City of Colton City Council
Special Session Meeting Agenda
Date: 09/15/2025 Time: 6:30 PM Meeting
Colton City Hall 309 E 4th St, Colton, SD,
57018

Call to Order/ Roll call: At 6:30pm, the meeting was called to order by Mayor Bunde in Colton City Hall. Council Members Bunjer, Evans, Lyon, Vande Voort, and Wochnick answered roll call. Finance Officer Pilker and Public Works Superintendent Jeritt Pedersen were also present.

1) A motion was made by Evans and seconded by Wochnick to approve the special meeting agenda. Motion passed with all members voting aye.

2) Public time had no requests at this meeting.

3) Ordinances, resolutions, policies, motions:
   a. A motion was made by Wochnick and seconded by Lyon for the Insurance Provider for the City of Colton to be switched to SDPAA. Motion passed with all members voting aye.
   b. A motion was made by Vande Voort and seconded by Bunjer adopt Resolution number 15-2025, for the Council to give Friends of Baseball authority for renovations and improvements to the Baseball Fields at Redway Park. Motion passed with all members voting aye.
   c. A motion was made by Lyon and seconded by Wochnick to approve coverage of $950.56 for the employee health plan for the Finance Office with the employee paying the additional coverage. Motion passed with all members voting aye.
   d. Council went over the first reading of the FY2026 budget. Adjustments will be made to reflect the new insurance provider, employee health plan, employee and council raises. Next budget reading will be at the October 20th regular monthly city council meeting.

3) Adjournment: The meeting was adjourned at 9:15pm by a motion made by Wochnick and seconded by Vande Voort. Motion passed with all members voting aye.

Respectfully Submitted,

Dawn Pilker

Colton Finance Officer

Published once at the approximate cost of $.

Mayor’s Summary for Resolution

The resolution before the Council gives the Colton Friends of Baseball, a dedicated local non-profit, clear and formal authority from the City of Colton to lead renovations and improvements to the baseball fields at Redway Park. By adopting this resolution, the City acknowledges the important role of Colton Friends of Baseball in maintaining and enhancing these facilities and entrusts them with the responsibility to move projects forward on behalf of the community.

While the Council will continue to provide oversight and final approval on proposed improvements, this action strengthens the partnership between the City and Colton Friends of Baseball by giving the organization expanded authority to plan, fundraise, and implement upgrades that will benefit the citizens of Colton and the surrounding Tri-Valley area.

Resolution No. 15-2025
City of Colton, South Dakota

A RESOLUTION AUTHORIZING THE COLTON FRIENDS OF BASEBALL TO RENOVATE THE BASEBALL FIELDS AT REDWAY PARK WITH COUNCIL APPROVAL

WHEREAS, the City of Colton recognizes the importance of providing and maintaining quality recreational facilities for the benefit of its residents and surrounding communities; and

WHEREAS, Redway Park is a vital community space that serves as a hub for youth recreation, community gatherings, and local baseball activities; and

WHEREAS, the Colton Friends of Baseball, a non-profit organization dedicated to promoting baseball and community engagement, has requested authority to plan and undertake renovations to the baseball fields located at Redway Park; and

WHEREAS, the City of Colton wishes to empower community-led efforts that improve public facilities, and recognizes the Colton Friends of Baseball as a trusted partner in carrying out these improvements.

NOW, THEREFORE, BE IT RESOLVED by the City Council of the City of Colton, South Dakota, that:

1. The Colton Friends of Baseball are hereby granted authority to plan and implement renovations to the baseball fields at Redway Park.

2. All renovation plans and construction activities must first be presented to and approved by the Colton City Council prior to commencement.

3. The City of Colton shall retain final oversight authority to ensure that the renovations meet community expectations, comply with applicable laws and regulations, and preserve the integrity of Redway Park as a public recreational facility.

4. The City of Colton hereby entrusts the Colton Friends of Baseball with primary responsibility for leading renovation and improvement efforts at the Redway Park baseball fields, working in partnership with the City Council.

5. The City of Colton extends its appreciation to the Colton Friends of Baseball for their leadership, commitment, and investment in improving recreational opportunities for current and future generations.

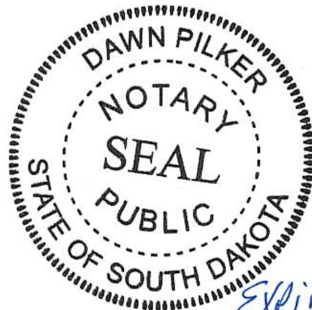
Adopted this 15 day of Sept, 2025, by the City Council of the City of Colton, South Dakota.

CITY OF COLTON, SOUTH DAKOTA

Mayor, Trevor Bunde

ATTEST:

Finance Officer



Expires 8-21-31

COUNCIL ACTION

Motion by: VandeVoort

Second by: Bunde

VOTE:
Yes ✓ No ______ Absent ______

Passed and approved this 15 day of Sept, 2025.

#103 - City of Colton 2025 RATES UPDATED

Monthly Billing Spreadsheet

PLAN_NAME	LAST_NAME	FIRST_NAME	SINGLE HEALTH	EMPLOYEE +1 HEALTH
~~HP1000~~	~~Fraser~~	~~Mikayla~~		

RETRO AMOUNTS

$0.00

TOTAL POLICIES	Amount	# of Policies	Total
Employee Health	$ 950.66	0	$0.00
Employee +1	$ 1,745.68	0	$0.00
Employee + Kids	$ 1,936.33	0	$0.00
Family	$ 2,251.56		$0.00

INVOICE TOTAL $0.00

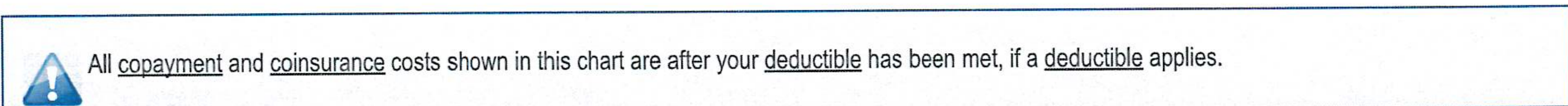
(Total coverage +/- Retros)

HP1000

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wellmark.com or call 1-800-774-0384. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-774-0384 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** person/**$2,000** family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care, in-network independent lab for mental health/substance abuse services and services subject to health and drug card copayments are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Health: **$2,000** person/**$4,000** family per calendar year. Drug Card: **$2,000** person/**$4,000** family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate together.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-774-0384 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why this Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per provider per date of service	40% coinsurance	Primary Care Provider (PCP) types can be found in the What You Pay section of your plan document.
	Specialist visit	$50 copay per provider per date of service	40% coinsurance	Applies to Non-PCP providers. $25 copay per provider per date of service for in-network chiropractic services. Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	Not covered	One preventive exam per calendar year. One mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. Waive cost-share on in-network independent lab services for mental health/ substance abuse.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	------None------

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-774-0384.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is at www.wellmark.com/prescriptions.	Tier 1	$10 copay per prescription	$10 copay per prescription	Refer to your Blue Rx Value Plus Drug List to determine the tier that applies to a covered drug. For out-of-network prescription drugs, you may be balance billed. 1 copay for 30-day supply. 2 copays for 90-day supply (Retail and Mail order). Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program. Specialty drugs on the PrudentRx drug list (found at Wellmark.com) will have 30% coinsurance. If you enroll with PrudentRx, you will have $0 member cost-share for drugs on the PrudentRx drug list. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
	Tier 2	$30 copay per prescription	$30 copay per prescription	
	Tier 3	$50 copay per prescription	$50 copay per prescription	
	Specialty drugs	Generic/Preferred: $85 copay per prescription Non-preferred: $150 copay per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	------None------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	------None------

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-774-0384.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	$200 copay per facility per date of service for facility and physician(s) combined	$200 copay per facility per date of service for facility and physician(s) combined	For emergency medical conditions treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act. When admitted from the emergency room, copay is waived and services are subject to deductible and coinsurance.
	Emergency medical transportation	20% coinsurance	20% coinsurance	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. You may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	Urgent care	$25 copay per provider per date of service for facility and physician(s) combined	40% coinsurance	CT, MRA, MRI, PET scans and voluntary sterilization are subject to deductible and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	------None------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $25 copay per provider per date of service Facility: 20% coinsurance	40% coinsurance	------None------
	Inpatient services	20% coinsurance	40% coinsurance	Residential treatment is covered with no 24 hour nursing supervision requirement.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	------None------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	------None------
	Rehabilitation services	Office: $25 PCP/$50 Non-PCP copay per provider per date of service Facility: 20% coinsurance	40% coinsurance	$25 copay per provider per date of service applies to in-network Physical and Occupational Therapists. Massage therapy is covered.
	Habilitation services	Office: $25 PCP/$50 Non-PCP copay per provider per date of service Facility: 20% coinsurance	40% coinsurance	$25 copay per provider per date of service applies to in-network Physical and Occupational Therapists. Massage therapy is covered.
	Skilled nursing care	20% coinsurance	40% coinsurance	------None------
	Durable medical equipment	20% coinsurance	40% coinsurance	Wigs are covered up to $500 per calendar year when hair loss results from alopecia or cancer. Orthopedic shoes, shoe inserts and accessories are covered. Trusses for back or hernia support are covered.
	Hospice services	20% coinsurance	40% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-774-0384.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	------None------
	Children's glasses	Not covered	Not covered	------None------
	Children's dental check-up	Not covered	Not covered	------None------

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-774-0384.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery • Custodial care - in home or facility • Dental care - Adult • Dental check-up • Extended home skilled nursing • Eye exam	• Glasses • Hearing aids • Infertility treatment • Long-term care • Routine eye care - Adult • Routine foot care • Some pharmacy drugs are not covered	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
• Applied Behavior Analysis therapy • Bariatric surgery • Chiropractic care • Most coverage provided outside the U.S. • Private-duty nursing - short term intermittent home skilled nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-774-0384 or the South Dakota Division of Insurance at 605-773-3563.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Wellmark Blue Cross and Blue Shield of South Dakota is an independent licensee of the Blue Cross and Blue Shield Association.

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

About These Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible — $1,000
- PCP copayment — $25
- Hospital(facility) coinsurance — 20%
- Other coinsurance — 20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$100
Coinsurance	$900
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$2,060**

Managing Joe's type 2 Diabetes
(a years of routine in-network care of a well-controlled condition)

- The plan's overall deductible — $1,000
- Specialist copayment — $50
- Hospital(facility) coinsurance — 20%
- Other coinsurance — 20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$1,370**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible — $1,000
- Specialist copayment — $50
- Hospital(facility) copayment — $200
- Other coinsurance — 20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

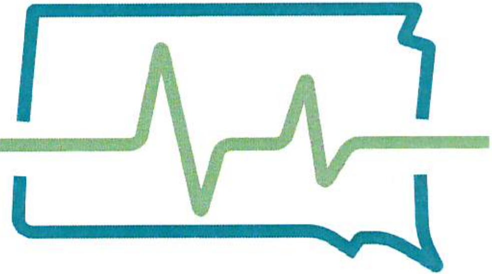
In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$500
Coinsurance	$40
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$1,540**

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Health Pool
of South Dakota



Health Coverage for Local Governments

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HEALTH CARE PLANS
Health Pool of South Dakota

	HP-1000	HP-2000	HP-3000	HP3500 (HDHP Embedded)	HP5000 (HDHP Embedded)
Deductible	$1000/$2000	$2000/$4000	$3000/$6000	$3500/$7000	$5000/$10000
Out of Pocket Max	$2000/$4000	$4000/$8000	$6000/$12000	$3500/$7000	$5000/$10000
Copay (PCP/nonPCP	25/$50	$30/$60	$40/$80	n/a	
Coinsurance		20%			
Urgent Care Copay	$25	$30	$40		
Doctor on Demand Copay		$15			
Emergency Copay		$200			
Rx Formulary		Blue Rx Value Plus		BlueRx Value Plus	
Copay		$10/$30/$50		n/a	
Biosimilar Specialty		$85			
Preferred Specialty		$85			
Non-preferred Specialty		$150			

Employee and dependant life insurance also available through our contractor, Mutual of Omaha.

GET A QUOTE

Lisa Nold, Director of Risk Sharing Services

800-658-3633

lisa@sdmunicipalleague.org

www.healthpoolsd.org

A risk-sharing pool created, sponsored, and endorsed by the **South Dakota Municipal League**