RESOLUTION 06-023

RESOLUTION OF THE CITY OF KETCHUM CITY COUNCIL APPROVING A CONTRACT WITH BLUE CROSS RENEWING HEALTH INSURANCE COVERAGE FOR CITY EMPLOYEES, AND AUTHORIZING THE MAYOR TO SIGN THE CONTRACT

WHEREAS, the City of Ketchum provides health insurance to its employees as part of a package of benefits used to retain existing employees and to recruit new employees, and

WHEREAS, city staff completed its due diligence and obtained competitive quotes from Blue Cross and from its main competitor, Blue Shield, as well as other cost-containment options from Blue Cross in addition to the current level of coverage, and

WHEREAS, the City anticipated and budgeted a 16% increase in health insurance costs, yet as a result of these efforts the increase will be approximated 7% over the previous year, and

NOW THEREFORE BE IT RESOLVED, that the Ketchum City Council approves the renewal of health insurance coverage with Blue Cross and authorizes the Mayor to sign the contract.

This Resolution will be in full force and effect upon its adoption this sixth (6th) day of February, 2006.

Randy Hall, Mayor

Attest:

Sandra Cady, CMC
City Treasurer/Clerk

Approved as to form and content:

Benjamin Worst, Esq.
City Attorney

ISC Insurance Solution Center™

...solution driven
Not product oriented...

Benefit/Premium Comparison Options

City of Ketchum

						(Rx Change)	
		2003	2004	2005	2006	2006	2006**
	Tier	**Regence**	**Cross**	**Cross**	**Cross**	**Cross**	**Regence**
Employee	33	$598	$373	$429	$458	$449	$393
Employee/Spouse	18	$1,239	$738	$849	$907	$889	$844
Employee/Child	4	$808	$458	$525	$561	$550	$550
Employee/2+ Children	3	$1,018	$707	$813	$869	$852	$727
Family	21	$1,869	$1,037	$1,191	$1,271	$1,248	$1,060
Totals	**79**	**$87,571**	**$51,323**	**$58,989**	**$62,982**	**$61,783**	**$54,802**
Annual Change (from 03)			($360,725)	($262,903)	($214,987)	($229,375)	
vs Prior Year			-59%	13%	6.30%	4.50%	
Total Employee Contributions		**$3,249**	**$3,249**	**$3,249**	**$3,249**	**$3,249**	**$3,249**

Cumulative Savings from 2003 $838,615

**Subject to Change Based On Change in Underwritten Medical Risk

City of Ketchum Cost						
Annual Premum	1,011,864	576,888	668,880	716,796	702,408	618,636
HRA Reimbursement	0	74,251	80,081	80,081	80,081	80,081
Vision Plan Reimbursements	0	0	5,801	5,801	5,801	5,801
Total Annual Cost	1,011,864	651,139	754,762	802,678	788,290	704,518
Average per Employee	12,808	8,242	9,553	10,160	9,978	8,917
Benefit						
Dr. Copay		Deductible	Deductible	Deductible	Deductible	Deductible
Prescription Copay		$10/$25/$40	$10/$25/$40	$10/$25/$40	$15/$30/$45	$7/30%/50%
Accident Benefit		$500	$500	$500	$500	$500
Wellness (first dollar)		$125	$125	$125	$125	Deductible
EAP		3 Visits	3 Visits	3 Visits	3 Visits	8 Visits
Deductible		$1,500	$1,500	$1,500	$1,500	$1,500
Coinsurance		80%	80%	80%	80%	80%
Stop Loss		$10,000	$10,000	$10,000	$10,000	$15,000
Out of Pocket		$2,000	$2,000	$2,000	$2,000	$3,000
Transplant Benefit		$1 Million	$1 Million	$1 Million	$1 Mllion	$250,000
Benefit Maximum		$1 Million	$1 Million	$1 Million	$1 Mllion	$1 Million
Refund Option				Yes	Yes	No

Note: Consumer Plan amounts for 2005 and 2006 are estimations based on date through 1.25.06
Based on the enrolled census the Blue Shield additional $1,000 out of pocket would add a potential $125,000 In Total Out of Pocket expenses to the group. Changes that will effect the employee most are the prescription card and wellness change.

Blue Cross of Idaho

An Independent Licensee of the Blue Cross and Blue Shield Association

Summary of Benefits	Business Blue℠
Benefit Period* Deductible	1,500 / 3,000
Coinsurance	80/20%
Out-of-pocket Limit	2,000 Per member
Comprehensive Lifetime Benefit Limit *(per insured)*	$1,000,000
Covered Services *(Some services may require prior authorization. Please refer to your policy for more detailed information or visit our Web site at www.bcidaho.com.)*	
Ambulance Transportation Services	Subject to your deductible and coinsurance
Chiropractic Care *(limited to $800 per benefit period)*	Subject to your deductible and coinsurance for contracting providers; deductible and 50% of the maximum allowance** for noncontracting providers
Dental Services Related to Injury *(covered only for the 12-month period immediately following the date of injury, providing the group's contract remains in effect during that 12-month period.)*	Subject to your deductible and coinsurance
Diabetes Education – Outpatient *(limited to $500 per benefit period)*	
Diagnostic Services	
Durable Medical Equipment	
Emergency Services	
Hospice Services *($10,000 lifetime benefit limit. There are no benefits for services rendered by noncontracting hospice providers.)*	BCI Pays 100% of maximum allowance** *(no deductible required)*
Hospital Services *(inpatient and outpatient services at a licensed general hospital or ambulatory surgical facility)*	Subject to your deductible and coinsurance
Mammography *(benefit will vary IF enhanced wellness benefit purchased)*	
Maternity Services	
Medical Services *(inpatient and outpatient)*	
Mental Health – Inpatient *(limited to 10 inpatient days per benefit period)*	
Mental Health – Outpatient *(limited to 18 outpatient visits per benefit period)*	Subject to your deductible and 50% coinsurance
Orthotic Devices	Subject to your deductible and coinsurance
Physician Office Visits	
Post-Mastectomy Reconstructive Surgery	
Home Health Skilled Nursing Services *(limited to $5,000 per benefit period)*	
Prosthetic Appliances	
Skilled Nursing Facility *(limited to 30 days per benefit period)*	
Surgical Services	
Therapy Services: Including chemotherapy, enterostomal therapy, growth hormone therapy, home intravenous therapy, radiation, renal dialysis, respiratory therapy, and inpatient occupational therapy	
Outpatient Rehabilitation Therapy Services: Physical, Speech & Occupational Therapies *(limited to a combined total of $2,000 per insured per benefit period)*	Subject to your deductible and 50% coinsurance
Inpatient Physical Rehabilitation *($150,000 lifetime benefit limit. There are no benefits for services rendered by a noncontracting facility provider.)*	Subject to your deductible and coinsurance
Transplant Services	
Wellness/Preventive Services *(benefit will vary IF enhanced wellness benefit purchased)*	

*The specified period of time in which an insured's benefits for incurred covered services accumulate toward annual benefit limits, deductible amounts and out-of-pocket limits.

**If you choose a noncontracting in- or out-of-state provider, you may also be responsible for payment of any charges exceeding our preestablished maximum allowance.

SUMMARY OF GENERAL EXCLUSIONS AND LIMITATIONS

No benefits will be provided for services, supplies, drugs or other charges that are:

- Not specifically listed as a covered service in the policy.
- Employment-related and covered by Workers' Compensation.
- The result of an insured's voluntary participation in the commission of a criminal offense.
- The result of any act of war.
- The legal responsibility of a third party.
- Not determined to be medically necessary.
- In excess of the maximum allowance.
- Investigational in nature.
- Furnished by a provider, who in the absence of coverage, would not assess a charge.
- For cosmetic procedures (including non-surgical services, drugs, and supplies intended to enhance the appearance), except for congenital anomalies in a dependent child.
- Rendered before your effective date or during an inpatient admission beginning before your effective date, except as specified in the general provisions section of the policy.
- For personal services, physical fitness equipment or programs, or convenience items, including any expenses related to any motor vehicle, even if deemed medically necessary.
- For telephone consultations, failure to keep appointments, completion of claim forms, or expenses related to securing services, or for failure to vacate your hospital room on time.
- For inpatient admissions for diagnostic or therapeutic services.
- For custodial care or behavioral modification therapy or services.
- For foot care primarily to relieve pain or enhance appearance.
- In any way incurred in connection with transsexual surgery, sexual dysfunction, gender transformation or sexual inadequacy, including erectile dysfunction and/or impotence.
- Furnished by a facility that is primarily a place for the treatment of the aged; or primarily a nursing home, a convalescent home or rest home.
- For care of mental health or substance abuse services or for pain rehabilitation, except as specifically provided for in the policy.
- Incurred by an eligible dependent child relating to pregnancy. Related to weight control, treatment, or surgery for obesity or morbid obesity. Revisions or reversals of surgery for obesity are excluded, except to correct an immediately life-threatening condition.
- For use of operating, cast, or treatment rooms or for equipment in a noncontracting provider's office, unless specifically provided as a covered service in the policy.
- For transplant services, except as specifically provided for in the policy.
- For acupuncture.
- For radial keratotomy and other related procedures.
- For hospice home care, except as specified in the policy.
- For pastoral, spiritual and bereavement counseling.
- For homemaker, housekeeping services, and home-delivered meals.
- For amounts paid by another group program that has primary responsibility for payment; or provided or paid for by any federal, state, or local government entity or unit where their charges would vary, or are, or would be affected by the existence of coverage under the policy (except when required by state or federal law).
- Received from a health or dental care department maintained on behalf of the employer or other related group.
- For contraceptives, unless specified as a covered service in the policy.
- For reversals of all sterilization procedures.
- For all fertilization procedures, and any treatment for infertility or to enhance an insured's reproductive capability.
- For screening exams, or exams required by employment, marriage, insurance, or camp application.
- For inpatient care for dental procedures, except as specified in the policy.
- For dental, vision, or hearing exams, procedures, or appliances, unless specifically provided as a covered service in the policy.
- For procedures relating to the teeth, including but not limited to orthagnathic surgery and treatment of temporomandibular joint (TMJ) syndrome, and alveolectomy or alveoloplasty when related to tooth extraction, unless specifically provided as a covered service in the policy.
- For congenital anomalies or developmental malformations related to the teeth.
- For an elective abortion.
- For breast reduction surgery or surgery for gynecomastia.
- For nutritional supplements, legend vitamins and minerals.
- For alterations to the home or vehicle.
- For special clothing, including shoes (unless permanently attached to a brace).
- Provided to a person enrolled as an eligible dependent, but who no longer qualifies as an eligible dependent due to a change in eligibility status that occurred after enrollment.
- Provided outside the United States, which if had been provided in the United States, would not be a covered service in the policy.
- Furnished by a provider or caregiver that is not listed as a covered provider, including but not limited to naturopaths.
- For outpatient pulmonary and/or cardiac rehabilitation.
- For complications arising from the acceptance or utilization of noncovered services.
- For the use of hypnosis, as anesthesia or other treatment, except as specified as a covered service in the policy.
- For dental implants, appliances, and/or prosthetics, and/or treatment related to orthodontia, even when medically necessary unless specified as a covered service in the policy.
- For arch supports, orthopedic shoes, and other foot devices.
- For wigs and cranial molding helmets.
- For surgical removal of excess skin that is the result of weight loss or gain, including but not limited to association with prior weight reduction (obesity) surgery.
- For the purchase of therapy or service dogs/animals and the cost of training/maintaining said animals.

These are the general exclusions and limitations of a Business Blue plan. Other exclusions and limitations are listed in the specific benefit sections of the Master Group Contract; i.e., pharmacy, dental, vision, etc.

This outline is a brief description of the coverage issued to the insured. Master Group Policy 3-248 (01-05) is the actual contract. Your policy describes in detail the rights and obligations of both you and Blue Cross of Idaho Health Service, Inc. It is important that you read your policy carefully. The benefits of the policy are governed primarily by the laws of the state of Idaho.

CITY OF KETCHUM

Summary of Benefits
Effective February 1, 2006

The Actual policy must be referred to for specific benefits, definitions and general provisions.

Deductible: $1,500 per insured; maximum $3,000 in the aggregate per family per calendar year.

Catastrophic Benefits: 100% of eligible charges paid by Regence BlueShield of Idaho after in insureds out-of-pocket Reaches $3,000 (80%-20%* in-network) and/or $4,000 (60%-40%* out-of-network) plus the deductible.

Lifetime Maximum: $1,000,000 per insured; automatic $5,000 reinstated annually.

Physician Services:
Office Calls.....80% *in-network 60% *out-of-network
Other services (to include lab, x-ray, surgery fee)..... ...80% *in-network 60% *out-of-network
Maternity charges.....80% *in-network 60% *out-of-network

Inpatient and Outpatient Hospital/Facility Services .....80% *in-network 60% *out-of-network

Supplemental Accident Benefit:.....$500 annual maximum

Emergency Room: Charges for the emergency room itself are subject to a $50 copayment. If admitted directly to the hospital from the emergency room, the $50 copayment is waived. This copayment is in addition to the deductible and is the responsibility of the insured. It can not be applied to the deductible or paid under the Supplemental Accident benefit. After the copayment and applicable deductible amounts are satisfied, benefits will be paid at 80%*in-network 60% *out-of-network

Mental or Neuropsychiatric Conditions: 16 outpatient MH visits w/4 outpt CD visits and 8 inpt MH Days w/2 inpt CD days per calendar year paid at 80% * in-network 60% * out-of-network

Employee Assistance Program: 100% * for 8 visits per incident (1-866-750-1326).

Chiropractic Benefits: 80% * up to a maximum of $500 per insured per calendar year. (Not applicable to Supplemental Accident Benefit)

Immunizations:.....100%

Prescription Drug Benefit: ..... $7 copay for generic
30% coinsurance for Formulary brand names
50% coinsurance for Non formulary brand
$3,500 calendar year max out-of-pocket

Regence Advantage (Discount program).....Included

Interactive Online Tool (myregence.com).....Included

*** ALLOWABLE CHARGES**