RESOLUTION NO. R15-59

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. R14-32 on June 3, 2014; 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 16, 2015, by Council Member Eaton.

PASSED and ADOPTED by the City Council of the City of Laurel, Montana, this 16th day of June, 2015.

APPROVED by the Mayor this 16th day of June, 2015.

CITY OF LAUREL

Mark A. Mace, Mayor

ATTEST:

Shirley Ewan, Clerk/Treasurer

Approved as to form:

Sam S. Painter, Civil City Attorney

Dearborn National

May 21, 2015

PEAK1 ADMINISTRATIONLLC
7600 MINERAL DRIVE STE 450
COEUR D'ALENE ID 83815

Subject: Renewal Analysis
Group Name: CITY OF LAUREL
Group Policy Number: MMX32155
Anniversary Date: August 1, 2015

Dear Policyholder:

Dearborn National would like to thank you for allowing us the opportunity to provide your customer with Group insurance products.

We have reviewed the current demographics of their group insurance programs. We are pleased to inform you that there will be no change in the existing rates for the upcoming renewal period. Rate will be guaranteed until August 1, 2017.

Products	Current Rates	Renewal Rates
Life	$0.36 per $1,000	$0.36 per $1,000
AD&D	$0.04 per $1,000	$0.04 per $1,000
Retiree Life	$0.82 per $1,000	$0.82 per $1,000

If you have any questions pertaining to your renewal, or would like more information including the availability of other products as well as a quote for additional benefit programs, please contact your local Dearborn National sales office.

We value our relationship with you and look forward to providing quality service to you in the future.

Sincerely,

Underwriting Department
In Force Team

Dearborn National®

June 1, 2015

CITY OF LAUREL
PO BOX 10
115 WEST 1ST STREET
LAUREL MT 590440010

Subject: Renewal Analysis
Group Policy Number: MMX32155
Anniversary Date: August 1, 2015

Dear Policyholder:

Dearborn National would like to thank you for allowing us the opportunity to provide you and your employees with Group insurance products.

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Retiree Life	$0.82 per $1,000	$0.82 per $1,000

If you have any questions pertaining to your renewal, or would like more information including the availability of other products as well as a quote for additional benefit programs, please contact your local Dearborn National sales office or insurance broker.

We value our relationship with you and look forward to providing quality service to you in the future.

Sincerely,

Underwriting Department
In Force Team

DELTA DENTAL

Delta Dental Insurance Company

March 23, 2015

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, 2015	
Contract term	July 1, 2015 – June 30, 2016	
% of Increase	2%	
	Current rates	**Renewal rates**
Employee	$ 45.28	$ 46.19
Employee & Spouse	$ 78.33	$ 79.90
Employee & Child(ren)	$ 91.07	$ 92.89
Employee & Family	$134.08	$136.76

30 West 14th Street
Suite 205
Helena, MT 59601

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

March 23, 2015
Contract #27-07774

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.

To renew your dental plan contract, please follow these steps:

1) Review this letter for changes to your dental plan for 2015.
2) Begin paying the rates outlined in this letter with your new contract term.

If you choose not to renew your contract, please notify Brittany Chandler at 800-547-1986 and advise us in writing.

If you have any questions about your renewal, your account manager will be happy to help. We appreciate your continued confidence in Delta Dental. We are proud of our association with you and look forward to a long and mutually successful relationship.

Sincerely,

Delta Dental Insurance Company

Melissa Fullerton
Vice President, Western Region

Brittany Chandler
Account Manager

c: Peak1 Administration, LLC

PEAK1 ADMINISTRATION

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

April 6, 2015

RE: 7/1/2015 VSP Renewal- Policy no longer available *Action Needed*

Dear Preferred Client:

We are sending you this letter to give you sufficient notice to review your current vision policy and consider moving to our new product offering. Your current Peak1-VSP Policy will no longer be offered as of your renewal date. 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. When you have made your decision on which plan meets your needs please fill out the master application and return to benefits@mypeak1.com.

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. These new rates include all of the new Affordable Care Act (ACA) taxes required by Federal Law. These rates are guaranteed for 12 months.

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,

Amy M Markham

Amy Markham
Peak1 Administration

PEAK1 ADMINISTRATION

VSP Choice Plan
Rates Presented to:
ENTER GROUP NAME HERE

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

[1]Elective Contacts in lieu of lenses and Frames

VSP Choice Plan	Exam	Lens	Frames
Plan B	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	$ 7.68	$ 15.37	$ 16.45	$ 26.27

Packaged (*49% or less ER contribution AND sold with another product through Peak1*)

Plan B[2]	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
$10 exam copay $25 materials copay	$ 6.73	$ 13.46	$ 14.40	$ 23.01

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	$ 6.59	$ 13.20	$ 14.13	$ 22.57

[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.

Rates are valid until July 31th , 2015

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

7600 Mineral Drive, Suite 450 Coeur d'Alene, Idaho 83815 // 866.449.9777 // sales@mypeak1.com

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*

7600 Mineral Drive, Suite 450 // Coeur d'Alene, ID 83815 // 866.449.9777 // benefits@mypeak1.com

Blue Cross Blue Shield of Montana

2180 Overland Avenue, Suite 103
PO Box 80826
Billings, Montana 59108
Customer Information Line: 800.447.7828

www.bcbsmt.com

April 9, 2015

Cathy Gabrian
City of Laurel
P.O. Box 10
Laurel, MT 59044-0010

Re: City of Laurel Fully Insured Group Health Plan Renewal – July 1, 2015

Dear Cathy,

For more than 75 years, Blue Cross and Blue Shield of Montana (BCBSMT) has provided quality, affordable health care benefits. During that time, we have developed a reputation as Montana's most trusted health insurer and third-party administrator (TPA). This reputation is built on caring service, innovation and a commitment to reducing health care costs. Today, these values form the foundation of our business as we take a leadership role in developing and implementing cutting-edge wellness, cost-containment and health care delivery programs.

BCBSMT's mission is to partner with Montanans to help them lead healthier lives. People are the focus of everything we do. We always put our customers first, take accountability for excellence, and go above and beyond to maintain courage and integrity. Our members are more than just customers—they are friends, neighbors, relatives. They are the future.

BCBSMT affords significant value to City of Laurel. Our core strengths—like innovative cost-containment programs, superior customer service and an unrivaled provider network—mean City of Laurel's employees and their families will receive the finest care at the fairest price wherever they live, work or play.

Montana's oldest and largest health insurer and TPA has gotten even better. Through our alliance with Health Care Service Corp. (HCSC), the largest customer-owned health insurance company in the nation operating through its Blue Cross and Blue Shield plans in Illinois, Montana, New Mexico, Oklahoma and Texas, brings the opportunity to provide even better service to our BCBSMT members while still maintaining our strong local presence.

BCBSMT, as a division of HCSC, is presenting the attached fully insured group health plan renewal for your review that underscores the value of our health plans. We appreciate the opportunity to continue serving you, your employees and their families. If you have questions about your renewal or any other issue, please do not hesitate to call your agent or me at (406) 437-6363.

Sincerely,

Shellie Wherley
Marketing Account Executive
Enclosures
cc: Dave Allen

2015 Renewal Information: 7/1/2015 Effective
Dual Option: Blue Dimensions PPO 80/20 & 70/30 Plans

Blue Dimensions PPO 80/20 Plan:

Plan Type	Blue Dimensions PPO 80/20 co-ins in-network; 65/35 co-ins out-of-network
Office Visit Copay	$25 OVC applies to Participating Professional Provider services done in office setting
Deductible	$500 Individual/$1,000 Family
Out-of-Pocket Maximum	$2,000 Individual/$4,000 Family
Efficient Rx Full Card	$50 Deductible waived on Generics; Retail $10/$40/60%; Mail Order/90 Day Supply - $20/$80/60% $100/$200 co-pays Specialty Drugs - • RX Copays & Deductible will accumulate to the Medical OOP Maximum **starting 1/1/15** • Efficient RX/Generics Plus Formulary
Accident	Process off Standard Medical Benefits
Preventive Benefit	100% coverage up to allowable fee for routine/preventive services including Well Child and Mammograms
COBRA HCSC administered	$75 monthly Administration Fee – **effective 7/1/15; not included in the renewal rates below**
EAP*	If group wishes to purchase EAP services – we can provide pricing thru Magellan Behavioral Health.

Blue Dimensions 80/20 Renewal	
Single	$714.00
Two Party	$1,584.00
Empl/Child(ren)	$1,136.00
Family	$1,820.00
S/Med	$400.00
2P/Med	$799.00

Blue Dimensions PPO 70/30 Plan:

Plan Type	Comprehensive Major Medical PPO 70/30 co-ins in-network; 55/45 co-ins out-of-network
Office Visit Copay	$35 applies to Participating Professional Provider services done in office setting
Deductible	$1,000 Individual/$2,000 Family
Out-of-Pocket Maximum	$3,000 Individual/$6,000 Family
Efficient Rx Full Card	$50 Deductible waived on Generics; Retail $10/$40/60%; Mail Order/90 Day Supply - $20/$80/60% $100/$200 co-pays Specialty Drugs - • RX Copays & Deductible will accumulate to the Medical OOP Maximum **starting 1/1/15** • Efficient RX/Generics Plus Formulary
Accident	Process off Standard Medical Benefits
Preventive Benefit	100% coverage up to allowable fee for routine/preventive services including Well Child and Mammograms
COBRA HCSC administered	$75 monthly Administration Fee – **effective 7/1/15; not included in the renewal rates below**
EAP*	If group wishes to purchase EAP services – we can provide pricing thru Magellan Behavioral Health.

Blue Dimensions 70/30 Renewal	
Single	$671.00
Two Party	$1,489.00
Empl/Child(ren)	$1,066.00
Family	$1,710.00
S/Med	$376.00
2P/Med	$752.00

✓ To ensure uninterrupted coverage and the best possible service, please submit your renewal paperwork **30** days prior to your renewal date which will enable us to process the renewal and get a premium bill out by the effective date of coverage. BCBSMT is unable to process claims until a premium bill has been generated/paid

✓ Enclosed is an open enrollment notice for you to share with your employees.

✓ Prescription Drug Changes Memo

✓ Coverage for Women's Preventive Services as detailed in an enclosed attachment. Some of the services are in addition to the Preventive Services that were included in the original implementation of PPACA.

✓ BCBSMT is now required to provide a Summary of Benefits and Coverage (SBC) with your renewal packet. **You, as the employer, must** distribute a copy of the enclosed SBC to all individuals eligible for your group health insurance policy. The requirements and timelines are detailed in an enclosed attachment.

- ✓ The enclosed brochures provide you an overview of the additional services that are provided to your employees and their families. We encourage you to share this information with them. If you would like to order any of these materials, please contact me.

- ✓ Participation Requirement Notice

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): 138706 Section Number(s): 0003,0004,0005,9903,0006,0007, 0008,9904

Contract Effective Date: 07/01/15 Contract Anniversary Date (AD): 07/01/16

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: 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 State: MT Zip: 59102

Phone: (406) 656-2324 Fax: (406) 294-0276 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: _____ 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:** 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: 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 _____ day of employment (select any number of days less than or equal to 91; 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: 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	**15th of the month group renewal and billing date**
☒ Last day of the month in which the covered person(s) is (are) no longer eligible.	☐ 14th of the month in which the covered person(s) is (are) no longer eligible
☐ Other (please specify): _____	☐ 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.

CURRENT ELIGIBILITY INFORMATION

☐ **NO CHANGES**

Total number of Employees/Subscribers:

1. On payroll 163
2. On COBRA continuation coverage 0
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 Plan	$1,000 / $2,000	70/30%/55/45%	$3,000 / $6,000	$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:	$ / $	%/ %	$ / $	$

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 in small merit pool 8.6% increase on current Blue Dimensions Dual Option Plans; with Standard Acupuncture Benefit added at renewal; RX Shared Acumulators apply to medical OOP effective 1/1/15. Group's $75 COBRA administration fee with HCSC will apply effective 7/1/15 it was previously waived as part of MT transition.

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.** SEE ATTACHED SCHEDULE

PRODUCT	Employee	Eligible Dependents
HEALTH		
Plan 1 Blue Dimensions 80/20	% or $716.22	Varies % or $
Plan 2 Blue Dimensions 70/30	% or $716.22	Varies% 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.

767.87 BD

BD **Additional Information/Comments:** City of Laurel provides a flat $ contribution as follows: ~~$716.22~~ 767.87 - Employee; ~~$716.22~~ Emp/Children; $1,100 - Empl/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

Contribution of premium to be paid by the employer, City of Laurel for FY 2015-2016.

Employee only	$ 767.87
Employee/child	$ 767.87
Employee /spouse	$ 1,100.00
Family	$ 1,100.00

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: MAM Date: 6/16/2015

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.

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. 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".

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 a flat, per member, per month fee. The temporary reinsurance programs funded by these Reinsurance Fees 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. These rates may be adjusted on an annual basis for any incremental changes in Health Insurer Fees and Reinsurance Fees.

Additional Information:

INDERSTAND AND AGREE THAT:

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).

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.

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."

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.

uthorized BCBSMT Representative	X Mark A Mace Signature of Authorized Purchaser
itle	MAYOR Title
06-15-15 ate	6-16-15 Date
roducer 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: Mark A Mace Mayor

Print Signer's Name Here

➡ X Mark A Mace

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
Effective Date: 07/01/2015
Current Benefit: Dual Opt Blue Dimensions PPO $25 OVC Par Prof Prov; $500 ind/$1,000 Fam Deductible; 80/20 in-ntwrk/65/35 out-ntwrk co-ins; $2000 Ind/$4000 Fam OOP; RX

THIS DOES NOT INCLUDE COBRA FEES

Current Rates

Contract Type	Medical	Drug	Dental	Vision	Total
Single	$657.00				$657.00
Two Party	$1,459.00				$1,459.00
Emp/Chd(ren)	$1,046.00				$1,046.00
Family	$1,676.00				$1,676.00
S/Med	$368.00				$368.00
2P/Med	$736.00				$736.00

Group Leader Initials

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

Benefit: Dual Opt Blue Dimensions PPO $25 OVC Par Prof Prov; $500 ind/$1,000 Fam Deductible; 80/20 in-ntwrk/65/35 out-ntwrk co-ins; $2000 Ind/$4000 Fam OOP; RX $50 Ded waiv

Contract Type	Medical/Drug		Dental	Vision	Total less COBRA	Overall Increase	COBRA (until integration)	TOTAL
Single	$714.00				$714.00	8.7%		$714.00
Two Party	$1,584.00				$1,584.00	8.6%		$1,584.00
Emp/Chd(ren)	$1,136.00				$1,136.00	8.6%		$1,136.00
Family	$1,820.00				$1,820.00	8.6%		$1,820.00
S/Med	$400.00				$400.00	8.7%		$400.00
2P/Med	$799.00				$799.00	8.6%		$799.00

Group Leader Initials

The following Options are available for your consideration:

Option 1

Benefit Option 1:

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

Group Leader Initials

Option 2

Benefit Option 2:

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

Group Leader Initials

Comments 01/00/1900
Prepared By slw
Date 06/11/2015

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
Effective Date: 07/01/2015
Current Benefit: Dual Opt Blue Dimensions PPO $35 OVC Par Prof Prov; $1000 ind/$2,000 Fam Deductible; 70/30 in-ntwrk/55/45 out-ntwrk co-ins; $3000 Ind/$6000 Fam OOP; RX

THIS DOES NOT INCLUDE COBRA FEES

Current Rates

Contract Type	Medical	Drug	Dental	Vision	Total
Single	$618.00				$618.00
Two Party	$1,371.00				$1,371.00
Emp/Chd(ren)	$982.00				$982.00
Family	$1,575.00				$1,575.00
S/Med	$346.00				$346.00
2P/Med	$692.00				$692.00

Group Leader Initials

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

Benefit: Dual Opt Blue Dimensions PPO $35 OVC Par Prof Prov; $1000 ind/$2,000 Fam Deductible; 70/30 in-ntwrk/55/45 out-ntwrk co-ins; $3000 Ind/$6000 Fam OOP; RX $50 Ded wai

Contract Type	Medical/Drug		Dental	Vision	Total less COBRA	Overall Increase	COBRA (until integration)	TOTAL
Single	$671.00				$671.00	8.6%		$671.00
Two Party	$1,489.00				$1,489.00	8.6%		$1,489.00
Emp/Chd(ren)	$1,066.00				$1,066.00	8.6%		$1,066.00
Family	$1,710.00				$1,710.00	8.6%		$1,710.00
S/Med	$376.00				$376.00	8.7%		$376.00
2P/Med	$752.00				$752.00	8.7%		$752.00

Group Leader Initials

The following Options are available for your consideration:

Option 1

Benefit Option 1:

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

Group Leader Initials

Option 2

Benefit Option 2:

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

Group Leader Initials

Comments 01/00/1900
Prepared By slw
Date 06/11/2015

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%.

DELTA DENTAL

Delta Dental Insurance Company

March 23, 2015

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, 2015	
Contract term	July 1, 2015 – June 30, 2016	
% of Increase	2%	
	Current rates	**Renewal rates**
Employee	$ 45.28	$ 46.19
Employee & Spouse	$ 78.33	$ 79.90
Employee & Child(ren)	$ 91.07	$ 92.89
Employee & Family	$134.08	$136.76

30 West 14th Street
Suite 205
Helena, MT 59601

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

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: CITY OF LAUREL	Corporation Type: CITY GOVERNMENT		
Mailing Address: PO Box 10	City: LAUREL	State: MT	Zip: 59044
#Eligible Employees:	SIC: City Government		
Contact: CATHY GABRIAN	Contact Email: cgabrian@Laurel.mt.gov		
Phone: 406-628-7431	Fax: 406-628-2289		

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: 7.68 Employee+Spouse: 15.37 Employee+Child(ren) 16.45 Family: 26.27

Eligible Employees: Active regular full-time employees working 20 hours per week.

Wait Period: New employees will become eligible 1st of the month following 0 days of continuous employment.

Employer Contribution: 100 % Employee Contribution: 0 % (of Employee only Premium)

Requested Effective Date: (Must be 1st of the month) Month 07 Year 2015

This policy will become effective on the first day of July, 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): LAUREL, MT 59044	Date: June 16, 2015
Employer: CITY OF LAUREL	Federal Tax ID. Number: 81-6001283
Employer Signature: X Mark A Mace	Title: MAYOR
Agent Signature: David J. Allen	Agent Name: DAVID J. ALLEN
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

PEAK1 ADMINISTRATION

VSP Choice Plan
Rates Presented to:
ENTER GROUP NAME HERE

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

[1]Elective Contacts in lieu of lenses and Frames

VSP Choice Plan	Exam	Lens	Frames
Plan B	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	$ 7.68	$ 15.37	$ 16.45	$ 26.27

Packaged (*49% or less ER contribution AND sold with another product through Peak1*)

Plan B[2]	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
$10 exam copay $25 materials copay	$ 6.73	$ 13.46	$ 14.40	$ 23.01

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	$ 6.59	$ 13.20	$ 14.13	$ 22.57

[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.*

Rates are valid until July 31th , 2015