Personnel 2-17-14

CITY OF MANITOWOC

WISCONSIN, USA
www.manitowoc.org

088

February 13, 2014

Re: Contract Signatures

Memo for Council scheduled February 17th, 2014

The attached contracts are related to our Medical and Life renewals for 2014. The renewal rates have already been approved by Personnel therefore; these documents only need signatures for processing.

Thank you,

Jeri Johnson

Jeri Johnson
Human Resources Generalist

STOP LOSS INSURANCE

HCC LIFE INSURANCE COMPANY

Three Town Park Commons, 225 TownPark Drive, Suite 350
Kennesaw, Georgia 30144 (800 447-0460)

APPLICATION

1. Full Legal Name of Applicant and Address
City of Manitowoc
900 Quay Street
Manitowoc, WI 54221
Telephone No.:

2. Applicant is a (check one):
☒ Corporation ☐ Labor Union ☐ Trust
☐ Association ☐ PEO
☐ Partnership ☐ MEWA
Other:

3. Contract Period: **Effective Date: 01/01/2014** **Expiration Date: 12/31/2014**

4. Full Legal Name of Affiliates, Subsidiaries and other major locations to be included in coverage:
Manitowoc Public Utilities

Address of Affiliates or Subsidiaries: ☐ None ☐ See attached listing

5. Nature of Business of the Applicant to be Insured:
Executive Offices

6. Key Contact Person at Applicant:

7. Enter full name of the Employee Benefit Plan(s): **City of Manitowoc Health Plan**
A signed copy of such Employee Benefit Plan(s) must be attached and will form part of this contract.

8. Name and Address of Plan Supervisor:
Auxiant 2450 Rimrock Road, Suite 301 Madison, WI 53713

9. Agent of Record: **Auxiant**

10. Estimated Initial Enrollment: **Single: 99 Family: 199 Total Covered Units: 298**

11. Retirees Covered: ☒ Yes ☐ No

12. The Utilization Review vendor will be: **American Health Holding, Inc.**

13. Deposit Premium (Minimum of first month's estimated premium): **$** 34,425.01
Pleasereviewthedepositpremiumontheo MonthlyPremiumAccountingWorksheet.

14. **SPECIFIC STOP LOSS INSURANCE:** ☒ Yes ☐ No

A. Covered Expenses Paid under the Employee Benefit Plan for the following Plan Benefits are covered for Specific Stop Loss Insurance (not included unless checked):
☒ Medical ☒ Prescription Drug Card ☐ Prescription Drugs Under Medical ☐ Other:

B. Specific Deductible in each Contract Period per Covered Person: **$100,000**

C. Contract Basis: **Paid**
Covered Expenses Incurred no earlier than 12 months prior to the Original Effective date of the policy, and Paid from 01/01/2014 through 12/31/2014.

D. Unlimited Specific Lifetime Reimbursement Maximum per Covered Person
Specific Contract Period Reimbursement Maximum per Covered Person: **Unlimited**

E. Separate Individual Specific Deductible: **Brian Christensen ($200,000 - Paid Contract Basis)**

F. Monthly Specific Premium Rates:
Single: $51.45 Family: $138.02

G. Specific Percentage Reimbursable **100%**

H. Specific Terminal Liability Option: ☐ Yes ☒ No
Specific Terminal Liability Option premium per Covered Person per month:

Applicant's Initials: _____

15. **AGGREGATE STOP LOSS INSURANCE:** ☒ Yes ☐ No

A. Covered Expenses Paid under the Employee Benefit Plan for the following Plan Benefits are covered for Aggregate Stop Loss Insurance (not included unless checked):
☒ Medical ☐ Dental ☐ Weekly Income ☐ Vision ☒ Prescription Drug Card ☐ Prescription Drugs under Medical ☐ Other:

B. Minimum Annual Aggregate Deductible: **$4,931,340.12**
(Subject to the Definition of Minimum Annual Aggregate Deductible in the Policy)

C. Contract Basis: **Paid**
Covered Expenses Incurred no earlier than 12 months prior to the Original Effective date of the policy, and Paid from 01/01/2014 through 12/31/2014.
Run-in limit: N/A

D. Aggregate Contract Period Reimbursement Maximum: **$1,000,000**

E. Monthly Aggregate Factors:

Monthly Factors	Combined	Medical	Dental	Weekly Income	Vision	Prescription Drugs
Single	**$714.29**					
Family	**$1,709.70**					

F. Aggregate Percentage Reimbursable **100%**

G. Loss Limit: **$100,000**
For the purposes of Aggregate Stop Loss Insurance, the Loss Limit is the maximum amount of Covered Expenses Incurred by each Covered Person, which can be used to satisfy the Annual Aggregate Deductible.

H. Monthly Deductible Advance Reimbursement Option: ☐ Yes ☒ No

I. Aggregate Terminal Liability Option: ☐ Yes ☒ No

J. Aggregate Premium:
1. ☐ Annual Premium payable in advance for Contract Period:
2. ☒ Monthly Premium rate per Covered Unit: **$ 6.26**
3. ☐ Monthly Deductible Advance Reimbursement premium per Covered Unit per month:
4. ☐ Aggregate Terminal Liability Option premium per Covered Unit per month:

Applicant's Initials:_____

SPECIAL RISK LIMITATIONS are stated on the Addendum to Application (if applicable).

It is understood and agreed by the Applicant that:

1. The Applicant is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan, and
2. The Plan Supervisor retained by the Applicant will be considered the Applicant's Agent, and not the Company's Agent, and
3. All documentation requested by the Company must be received within 90 days of the Policy effective date, and is subject to approval by the Company and may require adjustment of rates, factors, and / or Special Limitations to accommodate for abnormal risks, and
4. The Stop Loss Insurance applied for herein will not become effective until accepted by the Company, and
5. Premiums are not considered paid until the premium check is received by the Company, is paid according to the rates set forth in the Application,a nd all items required to issue the Policy have been returned to the Company. Premiums are subject to refund should any outstanding policy requirement not be met within 90 days of the Policy's effective date, and
6. This Application will be attached to and made a part of the Policy issued by the Company, and
7. The Employee BenefitP lan(s) attached shall be the basis ofa ny Stop Loss Insurance provided by the Company and such Employee Benefit Plan(s) conforms with all applicable State and Federal statutes, and
8. Any reimbursement under the Stop Loss Insurance provided by the Company shall be based on Covered Expenses Paid by the Applicant In accordance with the Employee Benefit Plan(s) attached hereto, and
9. After diligent and complete review, the representations made in this Application,t he disclosures made,a nd all of the information provided for underwriters to evaluate the risk, are true and complete.

Any person who knowingly and'with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Full Legal Name of Applicant: **City of Manitowoc**

Applicant's Federal Tax I.D. Number: **396005511**

Dated at Manitowoc, Wisconsin this _____ day of February, 2014.

Officer / Partner Signature Justin M. Nickels
Mayor
Manitowoc Public Utilities

Jennifer Hudon, City Clerk (print name)

Licensed Agent Signature

Officer / Partner Signature (print name)

For HCC Life Insurance Company Office Use Only: ACCEPTANCE

Accepted on behalf of the Company, this ____ day of _____, 20____.

By: _____ Title: _____

Policy No.: _____

STOP LOSS INSURANCE
HCC LIFE INSURANCE COMPANY
ADDENDUM TO APPLICATION

Full Legal Name of Applicant: City of Manitowoc

Effective Date: 01/01/2014

SPECIAL RISK LIMITATIONS:

The maximum amount of Covered Expenses that are eligible to satisfy the Annual Aggregate deductible for an individual who has been assigned a higher Separate Individual Specific Deductible will be the amount as shown under Loss Limit on the Application.

Officer/Partner Signature Justin M. Nickels, Mayor

Officer/Partner Signature Jennifer Hudon, City Clerk

Licensed Agent Signature

[7037356]

HCC LIFE INSURANCE COMPANY

STOP LOSS POLICY
Endorsement for policyholder purchasing separate
Organ & Tissue Transplant coverage

Policy Number: HCL13181

Endorsement Number: 1

Policyholder: City of Manitowoc

Effective Date of Endorsement: 01/01/2014

This Stop Loss Policy has been underwritten, priced and issued based upon Your purchase, or Your intent to purchase, an Organ & Tissue Transplant Policy issued by National Union Fire Insurance Company of Pittsburgh, PA.

Therefore, in consideration of the Organ & Tissue Transplant Policy, You and We agree that the Stop Loss Policy is amended as follows:

Article I. DEFINITIONS is hereby amended by the addition of the following:

ORGAN & TISSUE TRANSPLANT POLICY. Any insurance policy issued by any insurance carrier purchased by You that insures Your Employee Benefit Plan participants on a fully insured basis for organ and / or tissue transplants or organ and / or tissue replacement.

Organ & Tissue Transplant Endorsement provisions:

You will provide to us, as soon as reasonably possible, a copy of Your Organ & Tissue Transplant Policy. You understand that the Organ & Tissue Transplant Policy was taken into consideration during the underwriting of this Policy, therefore a delay in providing Us with a copy of Your Organ & Tissue Transplant Policy may result in a delay in processing Your stop loss claims. Further, You understand that Your failure to provide Us with a copy of Your Organ & Tissue Transplant Policy may result in Our denial of transplant-related stop loss claims while this Policy is in force.

All transplant related expenses paid by You shall not be considered Covered Expenses under this Policy when such expenses are covered by the Organ & Tissue Transplant Policy.

It is also understood and mutually agreed that for all transplants and transplants related expenses, the Organ & Tissue Transplant Policy shall be primary to the Employee Benefit Plan. We will only consider for reimbursement under this Policy transplant related expenses that are not covered by the Organ & Tissue Transplant Policy, that are paid by You under Your Employee Benefit Plan and are otherwise reimbursable per the terms and conditions of this Policy. Should a non-network transplant facility be utilized, We will not reimburse You for Plan Benefits You pay for expenses not covered by the Organ & Tissue Transplant Policy or for Plan Benefits You pay in excess of the maximum benefit outlined in the Organ & Tissue Transplant Policy.

Under no circumstances will premiums or fees paid by You for the purchase of the Organ & Tissue Transplant Policy, or any expenses, claims or reimbursements paid by the Organ & Tissue Transplant Policy be considered Covered Expenses under the Stop Loss Policy.

Should the Organ & Tissue Transplant Policy be cancelled, terminated, or otherwise expire during the Contract Period of this Policy, We reserve the right to change any Specific or Aggregate Premium Rates, Monthly Aggregate Factors, other terms and conditions of this Policy, or to cancel this Policy retroactive to the date of cancellation or termination of the Organ & Tissue Transplant Policy with written notice to You. You are required to notify Us of such cancellation, termination or other form of expiration within 10 working days of such action upon which this Policy shall exclude all transplant related expenses until Our notification has been provided and You have accepted our required modifications to the rates, premium, factors or terms of coverage.

HCC LIFE INSURANCE COMPANY
STOP LOSS POLICY
Endorsement for policyholder purchasing separate
Organ & Tissue Transplant coverage

THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN STATED ABOVE.

City of Manitowoc
Full Legal Name of Applicant / Policyholder

Manitowoc, WI; Feb. , 2014
Signed At / Date Signed

Officer / Partner Signature Justin M. Nickels
Mayor
Manitowoc Public Utilities

Jennifer Hudon, City Clerk

Officer / Partner Signature (print name)

Licensed Agent Signature

FOR HCC LIFE INSURANCE COMPANY USE ONLY:

ACCEPTANCE

Accepted on behalf of the Company, this_____day of_____, _____

By_____

Title:_____

BUSINESS ASSOCIATE AGREEMENT FORM

Part I - Preamble

A. **Effective Date:** The effective date of this Business Associate Agreement ("Agreement") is 01/01/2014.

B. **Parties:** The parties to this Agreement are City of Manitowoc Health Plan, ("Covered Entity"), and HCC Life Insurance Company ("HCC Life" and "Business Associate"), an Indiana corporation. HCC Life is a stop loss insurance carrier and all references in this agreement to "stop loss insurance carrier" refer to HCC Life. For purposes of this Agreement, HCC Life is a business associate (as defined in the HIPAA Rules as defined below) of Covered Entity. Covered Entity and Business Associate agree that there shall be no third party beneficiaries to this Agreement, including but not limited to individuals whose Protected Health Information (defined below) is created, received, used, and/or disclosed by Business Associate in its role as business associate.

C. **Purpose:** The parties intend that this Agreement comply with the business associate agreement requirements set forth in HIPAA Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164, Subparts A and E, ("Privacy Standards"), the HIPAA Security Standards,45 C.F.R. Part 160 and Part 164, Subparts A and C ("Security Standards"), and the HIPAA Breach Notification Rule3, 45 C.F.R. Part 160 and Part 164, Subparts A and D ("Breach Notification Rule"), as amended from time to time (collectively, the "HIPAA Rules").

D. In connection with the Business Associate's creation, receipt, use, and/or disclosure of Protected Health Information, the parties agree as follows.

Part II - General Terminology

A. The following terms shall have the same meaning in this Agreement as is set forth in the HIPAA Rules: breach, data aggregation, designated record set, individual, required by law, Secretary, security incident and unsecured protected health information. Protected Health Information ("PHI") shall have the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, but limited to the information created or received by Business Associate from, or on behalf of, Covered Entity.

B. In the event of an inconsistency between the provisions of this Agreement and the mandatory terms of the HIPAA Rules, as may be expressly amended from time to time by the U.S. Department of Health and Human Services ("HHS") or as a result of interpretations by HHS, a court, or another regulatory agency with authority over the parties, the interpretation of HHS, such court, or regulatory agency shall prevail. In the event of a conflict among the interpretations of these entities, the conflict shall be resolved in accordance with rules of precedence.

C. Where there are provisions in this Agreement additional to those mandated by the HIPAA Rules, but which are not prohibited by the HIPAA Rules, the provisions of this Agreement will apply.

Part III – Permitted Uses and Disclosures by Business Associate

A. Except as otherwise provided in this Agreement, Business Associate may receive, use, disclose or maintain PHI on behalf of, or to provide services to, Covered Entity for the following purposes, if such use or disclosure of PHI would not violate the HIPAA Rules if done by Covered Entity: (1) those functions, activities, and/or services as are identified in the Stop Loss Policy between the Covered Entity and the Business Associate and/or (2) those functions, activities, and/or services provided by Business Associate in connection with application and underwriting processes.

B. As part of its providing functions, activities, and/or services to Covered Entity as identified in Part III.A., Business Associate may disclose information, including PHI, to other business associates of Covered Entity and may use and disclose information, including PHI, received from other business associates of Covered Entity as if this information was received from, or originated with, Covered Entity.

C. Business Associate agrees not to use or further disclose PHI other than as permitted or required by this Agreement or as required by law.

D. Business Associate agrees to use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Agreement or as required by law. Business Associate will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Covered Entity.

E. Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

F. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

G. Except as otherwise limited in this Agreement, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by the HIPAA Rules.

H. Business Associate agrees that it will enter into a written agreement with all subcontractors of Business Associate that: (i) applies the same restrictions and conditions of this Agreement to the subcontractor's disclosure, receipt, maintenance, transmission or use of PHI; (ii) complies with the terms of the HIPAA Rules; (iii) requires the subcontractor to notify Business Associate, who shall in turn promptly notify Covered Entity, of any security incident, breach of other impermissible use of disclosure of PHI that the subcontractor becomes aware of; and (iv) notifies such subcontractors that they will incur liability under the HIPAA Rules for non-compliance with such provisions.

I. If Business Associate becomes aware of any use or disclosure of PHI that is not provided for in this Agreement, Business Associate will report that use or disclosure to Covered Entity as soon as reasonably possible. If Business Associate becomes aware of any security incident concerning electronic PHI, Business Associate will report that incident to Covered Entity as soon as reasonably possible.

J. Business Associate agrees, at the written request of Covered Entity, to provide access to PHI in accordance with 45 C.F.R. § 164.524. Business Associate may require Covered Entity to pay certain fees, as delineated in 45 C.F.R. § 164.524(c)(4), for it to provide copies or summaries of PHI.

K. Upon receiving written notification from Covered Entity that it has directed or agreed, pursuant to 45 C.F.R. § 164.526, to amend PHI, Business Associate agrees to make PHI available for amendment and incorporate any such amendments to PHI as directed by Covered Entity.

L. In accordance with 45 C.F.R. § 164.528, Business Associate will retain and make available to Covered Entity, upon written request, the information required by Covered Entity to provide an accounting of disclosures, if so requested by an individual.

M. For the purpose of the Secretary determining Covered Entity's compliance with the HIPAA Rules, Business Associate shall make available to the Secretary the Business Associate's internal practices, books, and records relating to the use and disclosure of PHI. No attorney-client, accountant-client, or other legal privilege will be deemed to have been waived by Business Associate by virtue of this provision of the Agreement.

N. Business Associate agrees to, as soon as practicable, but in no case later than 30 calendar days after the discovery of a breach of unsecured protected health information, notify Covered Entity of such breach. A breach shall be treated as discovered as of the first day on which such breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is an employee, officer or agent of Business Associate. The notification shall include, to the extent possible, the identification of each individual whose unsecured protected health information has been, or is reasonably believed by Business Associate to have been, accessed, acquired, used or disclosed during the breach. In addition, Business Associate shall provide Covered Entity with any other available information that Covered Entity is required to include in the notification to the individual under 45 C.F.R. § 164.404(c) of the HIPAA Rules.

O. Business Associate agrees to take commercially reasonable steps to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate resulting from any unauthorized access, use, disclosure, modification or destruction of PHI.

P. Except as provided for by the stop loss policy, Business Associate will not directly or indirectly receive remuneration in exchange for any PHI of an individual.

Part IV - Obligations of Covered Entity

A. Upon request, Covered Entity shall provide, in a timely manner, Business Associate with the Notice of Privacy Practices that Covered Entity produces in accordance with 45 C.F.R. § 164.520, as well as any changes to such Notice.

B. Covered Entity shall provide Business Associate with any changes in, or revocation of, permissions by the Covered Entity or any individual to use or disclose PHI if such changes, revocations or permissions affect Business Associate's permitted or required uses and disclosures.

C. Covered Entity shall notify Business Associate, in writing and in a timely manner, of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522 to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

D. Except for Business Associate's management and administrative activities and data aggregation, Covered Entity shall not request that Business Associate use or disclose PHI in any manner that would not be permissible under the HIPAA Rules if done by Covered Entity.

Part V - Termination Provisions

A. This Agreement shall continue until it is terminated by any of the parties or if a Stop Loss Policy exists between the Covered Entity and the stop loss insurance carrier, the Stop Loss Policy expires without renewal. Any party to this Agreement may terminate this Agreement without the necessity of showing cause by the delivery of a written notice from the terminating party to the other parties. However, if a Stop Loss Policy exists between the Covered Entity and the stop loss insurance carrier,

then the termination of this Agreement shall not be effective until either (1) all claims under the Stop Loss Policy are received and processed by Business Associate or (2) the time period delineated in the Stop Loss Policy for claims to be submitted to Business Associate and processed by Business Associate upon the Policy's termination, has expired, whichever event occurs first. If no Stop Loss Policy exists between Covered Entity and the stop loss insurance carrier then the termination is effective ten (10) business days from the date that the party receives such notice. Notwithstanding any other provision of this Agreement, Covered Entity will not withhold PHI from Business Associate so as to prevent Business Associate from using its usual and routine claims processing procedures to process claims under this section.

B. If Covered Entity determines that Business Associate has violated a material term of this Agreement then Covered Entity shall inform Business Associate in writing of the violation and Business Associate shall either terminate this Agreement under paragraph Part V.A. or endeavor to cure such violation. If Business Associate endeavors to cure the violation but fails to do so in a reasonable period of time, Covered Entity may terminate this Agreement upon written notice. Such termination shall be effective on the date that Business Associate receives the termination notice from Covered Entity which states that Covered Entity wishes to terminate this Agreement under this provision and states the material term of this Agreement that Covered Entity believes has been violated by Business Associate; however, any amounts due from Covered Entity to Business Associate as of the effective date of the termination continue to be so due.

C. Subject to the Part V.A. above, if a Stop Loss Policy exists between Covered Entity and the stop loss insurance carrier and such Stop Loss Policy is terminated or expires, this Agreement shall be deemed to have terminated at the same moment the Stop Loss Policy's termination or expiration became effective. Similarly, and subject to Part.V.A. above, if this Agreement is terminated by any party, all other agreements then existing between Business Associate and Covered Entity, unless otherwise agreed to in writing by Business Associate and Covered Entity, are also deemed to have been terminated at the same moment this Agreement's termination became effective. However, in either case, any amounts due from Covered Entity to Business Associate under any such agreements as of the effective date of termination continue to be due.

D. Upon the termination of this Agreement, Business Associate will, if feasible, return to Covered Entity all PHI or, at its discretion, in the alternative, Business Associate will destroy all PHI. If such return or destruction is not feasible, Business Associate will continue to extend the protections of this Agreement to the PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI not feasible.

HCC Life Insurance Company

By: _____

Printed Name: _____

Title: _____

City of Manitowoc Health Plan

By: _____
Justin M. Nickels, Mayor

_____
Jennifer Hudon, City Clerk

Manitowoc Public Utilities

By: _____

Printed Name: _____

Title: _____

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, New York, NY 10038
(212) 770-7000
(a capital stock company, herein referred to as the Company)

Administrative Office:
AIG Benefit Solutions
7330 Woodland Drive, Suite 250
Indianapolis, Indiana 46278
(888) 449-2377

Specified Disease Application
Organ & Tissue Transplant

Policy Applicant: City of Manitowoc & Manitowoc Public Utiltites	**Telephone:** City - 920-686-6990 / MPU - 920-686-4342	**Tax ID:** City - 39-6005511 / MPU - 39-6005513
Address: City Hall, 900 Quay Street		
City: Manitowoc	**State:** WI	**Zip Code:** 54220
Name(s) of Affiliates to be Included:	**Locations:**	

The Applicant is: ☒ Single Employer ☐ Trust ☐ Other (Specify) ____

Does the Applicant currently have major medical coverage in force? ☒ Yes ☐ No
Applicants that do not have major medical coverage in force, or that only have medical coverage provided through a limited benefit plan (such as a critical illness or "mini-med" plan) are not eligible for this Policy.

Agent/Broker: Auxiant	Agent/Broker Contact Name: Joseph Holt
Agent/Broker's Phone Number: 414-475-1601	Agent/Broker's License Number:

Covered Transplants:

☒ Heart	☒ Heart/Lung	☒ Autologous Bone Marrow/Peripheral Stem Cell Including High Dose Chemo
☒ Lung/Double Lung	☒ Kidney/Pancreas	
☒ Kidney (living/deceased donor)	☒ Kidney/Liver	☒ Allogeneic Bone Marrow/Peripheral Stem Cell Including High Dose Chemo (related)
☒ Pancreas	☒ Liver/Intestine	
☒ Liver (living/deceased donor)	☒ Pancreas/Intestine	☒ Allogeneic Bone Marrow/Peripheral Stem Cell Including High Dose Chemo (non-related)
☒ Intestine	☒ Liver/Pancreas/Intestine	
	☐ Other (Specify): ____	☒ Cord Blood Including High Dose Chemo

Benefit Period Start Date: ☒ Date of Evaluation ☐ 10 Days Before Transplant

Benefit Period End Date: ☒ 365 Days After Transplant

Lifetime Limit: ☐ $1,000,000 ☐ $2,000,000 ☒ Unlimited

Non-Participating Provider Reimbursement: ☒ 80% ☐ Other (Specify) ____

Name of Medical Plan Administrator: Auxiant 2450 Rimrock Road, Suite 301, Madison, Wi 53713	Requested Policy Effective Date (subject to acceptance): January 1, 2014

Eligible Persons to be Covered Under the Policy:
☒ Employee ☒ Member ☒ Subscriber
☒ Spouse ☒ Dependents ☒ COBRA Continuee
☒ Retiree ☐ Other (Specify) ____

Within the past 24 months, have any individuals to be covered under the Policy (including but not limited to employees, members, and/or dependents):

1. Been advised by an attending physician that a transplant is needed?
2. Had, a transplant consultation, workup, or evaluation?
3. Been scheduled to have a transplant consultation, workup, or evaluation?
4. Received, or has been listed to receive, an organ or tissue transplant?
5. Received dialysis treatments, or been diagnosed with chronic kidney disease or end stage renal disease?

☐ Yes ☐ No

If "Yes", please provide a current list of all such persons who meet any the above criteria, complete with diagnosis, and: transplant type; dates of evaluation or acceptance by transplant facility; and transplant facility where listed, if applicable.

FRAUD WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

The Applicant hereby applies for insurance coverage for organ and/or tissue transplant resulting from a Specified Disease, and:

1. Represents that the answers included in this Application have been reviewed and are true and complete to the best of the Applicant's knowledge and belief;
2. Understands and agrees that insurance applied for shall not become effective until the Application is approved by the Company; and
3. Agrees that if the insurance applied for is approved by the Company, the Applicant will pay all premium due after the effective date of insurance, including any premium which may accumulate between the effective date of the insurance and the date the Policy is issued.

This Application, as it may be amended, will become part of the Policy, if issued.

City

Applicant's Signature: _____ Date: _____

Individual authorized to sign as Applicant

Printed Name: Justin M. Nickels

Title: Mayor

Jennifer Hudon, City Clerk

MPU

Applicant's Signature:

City of Manitowoc & Manitowoc Public Utilities

Contract Period: 1/1/14 through 12/31/14

ADMINISTRATION
Auxiant
2450 Rimrock Road, Suite 301
Madison, WI 53713

STOP-LOSS INSURANCE/MGU
HCC Life

I hereby acknowledge the following particulars:

A. Specific Stop Loss

The desired level of deductible is $100,000. There is a $200,000 Individual Specific Deductible on Brian Christensen. Only the amount up to the group specific will apply toward the aggregate.

A Paid contract for the policy period has been requested. The terms of this contract are for claims incurred no earlier than 12 months prior to the original effective date of the policy and paid from 1/1/14 through 12/31/14 Claims incurred no earlier than 12 months prior to the original effective date of the policy will not be covered by stop loss insurance. Claims not processed and funded prior to the end of the contract period will not be covered by the stop loss insurance.

Medical and Rx claims are included in the Specific coverage.

B. Aggregate Stop-Loss

A Paid contract for the policy period has been requested. The terms of this contract are for claims incurred no earlier than 12 months prior to the original effective date of the policy and paid from 1/1/14 through 12/31/14 Claims incurred no earlier than 12 months prior to the original effective date of the policy will not be covered by stop loss insurance. Claims not processed and funded prior to the end of the contract period will not be covered by the stop loss insurance.

Medical and Rx claims are included in the Aggregate coverage.

C. Disclosure of Large Claims

I acknowledge that, prior to the effective date of a new plan year, I have an affirmative duty to disclose to the stop loss carrier and/or managing general underwriter (a) any and all plan participants who have incurred medical claims of 50% of the specific deductible, or greater, during the current plan year and (b) any and all plan participants who, because of medical conditions, may incur medical expenses of 50% of the specific deductible. I further acknowledge that I am required to disclose (a) all COBRA participants; (b) all retirees covered by the plan and (c) any participant who will not be actively at work on the first day of the upcoming plan year, all to the best of my knowledge. I finally acknowledge that any failure to disclose any of the aforementioned plan participants may be grounds for the stop loss carrier to deny a specific or aggregate reimbursement if it could be demonstrated that I knew of any such plan participant with said conditions or, or should have known or could have discovered said conditions after reasonable inquiry.

D. Contingencies/Auxiant Proposal Assumptions (Stop Loss Quote)

I acknowledge that I have reviewed the contingencies in the stop loss quotation and all Auxiant proposal assumptions and realize that the terms of the stop loss insurance may be tentative until the carrier receives certain requested information. Contingencies may require more information on participants with on-going conditions; limits on run-in claims; twelve-months of paid claims before setting final aggregate factors. These are only several examples. All stop loss contingencies and Auxiant proposal assumptions should be reviewed in detail.

E. Exclusions (Stop Loss Policy)

I acknowledge that I have reviewed the stop loss policy in detail. I also acknowledge by signing this document the importance of reviewing this document due to the potential liability. I have reviewed the following particulars of the stop loss policy:

1. Specific Contract (incurred and paid dates)
2. Aggregate Premium
3. Run-in Limits
4. Exclusions/Limitations
5. Requirements, policies and procedures
6. Termination provisions
7. Premium
8. Individual Specific Deductible
9. Attachment Points
10. Minimum Aggregate
11. Minimum Specific and Aggregate premium requirements

F. Eligibility

I acknowledge that, as plan sponsor, I am responsible to monitoring employee eligibility, and further acknowledge that a stop loss carrier may deny a claim reimbursement if it determines the employee was not eligible to be on the health plan. I also acknowledge that the carrier has provisions in the stop loss policy that allow a change in premium or the aggregate factors based upon certain formulas when a reduction in employee lives on the medical plan occur.

G. Plan Document

I acknowledge that the stop loss policy only covers benefits authorized by the plan document, and any claims authorized to be paid outside the plan document by the employer, will not be covered by stop loss insurance. I also have reviewed the stop loss policy to make sure that the plan design incorporates any restrictions or limitations that are found in the stop loss policy. I also understand that the stop loss policy may incorporate exclusions that may eliminate coverage for benefits that are authorized by the plan document. I understand that it is important to review the stop loss coverage exclusions when considering policy coverage.

I acknowledge that all of the above have been reviewed with me and that my decision is based on my analysis of the various risk and reward factors.

I hereby authorize placement of my stop loss coverage on the above-described basis.

Plan Sponsor: City of Manitowoc & Manitowoc Public Utilities

By: _____ Date: _____

Title: Justin M. Nickels, Mayor

Jennifer Hudon, City Clerk

Plan Sponsor: Manitowoc Public Utilities

By: _____ Date: _____

Title: _____

Plan Administrator: Joseph Holt, Auxiant

By: _____ Date: _____

Title: _____

SCHEDULE A
CITY OF MANITOWOC
FEE & COMMISSION DISCLOSURE STATEMENT
JANUARY 1, 2014 THROUGH DECEMBER 31, 2014

Number of Employees Covered:	220	
Medical:	Single: 73	Family: 147
Dental:	Single: 56	Family: 140

Fees To Be Charged:	**Total**	**Auxiant**	**Broker**
Medical Admin Fee*	**Medical – 15.15** **Dental - 2.10**	**Medical – 15.15** **Dental - 2.10**	**0.00**
Utilization Review*	**2.85**	**2.85**	**0.00**
Annual Administration Fee: Medical	**1,000.00**	**1,000.00**	**0.00**
Annual Administration Fee: Dental	**500.00**	**500.00**	**0.00**
HIPAA Certificate*	**0.25**	**0.25**	**0.00**
PPO Fee: First Health wrap	**20% of Savings**	**5% of Savings**	**0.00**
PPO Fee: THN/HPS Solutions	**5.50**	**0.00**	**0.00**
COBRA Fee*	**0.75**	**0.75**	**0.00**
Broker Fee*	**16.00**	**0.00**	**16.00**
PBM Interface Fee	**1.50 per script**	**1.50 per script**	**0.00**
HRA Fee*	**4.25**	**4.25**	**0.00**
Vision (VSP) COBRA Fee*	**0.25**	**0.25**	**0.00**
NUF Transplant Premiums	**S-$1.03** **F-$2.35**	**S-$1.03** **F-$2.35**	**0%**
Subrogation *(Auxiant directed subrogation)*	**27% of recovery**	**5% of recovery**	**0%**
Subrogation *(Plan Sponsor's Vendor-Per Case)*		**$750 per case** ***(for preparation & coordination)***	
Stop Loss Fee	**5%**	**5%**	**0%**

** fee is per employee per month*

Please Note:

Auxiant may receive administration fees and/or rebate fees from the pharmacy benefits manager (PBM) to offset costs of integrating the Pharmacy Benefit Management program with the Health Plan. For this fee, Auxiant provides a variety of services to the Pharmacy Benefit Management program (which benefits the underlying plan and plan participants), including but not limited to integrating pharmacy information into stop loss claims, providing billing and remittance to the PBM, coordinating enrollment and termination information for the PBM, and producing identification cards for the PBM program.

Auxiant is an independent third-party administrator and is not owned by, controlled by, or has any financial ownership interest in any stop loss insurer or managing general underwriter with which it solicits quotes or places business, nor does it have any tie-in or exclusivity arrangements with any such insurer or entity. Auxiant is not affiliated with the insurer whose contract may be recommended to an Auxiant client.

Auxiant attempts to make commercially reasonable efforts to market a client's stop loss insurance needs with the widest range of stop loss carriers and managing general underwriters based upon the requirements and covered lives data provided by the client. Auxiant may receive commission overrides from a stop loss carrier based upon the volume of premiums placed by Auxiant with that stop loss carrier over the course of a year. Such overrides are not attributable to any one employer or plan, but are calculated based upon the total premium volume over the course of a year. If Auxiant is not paid these rebate fees, commissions, or overrides, our administrative fees are subject to change upon thirty (30) day notice.

The PPO fees listed above are to the best of Auxiant's knowledge and are subject to change. All PPO fee changes will be communicated directly by the PPO or the agent to the group. Auxiant is NOT responsible to communicate these changes and will not be held responsible for any PPO fee issues.

In signing this schedule, the Plan Sponsor acknowledges receipt, understanding, and approval of the fees detailed above.

	CITY OF MANITOWOC		Auxiant
By:	_____	By:	_____
Printed name	Justin M. Nickels, Mayor	Printed name	Steve Chapman
	_____	Title:	Vice President – Chief Operating Officer
	Jennifer Hudon, City Clerk		
Date:	_____	Date:	_____

Auxiant®

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