SJVIA
San Joaquin Valley Insurance Authority

# AGENDA



**Meeting Location:**
**Fresno County Employee Retirement Association Board Chambers**
**1111 H Street**
**Fresno, CA 93721**
**July 26, 2013**
**9:00 AM**

1. Call to Order
2. Roll Call
3. Approval of Agenda
4. Public Comment: At this time, members of the public may comment on any item, within the jurisdiction of the SJVIA, not appearing on the agenda. In order for everyone to be heard, please limit your comments to 3 minutes or less. Anyone wishing to be placed on the agenda for a specific topic should contact the SJVIA Manager's Office and submit correspondence at least 14 days before the desired date of appearance.
5. Approval of Minutes – Board Meeting of April 19, 2013
6. SJVIA Staff Change (A)
7. Authorization of the Release of Proposals and Execution of Participation Agreement(s)(A)
8. Approval of Amendment No. 3 to the Anthem Blue Cross Administrative Service Agreement (PPO), Anthem Blue Cross Group Benefit Agreement (HMO) and Funding Provision Minimum Premium Agreements (HMO) (A)
9. Approval of 2013 HM Life Specific and Aggregate Stop Loss Policy and Amendment No. 1 (A)
10. Extension of Agreements with Chimienti & Associates and Gallagher Benefit Services one-year through December 31, 2014 (A).
11. Receive and File Report on Retiree Pool Options (A)

*In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting, please contact the SJVIA Manager at 600-1810 or the Assistant SJVIA Manager at 636-4900. Notification 48 hours prior to the meeting will enable staff to make reasonable arrangements to ensure accessibility. Documents related to the items on this Agenda submitted to the Board after distribution of the Agenda packet are available for public inspection at the County of Fresno plaza Building, 2220 Tulare St, 14th Floor, Fresno, CA during normal business hours. All documents are also posted online to www.sjvia.org.*

SJVIA
San Joaquin Valley Insurance Authority

# AGENDA



**Meeting Location:**
**Fresno County Employee Retirement Association Board Chambers**
**1111 H Street**
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**July 26, 2013**
**9:00 AM**

12. Receive and File Preliminary January 1, 2014 health plan renewal. (I)
13. Receive and File Reports for Third Quarter Financial Statements and Investment Activity(I)
14. Receive and File SJVIA Executive Claims Summary through May 2013 (I)
15. Receive and File Report on Wellness Activities (I)
16. Directors Reports. (I)
17. Adjournment

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SJVIA
San Joaquin Valley Insurance Authority

# MINUTES



Meeting Location:
Tulare County
Human Resource and
Development Test Room
2900 W Burrel
Visalia, CA
April 19, 2013 9:00 AM

1. Call to Order

   Meeting was called to order by President Vander Poel at 9:04am.

2. Roll Call

   Roll was called by Brittany Howell, Gallagher Benefit Services. In attendance were Director Borgeas, Director Ennis, and Director Vander Poel. Director Steve Worthley was in attendance as an alternate. Director Case was not present at the time of roll but arrived at 9:08am.

3. Approval of Agenda

   President Vander Poel asked if there were any additions or corrections to the agenda. Jeff Cardell, SJVIA Manager, pointed out an error in the date on agenda item 5 which should be revised to February 1, 2013. Director Ennis moved to approve the agenda with the correction on the item 5; the motion was seconded by Director Worthley. The motion passed unanimously.

4. Public Comment: At this time, members of the public may comment on any item, within the jurisdiction of the SJVIA, not appearing on the agenda. In order for everyone to be heard, please limit your comments to 3 minutes or less. Anyone wishing to be placed on the agenda for a specific topic should contact the SJVIA Manager's Office and submit correspondence at least 14 days before the desired date of appearance.

   President Vander Poel opened the meeting for public comment.

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Meeting Location:
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Development Test Room
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Visalia, CA
April 19, 2013 9:00 AM

Margee Fallert, City of Tulare Administrative Services Director, informed the Board of the City's concern for their Pre-65 Retiree pool. Currently the City's early retirees are unblended from the actives. There are approximately 15 retirees on the plan and they are paying approximately $1,000 for single coverage. When joining SJVIA the City expressed a desire to create a larger retiree pool in order to lower the rates. The City would like these discussions regarding the Pre-65 program to begin among the Staff and Board Members as well as working on an actuarial study.

5. Approval of Minutes – Board Meeting of February 1, 2013

   Director Ennis moved to approve the February 1, 2013 Meeting Minutes, the motion was seconded by Director Worthley. The motion passed unanimously.

6. Receive and File Third Quarter Financial Statements and Investment Activity (I)

   Joseph Nuttman, ACTTC from Fresno County, gave a detailed overview of the quarterly financial reports. For the current quarter, the Revenue and Expenses Report shows that revenue is higher than budget and fixed costs are lower than budget. In addition, claims expenses are lower than budget. He pointed out a new section on the report which reflects Premium Expenses for Delta Dental and Vision Service Plan and both are running at lower than budget.

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Meeting Location:
Tulare County
Human Resource and
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2900 W Burrel
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April 19, 2013 9:00 AM

7. Receive and File SJVIA Executive Claims Summary through February 2013 (I)

   Alan Thaxter, Gallagher Benefit Services, gave a detailed overview of the claims summary. He pointed out the enrollment on page 5 which now includes the new entities, City of Tulare and City of Ceres, as well as the County of Tulare's HMO plan. In addition, page 8 reflects the total premium year to date and reserves thus far. He went on to explain that this reserve account is set aside for claims to be paid if the plan were ever to be terminated (incurred but not yet reported, IBNR). In addition, he pointed out that City of Ceres claims are not mature claims as they joined SJVIA this year.

8. Authorization of the Release of Proposals and Execution of Participation Agreement(s) (A)

   Paul Nerland, SJVIA Assistant Manager, asked for the approval to release illustrative proposals as well as participation agreements to those entities who are interested in joining SJVIA, specifically City of Sanger, City of Hanford, City of Shafter, City of Madera, City of Sonora, Amador Water District and San Joaquin Valley Air Pollution Control District. Of these entities, City of Sanger is highly likely to join SJVIA effective July 1, 2013. City of Hanford is very interested in joining SJVIA effective January 1, 2014 but they are currently with CalPERS and are still waiting for that renewal to be released.

   Director Case mentioned the fact that CalPERS includes all Retirees in their plan thus making it higher in cost and wondered how this might affect groups trying to leave that plan to join SJVIA. She asked if this

might create an opportunity to form a Post 65 Retiree plan or research what that may look like. Alan Thaxter suggested that Gallagher could find a more cost effective Post 65 solution for these entities who are leaving CalPERS and may need this option. This would also eliminate the GASB liability for the SJVIA on these Retirees.

Director Ennis moved to approve the Release of Proposals and Execution of Participation Agreements; the motion was seconded by Director Case. The motion passed unanimously.

9. Approve Amended & Restated JPA Agreement to Allow the Addition of the Central San Joaquin Valley Risk Management Authority as a Member of the San Joaquin Valley Insurance Authority (A)

Jeff Cardell, SJVIA Manager, explained the desire of the CSJVRMA to join SJVIA as a separate pool and asked for approval to amend the JPA Agreement to allow for this change. He stated that the RMA has gone through an extensive review process and will be making a recommendation to the Board of Directors in June to join SJVIA as a member entity. The benefit for SJVIA is that we are gaining a partner in the marketing efforts for SJVIA and essentially gaining membership. In addition, the RMA will benefit from this arrangement as the participating cities will be able to achieve a better rate by pooling their experience collectively rather than individually.

Director Case asked if the RMA joining SJVIA as a separate pool would hurt other entities joining SJVIA. Bruce Caldwell explained this probably would not happen due to the shared risk model that is in place currently because this model takes into account each entity's

experience but not at 100%. This allows the risk to be balanced between the participating entities.

Director Worthley moved to approve the Amended and Restated JPA Agreement, the motion was seconded by Director Ennis. The motion passed unanimously.

10. Results of the SJVIA Health Evaluations for 2013 (I)

Katie Nyby, Health and Wellness Consultant for Delta Health Systems, gave a detailed overview of the wellness results. The results showed a small decline in the participation from 2012 to 2013. Of those who participated this year, only 38% of the population who participated in 2012 returned. The top risk areas identified were high blood pressure, diabetes, liver conditions and high cholesterol. The average BMI was at the low end of obesity for females and high end of obesity for males. Approximately 57% of members were referred to a doctor however not all were critical. Alan Thaxter asked if benchmarking book of business or national averages can be added to the report.

Ms. Nyby went on to explain that in their book of business, participation is much higher when the employer offers an incentive to the wellness program. When there is zero incentive from the employer, Delta Health has found around 25% of the population will participate. Alternatively, participation moves to approximately 50% when there is an incentive from the employer. Director Vander Poel and Director Case agreed that SJVIA should consider moving forward in that direction by adding an incentive to the wellness program. In addition, Director Case suggested offering a second window for members to

participate in the program who were not able to take part earlier this year.

11. Funding Request for Wellness Activities (A)

Jeff Cardell gave some details on the Walking Challenge conducted last year between County of Tulare and County of Fresno. He explained the poor quality of pedometers received from the carriers last year and expressed the desire to purchase higher quality pedometers for each entity using SJVIA wellness funds for the Walking Challenge that will take place in May.

Director Worthley moved to approve the funding request, the motion was seconded by Director Ennis. The motion passed unanimously.

12. Revised Underwriting Guidelines (A)

Alan Thaxter gave details behind the underwriting guideline revisions and mentioned that the revisions are standard to all carrier underwriting guidelines. As we begin marketing to new groups, guidelines will be revised from time to time in order to keep SJVIA in the correct position as well as protect from adverse selection. Some of the revisions include added language in the guideline requirements, a surcharge added for some of the smaller groups and minor revisions to the stop loss coverage amounts for these smaller entities.

Director Worthley moved to approve the underwriting guidelines, the motion was seconded by Director Case. The motion passed unanimously.

SJVIA
San Joaquin Valley Insurance Authority

# MINUTES



Meeting Location:
Tulare County
Human Resource and
Development Test Room
2900 W Burrel
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April 19, 2013 9:00 AM

13. Directors Reports. (I)

    There were no reports.

14. Adjournment

    Meeting was adjourned at 10:34am by President Pete Vander Poel.

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SJVIA
San Joaquin Valley Insurance Authority



**Meeting Location:**
**Fresno County Employee Retirement Association Board Chambers**
**1111 H Street**
**Fresno, CA 93721**
**July 26, 2013 9:00 AM**

**AGENDA DATE:** July 26, 2013

**ITEM NUMBER:** 6

**SUBJECT:** SJVIA Staff Change

**REQUEST(S):** That the Board of Directors Appoint Paul Nerland as the SJVIA Manager and Rhonda Sjostrom as the Interim SJVIA Assistant Manager effective July 26, 2013.

**DESCRIPTION:**

Pursuant to the Joint Exercise of Powers Agreement creating the San Joaquin Valley Insurance Authority, certain staff members shall be appointed to serve at the pleasure of the Board of Directors. The Agreement reads that the SJVIA Manager shall be either the Humans Resources Director of the County of Tulare (COT) or the Director of Personnel Services or Employee Benefits Manager at the County of Fresno (COF).

At the November 9, 2012 meeting, your board appointed Jeffrey Cardell and Paul Nerland as Manager and Assistant Manager, respectively for a two year term as specified in the JPA Agreement. Recently, Jeffrey Cardell has accepted a position with another public entity and will no longer be serving as the Human Resources Director for the County of Tulare. As a result, today's recommendation is to appoint Paul Nerland as SJVIA Manager and Rhonda Sjostrom as Interim Assistant Manager to the SJVIA as she will fill the position as Interim Human Resource Director for the County of Tulare. Ms. Sjostrom

and Mr. Nerland will share the administrative responsibility required to oversee the SJVIA.

**FISCAL IMPACT/FINANCING:**

None at this time.

**ADMINISTRATIVE SIGN-OFF:**

Jeffrey Cardell
SJVIA Manager

Paul Nerland
Assistant SJVIA Manager

# BEFORE THE BOARD OF DIRECTORS
# SAN JOAQUIN VALLEY INSURANCE AUTHORITY

**IN THE MATTER OF** SJVIA Staff Change

**RESOLUTION NO.** _____
**AGREEMENT NO.** _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board of Directors Appointed Paul Nerland as the SJVIA Manager and Rhonda Sjostrom as the Interim SJVIA Assistant Manager effective July 26, 2013.

SJVIA
San Joaquin Valley Insurance Authority



**Meeting Location:**
**Fresno County Employee Retirement Association Board Chambers**
**1111 H Street**
**Fresno, CA 93721**
**July 26, 2013 9:00 AM**

**AGENDA DATE:** July 26, 2013

**ITEM NUMBER:** 7

**SUBJECT:** Authorization of the Release of Proposals and Execution of Participation Agreement(s)

**REQUEST(S):** That the Board of Directors approve the release of proposals for the Cities of Taft and Gustine and authorize the Board President to execute related participation agreements.

**DESCRIPTION:**

On November 5, 2010, to allow for growth of the SJVIA, your Board approved Member Underwriting Guidelines and the SJVIA Growth Implementation and Marketing Plan. These documents provide the framework for the prudent growth of the SJVIA which will facilitate fixed cost reductions and pricing stability over time.

Gallagher Benefit Services (GBS), at the direction of SJVIA Staff, has since undertaken marketing efforts to identify and make contact with prospective member entities to consider joining the JPA. Attached is an exhibit that shows the extent of these marketing efforts.

The Underwriting Committee has reviewed the proposals and seeks to release illustrative proposals to the Cities of Taft and Gustine.

**AGENDA**: San Joaquin Valley Insurance Authority

**DATE:** July 26, 2013

Contingent upon acceptance and approval of the respective entities governing bodies it is recommended that the Board authorize the Board President to execute the participation agreement(s).

**FISCAL IMPACT/FINANCING:**

None at this time. If any of the entities join the SJVIA the budget will be adjusted accordingly.

**ADMINISTRATIVE SIGN-OFF:**

Jeffrey Cardell
SJVIA Manager

Paul Nerland
Assistant SJVIA Manager

# BEFORE THE BOARD OF DIRECTORS
# SAN JOAQUIN VALLEY INSURANCE AUTHORITY

**IN THE MATTER OF** Authorization of the Release of Proposals and Execution of Participation Agreements.

**RESOLUTION NO.** _____
**AGREEMENT NO.** _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board of Directors approved releasing proposals for the Cities of Taft and Gustine and authorized the Board President to execute related participation agreements.

SJVIA
San Joaquin Valley
Insurance Authority

# New Member Activity

## MEMBER GROUPS:

| | City: | Status to Date: | Effective | EE's |
|---|---|---|---|---|
| 1 | **Ceres** | Joined SJVIA | Jan-13 | 115 |
| 2 | **Sanger** | Joined SJVIA | Jul-13 | 105 |
| 3 | **Shafter** | Joined SJVIA | Jul-13 | 60 |
| 4 | **Tulare** | Joined SJVIA | Jul-12 | 334 |
| 5 | **Waterford** | Joined SJVIA | Jun-13 | 12 |
| 6 | **San Joaquin** | Joined SJVIA | Jul-13 | 15 |
| | | | **TOTAL** | 641 |

## ACTIVE PROSPECTIVE NEW MEMBERS:

| | City: | Status to Date: | Effective | EE's | Quote request 2013 | Presentation Due: | Meeting Set 2013 | SJVIA Committee Approval | SJVIA Board Approval | Decision 2013 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **Lathrop** | Active | January | 78 | Stacy | Quote due: 4/22/2013 | 11-Jun-13 | Committee Approved | | |
| 2 | **Dos Palos** | Active | August | 17 | Stacy | Quote Delivered | 21-May-13 | Committee Approved | Board Approved | |
| 3 | **County of Glenn** | Active | January | 401 | Alan/Justin | Quote Due 5/13/13 | N/A | | | |
| 4 | **Hanford** | Active | January | 100 | Mark | Quote Delivered | 26-Apr-13 | Committee Approved | Board Approved | |
| 5 | **Reedley** | Active | January | 115 | LeRoy | Quote Delivered | 1-Jun-13 | Committee Approved | Board Approved | |
| 6 | **Gustine** | Active | July | 17 | Stacy | Quote Delivered | 2-May-13 | Committee Approved | | |
| 7 | **Huron** | Active | July | 15 | Stacy | Quote due: 4/22/2013 | 14-May-13 | Committee Approved | | |
| 8 | **Kerman** | Active | July | 53 | Stacy | Quote Delivered | 24-May-13 | Committee Approved | Board Approved | |
| 9 | **Atwater** | Active | January | 150 | Stacy | Need More Data | | | | |
| 10 | **Taft** | Active | September | 48 | Stacy | Quote due: 5/30/2013 | 19-Jun-13 | Committee Approved | | |
| 11 | **Port of Stockton** | Active | January | 68 | Alan/Justin | Quote Due: 4/22/2013 | N/A | | | |
| 12 | **City of Selma** | Active | January | 79 | Stacy | Quote Due: 7/12/2013 | | | | |
| 13 | **Hollister** | Active | January | 117 | Stacy | Quote due: Need info | | | | |

SJVIA
San Joaquin Valley Insurance Authority

# New Member Activity

## RECEIVED SJVIA PROPOSAL BUT ELECTED NOT TO JOIN:

| | City: | Status to Date: | Effective | EE's | Quote request 2013 | Presentation Due: | Meeting Set 2013 | SJVIA Committee Approval | SJVIA Board Approval | Decision 2013 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **City of Madera** | **Declined for 2013** | July | 246 | Keenan | Quote Delivered | 2-May-13 | Committee Approved | Board Approved | No |
| 2 | **Clovis** | **Declined for 2013** | January | 384 | Keenan | Quote Delivered | | | | No |
| 3 | **Corcoran** | **Declined for 2013** | July | 60 | LeRoy | Quote Delivered | | | | No |
| 4 | **Delano** | **Declined for 2013** | July | 197 | Alan | Quote Delivered | | | | No |
| 5 | **Escalon** | **Declined for 2013** | Jan | 23 | Stacy | Quote Delivered | | | | No |
| 6 | **Mendota** | **Declined for 2013** | May | 28 | Mark | Quote Delivered | | | | No |
| 7 | **Riverbank** | **Declined for 2013** | July | 45 | LeRoy | Quote Delivered | | | | No |
| 8 | **SJV Air Pollution Ctrl.** | **Declined for 2013** | January | 269 | Mark | Quote Delivered | | Committee Approved | Board Approved | No |
| 9 | **Sonora** | **Declined for 2013** | June | 35 | Stacy | Quote Delivered | 15-Apr-13 | Committee Approved | Board Approved | No |

## CONTACTED OR EXPRESSED INTEREST BUT DID NOT PROVIDE SUFFICIENT DATA TO QUOTE:

| | City: | Status to Date: | Effective | EE's | Quote request 2013 | Presentation Due: | Meeting Set 2013 | SJVIA Committee Approval | SJVIA Board Approval | Decision 2013 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **County of Madera** | **Declined for 2013** | December | 28 | Mark | | | | | No |
| 2 | **Amador Water Dist.** | Active- Quoting | January? | | Mark/Justin | Quote Delivered | | Committee Approved | Board Approved | No |
| 3 | **County of Stanislaus** | Active- Quoting | January? | | Mark | | | | | Inactive |
| 4 | **Arvin** | Inactive | January | 45 | Stacy | | | | | Inactive |
| 5 | **Avenal** | Inactive | October | 47 | Stacy | | | | | Inactive |
| 6 | **Chowchilla** | Inactive | June | 44 | Stacy | | | | | Inactive |
| 7 | **Dinuba** | Inactive | July | 122 | Stacy | | | | | Inactive |
| 8 | **Exeter** | Inactive | February | 38 | Stacy | | | | | Inactive |
| 9 | **Firebaugh** | Inactive | January | 37 | Stacy | | | | | Inactive |
| 10 | **Fowler** | Inactive | September | 20 | Stacy | | | | | Inactive |
| 11 | **Kingsburg** | Inactive | Feb | 45 | Stacy | | | | | Inactive |
| 12 | **Newman** | Inactive | January | 29 | Stacy | | | | | Inactive |
| 13 | **Orange Cove** | Inactive | July | 37 | Stacy | | | | | Inactive |
| 14 | **Ripon** | Inactive | January | 88 | Stacy | | | | | Inactive |
| 15 | **Tehachapi** | Inactive | January | 50 | Stacy | | | | | Inactive |
| 16 | **Wasco** | Inactive | January | 54 | Stacy | | | | | Inactive |
| 17 | **Woodlake** | Inactive | December | 28 | Stacy | | | | | Inactive |

SJVIA
San Joaquin Valley Insurance Authority



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**1111 H Street**
**Fresno, CA 93721**
**July 26, 2013 9:00 AM**

**AGENDA DATE:** July 26, 2013

**ITEM NUMBER:** 8

**SUBJECT:** Approval of Amendment 3 to the Anthem Blue Cross Administrative Service Agreement (PPO), Anthem Blue Cross Group Benefit Agreement (HMO) and Funding Provision Minimum Premium Agreements (HMO)

**REQUEST(S):** That the Board approve Amendment 3 to the Anthem Blue Cross Administrative Services Only Agreement (PPO), Anthem Blue Cross Group Benefit Agreement (HMO) and Funding Provision Minimum Premium Agreements (HMO) and authorize the SJVIA Board President to execute the agreements.

**DESCRIPTION:**

The 2013 Anthem Blue Cross Contracts for Administrative services for the PPO plans as well as the 2013 Minimum Premium Agreement for the HMO plan have been reviewed and approved by SJVIA Counsel, SJVIA Staff and Gallagher Benefit Services. These contracts are ready for approval by the SJVIA Board and execution by the SJVIA Board President. The primary difference between the 2012 and 2013 agreements is the addition of new groups to the HMO plan has resulted in additional funding provisions to recognize the demographic and geographical impacts for each group. Specifically, the County of Tulare and the City of Ceres began participating in the SJVIA HMO plan effective January 1, 2013. Costs referenced in this agreement are consistent with rates that are already incorporated in the approved 2013 SJVIA health rates.

| **Agreement** | **Summary of Services** |
|---|---|
| 2013 Anthem Blue Cross Minimum Premium Master/Funding Agreements | This Agreement governs the banking and claims liability for the HMO program. Due to multiple factors reviewed in the underwriting processes, groups participating in the HMO may receive pricing different from the core HMO participant, the County of Fresno. Separate Funding Agreements are included for County of Fresno, County of Tulare, and City of Ceres. Additional documents for groups added to follow as required. |
| 2013 Anthem Blue Cross HMO Group Benefit Agreement | This Agreement governs the HMO program and specifies eligibility, rates, payment terms. This document also contains the evidence of coverage and disclosure forms that are issued to all participants covered by this agreement. This document does not require signature but is referenced in the Minimum Premium Funding Agreement. |
| 2013 Amendment 3 to the Anthem Administrative Services Agreement | Anthem Blue Cross provides administrative services for the PPO plans for the SJVIA. Anthem adjudicates and pays claims to providers for the 7 PPO plans the SJVIA offers. In addition to Anthem's administrative services, this contract also provides access to the Anthem Blue Cross network of providers. This amendment updates the contract with current rates and other contract provisions. |

**AGENDA**: San Joaquin Valley Insurance Authority

**DATE:** July 26, 2013

**FISCAL IMPACT/FINANCING:**

None at this time.

**ADMINISTRATIVE SIGN-OFF:**

| | |
|---|---|
| Jeffrey Cardell<br>SJVIA Manager | Paul Nerland<br>Assistant SJVIA Manager |

# BEFORE THE BOARD OF DIRECTORS
# SAN JOAQUIN VALLEY INSURANCE AUTHORITY

**IN THE MATTER OF** Approval of Amendment 3 to the Anthem Blue Cross Administrative Service Agreement (PPO), Anthem Blue Cross Group Benefit Agreement (HMO) and Funding Provision Minimum Premium Agreement (HMO)

**RESOLUTION NO.** _____
**AGREEMENT NO.** _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * * *

That the Board Approved Amendment 3 to the Anthem Blue Cross Administrative Services Only Agreement (PPO), Anthem Blue Cross Group Benefit Agreement (HMO) and Funding Provision Minimum Premium Agreement (HMO) and authorized the SJVIA Board President to execute the agreements.

**AMENDMENT 3 TO THE**
**ADMINISTRATIVE SERVICES AGREEMENT**
**WITH**
**San Joaquin Valley Insurance Authority**

This is an Amendment to the Administrative Services Agreement as of January 1, 2013. This Amendment shall supplement and amend the Agreement between Plan Sponsor and Anthem Blue Cross Life and Health Insurance Company. If there are any inconsistencies between the terms of the Agreement and this Amendment, the terms of this Amendment shall control.

**1. The definition "PERFORMANCE PAYMENTS" is deleted in its entirety and replaced by the following:**

**PERFORMANCE PAYMENTS**. If a Provider or Vendor participates in any Anthem program in which performance incentives, rewards or bonuses ("Performance Payments") are paid based on the achievement of certain goals, outcomes or performance standards adopted by Anthem (collectively, "Performance Targets"), Paid Claims shall also include the amount of such Performance Payments. Such Performance Payments may be charged to Plan Sponsor on a per Claim, lump sum, per Subscriber, per Member, or a pro-rata apportionment basis. The amount charged to Plan Sponsor may be greater than the amount actually paid to any one particular Provider or Vendor pursuant to the terms of the contract with such Provider or Vendor. Anthem shall retain the difference, if any, between the amount invoiced to Plan Sponsor and the amount paid to any Provider or Vendor as a fee Anthem charges to oversee such programs. In no event shall the amount charged to Plan Sponsor be greater than its proportionate share of total Performance Payments

**2. The Agreement is expanded to include Article 2 - Administrative Services Provided by Anthem, as follows:**

y) Anthem will provide Plan Sponsor with Plan information and assistance necessary for the preparation of the Plan's Summary of Benefits and Coverage ("SBC") related to the elements of the Plan that Anthem administers. Plan Sponsor is solely responsible for ensuring that the SBC accurately reflects the benefits Plan Sponsor will offer and for finalizing and distributing the SBC to Subscribers. Notwithstanding the provisions in Article 18(a), if Plan Sponsor's open enrollment period is at a time other than 30 days prior to the end of an Agreement Period, Plan Sponsor agrees to provide Anthem with any changes to the benefits Anthem administers at least 60 days prior to the start of the open enrollment period.

**3. Paragraph c of Article 13 - Recovery Services is deleted in its entirety and replaced by the following:**

c) Notwithstanding any other provision of this Article 13, Anthem will periodically perform audits of Provider and Vendor contracts and other Claims audits to determine if Claims were accurately paid. Anthem shall have authority to enter into a settlement or compromise regarding these audits, including, but not limited to, the right to reduce future reimbursement to Provider or Vendor in lieu of a lump sum settlement. If Anthem conducts an audit and makes a recovery as a result of such audit of Claims accuracy, then Anthem shall provide Plan Sponsor a credit, after a reduction of third party vendor fees or costs, if any. Anthem shall credit Plan Sponsor a proportionate share of the net recovery equal to the ratio of (1) total Members' Paid Claims to such Provider or Vendor for the audit period, to (2) total payments made to such Provider or Vendor for all of Anthem's business during the audit period. Notwithstanding the above, Anthem shall retain any recoveries made from a Provider or Vendor resulting from any audits if the cost to administer the refund is likely to exceed the total recovery from the Provider or Vendor.

4. Schedule A is replaced by the attached Schedule A.

5. Schedule B is replaced by the attached Schedule B.

Anthem Blue Cross Life and Health
Insurance Company

By: Pam Kehaly

Title: President and General Manager

Date: November 26, 2012

**SCHEDULE A**
**TO**
**ADMINISTRATIVE SERVICES AGREEMENT**
**WITH**
**SAN JOAQUIN VALLEY INSURANCE AUTHORITY**

This Schedule A shall govern the Agreement Period from January 1, 2013 through December 31, 2013. For purposes of this Agreement Period, this Schedule shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules, and this Schedule A, the terms of this Schedule A shall control.

**Section 1. Effective Date and Renewal Notice**

This Agreement Period shall be from 12:01 a.m. January 1, 2013 to the end of the day of December 31, 2012.

Paid Claims shall be processed pursuant to the terms of this Agreement when incurred and paid as follows:

Incurred from December 1, 2009 through December 31, 2013 and
Paid from January 1, 2013 through December 31, 2013.

Anthem Blue Cross Life and Health shall provide any offer to renew this Agreement at least 120 days prior to the end of an Agreement Period.

**Section 2. Broker or Consultant Base Compensation**

Not Applicable

**Section 3. Fees**

**A. Administrative Services Fee**

PPO Plan Composite $27.53 per Subscriber per month

Lumenos Plan Composite $27.53 per Subscriber per month

Article 3(a) Retroactive Adjustments to Enrollment.

Anthem Blue Cross Life and Health shall credit Administrative Services Fees for each retroactive deletion up to a maximum of 60 days and shall charge Administrative Services Fees for each retroactive addition up to a maximum of 60 days.

**B. Optional Program Fees**

Not Applicable

**C. Other Fees or Credits**

Conversion right to an individual insured policy upon termination of coverage. Anthem Blue Cross Life and Health shall have no obligation to provide conversion rights in instances in which this Agreement is terminated for failure to pay any amounts due under this Agreement. The fee shall be:$1,500 per Member conversion

**Section 4. Paid Claims, Billing Cycle and Payment Method**

**A. Claims also include the following amounts or charges:**

NCN When Anthem Blue Cross Life and Health, in its discretion, forwards a non-Network Provider Claim to NCN to negotiate with the non-Network Provider, Plan Sponsor will pay a fee equal to 40% of the difference between the non-Network Provider's Billed Charges and the amount Anthem Blue Cross Life and Health

uses to calculate Plan liability for the Covered Services (the "Plan Liability Amount"). In the case of hospital or facility Provider Claims in non-Anthem Blue Cross Life and Health or non-Anthem Blue Cross Life and Health Affiliate states, if negotiations are successful, the Plan Liability Amount will be based on the negotiated rate. If negotiations are not successful, the Plan Liability Amount shall be determined using NCN's Data iSight tool if Data iSight pricing is lower than Host Blue pricing. If Data iSight pricing is not lower than Host Blue pricing, the Plan Liability Amount will be determined based on Host Blue pricing and there will be no fee charged. In the case of professional Provider Claims in all states, and/or hospital or facility Provider Claims in Anthem Blue Cross Life and Health states or Anthem Blue Cross Life and Health Affiliate states, if negotiations are successful the Plan Liability Amount will be based upon NCN's negotiated rate. If negotiations are not successful, there will be no fee charged as the Plan Liability Amount will be determined based on Host Blue pricing.

**B. Billing Cycle**

Refer to the Banking Arrangement Schedule of this Agreement.

**C. Payment Method**

Refer to the Banking Arrangement Schedule of this Agreement.

**Section 5. Administrative Services Fee Billing Cycle and Payment Method**

**A. Billing Cycle**

Monthly List Bill (pay as billed)

Anthem Blue Cross Life and Health shall notify Plan Sponsor of the amount due to Anthem Blue Cross Life and Health pursuant to Section 3 of Schedule A according to the billing cycle described above. The actual date of notification of amounts due and the Invoice Due Date will be determined according to Anthem Blue Cross Life and Health's regular business practices and systems capabilities.

**B. Payment Method**

Check Reimbursement. Plan Sponsor shall provide the amount due by check to Anthem Blue Cross Life and Health through a designated lockbox address as designated on the Administrative fee billing coupon. The check shall be made in accordance with any policies and regulations of the bank necessary to assure that the deposit is credited to Anthem Blue Cross Life and Health's account no later than the next business day.

**Section 6. Claims Runout Services**

**A. Claims Runout Period**

Claims Runout Period shall be for the 12 months following the date of termination of this Agreement.

**B. Claims Runout Administrative Services Fees**

Claims Runout Administrative Services Fee will be equal to 6% of Claims processed and paid by Anthem Blue Cross Life and Health or through the Inter-Plan Programs.

**Section 7. Other Amendments. The Administrative Services Agreement is otherwise amended as follows:**

BlueCard Program, Other Inter-Plan Programs and Non-Network Provider Fees

As described in Article 15, certain fees and compensation may be charged each time a Claim is processed through the BlueCard Program, other Inter-Plan Programs, including Negotiated National Account Arrangements, and non-participating Provider Claims. The extent to which they are (i) included in the Administrative Services Fee; or (ii) included in Paid Claims or separately billed to Plan Sponsor is as follows:

Included in Administrative Services Fee:

Negotiated National Account Arrangement administrative and/or network access fee. It may be based on either a per Claim, per Subscriber per month or per Member per month basis.

BlueCard Program toll-free number fee

BlueCard Program PPO health care provider directory fee

Included in Paid Claims or separately billed to Plan Sponsor:

Access fee, which is a percentage of the discount/differential Anthem Blue Cross Life and Health, receives from the Host Blue, based on the current rate in accordance with the BlueCard Program's standard procedures for establishing the access fee rate. The access fee will not exceed $2,000 for any Claim.

Administrative expense allowance fee ("AEA")

Central Financial Agency fee

ITS transaction fee

Non-Network Provider Claim fees, which include, but are not limited to (administrative expense allowance fees) (Central Financial Agency Fees) and (ITS Transaction Fees)

**Notice of Loss of Grandfathering Status**

In the event Plan Sponsor maintains a grandfathered health plan(s), as that term is used in the Patient Protection and Affordable Care Act ("PPACA"), Plan Sponsor shall not make any changes to such plan(s), including, but not limited to, changes with respect to Plan Sponsor contribution levels, without providing Anthem Blue Cross Life and Health with advance written notice of the intent to change such plan(s). Making changes to grandfathered plans without notice to Anthem Blue Cross Life and Health may result in the plan(s) losing grandfathered status and significant penalties and/or fines to Plan Sponsor and Anthem Blue Cross Life and Health. In the event Plan Sponsor implements changes to its plan(s) and does not provide advance notice to Anthem Blue Cross Life and Health, Plan Sponsor agrees to indemnify Anthem Blue Cross Life and Health according to the indemnification provisions set forth elsewhere in this Agreement for any penalties, fines or other costs assessed against Anthem Blue Cross Life and Health.

Additionally, at each renewal after September 23, 2010, Plan Sponsor shall affirm in writing, upon reasonable request of Anthem Blue Cross Life and Health, that it has not made changes to its plan(s) that would cause the plan(s) to lose its/their grandfathered status.

Anthem Blue Cross Life and Health Insurance Company

By: Pam Kehaly

Title: President and General Manager

Date: November 26, 2012

**SCHEDULE B**
**TO**
**ADMINISTRATIVE SERVICES AGREEMENT**
**WITH**
**SAN JOAQUIN VALLEY INSURANCE AUTHORITY**

This Schedule B shall govern the Agreement Period from January 1, 2013 through December 31, 2013. For the purposes of this Agreement Period, this Schedule B shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedule and this Schedule B, the terms of this Schedule B shall control.

**SERVICES INCLUDED IN THE ADMINISTRATION FEE IN SECTION 3A OF SCHEDULE A**

**Management Services**:

Anthem standard Benefits and administration, unless otherwise noted below::

- Anthem definitions, and exclusions
- Anthem complaint and appeals process
- Claims incurred and paid as provided in Schedule A
- Accumulation toward plan maximums beginning at zero on effective date
- Anthem Claim forms
- Standard ID card
- Standard Explanation of Benefits

Acceptance of electronic submission of eligibility information in HIPAA-compliant format

Preparation of Benefits Booklet (accessible via internet)

Account reporting – standard data reports

Billing and Banking Services

- See Schedules A and C of this Agreement

Plan Design consultation

Employer eServices

- Add and delete Members
- Download administrative forms
- View Member Benefits and request ID cards
- View eligibility
- View Claim status and detail

**Claims and Customer Services**:

Claims processing services

Coordination of Benefits

Recovery Services

Medicare crossover processing

Complaint and appeals processing

- One mandatory level of appeal, one voluntary level of appeal

Employer customer service, standard business hours

Member customer service, standard business hours

1099s prepared and delivered to Providers

Residency-based assessments and/or surcharges and other legislative reporting requirements Member eServices

**Prescription Benefit Services through PBM:**

- Mail Order pharmacy
- Specialty Pharmacy Services

- Prescription eServices
  - Pharmacy locator
  - Online formulary

- Point of sale claims processing
- Mail order claims processing
- Mail order call center with toll free number
- Mail order regular shipping and handling
- Standard management reports
- Ad hoc reports (subject to additional programming charge if required)
- Concurrent Drug Utilization Review (DUR) programs
- Retrospective DURs
- Administrative override (i.e., vacation, lost, stolen or spilled medications)
- Clinical review
- Pharmacy help desk with toll free number

Pharmacy audits (desk and onsite; routine, in depth or focused)

**Health Care Management and 360° Health Services**:

Health Care Management

- Referrals
- Utilization management
- Case management
- Anthem Medical Policy

SpecialOffers

HealthCare Advisor

Care Comparison (where available)

Transplant services – Blues Distinction

Healthy Solutions Newsletter (available online)

MyHealth (Member Portal)

Electronic Health Risk Assessment

Personal Health Record

Online Communities

Member Alerts

360° Health Services (PPO Plans)

- Core 5 Condition Care (inlcudes Asthma, Pulmonary Disease, Congestive Heart Failure, Coronary Artery Disease, & Diabetes), Future Mom's, Complex Care, & 24/7 Nurseline (w/o promotion)
- Bariatric Case Management

**Networks**:

- Access to networks
  - Provider Network
  - Mental Health/Substance Abuse Network
  - Coronary Services Network
  - Human Organ and Tissue Transplant Network
  - Complex and Rare Cancer Network
  - Bariatric Surgery Network

- Cost Management/Quality improvement program
  - Credentialing
  - Hospital audit program
  - Anthem standard Claims bundling edits

- Anthem.com Provider directory

**OPTIONAL PROGRAMS – FEES LISTED IN SECTION 3B, 3C OR 4A OF SCHEDULE A**

In addition to the services listed above, Anthem agrees to provide all services that are listed in Schedule A and for which Employer has agreed to pay a separate fee.

Anthem Blue Cross Life and Health Insurance Company

By: Pam Kehaly

Title: President and General Manager

Date: November 26, 2012

# ANTHEM BLUE CROSS HMO

## GROUP BENEFIT AGREEMENT

(the *agreement*)

for

## SAN JOAQUIN VALLEY INSURANCE AUTHORITY

(the *group*)

**AGREEMENT EFFECTIVE DATE: December 10, 2012**

BLUE CROSS OF CALIFORNIA, doing business under the trade name ANTHEM BLUE CROSS ("Anthem") agrees to provide the benefits of this *agreement* for enrolled *members* of the *group*. These benefits are subject to all of the terms and conditions of this *agreement*.

To the extent not preempted by federal law or regulation, this *agreement* will be governed, interpreted and enforced to remain in compliance with the laws of the state of California, along with applicable federal statutes and regulations. Nothing contained in this *agreement* will be construed as Anthem doing business in any state or jurisdiction in which it is not duly authorized.

This *agreement* has been approved by the officers of Anthem to become effective at 12:01 A.M. Pacific Standard Time on the Agreement Effective Date shown above. Payment of the first monthly subscription charges indicates the *group's* acceptance of this *agreement*. It continues from month to month as long as the required subscription charges are paid, unless it is terminated as described in GENERAL PROVISIONS: CANCELLATION.

The change in Agreement Effective Date from the preceding *agreement* indicates a change in terms and provisions and is thus a modification and continuation of the *agreement* between Anthem and the Group to provide group benefits.

President

Secretary

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The *italicized* terms appearing in these administrative pages are defined in the Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form.

# GENERAL PROVISIONS

## AGREEMENT COMPONENTS

The entire *agreement* consists of:

1. these administrative pages, including any endorsements;
2. all Combined Evidence of Coverage and Disclosure Forms, including any amendments, which are made a part of this *agreement*;
3. the application of the *group*; and
4. the individual applications, if any, of eligible persons.

This *agreement* does not include the charter or by-laws of Anthem.

## LIABILITY FOR STATEMENTS

No statement made by the *group*, unless it appears on the written application or is fraudulent, will be used in any contest of the coverage under this *agreement*. Statements made by the *group* shall not be deemed warranties. After the coverage under this *agreement* has been in force for 24 months, no statement will be used in any contest of the coverage under this *agreement*.

## ENROLLMENT REQUIREMENTS

All of the persons eligible to be employees, who are not enrolled under another group-sponsored plan, must be enrolled as employees under this *agreement*. If the number of employees enrolled falls below either: (1) **75%** of the persons eligible to enroll as employees; or (2) **40** employees, Anthem may cancel or decline to renew this *agreement*. Anthem may also cancel or decline to renew this *agreement* if the *group* has less than **51** eligible employees.

## AGREEMENT CHANGES

No agent of Anthem may change this *agreement* or waive any of its contents. Anthem and the *group* may change any of the provisions of this *agreement* at any time by mutual consent. Anthem may also change this *agreement* as provided in 2 below.

No change in this *agreement* is valid unless the change is made in one of the following ways:

1. In the case of a written request by the *group* for a change, by an endorsement signed by the officers of Anthem; and (b) accepted by the *group* as evidenced by its payment of the subscription charges on and after the effective date of such change.

2. In the case of a change required by Anthem, by an endorsement that is: (a) signed by the officers of Anthem; and (b) accepted by the *group* as evidenced by its payment of the subscription charges on and after the effective date of such change. Anthem will give the *group* written notice of its intent to make such a change at least 60 days in advance of its effective date.

# GENERAL PROVISIONS

## CONTRACT LANGUAGE

In the event the *group* maintains a grandfathered health plan(s), as that term is used in the Patient Protection and Affordable Care Act ("PPACA"), the *group* shall not make any changes to such plan(s), including, but not limited to, changes with respect to employer contribution levels, without providing Anthem with advance written notice of the intent to change such plan(s). Making changes to grandfathered plans without notice to Anthem may result in the plan(s) losing grandfathered status and significant penalties and/or fines to the *group* and Anthem. In the event the *group* implements changes to its plan(s) and does not provide advance notice to Anthem, the *group* agrees to hold harmless Anthem from any penalties, fines or other costs assessed against Anthem and to reimburse Anthem from any such penalties, fines or other costs.

Additionally, at each renewal after September 23, 2010, the *group* shall affirm in writing, upon reasonable request of Anthem, that it has not made changes to its plan(s) that would cause the plan(s) to lose it/their grandfathered status.

## INTERPRETATION OF PROVIDER CONTRACTS

Subject to applicable California state or federal law and regulation, Anthem shall have final authority to interpret its contracts with providers, and the *group* agrees that (a) it is not a party to Anthem's contracts with providers and (b) it will accept Anthem's interpretation of said provider contracts. Furthermore, Anthem shall have full authority and discretion to resolve any questions or disputes with providers that participate in any of Anthem's provider networks, except as applicable law provides for judicial or regulatory review of such disputes, and the *group* will accept said resolution of such matters as final.

## CLERICAL ERRORS

1. Clerical errors made by the *group* do not deprive any *member* of his or her coverage under this *agreement*, provided that the enrollment form or membership change form is: (a) completed according to the WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE section of the Evidence of Coverage Form; and (b) received by Anthem within 90 days of the eligibility date of a *member's* coverage. Enrollment forms which are received by Anthem more than 90 days after the *member's* eligibility date will be processed in accordance with the WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE section of the Evidence of Coverage Form.

2. Clerical errors made by the *group* will not continue any *member's* coverage which would not otherwise be effective.

3. Any subscription charge adjustment due to the correction of a clerical error will be made on the next Subscription Charge Due Date after the facts are made known to Anthem. Adjustments for retroactive changes are made in accordance with the "Accuracy of Information" provision of the section entitled SUBSCRIPTION CHARGE PROVISIONS.

## AGREEMENT EFFECTIVE DATE

The Agreement Effective Date is the date the *agreement* between Anthem and the *group* becomes effective. This date and any other date in this *agreement* begins at 12:01 a.m. Pacific Standard Time.

## AGREEMENT ANNIVERSARY DATE

The first Agreement Anniversary Date is the date one year following the Agreement Effective Date. Later Agreement Anniversary Dates are one year periods which start and end on succeeding Agreement Anniversary Dates.

# GENERAL PROVISIONS

## AGREEMENT RENEWAL

This *agreement* is considered to renew on each Agreement Anniversary Date. On this date, and on any Subscription Charge Due Date, upon 60-days written notice to the Policyholder, we may change the terms of the *agreement*, the terms of the *plan,* and the subscription charges.

## MAILING ADDRESSES

Any notice required of Anthem in this *agreement* will be mailed to the address of the *group* as shown on Anthem records. Any notice required of the *group* in this *agreement* must be mailed to Anthem Blue Cross at P.O. Box 4089, Woodland Hills, California 91365.

## ENROLLMENT APPLICATIONS

The *group* agrees to forward promptly all enrollment applications to Anthem. If this *agreement* replaces a prior Anthem *agreement* issued to the same *group*, applications are not required for any *members* enrolled immediately before termination of the prior *agreement*.

## CONFIDENTIALITY

The *group* agrees that it will, at all times under this *agreement*, require that each employee sign the disclosure authorization included on the enrollment form. From time to time, the *group* may receive from Anthem information marked “Confidential Information.” The *group* agrees that it shall hold all such information strictly confidential, and further agrees to indemnify and hold Anthem, its affiliates, officers, directors and employees harmless from any and all liability, claims, costs and expenses arising out of or in connection with the unauthorized disclosure of confidential information by the *group*, its employees, agents, officers or directors.

## DECLINATION FORMS

Each eligible *member* is required to enroll under a *group*-sponsored health plan. If any *member* does not enroll for such coverage, or is terminating coverage (disenrolling), the *group* agrees to obtain a written notice, signed by that *member* (or that *member's* guardian in the case of a minor), that the *member* declines coverage or is terminating coverage under all *group*-sponsored health plans.

This notice shall clearly indicate that the *member* is aware that if he or she does not enroll for coverage under the *plan* within 31 days from the *member's* eligibility date or disenrolls as described, the *member* may not be eligible to reapply for coverage until the *group’s* next open enrollment period.

The *group* shall maintain files for all such notices of declination of coverage, and shall, upon request, provide copies promptly to Anthem.

The *group* will indemnify, defend and save Anthem, and its affiliates, harmless from any claims, demands, loss, cost or expense, including attorney's fees, arising from or related to the *group’s* failure to fully and faithfully perform under this provision entitled "Declination Forms". If Anthem is required to provide coverage because of the *group’s* failure to fully and faithfully perform under this provision, in addition to any other claim Anthem may have against the *group* for such failure, the *group* will pay all subscription charges due for such coverage.

## GROUP RECORDS

The *group* is responsible for keeping records relating to this *agreement*. Anthem has the right to inspect and audit those records. In the event of the termination of this *agreement*, Anthem maintains the right to inspect those records pertinent to the period of time this *agreement* was in effect.

## COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORMS

The Combined Evidence of Coverage and Disclosure Forms describe the benefits to which the employee and enrolled family members are entitled, and other important terms of their coverage. For the employee, and their covered family members, Anthem has posted on its website, www.anthem.com/ca, the Combined Evidence of Coverage and Disclosure Forms that apply to the *group's* plan of benefits which the *members* can access using their own identification number shown on their ID card. Anthem will instruct the *group* on how to access the Combined Evidence of Coverage and Disclosure Forms and the *group* agrees to notify the employees of the location of the electronic Combined Evidence of Coverage and Disclosure Forms and how to access them, and subsequently, if changes are made in the plan of benefits, of the location of the amendments showing the changes. Further, Anthem Blue Cross agrees to furnish, and the *group* agrees to distribute promptly, upon request by the employee, an appropriate Combined Evidence of Coverage and Disclosure Form to each employee who requests one.

## SUMMARY OF BENEFITS AND COVERAGE

In advance of the next renewal year, within the time period designated by Anthem, the *group* shall provide Anthem with all necessary benefit information to enable Anthem to provide the *group* the Summary of Benefits and Coverage (SBC) as required by Paragraph three of this provision.

As may be required by law, Anthem shall (1) provide the *group* with an SBC and (2) provide the *group* an updated SBC in the context of a Notice of Material Modification (NMM). The *group* shall be solely responsible for disseminating an electronic copy (via the internet or otherwise) or a paper copy of the SBC to *members* (including pre-enrollees) in a manner compliant with (a) the Employee Retirement Income Security Act (ERISA), if applicable; (b) all the requirements of Section 2715 of the Public Health Service Act (PHSA) as added by Section 1001 of the Patient Protection and Affordable Care Act (PPACA) ; (c) any applicable regulations implementing PHSA Section 2715 codified in the Code of Federal Regulations; and (d) any sub-regulatory guidance regarding PHSA Section 2715. Notwithstanding the above, the *group* agrees that Anthem may, upon advance notice to the *group*, deliver the SBC to *members* via paper, electronic means, or internet access, as permitted by law. The *group* agrees that it will provide the NMM (including the updated SBC) to its *members* in accordance with the requirements set forth in the statutes and regulations referenced in this paragraph. The *group* will notify Anthem immediately if it fails to deliver the SBC to members.

The *group* shall defend, indemnify and hold harmless Anthem from all costs, including but not limited to all losses, claims, judgments, fines, assessments and fees (including attorneys' fees and other litigation costs), incurred by Anthem as a result of the *group's* failure (through no fault of Anthem) to (1) timely provide Anthem with all renewal information as required by this endorsement, and (2) distribute the SBCs to the group health plan *members* as required by PHSA Section 2715, 29 CFR Part 2590.715-2715, et seq. or 45 CFR Part 147.200, et seq.

## CANCELLATION

Anthem may terminate, cancel or decline to renew this *agreement* in the event of any of the following:

1. The *group's* failure to pay subscription charges as described below;

2. The *group's* failure to meet the conditions set forth in the section ENROLLMENT REQUIREMENTS as described below;

3. The *group's* fraud or intentional misrepresentation of material fact under the terms of this *agreement*, or the *group's* knowing permission of such fraud or intentional misrepresentation by another, including without limitation, any *member*;

4. The occurrence of any other event permitting termination, cancellation or nonrenewal described below; or

5. Anthem may terminate, cancel or decline to renew this *agreement* when required to effectuate the purposes of the Knox-Keene Health Care Service Plan Act, with the consent of the California Director of the Department of Managed Health Care. Additionally, Anthem may incorporate into this *agreement* any of the bases for termination, cancellation or nonrenewal described in items a or b below upon 60 days prior written notice to the *group*, in the event of:

    a. An amendment to the Knox-Keene Act, or a change in the applicable interpretations thereof, which expands the basis upon which a health plan may terminate, cancel or decline to renew group benefit agreements; or

    b. The approval by the California Director of the Department of Managed Health Care of good causes for termination, cancellation or nonrenewal of a group benefit agreement of Anthem other than as set forth in this *agreement*.

**Delinquent subscription charges.** If the *group* fails to pay subscription charges as they become due, Anthem may terminate this *agreement* as of the last day of the Grace Period described below. Nevertheless, Anthem will terminate this *agreement* only upon first giving the *group* a written Notice of Cancellation at least 30 days prior to that cancellation (or any longer period of time required for advance notice by applicable federal law, rule, or regulation).

The Notice of Cancellation shall state that this *agreement* shall not be terminated if the *group* makes appropriate payment in full within 30 days after Anthem issues the Notice of Cancellation (or any longer period of time required by applicable federal law, rule, or regulation). The Notice of Cancellation shall also inform the *group* that, if this *agreement* is terminated for nonpayment and the *group* wishes to apply for reinstatement, the *group* shall be required to submit a new application for coverage, and that Anthem either may decline to permit reinstatement in Anthem's sole discretion or may permit reinstatement upon terms and conditions as Anthem shall determine appropriate in its sole discretion.

**Failure to meet enrollment requirements**. In the event that the *group* fails to meet the conditions set forth in the section ENROLLMENT REQUIREMENTS, Anthem may terminate this *agreement* on any Subscription Charge Due Date by giving the *group* a written Notice of Cancellation, stating the reason for the cancellation, at least 30 days prior to the date of cancellation.

**No employee notification.** Anthem shall not in any event be required to issue to *members* any notice of termination, cancellation or nonrenewal of this *agreement*. The *group* shall promptly mail or deliver a legible, true copy of the termination, cancellation or nonrenewal notice it received from Anthem to each *member,* not later than seven days prior to the date coverage will end, and shall promptly provide Anthem with proof of that mailing or delivery has been made and the date thereof.

**COBRA ADMINISTRATION**

In no event will Anthem be the plan administrator with regard to the Consolidated Omnibus Budget Reconciliation Act (COBRA). The term "plan administrator" refers either to the *group* or to a person or entity other than Anthem, engaged by the *group* to perform or assist in performing administrative tasks in connection with the *group's* health *plan*. In providing notices and otherwise performing under the Continuation of Coverage provisions outlined in the *agreement*, the *group* is not acting as the agent of Anthem. Rather the *group* is fulfilling statutory obligations imposed on it by Federal Law and, where applicable, acting as the agent of the *member*.

## CALCOBRA NOTIFICATION REQUIREMENTS

Prior to termination of the *agreement*, the *group* shall notify both (a) those *members* who are receiving coverage under CalCOBRA and (b) qualified beneficiaries who have been notified of their ability to continue coverage through CalCOBRA, who have not yet elected such coverage and who may still elect coverage within the specified 60-day election period of their ability to continue coverage under a new group benefit plan for the remainder of the continuation period. This notification must be made at least 30 days prior to the termination of the *agreement* or at the time all *members* are notified, whichever is later. The *group* shall notify the successor plan, if any, in writing of those *members* who are receiving coverage under CalCOBRA and of those qualified beneficiaries who may still elect coverage through CalCOBRA.

## NOTIFICATION OF CONVERSION AND HIPAA COVERAGE

The *group* agrees to notify promptly, upon termination of coverage, any eligible person of conversion coverage availability and procedures for application. The *group* acknowledges its legal obligation under Health and Safety Code Section 1373.6, Labor Code Section 2800.2, and ERISA to provide this notification.

The *group* agrees to notify promptly any federally eligible defined person of the availability of health coverage through Article 4.6 of the Health and Safety Code and Section 2741 of the Public Health Service Act, and to provide such persons with the necessary information to make timely application for such coverage. The *group* acknowledges its legal obligations under ERISA to provide this notification.

The *group* agrees to indemnify and save Anthem harmless from any claim, demand, loss, damage, or expense (including reasonable attorney fees) arising from or in connection with any failure to properly provide the notifications described above.

## BLUE CROSS AND BLUE SHIELD ASSOCIATION DISCLOSURE

This *agreement* constitutes a contract solely between the *group* and Anthem, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the “Association”) permitting Anthem to use the Blue Cross Service Mark in the State of California, and that Anthem is not contracting as the agent of the Association. The *group*, on behalf of itself and its employees, acknowledges and agrees that it has not entered into this *agreement* based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem shall be held accountable or liable to the *group* for any of its obligations to the *group* created under this *agreement*. This provision shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under the other provisions of this *agreement*.

## INTER-PLAN PROGRAM DISCLOSURE

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever *members* access healthcare services outside the geographic area Anthem and/or the designated Anthem affiliate serve, the claim for those services may be processed through one of these Inter-Plan Programs and presented to Anthem for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to *members* under this *agreement* are described generally below.

Typically, *members*, when accessing care outside the geographic area Anthem serves, obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, *members* may obtain care from Non-Network Providers. Anthem’s payment practices in both instances are described below.

Anthem covers only limited healthcare services received outside of the service area Anthem and/or the designated Anthem affiliate serve. As used in this section, "out-of-area covered healthcare services" refers to emergency care and urgent care obtained outside the geographic area Anthem and/or the designated Anthem affiliate serve. Except for emergency care and urgent care, services must be provided or authorized by the *member's primary care doctor* or *medical group*.

**BlueCard® Program**

Under the BlueCard® Program, when *members* access out of area covered healthcare services within the geographic area served by a Host Blue, Anthem will remain responsible to group for fulfilling Anthem's contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

**Liability Calculation Method Per Claim:** The calculation of the *member* copay, if not a flat dollar copay, for out-of-area covered healthcare services processed through the BlueCard Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to Anthem by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to Anthem by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

(i) an actual price. An actual price is a negotiated payment without any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

(iii) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the *member* is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to Anthem is a final price irrespective of any future adjustments based on the use of estimated or average pricing. A small number of states require a Host Blue either (i) to use a basis for determining *member* liability for out-of-area covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Anthem would then calculate *member* liability in accordance with applicable law.

**Return of Overpayments***:* Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

## NON-NETWORK PROVIDERS OUTSIDE ANTHEM'S SERVICE AREA

**Member Copay Calculation***:* When out-of-area covered healthcare services are provided outside of Anthem's service area by Non-Network Providers, the copay, if not a flat dollar copay, a *member* pays for such services will generally be based on either the Host Blue's Non-Network Providers local payment or the pricing arrangements required by applicable state law.

**EXCEPTIONS***:* In some exception cases, Anthem may pay claims from Non-Network Providers outside of Anthem's service area based on the provider's billed charge, such as in situations where a *member* did not have reasonable access to a Network Provider, as determined by Anthem, in Anthem's sole and absolute discretion, or by applicable state law. In other exception cases, we may pay such a claim based on the payment we would make if Anthem were paying a Non-Network Provider inside of Anthem's service area, as described elsewhere in this *policy*, where the Host Blue's corresponding payment would be more than Anthem's in-service area Non-Network Provider payment, or in our sole and absolute discretion, we may negotiate a payment with such a provider on an exception basis.

## MISCELLANEOUS PROVISIONS

Anthem shall not decrease, in any manner, the benefits and coverages provided hereunder, except after at least 60 days prior written notice to the *group*.

Anthem shall provide written notice to the *group* within a reasonable period of time of any participating provider's termination, or breach of, or inability to perform under, any provider contract, if Anthem determines that the *group* or *members* may be materially and adversely affected thereby.

Upon the termination of the contract or other agreement with any participating provider, Anthem shall be liable to pay the cost of covered services (other than applicable Co-Payment) rendered by that provider to a *member* who retains eligibility under this *agreement* or by operation of law, and who is under the care of that provider at the time of such termination, and that provider shall continue to provide such services to the *member* in accordance with the terms of this *agreement*, until the services being rendered are completed, unless reasonable and medically appropriate provision is made for the assumption of such services by another provider.

Anthem is subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended, as set forth at Chapter 2.2 of Division 2 of Chapter 3 of Title 28 of the California Code of Regulations, and any provision required to be stated herein by either of the above shall bind Anthem whether or not provided in this *agreement*. This *agreement* shall be construed and enforced in accordance with the laws of the state of California.

## ASSIGNMENT

This *agreement* may not be assigned by the *group* without prior written consent of an officer of Anthem. Any purported assignment without such written consent shall be void as to Anthem.

# SUBSCRIPTION CHARGE PROVISIONS

## PAYMENT DATES

The term "subscription charges" refers to the payment due from the Group to Anthem which maintains the *agreement* in force. For this *agreement*, subscription charges are calculated under a minimum premium funding arrangement. The amount, method and timing of the subscription charge payment from the Group to Anthem is detailed in the Funding Provisions document which accompanies this *agreement*. The initial payment of subscription charges is due on or before the Agreement Effective Date.

## GRACE PERIOD

For every Subscription Charge Due Date except the first, there is a 31-day grace period in which to pay subscription charges. This *agreement* remains in force during the grace period. The *group* is liable for payment of subscription charges covering any period of time that this *agreement* remains in force. If the *group* fails to pay us the subscription charges due during the grace period, Anthem will not end coverage for covered employees or family members until the end of the grace period. The employees will not be required by Anthem to pay the subscription charges for the *group* nor will members be required to pay more than their copay for any services received during the grace period.

If subscription charges due are not paid by the end of the grace period, this *agreement* will be canceled as described above.

## SUBSCRIPTION CHARGE INCREASE

Anthem may not increase subscription charges without first providing written notification to the *group* at least 60 days prior to the date the increase is to take effect.

## ACCURACY OF INFORMATION

**Responsibilities of the Group**. The *group* is responsible for supplying up-to-date eligibility information. Anthem may rely upon the latest information received as correct without verification; however, Anthem maintains the right to verify any eligibility information provided by the *group*.

**Retroactive Credits.** In order for the *group* to receive full credit for a correction or change in eligibility information, any such change or correction must be received by Anthem within 90 days of the date a *member* ceases to be eligible under the plan. In any event, the maximum retroactive credit for subscription charges paid for an ineligible *member*, whether or not benefits are actually provided for that *member*, shall not exceed 60 days. In addition, benefits provided for an ineligible *member* because of inaccurate information supplied by the *group* are charged against the *group's* experience.

**Retroactive Subscription Charges.** Enrollment or membership change forms to add employees or family members must be completed in accordance with the WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE section of the Evidence of Coverage Form, and received by Anthem within 90 days of any such *member's* eligibility date. Retroactive subscription charges will then be billed to the *group* as of the *member's* effective date.

If such forms are received later than 90 days from the *member's* eligibility date, the *member's* effective date of coverage will be determined in accordance with the WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE section of the Evidence of Coverage Form. In no event will any retroactive effective date be more than 90 days prior to the date the enrollment or membership change forms are received by Anthem. Subscription charges will begin if, and when, that *member's* coverage becomes effective.

# SUBSCRIPTION CHARGE PROVISIONS

## TAX LIABILITY

If a state or any other taxing authority imposes a tax on Anthem which is based on subscription charges, the subscription charges stated in this *agreement* will be increased by an amount sufficient to cover that tax. Anthem will give the *group* at least 60-days advance written notice of the increase in subscription charges sufficient to coverage the tax prior to the date they tax goes in to affect. If it is not possible to give the *group* 60-days advance written notice of the increase in subscription charges due to the tax, Anthem will notify the *group* in writing as soon as possible and will increase the subscription charges on the date the tax goes into effect. Any subsequent change to the tax may result in a further increase in subscription charges upon appropriate written notice.

## REFUNDS OF UNEARNED SUBSCRIPTION CHARGES

If this *agreement* is terminated for any cause, any subscription charges received by Anthem for periods occurring after the effective date of that termination, less any amounts due to Anthem, will be refunded, and Anthem shall have no further liability or responsibility with regard to the *group* or any *member* under this *agreement*. If the termination is for any reason other than an employee's or a family member's fraud or deception in the use of services or facilities of Anthem (or knowingly permitting such fraud or deception by another), Anthem will make this refund within 30 days.

## MEDICAL LOSS RATIO REBATE

For any rebate due and payable as a consequence of the medical loss ratio ("MLR") requirements of the Patient Protection and Affordable Care Act ("PPACA") and/or applicable state law, all such rebates paid shall constitute a return of subscription charges. The *group* shall promptly provide Anthem with any information needed to calculate the applicable rebate amount. Anthem reserves the right to pay the rebate to either the *group* or the employee.

If Anthem pays the rebate to the *group*, the *group* shall promptly refund to each employee his/her proportional share of the rebate in accordance with the requirements of PPACA. Upon reasonable request, the *group* shall provide to Anthem documentation required by 45 CFR 158.242(b)(2) of the distribution of the rebate to employees. The *group* agrees to provide such documentation within the time frame designated by Anthem.

In the event of a claim related to the amount of the employee's rebate, the *group* shall cooperate with Anthem and provide Anthem with information required to investigate the claim. If Anthem is required to pay additional amounts to an employee due to the *group's* failure to either (1) provide accurate information to Anthem, or (2) make a refund of the appropriate rebate amount due to the employee, then the *group* agrees to reimburse Anthem for such additional amount paid by Anthem to the employee. This provision shall survive the termination of this *agreement*.

## COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORMS INCLUDED IN THIS AGREEMENT

Benefit provisions of this *agreement* appear in the Combined Evidence of Coverage and Disclosure Forms listed below. Copies of all Evidence of Coverage Forms and any applicable amendments issued to employees covered under this *agreement* are attached. These documents form an integral part of the entire *agreement*. In any interpretation of the *agreement,* all documents will be read together.

Employees are enrolled under the *plan* or *plans* indicated on their enrollment forms.

| PLAN DESCRIPTION | FORM NUMBER | EFFECTIVE DATE |
|---|---|---|
| Anthem Blue Cross HMO Plan (County of Fresno) | RT275341-1 1212 | December 10, 2012 |
| Anthem Blue Cross HMO Plan (County of Tulare) | RT275341-2 1212 | January 1, 2013 |

Anthem Blue Cross

# FUNDING PROVISIONS

## MINIMUM PREMIUM

with

## WEEKLY BANK TRANSFER AND CLAIMS LIABILITY LIMIT

between

## ANTHEM BLUE CROSS

and

## CITY OF CERES
(the Group)

**SECTION I: BASIC FACTS**

Group Benefit Agreement SF275341-C (R-1212) (the "Agreement") currently in effect between the Group and Anthem Blue Cross ("Anthem") is subject to the Funding Provisions of this endorsement.

Effective January 1, 2013, these Funding Provisions are made a part of the Agreement. All other provisions of the Agreement which are not inconsistent with this endorsement remain in effect.

With respect to these Funding Provisions, the Agreement Year will begin on the effective date of this endorsement and will end on December 31, 2013. Each subsequent Agreement Year will be a period of twelve (12) consecutive calendar months, beginning on January 1. Any Agreement Year will end, however, upon termination of the Agreement.

**SECTION II: PRINCIPAL RESOLUTION**

A. The Group agrees to reimburse Anthem according to the terms of these Funding Provisions for Non-Capitated Claims paid by Anthem on or after the effective date.

B. Anthem will provide the Group with coverage for Non-Capitated Claims in excess of the Pooling Limit and Claims Liability Limit, as specified in these Funding Provisions.

C. The Group agrees to pay Anthem applicable Subscription Charges, consisting of Retention Charges, Pooling Charges and Capitation Expense, as set forth in the **Schedule**.

D. Upon completion of the first three months of each Agreement Year, Anthem will make an evaluation of the Capitation Expense charged to the Group for that three-month period. Anthem reserves the right to reconcile such Capitation Expense, in accordance with the terms set forth in **Section X: Review and Reconciliation of Capitation Expense**, if it is determined that the amount charged for the three-month period was inadequate or excessive.

E. The Group agrees to pay Anthem applicable Administrative Fees for the use of the BlueCard Program, as set forth in the **Schedule**.

# FUNDING PROVISIONS

## SECTION III: DEFINITIONS

The following terms, when capitalized throughout this endorsement, shall have the meanings set forth below.

**Capitation** is a method of payment for health services in which a Physician or Hospital is paid a fixed amount for each person served regardless of the number or nature of services provided to each person.

**Capitation Expense** is the monthly fixed amount determined by Anthem which is due and payable to Anthem by the Group for each enrolled Member. Capitation Expense includes actual Capitation charges plus all related Capitation costs paid by Anthem to participating medical groups and independent practice associations to cover professional and other capitated health care services including, but not limited to, contributions to shared risk funds and provider incentive pools calculated in accordance with Anthem corporate policy.

**Claims Liability Limit** shall mean the maximum amount of Non-Capitated Claims for which the Group is liable during an Agreement Year, subject to the terms and conditions set forth in **Section VI**.

**Contract Type** means the category of enrollment, as designated in the **Schedule**, used to determine the monthly attachment point factor and the monthly Subscription Charges.

**Non-Capitated Claims** represent all claims incurred under the Plan for services or supplies which are not subject to Capitation.

**Plan Benefits** shall mean those benefits for which coverage is described under the Plan, including any extension of such coverage.

**Pooling Limit** is the dollar limit for which the Group is liable for Non-Capitated Claims paid on behalf of any one Member during an Agreement Year. The Pooling Limit is specified in the **Schedule**.

**Retention** means the amount charged by Anthem for expenses, commissions, taxes and risk. Retention Charges are shown in the **Schedule**.

**Subscription Charges** refers to the charges for Retention, Pooling and Capitation Expense calculated in accordance with these Funding Provisions, and subject to annual accounting. The Subscription Charges are specified in the **Schedule**.

**Surplus.** Surpluses on the Plan are determined by annual accounting performed by Anthem, as set forth in **Section VII: Annual Settlement**.

## SECTION IV: REIMBURSEMENT OF NON-CAPITATED CLAIMS

On the first working day of every week, Anthem will telephone to the Group the total amount of Non-Capitated Claims paid during the preceding week. The Group will immediately deposit this amount via wire transfer to a designated Anthem bank account. On the same day, Anthem will mail a written version of the request to the Group, together with a listing of Non-Capitated Claims.

At the end of each month, Anthem will mail a written summary of the Non-Capitated Claims billed to the Group and the amounts requested from the Group during the month. Adjustments of any discrepancies will be made at such time.

## SECTION V: POOLING LIMIT

The Group is liable for the accumulated paid Non-Capitated Claims of a Subscriber or Family Member up to the Pooling Limit, as set forth in the **Schedule**. Accumulation toward this Limit takes place over a period of twelve consecutive months, starting at the beginning of each Agreement Year.

If, in any Agreement Year, the accumulated paid Non-Capitated Claims for a Subscriber or Family Member equal the Pooling Limit for that Agreement Year, the Group shall continue to be responsible for funding any further Non-Capitated Claims paid for that Subscriber or Family Member for that month and each subsequent month during the remainder of that Agreement Year. However, Anthem shall reimburse the Group in the amount of such further paid Non-Capitated Claims during the month immediately following the month in which the Non-Capitated Claims are paid.

Anthem shall notify the Group when the Pooling Limit has been exceeded for a Subscriber or Family Member. Such notification shall be made one month following the month in which such Limit has been exceeded.

Non-Capitated Claims incurred but not paid during an Agreement Year will accumulate toward the Pooling Limit for the subsequent Agreement Year.

On the date the Agreement terminates, this Limit shall no longer apply. However, Non-Capitated Claims paid and applied to the Pooling Limit may be adjusted after the Agreement Year if Anthem recovers any overpayments, workers' compensation or third party liability liens, as specified in **Section XII**. Anthem will recalculate the Non-Capitated Claims applied to the Pooling Limit and the Group will reimburse Anthem for any adjustments made over the Pooling Limit.

**Note.** The Pooling Limit does not apply to Dental Benefits or Prescription Drug Benefits, nor will Non-Capitated Claims paid on these benefits be applied toward that Limit.

## SECTION VI: CLAIMS LIABILITY LIMIT

The Claims Liability Limit is the maximum amount of Non-Capitated Claims for which the Group is liable during an Agreement Year. The Claims Liability Limit is 125% of the projected paid Non-Capitated Claims for the Agreement Year.

The number of Subscribers per Contract Type which will be used to determine the Claims Liability Limit for the first three months of the first Agreement Year, shall be the number of such Subscribers covered on the first day of the first month of that Agreement Year.

Thereafter, the number of Subscribers per Contract Type to be used shall be the number of such Subscribers covered on the first day of the second preceding calendar month; however, if in any given month the number of Subscribers falls below 90% of the Initial Monthly Attachment Point, the number of Subscribers used to determine the Claims Liability Limit shall be equal to 90% of such Initial Monthly Attachment Point.

Non-Capitated Claims will be applied to the Claims Liability Limit. If the accumulated Non-Capitated Claims exceeds the Claims Liability Limit, the Group will no longer be responsible for any Non-Capitated Claims incurred after the Claims Liability Limit is reached.

## SECTION VII: ANNUAL SETTLEMENT

Within 120 days after the end of each Agreement Year, Anthem will perform an annual accounting in which the total Non-Capitated Claims paid under the Plan during the Agreement Year (excluding Non-Capitated Claims which exceed the Pooling Limit) are compared to the Claims Liability Limit.

- If the total amount of such Non-Capitated Claims paid for the Agreement Year exceeds the Claims Liability Limit, the excess will be refunded to the Group.

- If the Claims Liability Limit is greater than the amount of such Non-Capitated Claims paid during the Agreement Year, the difference between the two amounts is the amount of the Surplus on the Plan for the Agreement Year.

## SECTION VIII: SUBSCRIPTION CHARGES

Anthem will bill the Group each month for Subscription Charges, as specified in the **Schedule**. The first payment is due on the Agreement Effective Date. The Agreement remains in effect for the term of one month from that date. Succeeding Subscription Charges are due on the first day of each following month. This day is the Subscription Charge Due Date.

## SECTION IX: BLUECARD PROGRAM

Anthem is a member of the Blue Cross Blue Shield Association. The Blue Cross Blue Shield Association has a program (called the "BlueCard Program") which allows our Members who are traveling outside of California to have the reciprocal use of participating providers contracted under other states' Blue Cross Blue Shield plans. There are fees associated with the reciprocal use of such providers by Members and are determined in accordance with the applicable rules of the Blue Cross Blue Shield Association which will be charged back to the Group. These fees are:

A. **Access Fees.** Access fees are a percentage of the savings generated by the discounts between the Blue Cross Blue Shield Plan and the provider. Some plans may charge up to 7.75% of savings generated by their discounts, up to $2,000 per claim, as a network access charge. If there are no savings from the discounts, there will be no access fee charged.

B. **Administrative Fees.** Administrative fees are fees charged for each claim payment. There is a charge for each institutional and professional claim paid under this program, and an additional charge for each transaction. There is an electronics claims routing process fee for all non-participating provider claims. The charges are specified in the **Schedule**.

These fees are subject to change in accordance with the applicable rules of the Blue Cross Blue Shield Association and will be included in the Group's claims experience and will be charged to the Group as Non-Capitated Claims.

## SECTION X: REVIEW AND RECONCILIATION OF CAPITATION EXPENSE

A review of Capitation Expense by Anthem will take place 90 days after the initial effective date of these Funding Provisions and, subsequently, 90 days after the end of each Agreement Year, to verify the adequacy of the amount charged by Anthem to the Group. In this review, the Capitation Expense charged to the Group for the first three months of the Agreement Year will be compared to the actual Capitation Expense incurred, based on actual enrollment figures for that three-month period.

If it is determined by Anthem that the Capitation Expense charged for such three-month period was inadequate or excessive, Anthem may, at its sole discretion, reconcile that Capitation Expense to more accurately reflect the actual enrollment figures, plus any deficit attributable to the prior Agreement Year. Any such reconciliation of the Capitation Expense shall be reflected in the monthly billing to the Group during the remaining months of the Agreement Year. In such case, these Funding Provisions shall be reissued, notwithstanding any prior authorization thereof by the parties to this endorsement, to reflect the appropriate adjustment to Capitation Expense.

## SECTION XI: MODIFICATION OF FUNDING PROVISIONS

A. **Amendment of Terms.** Anthem may amend the terms of these Funding Provisions as follows:

1. At the beginning of any month or upon annual renewal of the Agreement, provided Anthem gives the Group thirty (30) days written notice;

2. Any time the provisions of the Agreement are changed; or

3. Any time there is a ten (10) percent or greater change in the number of Subscribers enrolled under the Agreement during the preceding three months, from the number of Subscribers enrolled at the start of the Agreement Year; or.

4. As specified in **Section X: Review and Reconciliation of Capitation Expense**.

B. **Adjustment of Retention.** Anthem may adjust the charge for Retention as follows:

1. On the date Anthem, at the Group's request, begins to perform additional administrative services relating to the Agreement;

2. On the effective date of any legislation or governmental regulations which impose additional administrative duties on Anthem relating to the Agreement;

3. On the effective date that any tax, which is based on Income, is imposed upon Anthem by the state or any other taxing authority. In such case, Anthem will increase the charge for Retention by an amount sufficient to cover the tax; or

4. As provided under items 1, 2 and 3 of paragraph A, **Amendment of Terms**.

C. **Adjustment of Attachment Point Factors.** Anthem reserves the right to change the monthly attachment point factors and the post-termination attachment point factors:

1. On the first day of any month after these Funding Provisions have been in effect for 12 months;

2. Whenever the terms of these Funding Provisions are changed;

3. On the effective date of any law or regulation which affects Anthem's liability under the Agreement;

4. Whenever benefits are changed under the Agreement; or

5. As provided under items 1, 2 and 3 of paragraph A, **Amendment of Terms**.

## SECTION XII: RECOVERY PROVISIONS

A. **Recovery of Overpayments.** If it is determined that any payment has been made under this Agreement to an ineligible person, or if it is determined that more or less than a correct amount has been paid by Anthem, Anthem shall make a reasonable effort to recover any such overpayment made or to adjust the payment, subject to the following:

1. Anthem, at its discretion, may use the services of subcontractors (collection agencies and bill audit firms) to identify and recover overpayments. Any expenses which Anthem incurs for such services are included in the retention.

2. Anthem will not be required to initiate court proceeding for any such recovery.

B. **Recovery of Liens.** Subject to the following, Anthem agrees to use reasonable diligence to identify and seek to recover third-party liability liens or workers' compensation liens:

1. In pursuing these recoveries, Anthem reserves the right to use its discretion in negotiating and compromising recoveries from third parties.

2. Anthem may engage the services of subcontractors to assist in the recovery process. Expenses which Anthem incurs for such services are included in the retention.

3. The Group will fully cooperate with Anthem in such recoveries and advise Anthem of any potential recoveries of which it becomes aware.

4. Anthem will not be required to initiate court proceeding for any such recovery.

5. Anthem will submit monthly reports to the Group listing all cases identified as subject to third party liens or workers' compensation liens, the amount of claims paid, the current status of collection efforts and a report of all amounts collected and waived. The Group will advise Anthem of those cases which, in the Group's determination, shall warrant recovery.

## SECTION XIII: AUDIT

A. **Authorization of Audits.** Anthem may authorize audits, subject to certain limitations, to be performed by auditors employed by the Group. The Group shall have the right to select an auditor of its choice, except that the auditor shall not be involved in, or be subsidiary to, a business engaged in activities competitive to Anthem or to subsidiaries or affiliates of Anthem. Such audits will be conducted in accordance with, and subject to, the auditing standards of the American Institute of Certified Public Accountants and the written audit policy of Anthem, a copy of which shall be provided to the auditor.

B. **Confidential and Proprietary Information.** Anthem shall make available such records as may be reasonably necessary for a valid audit. Access by the Group, or any third party acting on behalf of the Group, to Anthem's confidential and proprietary information shall be restricted to only such information as deemed necessary by Anthem to accomplish the audit. The Group and the Group's auditor shall agree in writing (by a separate "Audit Agreement") regarding the auditor's conduct, and to maintain the confidentiality of any trade secret or proprietary information of which it may become aware during the course of the audit.

C. **Reimbursement of Anthem for Expense.** The Group agrees to reimburse Anthem for all expense incurred by Anthem in support of the audit. Any such expense will be billed to the Group and the Group will remit the amount billed to Anthem within 15 days from the date of the bill. Failure of the Group to pay such bill by the end of that 15 day period shall be deemed reason for cancellation of the Agreement by Anthem.

## SECTION XIV: TERMINATION PROVISIONS

A. Either Anthem or the Group may terminate these Funding Provisions by giving written notice to the other party at least 31 days prior to the effective date of such termination.

B. Anthem may terminate these Funding Provisions upon thirty-one (31) days advance written notice to the Group, if enrollment under the Agreement falls below 100 Subscribers for a period of three consecutive months. In the event of such termination, the account will be converted to a non-refunding arrangement. Beginning with the effective date of such termination, the Group shall pay to Anthem the monthly Non-Refunding Subscription Charges specified in the Group Benefit Agreement for the remainder of the Agreement Year.

C. These Funding Provisions or the Agreement, at Anthem's election, shall terminate upon written notice to the Group:

   1. If Anthem determines that the continuance of these Funding Provisions is prohibited by the enactment, amendment or construction of a law or regulation of any state or other jurisdiction. These Funding Provisions shall terminate as of the date such law, regulation, amendment or construction is determined by Anthem to be effective.

   2. If the Group fails to comply with any of the terms or conditions of these Funding Provisions or otherwise breaches or defaults in its obligations hereunder. Any waiver of a right to terminate these Funding Provisions or the Agreement for cause shall be as to the particular default only and shall not waive any rights or remedies with respect to any subsequent default.

D. Upon termination of the Agreement, these Funding Provisions shall also terminate.

Notwithstanding the provisions set forth in paragraphs A., B., C. and D. above, the terms and conditions of the **Post-Termination Provisions** set forth in **Section XV** shall survive the termination of the Agreement or these Funding Provisions thereof.

## SECTION XV: POST-TERMINATION PROVISIONS

A. In the event of termination of the Agreement, the procedures and obligations described in this endorsement will, to the extent applicable, survive such termination and remain in effect while the Group remains liable. The Group will continue to reimburse Anthem for the Group's liability in accordance with the provisions of **Section IV: Reimbursement of Non-Capitated Claims** and, subject to the **Post-Termination Claims Liability Limit** provision below, the Group will be liable for and pay to Anthem:

   1. Non-Capitated Claims which are incurred prior to, but paid after the termination date;

   2. Non-Capitated Claims which are incurred after the termination date and are payable under the Extension of Benefits provision of the Plan; and

3. Post-Termination Administrative Charges for the administration of Non-Capitated Claims paid following the termination date. The amount of these charges will be based on a percentage of paid Non-Capitated Claims, as set forth in the **Schedule**. These charges will continue as long as Non-Capitated Claims are being paid under these Post-Termination Provisions. Post-Termination Administrative Charges do not apply toward the Post-Termination Claims Liability Limit.

4. Administrative Fees for the use of the BlueCard Program, as set forth in the **Schedule**. These Fees do not apply toward the Post-Termination Claims Liability Limit.

5. Post-Termination Capitation Expense, as determined by Anthem based on actual Capitation charges being incurred at the time of termination for individuals covered under the Extension of Benefits provision of the Agreement. Post-Termination Capitation Expense does not apply toward the Post-Termination Claims Liability Limit.

B. In the event that the funding arrangement described in this endorsement terminates while the Agreement remains in effect, subsection A immediately above will apply and, in addition, the Group shall also be liable for and pay to Anthem:

1. Non-Capitated Claims incurred during a confinement in a hospital, skilled nursing facility or hospice, which confinement began prior to the termination of this funding arrangement; and

2. Non-Capitated Claims incurred for ongoing services received from a home health agency, visiting nurse association or day treatment center, if the first date of service for the course of treatment giving rise to such Claims is prior to the termination of this funding arrangement.

C. **Post-Termination Claims Liability Limit*.** The Group's liability for Non-Capitated Claims, as determined in accordance with the subsection A above (other than items 3, 4 and 5 of such provision), shall not exceed the sum of items 1 and 2 below.

1. An amount equal to the sum of the products obtained by multiplying the number of Subscribers per Contract Type for the three months immediately prior to the termination of these Funding Provisions, by the appropriate Post-Termination Claims Liability Factors set forth in the **Schedule**; plus

2. The amount of the Surplus, if any, at the end of the Agreement Year.

***Note.** Post-Termination Administrative Charges, Administrative Fees charged for the use of the BlueCard Program, and Post-Termination Capitation Expense do not apply toward the Post-Termination Claims Liability Limit.

**Exception to "item 1" above.** If the number of Subscribers per Contract Type for any of the three months immediately prior to the termination of these Funding Provisions was less than "90% of the Initial Enrollment", the number of Subscribers per Contract Type which will be used to determine the Post-Termination Claims Liability Limit shall be "90% of the Initial Enrollment".

The **Initial Enrollment** is the number of Subscribers per Contract Type covered on the first day of the first month of the Agreement Year.

**Exception to "item 2" above.** If the term of the last Agreement Year is less than 12 months, item 2. above shall read: "An amount equal to the sum of the Surpluses for (a) the last Agreement Year, and (b) the Agreement Year immediately preceding that Year."

D. **Pooling Limit.** The liability of the Group under this section will not be subject to or limited by the Pooling Limit provisions of this endorsement.

E. **Cancellation of Funding Arrangement**. If the Agreement remains in force after the funding arrangement described in this endorsement terminates, the Group shall pay Subscription Charges to Anthem for continued coverage under the Agreement. Unless Anthem and the Group otherwise agree in writing, the amounts of the Subscription Charges will be determined by Anthem at its discretion.

F. **Final Settlement.** Subsequently, Anthem will perform a final settlement of all accounts in accordance with the following terms and conditions:

1. The final settlement will take place on a date determined by Anthem; however, in no event will such final settlement occur later than 24 months after the termination date.

2. Upon completion of the final settlement, Anthem will remit to the Group any unused amounts held in the Minimum Claims Deposit, subject to the Group's endorsement of the "Acknowledgment of Receipt and Release of Claim".

3. In the event that any Non-Capitated Claims incurred under the Agreement prior to the termination date are paid by Anthem after the final settlement, the Group will reimburse Anthem for the amount of such Non-Capitated Claims, plus Post-Termination Administrative Charges.

G. Anthem will not be responsible for the Group's use of any payment made by Anthem under the terms of these Funding Provisions.

## SECTION XVI: RESPONSIBILITIES OF THE GROUP

A. **Payments Made in Connection with a Judgment or Settlement.** The Group agrees to pay the amount of benefit payments included in any judgment or settlement to the extent of its Claims Liability Limit. Benefit payments made in accordance with the terms of any judgment or settlement shall be considered benefits paid under the Plan for the month in which such judgment or settlement is satisfied.

B. **Reimbursement of Benefits to a Person or Organization.** If any person or organization pays any amount of benefits which is an obligation of the Group, the Group shall reimburse such person or organization to the extent of such payment, plus any reasonable costs or charges in connection with such payment. In no event shall any such payment by either party to these Funding Provisions, or by any person or organization, be construed as obliging such party, person or organization for payment of benefits.

C. **Notice to Subscribers.** The Group shall furnish to covered Subscribers a written "Notice to Subscribers" advising that the Group is liable for payment of a portion of the benefits under the Plan and that this portion will not be insured by Anthem. The Group agrees to indemnify Anthem and hold Anthem harmless against any and all loss, damage and expense sustained by Anthem as a result of any failure by the Group to provide such notice.

D. **Notification of Required Information.** The Group shall notify Anthem immediately as to any modification or termination of the Plan. Anthem will not be responsible for any delay or non-performance of its functions under these Funding Provisions which is caused or contributed to in whole or in part by the failure of the Group to furnish any required information on a timely basis.

E. **Maintenance and Audit of Records.** The Group agrees to maintain and to permit Anthem to audit, at all reasonable times, all records required by Anthem for the administration of these Funding Provisions.

F. **Minimum Claims Deposit.** The Group agrees to provide, within two weeks after the effective date of these Funding Provisions, a Minimum Claims Deposit in an amount determined by Anthem. The Group agrees to maintain such Minimum Claims Deposit at Anthem for the term of the Agreement Year. The amount of the Minimum Claims Deposit is specified in the **Schedule**.

Anthem may change the amount of the Minimum Claims Deposit with prior written notice, as specified in **Section XI: Modification of Funding Provisions**. If Anthem decreases the amount of the Deposit required, Anthem will, upon the written request of the Group, refund the excess to the Group. If Anthem increases the amount of the Deposit required, the Group will, prior to the effective date of the change, remit to Anthem the additional amount required.

## SECTION XVII: ANTHEM DUTIES AS AGENT

Anthem as agent for and on behalf of the Group, shall:

A. Make final determination of the amount of benefits, if any, payable with respect to each Non-Capitated Claim for benefits under the Plan, in accordance with the terms and conditions described in the Agreement;

B. Undertake the defense of any suit brought with respect to any Non-Capitated Claim for benefits under the Plan and settle any such suit when in its judgment it appears expedient to do so; and

C. Make final determination of the amount of Plan Benefits payable from Group funds.

Anthem will use ordinary care and reasonable diligence in the exercise of its powers and the performance of its duties hereunder.

## SECTION XVIII: INDEMNIFICATION

A. Anthem agrees to indemnify the Group and hold the Group harmless against any and all loss, damage, and expense with respect to these Funding Provisions to the extent that such loss, damage and expense result from or arise out of negligent, dishonest, fraudulent, or criminal acts of Anthem employees, acting alone or in collusion with others, unless such collusion is with an employee of the Group, in which case Anthem shall be relieved of any obligations under this paragraph.

B. Except as provided in paragraph A above, the Group agrees to indemnify and hold Anthem harmless against any loss, expense, or other cost or obligation, resulting from or arising out of claims, assessments or taxes, including premium taxes, or resulting from the action of any government body.

C. If either Anthem or the Group has paid any benefits which were the responsibility of the other party, appropriate reimbursement will be made.

## SECTION XIX: FINANCIAL ARRANGEMENTS WITH PROVIDERS

Anthem or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as “Providers”) for the provision of and payment for health care services rendered to its Subscribers and Members/Insured Persons entitled to health care benefits under individual certificates and group policies or contracts to which Anthem or an affiliate is a party, including all persons covered under the Agreement.

## FUNDING PROVISIONS

Under the above-referenced contracts between Providers and Anthem or an affiliate, the negotiated rates paid for certain medical services provided to persons covered under the Agreement may differ from the rates paid for persons covered by other types of products or programs offered by Anthem or an affiliate for the same medical services. In negotiating the terms of the Agreement, the Group was aware that Anthem or its affiliates offer several types of products and programs. The Subscribers, Family Members and the Group are entitled to receive the benefits of only those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the Agreement.

Also, under arrangements with some Providers certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, pharmacy rebates, may be based on aggregate payments made by Anthem or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by Anthem or an affiliate. They are not attributed to specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by Anthem or an affiliate in determining its fees or subscription charges or premiums.

### SECTION XX: TERMINATION PROVISION

Any amounts due to Anthem under this funding arrangement are subscription charges under the Group Benefit Agreement to which these Funding Provisions are made a part. Any failure by the group to pay such additional subscription charges when due may result in, at Anthem' option either: (a) termination of these funding provisions and recalculation of the subscription charges under the Group Benefit Agreement; or (b) in accordance with the Group Benefit Agreement's Cancellation provisions, termination for failure to pay subscription charges as they become due.

### AUTHORIZATION

Authorized officers of Anthem and of the Group have approved this endorsement as of its effective date.

**FOR ANTHEM BLUE CROSS**

| | | | |
|---|---|---|---|
| by: | _____ | by: | _____ |
| | Pam Kehaly | | Kathy Kiefer |
| Title: | President | Title: | Secretary |

**FOR THE GROUP**

| | | | |
|---|---|---|---|
| by: | _____ | by: | _____ |
| Title: | _____ | Title: | _____ |

# SCHEDULE

## EFFECTIVE DATE

This Schedule reflects the Funding Provisions which become effective on January 1, 2013.

## MINIMUM CLAIMS DEPOSIT

The amount of the Minimum Claims Deposit to be maintained for the term of the Agreement Year is $49,702.

## POOLING LIMIT

The Pooling Limit for the Agreement Year is $400,000.00*.

*****This Limit does not apply to Dental Benefits or Prescription Drug Benefits, nor will claims paid on these benefits be applied toward the Pooling Limit.

# SCHEDULE

**MONTHLY ATTACHMENT POINT FACTORS**

| Contract Types | Monthly Attachment Point Factors | Post-Termination Attachment Point Factors |
|---|---|---|
| Composite Rate (per Subscriber) | $1111.28 | $1255.09 |

**SUBSCRIPTION CHARGES**

The monthly Subscription Charges during the Agreement Year is $409.35.

**BREAKDOWN OF SUBSCRIPTION CHARGES:**

The following is a breakdown of the above Subscription Charges:

**Retention Charges**

The monthly Retention Charges during the Agreement Year is $37.72 per Subscriber.

**Pooling Charges**

The monthly Pooling Charges during the Agreement Year is $53.13 per Subscriber.

**Capitation Expense**

The monthly charges for Capitation Expense during the Agreement Year is $318.50 per Subscriber.

**BLUECARD PROGRAM**

The Group will pay to Anthem the following Administrative Fees determined in accordance with the applicable rules of the Blue Cross Blue Shield Association for the use of Out-of-California Providers under the BlueCard Program:

| Administrative Fees | Per Claim |
|---|---|
| Institutional Claims | $ 11.00 |
| Professional Claims | $ 5.00 |
| Central Financial Agency Fee | $ .20 |
| Charge per transaction | $ .05 |
| Electronic Claims Routing Process (ECRP) (non-participating provider claims) | $ 1.00 |

These fees are subject to change in accordance with the applicable rules of the Blue Cross Blue Shield Association.

**POST-TERMINATION ADMINISTRATIVE CHARGES**

The monthly Post-Termination Administrative Charge is 6% of paid Non-Capitated Claims.

Anthem Blue Cross

# FUNDING PROVISIONS

## MINIMUM PREMIUM

with

## WEEKLY BANK TRANSFER AND CLAIMS LIABILITY LIMIT

between

## ANTHEM BLUE CROSS

and

## COUNTY OF TULARE

(the Group)

**SECTION I: BASIC FACTS**

Group Benefit Agreement SF275341-C (R-1212) (the "Agreement") currently in effect between the Group and Anthem Blue Cross ("Anthem") is subject to the Funding Provisions of this endorsement.

Effective January 1, 2013, these Funding Provisions are made a part of the Agreement. All other provisions of the Agreement which are not inconsistent with this endorsement remain in effect.

With respect to these Funding Provisions, the Agreement Year will begin on the effective date of this endorsement and will end on December 31, 2013. Each subsequent Agreement Year will be a period of twelve (12) consecutive calendar months, beginning on January 1. Any Agreement Year will end, however, upon termination of the Agreement.

**SECTION II: PRINCIPAL RESOLUTION**

A. The Group agrees to reimburse Anthem according to the terms of these Funding Provisions for Non-Capitated Claims paid by Anthem on or after the effective date.

B. Anthem will provide the Group with coverage for Non-Capitated Claims in excess of the Pooling Limit and Claims Liability Limit, as specified in these Funding Provisions.

C. The Group agrees to pay Anthem applicable Subscription Charges, consisting of Retention Charges, Pooling Charges and Capitation Expense, as set forth in the **Schedule**.

D. Upon completion of the first three months of each Agreement Year, Anthem will make an evaluation of the Capitation Expense charged to the Group for that three-month period. Anthem reserves the right to reconcile such Capitation Expense, in accordance with the terms set forth in **Section X: Review and Reconciliation of Capitation Expense**, if it is determined that the amount charged for the three-month period was inadequate or excessive.

E. The Group agrees to pay Anthem applicable Administrative Fees for the use of the BlueCard Program, as set forth in the **Schedule**.

# FUNDING PROVISIONS

## SECTION III: DEFINITIONS

The following terms, when capitalized throughout this endorsement, shall have the meanings set forth below.

**Capitation** is a method of payment for health services in which a Physician or Hospital is paid a fixed amount for each person served regardless of the number or nature of services provided to each person.

**Capitation Expense** is the monthly fixed amount determined by Anthem which is due and payable to Anthem by the Group for each enrolled Member. Capitation Expense includes actual Capitation charges plus all related Capitation costs paid by Anthem to participating medical groups and independent practice associations to cover professional and other capitated health care services including, but not limited to, contributions to shared risk funds and provider incentive pools calculated in accordance with Anthem corporate policy.

**Claims Liability Limit** shall mean the maximum amount of Non-Capitated Claims for which the Group is liable during an Agreement Year, subject to the terms and conditions set forth in **Section VI**.

**Contract Type** means the category of enrollment, as designated in the **Schedule**, used to determine the monthly attachment point factor and the monthly Subscription Charges.

**Non-Capitated Claims** represent all claims incurred under the Plan for services or supplies which are not subject to Capitation.

**Plan Benefits** shall mean those benefits for which coverage is described under the Plan, including any extension of such coverage.

**Pooling Limit** is the dollar limit for which the Group is liable for Non-Capitated Claims paid on behalf of any one Member during an Agreement Year. The Pooling Limit is specified in the **Schedule**.

**Retention** means the amount charged by Anthem for expenses, commissions, taxes and risk. Retention Charges are shown in the **Schedule**.

**Subscription Charges** refers to the charges for Retention, Pooling and Capitation Expense calculated in accordance with these Funding Provisions, and subject to annual accounting. The Subscription Charges are specified in the **Schedule**.

**Surplus.** Surpluses on the Plan are determined by annual accounting performed by Anthem, as set forth in **Section VII: Annual Settlement**.

## SECTION IV: REIMBURSEMENT OF NON-CAPITATED CLAIMS

On the first working day of every week, Anthem will telephone to the Group the total amount of Non-Capitated Claims paid during the preceding week. The Group will immediately deposit this amount via wire transfer to a designated Anthem bank account. On the same day, Anthem will mail a written version of the request to the Group, together with a listing of Non-Capitated Claims.

At the end of each month, Anthem will mail a written summary of the Non-Capitated Claims billed to the Group and the amounts requested from the Group during the month. Adjustments of any discrepancies will be made at such time.

## SECTION V: POOLING LIMIT

The Group is liable for the accumulated paid Non-Capitated Claims of a Subscriber or Family Member up to the Pooling Limit, as set forth in the **Schedule**. Accumulation toward this Limit takes place over a period of twelve consecutive months, starting at the beginning of each Agreement Year.

If, in any Agreement Year, the accumulated paid Non-Capitated Claims for a Subscriber or Family Member equal the Pooling Limit for that Agreement Year, the Group shall continue to be responsible for funding any further Non-Capitated Claims paid for that Subscriber or Family Member for that month and each subsequent month during the remainder of that Agreement Year. However, Anthem shall reimburse the Group in the amount of such further paid Non-Capitated Claims during the month immediately following the month in which the Non-Capitated Claims are paid.

Anthem shall notify the Group when the Pooling Limit has been exceeded for a Subscriber or Family Member. Such notification shall be made one month following the month in which such Limit has been exceeded.

Non-Capitated Claims incurred but not paid during an Agreement Year will accumulate toward the Pooling Limit for the subsequent Agreement Year.

On the date the Agreement terminates, this Limit shall no longer apply. However, Non-Capitated Claims paid and applied to the Pooling Limit may be adjusted after the Agreement Year if Anthem recovers any overpayments, workers' compensation or third party liability liens, as specified in **Section XII**. Anthem will recalculate the Non-Capitated Claims applied to the Pooling Limit and the Group will reimburse Anthem for any adjustments made over the Pooling Limit.

**Note.** The Pooling Limit does not apply to Dental Benefits or Prescription Drug Benefits, nor will Non-Capitated Claims paid on these benefits be applied toward that Limit.

## SECTION VI: CLAIMS LIABILITY LIMIT

The Claims Liability Limit is the maximum amount of Non-Capitated Claims for which the Group is liable during an Agreement Year. The Claims Liability Limit is 125% of the projected paid Non-Capitated Claims for the Agreement Year.

The number of Subscribers per Contract Type which will be used to determine the Claims Liability Limit for the first three months of the first Agreement Year, shall be the number of such Subscribers covered on the first day of the first month of that Agreement Year.

Thereafter, the number of Subscribers per Contract Type to be used shall be the number of such Subscribers covered on the first day of the second preceding calendar month; however, if in any given month the number of Subscribers falls below 90% of the Initial Monthly Attachment Point, the number of Subscribers used to determine the Claims Liability Limit shall be equal to 90% of such Initial Monthly Attachment Point.

Non-Capitated Claims will be applied to the Claims Liability Limit. If the accumulated Non-Capitated Claims exceeds the Claims Liability Limit, the Group will no longer be responsible for any Non-Capitated Claims incurred after the Claims Liability Limit is reached.

## SECTION VII: ANNUAL SETTLEMENT

Within 120 days after the end of each Agreement Year, Anthem will perform an annual accounting in which the total Non-Capitated Claims paid under the Plan during the Agreement Year (excluding Non-Capitated Claims which exceed the Pooling Limit) are compared to the Claims Liability Limit.

- If the total amount of such Non-Capitated Claims paid for the Agreement Year exceeds the Claims Liability Limit, the excess will be refunded to the Group.

- If the Claims Liability Limit is greater than the amount of such Non-Capitated Claims paid during the Agreement Year, the difference between the two amounts is the amount of the Surplus on the Plan for the Agreement Year.

## SECTION VIII: SUBSCRIPTION CHARGES

Anthem will bill the Group each month for Subscription Charges, as specified in the **Schedule**. The first payment is due on the Agreement Effective Date. The Agreement remains in effect for the term of one month from that date. Succeeding Subscription Charges are due on the first day of each following month. This day is the Subscription Charge Due Date.

## SECTION IX: BLUECARD PROGRAM

Anthem is a member of the Blue Cross Blue Shield Association. The Blue Cross Blue Shield Association has a program (called the "BlueCard Program") which allows our Members who are traveling outside of California to have the reciprocal use of participating providers contracted under other states' Blue Cross Blue Shield plans. There are fees associated with the reciprocal use of such providers by Members and are determined in accordance with the applicable rules of the Blue Cross Blue Shield Association which will be charged back to the Group. These fees are:

A. **Access Fees.** Access fees are a percentage of the savings generated by the discounts between the Blue Cross Blue Shield Plan and the provider. Some plans may charge up to 7.75% of savings generated by their discounts, up to $2,000 per claim, as a network access charge. If there are no savings from the discounts, there will be no access fee charged.

B. **Administrative Fees.** Administrative fees are fees charged for each claim payment. There is a charge for each institutional and professional claim paid under this program, and an additional charge for each transaction. There is an electronics claims routing process fee for all non-participating provider claims. The charges are specified in the **Schedule**.

These fees are subject to change in accordance with the applicable rules of the Blue Cross Blue Shield Association and will be included in the Group's claims experience and will be charged to the Group as Non-Capitated Claims.

## SECTION X: REVIEW AND RECONCILIATION OF CAPITATION EXPENSE

A review of Capitation Expense by Anthem will take place 90 days after the initial effective date of these Funding Provisions and, subsequently, 90 days after the end of each Agreement Year, to verify the adequacy of the amount charged by Anthem to the Group. In this review, the Capitation Expense charged to the Group for the first three months of the Agreement Year will be compared to the actual Capitation Expense incurred, based on actual enrollment figures for that three-month period.

If it is determined by Anthem that the Capitation Expense charged for such three-month period was inadequate or excessive, Anthem may, at its sole discretion, reconcile that Capitation Expense to more accurately reflect the actual enrollment figures, plus any deficit attributable to the prior Agreement Year. Any such reconciliation of the Capitation Expense shall be reflected in the monthly billing to the Group during the remaining months of the Agreement Year. In such case, these Funding Provisions shall be reissued, notwithstanding any prior authorization thereof by the parties to this endorsement, to reflect the appropriate adjustment to Capitation Expense.

## SECTION XI: MODIFICATION OF FUNDING PROVISIONS

A. **Amendment of Terms.** Anthem may amend the terms of these Funding Provisions as follows:

1. At the beginning of any month or upon annual renewal of the Agreement, provided Anthem gives the Group thirty (30) days written notice;

2. Any time the provisions of the Agreement are changed; or

3. Any time there is a ten (10) percent or greater change in the number of Subscribers enrolled under the Agreement during the preceding three months, from the number of Subscribers enrolled at the start of the Agreement Year; or.

4. As specified in **Section X: Review and Reconciliation of Capitation Expense**.

B. **Adjustment of Retention.** Anthem may adjust the charge for Retention as follows:

1. On the date Anthem, at the Group's request, begins to perform additional administrative services relating to the Agreement;

2. On the effective date of any legislation or governmental regulations which impose additional administrative duties on Anthem relating to the Agreement;

3. On the effective date that any tax, which is based on Income, is imposed upon Anthem by the state or any other taxing authority. In such case, Anthem will increase the charge for Retention by an amount sufficient to cover the tax; or

4. As provided under items 1, 2 and 3 of paragraph A, **Amendment of Terms**.

C. **Adjustment of Attachment Point Factors.** Anthem reserves the right to change the monthly attachment point factors and the post-termination attachment point factors:

1. On the first day of any month after these Funding Provisions have been in effect for 12 months;

2. Whenever the terms of these Funding Provisions are changed;

3. On the effective date of any law or regulation which affects Anthem's liability under the Agreement;

4. Whenever benefits are changed under the Agreement; or

5. As provided under items 1, 2 and 3 of paragraph A, **Amendment of Terms**.

## SECTION XII: RECOVERY PROVISIONS

A. **Recovery of Overpayments.** If it is determined that any payment has been made under this Agreement to an ineligible person, or if it is determined that more or less than a correct amount has been paid by Anthem, Anthem shall make a reasonable effort to recover any such overpayment made or to adjust the payment, subject to the following:

1. Anthem, at its discretion, may use the services of subcontractors (collection agencies and bill audit firms) to identify and recover overpayments. Any expenses which Anthem incurs for such services are included in the retention.

2. Anthem will not be required to initiate court proceeding for any such recovery.

B. **Recovery of Liens.** Subject to the following, Anthem agrees to use reasonable diligence to identify and seek to recover third-party liability liens or workers' compensation liens:

1. In pursuing these recoveries, Anthem reserves the right to use its discretion in negotiating and compromising recoveries from third parties.

2. Anthem may engage the services of subcontractors to assist in the recovery process. Expenses which Anthem incurs for such services are included in the retention.

3. The Group will fully cooperate with Anthem in such recoveries and advise Anthem of any potential recoveries of which it becomes aware.

4. Anthem will not be required to initiate court proceeding for any such recovery.

5. Anthem will submit monthly reports to the Group listing all cases identified as subject to third party liens or workers' compensation liens, the amount of claims paid, the current status of collection efforts and a report of all amounts collected and waived. The Group will advise Anthem of those cases which, in the Group's determination, shall warrant recovery.

## SECTION XIII: AUDIT

A. **Authorization of Audits.** Anthem may authorize audits, subject to certain limitations, to be performed by auditors employed by the Group. The Group shall have the right to select an auditor of its choice, except that the auditor shall not be involved in, or be subsidiary to, a business engaged in activities competitive to Anthem or to subsidiaries or affiliates of Anthem. Such audits will be conducted in accordance with, and subject to, the auditing standards of the American Institute of Certified Public Accountants and the written audit policy of Anthem, a copy of which shall be provided to the auditor.

B. **Confidential and Proprietary Information.** Anthem shall make available such records as may be reasonably necessary for a valid audit. Access by the Group, or any third party acting on behalf of the Group, to Anthem's confidential and proprietary information shall be restricted to only such information as deemed necessary by Anthem to accomplish the audit. The Group and the Group's auditor shall agree in writing (by a separate "Audit Agreement") regarding the auditor's conduct, and to maintain the confidentiality of any trade secret or proprietary information of which it may become aware during the course of the audit.

C. **Reimbursement of Anthem for Expense.** The Group agrees to reimburse Anthem for all expense incurred by Anthem in support of the audit. Any such expense will be billed to the Group and the Group will remit the amount billed to Anthem within 15 days from the date of the bill. Failure of the Group to pay such bill by the end of that 15 day period shall be deemed reason for cancellation of the Agreement by Anthem.

## SECTION XIV: TERMINATION PROVISIONS

A. Either Anthem or the Group may terminate these Funding Provisions by giving written notice to the other party at least 31 days prior to the effective date of such termination.

B. Anthem may terminate these Funding Provisions upon thirty-one (31) days advance written notice to the Group, if enrollment under the Agreement falls below 100 Subscribers for a period of three consecutive months. In the event of such termination, the account will be converted to a non-refunding arrangement. Beginning with the effective date of such termination, the Group shall pay to Anthem the monthly Non-Refunding Subscription Charges specified in the Group Benefit Agreement for the remainder of the Agreement Year.

C. These Funding Provisions or the Agreement, at Anthem's election, shall terminate upon written notice to the Group:

   1. If Anthem determines that the continuance of these Funding Provisions is prohibited by the enactment, amendment or construction of a law or regulation of any state or other jurisdiction. These Funding Provisions shall terminate as of the date such law, regulation, amendment or construction is determined by Anthem to be effective.

   2. If the Group fails to comply with any of the terms or conditions of these Funding Provisions or otherwise breaches or defaults in its obligations hereunder. Any waiver of a right to terminate these Funding Provisions or the Agreement for cause shall be as to the particular default only and shall not waive any rights or remedies with respect to any subsequent default.

D. Upon termination of the Agreement, these Funding Provisions shall also terminate.

Notwithstanding the provisions set forth in paragraphs A., B., C. and D. above, the terms and conditions of the **Post-Termination Provisions** set forth in **Section XV** shall survive the termination of the Agreement or these Funding Provisions thereof.

## SECTION XV: POST-TERMINATION PROVISIONS

A. In the event of termination of the Agreement, the procedures and obligations described in this endorsement will, to the extent applicable, survive such termination and remain in effect while the Group remains liable. The Group will continue to reimburse Anthem for the Group's liability in accordance with the provisions of **Section IV: Reimbursement of Non-Capitated Claims** and, subject to the **Post-Termination Claims Liability Limit** provision below, the Group will be liable for and pay to Anthem:

   1. Non-Capitated Claims which are incurred prior to, but paid after the termination date;

   2. Non-Capitated Claims which are incurred after the termination date and are payable under the Extension of Benefits provision of the Plan; and

3. Post-Termination Administrative Charges for the administration of Non-Capitated Claims paid following the termination date. The amount of these charges will be based on a percentage of paid Non-Capitated Claims, as set forth in the **Schedule**. These charges will continue as long as Non-Capitated Claims are being paid under these Post-Termination Provisions. Post-Termination Administrative Charges do not apply toward the Post-Termination Claims Liability Limit.

4. Administrative Fees for the use of the BlueCard Program, as set forth in the **Schedule**. These Fees do not apply toward the Post-Termination Claims Liability Limit.

5. Post-Termination Capitation Expense, as determined by Anthem based on actual Capitation charges being incurred at the time of termination for individuals covered under the Extension of Benefits provision of the Agreement. Post-Termination Capitation Expense does not apply toward the Post-Termination Claims Liability Limit.

B. In the event that the funding arrangement described in this endorsement terminates while the Agreement remains in effect, subsection A immediately above will apply and, in addition, the Group shall also be liable for and pay to Anthem:

1. Non-Capitated Claims incurred during a confinement in a hospital, skilled nursing facility or hospice, which confinement began prior to the termination of this funding arrangement; and

2. Non-Capitated Claims incurred for ongoing services received from a home health agency, visiting nurse association or day treatment center, if the first date of service for the course of treatment giving rise to such Claims is prior to the termination of this funding arrangement.

C. **Post-Termination Claims Liability Limit*.** The Group's liability for Non-Capitated Claims, as determined in accordance with the subsection A above (other than items 3, 4 and 5 of such provision), shall not exceed the sum of items 1 and 2 below.

1. An amount equal to the sum of the products obtained by multiplying the number of Subscribers per Contract Type for the three months immediately prior to the termination of these Funding Provisions, by the appropriate Post-Termination Claims Liability Factors set forth in the **Schedule**; plus

2. The amount of the Surplus, if any, at the end of the Agreement Year.

***Note.** Post-Termination Administrative Charges, Administrative Fees charged for the use of the BlueCard Program, and Post-Termination Capitation Expense do not apply toward the Post-Termination Claims Liability Limit.

**Exception to "item 1" above.** If the number of Subscribers per Contract Type for any of the three months immediately prior to the termination of these Funding Provisions was less than "90% of the Initial Enrollment", the number of Subscribers per Contract Type which will be used to determine the Post-Termination Claims Liability Limit shall be "90% of the Initial Enrollment".

The **Initial Enrollment** is the number of Subscribers per Contract Type covered on the first day of the first month of the Agreement Year.

**Exception to "item 2" above.** If the term of the last Agreement Year is less than 12 months, item 2. above shall read: "An amount equal to the sum of the Surpluses for (a) the last Agreement Year, and (b) the Agreement Year immediately preceding that Year."

D. **Pooling Limit.** The liability of the Group under this section will not be subject to or limited by the Pooling Limit provisions of this endorsement.

E. **Cancellation of Funding Arrangement**. If the Agreement remains in force after the funding arrangement described in this endorsement terminates, the Group shall pay Subscription Charges to Anthem for continued coverage under the Agreement. Unless Anthem and the Group otherwise agree in writing, the amounts of the Subscription Charges will be determined by Anthem at its discretion.

F. **Final Settlement.** Subsequently, Anthem will perform a final settlement of all accounts in accordance with the following terms and conditions:

1. The final settlement will take place on a date determined by Anthem; however, in no event will such final settlement occur later than 24 months after the termination date.

2. Upon completion of the final settlement, Anthem will remit to the Group any unused amounts held in the Minimum Claims Deposit, subject to the Group's endorsement of the "Acknowledgment of Receipt and Release of Claim".

3. In the event that any Non-Capitated Claims incurred under the Agreement prior to the termination date are paid by Anthem after the final settlement, the Group will reimburse Anthem for the amount of such Non-Capitated Claims, plus Post-Termination Administrative Charges.

G. Anthem will not be responsible for the Group's use of any payment made by Anthem under the terms of these Funding Provisions.

## SECTION XVI: RESPONSIBILITIES OF THE GROUP

A. **Payments Made in Connection with a Judgment or Settlement.** The Group agrees to pay the amount of benefit payments included in any judgment or settlement to the extent of its Claims Liability Limit. Benefit payments made in accordance with the terms of any judgment or settlement shall be considered benefits paid under the Plan for the month in which such judgment or settlement is satisfied.

B. **Reimbursement of Benefits to a Person or Organization.** If any person or organization pays any amount of benefits which is an obligation of the Group, the Group shall reimburse such person or organization to the extent of such payment, plus any reasonable costs or charges in connection with such payment. In no event shall any such payment by either party to these Funding Provisions, or by any person or organization, be construed as obliging such party, person or organization for payment of benefits.

C. **Notice to Subscribers.** The Group shall furnish to covered Subscribers a written "Notice to Subscribers" advising that the Group is liable for payment of a portion of the benefits under the Plan and that this portion will not be insured by Anthem. The Group agrees to indemnify Anthem and hold Anthem harmless against any and all loss, damage and expense sustained by Anthem as a result of any failure by the Group to provide such notice.

D. **Notification of Required Information.** The Group shall notify Anthem immediately as to any modification or termination of the Plan. Anthem will not be responsible for any delay or non-performance of its functions under these Funding Provisions which is caused or contributed to in whole or in part by the failure of the Group to furnish any required information on a timely basis.

E. **Maintenance and Audit of Records.** The Group agrees to maintain and to permit Anthem to audit, at all reasonable times, all records required by Anthem for the administration of these Funding Provisions.

F. **Minimum Claims Deposit.** The Group agrees to provide, within two weeks after the effective date of these Funding Provisions, a Minimum Claims Deposit in an amount determined by Anthem. The Group agrees to maintain such Minimum Claims Deposit at Anthem for the term of the Agreement Year. The amount of the Minimum Claims Deposit is specified in the **Schedule**.

Anthem may change the amount of the Minimum Claims Deposit with prior written notice, as specified in **Section XI: Modification of Funding Provisions**. If Anthem decreases the amount of the Deposit required, Anthem will, upon the written request of the Group, refund the excess to the Group. If Anthem increases the amount of the Deposit required, the Group will, prior to the effective date of the change, remit to Anthem the additional amount required.

## SECTION XVII: ANTHEM DUTIES AS AGENT

Anthem as agent for and on behalf of the Group, shall:

A. Make final determination of the amount of benefits, if any, payable with respect to each Non-Capitated Claim for benefits under the Plan, in accordance with the terms and conditions described in the Agreement;

B. Undertake the defense of any suit brought with respect to any Non-Capitated Claim for benefits under the Plan and settle any such suit when in its judgment it appears expedient to do so; and

C. Make final determination of the amount of Plan Benefits payable from Group funds.

Anthem will use ordinary care and reasonable diligence in the exercise of its powers and the performance of its duties hereunder.

## SECTION XVIII: INDEMNIFICATION

A. Anthem agrees to indemnify the Group and hold the Group harmless against any and all loss, damage, and expense with respect to these Funding Provisions to the extent that such loss, damage and expense result from or arise out of negligent, dishonest, fraudulent, or criminal acts of Anthem employees, acting alone or in collusion with others, unless such collusion is with an employee of the Group, in which case Anthem shall be relieved of any obligations under this paragraph.

B. Except as provided in paragraph A above, the Group agrees to indemnify and hold Anthem harmless against any loss, expense, or other cost or obligation, resulting from or arising out of claims, assessments or taxes, including premium taxes, or resulting from the action of any government body.

C. If either Anthem or the Group has paid any benefits which were the responsibility of the other party, appropriate reimbursement will be made.

## SECTION XIX: FINANCIAL ARRANGEMENTS WITH PROVIDERS

Anthem or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as “Providers”) for the provision of and payment for health care services rendered to its Subscribers and Members/Insured Persons entitled to health care benefits under individual certificates and group policies or contracts to which Anthem or an affiliate is a party, including all persons covered under the Agreement.

## FUNDING PROVISIONS

Under the above-referenced contracts between Providers and Anthem or an affiliate, the negotiated rates paid for certain medical services provided to persons covered under the Agreement may differ from the rates paid for persons covered by other types of products or programs offered by Anthem or an affiliate for the same medical services. In negotiating the terms of the Agreement, the Group was aware that Anthem or its affiliates offer several types of products and programs. The Subscribers, Family Members and the Group are entitled to receive the benefits of only those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the Agreement.

Also, under arrangements with some Providers certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, pharmacy rebates, may be based on aggregate payments made by Anthem or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by Anthem or an affiliate. They are not attributed to specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by Anthem or an affiliate in determining its fees or subscription charges or premiums.

### SECTION XX: TERMINATION PROVISION

Any amounts due to Anthem under this funding arrangement are subscription charges under the Group Benefit Agreement to which these Funding Provisions are made a part. Any failure by the group to pay such additional subscription charges when due may result in, at Anthem' option either: (a) termination of these funding provisions and recalculation of the subscription charges under the Group Benefit Agreement; or (b) in accordance with the Group Benefit Agreement's Cancellation provisions, termination for failure to pay subscription charges as they become due.

### AUTHORIZATION

Authorized officers of Anthem and of the Group have approved this endorsement as of its effective date.

**FOR ANTHEM BLUE CROSS**

| | | | |
|---|---|---|---|
| by: | _____ | by: | _____ |
| | Pam Kehaly | | Kathy Kiefer |
| Title: | President | Title: | Secretary |

**FOR THE GROUP**

| | | | |
|---|---|---|---|
| by: | _____ | by: | _____ |
| Title: | _____ | Title: | _____ |

# SCHEDULE

## EFFECTIVE DATE

This Schedule reflects the Funding Provisions which become effective on January 1, 2013.

## MINIMUM CLAIMS DEPOSIT

The amount of the Minimum Claims Deposit to be maintained for the term of the Agreement Year is $41,858.

## POOLING LIMIT

The Pooling Limit for the Agreement Year is $400,000.00*.

*****This Limit does not apply to Dental Benefits or Prescription Drug Benefits, nor will claims paid on these benefits be applied toward the Pooling Limit.

# SCHEDULE

**MONTHLY ATTACHMENT POINT FACTORS**

| Contract Types | Monthly Attachment Point Factors | Post-Termination Attachment Point Factors |
|---|---|---|
| Composite Rate (per Subscriber) | $ 509.37 | $ 448.28 |

**SUBSCRIPTION CHARGES**

The monthly Subscription Charges during the Agreement Year is $316.45 per Subscriber.

**BREAKDOWN OF SUBSCRIPTION CHARGES:**

The following is a breakdown of the above Subscription Charges:

**Retention Charges**

The monthly Retention Charges during the Agreement Year is $37.76 per Subscriber.

**Pooling Charges**

The monthly Pooling Charges during the Agreement Year is $21.02 per Subscriber.

**Capitation Expense**

The monthly charges for Capitation Expense during the Agreement Year is $257.71 per Subscriber.

**BLUECARD PROGRAM**

The Group will pay to Anthem the following Administrative Fees determined in accordance with the applicable rules of the Blue Cross Blue Shield Association for the use of Out-of-California Providers under the BlueCard Program:

| Administrative Fees | Per Claim |
|---|---|
| Institutional Claims | $ 11.00 |
| Professional Claims | $ 5.00 |
| Central Financial Agency Fee | $ .20 |
| Charge per transaction | $ .05 |
| Electronic Claims Routing Process (ECRP) (non-participating provider claims) | $ 1.00 |

These fees are subject to change in accordance with the applicable rules of the Blue Cross Blue Shield Association.

**POST-TERMINATION ADMINISTRATIVE CHARGES**

The monthly Post-Termination Administrative Charge is 6% of paid Non-Capitated Claims.

Anthem Blue Cross

# FUNDING PROVISIONS

## MINIMUM PREMIUM

with

## WEEKLY BANK TRANSFER AND CLAIMS LIABILITY LIMIT

between

## ANTHEM BLUE CROSS

and

## COUNTY OF FRESNO

(the Group)

**SECTION I: BASIC FACTS**

Group Benefit Agreement SF275341-C (R-1212) (the "Agreement") currently in effect between the Group and Anthem Blue Cross ("Anthem") is subject to the Funding Provisions of this endorsement.

Effective January 1, 2013, these Funding Provisions are made a part of the Agreement. All other provisions of the Agreement which are not inconsistent with this endorsement remain in effect.

With respect to these Funding Provisions, the Agreement Year will begin on the effective date of this endorsement and will end on December 31, 2013. Each subsequent Agreement Year will be a period of twelve (12) consecutive calendar months, beginning on January 1. Any Agreement Year will end, however, upon termination of the Agreement.

**SECTION II: PRINCIPAL RESOLUTION**

A. The Group agrees to reimburse Anthem according to the terms of these Funding Provisions for Non-Capitated Claims paid by Anthem on or after the effective date.

B. Anthem will provide the Group with coverage for Non-Capitated Claims in excess of the Pooling Limit and Claims Liability Limit, as specified in these Funding Provisions.

C. The Group agrees to pay Anthem applicable Subscription Charges, consisting of Retention Charges, Pooling Charges and Capitation Expense, as set forth in the **Schedule**.

D. Upon completion of the first three months of each Agreement Year, Anthem will make an evaluation of the Capitation Expense charged to the Group for that three-month period. Anthem reserves the right to reconcile such Capitation Expense, in accordance with the terms set forth in **Section X: Review and Reconciliation of Capitation Expense**, if it is determined that the amount charged for the three-month period was inadequate or excessive.

E. The Group agrees to pay Anthem applicable Administrative Fees for the use of the BlueCard Program, as set forth in the **Schedule**.

# FUNDING PROVISIONS

## SECTION III: DEFINITIONS

The following terms, when capitalized throughout this endorsement, shall have the meanings set forth below.

**Capitation** is a method of payment for health services in which a Physician or Hospital is paid a fixed amount for each person served regardless of the number or nature of services provided to each person.

**Capitation Expense** is the monthly fixed amount determined by Anthem which is due and payable to Anthem by the Group for each enrolled Member. Capitation Expense includes actual Capitation charges plus all related Capitation costs paid by Anthem to participating medical groups and independent practice associations to cover professional and other capitated health care services including, but not limited to, contributions to shared risk funds and provider incentive pools calculated in accordance with Anthem corporate policy.

**Claims Liability Limit** shall mean the maximum amount of Non-Capitated Claims for which the Group is liable during an Agreement Year, subject to the terms and conditions set forth in **Section VI**.

**Contract Type** means the category of enrollment, as designated in the **Schedule**, used to determine the monthly attachment point factor and the monthly Subscription Charges.

**Non-Capitated Claims** represent all claims incurred under the Plan for services or supplies which are not subject to Capitation.

**Plan Benefits** shall mean those benefits for which coverage is described under the Plan, including any extension of such coverage.

**Pooling Limit** is the dollar limit for which the Group is liable for Non-Capitated Claims paid on behalf of any one Member during an Agreement Year. The Pooling Limit is specified in the **Schedule**.

**Retention** means the amount charged by Anthem for expenses, commissions, taxes and risk. Retention Charges are shown in the **Schedule**.

**Subscription Charges** refers to the charges for Retention, Pooling and Capitation Expense calculated in accordance with these Funding Provisions, and subject to annual accounting. The Subscription Charges are specified in the **Schedule**.

**Surplus.** Surpluses on the Plan are determined by annual accounting performed by Anthem, as set forth in **Section VII: Annual Settlement**.

## SECTION IV: REIMBURSEMENT OF NON-CAPITATED CLAIMS

On the first working day of every week, Anthem will telephone to the Group the total amount of Non-Capitated Claims paid during the preceding week. The Group will immediately deposit this amount via wire transfer to a designated Anthem bank account. On the same day, Anthem will mail a written version of the request to the Group, together with a listing of Non-Capitated Claims.

At the end of each month, Anthem will mail a written summary of the Non-Capitated Claims billed to the Group and the amounts requested from the Group during the month. Adjustments of any discrepancies will be made at such time.

## SECTION V: POOLING LIMIT

The Group is liable for the accumulated paid Non-Capitated Claims of a Subscriber or Family Member up to the Pooling Limit, as set forth in the **Schedule**. Accumulation toward this Limit takes place over a period of twelve consecutive months, starting at the beginning of each Agreement Year.

If, in any Agreement Year, the accumulated paid Non-Capitated Claims for a Subscriber or Family Member equal the Pooling Limit for that Agreement Year, the Group shall continue to be responsible for funding any further Non-Capitated Claims paid for that Subscriber or Family Member for that month and each subsequent month during the remainder of that Agreement Year. However, Anthem shall reimburse the Group in the amount of such further paid Non-Capitated Claims during the month immediately following the month in which the Non-Capitated Claims are paid.

Anthem shall notify the Group when the Pooling Limit has been exceeded for a Subscriber or Family Member. Such notification shall be made one month following the month in which such Limit has been exceeded.

Non-Capitated Claims incurred but not paid during an Agreement Year will accumulate toward the Pooling Limit for the subsequent Agreement Year.

On the date the Agreement terminates, this Limit shall no longer apply. However, Non-Capitated Claims paid and applied to the Pooling Limit may be adjusted after the Agreement Year if Anthem recovers any overpayments, workers' compensation or third party liability liens, as specified in **Section XII**. Anthem will recalculate the Non-Capitated Claims applied to the Pooling Limit and the Group will reimburse Anthem for any adjustments made over the Pooling Limit.

**Note.** The Pooling Limit does not apply to Dental Benefits or Prescription Drug Benefits, nor will Non-Capitated Claims paid on these benefits be applied toward that Limit.

## SECTION VI: CLAIMS LIABILITY LIMIT

The Claims Liability Limit is the maximum amount of Non-Capitated Claims for which the Group is liable during an Agreement Year. The Claims Liability Limit is 125% of the projected paid Non-Capitated Claims for the Agreement Year.

The number of Subscribers per Contract Type which will be used to determine the Claims Liability Limit for the first three months of the first Agreement Year, shall be the number of such Subscribers covered on the first day of the first month of that Agreement Year.

Thereafter, the number of Subscribers per Contract Type to be used shall be the number of such Subscribers covered on the first day of the second preceding calendar month; however, if in any given month the number of Subscribers falls below 90% of the Initial Monthly Attachment Point, the number of Subscribers used to determine the Claims Liability Limit shall be equal to 90% of such Initial Monthly Attachment Point.

Non-Capitated Claims will be applied to the Claims Liability Limit. If the accumulated Non-Capitated Claims exceeds the Claims Liability Limit, the Group will no longer be responsible for any Non-Capitated Claims incurred after the Claims Liability Limit is reached.

## SECTION VII: ANNUAL SETTLEMENT

Within 120 days after the end of each Agreement Year, Anthem will perform an annual accounting in which the total Non-Capitated Claims paid under the Plan during the Agreement Year (excluding Non-Capitated Claims which exceed the Pooling Limit) are compared to the Claims Liability Limit.

- If the total amount of such Non-Capitated Claims paid for the Agreement Year exceeds the Claims Liability Limit, the excess will be refunded to the Group.

- If the Claims Liability Limit is greater than the amount of such Non-Capitated Claims paid during the Agreement Year, the difference between the two amounts is the amount of the Surplus on the Plan for the Agreement Year.

## SECTION VIII: SUBSCRIPTION CHARGES

Anthem will bill the Group each month for Subscription Charges, as specified in the **Schedule**. The first payment is due on the Agreement Effective Date. The Agreement remains in effect for the term of one month from that date. Succeeding Subscription Charges are due on the first day of each following month. This day is the Subscription Charge Due Date.

## SECTION IX: BLUECARD PROGRAM

Anthem is a member of the Blue Cross Blue Shield Association. The Blue Cross Blue Shield Association has a program (called the "BlueCard Program") which allows our Members who are traveling outside of California to have the reciprocal use of participating providers contracted under other states' Blue Cross Blue Shield plans. There are fees associated with the reciprocal use of such providers by Members and are determined in accordance with the applicable rules of the Blue Cross Blue Shield Association which will be charged back to the Group. These fees are:

A. **Access Fees.** Access fees are a percentage of the savings generated by the discounts between the Blue Cross Blue Shield Plan and the provider. Some plans may charge up to 7.75% of savings generated by their discounts, up to $2,000 per claim, as a network access charge. If there are no savings from the discounts, there will be no access fee charged.

B. **Administrative Fees.** Administrative fees are fees charged for each claim payment. There is a charge for each institutional and professional claim paid under this program, and an additional charge for each transaction. There is an electronics claims routing process fee for all non-participating provider claims. The charges are specified in the **Schedule**.

These fees are subject to change in accordance with the applicable rules of the Blue Cross Blue Shield Association and will be included in the Group's claims experience and will be charged to the Group as Non-Capitated Claims.

## SECTION X: REVIEW AND RECONCILIATION OF CAPITATION EXPENSE

A review of Capitation Expense by Anthem will take place 90 days after the initial effective date of these Funding Provisions and, subsequently, 90 days after the end of each Agreement Year, to verify the adequacy of the amount charged by Anthem to the Group. In this review, the Capitation Expense charged to the Group for the first three months of the Agreement Year will be compared to the actual Capitation Expense incurred, based on actual enrollment figures for that three-month period.

If it is determined by Anthem that the Capitation Expense charged for such three-month period was inadequate or excessive, Anthem may, at its sole discretion, reconcile that Capitation Expense to more accurately reflect the actual enrollment figures, plus any deficit attributable to the prior Agreement Year. Any such reconciliation of the Capitation Expense shall be reflected in the monthly billing to the Group during the remaining months of the Agreement Year. In such case, these Funding Provisions shall be reissued, notwithstanding any prior authorization thereof by the parties to this endorsement, to reflect the appropriate adjustment to Capitation Expense.

## SECTION XI: MODIFICATION OF FUNDING PROVISIONS

A. **Amendment of Terms.** Anthem may amend the terms of these Funding Provisions as follows:

1. At the beginning of any month or upon annual renewal of the Agreement, provided Anthem gives the Group thirty (30) days written notice;

2. Any time the provisions of the Agreement are changed; or

3. Any time there is a ten (10) percent or greater change in the number of Subscribers enrolled under the Agreement during the preceding three months, from the number of Subscribers enrolled at the start of the Agreement Year; or.

4. As specified in **Section X: Review and Reconciliation of Capitation Expense**.

B. **Adjustment of Retention.** Anthem may adjust the charge for Retention as follows:

1. On the date Anthem, at the Group's request, begins to perform additional administrative services relating to the Agreement;

2. On the effective date of any legislation or governmental regulations which impose additional administrative duties on Anthem relating to the Agreement;

3. On the effective date that any tax, which is based on Income, is imposed upon Anthem by the state or any other taxing authority. In such case, Anthem will increase the charge for Retention by an amount sufficient to cover the tax; or

4. As provided under items 1, 2 and 3 of paragraph A, **Amendment of Terms**.

C. **Adjustment of Attachment Point Factors.** Anthem reserves the right to change the monthly attachment point factors and the post-termination attachment point factors:

1. On the first day of any month after these Funding Provisions have been in effect for 12 months;

2. Whenever the terms of these Funding Provisions are changed;

3. On the effective date of any law or regulation which affects Anthem's liability under the Agreement;

4. Whenever benefits are changed under the Agreement; or

5. As provided under items 1, 2 and 3 of paragraph A, **Amendment of Terms**.

## SECTION XII: RECOVERY PROVISIONS

A. **Recovery of Overpayments.** If it is determined that any payment has been made under this Agreement to an ineligible person, or if it is determined that more or less than a correct amount has been paid by Anthem, Anthem shall make a reasonable effort to recover any such overpayment made or to adjust the payment, subject to the following:

1. Anthem, at its discretion, may use the services of subcontractors (collection agencies and bill audit firms) to identify and recover overpayments. Any expenses which Anthem incurs for such services are included in the retention.

2. Anthem will not be required to initiate court proceeding for any such recovery.

B. **Recovery of Liens.** Subject to the following, Anthem agrees to use reasonable diligence to identify and seek to recover third-party liability liens or workers' compensation liens:

1. In pursuing these recoveries, Anthem reserves the right to use its discretion in negotiating and compromising recoveries from third parties.

2. Anthem may engage the services of subcontractors to assist in the recovery process. Expenses which Anthem incurs for such services are included in the retention.

3. The Group will fully cooperate with Anthem in such recoveries and advise Anthem of any potential recoveries of which it becomes aware.

4. Anthem will not be required to initiate court proceeding for any such recovery.

5. Anthem will submit monthly reports to the Group listing all cases identified as subject to third party liens or workers' compensation liens, the amount of claims paid, the current status of collection efforts and a report of all amounts collected and waived. The Group will advise Anthem of those cases which, in the Group's determination, shall warrant recovery.

## SECTION XIII: AUDIT

A. **Authorization of Audits.** Anthem may authorize audits, subject to certain limitations, to be performed by auditors employed by the Group. The Group shall have the right to select an auditor of its choice, except that the auditor shall not be involved in, or be subsidiary to, a business engaged in activities competitive to Anthem or to subsidiaries or affiliates of Anthem. Such audits will be conducted in accordance with, and subject to, the auditing standards of the American Institute of Certified Public Accountants and the written audit policy of Anthem, a copy of which shall be provided to the auditor.

B. **Confidential and Proprietary Information.** Anthem shall make available such records as may be reasonably necessary for a valid audit. Access by the Group, or any third party acting on behalf of the Group, to Anthem's confidential and proprietary information shall be restricted to only such information as deemed necessary by Anthem to accomplish the audit. The Group and the Group's auditor shall agree in writing (by a separate "Audit Agreement") regarding the auditor's conduct, and to maintain the confidentiality of any trade secret or proprietary information of which it may become aware during the course of the audit.

C. **Reimbursement of Anthem for Expense.** The Group agrees to reimburse Anthem for all expense incurred by Anthem in support of the audit. Any such expense will be billed to the Group and the Group will remit the amount billed to Anthem within 15 days from the date of the bill. Failure of the Group to pay such bill by the end of that 15 day period shall be deemed reason for cancellation of the Agreement by Anthem.

## SECTION XIV: TERMINATION PROVISIONS

A. Either Anthem or the Group may terminate these Funding Provisions by giving written notice to the other party at least 31 days prior to the effective date of such termination.

B. Anthem may terminate these Funding Provisions upon thirty-one (31) days advance written notice to the Group, if enrollment under the Agreement falls below 100 Subscribers for a period of three consecutive months. In the event of such termination, the account will be converted to a non-refunding arrangement. Beginning with the effective date of such termination, the Group shall pay to Anthem the monthly Non-Refunding Subscription Charges specified in the Group Benefit Agreement for the remainder of the Agreement Year.

C. These Funding Provisions or the Agreement, at Anthem's election, shall terminate upon written notice to the Group:

1. If Anthem determines that the continuance of these Funding Provisions is prohibited by the enactment, amendment or construction of a law or regulation of any state or other jurisdiction. These Funding Provisions shall terminate as of the date such law, regulation, amendment or construction is determined by Anthem to be effective.

2. If the Group fails to comply with any of the terms or conditions of these Funding Provisions or otherwise breaches or defaults in its obligations hereunder. Any waiver of a right to terminate these Funding Provisions or the Agreement for cause shall be as to the particular default only and shall not waive any rights or remedies with respect to any subsequent default.

D. Upon termination of the Agreement, these Funding Provisions shall also terminate.

Notwithstanding the provisions set forth in paragraphs A., B., C. and D. above, the terms and conditions of the **Post-Termination Provisions** set forth in **Section XV** shall survive the termination of the Agreement or these Funding Provisions thereof.

## SECTION XV: POST-TERMINATION PROVISIONS

A. In the event of termination of the Agreement, the procedures and obligations described in this endorsement will, to the extent applicable, survive such termination and remain in effect while the Group remains liable. The Group will continue to reimburse Anthem for the Group's liability in accordance with the provisions of **Section IV: Reimbursement of Non-Capitated Claims** and, subject to the **Post-Termination Claims Liability Limit** provision below, the Group will be liable for and pay to Anthem:

1. Non-Capitated Claims which are incurred prior to, but paid after the termination date;

2. Non-Capitated Claims which are incurred after the termination date and are payable under the Extension of Benefits provision of the Plan; and

3. Post-Termination Administrative Charges for the administration of Non-Capitated Claims paid following the termination date. The amount of these charges will be based on a percentage of paid Non-Capitated Claims, as set forth in the **Schedule**. These charges will continue as long as Non-Capitated Claims are being paid under these Post-Termination Provisions. Post-Termination Administrative Charges do not apply toward the Post-Termination Claims Liability Limit.

4. Administrative Fees for the use of the BlueCard Program, as set forth in the **Schedule**. These Fees do not apply toward the Post-Termination Claims Liability Limit.

5. Post-Termination Capitation Expense, as determined by Anthem based on actual Capitation charges being incurred at the time of termination for individuals covered under the Extension of Benefits provision of the Agreement. Post-Termination Capitation Expense does not apply toward the Post-Termination Claims Liability Limit.

B. In the event that the funding arrangement described in this endorsement terminates while the Agreement remains in effect, subsection A immediately above will apply and, in addition, the Group shall also be liable for and pay to Anthem:

1. Non-Capitated Claims incurred during a confinement in a hospital, skilled nursing facility or hospice, which confinement began prior to the termination of this funding arrangement; and

2. Non-Capitated Claims incurred for ongoing services received from a home health agency, visiting nurse association or day treatment center, if the first date of service for the course of treatment giving rise to such Claims is prior to the termination of this funding arrangement.

C. **Post-Termination Claims Liability Limit*.** The Group's liability for Non-Capitated Claims, as determined in accordance with the subsection A above (other than items 3, 4 and 5 of such provision), shall not exceed the sum of items 1 and 2 below.

1. An amount equal to the sum of the products obtained by multiplying the number of Subscribers per Contract Type for the three months immediately prior to the termination of these Funding Provisions, by the appropriate Post-Termination Claims Liability Factors set forth in the **Schedule**; plus

2. The amount of the Surplus, if any, at the end of the Agreement Year.

***Note.** Post-Termination Administrative Charges, Administrative Fees charged for the use of the BlueCard Program, and Post-Termination Capitation Expense do not apply toward the Post-Termination Claims Liability Limit.

**Exception to "item 1" above.** If the number of Subscribers per Contract Type for any of the three months immediately prior to the termination of these Funding Provisions was less than "90% of the Initial Enrollment", the number of Subscribers per Contract Type which will be used to determine the Post-Termination Claims Liability Limit shall be "90% of the Initial Enrollment".

The **Initial Enrollment** is the number of Subscribers per Contract Type covered on the first day of the first month of the Agreement Year.

**Exception to "item 2" above.** If the term of the last Agreement Year is less than 12 months, item 2. above shall read: "An amount equal to the sum of the Surpluses for (a) the last Agreement Year, and (b) the Agreement Year immediately preceding that Year."

D. **Pooling Limit.** The liability of the Group under this section will not be subject to or limited by the Pooling Limit provisions of this endorsement.

E. **Cancellation of Funding Arrangement**. If the Agreement remains in force after the funding arrangement described in this endorsement terminates, the Group shall pay Subscription Charges to Anthem for continued coverage under the Agreement. Unless Anthem and the Group otherwise agree in writing, the amounts of the Subscription Charges will be determined by Anthem at its discretion.

F. **Final Settlement.** Subsequently, Anthem will perform a final settlement of all accounts in accordance with the following terms and conditions:

1. The final settlement will take place on a date determined by Anthem; however, in no event will such final settlement occur later than 24 months after the termination date.

2. Upon completion of the final settlement, Anthem will remit to the Group any unused amounts held in the Minimum Claims Deposit, subject to the Group's endorsement of the "Acknowledgment of Receipt and Release of Claim".

3. In the event that any Non-Capitated Claims incurred under the Agreement prior to the termination date are paid by Anthem after the final settlement, the Group will reimburse Anthem for the amount of such Non-Capitated Claims, plus Post-Termination Administrative Charges.

G. Anthem will not be responsible for the Group's use of any payment made by Anthem under the terms of these Funding Provisions.

## SECTION XVI: RESPONSIBILITIES OF THE GROUP

A. **Payments Made in Connection with a Judgment or Settlement.** The Group agrees to pay the amount of benefit payments included in any judgment or settlement to the extent of its Claims Liability Limit. Benefit payments made in accordance with the terms of any judgment or settlement shall be considered benefits paid under the Plan for the month in which such judgment or settlement is satisfied.

B. **Reimbursement of Benefits to a Person or Organization.** If any person or organization pays any amount of benefits which is an obligation of the Group, the Group shall reimburse such person or organization to the extent of such payment, plus any reasonable costs or charges in connection with such payment. In no event shall any such payment by either party to these Funding Provisions, or by any person or organization, be construed as obliging such party, person or organization for payment of benefits.

C. **Notice to Subscribers.** The Group shall furnish to covered Subscribers a written "Notice to Subscribers" advising that the Group is liable for payment of a portion of the benefits under the Plan and that this portion will not be insured by Anthem. The Group agrees to indemnify Anthem and hold Anthem harmless against any and all loss, damage and expense sustained by Anthem as a result of any failure by the Group to provide such notice.

D. **Notification of Required Information.** The Group shall notify Anthem immediately as to any modification or termination of the Plan. Anthem will not be responsible for any delay or non-performance of its functions under these Funding Provisions which is caused or contributed to in whole or in part by the failure of the Group to furnish any required information on a timely basis.

E. **Maintenance and Audit of Records.** The Group agrees to maintain and to permit Anthem to audit, at all reasonable times, all records required by Anthem for the administration of these Funding Provisions.

F. **Minimum Claims Deposit.** The Group agrees to provide, within two weeks after the effective date of these Funding Provisions, a Minimum Claims Deposit in an amount determined by Anthem. The Group agrees to maintain such Minimum Claims Deposit at Anthem for the term of the Agreement Year. The amount of the Minimum Claims Deposit is specified in the **Schedule**.

Anthem may change the amount of the Minimum Claims Deposit with prior written notice, as specified in **Section XI: Modification of Funding Provisions**. If Anthem decreases the amount of the Deposit required, Anthem will, upon the written request of the Group, refund the excess to the Group. If Anthem increases the amount of the Deposit required, the Group will, prior to the effective date of the change, remit to Anthem the additional amount required.

## SECTION XVII: ANTHEM DUTIES AS AGENT

Anthem as agent for and on behalf of the Group, shall:

A. Make final determination of the amount of benefits, if any, payable with respect to each Non-Capitated Claim for benefits under the Plan, in accordance with the terms and conditions described in the Agreement;

B. Undertake the defense of any suit brought with respect to any Non-Capitated Claim for benefits under the Plan and settle any such suit when in its judgment it appears expedient to do so; and

C. Make final determination of the amount of Plan Benefits payable from Group funds.

Anthem will use ordinary care and reasonable diligence in the exercise of its powers and the performance of its duties hereunder.

## SECTION XVIII: INDEMNIFICATION

A. Anthem agrees to indemnify the Group and hold the Group harmless against any and all loss, damage, and expense with respect to these Funding Provisions to the extent that such loss, damage and expense result from or arise out of negligent, dishonest, fraudulent, or criminal acts of Anthem employees, acting alone or in collusion with others, unless such collusion is with an employee of the Group, in which case Anthem shall be relieved of any obligations under this paragraph.

B. Except as provided in paragraph A above, the Group agrees to indemnify and hold Anthem harmless against any loss, expense, or other cost or obligation, resulting from or arising out of claims, assessments or taxes, including premium taxes, or resulting from the action of any government body.

C. If either Anthem or the Group has paid any benefits which were the responsibility of the other party, appropriate reimbursement will be made.

## SECTION XIX: FINANCIAL ARRANGEMENTS WITH PROVIDERS

Anthem or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as “Providers”) for the provision of and payment for health care services rendered to its Subscribers and Members/Insured Persons entitled to health care benefits under individual certificates and group policies or contracts to which Anthem or an affiliate is a party, including all persons covered under the Agreement.

## FUNDING PROVISIONS

Under the above-referenced contracts between Providers and Anthem or an affiliate, the negotiated rates paid for certain medical services provided to persons covered under the Agreement may differ from the rates paid for persons covered by other types of products or programs offered by Anthem or an affiliate for the same medical services. In negotiating the terms of the Agreement, the Group was aware that Anthem or its affiliates offer several types of products and programs. The Subscribers, Family Members and the Group are entitled to receive the benefits of only those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the Agreement.

Also, under arrangements with some Providers certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, pharmacy rebates, may be based on aggregate payments made by Anthem or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by Anthem or an affiliate. They are not attributed to specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by Anthem or an affiliate in determining its fees or subscription charges or premiums.

### SECTION XX: TERMINATION PROVISION

Any amounts due to Anthem under this funding arrangement are subscription charges under the Group Benefit Agreement to which these Funding Provisions are made a part. Any failure by the group to pay such additional subscription charges when due may result in, at Anthem' option either: (a) termination of these funding provisions and recalculation of the subscription charges under the Group Benefit Agreement; or (b) in accordance with the Group Benefit Agreement's Cancellation provisions, termination for failure to pay subscription charges as they become due.

### AUTHORIZATION

Authorized officers of Anthem and of the Group have approved this endorsement as of its effective date.

**FOR ANTHEM BLUE CROSS**

| | | | |
|---|---|---|---|
| by: | _____ | by: | _____ |
| | Pam Kehaly | | Kathy Kiefer |
| Title: | President | Title: | Secretary |

**FOR THE GROUP**

| | | | |
|---|---|---|---|
| by: | _____ | by: | _____ |
| Title: | _____ | Title: | _____ |

# SCHEDULE

## EFFECTIVE DATE

This Schedule reflects the Funding Provisions which become effective on January 1, 2013.

## MINIMUM CLAIMS DEPOSIT

The amount of the Minimum Claims Deposit to be maintained for the term of the Agreement Year is $855,888.

## POOLING LIMIT

The Pooling Limit for the Agreement Year is $400,000.00*.

*****This Limit does not apply to Dental Benefits or Prescription Drug Benefits, nor will claims paid on these benefits be applied toward the Pooling Limit.

# SCHEDULE

**MONTHLY ATTACHMENT POINT FACTORS**

| Contract Types | Monthly Attachment Point Factors | Post-Termination Attachment Point Factors |
|---|---|---|
| Composite Rate (per Subscriber) | $ 509.37 | $ 448.29 |

**SUBSCRIPTION CHARGES**

The monthly Subscription Charges during the Agreement Year is $316.45 per Subscriber.

**BREAKDOWN OF SUBSCRIPTION CHARGES:**

The following is a breakdown of the above Subscription Charges:

**Retention Charges**

The monthly Retention Charges during the Agreement Year is $37.76 per Subscriber.

**Pooling Charges**

The monthly Pooling Charges during the Agreement Year is $21.02 per Subscriber.

**Capitation Expense**

The monthly charges for Capitation Expense during the Agreement Year is $257.71 per Subscriber.

**BLUECARD PROGRAM**

The Group will pay to Anthem the following Administrative Fees determined in accordance with the applicable rules of the Blue Cross Blue Shield Association for the use of Out-of-California Providers under the BlueCard Program:

| Administrative Fees | Per Claim |
|---|---|
| Institutional Claims | $ 11.00 |
| Professional Claims | $ 5.00 |
| Central Financial Agency Fee | $ .20 |
| Charge per transaction | $ .05 |
| Electronic Claims Routing Process (ECRP) (non-participating provider claims) | $ 1.00 |

These fees are subject to change in accordance with the applicable rules of the Blue Cross Blue Shield Association.

**POST-TERMINATION ADMINISTRATIVE CHARGES**

The monthly Post-Termination Administrative Charge is 6% of paid Non-Capitated Claims.

SJVIA
San Joaquin Valley Insurance Authority



**Meeting Location:**
**Fresno County Employee Retirement Association Board Chambers**
**1111 H Street**
**Fresno, CA 93721**
**July 26, 2013**
**9:00 AM**

**AGENDA DATE:** July 26, 2013

**ITEM NUMBER:** 9

**SUBJECT:** 2013 HM Life Specific and Aggregate Stop Loss Policy and Amendment No. 1

**REQUEST(S):** That the Board Approve and Accept the Agreement with HM Life Insurance Company for Specific and Aggregate Stop Loss Insurance coverage for the period January 1, 2013 through December 31, 2013.

**DESCRIPTION:**

HM Life provides specific and aggregate stop loss insurance to limit claims payment exposure to the SJVIA. HM Life has been the stop loss vendor since the inception of the SJVIA and has continued to offer competitive rates. Currently the specific stop loss deductible is set at $450,000 per calendar year. The aggregate stop-loss is designed to provide insurance protection when the annual aggregate, or total annual claims paid under the contract, (less any claims paid in excess of the $450,000 specific stop-loss deductible during the contract period), exceed the annual aggregate attachment point specified in the policy.

**AGENDA**: San Joaquin Valley Insurance Authority

**DATE:** July 26, 2013

**FISCAL IMPACT/FINANCING:**

Costs associated with this contract have been included in the FY 12/13 SJVIA budget in the amount of $523,968 and are built into the SJVIA premiums approved by your Board. The Specific Stop Loss coverage is $11.74 per employee per month and the Aggregate Stop Loss is $.085 per employee per month

**ADMINISTRATIVE SIGN-OFF:**

Jeffrey Cardell
SJVIA Manager

Paul Nerland
Assistant SJVIA Manager

# BEFORE THE BOARD OF DIRECTORS
# SAN JOAQUIN VALLEY INSURANCE AUTHORITY

**IN THE MATTER OF** 2013 HM Life Specific and Aggregate Stop Loss Policy and Amendment No. 1

**RESOLUTION NO.** _____
**AGREEMENT NO.** _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board Approved and Accepted the Agreement with HM Life Insurance Company for Specific and Aggregate Stop Loss Insurance coverage for the period January 1, 2013 through December 31, 2013.

# HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099

1-800-328-5433

| | |
|---|---|
| **POLICY NUMBER** | 402851-C |
| **NAME OF POLICYHOLDER** | San Joaquin Valley Insurance Authority |
| **TYPE OF COVERAGE** | Stop Loss Insurance |
| **EFFECTIVE DATE** | January 01, 2013 |
| **POLICY TERM** | January 01, 2013 through December 31, 2013 |
| **POLICY DELIVERED IN** | California and governed by the laws of that state. |

**HM Life Insurance Company** agrees to pay the benefits provided by this Policy, in accordance with the provisions of this Policy.

The consideration for this Policy is the application of the Policyholder and the payment by the Policyholder of premiums as provided herein.

This Policy provides benefits to the Policyholder when Eligible Claims Expenses, which are actually Paid by the Policyholder through the Covered Underlying Plan(s), exceed the levels defined in this Policy. The benefits of this Policy and the terms and conditions that apply to this Policy are explained herein.

This Policy begins at 12:01 AM current Eastern Time on the first day of the current Policy Term and ends at 11:59 PM current Eastern Time on the last day of the current Policy Term, and may be renewed for subsequent Policy Terms. If this Policy is renewed the terms and conditions of this Policy may be revised.

This Policy will terminate automatically upon the failure of the Policyholder to pay any premium within the Grace Period. Termination of this Policy for any reason other than non-payment of premium will occur following written notice by the Policyholder or us.

All provisions on this and the following pages are a part of this Policy. The definitions of terms apply whenever the terms are used anywhere in this Policy. "We", "us", and "our" refer to **HM Life Insurance Company**. Other defined terms are printed with an initial capital letter.

**HM Life Insurance Company**

By

President

This Policy is Non-Participating

REQUIRED CALIFORNIA NOTICE

To Our California Policyholders and Certificate Holders:

We are here to serve you . . .

As our policyholder or certificate holder, your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion. In the event you need to contact someone about this policy for any reason, please contact your agent. If you have additional questions, you may contact HM Life Insurance Company at the following address and toll-free telephone number:

HM Life Insurance Company
120 Fifth Avenue, Fifth Avenue Place
Pittsburgh, PA 15222-3099

Telephone number: 1-800-328-5433

If you are not satisfied . . .

Should you feel you are not being treated fairly and you have been unable to contact or obtain satisfaction from us or the agent, we want you to know you may contact the California Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact the Department, write or call:

Consumer Services Division
California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013

Telephone number: 1-800-927-HELP

**Notice of Non-Coverage**
**California Life and Health Insurance Guarantee Association Act**

**This policy is NOT covered by The California Life and Health Insurance Guarantee Association**

**EXCLUSIONS FROM COVERAGE**

The following are not covered by the California Life and Health Insurance Guarantee Association:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by individuals and which guarantee rights to group contract holders, not individuals;
- Employer and association plans, to the extent they are self-funded or uninsured;
- Synthetic guaranteed interest contracts;
- Any policy or any portion of it that is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields that exceed an average rate;
- Any portion of a contract that provides dividends or experience rating credits.

A determination as to whether an insurance contract is covered under the Guarantee Association or whether an annuity contract is allocated or unallocated must initially be made by the insurer based on its knowledge of the specific contract offered.

Also, you are not protected by this Association if:

- The insurer was not authorized to do business in this state when it issued the policy or contract;
- The policy was issued by a health care service plan (HMO), Blue Cross, Blue Shield, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- You are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guarantee association protects insureds who live outside that state.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guarantee Association to induce you to purchase any kind of insurance policy.

If you have questions concerning this Notice, you may contact:

| | | |
|---|---|---|
| California Life and Health Insurance Guarantee Association<br>P.O. Box 17319<br>Beverly Hills, CA 90209-3319<br>(213) 782-0182 | or | Consumer Service Division<br>California Department of Insurance<br>300 South Spring Street<br>Los Angeles, CA 90013<br>(800) 927-4357 or (213) 897-8921 |

Questions as to specific policies or annuities should be directed to the insurance company offering the product.

**Table of Contents**

## Part 1. DECLARATION PAGE

A. POLICY INFORMATION

| | | |
|---|---|---|
| 1. | Policy Number | 402851-C |
| 2. | Policyholder | San Joaquin Valley Insurance Authority |
| 3. | Current Policy Term | January 01, 2013 through December 31, 2013 |
| 4. | Covered Underlying Plan(s) | San Joaquin Valley Insurance Authority Health Plan |
| 5. | Claims Administrator | Anthem Blue Cross of CA |

B. SPECIFIC BENEFIT SCHEDULE

For all Eligible Claims Expenses except those to which a Special Risk Limitation applies:

1. Covered Claims Basis

**Incurred & Paid:** Eligible Claims Expenses Incurred from January 01, 2013 through December 31, 2013 and actually Paid from January 01, 2013 through March 31, 2014.

2. Specific Eligible Claims Expenses include:

| | |
|---|---|
| Health Care | Yes |
| Dental | No |
| Vision | No |
| Prescription Drug Card | Yes |
| Short Term Disability | No |
| Other: | No |

3. Number of Covered Units

| | |
|---|---|
| Composite | 3,557 |

4. Specific Deductible

| | |
|---|---|
| Per Participant | $450,000 |

5. Specific Payable Percentage (in excess of Specific Deductible) 100%

6. Maximum Specific Benefit

| | |
|---|---|
| Per Participant in excess of the Specific Deductible | |
| Per Policy Term | $4,550,000 |
| Per Lifetime | Unlimited |

C. AGGREGATE BENEFIT SCHEDULE

For all Eligible Claims Expenses except those to which a Special Risk Limitation applies:

1. Covered Claims Basis

   **Incurred & Paid:** Eligible Claims Expenses Incurred from January 01, 2013 through December 31, 2013 and actually Paid from January 01, 2013 through March 31, 2014.

2. Aggregate Eligible Claims Expenses include:

| | |
|---|---|
| Health Care | Yes |
| Dental | No |
| Vision | No |
| Prescription Drug Card | Yes |
| Short Term Disability | No |
| Other: | No |

3. Number of Covered Units

| | |
|---|---|
| Composite | 3,557 |

4. Aggregate Payable Percentage (excess of Deductible): 100%

5. Aggregate Attachment Point (Corridor) 125%

6. Annual Aggregate Deductible equals A or B whichever is greater, where:

   A= The sum of the Monthly Aggregate Deductible Amounts applicable to each Policy Month in the current Policy Term

   B = The Minimum Aggregate Deductible

   Note: The Annual Aggregate Deductible cannot be finally determined until the Aggregate Monthly Deductible Amounts have been calculated for each Policy Month of the Policy Term.

7. Monthly Aggregate Factor

   Per Composite Unit per Policy Month $803.33

8. Maximum Aggregate Eligible Claims Expense

   Per Participant $450,000

9. Maximum Aggregate Benefit (in excess of the Annual Aggregate Deductible per Policy Term) $1,000,000

D. PREMIUM

Specific Premium per Month

| | |
|---|---|
| Composite: | $11.74 |

Specific Rate Guarantee Period: 12 Months

Aggregate Premium per Month Per Covered Unit: $.85

The Specific Premium per Month and the Aggregate Premium per Month per Covered Unit only apply to the current Policy Term.

E. SPECIAL RISK LIMITATIONS:

| | |
|---|---|
| Disabled/Hospital Confined, actively at work, activity of daily living, out of hospital, or similar requirements waived with Disclosure | Yes |
| Retirees Included | Yes |

F. AFFILIATES

| Name | Covered Underlying Plan(s) |
|---|---|
| County of Fresno | Same as Policyholder's |
| County of Tulare | Same as Policyholder's |

## Part 2. BENEFITS

Unless otherwise indicated in the Covered Claims Basis section(s) in the Specific Benefit Schedule or the Aggregate Benefit Schedule, benefits under this Policy will only be paid by us based on Eligible Claims Expenses through the Covered Underlying Plan(s) which are Incurred and or actually Paid after the Effective Date of this Policy and which are actually Paid by the Policyholder during the Policy Term. The Specific Benefit Schedule, Aggregate Benefit Schedule and Policy Term are shown on the Declaration Page.

A. SPECIFIC BENEFIT

We will pay the Policyholder the following Specific Benefit, in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Specific Benefit payable with respect to a Participant will equal the amount of Eligible Claims Expenses which are actually Paid by the Policyholder for that Participant during the current Policy Term reduced by the Specific Deductible for the Participant times the Specific Payable Percentage.

We will pay Specific Benefits as they become due following satisfaction of the Specific Deductible, subject to the terms and conditions of this Policy.

The Specific Benefit payable does not include any amount actually Paid by the Policyholder for the Policy Term for Excluded Claims Expenses.

In no event will the Specific Benefit paid by us with respect to Eligible Claims Expenses Incurred by any one Participant exceed the Maximum Specific Benefit.

B. AGGREGATE BENEFIT

We will pay the Policyholder an Aggregate Benefit, in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Aggregate Benefit payable will equal the total amount of the Aggregate Eligible Claims Expenses which are actually Paid by the Policyholder for all Covered Units during the current Policy Term minus (A plus B), where:

A = The Annual Aggregate Deductible for the Policy Term.

B = Any amount in excess of the Maximum Aggregate Eligible Claims Expense per Covered Unit.

Times the Aggregate Payable Percentage.

The Covered Claims Basis for the Aggregate Benefit during the Policy Term does not include any amount actually Paid by the Policyholder for Excluded Claims Expenses.

We will pay the Aggregate Benefit at the end of each Policy Term, subject to the terms and conditions of this Policy.

In no event will the Aggregate Benefit paid by us for the Policy Term exceed the Maximum Aggregate Benefit per Policy Term shown in the Aggregate Benefit Schedule.

## Part 3. EXCLUSIONS AND LIMITATIONS

No Deductible of this Policy will be satisfied and no benefit of this Policy will be paid for:

1. UNDERLYING PLAN: Any amount actually Paid by the Policyholder for an expense Incurred:

    a. When the Covered Underlying Plan is not in effect; or

    b. By a person who is not a Participant when the expense is Incurred; or

    c. That is not specifically covered under the terms of the Covered Underlying Plan, or that the Policyholder is not required to pay in accordance with the terms of the Covered Underlying Plan; or

    d. Prior to the initial Incurred date shown in Covered Claims Basis on the Declaration Page.

2. NONDISCLOSURE: Any amount which is actually Paid by the Policyholder for an expense which is Incurred by a Participant who:

    a. Was a Participant at the time of the initial underwriting of this Policy, but whose Known medical conditions were not accurately Disclosed to us at that time by the Policyholder or the Policyholder's Claims Administrator.

    b. Was a Participant at the end of the Policy Term, but whose Known medical conditions were not accurately Disclosed to us by the Policyholder or the Policyholder's Claims Administrator prior to the date this Policy is renewed for a subsequent Policy Term.

    c. Becomes a Participant after the Effective Date of this Policy, but whose Known medical conditions were not accurately Disclosed to us by the Policyholder or the Policyholder's Claims Administrator before the date the Policyholder acquires another Affiliate, establishes another class of employees eligible for coverage through the Covered Underlying Plan(s).

3. OTHER COVERAGE: The amount of any expenses for benefits to any Participant with coverage under any other plan which, when combined with the benefits payable by such other plan, would cause the total paid by that plan and the Covered Underlying Plan(s) to exceed 100% of the Participant's actual expenses.

4. ADMINISTRATIVE COSTS: Any amount, which is actually Paid by the Policyholder for:

    a. Administrative costs, including but not limited to, administrative costs for claim payments, networks, case management fees in excess of the usual and customary charge, PPO access fees and Prescription Drug administration fees; or

    b. Capitation fees; or

    c. The expense of litigation; or

    d. Extra contractual damages, compensatory damages, or punitive damages.

5. LOST PROVIDER DISCOUNTS: Provider discounts of any kind lost due to untimely payment of claims by the Policyholder or the Policyholder's authorized representative.

## Part 4. CLAIMS ADMINISTRATOR

The Policyholder must retain a Claims Administrator at all times. All Claims Administrators must be approved by us. The Claims Administrator performs as the Policyholder's agent and we will not be held liable for any act or omission of the Claims Administrator.

We will only reimburse the Policyholder for Eligible Claims Expenses paid by an approved Claims Administrator.

The Claims Administrator will:

1. Supervise the administration and adjustment of all claims and verify the accuracy and computation of all claims in accordance with the terms of the Covered Underlying Plan;

2. Maintain accurate records of all claim payments;

3. Maintain separate records of expenses not covered; and

4. Provide us with the following data for the preceding Policy Month on or before the 30th day of each succeeding Policy Month:

    a. notice of claims that reach 50% of the Specific Deductible; and

    b. number of Covered Units or Covered Family Units;

    c. total amount of claims paid.

5. Secure and keep renewed, at their expense, all licenses, permits, authorizations or certificates of authority in the states where the Claims Administrator conducts the business of insurance in accordance with statutory requirements.

We will not be responsible for any compensation due to the Claims Administrator for functions performed by the Claims Administrator for the Policyholder.

This Policy will not be deemed to make us a party to any agreement between the Policyholder and the Claims Administrator.

For the purpose of any notice required from us under the provisions of this Policy, notice to the Policyholder's Claims Administrator will be considered notice to the Policyholder and notice to the Policyholder will be considered notice to the Policyholder's Claims Administrator.

## Part 5. CLAIM PROVISIONS

A. NOTICE OF CLAIM

The Policyholder or the Policyholder's Claims Administrator must notify us within 20 days of the date:

1. The Policyholder or the Policyholder's Claims Administrator is notified that a Participant has Incurred Eligible Claims Expenses through the Covered Underlying Plan for a Catastrophic Claim, Large Claim or Shock Loss; or

2. The Policyholder or the Policyholder's Claims Administrator is notified that a Participant has Incurred Eligible Claims Expenses through the Covered Underlying Plan that exceed 50% of the Specific Deductible.

Failure to give notice within such time will not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice in time and that notice was given as soon as was reasonably possible. The notice to us must include:

1. The identity of or unique identifier associated with the Participant.

2. A description of the illness or accident and the prognosis.

3. A listing of the Eligible Claims Expenses Incurred by or Known to the Policyholder to date through the Covered Underlying Plan(s).

B. PROOF OF LOSS

The Policyholder or the Policyholder's Claims Administrator must provide satisfactory proof of loss to support a claim within 90 days after the end of the current Policy Term or the end of the Paid period shown in Covered Claims Basis for the current Policy Term, if later. Claims not filed within this time limit will be denied and no benefits will be paid by us.

Upon presentation of satisfactory proof of loss the Policyholder represents that all monies necessary to pay for services and supplies have been paid to the Participant or respective providers of medical services or supplies to which the claim for reimbursement under the Policy relates.

## Part 6. MATERIAL CHANGES

We reserve the right to approve any Material Change or Change. The Policyholder or the Policyholder's Claims Administrator must notify us of any Change in writing prior to the effective date of such Change.

Upon receipt of a Material Change we reserve the right to:

1. Accept the Change without revising the Premium Rates and/or other terms and conditions of this Policy; or

2. Accept the Change and revise the Premium Rates and/or other terms and conditions of this Policy; or

3. Not accept the Change and pay benefits under this Policy as if the Change had not occurred.

If we accept the Change we will consider the Change approved on the date of the Change.

Payment of any benefits under this Policy based on a Change is subject to the Policyholder's written acceptance of any necessary adjustment to the premium.

## Part 7. TERMINATION AND RENEWAL

A. TERMINATION

This Policy and all coverage under this Policy will terminate 11:59 PM current Eastern Time on the earliest of the following dates:

1. The end of the last period for which premiums were paid.

2. The Premium Due Date next following receipt by us of written notice from the Policyholder that this Policy is to be terminated.

3. The end of any Policy Term, following 30 days prior written notice to the Policyholder of termination.

4. The Premium Due Date following 30 days prior written notice to the Policyholder that we are planning to terminate this Policy because:

   a. there are fewer than 50 Covered Units; or

   b. we have refused to accept a Material Change; or

   c. the Policyholder has refused to accept any necessary adjustment to the premium due to a Material Change; or.

5. The date the Covered Underlying Plan(s) and all coverage under such plan(s) end.

6. The date of cancellation of the administrative agreement between the Policyholder and the Policyholder's Claims Administrator, unless the Policyholder has selected another administrator prior to such cancellation and we have consented to the Policyholder's selection in writing.

7. On any date mutually agreed to by the Policyholder and us.

If this Policy terminates prior to the end of the current Policy Term, the Covered Claims Basis of this Policy will be limited to Eligible Claims Expenses Incurred and actually Paid by 11:59 PM current Eastern Time up to the date this Policy terminates. However, if this Policy terminates prior to the end of the Policy Term, the Aggregate Benefit, if any, will not be pro-rated and the full Minimum Aggregate Deductible will still apply to Eligible Claims Expenses Incurred and or actually Paid by 11:59 PM current Eastern Time on the date this Policy terminates.

B. RENEWAL

Unless terminated during or prior to the end of current Policy Term, this Policy may be renewed at the end of any Policy Term. At renewal we reserve the right to revise the terms and conditions that apply to the Policy including the rates, Deductibles, and the terms and conditions of this Policy by providing written notice to the Policyholder.

Renewal is subject to:

1. Receipt of any requested Claim Information prior to the beginning of the subsequent Policy Term; and

2. The Policyholder's written acceptance of the terms and conditions that apply to the renewal prior to the beginning of the subsequent Policy Term.

## Part 8. PREMIUMS

A. AMOUNT OF PREMIUMS

Premium is calculated based upon the number of Covered Units reported in any given Policy Month. The number of Covered Units for each Policy Month will be determined in accordance with the definition of Covered Unit. The estimated number of Covered Units for the first Policy Month shown in the Specific Benefit Schedule and Aggregate Benefit Schedule is based on the estimated initial enrollment.

B. CHANGES IN PREMIUM RATES

We reserve the right to change any rate or percentage used in determining the monthly premium. The change may occur on one of the following dates:

1. On any Premium Due Date, if the number of Covered Units changes by more than 10% on the Effective Date of this Policy or the number on the date of the last Policy Anniversary, whichever is the later date.

2. Retroactively to the beginning of the Policy Term, if we determine that claim payments are not being made in accordance with the terms and conditions of the Covered Underlying Plan(s).

3. On the date of any Material Change approved by us.

4. The date of an administrative agreement between the Policyholder and a new Claims Administrator is effective provided we have consented to the Policyholder's selection in writing.

5. On any Policy Anniversary.

6. At the end of any Policy Term.

We will give the Policyholder 30 days prior written notice of any change in any rate or percentage used in determining the monthly premium.

C. PAYMENT OF PREMIUMS

All premiums are due on the applicable Premium Due Date. Each premium is payable by the Policyholder on or before the Premium Due Date direct to us at our Home Office. The payment of each premium as it becomes due will maintain this Policy in force through the date immediately preceding the next Premium Due Date.

D. GRACE PERIOD

A Grace Period of 31 days will be allowed for the payment of each premium after the first premium. Should a premium which is otherwise due not be paid during the Grace Period, this Policy will automatically terminate on the last day of the Policy Month for which premiums were last paid at 11:59 PM current Eastern Time, without further notice to the Policyholder. Our liability will be limited to Eligible Claims Expenses that are Paid by the Policyholder prior to 11:59 PM current Eastern Time on last day of the Policy Month for which premiums were last paid.

## Part 9. GENERAL PROVISIONS

A. HOLD HARMLESS

1. The Policyholder agrees to hold us harmless from any legal expenses incurred or judgments awarded arising out of any dispute involving a current or former Participant in the Policyholder's Covered Underlying Plan(s), to the extent such legal expenses or judgments were not incurred as a result of our negligence or intentional wrongful acts.

   If we are notified that we have been named, or are likely to be named, as a defendant in any action involving a current or former Participant in the Policyholder's Covered Underlying Plan(s) we will give the Policyholder written notice of the dispute within a reasonable time. We will make all probative material available to the Policyholder upon written request from the Policyholder. We will cooperate with the Policyholder in matters pertaining to the dispute. However, such cooperation with the Policyholder will not waive our right to solely defend or settle any such action in any manner we deem prudent.

2. We agree to hold the Policyholder harmless from any legal expenses incurred or judgments(s) awarded arising out of any breach of this Policy by us arising out of our negligence or wrongful acts to the extent such legal expenses or judgments(s) were not incurred as a result of the Policyholder's intentional negligence or intentional wrongful acts.

   If the Policyholder is notified that they have been named, or are likely to be named, as a defendant in any action involving a current or former Participant in the Policyholder's Covered Underlying Plan(s), the Policyholder will give us written notice of the dispute within a reasonable time. The Policyholder will make all probative material available to us upon our written request. The Policyholder will cooperate with us in matters pertaining to the dispute. However, such cooperation will not waive the Policyholder's right to solely defend or settle any such action in any manner they deem prudent.

B. TAXES

The Policyholder agrees to hold us harmless from any state premium taxes incurred with respect to funds paid to or by the Policyholder through the Covered Underlying Plan(s). If any state premium tax is assessed against us with respect to such funds, the Policyholder must reimburse us for the amount of the state premium tax liability including any interest, penalty and costs incurred by us as a result of the assessment. Taxes incurred with respect to premiums paid for this Policy will be our responsibility.

C. NOTICE OF OBJECTION

Any objection, notice of legal action, or complaint received on a claim processed by the Policyholder or the Policyholder's Claims Administrator and on which it reasonably appears a benefit will be payable to the Policyholder under this Policy, must be brought to the immediate attention of our claims department.

D. POLICY NON-PARTICIPATING

This Policy is non-participating and does not share in our surplus earnings.

E. OFFSET

We have the right to offset any benefits payable to the Policyholder under this Policy against premiums due and unpaid by the Policyholder, but this right will not prevent the termination of this Policy for non-payment of premium.

F. REIMBURSEMENT

In the event that the Policyholder recovers from a third party with respect to any Eligible Claims Expenses for which benefits were paid under this Policy, the Policyholder must repay us. The full amount of any and all such funds recovered must be returned to us first before any Deductible under this Policy will be satisfied. No part of any Eligible Claims Expense which is actually Paid by the Policyholder and for which the Policyholder has been reimbursed by a third party may be used to meet any Deductible under this Policy. This provision will survive the termination of this Policy.

G. WAIVER

Our failure to insist upon the Policyholder's or the Policyholder's Claim Administrator's strict compliance with any requirement or condition of this Policy at any time or under any circumstance will not constitute a waiver of any such requirement or condition by us at any time under the same or different circumstances.

H. ARBITRATION

In the event of a dispute between the parties to this Policy as to whether coverage is provided under this Policy for a claim made by or against the Policyholder, both parties may, by mutual consent, agree in writing to arbitration of the disagreement.

If both parties agree to arbitrate, each party will select an arbitrator. The two arbitrators will select a third arbitrator. If they cannot agree within 30 days upon a third arbitrator, both parties must request that selection of a third arbitrator be made by a judge of a court having jurisdiction.

Unless both parties agree otherwise, arbitration will take place in Allegheny County, Pittsburgh, PA.

Local rules of law as to procedure and evidence will apply.

A decision agreed to by any two will be binding. Each party will:

1. Pay the expenses it incurs; and

2. Bear the expenses of the third arbitrator equally.

## Part 10. RECORDS AND REPORTS

A. REPORTING

The Policyholder or the Policyholder's Claims Administrator must:

1. Keep appropriate records regarding administration of the Covered Underlying Plans; and

2. Allow us to review and copy, during normal business hours, all records affecting our liability under this Policy; and

3. Submit all proofs, reports, and supporting documents requested by us, including, but not limited to, a monthly summary of all Eligible Claims Expenses which were processed by the Policyholder or the Policyholder's Claims Administrator on a timely basis.

Clerical error, whether by the Policyholder or by us, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

B. AUDITS

We reserve the right to inspect and audit all of the Policyholder's and the Policyholder's Claims Administrator's records and procedures that pertain to this Policy prior to or after processing a claim for benefits. We also reserve the right to require proof that payment of Eligible Claims Expenses has been made to the Participant or the provider of the Covered Services that are the basis for any claim by the Policyholder under this Policy.

C. UNDERWRITING INFORMATION

We rely on the underwriting information and Claim Information provided by the Policyholder or the Policyholder's Claims Administrator:

1. To issue this Policy; and

2. To accept a person as a Participant; and

3. To renew this Policy.

Should additional information become Known after one of these events that affect the rates, deductibles, or the terms and conditions of this Policy, we reserve the right to revise the rates, deductibles, and the terms and conditions of this Policy retroactive to the effective date of the current Policy Term by providing written notice to the Policyholder.

## Part 11. LIABILITY AND INDEMNIFICATION

A. LIABILITY

We will have neither the right nor the obligation under this Policy to directly pay any Participant or provider of Covered Services for any benefit that the Policyholder has agreed to provide through the terms of the Covered Underlying Plan(s). Our sole liability under this Policy is to the Policyholder.

B. INDEMNIFICATION

To the extent we suffer any liability, loss or expense due to a misstatement or failure to provide any Known or requested information, or failure to provide any additional information requested by us on a Participant or a person for whom we have requested Disclosure or Claim Information, the Policyholder agrees to indemnify us up to the amount of such liability, loss or expense, and all costs associated with such liability, loss or expense.

To the extent the Policyholder suffers any liability, loss or expense due to our breach of this Policy or due to our negligence or wrongful acts, we agree to indemnify the Policyholder up to the amount of such liability, loss or expense, and all costs associated with such liability, loss or expense.

## Part 12. ENTIRE CONTRACT, CHANGES

The entire contract consists of:

1. The pages of this Policy including any amendments, endorsements or riders; and

2. The Application; and

3. Submitted Claim Information; and

4. Disclosure Statements and Disclosure Forms; and

5. Attached documents necessary for the administration of this Policy.

This Policy or the Policyholder's coverage under this Policy may be amended at any time by mutual consent between the parties. No change in this Policy will be valid unless it is approved in writing by one of our executive officers and delivered to the Policyholder for attachment to this Policy. This approval must be shown on or attached to this Policy. No Agent or Claims Administrator has authority to change this Policy or to waive any of its provisions.

## Part 13. INCONTESTABLE CLAUSE

In the absence of fraud, any statement made by the Policyholder is a representation and not a warranty. No statement made by the Policyholder affecting this Policy will be used to deny a claim or to deny the validity of this Policy unless contained in a written instrument signed by the Policyholder and a copy of the written instrument has been given to the Policyholder.

## Part 14. LEGAL ACTIONS

No action at law or in equity may be brought to recover under this Policy until 60 days after written proof of loss has been furnished to us. No such action may be brought more than three years after the time within which proof of loss is required to be furnished.

## Part 15. INSOLVENCY

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder or the Policyholder's Claims Administrator will not impose upon us any liability other than the liability defined in this Policy.

## Part 16. ASSIGNMENT

The Policyholder's rights and benefits under this Policy cannot be assigned.

## Part 17. DEFINITIONS

**AFFILIATE** means a company subsidiary to, affiliated with, or controlled by the Policyholder. Eligible Affiliates are shown in the Declaration Page. Additions and terminations may only be made by amendment to coverage under this Policy. Termination of an Affiliate is treated as termination of coverage for that company only.

**AGENT** means the Policyholder's representative, including but not limited to, the agent, producer or broker of record, or Claims Administrator.

**AGGREGATE ATTACHMENT POINT (Corridor)** means the percentage of anticipated Aggregate Eligible Claims Expenses which the Policyholder must pay before an Aggregate Benefit becomes payable to the Policyholder. The Aggregate Attachment Point (Corridor) shown in the Aggregate Benefit Schedule, is used to determine the Monthly Aggregate Deductible Amount for the Policy Term.

**AGGREGATE BENEFIT** means a benefit that is paid when Aggregate Eligible Claims Expenses actually Paid by the Policyholder on all Covered Units in a Policy Term exceed the Annual Aggregate Deductible shown in the Aggregate Benefit Schedule.

**AGGREGATE ELIGIBLE CLAIMS EXPENSE** means Eligible Claims Expenses that are actually Paid by the Policyholder during the current Policy Term used to calculate the Aggregate Benefit for that Policy Term. The term does not include any eligible Claims Expenses that exceed the Maximum Aggregate Eligible Claim Expense (Per Participant) as shown in the schedule.

**AGGREGATE FACTOR** means the dollar amount shown in the Aggregate Benefit Schedule.

**AGGREGATE PAYABLE PERCENTAGE** means the percentage of the Aggregate Benefit, otherwise payable to the Policyholder that will be paid when Aggregate Eligible Claims Expenses, which are actually Paid by the Policyholder in the current Policy Term, exceed the Aggregate Attachment Point (Corridor).

**ALTERNATE SPECIFIC DEDUCTIBLE** means a separate Specific Deductible, if any, shown in Special Risk Limitations for certain participants identified in the Policy which must be satisfied prior to any Specific Benefit becoming payable with respect to such participants.

**ANNUAL AGGREGATE DEDUCTIBLE** means the dollar amount of Aggregate Eligible Claims Expenses that must be actually Paid by the Policyholder during any Policy Term for all Covered Units before an Aggregate Benefit becomes payable to the Policyholder.

This amount cannot be finally determined until the end of the current Policy Term; that calculation is based on the formula shown in the Aggregate Benefit Schedule.

**APPLICANT** means the entity; that has contracted with us to provide Stop Loss coverage.

**APPLICATION** means the written request of an entity through its duly authorized representative(s) for insurance under this Policy on a form acceptable to us.

**CATASTROPHIC CLAIM** means any Known claim for a Covered Claim Expense Incurred, or expected to be Incurred by a Participant that may reasonably be assumed will exceed 10% of the Annual Aggregate Deductible in the current or next Policy Term.

**CLAIM INFORMATION** means to provide Complete Details following a Diligent Review of the data requested by us in connection with the application for, or renewal of, this Policy on any claim incurred, paid or pended 30 days prior to the beginning of any Policy Term or prior to a Material Change, Claim Information includes but is not limited to Catastrophic Claims, Large Claims and Shock Losses.

**CLAIMS ADMINISTRATOR** means the third party administrator designated by the Policyholder and approved by us. The Claims Administrator is shown in the Declaration Page.

**COMPLETE DETAILS** means detailed information including, but not limited to the Participant's name and social security number, date of birth, diagnosis, prognosis (unless prognosis cannot be obtained due to reasons beyond the Policyholder's or the Policyholder's Claims Administrator's control), and provider name on any Participant covered by, or eligible for coverage, under a Covered Underlying Plan. For purposes of privacy, a unique identifier may be used to identify the Participant in lieu of the person's name, social security number and date of birth.

**COVERED CLAIMS BASIS** means the time period shown in the Specific Benefit Schedule and the Aggregate Benefit Schedule during which an Eligible Claims Expense must be Incurred and the time period during which an Eligible Claims Expense must be actually Paid by the Policyholder in any Policy Term. The Covered Claim Basis is shown in the Specific Benefit Schedule and the Aggregate Benefit Schedule.

**COVERED SERVICE or SERVICES** means a service, supply or treatment for which the Participant has incurred an Eligible Claims Expense and for which benefits are payable through the Covered Underlying Plan(s). This does not include any service excluded under Special Risk Limitations.

**COVERED UNDERLYING PLAN(S)** means the employer's plan of benefits which are identified in this Policy. This does not include any plan excluded under Special Risk Limitations.

**COVERED UNIT or COVERED UNIT(S)** means a group of one or more Participants composed of one or more of the following types of Covered Units:

1. Composite - the employee, associate or member and all members of his or her family.

The number of Covered Units is used to calculate the premium due each month. The estimated number and type of Covered Units for the first Policy Month of the current Policy Term is shown under Number of Covered Units in the Specific Benefit Schedule and the Aggregate Benefit Schedule.

**DEDUCTIBLE(S)** means the Specific Deductible, Alternate Specific Deductible, or Aggregate Deductible, as shown in the Specific Benefit Schedule, the Aggregate Benefit Schedule or under Special Risk Limitations.

**DILIGENT REVIEW** means a complete review by the Policyholder or Policyholder's Claims Administrator of the Covered Underlying Plan prior to the beginning of any Policy Term for Known potential Large Claims. The potential for a Large Claim is Known if prior to the beginning of any Policy Term or prior to a Material Change a reasonable person could assume the Policyholder or the Policyholder's Claims Administrator has actual information about such claim.

**DISCLOSURE FORM OR DISCLOSURE STATEMENT** means the document signed by the Policyholder following a Diligent Review that provides information, upon which we will rely, in part, to issue the Policy.

**DISCLOSURE OR DISCLOSED** means to provide Complete Details and any other documentation requested following a Diligent Review including but not limited to census information and Claim Information prior to the beginning of any Policy Term or prior to a Material Change.

**EFFECTIVE DATE** means the date shown on the cover page of this Policy.

**ELIGIBLE CLAIMS EXPENSE** means an expense for a Covered Service which is Incurred by a Participant and for which benefits have been actually Paid by the Policyholder in accordance with the terms of the Covered Underlying Plan(s). This term does not include an expense:

1. Not specifically included under the terms of the Covered Underlying Plan; or

2. Excluded under the terms of the Covered Underlying Plan; or

3. Excluded under the terms of this Policy including Excluded Claims Expenses, if any, shown in Special Risk Limitations.

**EXCLUDED CLAIMS EXPENSES** means expenses which are Incurred by a Participant for services, supplies and treatment for, or related to, the condition, or resulting complications, of an injury or sickness described in Special Risk Limitations.

**INCURRED** means the date a Participant receives a service, supply or treatment for an Eligible Claims Expense.

**KNOWN** means information affecting the administration or underwriting of this Policy, which a reasonable person can assume the Policyholder or the Policyholder's Claims Administrator had knowledge of prior to a request for Disclosure or Claim Information.

**LARGE CLAIM, SHOCK CLAIM OR SHOCK LOSS** means any loss that is reasonably likely to result in a potentially Catastrophic Claim, or any other loss due to the nature of the injury, illness or diagnosis that the Policyholder or the Policyholder's Claims Administrator reasonably assumes will result in a significant medical expense in the current or next Policy Term.

**MATERIAL CHANGE or CHANGE** means an action by the Policyholder that may have an economic impact on our liability under this Policy. Material Changes include, but are not limited to, the following:

1 Changes in:

   a. The information Disclosed or submitted by the Policyholder upon which our assessment of risk was based; or

   b. The Covered Underlying Plan(s); or

   c. The Claims Administrator.

2. An increase or decrease of the number of Covered Units by more than 10% from the Effective Date of this Policy or the date of the last Policy Anniversary, whichever is the later date.

3. A merger, acquisition, divestiture or similar transaction involving the Policyholder.

4. A bankruptcy proceeding involving the Policyholder or an Affiliate.

5. Any other change in factors bearing on the risk assumed by us, including but not limited to the age, sex, geographic location and occupation of a Participant or a change in law or legislation changes the nature of the risk assumed by us under this Policy.

This term does not include a change in the Covered Underlying Plan required by state or federal law.

**MAXIMUM AGGREGATE BENEFIT** means the maximum dollar amount we will pay the Policyholder for the Aggregate Benefit in the current Policy Term. The Maximum Aggregate Benefit is shown in the Aggregate Benefit Schedule.

**MAXIMUM AGGREGATE ELIGIBLE CLAIMS EXPENSE** means the maximum dollar amount of Eligible Claims Expenses that are actually Paid by the Policyholder for a Covered Unit during the current Policy Term which can be used either to satisfy the Annual Aggregate Deductibles or included in the calculation of the Aggregate Benefit for that Policy Term. The Maximum Aggregate Claims Expense is shown in the Aggregate Benefit Schedule.

**MAXIMUM SPECIFIC BENEFIT** means the maximum dollar amount we will pay the Policyholder per Participant for the Specific Benefit. The Maximum Specific Benefit is shown in the Specific Benefit Schedule.

**MINIMUM AGGREGATE DEDUCTIBLE** means A times B times C, where:

A = The Aggregate Factor shown in the Aggregate Benefit Schedule.

B = The number of Covered Units reported by the Policyholder to the Policyholder's Claims Administrator for the first Policy Month of the current Policy Term.

C= The number of months applicable to the current Policy Term.

Times 100%.

**MONTHLY AGGREGATE DEDUCTIBLE AMOUNT** means, for each Policy Month in the Policy Term, A times B where:

A = The Aggregate Factor shown in the Aggregate Benefit Schedule

B = The number of Covered Units reported by the Policyholder to the Policyholder's Claims Administrator at the start of that Policy Month.

**PAID** means the date:

1. Eligible Claims Expenses have been adjudicated and approved by the Policyholder or the Policyholder's Claims Administrator; and

2. A check or draft for remuneration has been issued and deposited in the U.S. Mail (or other similar conveyance), or is otherwise delivered to the payee electronically or in person; or a credit transaction has been agreed to by the Policyholder or the Policyholder's Claims Administrator and received by to the payee electronically or in person; and

3. Sufficient funds are on deposit the date the check or draft is issued to permit the check or draft to be honored; or a sufficient line of credit exists to honor the check, draft or transaction.

A claim will not be considered actually Paid until all of these conditions are satisfied. A draft or check returned to the Policyholder or Claims Administrator for any reason, or any credit transaction not honored by the payee for any reason will not be considered actually Paid.

For purposes of this definition, "payee" means a Participant that received the Covered Service or the health care provider that provided the Covered Service to the Participant.

**PARTICIPANT or PARTICIPANTS** means a person who is an employee, associate or member of the Policyholder or Affiliate, and the dependents of such persons who are covered, or who become eligible for coverage, through a Covered Underlying Plan.

**POLICY** means this contract between the Policyholder and us with respect to Stop Loss Insurance.

**POLICY ANNIVERSARY** means each anniversary of the Effective Date of this Policy, unless changed by agreement between the Policyholder and us.

**POLICYHOLDER** means the entity shown on the cover page of this Policy.

**POLICY MONTH** means successive intervals of time, while this Policy is in effect, determined on a monthly basis starting on the Effective Date of this Policy. Each new interval will begin on a day that corresponds to the Effective Date of this Policy. If there is no such day in any applicable month, then the last day of the month will be used.

**POLICY TERM** means the time period shown in the Declaration Page. For purposes of this definition:

1. An initial Policy Term is the period of time from the effective date of the policy to the date of the first Policy Anniversary.

2. A current or renewal Policy Term is the period of time either from the effective date of the Policy, or the date of the last Policy Anniversary, to the date of the next Policy Anniversary.

Each Policy Term after the initial Policy term will begin on the Policy Anniversary. The initial Policy Term will begin on the Effective Date of this Policy.

**PREMIUM DUE DATE** means the Effective Date of this Policy and the first day of each following Policy Month.

**SPECIAL RISK LIMITATION** means any modification of the terms or conditions of this Policy.

**SPECIFIC BENEFIT** means the benefit paid when Eligible Claims Expenses actually Paid by the Policyholder for a Participant in any Policy Term exceed the Specific Deductible.

**SPECIFIC DEDUCTIBLE** means the dollar amount which must be satisfied prior to any Specific Benefit becoming payable. The Specific Deductible is shown in the Specific Benefit Schedule.

**SPECIFIC PAYABLE PERCENTAGE** means the percentage of the Specific Benefit, otherwise payable to the Policyholder, that will be paid when Eligible Claims Expenses, which are actually Paid by the Policyholder for a Participant, exceed the Specific Deductible. The Specific Payable Percentage is shown in the Specific Benefit Schedule.

**STOP LOSS INSURANCE** means the coverage provided under this Policy, which provides benefits to the Policyholder when Eligible Claims Expenses which are actually Paid by the Policyholder through the Covered Underlying Plan(s) exceed the levels defined in this Policy.

**UNDERLYING PLAN(S)** means the employee benefit plans of the Policyholder which provide the benefits identified in the Specific Benefit Schedule or the Aggregate Benefit Schedule to the Policyholder's or an Affiliate's employees, associates or members and their dependents. This Policy insures the Policyholder for excess losses through the employee benefit plans identified in this Policy as a Covered Underlying Plan. This term does not include any employee benefit plan of the Policyholder that is not identified as a Covered Underlying Plan in this Policy.

# HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099

1-800-328-5433

**RENEWAL RIDER**

To be attached to and made part of Policy 402851-C issued to San Joaquin Valley Insurance Authority as Policyholder.

It is hereby agreed effective January 01, 2013 that Policy 402851-C replaces Policy 402851-B for the Policy term beginning January 01, 2013 and ending December 31, 2013 in its entirety.

All other terms and conditions of the Policy will continue to apply including but not limited to reapplication of the Specific Deductible and Aggregate Deductible in the next Policy Term.

**HM Life Insurance Company**

By

President

# HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099

1-800-328-5433

**SPECIFIC ADVANCE FUNDING RIDER**

To be attached to and made part of Policy 402851-C issued to San Joaquin Valley Insurance Authority as Policyholder. Effective January 01, 2013 it is hereby agreed:

The only Covered Expenses eligible for Specific Advance Funding are those that exceed the sum of the Specific Deductible per Participant or the Alternate Specific Deductible shown in the Special Risk Limitations.

Specific Advance Funding is available if all of the following conditions have been met:

1. The Specific Deductible per Participant or the Alternate Specific Deductible per Participant has been met.

2. Claims submitted for an advance must be fully processed by the Claims Administrator and ready for payment according to the terms of the Covered Underlying Plan within the current Policy Term.

3. Each request for an advance must be equal to or greater than $1,000.

4. Claims must be Incurred during the current Policy Term and we must receive the request for an advance no later than 15 days prior to the end of the current Policy Term. Any request received after this period is not eligible for Advance Specific Funding.

5. The Covered Expense for which funds were advanced must be actually Paid within 5 working days after receiving the advance for such expense. We will consider any Covered Expense actually Paid within this time period to have been Paid within the current Policy Term, or at the end of the Paid period for that term, if later, even if such payment occurs after the end of the current Policy Term. If the Policyholder does not pay the Covered Expense within this time period, the advance must be refunded to us within 5 working days.

6. Any funds advanced by us not used to pay a Covered Expense due to any type of discounting must be refunded to us within 5 working days.

7. Premiums must be paid prior to the Premium Due Date. Should a premium which is otherwise due not be paid prior to the end of the Grace Period:

    a. The Policy will automatically terminate on the last day of the Policy Month for which premiums were last paid; and

    b. The Policyholder must reimburse us for the any funds advanced by us within 5 working days.

All other terms and provisions of the Policy will apply.

**HM Life Insurance Company**

By

President

# HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099

1-800-328-5433

**BRIDGE RENEWAL RIDER**

To be attached to and made part of Policy 402851-C issued to San Joaquin Valley Insurance Authority as Policyholder. Effective January 01, 2013 it is hereby agreed that the Covered Claims Basis in the Specific Benefit Schedule is amended by the addition of:

> If you renew this Policy the Covered Claims Basis for this Policy Term will be revised so that Eligible Claims Expenses include only such expenses Incurred from January 01, 2013 through December 31, 2013 and actually Paid January 1, 2013 through December 31, 2014 .

All other terms and provisions of the Policy will continue to apply.

**HM Life Insurance Company**

By

President

# HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099

1-800-328-5433

**CANCER CLINICAL TRIAL RIDER**

To be attached to and made part of Policy 402851-C issued to San Joaquin Valley Insurance Authority as Policyholder. Effective January 01, 2013 it is hereby agreed that the definition of Eligible Claims Expenses is amended by the addition of:

This term includes the following items and services in connection with an approved cancer clinical trial:

1. Otherwise covered physician fees, laboratory expenses, and expenses associated with a hospitalization; and

2. Evaluation and treatment of the patient associated with the underlying disease; and

3. The cost of care consistent with the usual standards of care whenever a patient receives medical care associated with an approved cancer clinical trial; and

4. Care that would be covered by the Covered Underlying Plan if such items and services were provided other than in connection with an approved cancer clinical trial.

The term does not include the following items and services in connection with a cancer clinical trial:

1. The costs of the investigational drugs or devices themselves; or

2. The costs of any non-health service that might be required for a Participant to receive the treatment or intervention (e.g., transportation, hotel, meals, and other travel expenses); or

3. The costs of managing the research; or

4. Any cost which would not be covered under the Covered Underlying Plan's benefits for non-investigational treatments.

An approved cancer clinical trial must include a scientific study of a new therapy or intervention for the treatment, palliation, or prevention of cancer in human beings that meets all of the following requirements:

1. The treatment or intervention is provided pursuant to an approved cancer clinical trial that has been funded, authorized or approved by one of the following:

    a. The National Institutes of Health (NIH) including the National Cancer Institute (NCI); or

    b. The United States Food and Drug Administration (FDA) in the form of an investigational new drug (IND) exemption; or

    c. The United States Department of Veterans Affairs (VA); or

    d. Centers for Disease Control and Prevention (CDC); or

2. The proposed therapy has been reviewed and approved by the applicable qualified Institutional Review Board.

3. The available clinical or pre-clinical data indicate that the treatment or intervention provided pursuant to the approved cancer clinical trial will be at least as effective as standard therapy, if such therapy exists, and is anticipated to constitute an improvement in effectiveness for treatment, prevention, or palliation of cancer.

4. The facility and personnel providing the treatment are capable of doing so by virtue of their experience and training.

5. The trial consists of a scientific plan of treatment that includes specific goals, a rationale and background for the plan, criteria for patient selection, specific directions for administering therapy and monitoring patients, a definition of the quantitative measures for determining treatment response, and methods for documenting and treating adverse reactions. All such trials must have undergone a review for scientific content and validity, as evidenced by approval from one of the federal entities identified above.

6. The trial must:

    a. Evaluate a service which is otherwise an Eligible Claims Expense; and

    b. Have a therapeutic intent (i.e., not designed exclusively to test toxicity or disease pathophysiology); and

    c. Enroll diagnosed Participants.

All other terms and provisions of the Policy will continue to apply.

**HM Life Insurance Company**

By

President

# HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099

1-800-328-5433

**EXTENDED LIABILITY RIDER**

To be attached to and made part of Policy 402851-C issued to San Joaquin Valley Insurance Authority as Policyholder. Effective January 01, 2013 it is hereby agreed that the Covered Claims Basis in the Specific Benefit Schedule and the Aggregate Benefit Schedule is amended by the addition of:

If an Eligible Claim Expense is denied by the Policy and that denial is subsequently reversed by an Independent Review Organization (IRO) the Covered Claims Basis for the Policy Term in which such Eligible Claim Expense was denied will include all such Eligible Claim Expenses reversed by an Independent Review Organization (IRO).

**Independent Review Organization (IRO**) means the organization for external review as required under the external review process of the Patient Protection and Affordable Care Act.

If the Policy terminates prior to the end of the current Policy Term:

1. The Covered Claims Basis in the Specific Benefit Schedule and Aggregate Benefit Schedule is limited to Eligible Claims Expenses Incurred and actually Paid by 11:59 PM current Eastern Time up to the date the Policy terminates; and

2. No Deductible of the Policy will be satisfied and no benefit will be paid under the Policy for Eligible Claim Expenses denied prior to the date the Policy terminates that are subsequently reversed by an Independent Review Organization (IRO).

All other terms and provisions of the Policy will continue to apply.

**HM Life Insurance Company**

By

President

**POLICY AMENDMENT NO. 1**

Attached to and made a part of Policy 402851-C
issued to San Joaquin Valley Insurance Authority as Policyholder.

It is agreed that the Stop Loss Insurance Policy 402851-C issued to San Joaquin Valley Insurance Authority is amended as follows:

1. The Affiliates within Section F of the Declaration Page is amended to read as follows:

F. AFFILIATES

| Name | Covered Underlying Plan(s) |
|---|---|
| County of Fresno | Same as Policyholder's |
| County of Tulare | Same as Policyholder's |
| City of Tulare | Same as Policyholder's |
| City of Ceres | Same as Policyholder's |

This amendment is effective January 1, 2013.

**HM Life Insurance Company**

By

President

SJVIA
San Joaquin Valley Insurance Authority



**Meeting Location:**
**Fresno County Employee Retirement Association Board Chambers**
**1111 H Street**
**Fresno, CA 93721**
**July 26, 2013 9:00 AM**

**AGENDA DATE:** July 26, 2013

**ITEM NUMBER:** 10

**SUBJECT:** Extension of Agreements with Chimienti & Associates and Gallagher Benefit Services for one year through December 31, 2014

**REQUEST(S):** That the Board Direct Staff to amend and extend agreements with Chimienti & Associates and Gallagher Benefit Services for one year under the same terms, conditions and pricing as the current agreements through December 31, 2014.

**DESCRIPTION:**

The SJVIA currently has agreements in place with Chimienti & Associates and Gallagher Benefit Services (GBS) for specific administrative and consulting tasks that are essential to day-to-day operations. Both agreements were executed at the inception of the SJVIA in 2010. The agreement with Chimienti & Associates provides consolidated eligibility, vendor billing, accounting and payment reconciliation, COBRA Administration, Flexible Spending Account Administration and voluntary supplemental benefits. The complexity of the SJVIA rate structure and flexibility afforded by use of the "Admin Direct" benefits eligibility system has assisted the SJVIA is recent expansion efforts. The agreement provides that GBS provide services related to strategic planning, financial monitoring and reporting, renewal services, renewal underwriting and rate setting, vendor management, compliance services, member agency support services and program marketing and promotion.

Both the Chimienti and GBS agreements were extended from their initial termination date of December 31, 2012 to December 31, 2013 with the intent of completing a competitive bidding process this year. However, staff delayed releasing the request for proposals for both agreements as the complexities of implementation of the Patient Protection & Affordable Care Act (PPACA) became apparent and required additional information. For example, guidance has not been released on the PPACA's rolling "look-back" period to determine eligibility for part-time or seasonal employees. Although it was announced this month that the employer-mandate provision will be delayed one year, it is important that the eligibility and billing system allows for all requirements under PPACA. Additionally, the SJVIA has been adding new entities consistent with the growth and marketing plan and any RFP will need to take the complexities of multiple entities into account.

The recommended action would direct staff to execute amendments with both Chimienti & Associates and GBS to extend the agreements one additional year (January 1, 2014 through December 31, 2014) under the same terms, conditions and pricing as the current agreement. Staff will return to your Board with the extension and a timeline for the RFPs for both Chimienti and GBS.

**FISCAL IMPACT/FINANCING:**

The fee for the Chimienti & Associates services to the SJVIA amounts to $6.50 per employee per month (PEPM) and applies only to member entities participating in the Anthem plan offerings. Based on current enrollment at member entities, Chimienti would receive approximately $650,000 in 2014. The GBS fee to the SJVIA for services amounts to $4.00 per employee per month (PEPM). Based on current enrollment at member entities, GBS would receive approximately $415,000 in 2014.

These expenses are included in the adopted FY 12/13 SJVIA budget and will be part of the renewal calculations for the Plan Year 2014 rates.

**AGENDA**: San Joaquin Valley Insurance Authority

**DATE:** July 26, 2013

**ADMINISTRATIVE SIGN-OFF:**

Jeffrey Cardell
SJVIA Manager

Paul Nerland
Assistant SJVIA Manager

# BEFORE THE BOARD OF DIRECTORS
# SAN JOAQUIN VALLEY INSURANCE AUTHORITY

**IN THE MATTER OF** Extension of Agreements with Chimienti & Associates and Gallagher Benefit Services for one year through December 31, 2014

**RESOLUTION NO.** _____
**AGREEMENT NO.** _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board directed staff to amend and extend agreements with Chimienti & Associates and Gallagher Benefit Services for one year under the same terms, conditions and pricing as the current agreements through December 31, 2014.

SJVIA
San Joaquin Valley Insurance Authority



**Meeting Location:**
**Fresno County Employee Retirement Association Board Chambers**
**1111 H Street**
**Fresno, CA 93721**
**July 26, 2013 9:00 AM**

**AGENDA DATE:** July 26, 2013

**ITEM NUMBER:** 11

**SUBJECT:** Report on Retiree Pool Options

**REQUEST(S):** That the Board of Directors receive the report on retiree pool options within the SJVIA and provide direction to staff.

**DESCRIPTION:**

In response to a request from the City of Tulare, GBS was asked to review the feasibility, methodology, potential opportunities and impact of rating the Pre65 retiree population separately within the SJVIA . As a general rule of thumb, rating a population as a 'pool within a pool' is typically not viable unless there are more than 500 subscribers.

Currently, there are approximately 400 Pre65 subscribers within the SJVIA and all participants are rated as one unit. Some member entities then adjust premiums for this pre-65 retiree population to eliminate an implicit rate subsidy. Blending the rates for the actives and retirees creates an implicit rate subsidy that is accounted for by the participating entity in their financial statements consistent with Governmental Accounting Standards Board (GASB) statement 45.

A summary of retiree benefits for the SJVIA's Participating Entities follows:

- **County of Tulare**: 340 retirees are covered in the SJVIA. 129 are Pre65 and 211 Post65. The rate structure is "blended" meaning that the retirees have common plan designs and share risk in the same rate structure to that of the active employees. This creates a GASB 45 implicit subsidy.

- **County of Fresno**: 268 Pre65 retirees are covered in the SJVIA. Post65 retirees are covered outside of the SJVIA on group plans offered by the County. The Pre65 and Post65 rates are unblended resulting in a separate rate structure from that of the employees. Prior to the SJVIA, the Pre65 retiree rates were developed based on the actual claims experience of that subset population. Since the formation of the SJVIA, the cost differential between retiree and active rates was maintained based on the differential that existed prior . Because the retiree rates are unblended, the County of Fresno does not have a GASB 45 implicit subsidy. Since the unblending of the retiree rates, many Pre65 retirees at the County of Fresno elect COBRA (18 months) and CalCOBRA (18 months) at their retirement date. Currently, there are approximately 200 retirees electing COBRA.

- **City of Tulare**: 25 Pre65 retirees are covered in the SJVIA. Post65 retirees are covered outside of the SJVIA on a group plan through the City. Like the County of Fresno, the rates are unblended. Prior to the SJVIA, the retiree rates were developed based on an accepted actuarial methodology that called for retiree rates to be 1.85 times that of the active rates. This methodology was adopted to alleviate the radical fluctuations that existed in the past when the City used a true cost methodology to calculate rates based only on retiree claims experience (fewer retirees resulted in higher volatility in the rates). Since the formation of the SJVIA, the cost differential between retiree and active rates has been maintained with the 1.85 differential that existed prior to joining. Because the retiree rates are unblended, the City of Tulare does not have a GASB 45 implicit subsidy.

**Analysis**

Establishing a 'pool within a pool' would constitute a change in underwriting methodology from the Board approved existing methodology. GBS and SJVIA staff have worked with Glen Volk, Actuarial Consulting Manager for GBS

Analytics to complete the attached report (Exhibit A) summarizing and analyzing the opportunity for establishing a retiree pool within the SJVIA. In this study, retiree information consisting of census demographics, plan selection, and rate structure by member entity is compared against active membership by member entity as well as to that of entire SJVIA.

This analysis deals primarily with the pre-Medicare retirees. Experience on Medicare retirees is more similar to the active experience, thus suggesting that there should be some consideration to have a separate pool for Medicare retirees. Fewer employers offer coverage to Medicare retirees, so this issue will affect a smaller subset of the participating entities.

**Staff & GBS Recommendation**

If the SJVIA elects to move forward with a retiree pool, we would recommend focusing on the Medicare retirees in that pool at this time, but with separate rates to reflect the impact of Medicare being the primacy payer for medical claims. Once the pre 65 population reaches 500 participants it is recommended that the staff return to the Board with a plan pool structure for consideration. Currently, approximately 1,000 County of Fresno Medicare retirees are covered outside of the SJVIA under a Kaiser plan along with a Hartford Benistar plan. The current rates and benefits for these plans are included with this item (Exhibit B). Improved pricing may be achieved for 2014 if the County of Fresno, Tulare, and City of Tulare were to come together to form a SJVIA Medicare Retiree Pool. We recommend further exploration of this concept and return to your Board with plan options and 2014 pricing at the next Board meeting.

**FISCAL IMPACT/FINANCING:**

None at this time.

**AGENDA**: San Joaquin Valley Insurance Authority

**DATE:** July 26, 2013

**ADMINISTRATIVE SIGN-OFF:**

Jeffrey Cardell
SJVIA Manager

Paul Nerland
Assistant SJVIA Manager

# BEFORE THE BOARD OF DIRECTORS
# SAN JOAQUIN VALLEY INSURANCE AUTHORITY

**IN THE MATTER OF** Report on Retiree Pool Options

**RESOLUTION NO.** _____
**AGREEMENT NO.** _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board of Directors received the report on retiree pool options within the SJVIA and provided staff with direction.

# San Joaquin Valley Insurance Authority

# Analysis of Establishing a Separate Retiree Pool

**Presented By:**
**Healthcare Analytics**
**A Division of Gallagher Benefit Services**

**June 2013**

## TABLE OF CONTENTS

## 1. Plan Background

The San Joaquin Valley Insurance Authority ("SJVIA") is a Joint Purchasing Authority ("JPA") providing health insurance coverage to several municipal employers in the San Joaquin Valley area. In addition to covering active employees, most of the participating entities offer coverage to retirees who are not yet eligible for Medicare, although there is a wide variation between entities in how much the retirees are required to pay for coverage. In addition, one current participating entity offers coverage to Medicare eligible retirees.

Claim costs for retirees are usually very different than they are for active employees. Pre-Medicare retirees tend to be much more costly due to the demographic differences. Once employees become eligible for Medicare, the medical portion of their claims are greatly reduced because Medicare is primary for retirees. Pharmacy claims for Medicare eligible retirees are not offset by Medicare and typically make up over half of the claim cost for this population. In total, claim costs for Medicare retirees are similar to claim costs for active employees.

Because of the variation in claim costs for retirees, particularly for pre-Medicare retirees, the inclusion of those retirees will cause the overall experience of the pool to be worse than it would be without that subset. If pre-Medicare retirees are funded at the same rates as actives, an implicit subsidy is created under which the funding rates for active employees subsidize the cost of the pre-65 retirees. Under GASB 45, this blended funding approach creates an implicit liability which in turn generates an Other Postemployment Benefit ("OPEB") expense that must be reported and accrued each year. If an employer charges the pre-Medicare retirees rates that are based on the expected cost of those lives on a standalone basis, the implicit subsidy is eliminated (and the rates for active employees will be lower). Consequently, the manner in which the pre-Medicare retirees are rated can have a material impact on the employer's financial reporting.

Because the cost for Medicare eligible retirees is much closer to the cost of active employees, there is usually a much smaller implicit subsidy under GASB 45 for the Medicare eligible retiree population. In addition, because Medicare eligible retirees have options for securing adequate coverage at much more affordable premiums than pre-Medicare retirees, many employers do not allow retirees to remain on the plan once they are eligible for Medicare. In addition to Medicare itself, these retirees are eligible for Medicare supplement policies and in many locations a variety of Medicare Advantage plans. They also have access to prescription drug coverage under Medicare Advantage plans or through standalone Prescription Drug Plans ("PDPs") under the Medicare Part D program. All of these plans tend to be much more affordable than any coverage available to pre-Medicare retirees.

There is a great deal of variation in how the entities currently participating in the SJVIA pool treat retirees. The following table summarizes the current practices. In the table, "Blended" means the same rates are used for actives and retirees, while "Self-Supporting" means the retiree rates are set separately with the intent of supporting their own expense.

| Entity | Retirees Covered | | Retiree Pricing Method | |
|---|---|---|---|---|
| | Pre-65 | 65+ | Pre-65 | 65+ |
| County of Tulare | 129 | 211 | Blended | Blended |
| County of Fresno | 268 | N/A | Self-Supporting | N/A |
| City of Tulare | 25 | N/A | Self-Supporting | N/A |
| City of Ceres | Very few | N/A | Blended | N/A |

For the County of Fresno, many of the retirees are actually taking COBRA and are expected to drop their coverage when the COBRA period ends.

As the pool expands, it is likely that there will be even greater variation in how participating entities handle retiree coverage. At the request of the SJVIA, Gallagher Benefit Services has compiled information about the retiree experience of the entities above and considered the impact of setting up a separate pool, or pools, for retirees. Our analysis is summarized in the following sections.

## 2. Historical Retiree Experience

We reviewed the premium and expense for active and retiree coverage for 2011 and 2012 for each participating entity. The data was prepared for us by the Gallagher Fresno office. We did not audit the data but we did review if for reasonableness and consistency and we believe it is sufficient for the purposes of this analysis. Due to the size of the retiree population, this experience is not completely credible but it does illustrate some interesting trends that can be used in the development of a retiree strategy. The key results for each entity are summarized below, and the complete analysis is included as an attachment to this report.

County of Tulare

The County of Tulare allows pre- and post-Medicare retirees to select from the same plans that are offered to active employees. Retirees pay 100% of the blended premium rate. The enrollment in the pre-Medicare retiree plan has a similar distribution across the plans to the active enrollees, while Medicare eligible retirees who participate are far more likely to take the $1000 deductible plan and less likely to take the $0 and $500 deductible plans.

As measured on a per member per month ("pmpm") basis, where members include employees and dependents, the experience is similar to what we would expect. Pre-Medicare retirees on average have claims that are double the average of active members. There is significant variation by plan, which is likely attributable to the smaller sample size within any one plan. As a rule of thumb, we expect pre-Medicare retirees to average 75% to 100% more than actives, so these results, in aggregate, are not surprising.

Medicare retirees cost, on average, 25% to 30% more than actives over the two years, despite a lower average plan value due to the higher enrollment in the $1000 deductible plan. Pharmacy claims accounted for 60% of the total claim cost for this group over the 2 year period. Our rule of thumb for Medicare retirees is that they cost 100% to 120% of what actives do, so the County's experience is slightly outside the norm. Given the relatively small number of members, some variation from our norms is not surprising.

Since the premium rates are the same for actives and both retiree categories, it is not surprising, given the results above, that the active lives did indeed subsidize the retiree experience significantly. We estimate the underwriting gain/ (loss) by class for each year as follows (excluding stop loss recoveries of approximately $200,000 in each year):

| Class | 2011 | 2012 |
|---|---|---|
| Actives | $2,043,985 | $1,067,155 |
| Pre Medicare Retirees | ($992,609) | ($892,500) |
| Medicare Retirees | ($126,064) | ($246,833) |
| Total | $925,311 | ($72,177) |

Based on these results, there is a significant implicit subsidy built into the blended rates to cover the costs of the retirees. This subsidy must be measured and reported under the requirements of

GASB 45. Overall, the County of Tulare's results are typical of what we see for employers using the blended rating approach.

County of Fresno

The County of Fresno allows pre-Medicare retirees to participate only in the High Deductible PPO plan. The County charges its pre-Medicare retirees more than the premium rates for actives, although the loads are not uniform by tier and are less than we would expect to be necessary to fund the full expense. The active and retiree rates for 2013 are summarized in the following table:

| Tier | Active | Retiree | Dollar Difference | % Difference |
|---|---|---|---|---|
| Employee | $440.82 | $617.08 | $176.26 | 40% |
| Employee/Spouse | $933.73 | $1,092.43 | $158.70 | 17% |
| Employee/Child(ren) | $837.11 | $963.97 | $126.86 | 15% |
| Employee/Family | $1,275.65 | $1,438.15 | $162.50 | 13% |

The comparison of the active and retiree experience is more complicated for the County of Fresno because the active lives are spread across two plans but the retirees are all in one plan. We would normally expect the active High Deductible plan would attract a healthier than average population, so a straight comparison between the active and retiree high deductible plans may be somewhat skewed. In fact, the active PPO pmpm claims were over 3 times as high as the high deductible pmpm claims in both 2011 and 2012, so it appears that the active high deductible plan is the beneficiary of very positive selection. Given that, it is not surprising that the retiree pmpm claims exceeded the active pmpm for the high deductible plan by 62% in 2011 and by over 150% in 2012. But if we compare the retiree pmpm cost to the active cost across all plans, the pmpm retiree claims were actually 29% lower in 2011 and 12% higher in 2012.

The underwriting results for the County of Fresno are much different than for the County of Tulare, due to the higher retiree premiums and the more favorable retiree experience. The 2011 and 2012 underwriting results are summarized in the following table.

| Class | 2011 | 2012 |
|---|---|---|
| Actives | ($420,995) | $380,100 |
| Retirees | $436,513 | ($7,039) |
| Total | $15,517 | $373,061 |

In 2011, the retiree plan actually produced a gain, which is very surprising even considering the higher premiums. In 2012, the retiree plan broke even, and even that is perhaps slightly surprising since the premium loads are not as large as the expected difference in claim costs. Again, the small population will see large swings from year to year, and it may be that we simply saw an unusually good year in 2011 and experience is now regressing back to the norm for the retiree population. At the noted premium loads, we expect that over time the County of Fresno plan will also see an implicit subsidy on its retiree coverage, with the resulting GASB 45 liability and expense.

City of Tulare

Because the City of Tulare has such a small number of retirees, the experience has no credibility and we limited our review to a comparison of the premium rates between active and retiree plans. The City offers PPO plans with deductibles of $500, $1000, and $3000 to retirees. It offers the same $500 and $1000 deductible plans to retirees, but also offers a $0 deductible plan to actives rather than the $3000 deductible plan. The retiree rates for the $500 and $1000 plans are considerably higher than the rates for the corresponding active plans, as summarized in the following table.

| Plan | Tier | Active | Retiree | $ Difference | % Difference |
|---|---|---|---|---|---|
| **$500 Deductible** | Employee | $484.48 | $961.83 | $477.35 | 99% |
| | Employee + 1 | N/A | $1,923.68 | N/A | N/A |
| | Family | $1,065.85 | $2,693.14 | $1,627.29 | 153% |
| **$1,000 Deductible** | Employee | $435.67 | $877.42 | $441.75 | 101% |
| | Employee + 1 | N/A | $1,754.84 | N/A | N/A |
| | Family | $958.48 | $2,456.77 | $1,498.29 | 156% |

The retiree premiums for single coverage are approximately double, while the premiums for family coverage are 2.5 times as high as the active rates. At these rates, we believe the retiree plan can be expected to be self-supporting and we do not expect an implicit subsidy for retiree coverage.

City of Ceres

We do not have complete data for the City, and once again the retiree population is very small, so the experience will not be credible. Since the retiree rates are the same as the active rates, we expect there will be an implicit subsidy for the City.

Summary

With the possible exception of the retiree experience for the County of Fresno, the results are consistent with our expectations. Pre-Medicare retirees are generally much more expensive than active members, and including them in the active rating pool creates a subsidy under which the active rates subsidize the retirees. The County of Tulare is the only participant that provides retiree coverage for Medicare eligible retirees through the pool, and the experience for that plan suggests there is also an implicit subsidy for that population if they are rated on a blended basis, though it is much smaller than the implicit subsidy we see for the pre-Medicare retirees.

## 3. Pros and Cons of a Separate Pre-Medicare Retiree Pool

The SJVIA could create a separate pool for pre-Medicare retirees (or all retirees). Under this approach, the retirees of all participating entities would be assigned to a separate rating pool, and rates would be set to make that pool self supporting. Some advantages of this approach are as follows.

1. The current rates for active employees are higher than they need to be because they are supporting the more expensive retirees, at least for some participants. If new participants bring additional retirees who are priced at blended rates, this implicit subsidy could get worse. This could hurt the competitiveness of the pool, especially when quoting on smaller, manually rated prospective participants that do not cover retirees. A separate retiree pool should make the rates charged for active employees more competitive.

2. Carving out the retirees and pricing them appropriately will eliminate the implicit subsidy associated with the retirees under GASB 45, although it would still provide a coverage option for these retirees.

3. The retiree pool could still allow participating entities to subsidize retiree premiums, so those who wanted to keep the retiree premiums lower could do that with an explicit premium subsidy rather than the implicit subsidy that a blended rate structure produces.

4. Self-supporting rates for pre-Medicare retirees will result in rates that are much more consistent with what retirees are likely to see in the state Exchange. This will help justify the rates when retirees complain that the self-supporting rates are excessive. It will also encourage retirees to seriously consider the Exchange, especially if they qualify for premium assistance through the Exchange. There is no penalty on the employer if retirees go to the Exchange and obtain subsidized coverage.

There are also some potential disadvantages of setting up a separate retiree pool.

1. The feasibility and/or desire for an entity to adjust their contributions to an existing retiree is very low. Entities are often more open to adjusting rate blending to mitigate GASB 45 implicit subsidy than to modifying contributions impacting explicit subsidies. Also, contribution amounts are more clearly defined than rate structure in bargaining agreements.

2. For those participants that currently charge a blended rate, the increase under a self-supporting separate pool will be very large. This may cause bad publicity and is likely to be a hardship for current retirees, depending on what coverage is available through the State Exchange.

3. Even for those participants that already have separate rates for pre-Medicare retirees, it is possible that the retiree pool rate structure would result in a significant change to some

rates. For example, the current loads in the retiree premiums for the County of Fresno would probably go up under a separate retiree pool.

4. It is possible that by raising retiree rates, the pool may subject itself to a higher degree of anti selection. The more retirees are asked to pay, the more the healthier ones will look for other options, leaving a potentially even higher cost retiree pool.

5. Adding a separate pool may result in a greater administrative burden. This should not be a significant factor.

6. The separate pool may be perceived negatively by future prospective participants if they do not share the desire to charge retirees self-supporting rates. As noted above, they could still provide an explicit subsidy to keep the retiree premiums more in line with where they are today.

A factor that lends support to the decision to move to a separate pool for pre-Medicare retirees, or all retirees, is that it gives participating entities an opportunity to avoid the implicit subsidy under GASB, but does not preclude an entity from replacing the implicit subsidy with an explicit subsidy if they prefer to keep the retiree premiums at the blended active/retiree level. So there is an advantage for those that want it, but the change is not forced on those that don't. However, this factor does not take into account the current rate blending flexibility in place with the SJVIA at the member level. The existing structure allows for member entities that have unblended rates to join the SJVIA with rate structure intact by adhering their prior cost differential for active employees versus retirees. Again, the flexibility or willingness to adjust implicit subsidy for member entities seems to be much greater than to adjust explicit subsidy (contributions for retiree coverage). The appeal of the SJVIA to prospective members may be diminished if the current active/retiree rate flexibility is replaced by a requisite to unblend rates and increase explicit subsidies. The transition of the potential rating may prove problematic to existing member entities that have joined under a certain underwriting methodology and with rate guarantees in place. Further, the County of Fresno may be advised to resist this potential change as they do not presently have an implicit OR explicit GASB 45 subsidy position (unblended rates and no retiree contribution).

From an underwriting perspective, a separate retiree pool provides a greater opportunity to charge premiums that are more consistent with the underlying risk. The current approach is not wrong or especially problematic, but a separate pool could be considered a small improvement from a rating perspective. The pool would need to larger than its current size of 400 retirees. In order for it to function well it would need to be over 1,000.

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## 4. Next Steps

If the SJVIA elects not to establish the separate pool for retirees, no further action is needed. The pool will continue to operate as it has been.

If the SJVIA elects to move ahead with the separate pool, then as part of the 2014 renewal process Gallagher will do a separate renewal calculation for the retiree lives. That calculation will look at the cost across all entities, with an adjustment for plan designs, to produce a pmpm cost for a benchmark retiree plan design. Plan factors will be applied to get the comparable pmpm cost for all retiree plans offered by participating entities.

The renewal for active employees will be prepared just as it has in the past, but with the retiree experience removed.

As a final step, the rates of the actives and retirees will be compared for reasonableness. Because the retiree population will not be fully credible, it may be necessary to make an adjustment to the retiree rates to keep the active/retiree relationship appropriate.

This analysis deals primarily with the pre-Medicare retirees. As noted earlier, experience on Medicare retirees is more similar to the active experience, but it is also possible to have a third pool for Medicare retirees, or a single retiree pool that has separate rates for pre- and post-Medicare retirees. Many employers have separate rates for Medicare retirees. Fewer employers offer coverage to Medicare retirees, so this issue will affect a smaller subset of the participating entities. If the SJVIA elects to move forward with a retiree pool, we would recommend focusing on the Medicare retirees in that pool, but with separate rates to reflect the impact of Medicare being the primacy payer for medical claims.

## 5. Certification

I, Glen R. Volk, am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I am a Consulting Actuary with Healthcare Analytics, a division of Gallagher Benefit Services. I have prepared this analysis at the request of the Fresno office of Gallagher Benefit Services. I certify that to the best of my knowledge and judgment:

- I have relied on data provided by the Gallagher Fresno office and I believe the data is appropriate for the purposes of this analysis.
- I am not aware of any relation between myself, the Gallagher Benefits Fresno office, or the SJVIA, that would impair or appear to impair my ability to conduct this analysis in an unbiased manner.
- This analysis is prepared for the purposes described in the report. Any other use of the analysis or results in inappropriate.
- I satisfy the American Academy of Actuaries qualification standards for issuing this opinion.

_____

Glen R. Volk
June 13, 2013

**San Joaquin Valley Insurance Authority**
**Summary of Retiree Experience and Rates Compared to Active**

**County of Fresno**

**2011**

| | Under 65 | | | | | | % of | % of Active | % of | % of Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Plan | Employees | Members | Medical | Pharmacy | Total | PMPM | Active | HDHP | Total | HDHP |
| HDHP | 3,288 | 4,180 | $1,275,582 | $433,231 | $1,708,813 | $408.81 | 71% | 162% | 78% | 121% |

| | Actives | | | | | | % of | | % of | |
|---|---|---|---|---|---|---|---|---|---|---|
| Plan | Employees | Members | Medical | Pharmacy | Total | PMPM | Active | | Total | |
| PPO | 4,453 | 5,687 | $3,410,075 | $1,006,898 | $4,416,973 | $776.68 | 100% | | 100% | |
| HDHP | 2,724 | 3,513 | $692,872 | $195,619 | $888,491 | $252.92 | 100% | | 75% | |
| Total | 7,177 | 9,200 | $4,102,947 | $1,202,517 | $5,305,464 | $576.68 | 100% | | 110% | |

| | Total Active and Retiree | | | | | | % of | % of Active | % of |
|---|---|---|---|---|---|---|---|---|---|
| Plan | Employees | Members | Medical | Pharmacy | Total | PMPM | Active | HDHP | Total |
| PPO | 4,453 | 5,687 | $3,410,075 | $1,006,898 | $4,416,973 | $776.68 | 100% | | 100% |
| HDHP | 6,012 | 7,693 | $1,968,454 | $628,850 | $2,597,304 | $337.62 | 133% | 133% | 100% |
| Total | 10,465 | 13,380 | $5,378,529 | $1,635,747 | $7,014,276 | $524.24 | 91% | | 100% |

| | Retiree | Active | Total |
|---|---|---|---|
| Premium | $2,312,520 | $5,249,419 | $7,561,939 |
| Claims | $1,708,813 | $5,305,464 | $7,014,276 |
| Fixed Costs | $167,195 | $364,950 | $532,145 |
| Gain/(Loss) | $436,513 | ($420,995) | $15,517 |
| % Gain/(Loss) | 18.9% | -8.0% | 0.2% |

**2012**

| | Under 65 | | | | | | % of | % of Active | % of | % of Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Plan | Employees | Members | Medical | Pharmacy | Total | PMPM | Active | HDHP | Total | HDHP |
| HDHP | 3,247 | 3,991 | $1,566,447 | $480,477 | $2,046,924 | $512.88 | 112% | 253% | 108% | 144% |

| | Actives | | | | | | % of | | % of | |
|---|---|---|---|---|---|---|---|---|---|---|
| Plan | Employees | Members | Medical | Pharmacy | Total | PMPM | Active | | Total | |
| PPO | 3,464 | 4,320 | $2,248,228 | $775,067 | $3,023,295 | $699.84 | 100% | | 100% | |
| HDHP | 3,234 | 4,131 | $667,177 | $169,606 | $836,783 | $202.56 | 100% | | 57% | |
| Total | 6,698 | 8,451 | $2,915,405 | $944,673 | $3,860,078 | $456.76 | 100% | | 96% | |

| | Total Active and Retiree | | | | | | % of | % of Active | % of |
|---|---|---|---|---|---|---|---|---|---|
| Plan | Employees | Members | Medical | Pharmacy | Total | PMPM | Active | HDHP | Total |
| PPO | 3,464 | 4,320 | $2,248,228 | $775,067 | $3,023,295 | $699.84 | 100% | | 100% |
| HDHP | 6,481 | 8,122 | $2,233,624 | $650,083 | $2,883,707 | $355.05 | 175% | 175% | 100% |
| Total | 9,945 | 12,442 | $4,481,852 | $1,425,150 | $5,907,002 | $474.76 | 104% | | 100% |

| | Retiree | Active | Total |
|---|---|---|---|
| Premium | $2,212,690 | $4,596,655 | $6,809,346 |
| Claims | $2,046,924 | $3,860,078 | $5,907,002 |
| Fixed Costs | $172,805 | $356,476 | $529,282 |
| Gain/(Loss) | ($7,039) | $380,100 | $373,061 |
| % Gain/(Loss) | -0.3% | 8.3% | 5.5% |

**San Joaquin Valley Insurance Authority**
**Summary of Retiree Experience and Rates Compared to Active**

**City of Tulare**

No credible experience

Premium Rate Comparision

PPO 500

| | Retiree | | | Active | | Retiree as % of Active | |
|---|---|---|---|---|---|---|---|
| Year | EE | EE + 1 | EF | EE | EF | EE | EF |
| 2012 | $961.83 | $1,923.68 | $2,693.14 | $484.48 | $1,065.85 | 199% | 253% |
| 2013 | $961.83 | $1,923.68 | $2,693.14 | $484.48 | $1,065.85 | 199% | 253% |

PPO 1000

| | Retiree | | | Active | | Retiree as % of Active | |
|---|---|---|---|---|---|---|---|
| | EE | EE + 1 | EF | EE | EF | EE | EF |
| 2012 | $877.42 | $1,754.84 | $2,456.77 | $435.67 | $958.48 | 201% | 256% |
| 2013 | $877.42 | $1,754.84 | $2,456.77 | $435.67 | $958.48 | 201% | 256% |

PPO 3000

| | Retiree | | |
|---|---|---|---|
| | EE | EE + 1 | EF |
| 2012 | $631.40 | $1,262.80 | $1,767.92 |
| 2013 | $631.40 | $1,262.80 | $1,767.92 |

**San Joaquin Valley Insurance Authority**
**Summary of Retiree Experience and Rates Compared to Active**

**County of Tulare**

**2011**

| | Under 65 | | | | | | % of | % of |
|---|---|---|---|---|---|---|---|---|
| Plan | Employees | Members | Medical | Pharmacy | Total | PMPM | Active | Total |
| $0 ded | 468 | 504 | $429,755 | $153,015 | $582,770 | 1,156.29 | 146% | 136% |
| $500 Ded | 737 | 941 | $690,123 | $259,795 | $949,918 | 1,009.48 | 228% | 210% |
| $1000 Ded | 1,102 | 1,400 | $427,008 | $244,522 | $671,530 | 479.66 | 232% | 188% |
| $2500 Ded | 12 | 24 | $1,201 | $17,834 | $19,035 | 793.13 | 2627% | 860% |
| Total | 2,319 | 2,869 | $1,548,087 | $675,165 | $2,223,252 | 774.92 | 210% | 190% |

| | Over 65 | | | | | | % of | % of |
|---|---|---|---|---|---|---|---|---|
| Plan | Employees | Members | Medical | Pharmacy | Total | PMPM | Active | Total |
| $0 ded | 81 | 117 | $133,573 | $70,410 | $203,983 | 1,743.45 | 220% | 206% |
| $500 Ded | 243 | 340 | $53,798 | $61,076 | $114,874 | 337.87 | 76% | 70% |
| $1000 Ded | 2,219 | 2,882 | $479,647 | $767,734 | $1,247,381 | 432.82 | 209% | 169% |
| $2500 Ded | - | - | $0 | $0 | $0 | - | 0% | 0% |
| Total | 2,543 | 3,339 | $667,018 | $899,221 | $1,566,239 | 469.07 | 127% | 115% |

| | Total | | | | | | % of | % of |
|---|---|---|---|---|---|---|---|---|
| Plan | Employees | Members | Medical | Pharmacy | Total | PMPM | Active | Total |
| $0 ded | 4,523 | 5,324 | $3,515,409 | $997,317 | $4,512,726 | 847.62 | 107% | 100% |
| $500 Ded | 10,337 | 13,060 | $4,548,485 | $1,739,749 | $6,288,234 | 481.49 | 109% | 100% |
| $1000 Ded | 16,071 | 21,235 | $3,556,162 | $1,866,849 | $5,423,011 | 255.38 | 124% | 100% |
| $2500 Ded | 238 | 295 | $6,333 | $20,883 | $27,217 | 92.26 | 306% | 100% |
| Total | 31,169 | 39,914 | $11,626,389 | $4,624,798 | $16,251,188 | 407.16 | 110% | 100% |

| | Actives | | | | | | % of | % of |
|---|---|---|---|---|---|---|---|---|
| Plan | Employees | Members | Medical | Pharmacy | Total | PMPM | Active | Total |
| $0 ded | 3,974 | 4,703 | $2,952,081 | $773,893 | $3,725,974 | 792.25 | 100% | 93% |
| $500 Ded | 9,357 | 11,779 | $3,804,564 | $1,418,878 | $5,223,442 | 443.45 | 100% | 92% |
| $1000 Ded | 12,750 | 16,953 | $2,649,507 | $854,593 | $3,504,100 | 206.69 | 100% | 81% |
| $2500 Ded | 226 | 271 | $5,132 | $3,049 | $8,182 | 30.19 | 100% | 33% |
| Total | 26,307 | 33,706 | $9,411,284 | $3,050,413 | $12,461,697 | 369.72 | 100% | 91% |

| | Pre 65 Retiree | 65+ Retiree | Active | Total | |
|---|---|---|---|---|---|
| Premium | $1,348,564 | $1,569,486 | $15,843,393 | $18,761,442 | Allocated on pmpm basis |
| Claims | $2,223,252 | $1,566,239 | $12,461,697 | $16,251,188 | |
| Fixed Costs | $117,921 | $129,312 | $1,337,711 | $1,584,944 | |
| Gain/(Loss) | ($992,609) | ($126,064) | $2,043,985 | $925,311 | Excludes $220K stop loss recovery (active) |
| % Gain/(Loss) | -73.6% | -8.0% | 12.9% | 4.9% | |

**San Joaquin Valley Insurance Authority**
**Summary of Retiree Experience and Rates Compared to Active**

**County of Tulare**

**2012**

| | Under 65 | | | | | | % of | % of |
|---|---|---|---|---|---|---|---|---|
| Plan | Employees | Members | Medical | Pharmacy | Total | PMPM | Active | Total |
| $0 ded | 285 | 324 | $162,358 | $95,717 | $258,075 | 796.53 | 108% | 105% |
| $500 Ded | 550 | 699 | $948,551 | $186,884 | $1,135,435 | 1,624.37 | 351% | 308% |
| $1000 Ded | 980 | 1,246 | $249,697 | $163,831 | $413,528 | 331.88 | 126% | 113% |
| $2500 Ded | 20 | 32 | $27,066 | $21,220 | $48,286 | 1,508.94 | 967% | 558% |
| Total | 1,835 | 2,301 | $1,387,672 | $467,651 | $1,855,323 | 806.31 | 207% | 191% |

| | Over 65 | | | | | | % of | % of |
|---|---|---|---|---|---|---|---|---|
| Plan | Employees | Members | Medical | Pharmacy | Total | PMPM | Active | Total |
| $0 ded | 61 | 91 | $68,871 | $61,089 | $129,960 | 1,428.13 | 193% | 189% |
| $500 Ded | 222 | 307 | $62,362 | $81,668 | $144,030 | 469.15 | 101% | 89% |
| $1000 Ded | 2,213 | 2,846 | $463,806 | $871,292 | $1,335,098 | 469.11 | 177% | 160% |
| $2500 Ded | - | - | $0 | $0 | $0 | - | 0% | 0% |
| Total | 2,496 | 3,244 | $595,039 | $1,014,048 | $1,609,087 | 496.02 | 128% | 118% |

| | Total | | | | | | % of | % of |
|---|---|---|---|---|---|---|---|---|
| Plan | Employees | Members | Medical | Pharmacy | Total | PMPM | Active | Total |
| $0 ded | 4,081 | 4,826 | $2,733,684 | $914,039 | $3,647,723 | 755.85 | 102% | 100% |
| $500 Ded | 9,957 | 12,554 | $4,915,670 | $1,710,647 | $6,626,317 | 527.83 | 114% | 100% |
| $1000 Ded | 17,145 | 22,713 | $4,472,312 | $2,199,703 | $6,672,015 | 293.75 | 111% | 100% |
| $2500 Ded | 316 | 379 | $74,713 | $27,723 | $102,436 | 270.28 | 173% | 100% |
| Total | 31,499 | 40,472 | $12,196,379 | $4,852,112 | $17,048,491 | 421.24 | 108% | 100% |

| | Actives | | | | | | % of | % of |
|---|---|---|---|---|---|---|---|---|
| Plan | Employees | Members | Medical | Pharmacy | Total | PMPM | Active | Total |
| $0 ded | 3,735 | 4,411 | $2,502,455 | $757,233 | $3,259,688 | 738.99 | 100% | 98% |
| $500 Ded | 9,185 | 11,548 | $3,904,757 | $1,442,096 | $5,346,853 | 463.01 | 100% | 88% |
| $1000 Ded | 13,952 | 18,621 | $3,758,809 | $1,164,581 | $4,923,390 | 264.40 | 100% | 90% |
| $2500 Ded | 296 | 347 | $47,647 | $6,503 | $54,150 | 156.05 | 100% | 58% |
| Total | 27,168 | 34,927 | $10,213,668 | $3,370,412 | $13,584,080 | 388.93 | 100% | 92% |

| | Pre 65 Retiree | 65+ Retiree | Active | Total | |
|---|---|---|---|---|---|
| Premium | $1,060,482 | $1,495,091 | $16,097,117 | $18,652,690 | Allocated on pmpm basis |
| Claims | $1,855,323 | $1,609,087 | $13,584,080 | $17,048,491 | |
| Fixed Costs | $97,659 | $132,837 | $1,445,881 | $1,676,377 | |
| Gain/(Loss) | ($892,500) | ($246,833) | $1,067,155 | ($72,177) | Excludes $228K stop loss recovery (active) |
| % Gain/(Loss) | -84.2% | -16.5% | 6.6% | -0.4% | |

**San Joaquin Valley Insurance Authority**
**Summary of Retiree Experience and Rates Compared to Active**

**Retiree Census Summary**

| | County of Fresno | | | County of Tulare | | | City of Tulare | | |
|---|---|---|---|---|---|---|---|---|---|
| Age Band | # | % of </>= 65 | % of Total | # | % of </>= 65 | % of Total | # | % of </>= 65 | % of Total |
| <55 | 3 | 1.3% | 1.1% | 13 | 9.4% | 3.6% | 3 | 12.0% | 11.5% |
| 55-59 | 36 | 15.9% | 13.3% | 35 | 25.2% | 9.7% | 6 | 24.0% | 23.1% |
| 60-64 | 187 | 82.7% | 69.3% | 91 | 65.5% | 25.3% | 16 | 64.0% | 61.5% |
| Subtotal <65 | 226 | 100.0% | 83.7% | 139 | 100.0% | 38.6% | 25 | 100.0% | 96.2% |
| 65-69 | 30 | 68.2% | 11.1% | 65 | 29.4% | 18.1% | 1 | 100.0% | 3.8% |
| 70-74 | 9 | 20.5% | 3.3% | 43 | 19.5% | 11.9% | 0 | 0.0% | 0.0% |
| 75-79 | 1 | 2.3% | 0.4% | 34 | 15.4% | 9.4% | 0 | 0.0% | 0.0% |
| 80-84 | 4 | 9.1% | 1.5% | 35 | 15.8% | 9.7% | 0 | 0.0% | 0.0% |
| 85+ | 0 | 0.0% | 0.0% | 44 | 19.9% | 12.2% | 0 | 0.0% | 0.0% |
| Subtotal 65+ | 44 | 100.0% | 16.3% | 221 | 100.0% | 61.4% | 1 | 100.0% | 3.8% |
| Total | 270 | | | 360 | | | 26 | | |
| Average Age | | | | | | | | | |
| <65 | 62.0 | | | 60.1 | | | 60.7 | | |
| 65+ | 69.5 | | | 76.2 | | | 65.5 | | |

**EXHIBIT B**

# County of Fresno

**Proposed Effective Date: January 1, 2013**

| | Current | | | Renewal | | |
|---|---|---|---|---|---|---|
| | **Hartford/Benistar Retiree Medicare Plan** | **Kaiser Kaiser Sr. Advantage HIGH** | **Kaiser Kaiser Sr. Advantage LOW** | **Hartford/Benistar Retiree Medicare Plan** | **Kaiser Kaiser Sr. Advantage HIGH** | **Kaiser Kaiser Sr. Advantage LOW** |
| **DEDUCTIBLE** | | | | | | |
| Per Individual | $0 | $0 | $0 | $0 | $0 | $0 |
| **COINSURANCE RATE** | n/a | 0% | 0% | n/a | 0% | 0% |
| **OUT OF POCKET MAX** | | | | | | |
| Per Individual | $0 | $1,500 per person | $1,500 per person | $0 | $1,500 per person | $1,500 per person |
| **PHYSICIAN SERVICES** | | | | | | |
| Routine Exam | $0 | $15 | $15 | $0 | $15 | $15 |
| Physician & Specialist Office Visits | $0 | $15 | $15 | $0 | $15 | $15 |
| Excess Above Medicare Allowable | $0 | | | $0 | | |
| **PREVENTATIVE SERVICES*** | 100% after Medicare | $15 | $15 | 100% after Medicare | $15 | $15 |
| **OUTPATIENT HOSPITAL CARE** | $0 | $50/procedure | $50/procedure | $0 | $50/procedure | $50/procedure |
| **INPATIENT HOSPITAL STAY** | $0 | No charge | No charge | $0 | No charge | No charge |
| **AMBULATORY SURGICAL CENTERS** | $0 | No charge | No charge | $0 | No charge | No charge |
| **URGENT CARE** | $0 | $15 | $15 | $0 | $15 | $15 |
| **RADIOLOGY** | $0 | $15 | $15 | $0 | $15 | $15 |
| **LABORATORY** | $0 | No charge | No charge | $0 | No charge | No charge |
| **PRESCRIPTION DRUGS** | | 100 day supply | 30 day supply | | 100 day supply | 30 day supply |
| Generic | $10 | $5 | $10 | $10 | $5 | $10 |
| Brand Name | $20 | $20 | $25 | $20 | $20 | $25 |
| Brand Name Non-Formulary | $30 | n/a | n/a | $30 | n/a | n/a |
| **Monthly Rates** | Includes M&N Carve Out | | | **Excludes M&N Carve Out | | |
| **Current Enrollment** | **Hartford** / **KP** | | | | | |
| Retiree Only | 600 / 443 | $479.26 | $308.95 | $277.72 | $482.97 | $308.54 | $277.58 |
| **Annual Increase/Decrease - %** | | **n/a** | **n/a** | **n/a** | **0.77%** | **-0.13%** | **-0.05%** |

*Adult Preventative Cancer Screening Services (including mammograms, pap smears, prostate cancer screenings & colorectal cancer screenings)

SJVIA
San Joaquin Valley Insurance Authority



Meeting Location:
**Fresno County Employee Retirement Association Board Chambers**
**1111 H Street**
**Fresno, CA 93721**
**July 26, 2013**
**9:00 AM**

**AGENDA DATE:** July 26, 2013

**ITEM NUMBER** 12

**SUBJECT** Preliminary 2014 Health Plan Renewal

**REQUEST(S):** That the Board receive a report projecting the 2014 renewal rate action.

**DESCRIPTION:**

For the third plan year the SJVIA is using the Board approved, shared risk underwriting methodology to calculate the plan year renewals. Under this underwriting arrangement, the SJVIA is reviewed as a unit for claims and reserves and then each agency/plan is also reviewed to determine how their agency specific experience relates to the overall SJVIA pool. The participating agency is then issued a renewal based on the experience of the SJVIA pool, adjusted according to their specific plan performance consistent with the Underwriting Guidelines. This approach provides rate smoothing and stability for all agencies and is employed by many JPAs.

For the preliminary renewal projection, Gallagher Benefit Services, has projected the overall SJVIA renewal for 2014 would require an increase between 7% and 11%. This initial renewal projection is based on claims data through May 2013 and current demographic information on all participating agencies. This preliminary renewal also contains preliminary rate renewal from the respective vendors for various plan components in addition to fees associated with the Affordable Care Act.

**SUBJECT**: Preliminary 2014 Health Plan Renewal

**DATE:** July 26, 2013

The final rate recommendation will be completed using claims data updated through June 2013 and presented at the August 23, 2013 SJVIA Board of Directors meeting. The presentation at that time will have the 2014 percentage increase for the overall SJVIA, as well as the specific rate increases for each plan and member agency, all developed using the approved shared risk underwriting methodology. Additionally, the recommendation will consider the SJVIA's reserve position for Incurred but Not Reported (IBNR) liability and consider the impact of alternatives.

**FISCAL IMPACT/FINANCING:**

Projected renewal rate increases will be added to the budget for the 2013-14 fiscal year to be amended and approved at a future meeting.

**ADMINISTRATIVE SIGN-OFF:**

Jeffrey Cardell
SJVIA Manager

Paul Nerland
Assistant SJVIA Manager

# BEFORE THE BOARD OF DIRECTORS
# SAN JOAQUIN VALLEY INSURANCE AUTHORITY

**IN THE MATTER OF** Preliminary 2014 Health Plan Renewal

**RESOLUTION NO.** _____
**AGREEMENT NO.** _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * * *

That the Board received a report projecting 2014 renewal rate action.

Gallagher Benefit Services, Inc.
thinking ahead

# Preliminary Renewal

**for**

SJVIA
San Joaquin Valley Insurance Authority

Plan Year: January 1, 2014 - December 31, 2014

Presented By:

## Gallagher Benefit Services

CA License #: 0D36879

July 26, 2013

**Important Note:** This presentation represents estimations of the scope, size and operation of SJVIA subject to its formation and inclusion of the counties to which it is presenting. This analysis is for illustrative purposes only, and is not a guarantee of future expenses, claims costs, managed care savings, etc. There are many variables that can affect future health care costs including utilization patterns, catastrophic claims, changes in plan design, health care trend increases, etc. This analysis does not amend, extend, or alter the coverage provided by the actual insurance policies and contracts. Please see your policy or contact us for specific information or further details in this regard.

## San Joaquin Valley Insurance Authority

# Paid Claims History - All PPO Plans

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **2010 Plan Year** | | | | | | | | |
| **Totals** | | | | | **44,423** | **$17,200,878** | **$5,311,947** | **$22,512,825** |
| **Average per Employee** | | | | | | **$387.21** | **$119.58** | **$506.78** |
| | | | | | | | | |
| **2011 Plan Year** | | | | | | | | |
| **Totals** | | | | | **41,718** | **$16,784,754** | **$6,260,546** | **$23,045,300** |
| **Average per Employee (Enrollment lagged 2 months)** | | | | | **42,120** | **$398.50** | **$148.64** | **$547.13** |
| **Percentage Change from Prior Year** | | | | | | **2.92%** | **24.30%** | **7.96%** |
| | | | | | | | | |
| **2012 Plan Year** | | | | | | | | |
| | Enrollment | | | | | Paid Claims | | |
| **Month-Year** | **EE** | **ES** | **EC** | **EF** | **Total EE's** | **Medical** | **Rx** | **Combined** |
| Jan-12 | 2,744 | 414 | 147 | 85 | 3,390 | 1,286,008 | 492,397 | 1,778,405 |
| Feb-12 | 2,785 | 415 | 150 | 88 | 3,438 | 1,443,721 | 464,802 | 1,908,523 |
| Mar-12 | 2,774 | 412 | 150 | 90 | 3,426 | 1,651,732 | 512,848 | 2,164,580 |
| Apr-12 | 2,778 | 407 | 154 | 90 | 3,429 | 1,374,121 | 496,552 | 1,870,673 |
| May-12 | 2,796 | 402 | 157 | 90 | 3,445 | 1,153,853 | 549,850 | 1,703,703 |
| Jun-12 | 2,821 | 401 | 155 | 90 | 3,467 | 1,346,162 | 564,170 | 1,910,332 |
| 7/1/2012* | 2,978 | 403 | 151 | 260 | 3,792 | 1,294,539 | 619,173 | 1,913,712 |
| Aug-12 | 2,986 | 401 | 155 | 257 | 3,799 | 1,467,322 | 619,485 | 2,086,807 |
| Sep-12 | 2,979 | 405 | 155 | 257 | 3,795 | 1,280,728 | 641,239 | 1,921,966 |
| Oct-12 | 2,993 | 405 | 155 | 256 | 3,809 | 1,667,499 | 573,307 | 2,240,806 |
| Nov-12 | 3,003 | 402 | 156 | 257 | 3,817 | 1,714,342 | 599,113 | 2,313,455 |
| Dec-12 | 2,993 | 400 | 154 | 259 | 3,806 | 1,276,207 | 518,434 | 1,794,641 |
| Sub Total | 34,629 | 4,866 | 1,839 | 2,079 | 43,412 | 16,956,235 | 6,651,370 | 23,607,605 |
| Stop Loss Reimbursement (Pooling Limit @ $450K) | | | | | | - | - | - |
| City of Tulare Run-Out Claims | | | | | | 315,409 | - | 315,409 |
| **Totals** | | | | | | **$17,271,644** | **$6,651,370** | **$23,923,014** |
| **Average per Employee (Enrollment lagged 2 months)** | | | | | **42,630** | **$405.16** | **$156.03** | **$561.18** |
| **Percentage Change from Prior Year** | | | | | | **1.67%** | **4.97%** | **2.57%** |

**City of Tulare Joined SJVIA with enrollment in EE, ES, and EF Tiers*

**2013 Plan Year**

| | Enrollment | | | | | Paid Claims | | |
|---|---|---|---|---|---|---|---|---|
| **Month-Year** | **EE** | **ES** | **EC** | **EF** | **Total EE's** | **Medical** | **Rx** | **Combined** |
| Jan-13 | 2,914 | 382 | 133 | 244 | 3,673 | 1,379,070 | 555,128 | 1,934,197 |
| Feb-13 | 2,914 | 385 | 132 | 244 | 3,675 | 1,355,513 | 526,154 | 1,881,668 |
| Mar-13 | 2,891 | 384 | 129 | 248 | 3,652 | 1,521,017 | 534,131 | 2,055,148 |
| Apr-13 | 2,888 | 377 | 130 | 246 | 3,641 | 1,329,384 | 558,015 | 1,887,399 |
| May-13 | 2,894 | 369 | 131 | 252 | 3,646 | 1,190,872 | 594,640 | 1,785,512 |
| Sub Total | 14,501 | 1,897 | 655 | 1,234 | 18,287 | 6,775,856 | 2,768,068 | 9,543,924 |
| Rolling 12 month Stop Loss Reimbursement | | | | | | - | - | - |
| City of Tulare Run-Out Claims | | | | | | 10,586 | - | 10,586 |
| **Totals** | | | | | | **$6,786,442** | **$2,768,068** | **$9,554,510** |
| **Average per Employee (Enrollment lagged 2 months)** | | | | | **18,623** | **$364.42** | **$148.64** | **$513.06** |
| **Percentage Change from Prior Year** | | | | | | **-10.05%** | **-4.73%** | **-8.57%** |
| | | | | | | | | |
| **Rolling 12 Month Totals (Enrollment lagged 2 months)** | | | | | **44,158** | **$17,148,651** | **$6,902,988** | **$24,051,639** |
| **Average per Employee (Enrollment lagged 2 months)** | | | | | | **$388.35** | **$156.32** | **$544.67** |
| **Percentage Change from Prior Year** | | | | | | **-4.15%** | **0.19%** | **-2.94%** |

## SJVIA PPO

# 2014 Claims Projection

### Paid Claims Period: June 2012 through May 2013

| | Medical | Rx | Total |
|---|---|---|---|
| Total Paid Claims | $17,148,651 | $6,902,988 | $24,051,639 |
| Claims in Excess of Pooling | - | - | - |
| Total Paid Claims Net of Pooling | $17,148,651 | $6,902,988 | $24,051,639 |
| Enrollment lagged 2 months | 44,158 | 44,158 | |
| Average Paid Claim for Period | $388.35 | $156.32 | $544.67 |
| Trend (Med.- 8.25%, Rx - 4.5%) | 1.1306 | 1.0713 | 1.1136 |
| Benefit Modification Factor | 1.0000 | 1.0000 | 1.0000 |
| Provider Discount Factor | 1.0000 | 1.0000 | 1.0000 |
| Demographic Adjustment | 1.0000 | 1.0000 | 1.0000 |
| **Projected Paid Claim** | **$439.07** | **$167.46** | **$606.54** |
| Current Monthly Enrollment (May 2013) | 3,646 | 3,646 | |
| Monthly Projected Paid Claims | $1,600,863 | $610,567 | $2,211,430 |
| Weighting Factor | 1.00000 | 1.00000 | 1.00000 |
| **2014 Annual Projected Paid Claims** | **$19,210,356** | **$7,326,809** | **$26,537,165** |

| | | | |
|---|---|---|---|
| **Projected Required Reserve (12.5%/5% Rx)** | **$2,401,295** | **$366,340** | **$2,767,635** |
| **Current Reserve*** | | | **$8,701,575** |
| **Contingent Reserve** | | | **$5,933,940** |
| **Projected Required Reserve (16.%/5% Rx)** | **$3,073,657** | **$366,340** | **$3,439,997** |
| **Current Reserve*** | | | **$8,701,575** |
| **Contingent Reserve** | | | **$5,261,577** |

**Calculated from May 2013 Claims Data - represents all premiums paid from inception less all costs from inception*

# SJVIA 2011 -2014 PPO Cost Worksheet: Combined - Anthem Blue Cross

| Enrollment | Single | EE +Sp | EE + Ch | Family | Total | Members |
|---|---|---|---|---|---|---|
| **Total PPO** | **2,894** | **369** | **131** | **252** | **3,646** | **4,572** |

| **2011 Fixed Costs:** | Single | EE +Sp | EE + Ch | Family | Totals |
|---|---|---|---|---|---|
| **PPO** - Specific Stop Loss (HM Life $450,000 ded. 12/15) | $ 8.88 | $ 8.88 | $ 8.88 | $ 8.88 | $ 388,518 |
| **PPO** - Aggregate Stop Loss (HM Life 12/15) | $ 0.80 | $ 0.80 | $ 0.80 | $ 0.80 | $ 35,002 |
| **PPO** - Blue Cross Core Administration | $ 23.42 | $ 23.42 | $ 23.42 | $ 23.42 | $ 1,024,672 |
| **PPO** - Blue Cross 360 Claims Management | $ 2.25 | $ 2.25 | $ 2.25 | $ 2.25 | $ 98,442 |
| Claims Management/Communication | $ 3.00 | $ 3.00 | $ 3.00 | $ 3.00 | $ 131,256 |
| JPA Consulting | $ 4.00 | $ 4.00 | $ 4.00 | $ 4.00 | $ 175,008 |
| SJVIA Fee | $ 2.00 | $ 2.00 | $ 2.00 | $ 2.00 | $ 87,504 |
| Hourglass (Consolidated Billing, COBRA, Flex Admin) | $ 6.50 | $ 6.50 | $ 6.50 | $ 6.50 | $ 284,388 |
| **Total Fixed Cost** | $ 50.85 | $ 50.85 | $ 50.85 | $ 50.85 | **$ 2,224,789** |
| **2011 Claims Costs:** | | | | | |
| **PPO** - Projected Claims | $ 413.21 | $ 413.21 | $ 413.21 | $ 413.21 | $ 18,078,676 |
| **PPO** - Projected Rx Claims | $ 151.71 | $ 151.71 | $ 151.71 | $ 151.71 | $ 6,637,675 |
| **Total Claims** | | | | | **$ 24,716,351** |
| *Aggregate Attachment Factors* | *$ 723.09* | *$ 723.09* | *$ 723.09* | *$ 723.09* | *$ 31,636,634* |
| **Current Total PPO Cost** | | | | | **$ 26,941,140** |

| **2012 Fixed Costs:** | Single | EE +Sp | EE + Ch | Family | Totals | Increase |
|---|---|---|---|---|---|---|
| **PPO** - Specific Stop Loss (HM Life $450,000 ded. 12/15) | $ 10.21 | $ 10.21 | $ 10.21 | $ 10.21 | $ 446,708 | 15.0% |
| **PPO** - Aggregate Stop Loss (HM Life 12/15) | $ 0.80 | $ 0.80 | $ 0.80 | $ 0.80 | $ 35,002 | 0.0% |
| **PPO** - Blue Cross Core Administration | $ 24.36 | $ 24.36 | $ 24.36 | $ 24.36 | $ 1,065,799 | 4.0% |
| **PPO** - Blue Cross 360 Claims Management | $ 2.35 | $ 2.35 | $ 2.35 | $ 2.35 | $ 102,817 | 4.4% |
| Claims Management/Communication | $ 3.00 | $ 3.00 | $ 3.00 | $ 3.00 | $ 131,256 | 0.0% |
| JPA Consulting | $ 4.00 | $ 4.00 | $ 4.00 | $ 4.00 | $ 175,008 | 0.0% |
| SJVIA Fee | $ 2.00 | $ 2.00 | $ 2.00 | $ 2.00 | $ 87,504 | 0.0% |
| Hourglass (Consolidated Billing, COBRA, Flex Admin) | $ 6.50 | $ 6.50 | $ 6.50 | $ 6.50 | $ 284,388 | 0.0% |
| **Total Fixed Cost** | $ 53.22 | $ 53.22 | $ 53.22 | $ 53.22 | **$ 2,328,481** | 4.7% |
| **2012 Claims Costs:** | | | | | | |
| **PPO** - Projected Claims | $ 413.21 | $ 413.21 | $ 413.21 | $ 413.21 | $ 18,078,676 | 0.0% |
| **PPO** - Projected Rx Claims | $ 151.71 | $ 151.71 | $ 151.71 | $ 151.71 | $ 6,637,675 | 0.0% |
| **Total Claims** | | | | | **$ 24,716,351** | 0.0% |
| *Aggregate Attachment Factors* | *$ 756.93* | *$ 756.93* | *$ 756.93* | *$ 756.93* | *$ 33,117,201* | 4.7% |
| **Projected Total PPO Cost** | | | | | **$ 27,044,832** | 0.4% |

| **2013 Fixed Costs:** | Single | EE +Sp | EE + Ch | Family | Totals | Increase |
|---|---|---|---|---|---|---|
| **PPO** - Specific Stop Loss (HM Life $450,000 ded. 12/15) | $ 11.74 | $ 11.74 | $ 11.74 | $ 11.74 | $ 513,648 | 15.0% |
| **PPO** - Aggregate Stop Loss (HM Life 12/15) | $ 0.85 | $ 0.85 | $ 0.85 | $ 0.85 | $ 37,189 | 6.2% |
| **PPO** - Blue Cross Core Administration | $ 25.55 | $ 25.55 | $ 25.55 | $ 25.55 | $ 1,117,864 | 4.9% |
| **PPO** - Blue Cross 360 Claims Management | $ 1.98 | $ 1.98 | $ 1.98 | $ 1.98 | $ 86,629 | -15.7% |
| Claims Management/Communication | $ 3.00 | $ 3.00 | $ 3.00 | $ 3.00 | $ 131,256 | 0.0% |
| JPA Consulting | $ 4.00 | $ 4.00 | $ 4.00 | $ 4.00 | $ 175,008 | 0.0% |
| SJVIA Fee | $ 2.00 | $ 2.00 | $ 2.00 | $ 2.00 | $ 87,504 | 0.0% |
| Hourglass (Consolidated Billing, COBRA, Flex Admin) | $ 6.50 | $ 6.50 | $ 6.50 | $ 6.50 | $ 284,388 | 0.0% |
| **Total Fixed Cost** | $ 55.62 | $ 55.62 | $ 55.62 | $ 55.62 | **$ 2,433,486** | 4.5% |
| **2013 Claims Costs:** | | | | | | |
| **PPO** - Medical Claims | $ 388.35 | $ 447.68 | $ 447.68 | $ 447.68 | $ 16,990,918 | -6.0% |
| **PPO** - Rx Claims | $ 156.32 | $ 163.55 | $ 163.55 | $ 163.55 | $ 6,839,495 | 3.0% |
| **Total Claims** | $ 544.67 | $ 611.23 | $ 611.23 | $ 611.23 | **$ 23,830,412** | -3.6% |
| *Aggregate Attachment Factors* | *$ 803.33* | *$ 803.33* | *$ 803.33* | *$ 803.33* | *$ 35,147,294* | 6.1% |
| **Projected Total PPO Cost** | | | | | **$ 26,263,899** | -2.9% |

| **2014 Fixed Costs:** | Single | EE +Sp | EE + Ch | Family | Totals | Increase |
|---|---|---|---|---|---|---|
| **PPO** - Specific Stop Loss (HM Life $450,000 ded. 12/15) | $ 14.68 | $ 14.68 | $ 14.68 | $ 14.68 | $ 642,279 | 25% |
| **PPO** - Aggregate Stop Loss (HM Life 12/15) | $ 0.85 | $ 0.85 | $ 0.85 | $ 0.85 | $ 37,189 | 0% |
| **PPO** - Blue Cross Core Administration | $ 26.57 | $ 26.83 | $ 26.83 | $ 26.83 | $ 1,162,491 | 4% |
| **PPO** - Blue Cross 360 Claims Management | $ 2.10 | $ 2.08 | $ 2.08 | $ 2.08 | $ 91,879 | 6% |
| Claims Management/Communication | $ 3.00 | $ 3.00 | $ 3.00 | $ 3.00 | $ 131,256 | 0% |
| JPA Consulting | $ 4.00 | $ 4.00 | $ 4.00 | $ 4.00 | $ 175,008 | 0% |
| SJVIA Fee | $ 2.00 | $ 2.00 | $ 2.00 | $ 2.00 | $ 87,504 | 0% |
| Hourglass (Consolidated Billing, COBRA, Flex Admin) | $ 6.50 | $ 6.50 | $ 6.50 | $ 6.50 | $ 284,388 | 0% |
| PCORI Fee | $ 0.21 | $ 0.21 | $ 0.21 | $ 0.21 | $ 9,145 | N/A |
| Transitional Reinsurance Fee | $ 6.58 | $ 6.58 | $ 6.58 | $ 6.58 | $ 288,055 | N/A |
| **Total Fixed Cost** | **$ 66.49** | **$ 66.73** | **$ 66.73** | **$ 66.73** | **$ 2,909,194** | |
| **2014 Claims Costs:** | | | | | | |
| **PPO** - Projected Claims | $ 439.07 | $ 439.07 | $ 439.07 | $ 439.07 | $ 19,210,356 | 13% |
| **PPO** - Projected Rx Claims | $ 167.46 | $ 167.46 | $ 167.46 | $ 167.46 | $ 7,326,809 | 7% |
| **Total Claims** | **$ 606.54** | **$ 606.54** | **$ 606.54** | **$ 606.54** | **$ 26,537,165** | 11% |
| *Aggregate Attachment Factors* | *$ 803.33* | *$ 803.33* | *$ 803.33* | *$ 803.33* | *$ 35,147,294* | 0% |
| **Projected Total PPO Cost** | | | | | **$ 29,446,359** | 12% |
| **Current PPO Plan Funding** | | | | | **$ 31,569,171** | |
| Projected Increase | | | | | -6.7% | |

San Joaquin Valley Insurance Authority

# Paid Claims History - All HMO Plans

**2010 Plan Year**

| | Enrollment | | | | | Non Capitated | | | |
|---|---|---|---|---|---|---|---|---|---|
| Month-Year | EE | ES | EC | EF | Total EE's | Capitation | Medical | Rx | Combined |
| **Totals** | **27,516** | **8,247** | **16,644** | **8,194** | **60,601** | **$ 12,438,557** | **$ 18,037,889** | **$ 6,196,669** | **$ 38,336,460** |
| **Average per Employee** | | | | | | | **$297.65** | **$102.25** | **$632.60** |

**2011 Plan Year**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Totals** | **25,459** | **8,099** | **17,456** | **8,064** | **59,078** | **$13,198,510** | **$17,891,946** | **$7,249,950** | **$38,340,406** |
| **Average per Employee (Enrollment lagged 2 months)** | | | | | **59,329** | **$240.97** | **$301.57** | **$122.20** | **$646.23** |
| **Percentage Change from Prior Year** | | | | | | | **1.32%** | **19.51%** | **2.15%** |

**2012 Plan Year**

| | Enrollment | | | | | Non Capitated Paid Claims | | | |
|---|---|---|---|---|---|---|---|---|---|
| Month-Year | EE | ES | EC | EF | Total EE's | Capitation | Medical | Rx | Combined |
| Jan-12 | 1,950 | 628 | 1,348 | 609 | 4,534 | 1,124,625 | 1,128,332 | 660,723 | 2,913,680 |
| Feb-12 | 1,962 | 629 | 1,360 | 609 | 4,559 | 1,130,827 | 1,941,584 | 647,395 | 3,719,806 |
| Mar-12 | 1,973 | 623 | 1,348 | 600 | 4,543 | 1,126,982 | 1,376,948 | 661,476 | 3,165,406 |
| Apr-12 | 1,952 | 623 | 1,345 | 607 | 4,526 | 1,122,765 | 1,816,134 | 601,293 | 3,540,192 |
| May-12 | 1,962 | 618 | 1,344 | 602 | 4,527 | 1,123,013 | 2,330,814 | 628,846 | 4,082,673 |
| Jun-12 | 1,977 | 620 | 1,343 | 604 | 4,543 | 1,126,982 | 1,662,356 | 585,061 | 3,374,400 |
| Jul-12 | 1,988 | 617 | 1,346 | 607 | 4,558 | 1,130,703 | 2,054,136 | 636,179 | 3,821,018 |
| Aug-12 | 1,998 | 618 | 1,346 | 607 | 4,569 | 1,133,432 | 1,679,713 | 650,205 | 3,463,350 |
| Sep-12 | 2,016 | 612 | 1,346 | 608 | 4,582 | 1,136,657 | 1,433,160 | 601,331 | 3,171,148 |
| Oct-12 | 2,035 | 613 | 1,357 | 606 | 4,611 | 1,143,768 | 2,636,011 | 666,803 | 4,446,583 |
| Nov-12 | 2,042 | 602 | 1,365 | 609 | 4,618 | 1,145,587 | 1,453,372 | 592,884 | 3,191,843 |
| Dec-12 | 2,042 | 600 | 1,377 | 608 | 4,627 | 1,147,820 | 1,296,919 | 246,944 | 2,691,683 |
| Sub Total | 11,775 | 3,740 | 8,086 | 3,630 | 27,231 | 13,593,161 | 20,809,479 | 7,179,142 | 41,581,781 |
| Large Claim Credit (Pooling Limit @ $250K) | | | | | | | 1,140,790 | n/a | 1,140,790 |
| **Totals** | | | | | | **$13,593,161** | **$19,668,689** | **$7,179,142** | **$40,440,991** |
| **Average per Employee (Enrollment lagged 2 months)** | | | | | **55,305** | **$248.07** | **$355.64** | **$129.81** | **$731.24** |
| **Percentage Change from Prior Year** | | | | | | | **17.93%** | **6.23%** | **13.15%** |

**2013 Plan Year**

| | Enrollment | | | | | Non Capitated Paid Claims | | | |
|---|---|---|---|---|---|---|---|---|---|
| Month-Year | EE | ES | EC | EF | Total EE's | Capitation | Medical | Rx | Combined |
| Jan-13 | 2,241 | 646 | 1,456 | 612 | 4,955 | 1,282,850 | 1,758,813 | 713,502 | 3,755,165 |
| Feb-13 | 2,265 | 644 | 1,458 | 618 | 4,985 | 1,290,885 | 1,553,541 | 664,853 | 3,509,280 |
| Mar-13 | 2,289 | 640 | 1,464 | 620 | 5,013 | 1,298,101 | 2,201,042 | 727,365 | 4,226,507 |
| Apr-13 | 2,292 | 633 | 1,461 | 613 | 4,999 | 1,294,493 | 1,884,434 | 757,054 | 3,935,981 |
| May-13 | 2,294 | 639 | 1,475 | 617 | 5,025 | 1,301,072 | 2,236,723 | 741,845 | 4,279,640 |
| Sub Total | 11,381 | 3,202 | 7,314 | 3,080 | 24,977 | 6,467,400 | 9,634,554 | 3,604,619 | 19,706,573 |
| Rolling 12 month Large Claim Credit (Pooling Limit @ $400K) | | | | | | | 614,773 | n/a | 614,773 |
| **Totals** | | | | | **24,977** | **$6,467,400** | **$9,019,781** | **$3,604,619** | **$19,091,800** |
| **Average per Employee (Enrollment lagged 2 months)** | | | | | **24,198** | **$267.27** | **$372.75** | **$148.96** | **$788.98** |
| **Percentage Change from Prior Year** | | | | | | | **4.81%** | **14.75%** | **7.90%** |
| | | | | | | | | | |
| **Rolling 12 Month Totals (Enrollment lagged 2 months)** | | | | | **56,114** | **$14,432,349** | **$21,850,221** | **$7,584,028** | **$43,866,598** |
| **Average per Employee (Enrollment lagged 2 months)** | | | | | | **$257.20** | **$378.44** | **$135.15** | **$770.79** |
| **Percentage Change from Prior Year** | | | | | | | **6.41%** | **4.12%** | **5.41%** |

# SJVIA HMO
# 2014 Claims Projection - All HMO Plans
## Paid Claims Period: June 2012 through May 2013

| | Non Capitated | Capitation | Rx | Total |
|---|---|---|---|---|
| Total Paid Claims | $ 21,850,221 | $ 14,432,349 | $ 7,584,028 | $ 43,866,598 |
| Claims in Excess of Pooling | 614,773 | - | - | 614,773 |
| Total Paid Claims Net of Pooling | $ 21,235,448 | $ 14,432,349 | $ 7,584,028 | $ 43,251,825 |
| Enrollment lagged 2 months | 56,114 | 56,114 | 56,114 | 56,114 |
| Average Paid Claim for Period (Non-Cap) | $ 378.44 | $ 257.71 | $ 135.15 | $ 771.30 |
| Trend (Med.- 8.25,Cap - 5%, Rx -4.5) | 1.1306 | 1.0495 | 1.0713 | 1.0931 |
| Benefit Modification Factor | 1.0000 | 1.0000 | 1.0000 | 1.0000 |
| Provider Discount Factor | 1.0000 | 1.0000 | 1.0000 | 1.0000 |
| Demographic Adjustment | 1.0000 | 1.0000 | 1.0000 | 1.0000 |
| **Projected Paid Claim** | **$ 427.87** | **$ 270.46** | **$ 144.78** | **$ 843.11** |
| Current Monthly Enrollment (May 2013) | 5,025 | 5,025 | 5,025 | |
| Monthly Projected Paid Claims | 2,150,044 | 1,359,062 | 727,542 | 4,236,648 |
| Weighting Factor | 1.00000 | 1.00000 | 1.00000 | 1.00000 |
| **2014 Annual Projected Paid Claims** | **$ 25,800,533** | **$ 16,308,738** | **$ 8,730,506** | **$ 50,839,777** |

| | | | | |
|---|---|---|---|---|
| **Projected Required Reserve (12.5% Medical/5% Rx)** | **$3,225,067** | **N/A** | **$436,525** | **$3,661,592** |
| **Current Reserve*** | | | | **$3,831,033** |
| **Contingent Reserve** | | | | **$169,441** |
| **Projected Required Reserve (16% Medical/5% Rx)** | **$4,128,085** | **N/A** | **$436,525** | **$4,564,611** |
| **Current Reserve*** | | | | **$3,831,033** |
| **Contingent Reserve** | | | | **-$733,577** |

**Calculated from May 2013 Claims Data - represents all premiums paid from inception less all costs from inception*

# SJVIA 2011 - 2014 HMO Cost Worksheet: Combined - Anthem Blue Cross

| Enrollment | Single | EE +Sp | EE + Ch | Family | Total |
|---|---|---|---|---|---|
| **Total HMO** | **2,294** | **639** | **1,475** | **617** | **5,025** |

| **2011 Fixed Costs:** | Single | EE +Sp | EE + Ch | Family | Totals |
|---|---|---|---|---|---|
| **HMO** - Pooling ($250,000) | $ 28.39 | $ 28.39 | $ 28.39 | $ 28.39 | $ 1,711,917 |
| **HMO** - Blue Cross MPP Retention (incl 360 Health) | $ 34.58 | $ 34.58 | $ 34.58 | $ 34.58 | $ 2,085,174 |
| Claims Management/Communication | $ 3.00 | $ 3.00 | $ 3.00 | $ 3.00 | $ 180,900 |
| JPA Consulting | $ 4.00 | $ 4.00 | $ 4.00 | $ 4.00 | $ 241,200 |
| SJVIA Fee | $ 2.00 | $ 2.00 | $ 2.00 | $ 2.00 | $ 120,600 |
| Hourglass (Consolidated Billing, COBRA, Flex Admin) | $ 6.50 | $ 6.50 | $ 6.50 | $ 6.50 | $ 391,950 |
| **Total Fixed Cost (2012)** | $ 78.47 | $ 78.47 | $ 78.47 | $ 78.47 | **$ 4,731,741** |
| **2011Claims Costs:** | | | | | |
| **HMO** - Capitation | $ 240.97 | $ 240.97 | $ 240.97 | $ 240.97 | $ 14,530,491 |
| **HMO** - Projected Medical Claims | $ 333.01 | $ 333.01 | $ 333.01 | $ 333.01 | $ 20,080,261 |
| **HMO** - Projected Rx Claims | $ 131.16 | $ 131.16 | $ 131.16 | $ 131.16 | $ 7,908,659 |
| **Total Claims** | | | | | **$ 42,519,411** |
| *Aggregate Factors* | *$ 453.39* | *$ 453.39* | *$ 453.39* | *$ 453.39* | *$ 27,339,417* |
| **Current Total Projected Cost** | | | | | **$ 47,251,152** |

| **2012 Fixed Costs:** | Single | EE +Sp | EE + Ch | Family | Totals | |
|---|---|---|---|---|---|---|
| **HMO** - Pooling ($250,000) | $ 27.11 | $ 27.11 | $ 27.11 | $ 27.11 | $ 1,634,733 | -5% |
| **HMO** - Blue Cross MPP Retention (incl 360 Health) | $ 36.10 | $ 36.10 | $ 36.10 | $ 36.10 | $ 2,176,830 | 4% |
| Claims Management/Communication | $ 3.00 | $ 3.00 | $ 3.00 | $ 3.00 | $ 180,900 | 0% |
| JPA Consulting | $ 4.00 | $ 4.00 | $ 4.00 | $ 4.00 | $ 241,200 | 0% |
| SJVIA Fee | $ 2.00 | $ 2.00 | $ 2.00 | $ 2.00 | $ 120,600 | 0% |
| Hourglass (Consolidated Billing, COBRA, Flex Admin) | $ 6.50 | $ 6.50 | $ 6.50 | $ 6.50 | $ 391,950 | 0% |
| **Total Fixed Cost (2012)** | $ 78.71 | $ 78.71 | $ 78.71 | $ 78.71 | **$ 4,746,213** | 0% |
| **2012 Claims Costs:** | | | | | | |
| **HMO** - Capitation | $ 248.07 | $ 248.07 | $ 248.07 | $ 248.07 | $ 14,958,621 | 3% |
| **HMO** - Projected Medical Claims | $ 333.01 | $ 333.01 | $ 333.01 | $ 333.01 | $ 20,080,261 | 0% |
| **HMO** - Projected Rx Claims | $ 131.16 | $ 131.16 | $ 131.16 | $ 131.16 | $ 7,908,659 | 0% |
| **Total Claims** | | | | | **$ 42,947,541** | |
| *Aggregate Factors* | *$ 377.13* | *$ 377.13* | *$ 377.13* | *$ 377.13* | *$ 22,740,939* | -17% |
| **Renewal Total Projected Cost** | | | | | **$ 47,693,754** | |

| **2013 Fixed Costs:** | Single | EE +Sp | EE + Ch | Family | Totals | Increase |
|---|---|---|---|---|---|---|
| **HMO** - Pooling ($400,000) | $ 21.02 | $ 21.02 | $ 21.02 | $ 21.02 | $ 1,267,506 | -22% |
| **HMO** - Blue Cross MPP Retention (incl 360 Health) | $ 37.76 | $ 37.76 | $ 37.76 | $ 37.76 | $ 2,276,928 | 5% |
| Claims Management/Communication | $ 3.00 | $ 3.00 | $ 3.00 | $ 3.00 | $ 180,900 | 0% |
| JPA Consulting | $ 4.00 | $ 4.00 | $ 4.00 | $ 4.00 | $ 241,200 | 0% |
| SJVIA Fee | $ 2.00 | $ 2.00 | $ 2.00 | $ 2.00 | $ 120,600 | 0% |
| Hourglass (Consolidated Billing, COBRA, Flex Admin) | $ 6.50 | $ 6.50 | $ 6.50 | $ 6.50 | $ 391,950 | 0% |
| **Total Fixed Cost** | $ 74.28 | $ 74.28 | $ 74.28 | $ 74.28 | **$ 4,479,084** | -6% |
| **2013 Claims Costs:** | | | | | | |
| **HMO** - Capitation | $ 257.71 | $ 257.71 | $ 257.71 | $ 257.71 | $ 15,539,913 | 4% |
| **HMO** - Medical Claims | $ 378.44 | $ 378.44 | $ 378.44 | $ 378.44 | $ 22,819,708 | 14% |
| **HMO** - Rx Claims | $ 135.15 | $ 135.15 | $ 135.15 | $ 135.15 | $ 8,149,831 | 3% |
| **Total Claims** | $ 771.30 | $ 771.30 | $ 771.30 | $ 771.30 | **$ 46,509,452** | |
| *Aggregate Factors* | *$ 509.37* | *$ 509.37* | *$ 509.37* | *$ 509.37* | *$ 30,715,011* | 35% |
| **Renewal Total Projected Cost** | | | | | **$ 50,988,536** | |

| **2014 Fixed Costs:** | Single | EE +Sp | EE + Ch | Family | Totals | Increase |
|---|---|---|---|---|---|---|
| **HMO** - Pooling ($400,000) | $ 22.72 | $ 22.72 | $ 22.72 | $ 22.72 | $ 1,370,016 | 8% |
| **HMO** - Blue Cross MPP Retention (incl 360 Health) | $ 39.27 | $ 39.27 | $ 39.27 | $ 39.27 | $ 2,367,981 | 4% |
| ACA Reinsurance | $ 11.37 | $ 11.37 | $ 11.37 | $ 11.37 | $ 685,611 | N/A |
| ACA Insurer | $ 22.24 | $ 22.24 | $ 22.24 | $ 22.24 | $ 1,341,072 | N/A |
| Claims Management/Communication | $ 3.00 | $ 3.00 | $ 3.00 | $ 3.00 | $ 180,900 | 0% |
| JPA Consulting | $ 4.00 | $ 4.00 | $ 4.00 | $ 4.00 | $ 241,200 | 0% |
| SJVIA Fee | $ 2.00 | $ 2.00 | $ 2.00 | $ 2.00 | $ 120,600 | 0% |
| Hourglass (Consolidated Billing, COBRA, Flex Admin) | $ 6.50 | $ 6.50 | $ 6.50 | $ 6.50 | $ 391,950 | 0% |
| **Total Fixed Cost** | $ 111.10 | $ 111.10 | $ 111.10 | $ 111.10 | **$ 6,699,330** | 50% |
| **2014 Claims Costs:** | | | | | | |
| **HMO** - Capitation | $ 270.46 | $ 270.46 | $ 270.46 | $ 270.46 | $ 16,308,738 | 5% |
| **HMO** - Projected Medical Claims | $ 427.87 | $ 427.87 | $ 427.87 | $ 427.87 | $ 25,800,533 | 13% |
| **HMO** - Projected Rx Claims | $ 144.78 | $ 144.78 | $ 144.78 | $ 144.78 | $ 8,730,506 | 7% |
| **Total Claims** | $ 843.11 | $ 843.11 | $ 843.11 | $ 843.11 | **$ 50,839,777** | |
| *Aggregate Factors* | *$ 548.65* | *$ 548.65* | *$ 548.65* | *$ 548.65* | *$ 33,083,595* | 8% |
| **Projected Total HMO Cost** | | | | | **$ 57,539,107** | |
| **Current HMO Plan Funding** | | | | | **$ 49,554,266** | |
| Projected Increase | | | | | 16.1% | |

## San Joaquin Valley Insurance Authority

# 2014 Renewal Summary

**Effective January 1, 2014**

**Cost Recap**

| | PPO | HMO | SJVIA Total |
|---|---|---|---|
| **2013 Premium Funding** | $31,569,171 | $49,554,266 | $81,123,437 |
| **2014 Projected Costs** | $29,446,359 | $57,539,107 | $86,985,466 |
| **Change** | **-6.7%** | **16.1%** | **7.2%** |

**Reserve Recap - All Plans**

| | Medical | Rx | Total |
|---|---|---|---|
| **Projected Required Reserve (12.5% Medical/5% Rx)** | **$5,626,361** | **$802,866** | **$6,429,227** |
| **Current Reserve*** | | | **$12,532,608** |
| **Contingent Reserve** | | | **$6,103,381** |
| **Projected Required Reserve (16% Medical/5% Rx)** | **$7,201,742** | **$802,866** | **$8,004,608** |
| **Current Reserve*** | | | **$12,532,608** |
| **Contingent Reserve** | | | **$4,528,000** |

**Calculated from May 2013 Claims Data - represents all premiums paid from inception less all costs from inception*

SJVIA
San Joaquin Valley Insurance Authority



Meeting Location:
Fresno County Employee Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
July 26, 2013
9:00 AM

**AGENDA DATE:** July 26, 2013

**ITEM NUMBER:** 13

**SUBJECT:** Quarterly SJVIA Financial Update

**REQUEST(S):** That the Board receives the Financial Update through 4th Quarter, 2012-13

**DESCRIPTION:** Informational Item. Please see attached report.

**FISCAL IMPACT/FINANCING:** None.

**ADMINISTRATIVE SIGN-OFF:**

Vicki Crow

Vicki Crow
SJVIA Auditor-Treasurer

# SAN JOAQUIN VALLEY INSURANCE AUTHORITY

## ACTUALS VS. BUDGETED REVENUES & EXPENSES

## FOR THE THREE AND TWELVE MONTHS ENDED JUNE 30, 2013

| | Current Quarter | | | | Year-To-Date | | | |
|---|---|---|---|---|---|---|---|---|
| | ACTUALS | BUDGET | (OVER) / UNDER BUDGET | % VARIANCE | ACTUALS | BUDGET | (OVER) / UNDER BUDGET | % VARIANCE |
| **REVENUE** | | | | | | | | |
| ***TOTAL REVENUE** | **$19,896,977** | **$20,301,409** | **$404,432** | **2%** | **$72,690,867** | **$76,850,090** | **$4,159,223** | **5%** |
| **EXPENSES: Fixed** | | | | | | | | |
| 1 Specific & Aggregate Stop Loss Insurance (PPO) | 134,454 | 135,550 | 1,096 | 1% | 525,339 | 523,968 | (1,371) | (0%) |
| 2 Anthem ASO Administration & Network Fees (PPO) | 298,409 | 307,118 | 8,709 | 3% | 1,237,483 | 1,243,450 | 5,967 | 0% |
| *3 Chimenti Associates/Hourglass Administration(PPO & Anthem HMO) | 168,794 | 156,369 | (12,425) | (8%) | 637,228 | 625,092 | (12,136) | (2%) |
| 4 GBS Consulting | 106,697 | 100,499 | (6,198) | (6%) | 407,763 | 403,104 | (4,659) | (1%) |
| 5 SJVIA Administration | 46,138 | 52,697 | 6,559 | 12% | 229,689 | 211,344 | (18,345) | (9%) |
| 6 Wellness | 140,205 | 62,812 | (77,393) | (123%) | 202,804 | 251,940 | 49,136 | 20% |
| 7 Communications | 6,340 | 12,562 | 6,222 | 50% | 16,866 | 50,388 | 33,522 | 67% |
| 8 Anthem HMO Pooling | 342,318 | 303,767 | (38,551) | (13%) | 1,399,345 | 1,362,441 | (36,904) | (3%) |
| 9 Anthem HMO Administration/Retention | 602,737 | 537,117 | (65,620) | (12%) | 2,109,497 | 2,069,679 | (39,818) | (2%) |
| **TOTAL FIXED EXPENSES** | **1,846,092** | **1,668,491** | **(177,601)** | **(11%)** | **6,766,014** | **6,741,406** | **(24,608)** | **(0%)** |
| **EXPENSES: Claims** | | | | | | | | |
| 10 Projected Paid Medical & Rx Claims-PPO and Non-Cap HMO | 13,186,584 | 13,959,065 | 772,481 | 6% | 47,631,397 | 53,435,435 | 5,804,038 | 11% |
| 11 Anthem MMP HMO Capitation | 4,126,117 | 3,674,824 | (451,293) | (12%) | 14,478,374 | 14,207,621 | (270,753) | (2%) |
| **TOTAL CLAIMS EXPENSES** | **17,312,701** | **17,633,889** | **321,188** | **2%** | **62,109,771** | **67,643,056** | **5,533,285** | **8%** |
| **EXPENSES: Premiums** | | | | | | | | |
| 12 Delta Dental | 1,445,156 | 1,358,621 | (86,535) | (6%) | 2,617,654 | 2,717,243 | 99,589 | 4% |
| 13 Vision Service Plan | 239,869 | 222,293 | (17,576) | (8%) | 425,593 | 444,588 | 18,995 | 4% |
| **TOTAL PREMIUM EXPENSES** | **1,685,025** | **1,580,914** | **(104,111)** | **(7%)** | **3,043,247** | **3,161,831** | **118,584** | **4%** |
| **TOTAL EXPENSES** | **20,843,818** | **20,883,294** | **39,476** | **0%** | **71,919,032** | **77,546,293** | **5,627,261** | **7%** |
| 14 Reserve (Deficit)/Surplus | (946,841) | (581,885) | 364,956 | (63%) | 771,835 | (696,203) | (1,468,038) | 211% |
| **COMBINED EXPENSES & RESERVES** | **$19,896,977** | **$20,301,409** | **$404,432** | **2%** | **$72,690,867** | **$76,850,090** | **$4,159,223** | **5%** |

*The Chimenti expenses & related revenue have been adjusted by the following overpayments: Year-to-Date $51,586

# SAN JOAQUIN VALLEY INSURANCE AUTHORITY

## ANALYSIS OF ADMINISTRATION, WELLNESS & COMMUNICATIONS (FEES) - REVENUES & EXPENSES

## FOR THE THREE AND TWELVE MONTHS ENDED JUNE 30, 2013

| | Current Quarter | | | Year-To-Date | | |
|---|---|---|---|---|---|---|
| | SJVIA FEES | | | SJVIA FEES | | |
| **FY12-13** | **Administration (*Line 5)** | **Wellness (*Line 6)** | **Communications (*Line 7)** | **Administration (*Line 5)** | **Wellness (*Line 6)** | **Communications (*Line 7)** |
| **Revenue**** | **$49,374** | **$60,081** | **$11,613** | **$211,422** | **$254,690** | **$50,137** |
| **Expenses:** | | | | | | |
| Auditor-Treasurer Services | 27,264 | | | 110,255 | | |
| County Counsel Services | 994 | | | 6,127 | | |
| Personnel Services | 14,155 | | | 29,694 | | |
| Membership Fees | | | | | | |
| Insurance (Liability, Bond, Etc) | | | | 64,480 | | |
| Audit Fees | | | | 9,750 | | |
| Bank Service Fees | 3,725 | | | 9,383 | | |
| Wellness | | 140,205 | | | 202,804 | |
| Communications | | | 6,340 | | | 16,866 |
| **Total Expenses** | **46,138** | **140,205** | **6,340** | **229,689** | **202,804** | **16,866** |
| **Administration, Wellness & Communications Surplus/(Deficit)** | **$3,236** | **($80,124)** | **$5,273** | **($18,267)** | **$51,886** | **$33,271** |

*Total expenses for each column correspond to the line number shown on the "ACTUALS VS. BUDGETED REVENUES & EXPENSES" report.

**Revenue consists of fees collected from enrollees at the following rates per employee per month: $4.00 for administration($2.00 for SJVIA administration fees & $2.00 for non-founding member fees), $2.50 for wellness fees & $.50 for communications fees.

**SJVIA**
Schedule of Cash Flow by Month
For the Twelve Months Ended June 30, 2013

| | JULY | AUGUST | SEPTEMBER | OCTOBER | NOVEMBER | DECEMBER | JANUARY | FEBRUARY | MARCH | APRIL | MAY | JUNE | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BEGINNING CASH BALANCES: | | | | | | | | | | | | | |
| Claims Funding Account-844535294 | $709,397 | $348,046 | $574,059 | $486,928 | $504,670 | $542,101 | $440,903 | $471,204 | $710,827 | $531,112 | $347,333 | $543,423 | $709,397 |
| Fixed Cost Account-844535120 | 301,657 | 331,453 | 337,327 | 363,858 | 376,218 | 398,690 | 383,397 | 299,149 | 326,913 | 703,462 | 740,326 | 453,192 | 301,657 |
| Claims Reserve Account-428255819 | 8,177,407 | 8,611,368 | 9,708,781 | 8,472,345 | 8,242,150 | 9,223,324 | 4,309,730 | 4,221,834 | 3,801,883 | 4,913,989 | 4,950,267 | 4,271,018 | 8,177,407 |
| Total Beginning Balances | 9,188,461 | 9,290,867 | 10,620,167 | 9,323,131 | 9,123,038 | 10,164,115 | 5,134,030 | 4,992,187 | 4,839,623 | 6,148,563 | 6,037,926 | 5,267,633 | 9,188,461 |
| RECEIPTS: | | | | | | | | | | | | | |
| Claims Funding Account-844535294 | 2,415,008 | 3,197,799 | 2,339,349 | 4,482,637 | 2,414,094 | 2,660,316 | 3,205,782 | 3,088,488 | 3,564,159 | 3,040,452 | 3,625,155 | 2,912,642 | 36,945,881 |
| Fixed Cost Account-844535120 | 1,614,381 | 1,667,875 | 1,519,225 | 2,288,955 | 1,616,994 | 1,724,458 | 1,995,539 | 2,236,052 | 2,709,835 | 2,266,233 | 2,775,756 | 2,230,377 | 24,645,680 |
| Claims Reserve Account-428255819 | 3,207,310 | 4,809,857 | 1,804,804 | 4,757,122 | 3,539,211 | 3,591,384 | 4,435,533 | 4,819,894 | 6,122,947 | 4,397,138 | 4,330,883 | 4,165,658 | 49,981,741 |
| TOTAL RECEIPTS | 7,236,699 | 9,675,531 | 5,663,378 | 11,528,714 | 7,570,299 | 7,976,158 | 9,636,854 | 10,144,434 | 12,396,941 | 9,703,823 | 10,731,794 | 9,308,677 | 111,573,302 |
| DISBURSEMENTS: | | | | | | | | | | | | | |
| Claims Funding Account-844535294 | 2,776,359 | 2,971,786 | 2,426,480 | 4,464,895 | 2,376,663 | 2,761,514 | 3,175,481 | 2,848,865 | 3,743,874 | 3,224,231 | 3,429,065 | 2,904,996 | 37,104,209 |
| Fixed Cost Account-844535120 | 1,584,585 | 1,662,001 | 1,492,694 | 2,276,595 | 1,594,522 | 1,739,751 | 2,079,787 | 2,208,288 | 2,333,286 | 2,229,369 | 3,062,890 | 2,361,248 | 24,625,016 |
| Claims Reserve Account-428255819 | 2,773,349 | 3,712,444 | 3,041,240 | 4,987,317 | 2,558,037 | 8,504,978 | 4,523,429 | 5,239,845 | 5,010,841 | 4,360,860 | 5,010,132 | 4,170,299 | 53,892,771 |
| TOTAL DISBURSEMENTS | 7,134,293 | 8,346,231 | 6,960,414 | 11,728,807 | 6,529,222 | 13,006,243 | 9,778,697 | 10,296,998 | 11,088,001 | 9,814,460 | 11,502,087 | 9,436,543 | 115,621,996 |
| ENDING CASH BALANCES: | | | | | | | | | | | | | |
| Claims Funding Account-844535294 | 348,046 | 574,059 | 486,928 | 504,670 | 542,101 | 440,903 | 471,204 | 710,827 | 531,112 | 347,333 | 543,423 | 551,069 | 551,069 |
| Fixed Cost Account-844535120 | 331,453 | 337,327 | 363,858 | 376,218 | 398,690 | 383,397 | 299,149 | 326,913 | 703,462 | 740,326 | 453,192 | 322,321 | 322,321 |
| Claims Reserve Account-428255819 | 8,611,368 | 9,708,781 | 8,472,345 | 8,242,150 | 9,223,324 | 4,309,730 | 4,221,834 | 3,801,883 | 4,913,989 | 4,950,267 | 4,271,018 | 4,266,377 | 4,266,377 |
| Total Ending Balances | $9,290,867 | $10,620,167 | $9,323,131 | $9,123,038 | $10,164,115 | $5,134,030 | $4,992,187 | $4,839,623 | $6,148,563 | $6,037,926 | $5,267,633 | $5,139,767 | $5,139,767 |
| **Investments:** | | | | | | | | | | | | | |
| Total Ending Balances | $0 | $0 | $0 | $0 | $0 | $5,001,782 | $5,001,782 | $5,001,782 | $5,014,955 | $5,014,955 | $5,014,955 | $5,027,974 | $5,027,974 |

The SJVIA invested $5 million into the County of Tulare pool on December 21, 2012. These funds were moved from the JP Morgan Chase “Claims Reserve Account”. The yield earned for the quarter ended 6/30/13 was 1.04% with quarterly earnings of $13,020.

## Glossary of Terms:

1 **Specific & Aggregate Stop Loss Insurance (PPO)**

Specific: Insurance coverage for eligible individual specific claims in excess of the $450,000 plan year deductible up to the lifetime maximum of $6 million.

Aggregate: Insurance coverage for eligible claims under the specific deductible on the aggregated amount for all member claims.

2 **Anthem ASO Administration & Network Fees (PPO):**

ASO is "Administrative Services Only". This definition includes Anthem Blue Cross administration fees and includes access fees to use the Blue Cross network of providers. This is the administration fee for the PPO plan(s), not the HMO plan.

3 **Chimienti Associates/Hourglass Administration (PPO & Anthem HMO)**

Chimienti & Associates is an independent vendor providing consolidated billing, eligibility, automated enrollment and Section 125 administrative services. Hourglass and ASI are subcontractors to Chimienti Associates that assist in these administrative processes. This line is for non-Kaiser business.

4 **GBS Consulting**

Gallagher Benefit Services (GBS) is a national benefit consultant who provides professional guidance to SJVIA and respective members concerning health plan matters including but not limited to compliance, underwriting, renewal bidding, employee communication, cost analysis, actuarial, etc. GBS played a significant role in the formation and establishment of SJVIA.

5 **SJVIA Administration**

This rate category is for administrative, management, legal, accounting and other services needed to effectively establish and maintain proper functioning of the Joint Powers Authority.

6 **Wellness**

This rate category is for special claims management services and may include some wellness applications that are outside and additional to the claims management services provided by the insurance company.

7 **Communications**

This rate category is for special employee communication materials and prospective new City/County member promotional materials. It may include fees for maintaining a presence at such trade associations as CALPELRA, etc.

8 **Anthem HMO Pooling**

This is for the specific stop loss pooling insurance for claims in excess of $400k within the HMO (not PPO).

9 **Anthem HMO Administration/Retention**

Anthem Blue Cross administration fees and includes access fees to use the Blue Cross network of providers for the HMO plan.

10 **Projected Paid Medical & Rx Claims-PPO and Non-Cap HMO**

Projected self-insured PPO claims for medical and Rx and non-capitated HMO claims (hospital).

11 **Anthem MPP HMO Capitation**

Amount paid in advance of services on a fixed per member per month basis for professional services (physician) as part of the HMO.

12 **Delta Dental**

This amount represents a fixed claim (premium) paid to Delta Dental for the dental program at both the County of Fresno and the County of Tulare. Because dental coverage came under the SJVIA effective 1/1/2013, this amount represents premium from 1/1/2013 through 6/30/2013.

13 **Vision Service Plan**

This amount represents a fixed claim (premium) paid to VSP for the vision program at both the County of Fresno and the County of Tulare. Because vision coverage came under the SJVIA effective 1/1/2013, this amount represents premium from 1/1/2013 through 6/30/2013.

14 **Reserve Surplus/Deficit**

Projected excess revenue over projected claims, premiums and fixed costs.

SJVIA
San Joaquin Valley Insurance Authority



**Meeting Location:**
**Fresno County Employee Retirement Association Board Chambers**
**1111 H Street**
**Fresno, CA 93721**
**July 26, 2013**
**9:00 AM**

**AGENDA DATE:** July 26, 2013

**ITEM NUMBER:** 14

**SUBJECT:** Receive and File SJVIA Executive Claims Summary through May 2013 (I)

**REQUEST(S):** That the Board Receive and File SJVIA Executive Claims Summary through May 2013

**DESCRIPTION:**

The attached report provides an overview of several key plan metrics and is used to identify trends and outliers. As requested by your board, a Large Claim Report has been included in the Monthly Claim Report (page 3). This summary details on-going claims that are over $100,000 paid-to-date. For historical purposes, the pooling point for the HMO plan is $400,000 and the pooling point for the PPO plan is $450,000. The pooling point for the HMO plan was increased from $250,000 to $400,000 in plan year 2013.

The attached Monthly Claims Report reflects claims data through May 2013.

**AGENDA**: San Joaquin Valley Insurance Authority

**DATE:** July 26, 2013

For comparative purposes, the attached report includes 2012 data tables. In addition, this report includes data for the City of Tulare, which began participating in the SJVIA as of July 1, 2012 and the City of Ceres, which joined SJVIA as of January 1, 2013.

Of particular note:

**Page 5** – Year-to-date enrollment in the SJVIA has increased 8.9% (Jan-May 2012 enrollment vs Jan-May 2013 enrollment)

**Page 6** – Year-to-date premium collected in the SJVIA has increased 15.1% (Jan-May 2012 premium collected vs Jan-May 2013 premium collected)

**Page 7** – Year-to-date claims in the SJVIA have increased 9.3% (Jan-May 2012 claims vs Jan-May 2013 claims)

**Page 10** – Comparing claims "Per Employee Per Month" (PEPM) can be a good indicator for comparative purposes. Although page 10 shows the PEPM trend each month for each year, the overall averages are below:

| Plan Year | HMO | PPO | Overall |
|---|---|---|---|
| 2010 | $586.15 PEPM | $495.09 PEPM | $547.67 PEPM |
| 2011 | $681.06 PEPM | $553.64 PEPM | $628.33 PEPM |
| 2012 | $713.19 PEPM | $551.65 PEPM | $637.06 PEPM |
| 2013 (through May) | $789.72 PEPM | $522.05 PEPM | $676.58 PEPM |

**FISCAL IMPACT/FINANCING:**

Informational Only

**AGENDA**: San Joaquin Valley Insurance Authority

**DATE:** July 26, 2013

**ADMINISTRATIVE SIGN-OFF:**

Jeffrey Cardell
SJVIA Manager

Paul Nerland
Assistant SJVIA Manager

# BEFORE THE BOARD OF DIRECTORS
# SAN JOAQUIN VALLEY INSURANCE AUTHORITY

**IN THE MATTER OF** Receive and File SJVIA Executive Claims Summary through May 2013 (I)

**RESOLUTION NO.** _____
**AGREEMENT NO.** _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * * *

That the Board received and filed SJVIA Executive Claims Summary through May 2013

Gallagher Benefit Services, Inc.
thinking ahead

# 2013 SJVIA Claims Report

Claims Data Through May 2013

www.gallagherbenefits.com

- **Prepared By Gallagher Benefit Services**

**July 15, 2013**

# Large Claim Report - 2013

## San Joaquin Valley Insurance Authority

### Potential Large Dollar Claimants >$100,000

### HMO Plan

### January 1, 2013 through December 31, 2013 as of May 2013

Pooling Point $400,000

| Relationship | Paid | Diagnosis | Reimbursment |
|---|---|---|---|
| Dependent | $ 181,245 | Circulatory System (05) | $ - |
| Subscriber | $ 167,366 | Muscle/Tissue Disorders (08) | $ - |
| Dependent | $ 158,048 | Myeloid Disorders (17) | $ - |
| Dependent | $ 145,500 | Injuries/Poisonings (21) | $ - |
| Subscriber | $ 137,915 | Digestive System (06) | $ - |
| Subscriber | $ 125,009 | Digestive System (06) | $ - |

**Total HMO Pooling Reimbursements** **$ -**

### PPO Plan

### January 1, 2013 through December 31, 2013 as of March 2013

Stop Loss Deductible $450,000

| Relationship | Paid | Diagnosis | Reimbursment |
|---|---|---|---|
| Dependent | $ 214,834 | Curculatory System (05 | $ - |
| Subscriber | $ 137,138 | Muscle/Tissue Disorders (08) | $ - |
| Dependent | $ 113,133 | Muscle/Tissue Disorders (08) | $ - |
| | | | $ - |

**Total PPO Stop Loss Reimbursements** **$ -**

**Total SJVIA Pooling and Stop Loss Reimbursements** **$ -**

# Large Claim Report - 2012

## San Joaquin Valley Insurance Authority

### Potential Large Dollar Claimants

### HMO Plan

### January 1, 2012 through December 31, 2012 as of September 2012

Pooling Point $250,000

| Relationship | Paid | Diagnosis | Reimbursment |
|---|---|---|---|
| Subscriber | $ 1,225,803 | Blood Disorders(16) | $ 975,803 |
| Dependent | $ 945,511 | Myeloid Disorders (17) | $ 695,511 |
| Dependent | $ 847,166 | Digestive System (06) | $ 597,166 |
| Dependent | $ 425,472 | Muscle/Tissue Disorders(08) | $ 175,472 |
| Dependent | $ 320,326 | Circulatory System (05) | $ 70,326 |
| Subscriber | $ 286,720 | Myeloid Disorders (17) | $ 36,720 |

**Total HMO Pooling Reimbursements** **$ 2,550,998**

### PPO Plan

### January 1, 2012 through December 31, 2012 as of September 2012

Stop Loss Deductible $450,000

| Relationship | Paid | Diagnosis | Reimbursment |
|---|---|---|---|
| Subscriber | $ 586,616 | Digestive System (06) | $ 136,616 |
| Subscriber | $ 541,759 | Nervous System (01) | $ 91,759 |

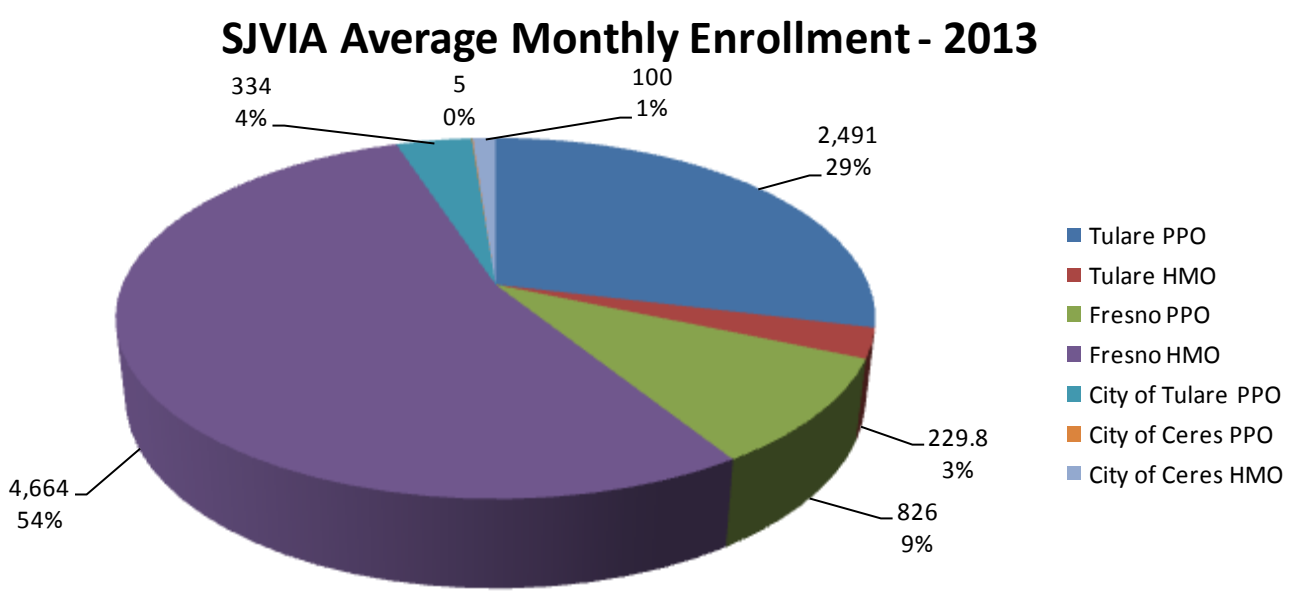
*Anthem Blue Cross does not begin reporting large claims until they reach $50,000

**Total PPO Stop Loss Reimbursements** **$ 228,375**

**Total SJVIA Pooling and Stop Loss Reimbursements** **$ 2,779,373.00**

# SJVIA - All Plans

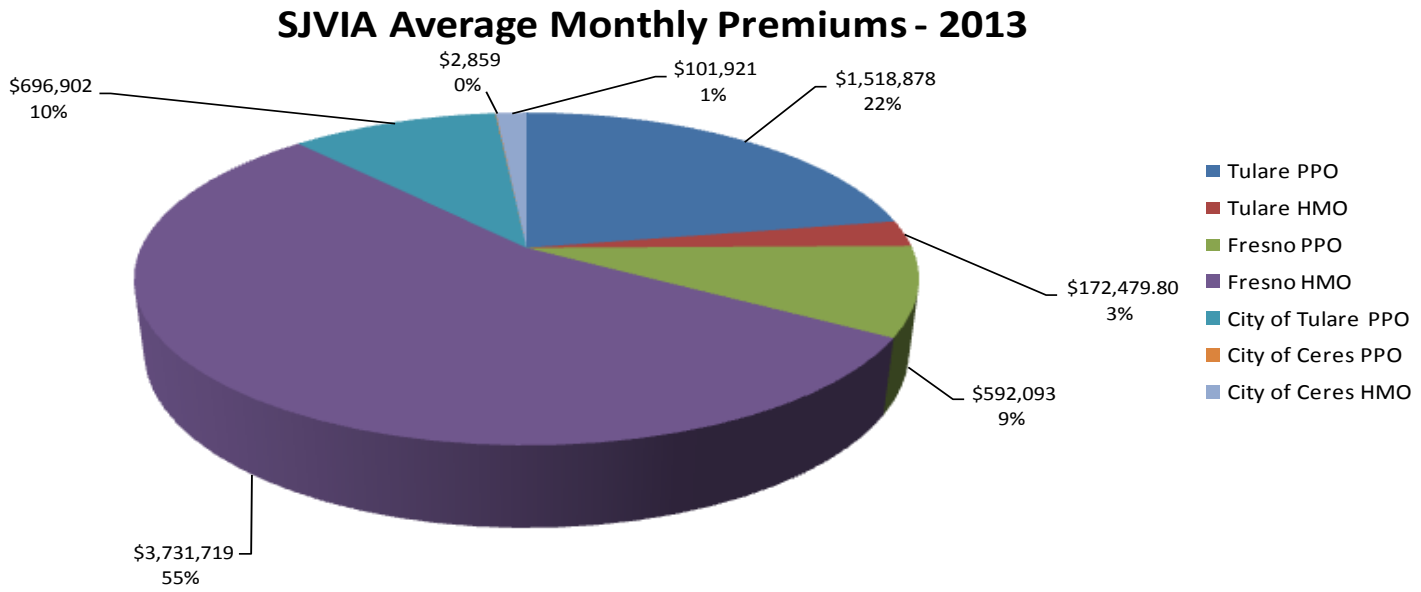
# SJVIA - All Plans




| 2013 Enrollment - All Plans | January | February | March | April | May | June | July | August | September | October | November | December | YTD Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CoT PPO | 2,505 | 2,508 | 2,482 | 2,475 | 2,485 | | | | | | | | 12,455 |
| CoT HMO | 224 | 224 | 228 | 229 | 244 | | | | | | | | 1,149 |
| CoF PPO | 831 | 824 | 829 | 827 | 820 | | | | | | | | 4,131 |
| CoF HMO | 4,634 | 4,654 | 4,683 | 4,668 | 4,681 | | | | | | | | 23,320 |
| City of Tulare PPO | 331 | 334 | 336 | 334 | 336 | | | | | | | | 1,671 |
| City of Ceres PPO | 5 | 5 | 5 | 5 | 5 | | | | | | | | 25 |
| City of Ceres HMO | 96 | 100 | 102 | 102 | 100 | | | | | | | | 500 |
| **Total** | **8,626** | **8,649** | **8,665** | **8,640** | **8,671** | | | | | | | | **43,251** |

| 2012 Enrollment - All Plans | January | February | March | April | May | June | July | August | September | October | November | December | YTD Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CoT PPO | 2,578 | 2,622 | 2,603 | 2,601 | 2,617 | 2,633 | 2,633 | 2,634 | 2,643 | 2,649 | 2,649 | 2,649 | 31,511 |
| CoF PPO | 810 | 810 | 822 | 819 | 823 | 836 | 829 | 837 | 836 | 834 | 842 | 830 | 9,928 |
| CoF HMO | 4,538 | 4,542 | 4,551 | 4,495 | 4,455 | 4,544 | 4,558 | 4,569 | 4,592 | 4,611 | 4,618 | 4,627 | 54,700 |
| City of Tulare | | | | | | | 333 | 328 | 327 | 326 | 327 | 328 | 1,969 |
| **Total** | **7,926** | **7,974** | **7,976** | **7,915** | **7,895** | **8,013** | **8,353** | **8,368** | **8,398** | **8,420** | **8,436** | **8,434** | **98,108** |

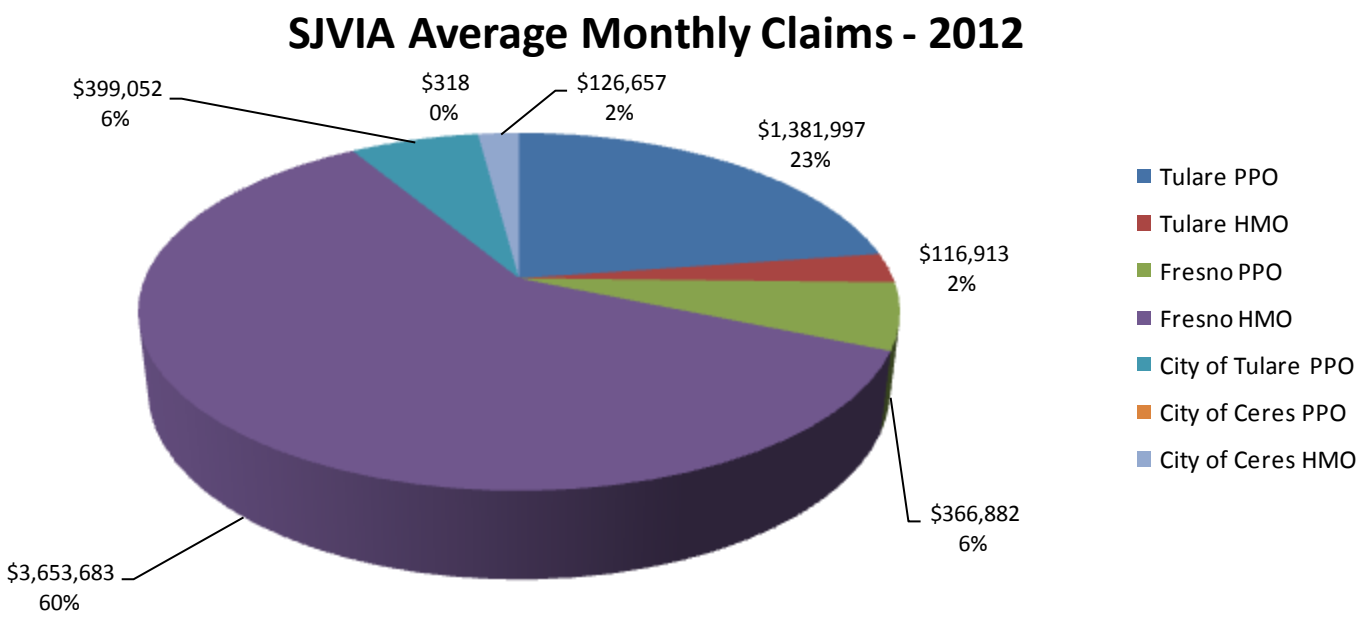
# SJVIA - All Plans




| 2013 Premiums - All Plans | January | February | March | April | May | June | July | August | September | October | November | December | YTD Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CoT PPO | $1,526,546 | $1,529,099 | $1,514,514 | $1,510,792 | $1,513,440 | | | | | | | | $7,594,392 |
| CoT HMO | $168,201 | $167,765 | $171,109 | $172,113 | $183,210 | | | | | | | | $862,399 |
| CoF PPO | $595,127 | $590,835 | $596,516 | $591,930 | $586,059 | | | | | | | | $2,960,467 |
| CoF HMO | $3,713,770 | $3,728,822 | $3,745,036 | $3,727,939 | $3,743,030 | | | | | | | | $18,658,597 |
| City of Tulare PPO | $276,437 | $278,228 | $280,436 | $278,266 | $280,436 | | | | | | | | $1,393,804 |
| City of Ceres PPO | $2,859 | $2,859 | $2,859 | $2,859 | $2,859 | | | | | | | | $14,297 |
| City of Ceres HMO | $97,591 | $103,183 | $104,109 | $103,081 | $101,641 | | | | | | | | $509,604 |
| **Total** | **$6,380,531** | **$6,400,792** | **$6,414,580** | **$6,386,981** | **$6,410,676** | | | | | | | | **$31,993,560** |

| 2012 Premiums - All Plans | January | February | March | April | May | June | July | August | September | October | November | December | YTD Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CoT PPO | $1,532,991 | $1,557,210 | $1,545,778 | $1,542,574 | $ 1,552,519 | $1,557,795 | $1,557,795 | $ 1,557,024 | $1,561,361 | $ 1,565,391 | $1,565,391 | $1,565,391 | $ 18,661,218 |
| CoF PPO | $ 573,804 | $ 574,013 | $ 580,838 | $ 579,490 | $ 581,428 | $ 586,528 | $ 580,393 | $ 582,946 | $ 582,907 | $ 581,475 | $ 581,090 | $ 570,270 | $ 6,955,181 |
| CoF HMO | $3,456,547 | $3,457,039 | $3,458,125 | $3,419,330 | $ 3,383,249 | $3,444,977 | $3,454,073 | $ 3,460,240 | $3,473,467 | $ 3,482,775 | $3,486,451 | $3,493,192 | $ 41,469,464 |
| City of Tulare | | | | | | | $ 277,736 | $ 273,462 | $ 273,175 | $ 272,002 | $ 272,699 | $ 272,932 | $ 1,642,007 |
| **Total** | **$5,563,341** | **$5,588,262** | **$5,584,740** | **$5,541,393** | **$ 5,517,195** | **$5,589,300** | **$5,869,998** | **$ 5,873,672** | **$5,890,911** | **$ 5,901,643** | **$5,905,631** | **$5,901,784** | **$ 68,727,870** |

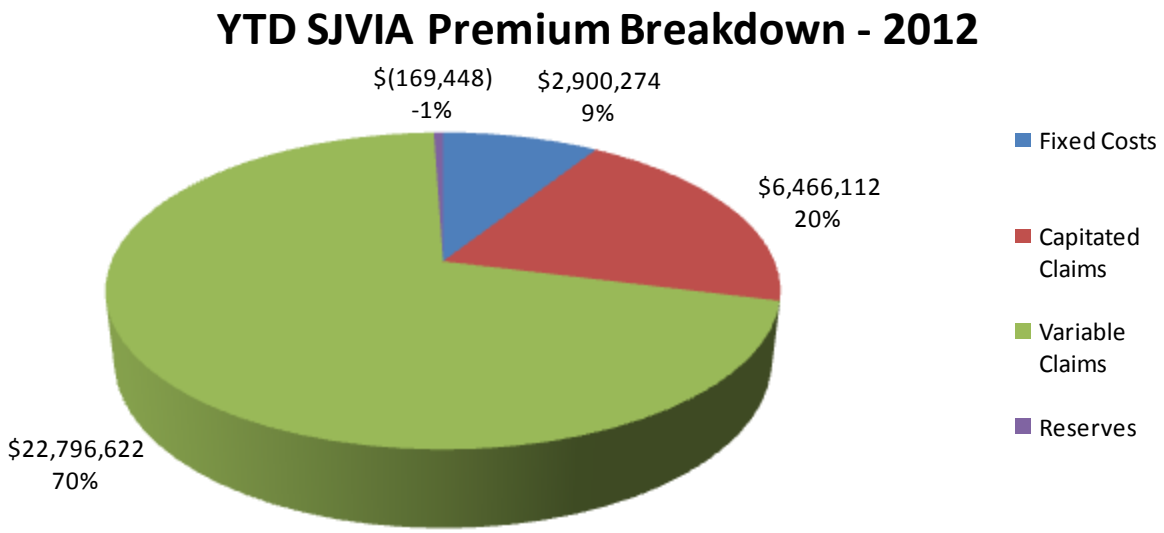
# SJVIA - All Plans




| 2013 Claims - All Plans | January | February | March | April | May | June | July | August | September | October | November | December | YTD Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CoT PPO | $1,328,133 | $1,348,396 | $1,536,642 | $1,502,111 | $1,194,704 | | | | | | | | $6,909,986 |
| CoT HMO | $81,808 | $103,800 | $232,302 | $170,104 | $228,931 | | | | | | | | $816,945 |
| CoF PPO | $446,175 | $382,584 | $326,185 | $261,659 | $417,808 | | | | | | | | $1,834,411 |
| CoF HMO | $3,633,234 | $3,379,414 | $3,799,686 | $3,542,086 | $3,913,994 | | | | | | | | $18,268,414 |
| City of Tulare PPO | $158,965 | $150,663 | $192,288 | $123,247 | $172,941 | | | | | | | | $798,104 |
| City of Ceres PPO | $1,090 | $25 | $33 | $383 | $60 | | | | | | | | $1,591 |
| City of Ceres HMO | $41,408 | $42,586 | $188,782 | $223,792 | $136,715 | | | | | | | | $633,283 |
| **Total** | **$5,690,813** | **$5,407,468** | **$6,275,918** | **$5,823,382** | **$6,065,153** | | | | | | | | **$29,262,734** |

| 2012 Claims - All Plans | January | February | March | April | May | June | July | August | September | October | November | December | YTD Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CoT PPO | $1,347,900 | $1,417,340 | $1,637,712 | $1,363,071 | $ 1,265,474 | $1,392,625 | $1,320,460 | $ 1,192,627 | $1,500,032 | $ 1,764,271 | $1,211,139 | $1,582,166 | $ 16,994,817 |
| CoF PPO | $ 385,926 | $ 490,303 | $ 526,293 | $ 500,279 | $ 437,872 | $ 517,707 | $ 432,823 | $ 650,127 | $ 538,280 | $ 589,208 | $ 416,006 | $ 422,179 | $ 5,907,003 |
| CoF HMO | $2,914,797 | $3,715,713 | $3,167,391 | $3,532,502 | $ 4,064,812 | $3,374,399 | $3,821,018 | $ 3,468,350 | $3,173,628 | $ 4,446,582 | $3,191,843 | $2,691,683 | $ 41,562,719 |
| City of Tulare | | | | | | | $ 52,996 | $ 134,658 | $ 172,683 | $ 150,838 | $ 141,869 | $ 162,624 | $ 815,668 |
| **Total** | **$4,648,623** | **$5,623,356** | **$5,331,396** | **$5,395,852** | **$ 5,768,158** | **$5,284,731** | **$5,627,297** | **$ 5,445,762** | **$5,384,624** | **$ 6,950,899** | **$4,960,857** | **$4,858,652** | **$ 65,280,207** |

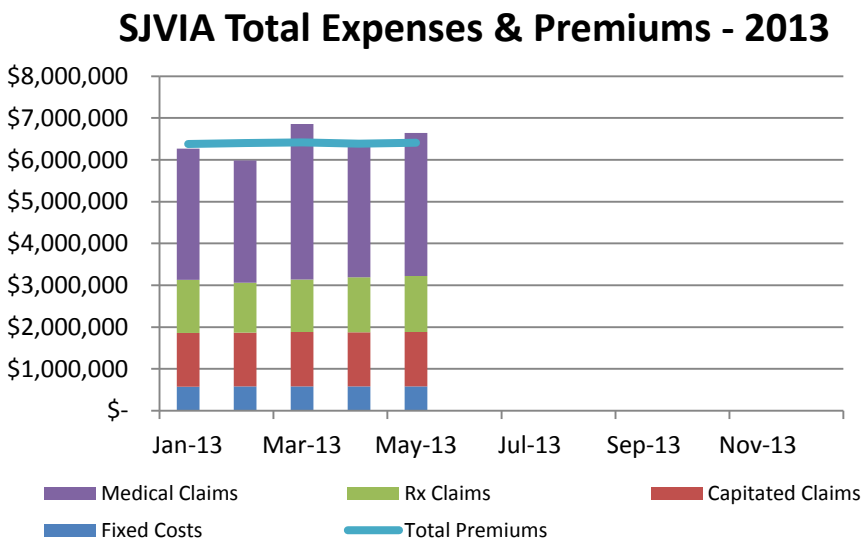
# SJVIA - All Plans

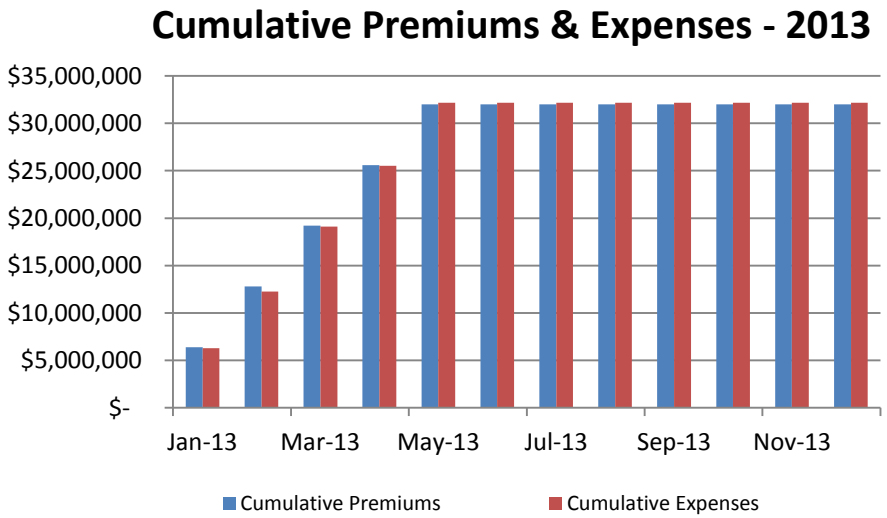



| 2013 Premium Breakdown - All Plans | January | February | March | April | May | June | July | August | September | October | November | December |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fixed Costs | $ 577,807 | $ 579,692 | $ 581,317 | $ 579,651 | $ 581,807 | | | | | | | |
| Capitated Claims | $1,283,487 | $1,288,959 | $1,298,101 | $1,294,493 | $ 1,301,072 | | | | | | | |
| Variable Claims | $4,407,326 | $4,118,509 | $4,977,817 | $4,528,889 | $ 4,764,081 | | | | | | | |
| Reserves | $ 111,910 | $ 413,632 | $ (442,655) | $ (16,052) | $ (236,284) | | | | | | | |
| **Total** | **$6,380,531** | **$6,400,792** | **$6,414,580** | **$6,386,981** | **$ 6,410,676** | | | | | | | |

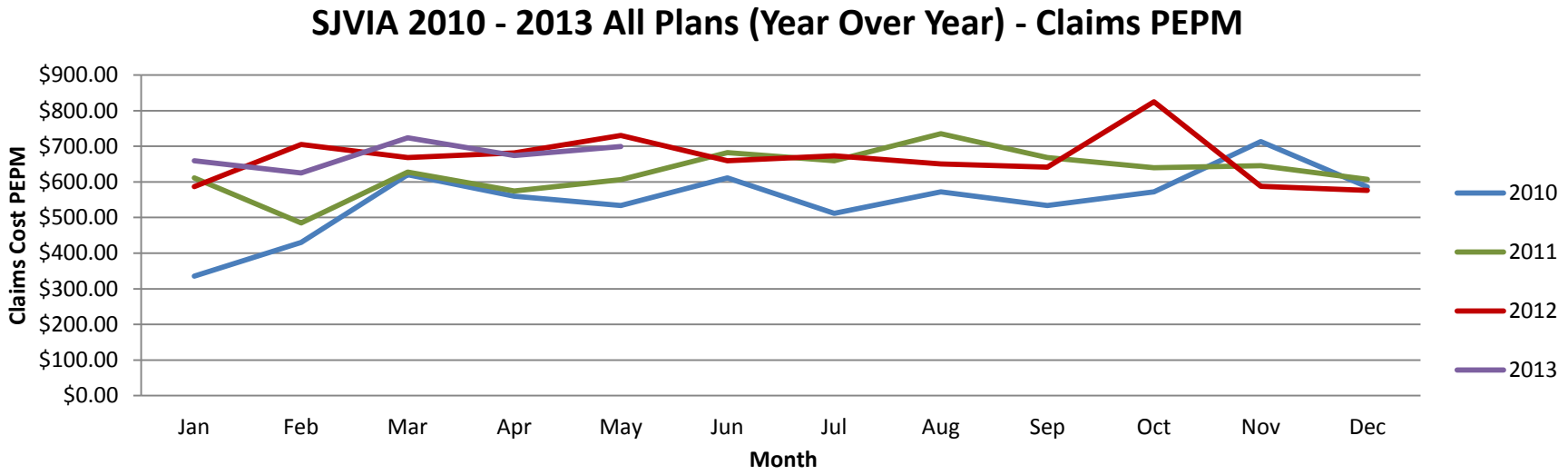
| 2012 Premium Breakdown - All Plans | January | February | March | April | May | June | July | August | September | October | November | December | YTD Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fixed Costs | $ 539,562 | $ 542,245 | $ 542,577 | $ 537,900 | $ 535,828 | $ 544,395 | $ 545,120 | $ 546,470 | $ 548,711 | $ 550,422 | $ 551,403 | $ 551,466 | $ 6,536,098 |
| Capitated Claims | $1,125,742 | $1,126,734 | $1,128,967 | $1,115,075 | $ 1,105,152 | $1,126,982 | $1,130,703 | $ 1,138,432 | $1,139,137 | $ 1,143,768 | $1,145,587 | $1,147,820 | $ 13,574,099 |
| Variable Claims | $3,522,881 | $4,496,622 | $4,202,429 | $4,280,777 | $ 4,663,006 | $4,157,749 | $4,496,594 | $ 4,307,330 | $4,245,487 | $ 5,807,131 | $3,815,270 | $3,710,832 | $ 51,706,108 |
| Reserves | $ 375,156 | $ (577,340) | $ (289,233) | $ (392,359) | $ (786,791) | $ (239,826) | $ (302,419) | $ (118,560) | $ (42,424) | $(1,599,678) | $ 393,371 | $ 491,666 | $ (3,088,436) |

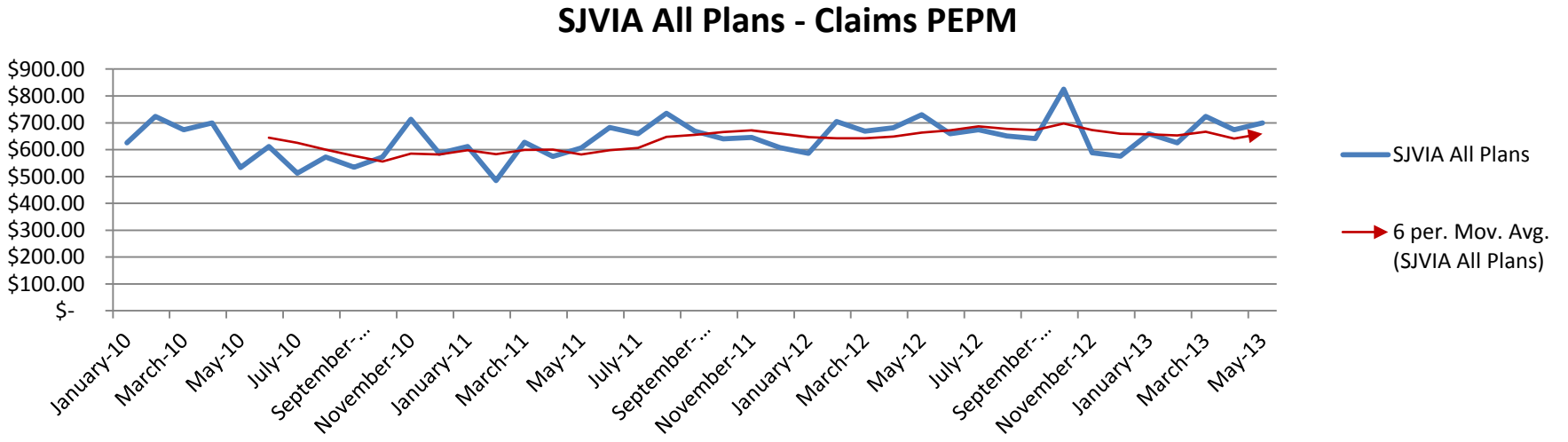
# SJVIA – All Plans



# SJVIA - All Plans



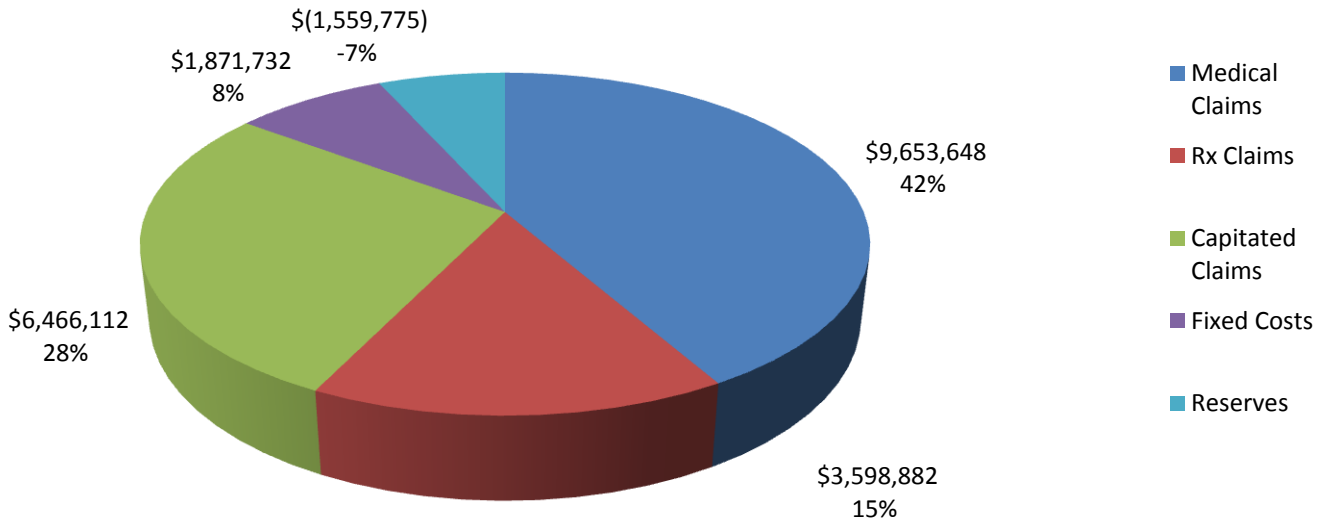




***PEPM – Per Employee Per Month**

# SJVIA - HMO

# SJVIA - HMO

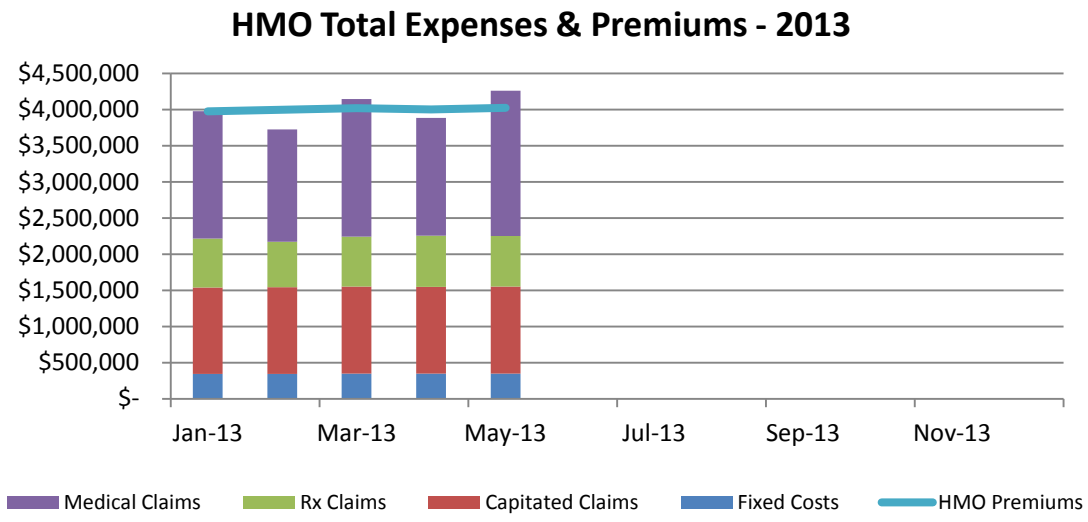
## YTD HMO Premium Breakdown - 2013

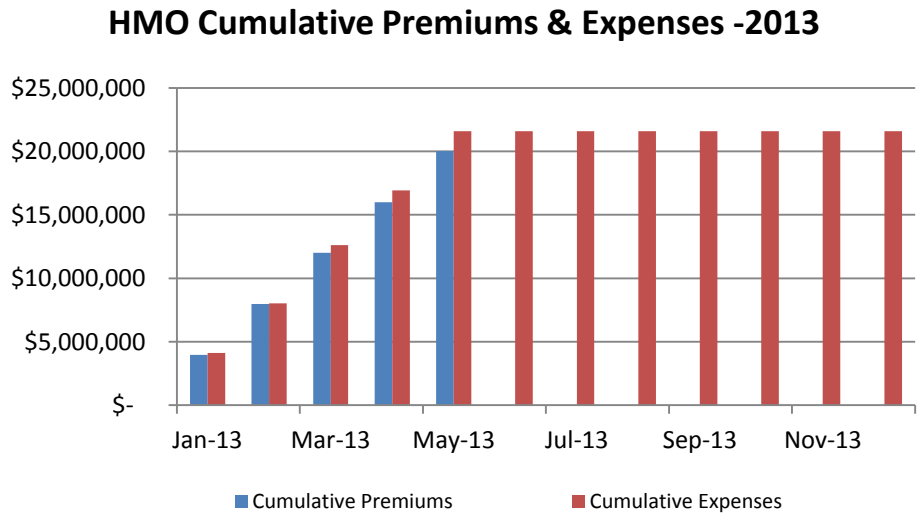



| 2013 Premium Breakdown - HMO | January | February | March | April | May | June | July | August | September | October | November | December | YTD Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fixed Costs | $ 371,254 | $ 373,173 | $ 375,841 | $ 374,801 | $ 376,664 | | | | | | | | $ 1,871,732 |
| Capitated Claims | $1,283,487 | $1,288,959 | $1,298,101 | $1,294,493 | $ 1,301,072 | | | | | | | | $ 6,466,112 |
| Medical Claims | $1,759,461 | $1,571,987 | $2,201,042 | $1,884,435 | $ 2,236,723 | | | | | | | | $ 9,653,648 |
| Rx Claims | $ 713,502 | $ 664,854 | $ 721,627 | $ 757,054 | $ 741,845 | | | | | | | | $ 3,598,882 |
| Reserves | $ (148,142) | $ 100,797 | $ (576,357) | $ (307,650) | $ (628,423) | | | | | | | | $ (1,559,775) |
| **Total** | **$3,979,562** | **$3,999,770** | **$4,020,254** | **$4,003,133** | **$ 4,027,881** | | | | | | | | **$20,030,600** |

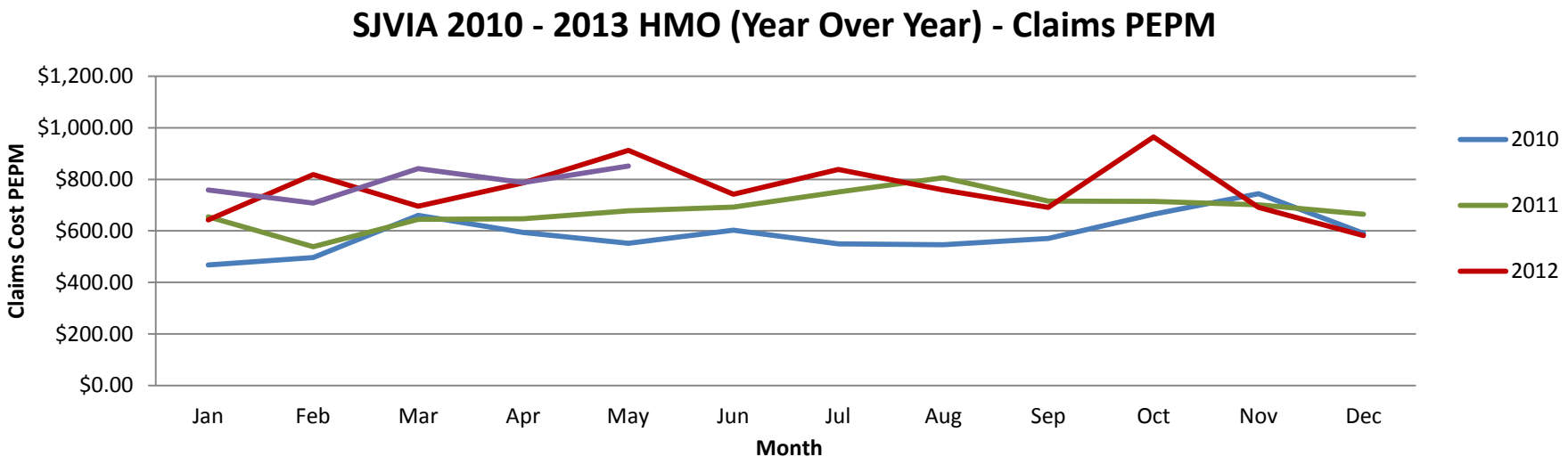
| 2012 Premium Breakdown - HMO | January | February | March | April | May | June | July | August | September | October | November | December | YTD Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fixed Costs | $ 357,186 | $ 357,501 | $ 358,209 | $ 353,801 | $ 350,653 | $ 357,658 | $ 358,760 | $ 359,626 | $ 361,436 | $ 362,932 | $ 363,483 | $ 364,191 | $ 4,305,437 |
| Capitated Claims | $1,125,742 | $1,126,734 | $1,128,967 | $1,115,075 | $ 1,105,152 | $1,126,982 | $1,130,703 | $ 1,138,432 | $1,139,137 | $ 1,143,768 | $1,145,587 | $1,147,820 | $ 13,574,099 |
| Medical Claims | $1,128,332 | $1,941,584 | $1,376,948 | $1,816,134 | $ 2,330,814 | $1,662,356 | $2,054,136 | $ 1,679,713 | $1,433,160 | $ 2,636,011 | $1,453,372 | $1,296,919 | $ 20,809,479 |
| Rx Claims | $ 660,723 | $ 647,395 | $ 661,476 | $ 601,293 | $ 628,846 | $ 585,061 | $ 636,179 | $ 650,205 | $ 601,331 | $ 666,803 | $ 592,884 | $ 246,944 | $ 7,179,141 |
| Reserves | $ 184,564 | $ (616,175) | $ (67,475) | $ (466,974) | $(1,032,216) | $ (287,080) | $ (725,705) | $ (367,736) | $ (61,597) | $(1,326,739) | $ (68,875) | $ 437,317 | $ (4,398,692) |

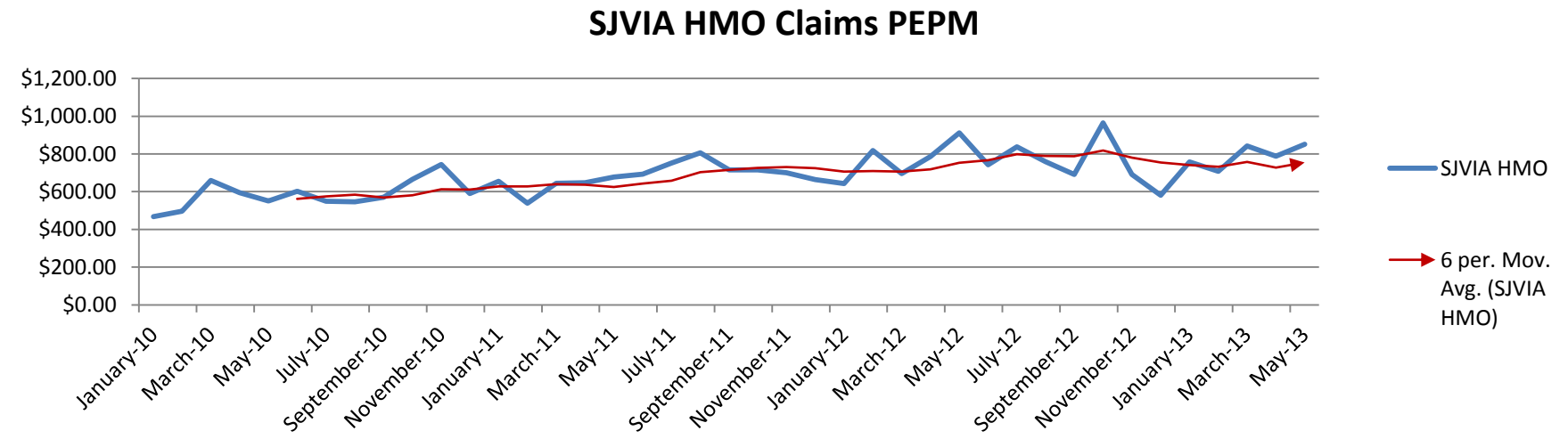
# SJVIA – HMO



# SJVIA – HMO

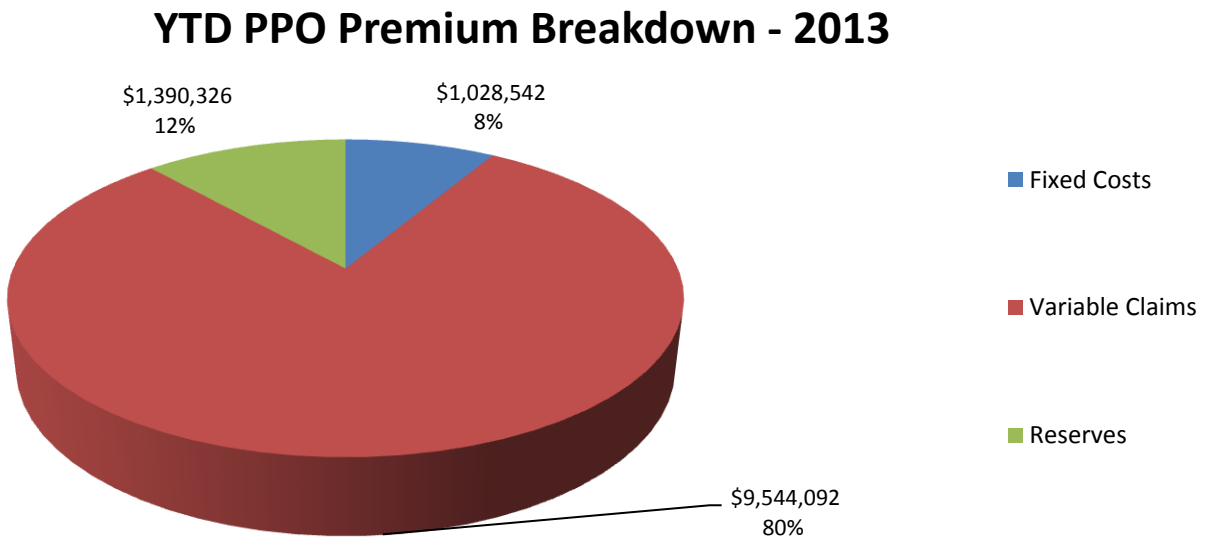



***PEPM – Per Employee Per Month**

# SJVIA - PPO

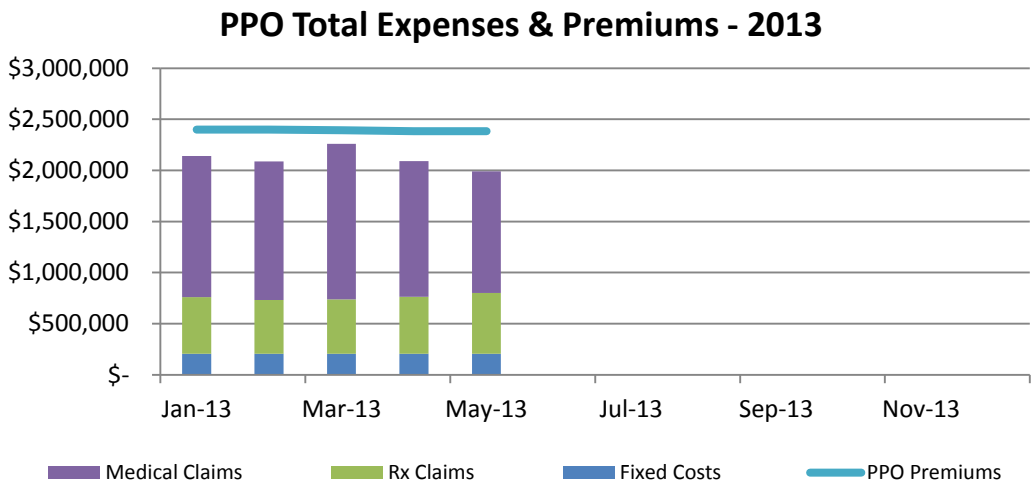
# SJVIA - PPO Premium Breakdown

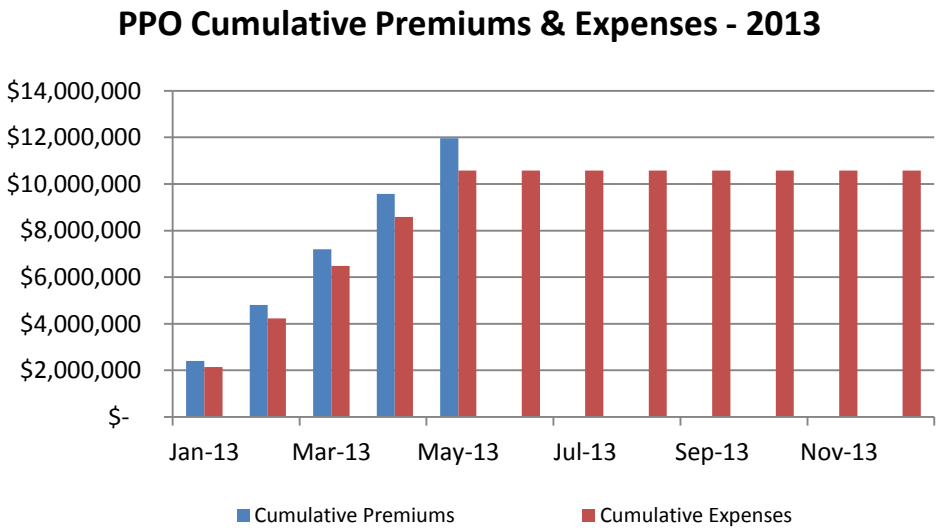



| 2013 Premium Breakdown - PPO | January | February | March | April | May | June | July | August | September | October | November | December | YTD Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fixed Costs | $ 206,554 | $ 206,519 | $ 205,476 | $ 204,850 | $ 205,143 | | | | | | | | $ 1,028,542 |
| Variable Claims | $ 1,934,363 | $ 1,881,668 | $ 2,055,148 | $ 1,887,400 | $ 1,785,513 | | | | | | | | $ 9,544,092 |
| Reserves | $ 260,052 | $ 312,835 | $ 133,702 | $ 291,597 | $ 392,139 | | | | | | | | $ 1,390,326 |
| **Total** | **$ 2,400,969** | **$ 2,401,022** | **$ 2,394,326** | **$ 2,383,848** | **$ 2,382,795** | | | | | | | | **$ 11,962,960** |

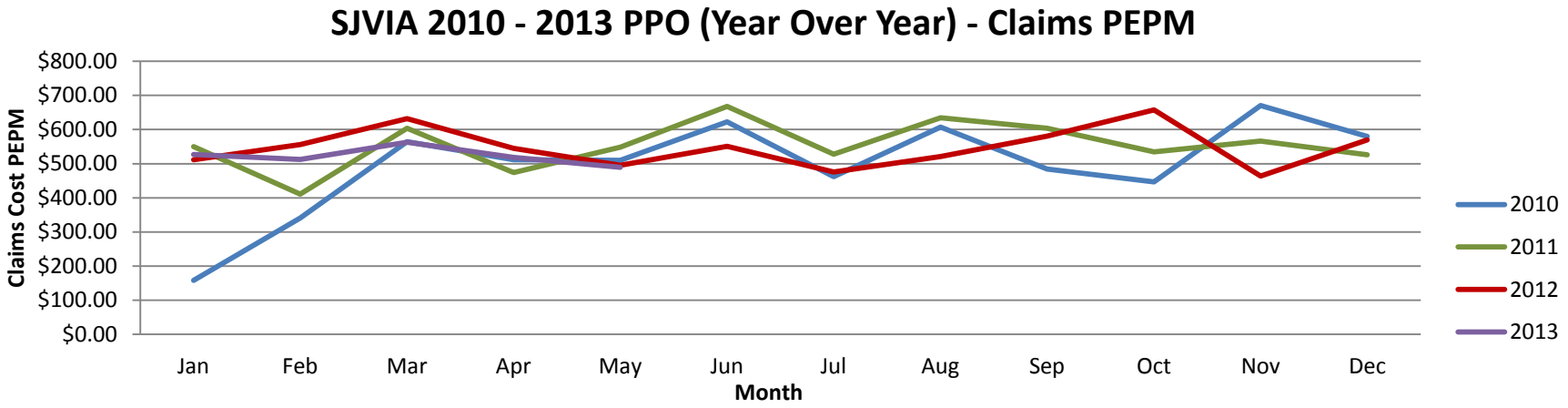
| 2012 Premium Breakdown - PPO | January | February | March | April | May | June | July | August | September | October | November | December | YTD Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fixed Costs | $ 182,376 | $ 184,745 | $ 184,368 | $ 184,099 | $ 185,175 | $ 186,736 | $ 186,359 | $ 186,844 | $ 187,275 | $ 187,490 | $ 187,921 | $ 187,275 | $ 2,230,661 |
| Variable Claims | $ 1,733,826 | $ 1,907,643 | $ 2,164,005 | $ 1,863,350 | $ 1,703,346 | $ 1,910,332 | $ 1,806,279 | $ 1,977,412 | $ 2,210,996 | $ 2,504,317 | $ 1,769,014 | $ 2,166,969 | $ 23,717,489 |
| Reserves | $ 190,592 | $ 38,835 | $ (221,757) | $ 74,615 | $ 245,425 | $ 47,254 | $ 423,286 | $ 249,177 | $ 19,173 | $ (272,939) | $ 462,246 | $ 54,349 | $ 1,310,256 |

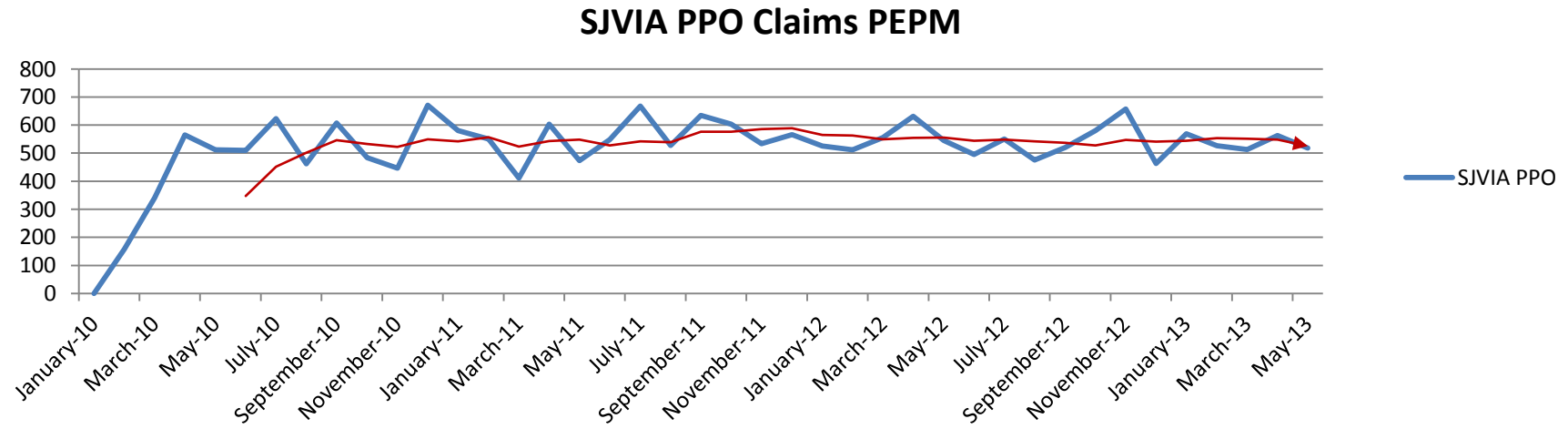
# SJVIA - PPO Plans



# SJVIA – PPO Claims PEPM




***PEPM – Per Employee Per Month**

# SJVIA - Monthly Data

# SJVIA - All Plans

| 2013 SJVIA Enrollment - All Plans | January | February | March | April | May | June | July | August | September | October | November | December | YTD Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| - Employee Only | 5,154 | 5,167 | 5,180 | 5,180 | 5,188 | | | | | | | | 25,869 |
| - Employee + Spouse | 1,029 | 1,024 | 1,024 | 1,010 | 1,008 | | | | | | | | 5,095 |
| - Employee + Child(ren) | 1,546 | 1,549 | 1,547 | 1,545 | 1,560 | | | | | | | | 7,747 |
| - Employee + Family | 897 | 909 | 914 | 905 | 915 | | | | | | | | 4,540 |
| **SJVIA Total Enrollment** | **8,626** | **8,649** | **8,665** | **8,640** | **8,671** | | | | | | | | 43,251 |
| **SJVIA Total Premiums** | **$6,380,531** | **$6,400,792** | **$6,414,580** | **$6,386,981** | **$ 6,410,676** | | | | | | | | **$31,993,560** |
| SJVIA Premiums PEPM | $ 739.69 | $ 740.06 | $ 740.29 | $ 739.23 | $ 739.32 | | | | | | | | $ 739.72 |
| **SJVIA Total Claims** | **January** | **February** | | | | | | | | | | | **YTD Totals** |
| - Medical Claims | $3,138,697 | $2,927,501 | $3,722,059 | $3,213,820 | $ 3,427,595 | | | | | | | | $16,429,672 |
| - Rx Claims | $1,268,629 | $1,191,008 | $1,255,758 | $1,315,069 | $ 1,336,486 | | | | | | | | $ 6,366,950 |
| - Stop-Loss Refunds | $ - | $ - | | | | | | | | | | | |
| - Capitated Claims (HMO) | $1,283,487 | $1,288,959 | $1,298,101 | $1,294,493 | $ 1,301,072 | | | | | | | | $ 6,466,112 |
| **SJVIA Total Claims** | **$5,690,813** | **$5,407,468** | **$6,275,918** | **$5,823,382** | **$ 6,065,153** | | | | | | | | **$29,262,734** |
| SJVIA Claims PEPM | $ 659.73 | $ 625.21 | $ 724.28 | $ 674.00 | $ 699.48 | | | | | | | | $ 676.58 |
| **SJVIA Fixed Costs** | **$ 577,807** | **$ 579,692** | **$ 581,317** | **$ 579,651** | **$ 581,807** | | | | | | | | **$ 2,900,274** |
| **SJVIA Total Costs** | **$6,268,620** | **$5,987,160** | **$6,857,235** | **$6,403,033** | **$ 6,646,960** | | | | | | | | **$32,163,008** |
| SJVIA Cost PEPM | $ 726.71 | $ 692.24 | $ 791.37 | $ 741.09 | $ 766.57 | | | | | | | | $ 743.64 |
| **SJVIA Total Reserve - Increase/(Decrease)** | **$ 111,910** | **$ 413,632** | **$ (442,655)** | **$ (16,052)** | **$ (236,284)** | | | | | | | | **$ (169,448)** |
| **Reserve % of Non Cap. Claims** | **2.5%** | **10.0%** | **-8.9%** | **-0.4%** | **-5.0%** | | | | | | | | **-0.7%** |

# SJVIA - HMO

| 2013 HMO Enrollment | January | February | March | April | May | June | July | August | September | October | November | December | YTD Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| - Employee Only | 2,240 | 2,256 | 2,289 | 2,292 | 2,294 | | | | | | | | 11,371 |
| - Employee + Spouse | 647 | 640 | 640 | 633 | 639 | | | | | | | | 3,199 |
| - Employee + Child(ren) | 1,413 | 1,417 | 1,418 | 1,415 | 1,429 | | | | | | | | 7,092 |
| - Employee + Family | 654 | 665 | 666 | 659 | 663 | | | | | | | | 3,307 |
| **HMO Total Enroll.** | **4,954** | **4,978** | **5,013** | **4,999** | **5,025** | | | | | | | | **24,969** |
| **HMO Premiums** | **$ 3,979,562** | **$ 3,999,770** | **$ 4,020,254** | **$ 4,003,133** | **$ 4,027,881** | | | | | | | | **$ 20,030,600** |
| HMO Premiums PEPM | $ 803.30 | $ 803.49 | $ 801.97 | $ 800.79 | $ 801.57 | | | | | | | | $ 802.22 |
| **HMO Claims** | **January** | **February** | | | | | | | | | | | **YTD Totals** |
| - Medical Claims | $ 1,759,461 | $ 1,571,987 | $ 2,201,042 | $ 1,884,435 | $ 2,236,723 | | | | | | | | $ 9,653,648 |
| - Rx Claims | $ 713,502 | $ 664,854 | $ 721,627 | $ 757,054 | $ 741,845 | | | | | | | | $ 3,598,882 |
| - Capitated Claims | $ 1,283,487 | $ 1,288,959 | $ 1,298,101 | $ 1,294,493 | $ 1,301,072 | | | | | | | | $ 6,466,112 |
| Pooling Reimbursements | | | | | | | | | | | | | |
| **HMO Total Claims** | **$ 3,756,450** | **$ 3,525,800** | **$ 4,220,770** | **$ 3,935,982** | **$ 4,279,640** | | | | | | | | **$ 19,718,642** |
| HMO Claims PEPM | $ 758.27 | $ 708.28 | $ 841.96 | $ 787.35 | $ 851.67 | | | | | | | | $ 789.72 |
| **HMO Fixed Costs** | **$ 371,254** | **$ 373,173** | **$ 375,841** | **$ 374,801** | **$ 376,664** | | | | | | | | **$ 1,871,732** |
| **HMO Total Costs** | **$ 4,127,704** | **$ 3,898,973** | **$ 4,596,611** | **$ 4,310,783** | **$ 4,656,304** | | | | | | | | **$ 21,590,374** |
| HMO Costs PEPM | $ 833.21 | $ 783.24 | $ 916.94 | $ 862.33 | $ 926.63 | | | | | | | | $ 864.69 |
| **HMO Plan Reserve - Increase/(Decrease)** | **$ (148,142)** | **$ 100,797** | **$ (576,357)** | **$ (307,650)** | **$ (628,423)** | | | | | | | | **$ (1,559,775)** |
| **Reserve % of Non Cap. Claims** | **-6.0%** | **4.5%** | **-19.7%** | **-11.6%** | **-21.1%** | | | | | | | | **-11.8%** |

# SJVIA - PPO

| 2013 PPO Enrollment - All Plans | January | February | March | April | May | June | July | August | September | October | November | December | YTD Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| - Employee Only | 2,914 | 2,911 | 2,891 | 2,888 | 2,894 | | | | | | | | 14,498 |
| - Employee + Spouse | 382 | 384 | 384 | 377 | 369 | | | | | | | | 1,896 |
| - Employee + Child(ren) | 133 | 132 | 129 | 130 | 131 | | | | | | | | 655 |
| - Employee + Family | 243 | 244 | 248 | 246 | 252 | | | | | | | | 1,233 |
| **PPO Plans Total Enrollment** | **3,672** | **3,671** | **3,652** | **3,641** | **3,646** | | | | | | | | **18,282** |
| **PPO Plans Total Premiums** | **$ 2,400,969** | **$ 2,401,022** | **$ 2,394,326** | **$ 2,383,848** | **$ 2,382,795** | | | | | | | | **$ 11,962,960** |
| PPO Premiums PEPM | $ 653.86 | $ 654.05 | $ 655.62 | $ 654.72 | $ 653.54 | | | | | | | | $ 654.36 |
| **PPO Plans Total Claims** | **January** | **February** | | | | | | | | | | | **YTD Totals** |
| - Medical Claims | $ 1,379,236 | $ 1,355,514 | $ 1,521,017 | $ 1,329,385 | $ 1,190,872 | | | | | | | | $ 6,776,024 |
| - Rx Claims | $ 555,127 | $ 526,154 | $ 534,131 | $ 558,015 | $ 594,641 | | | | | | | | $ 2,768,068 |
| - Stop-Loss Refunds | $ - | $ - | | | | | | | | | | | |
| **PPO Plans Net Claims** | **$ 1,934,363** | **$ 1,881,668** | **$ 2,055,148** | **$ 1,887,400** | **$ 1,785,513** | | | | | | | | **$ 9,544,092** |
| PPO Plans Claims PEPM | $ 526.79 | $ 512.58 | $ 562.75 | $ 518.37 | $ 489.72 | | | | | | | | $ 522.05 |
| **PPO Plans Fixed Costs** | **$ 206,554** | **$ 206,519** | **$ 205,476** | **$ 204,850** | **$ 205,143** | | | | | | | | **$ 1,028,542** |
| **PPO Plans Total Costs** | **$ 2,140,917** | **$ 2,088,187** | **$ 2,260,624** | **$ 2,092,250** | **$ 1,990,656** | | | | | | | | **$ 10,572,634** |
| PPO Plans Cost PEPM | $ 583.04 | $ 568.83 | $ 619.01 | $ 574.64 | $ 545.98 | | | | | | | | $ 578.31 |
| **PPO Plans Total Reserve - Increase/(Decrease)** | **$ 260,052** | **$ 312,835** | **$ 133,702** | **$ 291,597** | **$ 392,139** | | | | | | | | **$ 1,390,326** |
| **Reserve % of Net Claims** | **13.4%** | **16.6%** | **6.5%** | **15.4%** | **22.0%** | | | | | | | | **14.6%** |

SJVIA
San Joaquin Valley Insurance Authority



**Meeting Location:**
**Fresno County Employee Retirement Association Board Chambers**
**1111 H Street**
**Fresno, CA 93721**
**July 26, 2013 9:00 AM**

**AGENDA DATE:** July 26, 2013

**ITEM NUMBER:** 15

**SUBJECT:** Receive and File Report on Wellness Activities (I)

**REQUEST(S):** That the Board of Directors receive and file the report on wellness activities.

**DESCRIPTION:**

As part of the ongoing campaign to raise awareness of healthy habits and encourage smart lifestyle choices, the participant entities of the SJVIA engaged in a "Walking Works" challenge from May 20th through the 24th for the second year in a row

This year the entities that participated in the event include:

- The County of Fresno
- The County of Tulare
- The City of Tulare
- The City of Ceres

Participants received free pedometers sponsored by various vendors of the SJVIA including Anthem Blue Cross, Delta Health Systems, and Health Now Administrative Services. The daily results were tracked online at each entity .

Prizes were donated by entities that provide services to the SJVIA including:

- Anthem Blue Cross – Gift Cards to local sports/fitness stores
- US Script – several Fitbit fitness trackers
- VSP – several pairs of sunglasses
- Delta Dental – electric toothbrushes
- BenefitMall (stop loss) – several Fitbit fitness trackers
- Chimienti and Associates – gift cards to local sports/fitness stores
- Hourglass Systems – two mountain bikes
- Gallagher Benefit Services – several gift cards to Target

In addition to the prizes above, many local business donated prizes as well. All participants were eligible for the prizes which were awarded via random drawing. In addition to the prizes at the individual entities, results were tracked for each entity for highest percentage of participation and highest average number of steps. The City of Tulare won overall in both of these categories.

| | | Participation | | Steps |
|---|---|---|---|---|
| Department | # of EE's | # | % | Average |
| COUNTY OF TULARE | 3992 | 689 | 17% | 8711 |
| COUNTY OF FRESNO | 6741 | 1196 | 18% | 7610 |
| CITY OF TULARE | 320 | 190 | 60% | 9269 |
| CITY OF CERES | 181 | 50 | 28% | 8494 |

**FISCAL IMPACT/FINANCING:**

None at this time.

**AGENDA**: San Joaquin Valley Insurance Authority

**DATE:** July 26, 2013

**ADMINISTRATIVE SIGN-OFF:**

Jeffrey Cardell
SJVIA Manager

Paul Nerland
Assistant SJVIA Manager

# BEFORE THE BOARD OF DIRECTORS SAN JOAQUIN VALLEY INSURANCE AUTHORITY

**IN THE MATTER OF** Receive and File Report on Wellness Activities

**RESOLUTION NO.** _____
**AGREEMENT NO.** _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board of Directors received and filed the report on wellness activities

Walking Works!

# Final Results!

A **BIG** thank you to everyone who participated in the “Walking Works!” Challenge, especially the Department Liaisons. This event was a huge success and we hope that you have been inspired and will remain motivated to keep walking for the benefit of your health!

**Final "Walking Works!" Challenge Results.**

Hundreds of County employees reported thousands of steps! Congratulations goes to the following departments for leading the way!

Are you going to continue to walk? What changes are you making as a result of this Challenge? Tell you your story and we may use it in an upcoming feature. Click **here**.

- **HIGHEST PERCENTAGE OF PARTICIPATION**:

**Fresno County Employees Retirement Association (FCERA)** had the highest percentage of participation at **98%**! Way to go!

Walking Works!

# PRIZES!

The County of Fresno would like to thank the following donors for their generous contribution toward the Walking Works! Challenge. Their donation helped us make this year's challenge even better. We value their commitment towards helping our employees lead healthier lives. Prizes were randomly awarded to Fresno County participants from each day of the challenge.

**Prizes:**

- **One month of free produce** (T.D. Willey Farms): **Luvenia Johnson - DCSS**


- **BBQ Serving Set** (Costco): **Shaun Johnston - Internal Services**


- **Exercise gear** (Sierra Running Company): **Brad Farr - Public Health**


- **Power Toothbrush & floss brush pack** (Delta Dental): **Deborah Cooley - DSS; Linda Calandra - Library; Mike Yang - Behavioral Health; Martin Coldwell - Public Works**




- **Three Target gift cards** (Gallagher Benefit Services and Employee Benefit Specialists): **Matthew Gonzalez - ACTTC $25; Helen Marquez - DA $25; Carmen Perez - DSS $50**


- **$100 Whole Foods gift card** (Liberty Mutual): **Beatrice Sanchez - Probation**

- **Stress relief gift set** (Kaiser Permanente): **Celeste Ramos - DSS; Maria Rojas Singh - Public Health**


- **Two free climbing classes** (Touchstone Climbing & Fitness): **Nicole Moses - DSS; Surinder Sandhu - Sheriff; Jennifer Bethel - Public Works; Erika Rojas - DSS**

- **Three Dick's Sporting Goods gift cards** (Anthem Blue Cross and Chimienti & Associates): **Nina Quiroz - Probation $100; Joanna Chase - Library $50; Shelly Dorn - DSS $50**


- **$100 value Nautica and Michael Kors sunglasses** (VSP): **Leticia Molano - Library; Brian Burton - Agriculture**




- **Fitbit Activity Tracker** (US Script and Benefit Mall): **Phil Guth - DSS; Randy Bell - Library; Denise Myers - DCSS; John Baker - DSS**

- **Diamondback mountain bike** (Hourglass Systems): **Lori Liles, DA**

- **HIGHEST AVERAGE STEPS**:

**County Counsel** led the way with the highest average steps taken at **12,641!** Great job!


- **OVERALL RESULTS**: View the final results of all departments by clicking **here**.

**Competition Results for the County of Fresno**

- The City of Tulare won both the percentage of participation with 59**%** and the highest average number of steps at 9,095.

**Prizes**

A random drawing was held to award prizes to employees who participated in the "Walking Works!" Challenge. Click **here** to see who the lucky winners are!

**WALKING WORKS HOME**

# Walking Works Across The Valley

By KSEE News

June 3, 2013

Updated Jun 3, 2013 at 9:54 AM PDT

Last week employees from the Counties of Fresno & Tulare and the cities of Tulare, Ceres & Waterford put their best feet forward for good health. It was all part of the San Joaquin Valley Insurance Authority's push to improve physical fitness. In addition to getting folks moving, the week-long challenge also created a little friendly competition between the groups of walkers.

# Walking Works! Challenge

The County of Tulare would like to thank the following vendors (donors) for their generous contribution toward the Walking Works! Challenge. Their donation helped us make this year's challenge even better. We value their commitment towards helping our employees lead healthier lives. Prizes were randomly awarded to Tulare County participants from the week's challenge.

## Prizes

- Mountain Bike (Hourglass)
  **Edward Frankovic, TCIT**
- (2) $50 Gift Cards (Chimienti & Associates)
  **Detra Bond-Farias, HHSA**
  **Adriana Sanchez, Sheriff**
- (2) Nike Sunglasses (VSP)
  **Delia Huerta, Probation;**
  **Kirk Gullotto, General Services**
- Electric Toothbrush (Delta Dental)
  **Petra Cisneros, Sheriff**
- $100 Sports Chalet Gift Card (Anthem Blue Cross)
  **Tami Stephens, TCIT**
- $50 Target Gift Card (Gallagher Benefits Services)
  **Karla Doyer, Purchasing**
- (4) Fitbit Activity Tracker (US Script and Benefit Mall)
  **Melinda Benton, CAO**
  **Jennifer Brown, Probation**
  **Rebecca Arellano, Probation**
  **Andrea Castillo, HHSA**

***Edward Frankovic***

***Kirk Gullotto***

***Tami Stephens***

***Karla Doyer***

***Jennifer Brown***

***Andrea Castillo***

# Walking Works! Challenge

## Tulare County Employees



**Most Average Steps**
Auditor-Controller's - Bean Crushers Team

Chairman Pete Vander Poel and Employees from **Visalia Gov't Plaza**