050148

VILLAGE OF LOMBARD
REQUEST FOR BOARD OF TRUSTEES ACTION

__X__ Resolution or Ordinance (Blue) *Waiver of First requested* __
_____ Recommendations of Boards, Commissions & Committees (Green)
_____ Other Business (Pink)

TO: PRESIDENT AND BOARD OF TRUSTEES

FROM: William T. Lichter, Village Manager

DATE: March 21, 2005 (B of T) Date: April 7, 2005

TITLE: A Resolution authorizing Approval of President & Clerk on an Agreement for Blue Cross/Blue Shield PPO Health Insurance, HMO Illinois Health Insurance, & HMO Blue Advantage Insurance

SUBMITTED BY: Kathleen Dunne, Human Resource Analyst

BACKGROUND/POLICY IMPLICATIONS:

Please find attached a renewal benefit program application with BlueCross BlueShield of Illinois for Fiscal Year 2005/2006 Health Insurance Programs.

See attached memorandum for more information.

FISCAL IMPACT/FUNDING SOURCE: $

Village Attorney _____ Date _____
Finance Director _____ Date _____
Village Manager Leonard J. Hoot Date 03/30/05

Return

BlueCross BlueShield of Illinois

Benefit Program Application

(Applicable to Unified 151-Plus Insured Group Accounts)

Account Number	206522
HMO Illinois Group Number(s)	H56789
HMO Illinois Section Number(s)	0100,0200,0300,0400,0500,8888,8889
BlueAdvantage HMO Group Number(s)	B56789
BlueAdvantage HMO Section Number(s):	0100,0200,0300,0400,0500,8888,8889
Non-HMO Plan Employer Group Number(s):	P06522
Non-HMO Plan Section Number(s):	0100,0200,0300,0400,0500,8888,8880

Employer Name: Village of Lombard

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

Address: 255 E. Wilson

City: Lombard State: IL Zip: 60148

Subsidiaries:

Affiliated Companies:

Administrative Contact: Kathy Dunne Phone Number: 630 620-5918 Fax Number:

Effective Date of Coverage: June 1, 2005 Anniversary Date: June 1, 2006

SCHEDULE OF ELIGIBILITY

Applicable to the HMO plan and the Non-HMO plan unless otherwise specified.

1. Eligible Person means:

   For the HMO plan, an eligible person must reside in the Service Area of a Participating IPA.

   ☒ A full-time employee of the Employer.

   ☐ A full-time employee who is a member of: _____ (Enter name of union or association)

   ☒ Other: Active elected officials who pay the fully applicable payment with no Village contribution per Village Board Policy 98-3. Retirees per IMRF guidelines

   Full-Time Employee means:

   ☒ A person who is regularly scheduled to work a minimum of 40 hours per week and who is on the permanent payroll of the Employer.

   ☐ Other:

   ☒ An Eligible Person may also include a retiree of the Employer. Please specify: Per IMRF guidelines.

2. Domestic Partners covered: ☐ Yes ☒ No

   If yes: A Domestic Partner, as defined in the Group Policy, shall be considered eligible for coverage. The Policyholder is responsible for providing notice of possible tax implications to those Insureds with Domestic Partners.

3. Limiting Age for covered unmarried children:

   ☐ The limiting age for covered unmarried children is _____.

   ☒ The limiting age for covered unmarried children is 19; age 23 if a full-time student.

☐ Other:

Termination of coverage upon reaching the Limiting Age:

For the Non-HMO Plan, please select one of the following:

☐ Coverage is terminated on the birthday.

☒ Coverage is terminated on the last day of the month in which the limiting age is reached.

For the HMO Plan, please select one of the following:

☒ Coverage is terminated on the last day of the month in which the limiting age is reached.

☐ Coverage is terminated on the last day of the year in which the limiting age is reached.

☐ Other:

4. The Eligibility Date for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan:

☒ The date of employment.

☐ The _____ day of employment.

☐ The _____ day of the month following _____ month(s) or _____ days of employment.

☐ The _____ day of the month following the date of employment.

☐ Other:

☒ For the HMO plan, a full month's premium will be charged for the first month of coverage for those employees whose Coverage Dates fall between the first and fifteenth day of the Premium Period. No premium will be charged for the first month of coverage for those employees whose Coverage Dates fall between the sixteenth day and the end of the Premium Period.

5. Specify Annual Open Enrollment Period:Apirl 26 - May 21. An Eligible Person may apply for coverage, Family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Annual Open Enrollment Period. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by HCSC and the Employer. Such date shall be subsequent to the annual open enrollment period.

6. For the HMO plan, the Effective Date of Termination for a person who ceases to meet the definition of an Eligible Person:

☐ The date such person ceases to meet the definition of Eligible Person.

☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.

☐ Other (please specify):

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

Temporary Layoff: 0 days Disability: 0 days Leave of Absence: 0 days

☐ Other: (please specify):

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

8. Please complete for the HMO Plan:

Total Number of Employees (Please indicate the total number of actual employees, not enrollees):

In the Group: 287 Illinois employees: 287 National employees: 0

COMPLETE THE APPLICABLE FUNDING INFORMATION BELOW

FUNDING ARRANGEMENT (Applicable to the HMO and Non-HMO Plan):

☒ Standard Premium - Prospective ☐ Cost Plus Program

STANDARD PREMIUM INFORMATION:

(a) Premium Period:
- ☒ The first day of each calendar month through the last day of each calendar month.
- ☐ The _____ day of each calendar month through the _____ day of the next calendar month.
- ☐ Other:

(b) The Employer contribution is:

HMO Plan:
- ☒ HMO Illinois: 96% of the Individual Coverage Premium and 86% of Family Coverage Premium.
- ☒ BlueAdvantage HMO: 96% of the Individual Coverage Premium and 86% of the Family Coverage Premium.
- ☐ Other:

Non-HMO Plan:
- ☐ 100% of the Individual Coverage Premium and an amount equal to 100% of the Individual Coverage Premium will be contributed toward the Family Coverage Premium.
- ☒ 90% of the Individual Coverage Premium and 70% of the Family Coverage Premium.
- ☐ Other:

(c) Please complete for the Non-HMO Plan:
It is understood that no Policy will be issued or renewed on a contributory basis unless at least 75% of the Eligible Persons and, for Family Coverage, 75% of the Eligible Persons with eligible dependents have enrolled for coverage.

STANDARD PREMIUM RATES
☒ Yes ☐ No

	For Internal Use Only - BlueStar Ben.Agree#: **HMO Illinois H56789**	*For Internal Use Only - BlueStar Ben.Agree#:* **Blue Advantage HMO B56789**	*For Internal Use Only - BlueStar Ben.Agree#:* **Non-HMO Health Coverage: P06522**	*For Internal Use Only - BlueStar Ben.Agree#:* **Non-HMO Health Coverage:**	*For Internal Use Only - BlueStar Ben.Agree#:* **Dental Coverage:**	**Total**
1. Employee only :	$354.93	$315.89	$392.32	$	$	$
2. Employee with one dependent:	$	$	$	$	$	$
3. Employee and two or more dependents:	$	$	$	$	$	$
4. Employee plus Spouse:	$	$	$	$	$	$
5. Employee plus Child(ren):	$	$	$	$	$	$
6. Employee plus Family / Family:	$973.94	$868.51	$1,112.56	$	$	$
7. Other:	$	$	$	$	$	$
Single Tier Rate structure - Complete item 1.						
Two Tier Rate structure - Complete items 1. and 6.						
Three Tier Rate structure - Complete items 1., 2., and 3.						
Four Tier Rate Structure - Complete items 1., 4., 5., and 6.						
Indicate "N/A" in any rate field that does not apply.						
Medicare Eligible Rates (When HCSC is Secondary Payer)						
Single Coverage:	$354.93	$315.89	$255.01	$		$
Family Coverage:	$709.86	$631.78	$510.02	$		$

COST PLUS PROGRAM
☐ Yes ☒ No

Service Charges:

HMO Plan:

a) Service Charges for Claim Payments:

☐ HMO Illinois: % of Claim Payments; **or** $ per Enrollee per month for health Claim Payments

☐ BlueAdvantage HMO: % of Claim Payments; **or** $ per Enrollee per month for health Claim Payments

b) Physician's Services Fees:

☐ HMO Illinois: $ per month per single Enrollee; or $ per Month per Enrollee with one or more dependents.

☐ BlueAdvantage HMO: $ Per month per single Enrollee; or $ Per Month per Enrollee with one or more dependents.

Non-HMO Plan:

☐ _____% of Net Claim Payments **or** $_____ per employee per month.

☐ Applies to all coverage

☐ Different percentage(s) or amount(s) for the following types of coverage. Please specify below:
For _____ Coverage: _____% of _____ Claim Payments **or** $_____ per employee per month
For _____ Coverage: _____% of _____ Claim Payments **or** $_____ per employee per month
Other (please specify):

☐$_____ per employee per month for administration of Utilization Management - The Medical Services Advisory ("MSA") and Enhanced Utilization Management ("EUM") Programs

☐$_____ per employee per month for administration of the Medical Services Advisory Program (MSA)

Payment Method: ☐ Transfer Payment ☐ Post Payment

If Transfer Payment --
Method of Transfer Payment:
☐ Wire Transfer ☐ Draft ☐ Electronic Fund Transfer ☐ Other (please specify):

Payment Period: ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly
☐ Other (please specify):

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

If Transfer Payment --
Tentative Final Settlement Period:
Transfer Payments to be made for:
☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other : (please specify):
after termination. *(Applicable to Transfer Payment only)*

For Non-HMO Cost Plus plans: Effective Date of Termination for a person who ceases to meet the definition of Eligible Person:
☐ The date such person ceases to meet the definition of Eligible Person.
☐ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
☐ Other:

Prescription Drug Rebate: $ per Covered Employee per month or, for the HMO Plan, per Enrollee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit.

APPLICABLE TO NON-HMO COST-PLUS PROGRAMS ONLY: PLAN PROVIDER ACCESS FEE(S ☐ Yes ☐ No
Group Number(s):
☐% of ADP Savings: %
☐ $ Per Employee per Month: $
Please complete for Groups with multiple products (for example, Comprehensive Major Medical and PPO plans) with separate access fees: **Group Number(s):**
☐% of ADP Savings: %
☐ $ Per Employee per Month: $

The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Group, has provided the information requested in this Benefit Program Application (BPA) and on behalf of the Group offers to purchase the benefit program as outlined in the Request For Proposal (RFP) or, in the case of an HMO Plan, the proposal document submitted to the Group by the Sales Representative. Any changes to the RFP are specified below. It is understood and agreed that the actual terms and conditions of the benefit program are those contained in the Group Policy. This BPA is subject to acceptance by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"). Upon acceptance, HCSC shall issue a Group Policy to the Employer and this BPA shall be incorporated and made a part of the Group Policy. Upon acceptance of this BPA and issuance of the Group Policy, the Employer shall be referred to as the Policyholder. In the event of any conflict between the RFP and the Group Policy, the provisions of the Group Policy shall prevail.

The undersigned representative acknowledges that the Employee Retirement Income Security Act of 1974, as amended, (ERISA) establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term "employee welfare benefit plan" includes any plan, fund or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital benefits, or benefits in the event of sickness, accident or disability. The undersigned representative further acknowledges that: (i) an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and that (ii) an employee welfare benefit plan document may provide for the allocation or delegation of responsibilities thereunder. However, notwithstanding anything contained in the employee welfare benefit plan document of the Group (or any Group member if the Group is an association), the Group agrees that no allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Group (or, for Non-HMO Plans, any Group member if the Group is an association) is effective with respect to or accepted by HCSC except to the extent specifically provided and accepted in this BPA or the Group Policy or otherwise accepted in writing by HCSC.

OTHER PROVISIONS APPLICABLE:

(a) Reimbursement Provision - HMO Plan: It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will deduct 25% of the net recovery from the amount credited to the Group's experience after attorneys' fees, if any, have been paid.

Reimbursement Provision - Non-HMO Plan: ☒ Yes ☐ No

If yes: It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will retain 25% of the net recovery (under cost-plus funding) or deduct 25% of the net recovery from the amount credited to the group's experience (under premium funding) after attorneys' fees, if any, have been paid.

(b) Certificate of Creditable Coverage: ☒ Yes ☐ No

If yes: It is understood and agreed that HCSC will issue to individuals, whose coverage under the Group Policy terminates during the term of the Group Policy, a Certificate of Creditable Coverage based upon coverage under the Group Policy and information provided to HCSC by the Employer.

If no: The Certificate of Creditable Coverage Release and Indemnification letter is attached to this BPA and made part of the Group Policy.

(c) DentaCap Coverage purchased: ☐ Yes ☒ No *(If yes, complete separate application.)*

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

(e) Excess Loss Coverage purchased: ☐ Yes ☒ No *(If yes, complete separate application.)*

(f) Please complete for the Non-HMO Plan:
Medical Services Advisory (MSA) / Individual Benefits Management Program (IBMP): ☒ Yes ☐ No

If yes: The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons in accordance with the provisions of the Group Policy.

(g) Electronic Issuance (Non-HMO Plans only): The Policyholder consents to receive, via an electronic file or access to an electronic file, a Certificate Booklet provided by HCSC to the Policyholder for delivery to each Insured. The Policyholder further agrees that it is solely responsible for providing each Insured access, via the internet, intranet or otherwise, to the most current version of any electronic file provided by HCSC to the Policyholder and, upon the Insured's request, a paper copy of the Certificate Booklet.

ADDITIONAL PROVISIONS: Renewal NO changes
☐ Additional Provisions are specified in the Exhibit attached hereto and made a part of this BPA.

Cindy Nelson	
Sales Representative	Signature of Authorized Purchaser
Metro Brokerage Sales	
District	Title
Tom Schaffler	
Producer Representative	Date
Lockton Companies	
Producer Firm	Witness
525 W. Monroe, Chicago 60661	
Producer Address	$ Amount Submitted
Tax I.D. No.	

UNDERWRITING USE ONLY
Date BPA approved:
Signature of Underwriter

PROXY

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

Group No.: _____ By: _____
Print Signer's Name Here

➡ _____
Signature and Title

Group Name: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Dated this _____ day of _____, _____
Month Year