090153

VILLAGE OF LOMBARD
REQUEST FOR BOARD OF TRUSTEES ACTION

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

TO: PRESIDENT AND BOARD OF TRUSTEES

FROM: David A. Hulseberg, Village Manager

DATE: March 25, 2009 (B of T) Date: April 2, 2009

TITLE: A motion to approve the Application with HumanaDental Insurance Company for two years.

SUBMITTED BY: Kathleen Dunne, Human Resource Administrator

BACKGROUND/POLICY IMPLICATIONS:

Please find attached application with HumanaDental. Switching from Guardian Dental to HumanaDental will result in an annual savings of 12.8%, or $5,241 for HMO rates, and 16.8%, or $15,786 for PPO rates. Humana is a very reputable, recognized provider. A switch from Guardian Dental to HumanaDental would be perceived as an upgrade in provider. This coupled with a guaranteed decrease in rates for the coming year and a 24-month rate guarantee strengthens the change in dental provider.

A motion to accept this application is requested. Upon approval, the contract will be effective from June 1, 2009 through May 31, 2011.

See attachments.

FISCAL IMPACT/FUNDING SOURCE:

Village Attorney _____ Date _____
Finance Director _____ Date _____
Village Manager _____ Date 3/25/09

HumanaDental

ILLINOIS
EMPLOYER GROUP APPLICATION

Please refer to your proposal to complete this application. This document will form part of any contract issued. Print clearly in black ink, and answer all questions or indicate "not applicable."

Plan Selection

Is this a SmartSuite selection? ☑ No ○ Yes

	Plan 1	Plan 2
Plan Name (as shown on your proposal)	Custom Traditional Preferred	IL Prepaid CS250
Coinsurance:	Participating (In) : % 100 / 80 / 50 Non-participating (Out): % 100 / 80 / 50	Participating (In) : % ___/___/___ Non-participating (Out): %___/___/___
Deductible:	Participating (In): $ 75/225 Non-participating (Out): $ 75/225	Participating (In): $ Non-participating (Out): $
Annual Maximum:	$ 1,000	$
Preventive Services Deductible Options:	○ Apply Deductible ☑ Waive Deductible	○ Apply Deductible ○ Waive Deductible
Periodontic/Endodontic Options:	○ Basic ☑ Major	○ Basic ○ Major
Orthodontia Options:	○ Child Only: Lifetime Orthodontia Maximum $_____ ○ Adult And Child: Lifetime Orthodontia Maximum $_____ PPO: NO DMO: YES	
Composite Fillings for Molars:	☑ No ○ Yes	○ No ○ Yes
Implant Coverage:	☑ No ○ Yes	○ No ○ Yes
Out of network reimbursement options:	☑ Maximum allowable fee ○ In-network fee schedule	○ Maximum allowable fee ○ In-network fee schedule
Open Enrollment:	○ No ☑ Yes	

Underwriting Requirements

- Underwriting approval is required to offer more than one dental carrier to your employees.
- Dental coverage is available to employers with two or more enrolled employees.
- If the only employees of a two-life group are husband and wife, each must enroll separately as an employee and maintain eligibility. The group is only eligible if a bona fide business entity exists.
- Minimum employer contribution toward employee premium is 25%. This minimum does not apply to Voluntary coverage.
- Retiree coverage is available to employers with 26 or more enrolled employees.
- Minimum age for retiree coverage is 65 for employers with 26 to 50 enrolled employees and must be at least 50 for 51+ enrolled employees.
- Excluded class options: hourly, salary, union, non-union, management, non-management.
- If you do not maintain eligibility, underwriting, and participation requirements, we will terminate your coverage.

Participation requirements:

Eligible Employees	Participation
2+ (Employer Pays 100% of Premium)	100%
2+ (Employees Contribute to Premium)	75%
2+ Eligible Employees with Spousal Waiver	50%

Voluntary Participation Requirements:

Eligible Employees	Participation
Traditional Preferred, PPO, Preventive Plus	
2+ Employees	Two enrolled employees or 25% whichever is greater.
Advantage Plus	
10+ Employees	Ten enrolled employees or 25% whichever is greater
Prepaid	
2+ Employees	Two or more enrolled employees
Prepaid with orthodontia coverage	
10 + employees	Ten or more employees

Group Information

How much will you contribute to premium? Employee 0 % Dependent 0 % (Voluntary Dental)

Are you offering dental coverage to retirees? ○ No ○ Yes If yes, required age: Minimum years of service:

Did you have prior group dental coverage? ○ No ☑ Yes
If yes, submit most recent carrier billing with effective and termination dates.

Did your prior dental coverage include orthodontia? ○ No ○ Yes PPO: No ; DHMO: Yes

Will your employees have access to another carrier's dental coverage by virtue of their employment with you? ☑ No ○ Yes
If yes, name of carrier:

The following applies to all companies and products

The companies listed on this Employer Group Application, severally or collectively as the context may require, are referred to in this application as we, us and our.

You, the participating employer, policyholder, contractholder, or group plan sponsor, intend to establish, sponsor, and endorse an employee benefit plan which will be governed by Employee Retirement Income Security Act of 1974 (ERISA). You are the ERISA plan administrator.

Small employer means a person, firm, corporation, partnership or association actively engaged in business, which employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year, unless otherwise provided under the state law. Entities that are affiliated companies or that are eligible to file a combined tax return for the purpose of taxation, are considered one employer.

You agree to make available your records which we determine are relevant to this application and group coverage for inspection by the Trustee, Administrator, us or our representative during your normal business hours.

As claims administrator with authority to make claim determinations as described in Section 503 of ERISA, we may make decisions under the Policy or Group Plan with respect to determining eligibility for coverage and paying claims for benefits, including deciding appeals of denied claims.

You understand and agree that failure to remit and pay premium when due will be considered a default in premium payment, and that coverage will be terminated by us, following a grace period of 31 days from the date of non-payment of premium. We may terminate your coverage according to the termination section of the Policy or Group Plan. Except for non-payment of premium or when a group or individual is not or has not been eligible for coverage, you will be provided with a 30 day advance written notice, unless a greater period is expressly specified in the Policy. If coverage is terminated by us for non-payment of premium, you will still owe and we will collect all due premium including premium for the grace period.

You understand and agree that your coverage is renewed on a monthly basis subject to timely payment of premium. We reserve the right to change the premium rates on any premium due date, as permitted by applicable law, after your insurance has been in effect under the Policy for six consecutive months. You will receive advance written notice.

For you to remain eligible for the Policy or Group Plan, the eligibility, underwriting and participation requirements must be maintained, for each respective coverage. Failure to maintain the plan eligibility, underwriting and participation requirements will terminate your coverage under the Policy or Group Plan. Other termination provisions are stated in the Policy or Group Plan.

Based upon our standard underwriting practice, we may require an employee or dependent to submit Evidence of Health Status. We have the right to use the information provided by you and any applicant (employee or dependent) to determine whether coverage will be provided, to determine eligibility and to establish appropriate premiums. Any health related information that has been provided will not be used to decline medical coverage unless permitted by law.

The following applies to medical products insured by Humana Insurance Company

You, the participating employer, apply to participate in the Employers Health Insurance Benefits Trust (No. 1 and/or No. 3) for insurance coverage, which may be modified from time to time, as underwritten by us.

If you are accepted, you acknowledge and agree on behalf of all persons who obtain insurance coverage through or under your application to the Trust, that the Trust Agreement, the provisions of the Trust, or any other written instrument the trustee signs on behalf of the Trust are fully binding upon you. The principal duties of the trustee are to hold the insurance policy(ies) through which insurance coverage is provided for employers in accordance with the terms of the Trust Agreement or any other written instrument which the trustee signs on behalf of the Trust.

The Trust Agreement, any other written instrument and the insurance policy(ies), are available for inspection by you or by any covered person through or under your participation in the Trust, during normal business hours at our home office. You further understand and agree that the Trust and Trustee are not insurers. You may withdraw from the Trust at any time subject to certain premium obligations described in the Employer Agreement section, thus terminating your insurance coverage, provided written notice of termination is received by us prior to the requested termination date.

HUMANA.
Guidance when you need it most

HMO plans offered by Humana Health Plan, Inc. PPO, Classic medical plans, Life and Short-Term Income Protection plans insured or administered by Humana Insurance Company.

HUMANA.
Specialty Benefits

Dental PPO and Traditional Preferred plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Dental prepaid plans and AdvantagePlus dental plans offered and administered by CompBenefits Dental, Inc. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.

Internal use only
Group number:

Employer Group Application

ILLINOIS
HUMANA / HUMANADENTAL / COMPBENEFITS

Please refer to your proposal to complete this application. This document will form part of any contract issued. Print clearly in black ink, and answer all questions or indicate "not applicable."

Your Business Profile

Business name Village of Lombard Federal tax ID number 36-6005975

Location address (not a P.O. Box) 255 E. Wilson Ave.

City Lombard State IL Zip code 60148 County DuPage

Do you have more than one location? X No O Yes

Billing address (if different) same as above

City State Zip code County

Nature of business or SIC number Local Government Date company established 1869

Business status: O Corporation O Partnership O Sole Proprietorship X Other: (explain) Local Government

Business phone number 630-620-5918 Fax number 630-620-8222

Management contact Kathleen Dunne Administrative contact Kathleen Schweigert

Management contact e-mail address dunneK@villageoflombard.org

Management contact: Mother's maiden name _____

This will be used to gain access to the Employer Self-Service Center on www.Humana.com.

General Eligibility

Requested effective date June 1, 2009 How many employees are on your payroll? 300

How many hours per week must your employees work to be eligible? (select between 20 and 40 hours) 40

Do you want to exclude a class of employees? X No O Yes

If yes, check class to exclude: (Options vary by plan. Refer to the Underwriting Requirements for each plan.)

O union O non union O hourly O salary O management O non-management

How long must employees wait after hire date to become eligible? X 0 days O 30 days O 60 days O 90 days

O Other, specify:

How many employees are eligible for coverage? 254

New employee effective date provision: O First of month following waiting period (required for Medical HMO or Prepaid Dental plans)

O Immediately following waiting period

On all plans, the employee termination date coincides with the effective date provision.* Date of Hire

Is this employer required to comply with COBRA regulation? O No X Yes

Is this employer required to comply with state continuation regulation? O No X Yes

Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? O No O Yes

If yes, enter information below. Attach a separate sheet if necessary.

Name of applicant	Qualifying event (e.g., termination of employment, divorce, etc.)	Date of qualifying event	Date COBRA or State Continuation coverage terminates

Employer Agreement

You the employer, understand, agree and represent:

- You have read this document and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records.
- You have received and reviewed a proposal and the applicable regulatory information required by your state.
- Neither you nor the agent/broker/producer has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind us by making any promise or representation, or waive any of our other rights or requirements. No waiver or change will bind us unless signed by an authorized officer of our company.
- The first month's estimated premium (which may include a monthly administrative fee), and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application before action is taken on this application. Unless we are informed differently, we will perform a one-time electronic check conversion of the first month's premium payment from the account and for the amount designated on the binder check.
- You will collect any employee contribution toward premium. Our acceptance of premium does not guarantee coverage.
- You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met.
- Only individuals who meet the eligibility requirements of the plan are eligible to maintain coverage.
- Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage.
- If choosing the HDHP Indexing plan, deductible and out of pocket amounts are established by IRS guidelines. Adjustments to these amounts by the IRS will be made to the policy, without notice, upon renewal of the group.

This document will form part of any contract issued. Coverage is not in effect unless and until you receive written notification from us.

If this application is declined, we will return the premium deposit submitted with this application.

Do not cancel any current group coverage until you receive written notice from us that we have issued coverage.

Dated on:_____ By:_____
(month, date, year) (employer signature)

Dated at:_____ By:_____
(city and state) (title)

Agent/Producer Information

1. Agent/Agency of Record (for commissions and correspondence):	2. Agent/Agency of Record (for split-commissions):
Name (print) Locktom Companies	Name (print)
(Tax ID) Social Security Number / Humana Agent Number 20-3354970	Tax ID / Social Security Number / Humana Agent Number
Commission split: ☑ No ○ Yes If yes, percentage: (total should equal 100%)	Percentage of sales: ○ No ○ Yes If yes, percentage: (total should equal 100%)
1. Writing Agent/Producer:	**2. Writing Agent/Producer:**
Name (print) Tom Schaffler	Name (print)
Social Security Number	Social Security Number
Commission split: ○ No ○ Yes If yes, percentage: (total should equal 100%)	Percentage of sales: ○ No ○ Yes If yes, percentage: (total should equal 100%)

General Agency

General agency information pertains to ☑ Agent/Agency of Record #1 ○ Agent/Agency of Record #2

Name (print) Lockton Companies Tax ID / Humana Agent Number

Address 525 W. Monroe Suite 600 City Chicago State IL Zip code 60661

As the Writing Agent/Producer, I acknowledge that I am responsible to meet with the employer submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the employer in the ~~Regulatory Pre-enrollment~~ Disclosure or other plan literature.

Writing Agent's Signature:_____ Date: 3/24/09

Dental Marketing – HMO Rates

LOCKTON

Monthly Rates		Guardian	Renewal	Proposed			
				Aetna	CIGNA	Delta Dental	Humana
37	Single	$16.83	$16.83	$15.89	$16.99	$16.31	$15.30
70	Family	$39.89	$39.89	$37.90	$40.26	$38.23	$34.46
107							
Total Annual Cost		$40,980	$40,980	$38,891	$41,362	$39,355	$35,740
Difference from Current (%)			0.0%	-5.1%	0.9%	-4.0%	-12.8%
Difference from Current ($)			$0	-$2,089	$382	-$1,625	-$5,241
Difference from Renewal (%)				-5.1%	0.9%	-4.0%	-12.8%
Difference from Renewal ($)				-$2,089	$382	-$1,625	-$5,241
Rate Guarantee				12 Months	24 Months	24 Months	24 Months

Dental Marketing – PPO Rates

LOCKTON

		Guardian Current	Guardian Renewal	Aetna	CIGNA	Delta Dental	Humana
Monthly Rates							
32	Single	$37.83	$37.83	$33.46	$36.26	$32.64	$31.47
63	Family	$104.93	$104.93	$92.03	$100.57	$89.74	$87.28
95							
Total Annual Cost		$93,854	$93,854	$82,423	$89,955	$80,377	$78,068
Difference from Current (%)			0.0%	-12.2%	-4.2%	-14.4%	-16.8%
Difference from Current ($)			$0	-$11,430	-$3,899	-$13,477	-$15,786
Difference from Renewal (%)				-12.2%	-4.2%	-14.4%	-16.8%
Difference from Renewal ($)				-$11,430	-$3,899	-$13,477	-$15,786
Rate Guarantee				12 Months	24 Months	12 months	24 months