RESOLUTION NO. R18-28

A RESOLUTION OF THE CITY COUNCIL AUTHORIZING THE MAYOR TO SIGN AN AGREEMENT WITH PACIFIC SOURCE HEALTH, DELTA DENTAL AND VSP FOR THE PROVISION OF THE EMPLOYEE HEALTH INSURANCE BENEFIT PROGRAM.

WHEREAS, the City Council previously authorized the City's Health Insurance Committee to seek bids to provide health insurance for the City's employees and dependents; and

WHEREAS, the City of Laurel complied with its procurement policy and Montana Law by utilizing a competitive bid process to ensure the selected bidder will provide satisfactory health care coverage and in the City's best interest; and

WHEREAS, City staff reviewed the proposals and determined the proposal submitted by PacificSource was the most responsive to the City's request, and hereby recommends selection of the same.

NOW THEREFORE BE IT RESOLVED by the City Council of the City of Laurel, Montana, that the Mayor is authorized to sign an agreement with PacificSource Health for the employee health insurance program, a copy of which is attached hereto; and

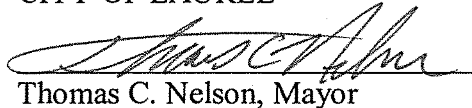
BE IT FURTHER RESOLVED, the Mayor is authorized to sign agreements with Delta Dental and VSP for the employee dental and health insurance.

Introduced at a regular meeting of the City Council on June 19, 2018 by Council Member McGee.

PASSED and ADOPTED by the City Council of the City of Laurel, Montana, this 19th day of June, 2018.

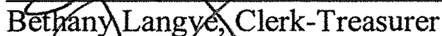
APPROVED by the Mayor this 19th day of June, 2018.

CITY OF LAUREL



Thomas C. Nelson, Mayor

ATTEST:



Bethany Langve, Clerk-Treasurer

Approved as to form:

Sam Painter Civil City Attorney

Group Master Application—Montana

Employer Information

Legal Name of Group City of Laurel
Requested Effective Date 7/1/2018
DBA Name (appears on bills)
SIC or NAICS Code 9910
Physical Address Required (no PO Box) 115 West 1st Street
City Laurel State MT ZIP 59044 County Yellowstone
Mailing Address (if different than Physical Address)
City State ZIP County
Federal Tax ID No. 816001283 Company Headquarters State MT Nature of Business City Government
Name(s) of All Owners and Partners

Form of Organization (check all that apply)

- Limited Liability Company
- Sole Proprietorship
- Subchapter S-Corp
- ✓ Government
- Partnership
- Association
- Nonprofit
- C-Corp
- MEWA
- Church
- Union
- Trust

Group Contact

	Name	Phone	Email	Fax
Name for Eligibility and Benefits	Kelly Strecker	406-628-7431 Ext 1	kstrecker@laurel.mt.go	406-628-2289
Name for Billing	Kelly Strecker	406-628-7431 Ext 1	kstrecker@laurel.mt.go	406-628-2289

Affiliates

Is your company affiliated with any other? Yes No **Will it be insured with PacificSource?** Yes, Common Ownership form is attached No
Name of Affiliate(s) No. of Employees
Address of Affiliate(s) Should each affiliate be billed separately? Yes No

Current Insurance (Required if you had prior coverage)

Medical
Carrier Blue Cross Blue Shield
Policy No. 138674
Term Date 06/30/2018

Dental
Carrier
Policy No.
Term Date

Who was eligible for your prior dental plan?
Children Only
Adults and Children

Existing Workers' Compensation
Carrier MMIA
Policy No. 069-WC-2018

Mail: 828 Great Northern Blvd, Ste 101, Helena, MT 59601
Fax: (406) 422-1010 | **Email:** MontanaSales@pacificsource.com

Benefit Information

Small Group
Indicate coverage with "yes" or "no".

Yes No **Medical**..Plan Name(s) ____________________
Deductible based on Calendar yr.

The medical policy you are applying for does not include coverage for pediatric dental care, which is considered an essential health benefit under the ACA for small groups. Pediatric dental care is available in the market and can be purchased as a stand-alone product. Contact your agent, your health insurance company, or Marketplace if you wish to purchase a stand-alone dental care product.

Yes No **Dental**.. Plan Name(s) ____________________
Yes No **Cosmetic Orthodontia** (16+ enrolled employees only) Plan Name ____________________

Large Group
Indicate coverage with "yes" or "no".

Yes No **Medical and Pharmacy**...................................Plan Name(s) See Attached Quote
Deductible based on Calendar yr. Contract yr.
Yes No **Chiropractic Manipulations and Acupuncture**....Maximum $ ____________________
Yes No **Vision**...Plan Name ____________________
Yes No **Additonal Accident**...Amount $ ____________________
Yes No **Dental**...Plan Name(s) ____________________
Yes No **Cosmetic Orthodontia** (16+ enrolled employees only) Plan Name ____________________

Employer Premium Contribution

Medical: Employee $803.52 Dependent See attached **Dental:** Employee ________ Dependent ________

Eligibility

Probationary Waiting Period
First of the month following your selection
✓ Date of hire 30 days 60 days
90 calendar days; effective on 91st calendar day (premium prorated first month)

If the last day of the probationary period falls on first day of the month, when will the new employee be effective?
✓ Eligible that day
Must wait until the first day of the following month or 91st day, whichever comes first (default if not marked)

Initial Enrollment
If the group has no prior coverage, then allow employees to waive probationary period at initial enrollment? Yes No

Minimum Hours
How many hours per week must employees work to be eligible for coverage?
Class All Employees Hours per week 20
Class ____________________ Hours per week ________

Eligible Members
Plan covers: ✓ Employee + spouse/domestic partner + children
Employee only (only for small group)
Employee + children (only for large group)

Retiree
Is the group a local government (school, city, county)? (Yes) No
If yes, is group coverage available to retirees? (Yes) No
If you offer health or dental coverage to your retirees, please attach the requirements and employer contribution (if any).

HSA, HRA, FSA, COBRA Administration, or EAP

Check accounts your group has HSA HRA FSA (COBRA Admin) EAP Employer Contribution to HRA or HSA ______

Third Party Administrator Name ______ Address ______ Phone ______

People to Be Insured

1. 132 Total number of employees (full-time, part-time, owner, partner, principal, probationary, and waiver; exclude continuation)
2. 3 Total no. former employees currently on Continuation or Retiree with your group health plan (submit Application and Waiver of Coverage Form)

A. 135 TOTAL NUMBER OF EMPLOYEES: Add numbers 1 and 2 above

3. 70 Total number of employees who do not qualify due to hourly requirement
4. ______ Total number of employees who do not qualify due to waiting period requirement
5. ______ Total number of employees waiving coverage due to other qualified coverage* (submit Application and Waiver of Coverage Form)
   **Qualified Coverage: Employer Plan, Medicare, Medicaid, Tricare, and Indian Health Service*
6. ______ Total number of employees not insured for reasons not stated above
   Please explain reason (e.g., classification not eligible, chose not to participate): ______

B. 70 TOTAL NUMBER OF EMPLOYEES NOT ENROLLING: Add numbers 3 through 6 above

C. 62 TOTAL NUMBER OF EMPLOYEES ENROLLING, including continuation: Subtract B from A above

SERVICE AREA: Do all employees reside within the PacificSource service area? Yes No If no, what state(s): ______

ERISA: Is your group comprised of employees of a government entity or church that is not subject to ERISA? Yes No

COBRA: Did you employ 20 or more total employees (full-time, part-time, seasonal) at least 50% of your business days in the **preceding calendar year**? Yes No

Employees on Conversion or COBRA continuation of coverage: Application and Waiver of Coverage Form must be submitted for each employee on continuation.

Name	Continuation Effective Date	Qualifying Event

Requirements—Must Be Submitted Prior to Policy Effective Date

Group Master Application—Dental Copy of Sold Rates Enrollment Application and Waiver Forms Binder Payment (est. first month premium; refunded if coverage not effectuated Electronic Funds Transfer Form, if you want monthly premium withdraw from a bank account Common Ownership Form, if applicable

Signature—Please Read Carefully

This is an application for group insurance. Under no circumstances will coverage be in force until the policy is issued by PacificSource and accepted by the employer. Once a policy is issued, the policy terms control in all cases.

I affirm that I have read this application in its entirety, and that the information I have provided is complete and correct. I understand that if this application contains any intentional misrepresentation of material fact or fraud, PacificSource Health Plans may modify or cancel the contract, and/or take any other legal action available by law. I will promptly inform PacificSource Health Plans in writing if anything happens before coverage takes effect that makes the information I have provided on this application incomplete or incorrect.

Group Representative **Title** Mayor **Date** 6/20/2018

I, the undersigned agent for this group, affirm that the information provided on this application is complete and correct to the best of my knowledge.

Agent's Name (printed) Eric Allen **Agent's Signature** **Agent No.** P00431301 **Date** 06/20/2018

Mail: 828 Great Northern Blvd, Ste 101, Helena, MT 59601
Fax: (406) 422-1010 | **Email:** MontanaSales@pacificsource.com

Quote Assumptions

Date Printed: June 20, 2018

Group Name: City of Laurel

Effective Date: July 1, 2018

Agent: Eric Allen

Enrollment: Enrolled Employees: 67

If enrollment differs by 10% or more, the rate guarantee is void and subject to a new rating evaluation.
If plan(s) quoted below are not purchased with 75 days of effective date stated above, the rate guarantee is void and subject to a new rating evaluation.

Contract Period: 12 month rate only

Medical Deductible Credit: Included at no charge
Medical OOP Credit: NOT Included, unavailable option
Rx, Dental, Vision and other deductible and OOP credits are not available.

Commissions: 1.32%

COBRA Administration: COBRA administration through PacificSource Administrators is included in premium.

Eligibility:
- Employees must work a normal workweek minimum of 20 or more hours
- PacificSource requires a minimum of 75% of all eligible employees to participate in the plan.

Note: ***Waiving to Individual coverage is counted against participation***
- PacificSource requires that the employer contribute a minimum of 75% to the employee rate or 50% of the total rate. Based on the information submitted, this is at 100% EE and fixed varying amount for dep and must be maintained by employer.

Yes	No	
✓		Are there retirees under 65 (Early Retirees)?
✓		Are there retirees over 65 (Medicare Eligible)?
	✓	Are there COBRA participants?

Other: Refer to Value Added Services

Quote Information:
Standard PacificSource benefit structure, limitations and exclusions apply.

Yes	No	
✓		Matching, as best as possible, Groups Ded/Coins/OOP/Copay structure ONLY?
✓		Benefits are Standard "chassis" PacificSource structure, limitations and exclusion?
	✓	Matching Groups current benefit limitations and exclusions?
	✓	If applicable, is the copay bundling option defined (PS Standard, Option B, Option A)?
	MDL	Rx Formulary?
		Which copay bundling option?

Any other Notes:
ER copay match does not apply

Rates:

Medical Plans:

	PSN 1000 25_20 2500	PSN 1500 35_30 3500	PSN 3500+Rx	PSN 500 25_20 2500
EE	$746.91	$701.93	$583.61	$779.77
ES	$1,657.02	$1,557.63	$1,295.02	$1,729.93
EC	$1,188.36	$1,115.14	$927.94	$1,240.65
EF	$1,903.89	$1,788.82	$1,487.62	$1,987.66
Smed	$450.15	$423.04		$469.96
2P Med	$900.30	$846.08		$939.91

PSN 1000 25_20 2500:
2x Family Ded/OOP
Rx 100, 10/40/60% to $200
2x Mail Order

PSN 1500 35_30 3500:
2x Family Ded/OOP
Rx 100, 10/40/60% to $200
2x Mail Order

PSN 3500+Rx:
2x Family Ded/OOP
2x OON Ded/OOP
Embedded Ded
Prev Rx

PSN 500 25_20 2500:
2x Family Ded/OOP
Rx 100, 10/40/60% to $200
2x Mail Order

Signature: ______ Date: 6/21/2018

Note: EAP is not included

Benefit Period: Calendar Year

Conditions:

- ✓ Offer assumes the contract situs and issuance of contract is in Montana
- ✓ This quote assumes PacificSource will be the only carrier providing coverage to the employer group's employees
- ✓ Open Enrollment will be one month prior to the renewal date
- ✓ Regulations require PacificSource to determine, based on the information provided in the quoting process, whether an employer is subject to Chapter 26 of the Montana Code Annotated. This proposal is made on the condition you are not a Small Employer
- ✓ Employer will promptly notify PacificSource of any change in participation and Employer contribution
- ✓ ACA established a number of taxes and fees that are incorporated into your premiums. Two of those fees are: (1) the Annual Fee on Health Insurers or "HIT(Health Insurer Tax)"; and (2) the Transitional Reinsurance Fee. Both fees began in 2014.

(1) Section 9010(a) of ACA requires that ("health insurers") pay an annual fee to the federal government, commonly referred to as the Health Insurer Fee. The amount of this fee will be determined by the federal government. This fee helps fund premium tax credits and cost-sharing subsidies offered to certain individuals who purchase coverage on health insurance exchanges. As of late 2015, this fee currently has been suspended for 2017 only. The fee still applies in 2016 and, pending any further legislation, could recontinue in 2018.

(2) Section 1341 of ACA provides for the establishment of a temporary reinsurance program (for a three year period (2014-2016) which is funded by Reinsurance Fees collected from health insurance issuers and self-funded group health plans. Federal and state governments provide information as to how these fees are calculated. Federal regulations establish a flat, per member, per month fee. The temporary reinsurance programs, funded by these Reinsurance Fees, help to stabilize premiums in the individual market.

City of Laurel

Additional Attachment

Contribution Schedule as of 06-20-2018

The City of Laurel provides a flat $ contribution cap as follows:

Employee $803.52

Employee +Child/ren $803.52

Employee +Spouse $1100.00

Employee +Family $1100.00

Scanned 6-26-18

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

April 2, 2018

RE: July 2018 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 6/30/2018		7/1/2018 Rates	
EE Only	$6.79	EE Only	$6.80
EE+Spouse	$13.59	EE+Spouse	$13.61
EE+Child(ren)	$14.55	EE+Child(ren)	$14.59
EE+Family	$23.25	EE+Family	$23.28

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

Signature: [signature] 6/26/2018

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 M Markham

Amy Markham
Implementation Coordinator
Peak1 Administration