RESOLUTION NO. R14-32

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

WHEREAS, the City Council approved agreements with Blue Cross Blue Shield of Montana, Delta Dental and VSP ("Insurers") for the City employee health insurance program through Resolution No. R13-30 on June 4, 2013; 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, Delta Dental and VSP for the employee health insurance program, copies of which are attached hereto.

Introduced at a regular meeting of the City Council on June 3, 2014, by Council Member Mountsier.

PASSED and ADOPTED by the City Council of the City of Laurel, Montana, this 3rd day of June, 2014.

APPROVED by the Mayor this 3rd day of June, 2014.

CITY OF LAUREL

Mark A. Mace

Mark A. Mace, Mayor

ATTEST:

Cathy Galerian for

Shirley Ewan, Clerk/Treasurer

Approved as to form:

Sam S. Painter, Civil City Attorney

DELTA DENTAL

Delta Dental Insurance Company

March 28, 2014

Ms. Cathy Gabrian
City of Laurel
115 West First Street
Laurel, MT 59044

RE: Contract renewal for City of Laurel
Group Number 27-07774

Dear Cathy:

We appreciate your business and thank you for choosing Delta Dental Insurance Company (Delta Dental). Your employees are among the millions nationwide who trust their smiles to Delta Dental.

We are pleased to present you with your dental plan contract renewal information. We are committed to providing you with quality plan designs combined with excellent customer service.

When reviewing your dental plan, we considered cost factors related to your group's dental service utilization and claims experience. Because of increases in one or both of these factors, we have determined that an increase in your current rate is necessary. We have made every attempt to keep this increase as low as possible.

We have calculated your rates based on the employer/employee contribution levels in your contract remaining the same. If the contribution levels and/or enrollment guidelines have changed or will change, please notify us immediately, as such a change may affect your renewal rate.

The rates for the renewal contract period are:

Effective date	July 1, 2014	
Contract term	July 1, 2014 – June 30, 2015	
	Current rates	**Renewal rates**
Employee	$ 42.52	$ 45.28
Employee & Spouse	$ 73.55	$ 78.33
Employee & Child(ren)	$ 85.51	$ 91.07
Employee & Family	$125.90	$134.08

Please keep this renewal letter with your contract documents. It serves as an amendment to your Delta Dental contracts for the rates and contract term.

55 West 14th Street
Suite 101
Helena, MT 59601

Telephone: 800-547-1986
Telephone: 406-449-0255
Facsimile: 406-449-2750

PEAK 1 ADMINISTRATION

City Of Laurel
Attn: Cathy Gabrian
PO Box 10
Laurel, MT 59044

April 4, 2014

RE: City Of Laurel July 2014 VSP Renewal

Dear Cathy Gabrian:

Please find your VSP renewal for this upcoming plan year, effective July 1, 2014, listed below. The rates are guaranteed for 12 months. As you know, Healthcare Reform took effect January 1, 2014. 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 6/30/2014		7/1/2014 Rates
EE Only	$13.37	EE Only	$13.94
EE+Spouse	$21.40	EE+Spouse	$22.26
EE+Child(ren)	$21.84	EE+Child(ren)	$22.74
EE+Family	$35.22	EE+Family	$36.66

Also for your consideration, we have attached a benefit summary and rates for our newest vision product offerings. These new plans offer rich benefits for using an in-network provider, along with attractive monthly premiums. Please call into your account manager here at Peak 1 with any questions.

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 866.449.9777 or email benefits@mypeak1.com. We appreciate your continued confidence in VSP and Peak1 Administration.

Sincerely,

Doug Jaworski

Doug Jaworski
General Agency Manager
DJaworski@mypeak1.com

7600 Mineral Drive, Suite 450 | Coeur d'Alene, ID | 83815 | 866.449.9777 | Fax: 208-772-3392

PEAK 1 ADMINISTRATION

VSP Choice Plan Rates

VSP Vision care for life

VSP Promise

- Committed to Eye Health & Wellness
- 100% Satisfaction Guaranteed
- Hassle-free Experience
- Privacy & Security
- Industry Benchmark of Quality

Choice & Convenience

- Unrestricted Benefits
- Open Access to Any Eyecare Location
- Choice of Any Eyewear Brand
- Retail & Medical Office Locations

Service

- 50+ Years of Experience
- Dedicated Client Account Teams
- Operational Stability
- World Class Call Center
- IVR Available 24/7
- Online Client Resources & Tools
- Member Communications Support

VSP Preferred Providers

- 45,000 Access Points Nationwide
- One-Stop Shopping
- Evening & Weekend Hours
- Average 21 Years in Practice

Enhanced Benefits

- Eye Health Management Program®
- Discounts on Lens Options
- Discounts on Laser Vision
- Correction & Additional Glasses
- Contact Lens Special Offers

Choice Full Service Plans (Voluntary & Non-Voluntary)

Plan Coverage Through a VSP Doctor		Out of Network Reimbursement Schedule (minus applicable copays)	
WellVision Exam®	Covered in Full After Copay	**Eye Exam**	$45
Contact Lens Exam[1]	Up to $60	**Contact Lens Exam**	N/A
Covered Lens		**Covered Lens**	
Single Vision Lens	Covered in full after copay	Single Vision Lens	$30
Bifocal Lens	Covered in full after copay	Bifocal Lens	$50
Trifocal Lens	Covered in full after copay	Trifocal Lens	$65
Frame	**Up to $150**	**Frame**	**$70**
OR		**OR**	
Elective Contacts	**Up to $150**	**Elective Contacts**	**$105**

Elective Contacts in lieu of lenses and Frames

VSP Choice Plan	Exam	Lenses	Frames
Plan B[2]	12 Months	12 Months	24 Months

Voluntary (*49% or less ER contribution*)

Plan B[2]	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
$10 exam copay $25 materials copay	$ 7.41	$ 14.32	$ 15.15	$ 24.21

Packaged (*49% or less ER contribution AND sold with another product through Peak 1*)

Plan B[2]	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
$10 exam copay $25 materials copay	$ 6.68	$ 12.85	$ 13.58	$ 21.70

Non-Voluntary (*50% or more ER contribution*)

Plan B[2]	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
$10 exam copay $25 materials copay	$ 6.57	$ 12.65	$ 13.37	$ 21.36

[1] Contact Lens Exam is covered in full, up to $60 at a VSP Provider. Members will not pay more than $60 for his or her Contact Lens Exam (standard and premium).
[2] Enhanced Plan B - If a patient uses their plan for contact lenses, they will be eligible for frame coverage in 12 months instead of 24 months. The frame frequency is still 24 months if a patient uses their plan for a frame purchase.

The rates listed are valid for 60 days from today's date: 04/18/2014

Leading the way in Employee Services

BlueCross BlueShield of Montana

LARGE GROUP APPLICATION ("Application")

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

51 OR MORE ELIGIBLE EMPLOYEES

Account Status: Existing with Changes

Employer Account Number (6-digits): 138674 Group Number(s): 138674 Section Number(s): 0001, 0002, 0003, 0004, 0005, 0006 9901, 9902 (Active, retiree under 65, Retiree over 65, COBRA Admin)

Contract Effective Date: 07/01/14 Contract Anniversary Date (AD): 07/01/15

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 Administrator*: _____

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: Cathy Gabrian Title: Deputy Clerk
Phone: (406) 628-7431 Fax: (406) 628-2289 Email: cgabrian@laurel.mt.gov

Physical Address (if different from Primary): 115 West 1st Street
City: Laurel State: MT Zip: 59044
Administrative Contact: Cathy Gabrian Title: Deputy Clerk
Phone: (406) 628-7431 Fax: (406) 628-2289 Email: cgabrian@laurel.mt.gov

Billing Address (if different from Primary):
City: State: Zip:
Billing Contact: Cathy Gabrian Title: Deputy Clerk
Phone: (406) 628-7431 Fax: (406) 628-2289 Email: cgabrian@laurel.mt.gov

Blue Access for Employers (BAE) Contact: Cathy Gabrian Title: Deputy 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 Fax: (406) 628-2289 Email: cgabrian@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: Billings Zip: 59102

Phone: (406) 656-2324 Fax: _____ Email: dave@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: _____ 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: _____
   ☐ 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:** The probationary waiting period means the period an Employee must satisfy 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: the probationary waiting period must not result in an effective date that exceeds 90 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 _____ day of employment (select any number of days less than or equal to 90; examples - 10th, 14th, or 21st day of employment).
   ☒ Other: 1st of the month following date of hire; unless date of hire falls on the 1st - then eligible to enroll date of hire

5. **Are there multiple new hire probationary waiting periods?** ☐ Yes ☒ No
   (Note: the combined probationary waiting periods must not result in an effective date that exceeds 90 calendar days from the date that an individual becomes eligible for coverage.)

   If Yes, attach eligibility and contribution details for each section.
   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 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.

CURRENT ELIGIBILITY INFORMATION

☐ **NO CHANGES**

Total number of Employees/Subscribers:

1. On payroll 64
2. On COBRA continuation coverage 1
3. With retiree coverage (if applicable) 2
4. Who work part-time 6
5. Serving the new hire probationary waiting period 0
6. Declining because of other **group** coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) 0
7. Declining coverage (not covered elsewhere) 0

☐**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 Plan	$500 / $1,000	80/20%/65/35%	$2,000 / $4,000	$25
Plan: 70/30	$1,000 / $2,000	70/30%/55/45%	$3,000 / $6,000	$35
☐ Blue Edge HSA Plus (PPO) (Embedded Deductible)				
Plan:	$ / $	% / %	$ / $	$
Plan:	$ / $	% / %	$ / $	$
☐ Blue Edge HSA Standard (PPO)				
Plan:	$ / $	% / %	$ / $	$
Plan:	$ / $	% / %	$ / $	$
☐ Comprehensive Major Medical (PPO)				
Plan:	$ / $	% / %	$ / $	$
Plan:	$ / $	% / %	$ / $	$
☐ Health First (PPO)				
Plan:	$ / $	% / %	$ / $	$
Plan:	$ / $	% / %	$ / $	$

Health Care Management Services

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

☐ **Employee Assistance Program (EAP)**

☐ **Employer-Paid Dental Coverage**

☐ **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 in small merit pool with benefit changes- changing from Big Sky Select plans to Blue dimensions options - 80/20 & 70/30 as outlined above with Full Efficient RX with $50 Deductible Card. Group is transitioning to HCSC COBRA effective 7/1/14

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	77 % or $	75 % or $
Plan 2 Blue Dimensions 70/30	23 % or $	100 % or $
Plan 3	% or $	% 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 (less valid waivers). 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 (less valid waivers) 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: _____

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 Admin

ID CARD DELIVERY

☒ **NO CHANGES**

Mail ID Cards to:

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

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 certificate-booklets 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: CD Date: 5-23-14

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 a multi-employer group health plan or association?

☒ No, our group health plan is NOT part of a multi-employer group health plan or association.

☐ Yes, our group health plan is part of a multi-employer group health plan or association. If yes, please provide a response to each of the following questions.

a. **Type** - What type of association? (Association, MEWA) Choose an item

b. **Category** - Are you an association consisting of groups, individuals or a combination of groups and individuals? Choose an item

c. **Relationship** - What is the relationship of the members to the association? (Employer-employee or Individual Member) Choose an item

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.

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. 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 (a) religious employer exemption, (b) any plan's exempt plan status (described above), (c) any directions, actions and interpretations of the Employer, (d) any provision of inaccurate information; (e) the SBC; and/or (f) Employer's selection of Essential Health Benefit ("EHB") benchmark for the purpose of ACA. 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.

D. ACA FEE NOTICE: ACA established a number of taxes and fees that will affect our customers and their benefit plans. Two of those fees are: (1) the Annual Fee on Health Insurers or "Health Insurer Fee"; and (2) the Transitional Reinsurance Program Contribution Fee or "Reinsurance Fee". Both the Reinsurance Fee and Health Insurer Fee go into effect in 2014.

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 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 provides for the establishment of a temporary reinsurance program(s) (for a three (3) year period (2014-2016)) which will be funded by Reinsurance Fees collected from health insurance issuers and self-funded group health plans. Federal and state governments will provide information as to how these fees are calculated. Federal regulations establish the fee at $5.25 per member per month for 2014. The temporary reinsurance programs funded by these Reinsurance Fees will help stabilize premiums in the individual market.

Beginning with your first bill for 2014 coverage, your premium will be adjusted to reflect the effects of the Health Insurer Fees and Reinsurance Fees.

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).

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.

Authorized BCBSMT Representative	Signature of Authorized Purchaser
Account Executive	Mayor
Title	Title
4/10/14	5-27-14
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.

Group No.: 138674 By: _____

Print Signer's Name Here

➡ _____

Signature and Title

Group Name: City of Laurel

Address: 115 W. 1st Street

City: Laurel State: MT Zip Code: 59044

Dated this _____ day of _____
Month Year

Option Sheet

Option chosen must be initialized by Group Leader or Officer of the Group

Group Name: City of Laurel X58045-144
Effective Date: -- 7/1/14
Current Benefit: Dual Option: Big Sky Select $25 OVC; $500/$1000 Lvl B/ $1000/$2000 Lvl C Deductible; 80/20 in ntwrk/65/35 Out-of-ntwrk Co-ins; $1500/$3000 OOP ded

THIS DOES NOT INCLUDE COBRA FEES

Current Rates

Contract Type	Medical	Drug	Dental	Vision	Total
Single	$552.28	$97.46			$649.74
Two Party	$1,226.09	$216.37			$1,442.46
Emp/Chd(ren)	$878.53	$155.03			$1,033.56
Family	$1,408.39	$248.54			$1,656.93
S/Med	$309.27	$54.57			$363.84
2P/Med	$618.55	$109.15			$727.70

Group Leader Initials

Renewal Rates w/ CURRENT Benefit (includes allocated ACA taxes and fees)

Benefit: Dual Option: Big Sky Select $25 OVC; $500/$1000 Lvl B/ $1000/$2000 Lvl C Deductible; 80/20 in ntwrk/65/35 Out-of-ntwrk Co-ins; $1500/$3000 OOP deductible not incl

Contract Type	Medical	Drug	Dental	Vision	Total less COBRA	Overall Increase	COBRA	TOTAL
Single	$601.00	$106.00			$707.00	8.8%	$0.00	$707.00
Two Party	$1,334.00	$235.00			$1,569.00	8.8%		$1,569.00
Emp/Chd(ren)	$956.00	$169.00			$1,125.00	8.8%		$1,125.00
Family	$1,533.00	$270.00			$1,803.00	8.8%		$1,803.00
S/Med	$337.00	$59.00			$396.00	8.8%		$396.00
2P/Med	$673.00	$119.00			$792.00	8.8%		$792.00

Group Leader Initials

The following Options are available for your consideration:

Option 1

Blue Dimensions: $25OVC; $500/$1000 Deductible; 80/20 in-ntwrk/65/35 out-ntwrk co-ins; $2000/$4000 OOP; Efficient RX $50 deductible waived generics $10/40/60%

Contract Type	Medical	Drug	Dental	Vision	Total less COBRA	Overall Increase	COBRA	TOTAL
Single	$558.00	$99.00			$657.00	1.1%	$0.00	$657.00
Two Party	$1,240.00	$219.00			$1,459.00	1.1%		$1,459.00
Emp/Chd(ren)	$889.00	$157.00			$1,046.00	1.2%		$1,046.00
Family	$1,425.00	$251.00			$1,676.00	1.2%		$1,676.00
S/Med	$313.00	$55.00			$368.00	1.1%		$368.00
2P/Med	$626.00	$110.00			$736.00	1.1%		$736.00

Group Leader Initials

Option 2

Contract Type	Medical	Drug	Dental	Vision	Total less COBRA	Overall Increase	COBRA	TOTAL
Single							$1.25	
Two Party								
Emp/Chd(ren)								
Family								
S/Med								
2P/Med								

Group Leader Initials

Comments 01/00/1900
Prepared By slw
Date 05/22/2014

The following factors are used in setting rates: the income and claims experience for the 12 months prior to rating calculations for the category of product being rated, the benefit difference for the deductible and copayment relationship for the specific products in a product category, the projected claims, income, and enrollment for the next 12-month rating period, projected expenses for the plan of the next rating period, and/or age of the application or subscriber, industry, and risk characteristics.

The trend of premium increases during the preceding five years is: 2009 - 15%, 2010 - 13%, 2011 - 13%, 2012 - 11%, 2013 - 11%.

Option Sheet

Option chosen must be initialized by Group Leader or Officer of the Group

Group Name: City of Laurel X58045-144
Effective Date: 07/1/14
Current Benefit: Dual Option: Big Sky Select $35 OVC; $1000/$2000 Lvl B/ $1000/$2000 Lvl C Deductible; 70/30 in ntwrk/55/45 Out-of-ntwrk Co-ins; $1500/$3000 OOP de

THIS DOES NOT INCLUDE COBRA FEES

Current Rates

Contract Type	Medical	Drug	Dental	Vision	Total
Single	$518.83	$91.56			$610.39
Two Party	$1,151.87	$203.27			$1,355.14
Emp/Chd(ren)	$825.33	$145.65			$970.98
Family	$1,323.14	$233.50			$1,556.64
S/Med	$290.55	$51.27			$341.82
2P/Med	$581.10	$102.55			$683.65

Group Leader Initials

Renewal Rates w/ CURRENT Benefit (includes allocated ACA taxes and fees)

Benefit: Dual Option: Big Sky Select $35 OVC; $1000/$2000 Lvl B/ $1000/$2000 Lvl C Deductible; 70/30 in ntwrk/55/45 Out-of-ntwrk Co-ins; $1500/$3000 OOP deductible not in

Contract Type	Medical	Drug	Dental	Vision	Total less COBRA	Overall Increase	COBRA	TOTAL
Single	$564.00	$100.00			$664.00	8.8%	$0.00	$664.00
Two Party	$1,253.00	$221.00			$1,474.00	8.8%		$1,474.00
Emp/Chd(ren)	$898.00	$158.00			$1,056.00	8.8%		$1,056.00
Family	$1,440.00	$254.00			$1,694.00	8.8%		$1,694.00
S/Med	$316.00	$56.00			$372.00	8.8%		$372.00
2P/Med	$632.00	$112.00			$744.00	8.8%		$744.00

Group Leader Initials

The following Options are available for your consideration:

Option 1

Benefit Option 1: Blue Dimensions: $35 OVC; $1000/$2000 Ind/Fam ded; 70/30 co-ins; $3000/$6000 OOP; Efficient RX $50 deduct waived on generics $10/$40/60%

Contract Type	Medical	Drug	Dental	Vision	Total less COBRA	Overall Increase	COBRA	TOTAL
Single	$525.00	$93.00			$618.00	1.2%	$0.00	$618.00
Two Party	$1,165.00	$206.00			$1,371.00	1.2%		$1,371.00
Emp/Chd(ren)	$835.00	$147.00			$982.00	1.1%		$982.00
Family	$1,339.00	$236.00			$1,575.00	1.2%		$1,575.00
S/Med	$294.00	$52.00			$346.00	1.2%		$346.00
2P/Med	$588.00	$104.00			$692.00	1.2%		$692.00

Group Leader Initials

Option 2

Contract Type	Medical	Drug	Dental	Vision	Total less COBRA	Overall Increase	COBRA	TOTAL
Single							$1.25	
Two Party								
Emp/Chd(ren)								
Family								
S/Med								
2P/Med								

Group Leader Initials

Comments 01/00/1900
Prepared By slw
Date 05/22/2014

The following factors are used in setting rates: the income and claims experience for the 12 months prior to rating calculations for the category of product being rated, the benefit difference for the deductible and copayment relationship for the specific products in a product category, the projected claims, income, and enrollment for the next 12-month rating period, projected expenses for the plan of the next rating period, and/or age of the application or subscriber, industry, and risk characteristics.

The trend of premium increases during the preceding five years is: 2009 - 15%, 2010 - 13%, 2011 - 13%, 2012 - 11%, 2013 - 11%.