AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Application; Specified Disease; Organ & Tissue Tra

Action Requested: County Manager Signature

Parties to the Agreement: Application

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

Application for insurance coverage for organ and/or tissue transplant resulting from a specified disease - GPA as TPA eff 01/01/2020

Fiscal Impact:

Submitted by: Cheryl Seling **Submitter's Email Address:** cseling@gunnisoncounty.org

Finance Review: (●) Required ( ) Not Required

Comments:
Total administration costs for TPA will be less in 2020 than 2019. However, higher stop-loss costs expected.

Reviewed by: GUNCOUNTY1\lNienhueser Discharge Date: 1/27/2020

County Attorney Review: (●) Required ( ) Not Required

Comments:
ok db 1/30/20

Reveiwed by: GUNCOUNTY1\dBaumgarten Discharge Date: 1/30/2020 Certificate of Insurance Required

Yes ( ) No (●)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\emense Discharge Date: 1/31/2020

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 2/4/2020

Revised April 2015

HCC LIFE INSURANCE COMPANY
225 TownPark Drive, Suite 350
Kennesaw, Georgia 30144
1-800-447-0460

Specified Disease – Organ & Tissue Transplant Application

Administrative Office:
HCC Life Insurance Company
3600 Woodview Trace, Suite 180
Indianapolis, Indiana 46268
(888) 449-2377

Policy Applicant: Gunnison County, Colorado	**Telephone:** 970-641-7962	**Tax ID:** 84-6000770
Street Address: 200 East Virginia Ave.		
City: Gunnison	**State:** CO	**Zip Code:** 81230
Name(s) of Affiliates to be Included:	**Locations:**	

The Applicant is: ☒ Single Employer ☐ Trust ☐ Other

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 of Record (Name of Entity):
McPeters, Jerry

Covered Transplants:

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

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%

Rates: Single: $7.73 Family: $19.16

Name of Medical Plan Administrator: Group & Pension Administrators, Inc.	Name of PPO Network: PHCS POPPO
Requested Policy Effective Date (subject to acceptance): 01/01/2020	Medical Plan Utilizes Reference Based Pricing? ☒ Yes ☐ No

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

Within the 24 Months prior to the proposed effective date, 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 evaluation or transplant may be needed (regardless of the timeframe to transplant evaluation or transplant, and regardless of the individual's decision to move forward or not move forward with a transplant consultation or transplant evaluation;
2. Had a transplant consultation and/or transplant evaluation (regardless of the outcome);
3. Been scheduled to have a transplant consultation and/or transplant evaluation (regardless of when the transplant consultation and/or transplant evaluation was to be done and regardless of the outcome);
4. Received, or has been listed to receive, an organ or tissue transplant; and/or
5. Received dialysis treatments or been diagnosed with Chronic Kidney Disease or End Stage Renal Disease (ESRD)?

☐ Yes ☐ No

If "Yes," please provide a current list of all such individuals who meet any the above criteria, including: diagnosis, transplant type, dates of evaluation or acceptance by transplant facility (if applicable), 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.

Applicant's Signature: _____ Date: _____
Individual authorized to sign as Applicant

Printed Name: _____
Title: _____

Licensed Agent's Signature: _____ Date: _____

Printed Name: Jerry L. McPeters