Finance Committee

October 15, 2019
5:30 p.m.

Civic Center
West Committee Room

Roll Call:
Alderpersons Wattawa, Feirer, Damon

1. Call to Order

2. Minute Approval
   - August 6, 2019 - Finance Minutes 08-06-2019

3. Discussion and Action Items:
   - WEA Trust Renewal – 2020 Health Insurance - WEA Trust
   - Presentation of 2020 Budget

4. Adjourn

PUBLIC NOTICE

Upon reasonable notice, a good faith effort will be made to accommodate the needs of individuals to participate in public hearings, which have a qualifying disability under the Americans with Disabilities Act. Requests should be made as far in advance as possible, preferably a minimum of 48 hours. For additional information or to request this service, contact the St. Francis City Clerk at 481-2300 Extension #4305. The meeting room is wheelchair accessible from the east and west entrances.

NOTE: There is a potential that a quorum of the Common Council may be present.

MINUTES OF THE FINANCE COMMITTEE MEETING HELD AUGUST 6, 2019

Present: Alderman Wattawa, Alderman Feirer, Alderman Damon

Also Present: City Administrator Johnsrud, City Clerk/Treasurer Uecker, City Attorney Alexy, Alderwoman Schandel, Alderman Brickner

Chairman Wattawa called the meeting to order at 6:34 p.m.

Moved by Alderman Feirer, seconded by Alderman Damon to place on file the minutes of the Finance Committee meeting held June 18, 2019. Motion carried.

Petition for Compromise of Property Tax Penalty – Tax Key #592-9928-002:
The petitioner is asking the City to refund the $2,223.50 penalty that was paid on the above referenced tax key due to financial hardship. There was discussion regarding the setting of a precedence if this is done. The Committee felt that there was no strong case for refunding the penalty paid.

Moved by Alderman Damon, seconded by Alderman Feirer to deny the request to refund the penalty for Tax Key #592-9928-002. Motion carried.

Contract Renewal for Property/Liability/Workers Compensation Insurance – Ansay & Associates:
The annual renewal is showing an overall decrease in premium of 2.04%.

Moved by Alderman Feirer, seconded by Alderman Damon to accept the contract renewal for the 2019-2020 property/liability/workers compensation insurance as presented by Ansay & Associates. Motion carried.

Moved by Alderman Damon, seconded by Alderman Feirer to adjourn. Motion carried.

Time: 6:43 p.m.

WEAtrust
45 Nob Hill Road | Madison, Wisconsin 53713-3959
800.279.4000 WEAtrust.com

Employer Group Application

Group Health Insurance

RENEWAL/CHANGE

Section 1—General Information

Employer (legal name): City of St. Francis **Group Number:** 32205

Address Changes:

Contact Person: Anne Anneu **Phone Number:** 414-481-2300 **E-mail:** anneu@stfranwi.org

Section 2—Health Plan Requested

1. **Effective Date of Health Plan Coverage:** 7/1/2020
   The employer must attach a copy of the proposal showing the plan type and benefits selected, signed and dated by the employer, herein incorporated by reference.
2. **Employer Contribution** (Indicate $ or %): **Single**: 13% **Family:** 13%

Section 3—Eligibility Information

1. **Employer Group Status:** Provide the average number of employees working at your business during the entire previous calendar year. Please use the numbers reported on **last year's** Quarterly Contribution Reports (UCT-101) filed with the State of Wisconsin to calculate average number of employees.
   Average Number of Employees: 103

   IMPORTANT: If average number of employees is 50 or less, STOP HERE—you are a small employer. Please contact a WEA Trust representative for information regarding a self-funded health plan option. The WEA Trust does not offer fully insured plans to small employers.

2. **Employee Information:** Please complete the following using the **most recent** Quarterly Contribution Report (UCT-101) and supporting Quarterly Wage Report (UC-7823). Enclose a copy of each with this application or submit a census of all employees, such as a current, complete payroll.
   a. Total number of employees: 146
   b. Number of seasonal, temporary, or part-time employees not eligible for coverage: 84
   c. Number of eligible employees (all permanent employees working at least 30 hours per week must be eligible for coverage): 62
   d. Number of eligible employees waiving coverage: 16
   e. Number of eligible employees applying for coverage (should equal the number in d subtracted from the number in c, and the number of subscribers enrolled): 46
3. **Define Eligible Employees for Your Plan:** List your current eligibility criteria, including class(es) of employee(s) and minimum hours per week required by employer to be eligible for coverage. (Must be 30 or fewer hours per week.) If you have different requirements for different classes of employees, please define each class and the applicable eligibility criteria for each class. All employees who work 30 hours or more per week
4. **If more than one health plan option is offered, are all plan options available to all eligible employee classes?**
   ☐ Yes ☐ No If no, please specify employee class(es) eligible for each. N/A
5. **Effective Date or Waiting Period for New Hires** (waiting period may not exceed 90 days):
   ■ First day worked ☐ First of month following _____ day(s) after first day worked. If hired on the first of the month, does coverage begin on the first of the month? ☐ YES ☐ NO ☐ Other:
   If you have different waiting periods for different classes of eligible employees, please list:

Employer Group Application
Group Health Insurance

WEA trust

Section 3—Eligibility Information (continued)

6. **Do you offer annual open enrollment in accordance with the Affordable Care Act (ACA)?** ☐NO ■YES
   If YES, please specify below when open enrollment will be held each year.
   Open Enrollment Period: From: Month_____Day_____ To: Month_____ Day_____
   (cannot exceed 31 days and must end prior to coverage effective date noted below)
   Coverage Effective Date: Month January Day 01
7. **Do you continue coverage for employees during a leave of absence?** ☐ NO ■ YES
   If coverage is continued during a paid leave of absence, for how long does it continue?
   ■ Until Accumulated Leave is Exhausted ☐ Other: _____

Section 4—Optional Eligibility Plan Provisions Elected (please select an option for each of the following)

1. **Retired Employee Continuation:** ☐ None ☐ Ongoing ■ Limited Duration*
2. **Disabled Employee Continuation:** ☐ None ☐ Ongoing ■ Limited Duration*
3. **Surviving Dependent Continuation:** ☐ None ☐ Ongoing ■ Limited Duration*
4. **Domestic Partner Coverage:** ■ NO ☐ YES
5. **Waiver of Premium:** ■ None ☐ 12 months ☐ 30 months
6. **Spouses Excluded:** ■ NO ☐ YES
7. **Drug Plan Coverage for Medicare Part D Eligible Individuals:** ■ NO ☐ YES

An Eligibility representative will call you.

Section 5—HRA and HSA Information

1. **Does your plan include an HSA?** ■ NO ☐ YES
2. **Does your plan include an HRA?** ☐ NO ■ YES
   If YES, complete the following:
   a. HRA Vendor: DBS
   b. HRA Covers: ■ Deductible ■ Copayment ☐ Coinsurance
   c. Class of Employees Eligible for HRA Reimbursement: _____
   d. If you have different eligibility requirements for different classes of employees, please list: _____
3. **If you provide continued coverage for retired employees, disabled employees, or surviving dependents as specified in Section 3 above, are these individuals eligible for the HRA?** ■ NO ☐ YES
4. **Claims Submission:** ☐ Electronic ■ Paper (member sends claims to HRA vendor for reimbursement)

Section 6—Employer's Certification

As an official representative for my organization, I understand and agree that:

- To the best of my knowledge and belief, all statements are true and accurate.
- The Trust may request further information if it deems necessary.
- The Trust may void or delay the implementation of coverage due to incomplete, inaccurate, or untimely information.
- An employee not actively at work on the assigned effective date will not be eligible until they have returned to work on a full-time basis, with the exception of vacation time, sick leave, or absence due to their own illness, medical condition or disability.
- I understand that no agent or other person has the authority to alter, bind the Trust, waive or change any terms, conditions, and/or provisions of the plan or any other requirement imposed by the Trust. Any alterations will invalidate this contract.
- This application is submitted to participate in the group health plan underwritten by the WEA Insurance Corporation.
- I have enclosed a copy of our most recent Quarterly Contribution Report (UCT-101) and supporting Quarterly Wage Report (UC-7823), or a current, complete employee census.

Employer Signature	**Date** (MM/DD/YYYY)
Print Name	**Title**