VILLAGE OF LOMBARD
REQUEST FOR BOARD OF TRUSTEES ACTION

#090096

__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: David A. Hulseberg, Village Manager

DATE: March 6, 2009 (B of T) Date: March 19, 2009

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 Administrator

BACKGROUND/POLICY IMPLICATIONS:

Please find attached a renewal benefit program application with BlueCross BlueShield of Illinois for Fiscal Year 2009/2010 Health Insurance Programs.

The attached resolution provides for new contracts between the Village of Lombard and Blue Cross/Blue Shield of Illinois. These contracts provide for a PPO option, and two HMO choices. The two HMO options are HMO Illinois and Blue Advantage. There will be an increase of 5.0%.

FISCAL IMPACT/FUNDING SOURCE:

Village Attorney _____ Date _____
Finance Director _____ Date 3/11/09
Village Manager _____ Date 3/11/09

RESOLUTION
R_____09

A RESOLUTION AUTHORIZING SIGNATURE OF PRESIDENT AND CLERK ON AN APPLICATION

WHEREAS, THE Corporate Authorities of the Village of Lombard have received an application for Blue Cross/Blue Shield PPO Health Insurance, HMO Illinois Health Insurance and HMO Blue Advantage Insurance; and

WHEREAS, THE Corporate Authorities deem it to be in the best interest of the Village of Lombard to approve the application as attached hereto and marked Exhibit "A".

NOW, THEREFORE, BE IT RESOLVED BY THE PRESIDENT AND BOARD OF TRUSTEES OF THE VILLAGE OF LOMBARD, DUPAGE COUNTY, ILLINOIS as follows:

SECTION I: That the Village President be and hereby is authorized to sign on behalf of the Village of Lombard said application as attached hereto.

SECTION 2: That the Village Clerk be and hereby is authorized to attest said application as attached hereto.

Adopted this _____day of _____,2009.

Ayes:_____

Nays:_____

Absent:_____

Approved this _____ day of _____,2009.

_____
William J. Mueller
Village President

ATTEST:

_____
Brigitte O'Brien
Village Clerk

APPROVAL AS TO FORM:

_____
Thomas P. Bayer
Village Attorney

BlueCross BlueShield of Illinois

BENEFIT PROGRAM APPLICATION ("BPA")

(Applicable to Unified 151-Plus Insured Group Accounts)
(All items are applicable to the HMO plan and the Non-HMO plan unless otherwise specified.)

Employer Account Number: 206522

HMO Illinois Employer Group Number(s): H56789

HMO Illinois Section Number(s): 0100, 0200, 0300, 0400, 0500, 0600, 8888, 8889

BlueAdvantage® HMO Employer Group Number(s): B56789

BlueAdvantage® HMO Section Number(s): 0100, 0200, 0300, 0400, 0500, 0600, 8888, 8889

Non-HMO Plan Employer Group Number(s): P06522

Non-HMO Plan Section Number(s): 0100, 0200, 0300, 0400, 0500, 0600, 8880, 8888

Employer Name: Village of Lombard

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

Address: 255 East East Willson City: Lombard State: IL Zip Code: 60148

Billing Address *(if different from above)* : 255 East Wilson Avenue City: Lombard State: IL Zip Code: 60148

Subsidiaries: n/a

Affiliated Companies: _____

(If Affiliated Companies to be covered are listed above, a separate "Addendum to the Benefit Program Application Regarding Affiliated Companies" must be completed, signed by the Employer's authorized representative, and attached to this BPA.)

Administrative Contact: Kathy Dunne Phone: 630-620-5918 Fax: 630-620-8222 Email: dunnek@villageoflomard.org

Policy Effective Date: June 1, 2009 Policy Anniversary Date: June, 1 2010

ERISA Plan: ☐ Yes ☒ No If Yes, specify ERISA Plan Year: _____

ERISA Plan Administrator: n/a

ERISA Plan Administrator's Address: n/a

City: _____ State: _____ Zip Code: _____

ERISA Plan Administrator's Email: n/a

ELIGIBILITY

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: _____ (name of union or association)

   ☒ Other (please specify): AActive 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 (please specify): _____

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

2. Domestic Partner Coverage: ☐ Yes ☒ No

   If yes, a Domestic Partner, as defined in the Policy, shall be considered eligible for coverage. The Policyholder is

responsible for providing notice of possible tax implications to those Insureds with Domestic Partner coverage.

3. Limiting Age for covered unmarried children is 26 years; n/a years if a full-time student.

   For Premium Funding, coverage will terminate at the end of the following period for which premium has been accepted:

   For the Non-HMO Plan:

   ☐ On birthday.

   ☒ The month in which the limiting age is reached.

   ☐ The year in which the limiting age is reached

   For the HMO Plan:

   ☒ The month in which the limiting age is reached.

   ☐ The year in which the limiting age is reached.

   ☐ Other (please specify): _____

   For Cost Plus Funding, coverage will terminate at the end of the following period:

   For the Non-HMO Plan:

   ☐ On birthday.

   ☐ The month in which the limiting age is reached.

   ☐ The year in which the limiting age is reached

   For the HMO Plan:

   ☐ The month in which the limiting age is reached.

   ☐ The year in which the limiting age is reached.

   ☐ Other (please specify): _____

4. 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 (please specify): _____

   ☒ 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. Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a Special Enrollment event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so. Such person's Coverage Date, Family Coverage Date, and /or dependent's Coverage Date will be effective on the date of the Special Enrollment event or, in the event of Special Enrollment due to termination of previous coverage, the date of application for coverage.

   Annual Open Enrollment: Specify Annual Open Enrollment Period:May for a June 1st effective date. 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 Blue

Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") and the Employer. Such date shall be subsequent to the annual open enrollment period.

6. 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.)

7. For the HMO Plan:

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

   Of the Employer: 289 Illinois employees: 289 National employees: 0

FUNDING ARRANGEMENT

☒ 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 (please specify): _____

(b) Employer contribution:

For the HMO Plan:
- ☐ HMO Illinois: _____% of the Individual Coverage Premium and _____% of Family Coverage Premium.
- ☐ BlueAdvantage® HMO: _____% of the Individual Coverage Premium and _____% of the Family Coverage Premium.
- ☒ Other (please specify): 96% for both HMOI and BHMO, individual and family.

For the 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 90% of the Family Coverage Premium.
- ☐ Other (please specify): _____

(c) 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#: 0005 HMO Illinois H56789	*For Internal Use Only - BlueStar Ben.Agree#: 0007* Blue Advantage® HMO B56789	*For Internal Use Only - BlueStar Ben.Agree#: 0006 PPO* 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:	$440.92	$396.18	$489.69	$	$	$
2. Employee plus one dependent:	$	$	$	$	$	$
3. Employee plus two or more dependents:	$	$	$	$	$	$
4. Employee plus Spouse:	$	$	$	$	$	$
5. Employee plus Child(ren):	$	$	$	$	$	$
6. Employee plus Family / Family:	$1209.89	$1089.25	$1388.72	$	$	$
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:	$440.92	$396.18	$489.69	$		$
Family Coverage:	$881.83	$792.35	$979.38	$		$

COST PLUS PROGRAM

☐ Yes ☒ No

Service Charges:
For the 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.

For the Non-HMO Plan:

☐ _____% of Net Claim Payments or $_____ per employee per month.
☐ Applies to all coverage(s)

☐ 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): _____

Blue Care Connection® ("BCC") (For the Non-HMO Plan):

BCC Program (may select one):
☐ Blue Care Advisor
☐ Please refer to Additional Provisions

☐ Fee: $_____ per covered employee per month for administration of the program.
☐ Fee is included in the Service Charges.

Blue Care Custom

☐ Health Dialog **(may select one)** Health Dialog Fee: $_____ per covered employee per month
- ☐ Health Coach Line (In bound)
- ☐ Health Coach Line (In and out bound)
- ☐ Health Coach Line (With Disease Management)
- ☐ Not applicable

☐ American Healthways **(may select one)**
- ☐ Package A
- ☐ Package B
- ☐ Package C
- ☐ Not applicable

American Healthways Program Fees, per participating Covered Person per month:

Conditions:	*Package A - Fees*	*Package B - Fees*	*Package C - Fees*
Diabetes:	$_____	$_____	$_____
Chronic Heart Disease:	$_____	$_____	$_____
Chronic Obstructive Pulmonary Disease	$_____	$_____	Not Applicable
Asthma:	$_____	$_____	Not Applicable
Impact Conditions:	$_____	Not Applicable	Not Applicable

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 the following time period after termination:
☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other (please specify): _____

For 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 (please specify): _____

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.

FOR 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) 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 Employer, has provided the information requested in this Benefit Program Application ("BPA") and, on behalf of the Employer, 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 Employer 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 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 Policy to the Employer and this BPA shall be incorporated and made a part of the Policy. Upon acceptance of this BPA and issuance of the Policy, the Employer shall be referred to as the Policyholder. In the event of any conflict between the RFP and the Policy, the provisions of the Policy shall prevail.

The undersigned representative acknowledges that any broker/producer is acting on behalf of the Employer for purposes of purchasing the Employer's insurance, and that if HCSC accepts this BPA and issues a Policy to the Employer, HCSC may pay the Employer's broker/producer a commission and/or other compensation in connection with the issuance of such Policy. The undersigned representative further acknowledges that if the Employer desires additional information regarding any commissions or other compensation paid the broker/producer by HCSC in connection with the issuance of a Policy, the Employer should contact its broker/producer.

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 Employer (or any group member if the group is an association), the Employer agrees that no allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Employer (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 Policy or otherwise accepted in writing by HCSC.

OTHER PROVISIONS:

(a) Reimbursement Provision for the 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 for the 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 a Certificate of Creditable Coverage consistent with the requirements under the Health Insurance Portability and Accountability Act of 1996. The Certificate of Creditable Coverage shall be based upon coverage under the Plan during the term of the 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 Policy.

(c) BlueCare® Dental HMO 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) For the Non-HMO Plan:
Case Management: ☒ 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 Policy.

(g) For the Non-HMO Plan: Electronic Issuance: 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.

(h) Massachusetts Health Care Reform Act: Notwithstanding anything to the contrary in this BPA, with respect to the Employer's employees who live in Massachusetts (if any) the Employer represents that it offers the health insurance benefits provided for herein to all full-time employees, and the Employer will not make a smaller premium contribution percentage to a full-time employee living in Massachusetts than to any other full-time employee living in Massachusetts who receives an equal or greater total hourly or annual salary. For purposes of this representation, a "full-time employee" is defined by Massachusetts law, generally an employee who is scheduled or expected to work at least the equivalent of an average of thirty-five (35) hours per week.

ADDITIONAL PROVISIONS:

Renewal Effective 06/01/2009.

Effective beginning June 1, 2009, this group health plan must abide by the provisions of Public Act 95-0958, a new Illinois law (215 ILCS 356z.12) that gives parents with insurance policies that cover dependents the right to elect coverage for qualifying dependents up to age 26 and up to age 30 for military veteran dependents.

Add HPV and Shingles vaccine per state mandate.

Cancel Benefit Agreement # 0009, 0010, and 0011 and move section 0600 to the corresponding Benefit Agreement. No longer need due to the IL dependent age law.

☐ Additional Provisions are specified in the Exhibit attached hereto and made a part of this BPA.

Nancy Chaidez

Sales Representative

822/046

District

Tom Schaffler

Producer Representative

Lockton Companies, LLC

Producer Firm

525 W. Monroe, St. Chicago, IL 60681

Producer Address

480763803

Producer Tax I.D. No.

Signature of Authorized Purchaser

Title

Date

Witness

$_____ Amount Submitted

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.: H56789
B56789
P06522

By: _____
Print Signer's Name Here

➡ _____
Signature and Title

Group Name: Village of Lombard

Address: 255 East Wilson Ave.

City: Lombard State: IL Zip Code: 60148

Dated this _____ day of _____, _____
Month Year