with effective dates on the 1st through the 15th day of the month. Premiums will not be billed for the month when the Member's effective date falls on the 16th day through the end of the month.

2. **Contribution of premium to be paid by the employer.**

PRODUCT	Employee	Eligible Dependents
HEALTH		
Plan 1 Blue Dimensions 80/20	% **or** ~~$784.69~~ 803.52	Varies% **or** $
Plan 2 Blue Dimensions 70/30	% **or** ~~$784.69~~ 803.52	Varies% **or** $
Plan 3 MBH3535D10	% **or** ~~$784.69~~ 803.52	Varies% **or** $
DENTAL		
Plan 1	% **or** $	% **or** $

BCBSMT reserves the right to take any or all of the following actions:

a) initial rates for new groups will be finalized for the effective date of the contract based on the enrolled participation and employer contribution levels; b) after the policy effective date, the group will be required to maintain a minimum employer contribution of 50%, and at least a 75% participation of eligible employees. In the event the group is unable to maintain the contribution and participation requirements, then the rates will be adjusted accordingly; and/or c) non-renew or discontinue coverage unless the 50% minimum employer contribution is met and at least 75% of eligible employees have enrolled for coverage.

BCBSMT reserves the right to change premium rates when a substantial change occurs in the number or composition of members covered. A substantial change will be deemed to have occurred when the number of Employees/Members covered changes by ten percent (10%) or more over a thirty (30) day period or twenty five percent (25%) or more over a ninety (90) day period.

Employer will promptly notify BCBSMT of any change in participation and Employer contribution.

Additional Information/Comments: City of Laurel provides a flat $ contribution as follows: - Emplyoyee: ~~$784.69~~ 803.52 Emp/Children ~~$784.69~~ $1,100 - Employee/Spouse: $1,100- Family.

BILLING SPECIFICATIONS

☒ **NO CHANGES**

The information provided within this section will be used to establish the format of your billing statement(s).

Member list sorted by: ☒ Unique Identification Number (standard) ☐ Social Security Number

Please provide a detailed description of the preferred billing format (for example: Billing statement to be broken out by Department, Location, Class): Active, Retirees Under 65; Retirees over 65, COBRA

ID CARD DELIVERY

☒ **NO CHANGES**

Mail ID Cards to:

- ☒ Member's home (standard)
- ☐ Account

LEGISLATIVE REQUIRMENT

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and the Consolidated Omnibus Budget Reconciliation Act (COBRA) are federally mandated requirements. Employer penalties for noncompliance may apply. It is your responsibility to annually inform BCBSMT of whether COBRA is applicable to you based upon your full and part-time Employee count in the prior calendar year.

Failure to advise BCBSMT of a change of status could subject you to governmental sanctions.

TEFRA is a Medicare secondary payer requirement that mandates Employers that employ 20 or more (full-time, part-time, seasonal, or partners) total Employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year to offer the same (primary) coverage to their age 65 or over Employees and the age 65 or over spouses of Employees of any age that they offer to younger Employees and spouses.

Are you subject to TEFRA? ☒ Yes ☐ No

COBRA allows qualified beneficiaries (generally, the covered employee or the covered employee's spouse and covered dependents) to continue to be covered by a group health plan any time the occurrent of one of more specified qualifying events would otherwise cause a loss of coverage.

a. Did your company employ 20 or more full-time and /or part-time Employees for at least 50% of the workdays of the preceding calendar year? ☒ Yes ☐ No
b. **Are you subject to COBRA?** ☒ Yes ☐ No

MEDICARE SECONDARY PAYER RULES

Under the **Medicare Secondary Payer Rules**, it is your responsibility to annually inform BCBSMT of proper Employee counts for the purpose of determining payment priority between Medicare and BCBSMT. **To satisfy this responsibility at this time, please complete, sign, date, and return the *Annual Medicare Secondary Payer Employer Acknowledgement Form along with this application.***

OTHER PROVISIONS

☐ **NO CHANGES**

1.) Electronic Issuance: The Employer consents to receive, via an electronic file or access to an electronic file, any Member Guide provided by BCBSMT to the Employer for delivery to each employee. The Employer further agrees that it is solely responsible for providing each Employee access to the most current version of any E-file Member Guide, amendment, or other revised form provided by BCBSMT, or to provide a paper copy of the same to an Employee upon request. The Employer is solely responsible and holds BCBSMT harmless from any misuse of the E-file provided by BCBSMT.

☐ Accept – Employer consents to receive electronic versions of Member Guides for covered Employees.

☒ Decline – Employer does not consent to receive electronic versions of certificate-booklets for covered Employees or the Contract and desires BCBSMT to print and distribute hard copy versions.
Authorized Company Official's Initials: _____ Date: _____

2.) **Summary of Benefits & Coverage:** BCBSMT will create SBC (only for benefits BCBSMT insures under the Contract) and provide SBC to the Employer. Employer will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law. The SBC Addendum is attached.

3.) **Association Plan.** Are you part of an association?

If yes, please state the name of the Association: _____

4.) This Application is incorporated into and made a part of the Contract entered into and agreed upon by BCBSMT and the account.

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

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

ADDITIONAL PROVISIONS:

A. Grandfathered Health Plans: Employer shall provide BCBSMT 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 BCBSMT to the terms and conditions of coverage. In no event shall BCBSMT 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 Application and Group Policy, and Employer represents and warrants that such Form is true, complete and accurate. If Employer fails to timely provide BCBSMT with any requested grandfathered health plan information, BCBSMT 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. If this Application includes any retiree only plans and/or excepted benefits, 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 BCBSMT to the terms and conditions of coverage. In no event shall BCBSMT 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. The provisions of paragraphs A-B (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.

D. ACA FEE NOTICE: ACA established a number of taxes and fees that will affect our customers and their benefit plans. One of those fees is: the Annual Fee on Health Insurers or "Health Insurer Fee."

Section 9010(a) of ACA requires that "covered entities" providing health insurance ("health insurers") pay an annual fee to the federal government, commonly referred to as the Health Insurer Fee. The amount of this fee for a given calendar year will be determined by the federal government and currently involves a formula based in part on a health insurer's net premiums written with respect to health insurance on certain health risk during the preceding calendar

year. This fee will go to help fund premium tax credits and cost-sharing subsidies offered to certain individuals who purchase coverage on health insurance exchanges.

In addition, ACA Section 1341 and/or other applicable laws may provide for the establishment of a temporary reinsurance program(s) that may be funded by reinsurance contributions or other amounts (collectively, the "Reinsurance Fees or Amounts") collected from health insurance issuers and/or self-funded group health plans. Federal and/or state governments may provide information as to how these Reinsurance Fees or Amounts are calculated. Federal regulations establish a flat per member per month fee. The temporary reinsurance programs funded by these Reinsurance Fees or Amounts will help stabilize premiums in the individual market.

Your premium, which already accounts for current applicable federal and state taxes, includes the effects of the Health Insurer Fees and Reinsurance Fees or Amounts, if any. These rates may be adjusted on an annual basis for any incremental changes in Health Insurer Fees and Reinsurance Fees or Amounts, if any.

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

Additional Information:

I UNDERSTAND AND AGREE THAT:

1. Producer Statement (if applicable): I certify that I have reviewed all enrollment materials. I have also advised the employer that I have no authority to bind these coverages, to alter the terms of the Contract(s), this Application or enrollment material in any manner or to adjust any claims for benefits under the Contract(s).
2. BCBSMT will report to ERISA plans with 100 or more participants the value of all remuneration paid by BCBSMT for use in the ERISA plans' preparation of ERISA Form 5500 schedules. Reporting will also be provided upon request to non-ERISA plans or plans with fewer than 100 participants. Reporting will include base commissions, bonuses, incentives, or other forms of remuneration for which your agent/consultant is eligible for the sale or renewal of self-funded and/or insured products.
3. The undersigned person represents that he/she is authorized and responsible for purchasing coverage on behalf of the employer. It is understood that the actual terms and conditions of coverage are those contained in the Contract into which this Application shall be incorporated at the time of acceptance by BCBSMT. Upon acceptance, BCBSMT shall issue a Contract to the employer and the employer shall be referred to as the "Employer or Contractholder."
4. The Employer's Group Application must pre-date the requested effective date and be received at BCBSMT at its Home Office no less than thirty (30) days prior to the requested effective date.

Shellie Wherley	X Mark A Mace
Authorized BCBSMT Representative	Signature of Authorized Purchaser
Account Executive	Mayor
Title	Title
	06/13/2017
Date	Date
Producer Representative (if applicable)	

Summary of Benefits and Coverage Addendum
to the Large Group Application

First Date of Employer's Open Enrollment Period for the next Plan Year (the "First Open Enrollment Date"): June 1st

The Affordable Care Act ("ACA") requires group health plans and/or insurance issuers to create and distribute a Summary of Benefits and Coverage (or alternate format permitted by ACA) (the "SBC"), to participants and beneficiaries in certain specified situations (the "SBC Requirements"). In accordance with the Employer's election on the most current Application, to have BCBSMT create and/or distribute the SBC, as of the First Open Enrollment Date, the Employer acknowledges and agrees:

1. BCBSMT's SBC services do not include the creation or distribution of coverage information for benefits it does not insure under the Contract, unless otherwise agreed to in the Application or this Addendum.

2. The Employer is responsible for the proper synthesizing of information from its various insurers and administrative service providers it uses for its group health plan (or providing multiple partial SBCs if permitted by law).

3. The Employer is responsible for SBC services performed by The Employer's third party vendors.

4. The Employer must review and approve the SBC prior to distribution and is responsible for the content of the SBC. Nothing in this Addendum or in the Contract relieves the Employer or its group health plan of their respective legal and regulatory obligations with respect to the SBC.

5. ACA and the SBC regulatory and sub-regulatory guidance (the "Guidance") are new (and subject to change) and the regulatory agencies and industry interpretations thereof are evolving; therefore, BCBSMT 's operations shall not be considered to be in breach of this Addendum or the Contract to the extent has worked diligently and in good faith to provide the SBC services, based on a reasonable interpretation of then-current SBC-related ACA provisions and Guidance, in a manner consistent with the SBC Requirements.

6. The Employer agrees to furnish to BCBSMT in a timely manner all information necessary for the timely distribution of SBCs, including but not limited to names and addresses for: (i) any person currently enrolled in any plan administered or insured by BCBSMT, and (ii) any person the employer tells us is eligible or may become eligible. The Employer's failure to furnish such information, to agree to an implementation plan or to promptly review/approve SBCs may substantially delay and/or jeopardize BCBSMT's SBC services and BCBSMT is relieved of its SBC obligations.

7. The Employer's failure to promptly review/approve SBCs may substantially delay and/or jeopardize BCBSMT's SBC services thereby relieving BCBSMT of its SBC obligations arising under this Addendum or its associated Large Group Application.

8. BCBSMT may, but is not required to, monitor Employer's performance of its SBC obligations, audit the Employer with respect to the SBC, request and receive information, documents and assurances from the Employer with respect to the SBC, provide its own SBC (or SBC corrections) to participants and beneficiaries, communicate with participants and beneficiaries regarding the SBC, respond to SBC-related inquiries from participants and beneficiaries, and/or take steps to avoid or correct potential violations of applicable laws or regulations.) The Employer will notify BCBSMT of any actual or potential non-compliance with the SBC Requirements.

9. The Employer shall indemnify and hold harmless BCBSMT 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 BCBSMT in connection with the SBC (and the Employer's or its vendors' distribution of the SBC).

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.

HCSC pays indemnification or advances expenses to a director, officer, employee or agent consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

Group No.: 138706/ 199106

By: Mark A. Mace
Print Signer's Name Here

➡ X Mark A. Mace Mayor
Signature and Title

Group Name: City of Laurel

Address: 115 W.1st Street

City: Laurel State: MT Zip Code: 59044

Dated this _____ day of _____ 2017
Month Year

PEAK1 ADMINISTRATION

City of Laurel
Attn: Benefit Contact
PO Box 10
Laurel, MT 59044

April 3, 2017

RE: July 2017 VSP Renewal

Dear: Benefit Contact

We appreciate your business and thank you for choosing VSP and Peak1 Administration. We are pleased to present you with our VSP contract renewal information. We are committed to providing you with quality plan designs combined with excellent customer service. As part of the law, carriers are required to apply additional taxes to their rates. Your new rates include all of the new Affordable Care Act (ACA) taxes required by Federal Law.

Rates thru 6/30/2017		7/1/2017 Rates	
EE Only	**$6.59**	**EE Only**	**$6.79**
EE+Spouse	$13.20	**EE+Spouse**	$13.59
EE+Child(ren)	**$14.13**	**EE+Child(ren)**	**$14.55**
EE+Family	$22.57	**EE+Family**	$23.25

Please sign below that you agree to the rates stated above and will renew as is:

Signature: X Mark A Mace, Mayor

If you need to make any changes, please complete the attached employer agreement and we will update accordingly.

Your business is very important to us. Thank you for allowing Peak1 Administration to serve your insurance and account based product needs. If you have any questions about your renewal, please give us a call at 877.404.9443 or email benefits@mypeak1.com. We appreciate your continued confidence in VSP and Peak1 Administration.

Sincerely,

Amy Markham

Amy Markham
Implementation Coordinator
Peak1 Administration

PEAK1 ADMINISTRATION

VSP Vision care for life

Employee Application

☐ New Employee
☐ Open Enrollment
☐ Change(list type of change): _____

Effective Date: _____
Hire Date: _____
Location: _____

Employee on Company Health Plan **Employee Not on Company Health Plan**

Employer: _____

Name: _____ **Date of Birth *(required)*:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **SSN: (Required)** _____ ☐Male ☐Female

COVERAGE OPTIONS

☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

FAMILY MEMBERS

Name	Relationship	Date of Birth	Gender

☐ I decline the vision coverage at this time

_____ _____

Member Signature *Date*

608 Northwest Boulevard, Suite 200 // Coeur d'Alene, ID 83814 // 877-404-9443 // benefits@mypeak1.com

PEAK1 ADMINISTRATION

VSP Vision care for life

Employer Participation Agreement

Group Information

Group (50% or more ER contribution) **Voluntary** (49% or less ER contribution) **Packaged** (Voluntary w/ another product added)

Group Name:	**Corporation Type:**		
Mailing Address:	**City:**	**State:**	**Zip:**
#Eligible Employees:	**SIC:**		
Contact:	**Contact Email:**		
Phone:	**Fax:**		

Plan Selection

Co-Pay:	**$10/$25**	**Allowance:**	**$130/$130**	**$150/150**
Frequency:	**Exam:**	**12 Months**		
	Lenses:	**12 Months**	**24 Months**	
	Frames:	**12 Months**	**24 Months**	

Rates

Employee: **Employee+Spouse:** **Employee+Child(ren)** **Family:**

Eligible Employees: Active regular full-time employees working _____ hours per week.

Wait Period: New employees will become eligible 1st of the month following _____ days of continuous employment.

Employer Contribution: _____ % Employee Contribution: _____%

Requested Effective Date: (Must be 1st of the month) Month_____ Year_____

This policy will become effective on the first day of _____, provided that all of the following has been completed prior to this effective date:

A. Group Application has been received and accepted by Peak1.
B. Peak1 has been furnished all employee applications, signed and dated by employee.
C. A check for the required premium is included; all future payments are due on the 1st of each month (***new groups only***).

Employer Agreement

The undersigned group hereby applies for vision care coverage through Vision Service Plan. It is understood that:

A. Participation Requirement: 5 minimum enrolled (***new groups only***).
B. Coverage will terminate for an employee on the last day of the month in which employment terminates.
C. Peak1 Administration will charge $25.00 NSF or returned item fee for each occurrence.
D. The individual signing this agreement is authorized to sign on behalf of the employer.

Signed at (City, State, Zip):	**Date:**
Employer:	**Federal Tax I.D. Number:**
Employer Signature:	**Title:**
Agent Signature:	**Agent Name:**
Peak1 Representative Signature:	**Representative:**

WARNING: Any person who knowingly and with intent to defraud any insurance company or other persons, files an application for insurance containing any materially false information and conceals information concerning any fact material thereto, commits a fraudulent insurance act which may subject such person to criminal and civil penalties. The undersigned has read this entire application for vision insurance and agrees: (a) the information provided is accurate to the best of my knowledge; (b) this application and any other information I provide shall serve as the basis for the insurance to be issued; (c) I have a duty to notify the Company of any changes.

New Groups - Submit two months premium for Group and 1 month for Voluntary
Make check payable to Peak1 Administration, LLC

608 Northwest Boulevard, Suite 200 Coeur d'Alene, Idaho 83814 // mypeak1.com