

RESOLUTION 2008-101

12-15-08

RESOLUTION BY THE ADMINISTRATION, PERSONNEL POLICY AND LEGAL COMMITTEE AUTHORIZING THE RENEWAL OF HEALTH INSURANCE AND RELATED COVERAGE FOR VILLAGE EMPLOYEES FOR 2009

WHEREAS, there is a need to obtain health insurance, dental insurance and vision insurance for village employees for 2009; and

WHEREAS, the Board of Trustees is satisfied with the present health insurance service provider and the proposed increase in health insurance premiums is approximately 16%;

NOW THEREFORE, the Village Board of the Village of Sturtevant, Racine County, Wisconsin does hereby resolve:

1. That the execution of an agreement with Anthem for health insurance coverage for the village for the year 2009 is authorized and approved subject to final review by the Village Administrator; and
2. That the annual premium will increase approximately 16% and the coverage is set forth in Exhibit A which is attached hereto and incorporated herein.
3. That dental insurance with Delta Dental and vision insurance with AIG as set forth in Exhibit B is authorized and approved.
4. The Village President and the Village Clerk are authorized to sign any agreements or other documents necessary to carry out the intent of this resolution;

Adopted by the Village Board of the Village of Sturtevant, Racine County, Wisconsin, this 16th day of December 2008.

Village of Sturtevant

By _____
Steven Jansen, President

Attest _____
Mary Hanstad, Village Clerk

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Exhibit A

Blue Preferred® Plus Option O2 with Rx Option T



Estimated Monthly Employee Benefit Premium Options

Account Name: Village Of Sturtevant
Effective Date: 01/01/2009

ZIP Code: 53177

Broker: Dallasanta, Robert J.
Account Executive: Wisconsin Sales

Indicate Option Choice	<input type="checkbox"/>
Type of Coverage	Blue Preferred Plus Option O2 with Rx Option T
Network Deductible: Single / Family	\$2,500 / \$7,500
Non-Network Deductible: Single / Family	\$5,000 / \$15,000
Network Out-of-Pocket: Single / Family	\$2,500 / \$7,500
Non-Network Out-of-Pocket: Single / Family	\$8,000 / \$21,000
Network : (PCP/SCP) Physician Home/Office Serv Preventive Care Services	\$30 / \$45 Paid based on place of service
Emergency Room: -Facility/Other Covered Services	\$100
Urgent Care: Network	\$50
Network : Inpat/Outpat Professional	0%
Network : Inpatient Facility	0%
Network : Outpatient Surgery @ Hospital or Alt. Care Facility	0%
Network : Other Outpatient Services	0%
Non-Network : Coins. for all covered services: Exceptions including but not limited to ER and Rx	30%
Network: Retail Pharmacy	\$15 /\$30 /\$50*

Rates / Month

Single 619.83

Spouse 1,301.64

Family 1,797.51

*Member may be responsible for additional cost when not selecting the available generic drug.

No Cost Share means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. Additional copayments/coinsurance and limits apply. Refer to the benefit summary for detailed information.

Estimated Total Cost	\$38,553.45
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Rates are proposed for an effective date of 01/01/2009. Rerate is required after this date. Final rates will be based on actual effective date. Rates are based primarily in the 53177 zip code area. Final rates will be based on actual location, enrolled census, final benefits selected and the underwriting rules in effect upon acceptance by Blue Cross and Blue Shield of Wisconsin, Compcare Health Services Insurance Corporation and Anthem Life. The proposal is subject to underwriting approval by Blue Cross and Blue Shield of Wisconsin, Compcare Health Services Insurance Corporation and Anthem Life; please do not cancel your coverage until the application has been approved in writing. The information is intended to present only a general overview of the benefits. The entire provisions of benefits and exclusions are contained in the group contract. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

NOTE: If the alternate Option request form is not received by the effective date listed on this proposal, a new proposal must be submitted.

The coverage indicated in the check box above has been selected for employees and eligible dependents; subject to the terms and conditions of this proposal and the application(s) to which this is attached.

Authorized Signature

Date

Blue Cross Blue Shield of Wisconsin ("BCBSWI") underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSWI collectively underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. *ANTHEM is a registered trademark. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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Exhibit B

VISION

Carrier	Current	
	In	Out
Vision Examination	\$10 Copay, then 100%	\$40 copay
Frame	\$130 allowance	\$45 allowance
Lenses (Clear, Standard, Glass or Plastic)		
Single Vision (Pair)	\$20 copay, then 100%	\$40 allowance
Bifocal (Pair)	\$20 copay, then 100%	\$60 allowance
Trifocal (Pair)	\$20 copay, then 100%	\$80 allowance
Contact Lenses (In lieu of Standard Eyeglass Lenses Benefit)		
Standard Correction/Elective	\$105 allowance	\$105 allowance
Sub-Normal Optical Correction/Medically Necessary (Pre-Approval from Vision Benefit Manager is required)	100%	100%
Frequency		
Vision Examination	Once every 12 months from the Date of Service per Plan Year	
Frame	Once every 12 months from the Date of Service per Plan Year	
Lenses	Once every 12 months from the Date of Service per Plan Year	
Contact Lenses	Once every 12 months from the Date of Service per Plan Year	
Rates:	Current	
Employee Only	\$8.83	
Employee + Spouse or One	\$13.71	
Employee + Children	\$14.28	
Family	\$19.16	
Participation Requirements	100% participation	
Rate Guarantee	1 year	

DENTAL

Carrier	Dental	
	In	Out
Deductible	\$25 Individual \$75 Family	
Waived for Preventive	yes	yes
Coinsurance for Preventive	100%	100%
Coinsurance for Basic	80%	60%
Perio Surgery and Endo	Basic	
Coinsurance for Major	50%	50%
Maximum	\$2,000	
Deductible for Ortho	\$0	\$0
Coinsurance for Orthodontia	50%	50%
Ortho Lifetime Maximum	\$1,500	
Rates:		
Employee Cost	\$29.60	
Employee + Spouse OR Employee + 1 dependent	\$58.33	
Employee + Child(ren)	\$62.49	
Family	\$107.76	
Monthly Premium	\$1,458.92	
Annual Premium	\$17,507.04	
Annual Difference in Premium	\$362.04	
Rate Guarantee	1 Year	