CITY OF GRAIN VALLEY BOARD OF ALDERMEN
SPECIAL MEETING AGENDA

JUNE 6, 2016
6:00 P.M.

OPEN TO THE PUBLIC

LOCATED IN THE COUNCIL CHAMBERS OF CITY HALL
711 MAIN STREET – GRAIN VALLEY, MISSOURI

ITEM I: CALL TO ORDER

- Mayor Mike Todd

ITEM II: ROLL CALL

- City Clerk Chenéy Parrish

ITEM III: DISCUSSION

- 2016-2017 City of Grain Valley Employee Benefits

ITEM IV: RESOLUTION

ITEM IV(A) R16-33 *Introduced by Alderman Yolanda West*	**A Resolution by the Board of Aldermen of the City of Grain Valley, Missouri Authorizing the City Administrator to Enter into an Agreement with Blue Cross Blue Shield of Kansas City for Employee Health Benefit Coverage and Delta Dental of Missouri for Employee Dental Benefit Coverage for the 2016-2017 Benefit Plan Year** To provide affordable health and dental insurance coverage to City of Grain Valley employees and their families

ITEM V: EXECUTIVE SESSION

- Legal Actions, Causes of Action of Litigation Pursuant to Section 610.021(1), RSMo. 1998, as Amended
- Leasing, Purchase or Sale of Real Estate Pursuant to Section 610.021(2), RSMo. 1998, as Amended
- Hiring, Firing, Disciplining or Promoting of Employees (personnel issues), Pursuant to Section 610.021(3), RSMo. 1998, as Amended
- Individually Identifiable Personnel Records, Personnel Records, Performance Ratings or Records Pertaining to Employees or Applicants for Employment, Pursuant to Section 610.021(13), RSMo 1998, as Amended

- **ITEM VI: ADJOURNMENT**

PLEASE NOTE

THE NEXT SCHEDULED MEETING OF THE CITY OF GRAIN VALLEY BOARD OF ALDERMEN WILL TAKE PLACE JUNE 13, 2016 AS A REGULAR MEETING AT 7:00 P.M. TO BE HELD IN THE COUNCIL CHAMBERS OF GRAIN VALLEY CITY HALL

PERSONS REQUIRING AN ACCOMMODATION TO ATTEND AND PARTICIPATE IN THE MEETING SHOULD CONTACT THE CITY CLERK AT 816.847.6211 AT LEAST 48 HOURS BEFORE THE MEETING

THE CITY OF GRAIN VALLEY IS INTERESTED IN EFFECTIVE COMMUNICATION FOR ALL PERSONS

UPON REQUEST, THE MINUTES FROM THIS MEETING CAN BE MADE AVAILABLE BY CALLING 816.847.6211

CITY OF GRAIN VALLEY BOARD OF ALDERMEN AGENDA ITEM		
MEETING DATE	06/06/2016	
BILL NUMBER	R16-33	
AGENDA TITLE	**A RESOLUTION AUTHORIZING THE CITY ADMINISTRATOR TO ENTER INTO AN AGREEMENT WITH BLUE CROSS BLUE SHIELD OF KANSAS CITY FOR EMPLOYEE HEALTH BENEFIT COVERAGE AND DELTA DENTAL OF MISSOURI FOR EMPLOYEE DENTAL BENEFIT COVERAGE FOR THE 2016-2017 BENEFIT PLAN YEAR**	
REQUESTING DEPARTMENT	Administration	
PRESENTER	Ryan Hunt, City Administrator	
FISCAL INFORMATION	Cost as recommended:	FY2016 FY2017 $193,263 $193,263 (61540) $30,000 $30,000 (61555) $15,657 $15,657 (61560)
	Budget Line Item:	All Funds/Departments: 61540: Health 61555: HSA 61560: Dental
	Balance Available	FY2016 FY2017 $206,071 N/A (61540) $38,180 N/A (61555) $16,775 N/A (61560)
	New Appropriation Required:	[ ] Yes [X] No
PURPOSE	To provide affordable health and dental insurance coverage to City of Grain Valley employees and their families	
BACKGROUND	Ordinance #2376 approved the 2016 Fiscal Year (“FY”) budget to include these items.	

SPECIAL NOTES	The City's health and dental insurance plan begins July 1st and ends June 30th of each year. Budget reflects remaining balance in funds appropriated in FY 2016.
ANALYSIS	None
PUBLIC INFORMATION PROCESS	Board of Aldermen meetings and work sessions held to discuss the 2016 Fiscal Year Budget on 10/08/2015 & 11/02/2015.
BOARD OR COMMISSION RECOMMENDATION	Board of Aldermen approved 2016 Fiscal Year Budget on 11/23/2015.
DEPARTMENT RECOMMENDATION	Staff Recommends Approval
REFERENCE DOCUMENTS ATTACHED	BlueCross BlueShield Renewal Agreement, BlueCross BlueShield Health Benefit Comparison Spreadsheet, Delta Dental of Missouri Renewal Letter, Short-term Disability Quote & Resolution

CITY OF GRAIN VALLEY **STATE OF MISSOURI**

June 6, 2016

RESOLUTION NUMBER *R16-33* SPONSORED BY: *ALDERMAN WEST*

A RESOLUTION AUTHORIZING THE CITY ADMINISTRATOR TO ENTER INTO AN AGREEMENT WITH BLUE CROSS BLUE SHIELD OF KANSAS CITY FOR EMPLOYEE HEALTH BENEFIT COVERAGE AND DELTA DENTAL OF MISSOURI FOR EMPLOYEE DENTAL BENEFIT COVERAGE FOR THE 2016-2017 BENEFIT PLAN YEAR

WHEREAS, the City of Grain Valley is interested in retaining the most qualified individuals as employees of the City; and

WHEREAS, the Board of Aldermen recognizes that in order to attract qualified applicants, the City must provide a competitive employee benefits package; and

WHEREAS, the City of Grain Valley is committed to providing its employees with affordable and comprehensive health and dental care coverage; and

WHEREAS, in providing an option to its employees, the City is offering a "base" health insurance plan following the premium rate coverage as outlined in the City of Grain Valley Employee Handbook, and a "buy-up" plan in which the employee will pay the difference in premium costs from the "base" plan as adopted herein; and

WHEREAS, the City is able to provide employees and their families with health and dental benefits within the amount budgeted in Fiscal Year 2016; and

WHEREAS, the City is confident in the sustainability of the health and dental plans outlined herein.

NOW THEREFORE, BE IT RESOLVED by the Board of Aldermen of the City of Grain Valley, Missouri as follows:

SECTION 1: The City Administrator is hereby authorized to enter into an agreement with BlueCross Blue Shield of Kansas City for the *BlueSaver HSA/Preferred Care Blue Health Insurance Plan* as the City's "Base" Plan with the following premium rates, as quoted:

BLUECROSS BLUESHIELD OF KANSAS CITY BLUESAVER HSA/PREFERRED CARE BLUE	
Coverage Type	*Monthly Premium Rates*
Employee Only	$379.55
Employee/Spouse	$797.05
Employee/Child	$721.14
Family	$1,176.60

The City Administrator is further authorized to contribute to all employees' Health Savings Accounts ("HSA") participating in the BlueSaver HSA/Preferred Care Blue Plan via the following formula:

BLUECROSS BLUESHIELD OF KANSAS CITY BLUESAVER HSA/PREFERRED CARE BLUE	
Coverage Type	*July – December 2016 Monthly Contribution*
Employee Only	$100.00
Employee/Spouse	$100.00
Employee/Child	$100.00
Family	$100.00

SECTION 2: The City Administrator is hereby authorized to enter into an agreement with BlueCross BlueShield of Kansas City for the *High PPO/Preferred Care Blue Health Insurance Plan* as the City's "Buy-Up" Plan with the following premium rates as quoted:

BLUECROSS BLUESHIELD OF KANSAS CITY HIGH PPO/PREFERRED CARE BLUE	
Coverage Type	*Monthly Premium Rates*
Employee Only	$447.14
Employee/Spouse	$938.99
Employee/Child	$849.56
Family	$1,386.13

SECTION 3: The City Administrator is hereby authorized to enter into an agreement with Delta Dental of Missouri for the *PPO/Premier Dental Insurance Plan* for the following rates as quoted:

DELTA DENTAL OF MISSOURI PPO/PREMIER	
Coverage Type	*Monthly Premium Rates*
Employee Only	$35.84
Employee/Spouse	$72.04
Employee/Child	$81.56
Family	$116.97

SECTION 4: All agreements will be for the 2016-2017 benefit plan year beginning July 1, 2016 and ending June 30, 2017.

PASSED and APPROVED, via voice vote, ( ) this 6TH Day of June, 2016.

_____

Mike Todd
Mayor

ATTEST:

_____

Chenéy Parrish
City Clerk

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FOR TODAY'S COMPANIES
THIS IS A PERFECT FIT

EMPLOYEES HAVE CHOICES

THE BLUE KC EXCHANGE

Backed by KC's most trusted insurer

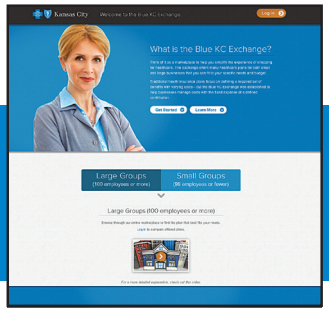
The Blue KC Exchange is an easy and innovative way for businesses to control healthcare costs while also providing more options. Employers can choose an amount to contribute and employees can choose a plan they want. That's why more than 500 employers are already enrolled. Since 2010, the Blue KC Exchange has given employers the opportunity to define their contribution and the flexibility to offer their employees the health plan that is right for them.

The Blue KC Exchange helps employers control cost. Employers set a defined contribution – a fixed amount to pay per employee per month. Each employee has 10 plans to choose from and pays only the difference, if any, toward the monthly premium after the employer's fixed contribution.

Here's a real-world example

ABC Company wants to keep employee health insurance, but heavy rate hikes are making it difficult. The company has raised its deductible twice in four years and changed carriers once. Through careful analysis, management determines **ABC Company** can afford $300 per employee per month toward health insurance.

Thankfully, the Blue KC Exchange has a solution. Each employee is given 10 plans to choose from, and the freedom to select based on his or her own budget and health coverage needs. Employees pay only the difference, if any, between the plan's monthly premium and the employer's $300 contribution.



For more information visit **BlueKCexchange.com** or call your Blue KC marketing representative at **816-395-2939**.

BlueKCexchange.com

Kansas City

LIVE FEARLESS™

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BlueCross BlueShield of Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Renewal Rates for: CITY OF GRAIN VALLEY
Presented By: DAVID JOHNSON
CBIZ BENEFITS & INSURANCE SERVICES INC

Package B	Blue-Care® HMO	Preferred-Care Blue® PPO	Preferred-Care Blue® PPO	AffordaBlue PPO	PersonalBlue PPO HRA**/HDHP***	BlueSaver® PPO-HSA Compatible
Deductible (Individual / Family)	--	$500/$1,500	$1,500 /$4,500	--	$3,000 /$6,000	$3,000 /$6,000
Physician Services						
Office Visits (Co-Pay)						
Primary Care Physician	--	$25	$35	--	$40	Deductible
Specialist	--	$25	$35	--	$40	Deductible
Co-Insurance						
In-Network	--	80%	80%	--	100%	100%
Out-of-Network	--	60%	60%	--	80%	80%
In-Patient/Out-Patient Surgery						
In-Network	--	Ded + 80%	Ded + 80%	--	Deductible	Deductible
Out-of-Network	--	Ded + 60%	Ded + 60%	--	Ded + 80%	Ded + 80%
Prescription Drug						
Short-Term/Long-Term (2.5x co-pay)						
Generic Prescriptions	--	$12 co-pay	$12 co-pay	--	$12 co-pay	Deductible
Brand Name Prescriptions	--	$45 co-pay	$45 co-pay	--	$45 co-pay	Deductible
Nonformulary Prescriptions	--	$70 co-pay	$70 co-pay	--	$70 co-pay	Deductible
Annual Out-of-Pocket Maximum						
In-Network						
Individual	--	$3,500	$4,500	--	$3,000	$3,000
Family	--	$7,000	$9,000	--	$6,000	$6,000
Out-of-Network						
Individual	--	$7,000	$9,000	--	$6,000	$6,000
Family	--	$14,000	$18,000	--	$12,000	$12,000

**A portion of the deductible may be satisfied by your Health Reimbursement Arrangement (HRA). The HRA is available to any one or all family members until the HRA is exhausted. HRA contribution is 2x for EE+1 and 3x for EE+2 or more. HRA contributions may only be allocated in $50 increments.

****HDHP options are available in lieu of an HRA or for owners who cannot fund HRA for themselves and state continuation. HDHP match HRA benefits and benefit factors.

BlueCross BlueShield of Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Renewal Rates for: CITY OF GRAIN VALLEY
Presented By: DAVID JOHNSON
CBIZ BENEFITS & INSURANCE SERVICES IN

Effective Date: 07/01/2016 **SIC Code:** 9199 **State:** MO **Area:** MOMETRO **Territory:** 038

The approximate increase for renewal of your health premium is 8.0%

Age Banded Non Carveout Medical Rate Summary (Monthly)

Plan: Preferred-Care Blue (high PPO) - B30PB (A412)

Age Range	EE Only	EE & Spouse	EE & Child(ren)	EE & Family
0 to 120	482.92	1,014.13	917.55	1,497.05

Age Banded Non Carveout Medical Rate Summary (Monthly)

Plan: BlueSaver (HSA) - B60BS (A416)

Age Range	EE Only	EE & Spouse	EE & Child(ren)	EE & Family
0 to 120	409.92	860.83	778.85	1,270.76

*Note Life & AD&D benefits are reduced for applicants over age 64. Please see the benefit summary for details.

Do not cancel your current coverage until coverage rates have been approved by BCBSKC.

Preferred-Care Blue - MISSOURI
PPO BENEFIT SCHEDULE

Package B High PPO Missouri B30PBM	**Dependent Limiting Age:** 26
Preexisting Condition Exclusion Period: Not applicable	

Covered Services	PREFERRED PROVIDER Copayment, Deductible, Coinsurance and limitations	NON-PREFERRED PROVIDER Deductible, Coinsurance and limitations
Calendar Year Deductible (Individual/Family)	$1,500/$4,500	$1,500/$4,500
Out-of-Pocket Maximum (Individual/Family) *Includes deductible, coinsurance, copays*	$4,500/$9,000	$9,000/$18,000
Physician Services	$35 Copayment *Copayment applies to the Office Visit Charge Only. Other procedures performed in a Physician's office are subject to the Preferred Provider Deductible and Coinsurance level unless otherwise specified in the Benefit Schedule.*	Deductible then 40% Coinsurance
Lab performed in Physician's Office / Independent Lab	No Copayment	Deductible then 40% Coinsurance
Lab performed in Hospital / Outpatient Facility	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
X-ray and other Radiology Procedures	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance*
Routine Preventive Care (See the Routine Preventive Care Benefit under the Covered Services Section for a description of Routine Preventive Services for which you have Benefits)	No Copayment	Deductible then 40% Coinsurance
Diagnostic and Routine Preventive Mammograms, Pap Smears and PSA tests	No Copayment	Deductible then 40% Coinsurance
Emergency Services *Copayment waived if admitted to a Hospital*	$100 Copayment per visit then 20% Coinsurance after Deductible.	$100 Copayment per visit then 20% Coinsurance after Deductible.
Ambulance	Deductible then 20% Coinsurance	Deductible then 20% Coinsurance
Inpatient Hospital Services**	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance*
Outpatient Surgery in Hospital or other Outpatient Facility**	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance*
Urgent Care	$35 Copayment***	Deductible then 40% Coinsurance
Durable Medical Equipment**	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
Formula and Food Products for Phenylketonuria	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance but never greater than 50% of the cost of the formula or food product
Home Health Services**	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
	60 visit Calendar Year Maximum	
Skilled Nursing Facility**	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
	30 day Calendar Year Maximum	
Outpatient Therapy (Speech, Hearing, Physical, and Occupational Therapy)**	Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
	Physical, Occupational: 60 visit Calendar Year Maximum *Speech and Hearing: 20 visit Calendar Year Maximum*	

Maternity - Covered

Preferred-Care Blue - MISSOURI
PPO BENEFIT SCHEDULE

Covered Services		PREFERRED PROVIDER Copayment, Deductible, Coinsurance and limitations	NON-PREFERRED PROVIDER Deductible, Coinsurance and limitations
Chiropractic Services		$35 Copayment *Office visit only. Other services/procedures, including skeletal manipulations, performed in a chiropractor's office are subject to the Network Deductible and Coinsurance level.*	Deductible then 40%**
Inpatient Mental Illness/Substance Abuse**		Deductible then 20% Coinsurance	Deductible then 40% Coinsurance*
Outpatient Mental Illness/Substance Abuse**		Deductible then 20% Coinsurance	Deductible then 40% Coinsurance*
Organ Transplant**		Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
Contraceptive devices, implants, injections and elective sterilization for women		Covered at 100%	Not Covered
Outpatient Prescription Drugs** Includes oral and injectable contraceptives, and contraceptive devices and implants		Covered. Not subject to Calendar Year Maximum.	
Short-Term Supply	**Tier 1**	$12 Copayment/contraceptives covered at 100%	$12 Copayment then 50% Coinsurance
	Tier 2	$45 Copayment	$45 Copayment then 50% Coinsurance
	Tier 3	$70 Copayment	$70 Copayment then 50% Coinsurance
Long-Term Supply	**Tier 1**	$30 Copayment/contraceptives covered at 100%	$30 Copayment then 50% Coinsurance
	Tier 2	$112.50 Copayment	$112.50 Copayment then 50% Coinsurance
	Tier 3	$175 Copayment	$175 Copayment then 50% Coinsurance
Vision Care ****		$20 Copayment	$20 Copayment then up to $45 benefit maximum.
All other Covered Services		Deductible then 20% Coinsurance	Deductible then 40% Coinsurance
Lifetime Maximum		Unlimited	

* Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to $200 per day. Inpatient hospital services in a Non-Participating Provider Hospital inside Our Service Area are limited to a $200 maximum per day. Outpatient Services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility inside Our Service Area are limited to $200 per day.

** Prior Authorization will be required for elective inpatient admissions, durable medical equipment (DME), high-tech diagnostic testing, infusion therapy and self injectables, organ and tissue transplants, some outpatient surgeries and services, hearing therapy, prosthetics and appliances, mental health and chemical dependency, some outpatient prescriptions, skilled nursing facility, dental implants and bone grafts, and chiropractic services received from a non-network chiropractor. This list of services is subject to change. Please refer to your contract for the current list of services, which require Prior Authorization.

*** Copayment applies to the Office Visit Charge Only. Lab performed by a contracted urgent care is paid at 100%. Other services/procedures that are performed by an urgent care provider are subject to the Network Deductible and Coinsurance level.

****Vision Care provided by Vision Service Plan (VSP).

The Covered Services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the Contract.

BlueSaver (HSA) – MISSOURI
PPO BENEFIT SCHEDULE

Package B BlueSaver (HSA) Missouri B60BSM	**Dependent Limiting Age:** 26
Preexisting Condition Exclusion Period: Not applicable	

	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Covered Services	**Copayment, Deductible, Coinsurance and limitations**	**Deductible, Coinsurance and limitations**
Calendar Year Deductible (Individual/Family)	$3,000/$6,000	$3,000/$6,000
Out-of-Pocket Maximum (Individual/Family) *Includes deductible, coinsurance, copays*	$3,000/$6,000	$6,000/$12,000
Physician Services	Deductible	Deductible then 20% Coinsurance
Lab Services	Deductible	Deductible then 20% Coinsurance
X-ray and other Radiology Procedures*	Deductible	Deductible then 20% Coinsurance
Routine Preventive Care *(See the Routine Preventive Care Benefit under the Covered Services Section for a description of Routine Preventive Services for which you have Benefits)*	No Copayment	Deductible then 20% Coinsurance
Diagnostic and Routine Preventive Mammograms, Pap Smears and PSA tests	No Copayment	Deductible then 20% Coinsurance
Emergency Services	Deductible	Deductible
Urgent Care	Deductible	Deductible then 20% Coinsurance
Ambulance	Deductible	Deductible
Inpatient Hospital Services**	Deductible	Deductible then 20% Coinsurance*
Outpatient Surgery in Hospital or other Outpatient Facility**	Deductible	Deductible then 20% Coinsurance*
Durable Medical Equipment**	Deductible	Deductible then 20% Coinsurance
Formula and Food Products for Phenylketonuria	Deductible	Deductible then 20% Coinsurance but never greater than 50% of the cost of the formula or food product
Home Health Services**	Deductible	Deductible then 20% Coinsurance
	60 visit Calendar Year Maximum	
Skilled Nursing Facility**	Deductible	Deductible then 20% Coinsurance
	30 day Calendar Year Maximum	
Outpatient Therapy *(Speech, Hearing, Physical, and Occupational Therapy)***	Deductible	Deductible then 20% Coinsurance
	Physical and Occupational: 60 visit Calendar Year Maximum *Speech and Hearing: 20 visit Calendar Year Maximum*	
Chiropractic Services	Deductible	Deductible then 20% Coinsurance**
Inpatient Mental Illness/Substance Abuse**	Deductible	Deductible then 20% Coinsurance*
Outpatient Mental Illness/Substance Abuse**	Deductible	Deductible then 20% Coinsurance*
Organ Transplant**	Deductible	Deductible then 20% Coinsurance

BlueSaver (HSA) – MISSOURI
PPO BENEFIT SCHEDULE

Covered Services		PREFERRED PROVIDER Copayment, Deductible, Coinsurance and limitations	NON-PREFERRED PROVIDER Deductible, Coinsurance and limitations
Contraceptive devices, implants, injections and elective sterilization for women		Covered at 100% in-network	Not Covered
Outpatient Prescription Drugs** Includes oral and injectable contraceptives, and contraceptive devices and implants		Covered. Not subject to Calendar Year Maximum.	
Short-Term Supply	**Tier 1**	Deductible/contraceptives covered at 100%	Deductible then $12 Copayment then 50% Coinsurance
	Tier 2	Deductible	Deductible then $45 Copayment then 50% Coinsurance
	Tier 3	Deductible	Deductible then $70 Copayment then 50% Coinsurance
Long-Term Supply	**Tier 1**	Deductible/contraceptives covered at 100%	Deductible then $30 Copayment then 50% Coinsurance
	Tier 2	Deductible	Deductible then $112.50 Copayment then 50% Coinsurance
	Tier 3	Deductible	Deductible then $175 Copayment then 50% Coinsurance
Vision Care ***		$20 Copayment	$20 Copayment then up to $45 benefit maximum.
All other Covered Services		Deductible	Deductible then 20% Coinsurance
Lifetime Maximum		Unlimited	

*Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to $200 per day. Inpatient hospital services in a Non-Participating Provider Hospital inside Our Service Area are limited to a $200 maximum per day. Outpatient Services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility inside Our Service Area are limited to $200 per day.

**Prior Authorization will be required for elective inpatient admissions, durable medical equipment (DME), high-tech diagnostic testing, infusion therapy and self injectables, organ and tissue transplants, some outpatient surgeries and services, hearing therapy, prosthetics and appliances, mental health and chemical dependency, some outpatient prescriptions, skilled nursing facility, dental implants and bone grafts, and chiropractic services received from a non-network chiropractor. This list of services is subject to change. Please refer to your contract for the current list of services, which require Prior Authorization.

***Vision Care provided by Vision Service Plan (VSP).

The Covered Services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the Contract. **Maternity – Covered**

Important Information

Blue Cross and Blue Shield of Kansas City (Blue KC) would like to inform you of some significant changes that may impact your plan. For your convenience, we have provided you with a summary of these changes:

Preventive Services Updates (Ongoing)

Blue KC health plans include routine preventive benefits that are consistent with the guidelines developed by the United States Preventive Services Task Force (USPSTF), Health Resources and Services Administration (HRSA), and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These guidelines are updated periodically. Blue KC monitors these guidelines and will make updates to your Plan as necessary to comply with current recommendations.

Changes to Out-of-Pocket Maximum Limits and Rules

The total 2016 out-of-pocket maximum limit will include both medical and pharmacy services. Specifically, the total 2016 out-of-pocket maximum must not exceed $6,850 for individuals and $13,700 for families. The IRS out-of-pocket maximum limits for HSA eligible plans must not exceed $6,550 for individuals and $13,100 for families. The rules continue to require that generally all member cost sharing, including deductibles, coinsurance and copays, apply to these limits.

Corresponding deductible adjustments were also made on some plans. Please refer to your plan details to determine how these changes will affect your specific plans.

Employer Shared Responsibility Payment

If you employ 50 or more full-time employees, including full-time equivalents, you may be subject to a penalty if you do not offer Minimum Essential Coverage that is affordable and provides minimum value to your full-time employees and their child dependents. The penalty applies if one or more full-time employees or their child dependents receive a subsidy on a state or federally facilitated exchange.

To avoid the penalty, the Minimum Essential Coverage offered must:

- Be Affordable – The employee's required contribution toward the cost of self-only coverage does not exceed 9.5% of the employee's household income.
- Provide Minimum Value - The plan's share of the total allowed costs of benefits provided under the plan is at least 60% of those costs.

2016/2017 City of Grain Valley Benefits Renewal

BlueSaver Health Savings Account (H.S.A)			
Coverage Class	Total Rate	City Pays	Employee Pays
EE	$ 409.92	$ 409.92	$ -
EC	$ 778.85	$ 594.39	$ 184.46
ES	$ 860.83	$ 635.38	$ 225.45
FF	$ 1,270.76	$ 840.34	$ 430.42

Preferred-Care Blue (PPO)			
Coverage Class	Total Rate	City Pays	Employee Pays
EE	$ 482.92	$ 482.92	$ -
EC	$ 917.55	$ 700.24	$ 217.31
ES	$ 1,014.13	$ 748.53	$ 265.60
FF	$ 1,497.05	$ 989.99	$ 507.06

Insurance Expenditures By Plan & Class

Employee Enrollment		
Coverage Class	H.S.A	PPO
EE	25	2
EC	13	2
ES	3	0
FF	9	1
Total	**50**	**5**
All Plans & Classes		***55***

Annual Cost to City		
Coverage Class	H.S.A	PPO
EE	$ 122,976.00	$ 11,590.08
EC	$ 92,724.84	$ 16,805.76
ES	$ 22,873.68	$ -
FF	$ 95,921.76	$ 11,879.88
Total	**$ 334,496.28**	**$ 40,275.72**
All Plans & Classes		***$ 374,772.00***

Legend

EE	*Employee Only*
EC	*Employee + Child(ren)*
ES	*Employee + Spouse*
FF	*Family*
H.S.A	*BlueSaver Health Savings Account*
PPO	*Prefered-Care Blue PPO*

2016-2017 Insurance Coverage Options

Cost to the City w/o ST Disability		
Insurance	$	374,772.00
H.S.A	$	60,000.00
Total 16/17 Contract	$	434,772.00
FY 2016 Expense	**$**	**217,386.00**

Cost to City Adding ST Disability		
Insurance	$	374,772.00
Short Term Disability	$	11,754.00
H.S.A	$	60,000.00
Total 16/17 Contract	$	446,526.00
	$	**223,263.00**

June 6, 2016

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CITY OF GRAIN VALLEY
711 MAIN ST
GRAIN VALLEY, MO 64029

To Whom It May Concern,

I personally want to thank you for placing your trust in Delta Dental of Missouri as your dental benefits provider. It has been our pleasure to serve **CITY OF GRAIN VALLEY (18511036)** and we hope your experience with Delta Dental has been equally exceptional.

Your group's anniversary date with Delta Dental is **July 1, 2016**. To assist you with your renewal, I have included a summary of your current rates along with your renewal rates and some plan design alternatives for your review and consideration.

This is also an opportunity to change your plan design, if desired, including items such as dependent age limits. If you have any questions or concerns related to these items, please do not hesitate to contact me or your broker directly.

	Current Rates	Renewal Rates	Enrollment
Employee	**$35.84**	**$36.92**	**23**
Employee & Spouse	**$72.04**	**$74.20**	**9**
Employee & Child(ren)	**$81.56**	**$84.01**	**10**
Family	**$116.97**	**$120.48**	**10**

Along with your renewal, we are pleased to offer you the option to select benefit enhancements from our new product, ***DeltaVision***! If you add ***DeltaVision*** with your dental renewal*, a **2% discount** will be applied to your dental renewal rates. **Applicable to new vision business only. Applicable to groups of a minimum of 10 enrolled.*

Please keep in mind that this is your open enrollment period. Now is the time for your employees to review and make changes to their current coverage, which will become effective on your anniversary.

Thank you for your continued partnership with Delta Dental.

Sincerely,

Stacy Buckallew

Stacy Buckallew
Account Manager
Phone: 816-931-5114
Fax: 816-931-5588

cc: Michael Varner
CBIZ Benefits & Insurance Services, Inc.

Renewal Options
Group Name: CITY OF GRAIN VALLEY
Group Number: 18511036
Effective Date: 7/1/2016

Benefit Coverage	Current Plan Delta Dental PPO *DentaCare M*			Option 1 Delta Dental PPO *DentaCare M*			Option 2 Delta Dental PPO *DentaFlex*		
	PPO Network	Premier Network	Out of Network	PPO Network	Premier Network	Out of Network	PPO Network	Premier Network	Out of Network
Preventative (A)	100%	100%	100%	100%	100%	100%	100%	100%	100%
Basic & Restorative (B)	80%	80%	80%	80%	80%	80%	80%	80%	80%
Major (C)	50%	50%	50%	50%	50%	50%	50%	50%	50%
Orthodontics (D)	50%	50%	50%	50%	50%	50%	50%	50%	50%
Deductible	$50	$50	$50	$75	$75	$75	$50	$50	$50
Family Deductible	$150	$150	$150	$225	$225	$225	$150	$150	$150
Applies to Preventative	No	No	No	No	No	No	No	No	No
Annual Max per Person	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000
Lifetime Ortho Max *(to dep age 19)*	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000
Dependent Age	26 / 26			26 / 26			26 / 26		

Monthly Rates			
Employee	$36.92	$35.94	$34.35
Employee & Spouse	$74.20	$72.23	$69.04
Employee & Child(ren)	$84.01	$82.03	$78.84
Family	$120.48	$117.58	$112.88
Rate Garantee	12 months	12 months	12 months

Please see enclosed comparison for Dentacare M, DentaFlex or Dentacare E plan if applicable.

Please sign below and return to Delta Dental to confirm the renewal of your current plan or the acceptance of the proposed alternate plan selected.

☐ Please renew our dental plan with our existing benefits.

☐ Please change our plan to the proposed Option ____ outlined above. This change will take place on our anniversary date.

Signature of Company Executive

Date

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DELTA DENTAL

Dentacare M vs. DentaFlex Benefit Comparison

Dentacare M (current plan)	**DentaFlex** (proposed new plan)
Coverage A Benefits: • Oral examinations, twice in any benefit period • Bitewing and periapical x-rays as required • Full-mouth x-rays, once in any 36 consecutive months • Prophylaxis (cleaning, scaling and polishing including periodontal maintenance visits), twice in any benefit period • Topical fluoride application for patients under age 19, once in any benefit period • Emergency palliative treatment as needed • Space maintainers for prematurely lost teeth of eligible dependent children under age 16 (once in 5 years)	**Coverage A Benefits:** • Oral examinations, twice in any benefit period • Periapical x-rays as required; ***Bitewing x-rays, one set per benefit period*** • Full-mouth x-rays, once in any 36 consecutive months • Prophylaxis (cleaning, scaling and polishing including periodontal maintenance visits), twice in any benefit period • Topical fluoride application for patients ***under age 16***, once in any benefit period • Emergency palliative treatment as needed • Space maintainers for prematurely lost teeth of eligible dependent children under age 16 (once in 5 years)
Coverage B Benefits: • Fillings: Amalgam, synthetic porcelain and plastic restorations (composite restorations on anterior teeth) • Simple and surgical extractions • Sealants for dependent children under age 19, limited to caries-free occlusal surfaces of the first and second permanent molars, once in 5 years • Periodontics: Surgical and non-surgical • Endodontics: Includes pulpal therapy and root canal filling • General anesthesia when administered by a dentist properly licensed to administer general anesthesia for certain covered procedures.	**Coverage B Benefits:** • Fillings: Amalgam, synthetic porcelain and plastic restorations (composite restorations on anterior teeth) • **Simple extractions** • Sealants for dependent children **to age 16**, limited to caries-free occlusal surfaces of the first and second molars, once in 5 years
Coverage C Benefits: • Prosthodontics: complete or partial dentures, fixed bridges, repairs of fixed bridges and dentures (once in 5 years) • Crowns, jackets, labial veneers, inlays and onlays when required for restorative purposes (once in 5 years) • Oral surgery, except for extractions under Coverage B	**Coverage C Benefits:** • Prosthodontics: complete or partial dentures, fixed bridges, repairs of fixed bridges and dentures **(once in 7 years)** • Crowns, jackets, labial veneers, inlays and onlays when required for restorative purposes **(once in 7 years)** • Oral surgery, except for extractions under Coverage B • **Periodontics: Surgical and non-surgical** • **Endodontics: Includes pulpal therapy and root canal filling** • **General anesthesia when administered by a dentist properly licensed to administer general anesthesia for certain covered procedures.**
Coverage D Benefits: • Orthodontic care for dependent children under age 19.	**Coverage D Benefits:** • Orthodontic care for dependent children under age 19.

DELTA DENTAL®

DeltaVision®

Adding DeltaVision to Your Benefit Offering

Delta Dental gives you everything you need to administer your employee eye health benefits plan.

National Network:
We offer a proprietary national network of optometrists and ophthalmologists with the convenience of both retail and independent provider locations.

Service Commitment:
Delta Dental account managers are held to the highest standards to ensure quick and informative responses to any and all inquiries.

Cost Control:
Delta Dental provides multi-year contracts and value-added benefit offerings.

Comprehensive Product Portfolio:
We offer a variety of plan designs that feature different co-payments and allowances for glasses and contacts.

Administered by Delta Dental of Missouri and Advantica
Underwritten by Advantica Insurance Company

For inquiries, contact Delta Dental of Missouri at 800-392-1167 and ask for an eye health benefits sales representative.

www.deltadentalmo.com/vision

City of Grain Valley, MO

Dental Benefits Renewal with Revised Rates

Effective July 1, 2016

DENTAL	Delta Dental of Missouri Current		
Carrier Website	www.deltaldentaltalmo.com		
Plan Type & Network	PPO/Premier		
	PPO In Network	***Premier Network***	***Out of Network***
Deductible			
Individual	$50		
Family	$150		
Waived for Preventive	Yes		
Coinsurance (member pays)			
Preventive	100%	100%	100%
Basic	80%	80%	80%
Major	50%	50%	50%
Orthodontia Dependent to age 19	50%	50%	50%
Maximum Benefits:			
Annual Max.	$1,000		
Orthodontia Lifetime Max (to dependent age 19)	$1,000		
Additional Provisions			
Coverage for Composite Fillings	Not for posterior teeth		
Endo/Periodontics	Basic		
Coverage for Dental Implants	Not covered		
UCR Percentile	MPA		
Late Entrants	Open enrollment only		
Waiting Period	No waiting period		
Dependent Child Age Limit	End of Year Age 26		
Unit Cost:	*Current*	Proposed Renewal	*Negotiated Renewal*
Employee Only	$35.84	$38.05	$36.92
Employee + One	$72.04	$76.49	$74.20
Employee + Child(ren)	$81.56	$86.66	$84.01
Employee + Family	$116.97	$124.20	$120.48

Prepared by:
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Kansas City, MO 64112
(816) 945-5500

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City of Grain Valley, MO

Group Short Term Disability Benefit Options

Effective July 1, 2016

SHORT TERM DISABILITY	Standard	
Benefit Provisions:		
Benefit Percentage	60%	
Maximum Weekly Benefit	$1,200	
Minimum Weekly Benefit	$15	
Elimination Period		
Accident	15th Day	30th Day
Illness	15th Day	30th Day
Benefit Duration	166 Days	150 Days
Additional Provisions:		
Partial Disability	Included	
Benefits will not be paid while member is eligible to receive sick pay	Included	
W-2 Preparation	Included	
Employer FICA Match Service	Included	
Guaranteed Issue Amount	Full Benefit	
Coverage Type	Non-Occupational	
Contributory Status	100% Employer Paid	
Limitations:		
Pre-existing Condition Limitation	None	
Unit Cost	**15th Day**	**30th Day**
Rate per $10/Weekly Benefit	**$0.330**	**$0.251**
Volume	**$29,683**	**$29,683**
STD Monthly Cost	**$979.54**	**$745.04**
Total Annual Cost	**$11,754.47**	**$8,940.52**
Participation Requirement	**100%**	
Rate Guarantee	**30 Months**	

Prepared by:

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Kansas City, MO 64112
816-945-5500

City of Grain Valley

Voluntary Life and AD&D Options

Effective July 1, 2016

VOLUNTARY LIFE	Standard			
EMPLOYEE BENEFIT	**Employee**		**Spouse**	
Employee Life and/0r AD&D Benefit	$10,000 Increments		$5,000 Increments	
Minimum Life Amount	$10,000		$5,000	
Maximum Life Amount	$300,000		$150,000	
Guarantee Issue-Employee	$50,000		$15,000	
DEPENDENT BENEFIT				
Dependent to age 20/24	$10,000			
Guarantee Issue Child	$10,000			
Age Rated Employee & Spouse	EE rate	AD&D rate	Spouse Rate	AD&D rate
<= 29	$0.098	$0.04	$0.071	$0.350
30-34	$0.101	$0.04	$0.072	$0.350
35-39	$0.115	$0.04	$0.081	$0.350
40-44	$0.172	$0.04	$0.124	$0.350
45-49	$0.247	$0.04	$0.176	$0.350
50-54	$0.421	$0.04	$0.306	$0.350
55-59	$0.691	$0.04	$0.519	$0.350
60-64	$0.939	$0.04	$0.807	$0.350
65-69	$1.671	$0.04	$1.437	$0.350
70-74	$3.645	$0.04	$3.134	$0.350
75+	$13.820	$0.04	$11.881	$0.350
Child rate	$0.20	$0.04		
Participation Requirement	20% of eligible ees. 0r 10			
PORTABLE	Yes		Yes	
Rate Guarantee	30 Months			
REDUCTION SCHEDULE				
VOLUNTARY	To 65% at Age 65 To 50% at Age 70 To 35% at Age 75		To 65% at Age 65 To 50% at Age 70 To 35% at Age 75	

SEE DISCLAIMER

City of Grain Valley, MO

Long Term Disability Benefit Comparison

Effective July 1, 2016

LONG TERM DISABILITY	Standard
Benefit Provisions:	
Benefit Percentage	60%
Maximum Monthly Benefit	$10,000
Guarantee Issue	Full Benefit
Minimum Monthly Benefit	$100
Elimination Period	180 Days
Benefit Duration	ADEA/SSNRA
Own Occupation	24 Months
Social Security Integration	Family Offset
Additional Provisions:	
Definition of Disability	Inability to Perform Reg. Occ. and 20% or more
Partial Disability	Yes
Survivor Benefit	3 Months
Actively at Work Waived?	No
Limitations:	
Drug & Alcohol Limitation	24 Months
Mental Illness Limitation	24 Months
Subjective/Self-Reported Limitation	24 Months
Pre-existing Condition Limitation	3/12
Unit Cost	100% Employer paid
Rate per $100 / Covered Payroll	**$0.37**
Volume	**$214,379**
Total Monthly Cost	**$793.20**
Total Annual Cost	**$9,518.43**
Participation Requirement	**100%**
Rate Guarantee	**30 months**

Prepared by:

CBIZ Benefits & Insurance Services, Inc.
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816-945-5500

CBIZ Disclaimer

DISCLAIMER:
CBIZ Benefits & Insurance Services has been and will continue to be committed to acting in our client's best interest by providing services and products that meet our client's needs as communicated to CBIZ. From time to time, CBIZ may participate in agreements with one or more insurance companies or third party vendors, in connection with the insurance related transactions, to receive additional compensation or consideration. These compensation arrangements are provided to CBIZ as a result of the performance and expertise by which products and services are provided to the client and may result in enhancing CBIZs ability to access certain markets and services on behalf of CBIZ clients. More information regarding these CBIZ agreements and the consideration received pursuant to these agreements is available upon written request.
The illustration presented is only a summary. Please refer to the booklet/certificate for specific details. If a conflict arises, the booklet/certificate will govern in all cases. This is not an offer of insurance coverage. Final Rates, coverages & limitations must come from the insurance company.