SJVIA
San Joaquin Valley Insurance Authority

AGENDA

Meeting Location:
Tulare County Employees' Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93291
July 25, 2014 9:00 AM

1. Call to Order
2. Roll Call
3. Approval of Agenda (A)
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 25, 2014 (A)
6. Receive and File Quarterly Financial Report (I)
7. Authorization of the Release of Proposals for Participation and Execution of Participation Agreement(s) (A)
8. Receive and File Update on Request for Proposal for Wellness Vendors Effective January 1, 2015 (I)
9. Receive and File Update on Request for Proposal for Administrative Services Vendors Effective January 1, 2015 (I)
10. Receive and File SJVIA Executive Claims Summary Through May 2014 (I)
11. Approve Recommended Annual Out-of-Pocket Maximum Change as Required by the Affordable Care Act Effective January 1, 2015 (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:
Tulare County Employees' Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93291
July 25, 2014 9:00 AM

12. Receive and File Updated Anthem HMO Administrative Fees Effective July 1, 2014 (I)
13. Receive and File Update Regarding US Script Guaranteed Pricing (I)
14. Approve the Amendment to the Participation Agreement for Member Entities with Additions or Changes to SJVIA (A)
15. Receive and File Preliminary January 1, 2015 Health Plan Renewal (I)
16. Approve and Authorize sending the 2014 Multi-County Biennial Notice to the California Fair Political Practices Commission (A)
17. Approve Appointment of HIPAA Privacy Officer (A)
18. Adjournment

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SJVIA
San Joaquin Valley Insurance Authority

MINUTES

Meeting Location:
Fresno County Employees' Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
April 25, 2014 9:00 AM

1. Call to Order

   Meeting was called to order by Director Case McNairy at 9:11am.

2. Roll Call

   Roll was called by Brittany Howell, Gallagher Benefit Services. In attendance were Director Case McNairy, Director Ennis, Director Larson, and Director Worthley.

3. Approval of Agenda (A)

   Director Case McNairy asked if there were any additions or corrections to the agenda. Director Ennis moved to approve the agenda with no changes; 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.

   Director Case McNairy opened the meeting for public comment – no public comment was given.

5. Approval of Minutes – Board Meeting of February 21, 2014 (A)

   Director Ennis moved to approve the February 21, 2014 Meeting Minutes; the motion was seconded by Director Larson. The motion passed unanimously.

6. Receive and File Quarterly Financial Report (I)

   Lawrence Seymour, ACTTC from Fresno County, gave an overview on the quarterly financial statements. For the current quarter, revenue is 2% under

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budget, fixed expenses are 2% under budget and claims expenses are 8% over budget. In looking at the fixed costs, SJVIA Administration shows a large variance which is mainly the result of the financial statement conversion process with the claims surfacing to the risk pooling model and the subsequent financial statements being prepared and audited. The 2012 statement was presented at the last meeting and currently the 2013 statement is being repaired and prepared for auditing. There was also a large variance in Wellness which is mainly due to the timing of the wellness expenditures such as the biometric screenings and walking challenge.

Director Case McNairy pointed out that Kaiser's budgeted verses actual shows a large variance. Michele Mills, Gallagher Benefit Services, explained that Kaiser came into the plan January 1, 2014 therefore two quarters of the fiscal year did not include them.

7. Receive verbal report on actuarial review of the SJVIA as required by GASB 10 (I)

   Paul Nerland indicated we would be calling Demsey, Filliger & Associates to report on this item.

   Lou Filliger, Demsey, Filliger & Associates Partner and Actuary, gave an overview on the GASB 10 study, which was conducted in June 2013. When this report is conducted for the first time, there are no historical reports to look back on. In order to obtain favorable numbers, there ought to be 3 to 9 years of experience. When an actuarial report is conducted for incurred but not reported claims, there is a theoretical estimate involved. He then took us further into how these factors were reached. Since these reports will be conducted in the future, this report serves to establish a ground work for what the reserving approach should be as we move forward.

   Director Case McNairy asked if there were actuarial standards or averages in the industry in regards to IBNR. Mr. Filliger pointed out the factors that were

used for this study are on Page 2 of the report. The factor used for medical claims is approximately 1.15 which is slightly lower than industry standards and pharmacy claims is 0.50 which is the industry standard.

8. Receive and File Executive Claims Summary through February 2014 (I)

   Alan Thaxter, Gallagher Benefit Services, presented the claims summary through February 2014. He pointed out this report includes the new members who joined January 1, 2014 – City of Riverbank, City of Reedley, City of Wasco, City of Newman and City of Farmersville. This now totals 14 entities within SJVIA, including the founding members. The claims cost per employee per month shows some volatility for the 2014 plan year due to these new entities joining with little claim information thus far. Enrollment is continuing to increase year over year and trend is substantially lower than other plans on the market.

9. Receive and File Report on Upcoming Wellness Activities (I)

   Brittany Howell, Gallagher Benefit Services, gave an update on the upcoming wellness activities, specifically the 2014 "Walking Works Challenge". Last year, Anthem Blue Cross donated $15,000 toward SJVIA wellness activities and due to the major growth this last year, they agreed to donate $25,000 in 2014. A portion of that money was used toward pedometers and goody bags for all employees who participate in the challenge as well as raffle prizes to be given out at the end of the competition. In addition, our other carriers have donated raffle prizes such as Mountain Bikes, FitBits, gift cards, gym bags, sunglasses, etc.

   There will be three different groups this year, according to size, and each entity within those groups will be competing against each other as well as against their internal departments for Average Steps Walked and Highest Participation. On top of that challenge, there will be a virtual "Walk to the Top" China Peak Challenge in which employees will be entered into a raffle to

win a China Peak lift ticket and t-shirt if they walk at least 10,000 steps every day of the challenge.

Of the fourteen entities within SJVIA, twelve have agreed to participate this year and everyone is very excited to get walking.

10. Approve the Acceptance of Revised Anthem Blue Cross Marketing Guidelines (A)

    Mark Tucker, Gallagher Benefit Services, explained the purpose of these new marketing guidelines for Anthem Blue Cross. Historically, Anthem has had a policy in place called "Blue on Blue" which prohibits business from moving from one Anthem health plan to another, in a sense, competing against themselves. The changes under way are related to this policy, where Anthem will allow groups to opt in to a revised policy waiving "Blue on Blue". In order to maintain a competitive position in the marketplace and gain more membership in the SJVIA, staff is recommending the Board approve the amended guidelines.

    Director Worthley moved to approve the Revised Anthem Blue Cross Marketing Guidelines; the motion was seconded by Director Ennis. The motion passed unanimously.

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

    Paul Nerland stated that Staff is seeking approval to release proposals for City of Hughson, City of Coalinga and Fresno Metropolitan Flood Control District to be effective July 1, 2014, as well as to authorize the Participation Agreements.

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

SJVIA
San Joaquin Valley Insurance Authority

MINUTES

Meeting Location:
Fresno County Employees' Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
April 25, 2014 9:00 AM

12. Approve the Revisions to the Participation Agreement for Non-founding Entities (A)

    Paul Nerland explained the purpose of this agenda item which is to discuss revising the Participation Agreement for each entity should any renewal changes be made. Participation Agreements are a minimum of three years commitment to SJVIA. This Agreement includes exhibits that state the benefit/rates that apply to the specific program that entity has chosen. Staff is recommending the Participation Agreement template for all new groups coming into the SJVIA be revised to allow for these annual changes to benefits/rates. For groups currently participating in programs under SJVIA, Staff will request an amendment to the Agreement allowing for these annual changes to benefits/rates.

    Director Larson approved revisions to the Participation Agreement for Non-founding entities; the motion was seconded by Director Worthley. The motion passed unanimously.

13. Adjournment

    Meeting was adjourned at 10:18am by Director Case McNairy.

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SJVIA

San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93921
July 25, 2014
9:00 AM

AGENDA DATE: July 25, 2014

ITEM NUMBER: 6

SUBJECT: Quarterly SJVIA financial update

REQUEST(S): That the Board receives the financial update through 4th quarter, 2013-14

DESCRIPTION: Informational item. Please see attached report.

FISCAL IMPACT/FINANCING: None.

ADMINISTRATIVE SIGN-OFF:

Vicki Crow

Vicki Crow
SJVIA Auditor-Treasurer

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF

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: _____

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

SAN JOAQUIN VALLEY INSURANCE AUTHORITY

ACTUALS VS. BUDGETED REVENUES & EXPENSES
FOR THE THREE AND TWELVE MONTHS ENDED JUNE 30, 2014

	Current Quarter				Year-To-Date			
	BUDGET*	ACTUALS	FAVORABLE/ (UNFAVORABLE)	% VARIANCE	BUDGET*	ACTUALS	FAVORABLE/ (UNFAVORABLE)	% VARIANCE
REVENUE								
TOTAL REVENUE	**$23,649,487**	**$23,336,643**	**($312,844)**	**(1%)**	**$94,597,949**	**$90,261,194**	**($4,336,755)**	**(5%)**
EXPENSES: Fixed								
1 Specific & Aggregate Stop Loss Insurance (PPO)	153,941	165,876	(11,935)	(8%)	615,764	610,363	5,401	1%
2 Anthem ASO Administration & Network Fees (PPO)	328,007	350,823	(22,816)	(7%)	1,312,027	1,324,959	(12,932)	(1%)
3 Chimenti Associates/Hourglass Administration(PPO & Anthem HMO)	176,475	191,212	(14,737)	(8%)	705,900	688,518	17,382	2%
4 GBS Consulting	108,600	120,904	(12,304)	(11%)	434,400	449,833	(15,433)	(4%)
5 SJVIA Administration	59,004	66,999	(7,995)	(14%)	236,016	305,391	(69,375)	(29%)
6 Wellness	67,875	48,501	19,374	29%	271,500	82,276	189,224	70%
7 Communications	13,575	0	13,575	100%	54,300	26,272	28,028	52%
8 Anthem HMO Pooling	338,748	380,794	(42,046)	(12%)	1,354,993	1,376,947	(21,954)	(2%)
9 Anthem HMO Administration/Retention	859,312	1,208,579	(349,267)	(41%)	3,437,246	3,324,111	113,135	3%
10 ACA Reinsurance (PPO)	40,647	0	40,647	100%	162,588	4,588	158,000	97%
TOTAL FIXED EXPENSES	**2,146,184**	**2,533,688**	**(387,504)**	**(18%)**	**8,584,734**	**8,193,258**	**391,476**	**5%**
EXPENSES: Claims								
11 Projected Paid Medical & Rx Claims-PPO and Non-Cap HMO	15,067,763	17,402,478	(2,334,715)	(15%)	60,271,052	60,006,713	264,339	0%
12 Anthem MMP HMO Capitation	4,089,842	4,531,660	(441,818)	(11%)	16,359,367	16,375,456	(16,089)	(0%)
TOTAL CLAIMS EXPENSES	**19,157,605**	**21,934,138**	**(2,776,533)**	**(14%)**	**76,630,419**	**76,382,169**	**248,250**	**0%**
EXPENSES: Premiums								
13 Delta Dental	1,363,515	1,588,059	(224,544)	(16%)	5,454,060	5,785,512	(331,452)	(6%)
14 Vision Service Plan	235,817	263,405	(27,588)	(12%)	943,266	962,612	(19,346)	(2%)
15 Kaiser Permanente	1,119,995	1,413,973	(293,978)	(26%)	4,479,980	2,574,970	1,905,010	43%
TOTAL PREMIUM EXPENSES	**2,719,327**	**3,265,437**	**(546,110)**	**(20%)**	**10,877,306**	**9,323,094**	**1,554,212**	**14%**
TOTAL EXPENSES	**24,023,116**	**27,733,263**	**(3,710,147)**	**(15%)**	**96,092,459**	**93,898,521**	**2,193,938**	**2%**
16 **Reserve Deficit**	(373,629)	(4,396,620)	(4,022,991)	(1077%)	(1,494,510)	(3,637,327)	(2,142,817)	(143%)
COMBINED EXPENSES & RESERVES	**$23,649,487**	**$23,336,643**	**($312,844)**	**(1%)**	**$94,597,949**	**$90,261,194**	**($4,336,755)**	**(5%)**

*The approved budget contains assumptions that may differ throughout the fiscal year. The budget amounts presented in this report are estimates, and are presented irrespective of the timing of those assumptions.

SAN JOAQUIN VALLEY INSURANCE AUTHORITY

ANALYSIS OF ADMINISTRATION, WELLNESS & COMMUNICATIONS (FEES) - REVENUES & EXPENSES

FOR THE THREE AND TWELVE MONTHS ENDED JUNE 30, 2014

	Current Quarter			Year-To-Date		
	SJVIA FEES			SJVIA FEES		
FY13-14	**Administration (*Line 5)**	**Wellness (*Line 6)**	**Communications (*Line 7)**	**Administration (*Line 5)**	**Wellness (*Line 6)**	**Communications (*Line 7)**
Revenue**	**$59,853**	**$68,579**	**$13,110**	**$233,117**	**$270,042**	**$51,597**
Expenses:						
Auditor-Treasurer Services	27,165			121,483		
County Counsel Services	4,181			9,067		
Personnel Services	13,327			44,424		
Membership Fees						
Insurance (Liability, Bond, Etc)	19,370			90,814		
Audit Fees				24,500		
Bank Service Fees	2,956			15,103		
Wellness		48,501			82,276	
Communications						26,272
Total Expenses	**66,999**	**48,501**		**305,391**	**82,276**	**26,272**
Administration, Wellness & Communications Deficit/Surplus	**($7,146)**	**$20,078**	**$13,110**	**($72,274)**	**$187,766**	**$25,325**

*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, 2014

	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	TOTAL
BEGINNING CASH BALANCES:													
Claims Funding Account-844535294	$551,069	$369,448	$784,967	$524,872	$423,437	$629,363	$569,319	$221,587	$707,709	$308,246	$75,336	$839,907	$551,069
Fixed Cost Account-844535120	322,321	613,622	304,292	349,020	34,572	332,421	336,365	2,343,369	2,433,788	2,452,905	1,326,052	3,968,213	322,321
Claims Reserve Account-428255819	4,266,377	4,832,847	3,333,752	3,907,007	2,571,442	3,529,897	3,972,440	3,300,870	4,182,023	3,638,447	3,597,022	1,391,620	4,266,377
Total Beginning Balances	5,139,767	5,815,917	4,423,011	4,780,899	3,029,451	4,491,681	4,878,124	5,865,826	7,323,520	6,399,598	4,998,410	6,199,740	5,139,767
RECEIPTS:													
Claims Funding Account-844535294	2,673,807	4,395,424	3,273,144	3,696,488	3,513,644	3,702,300	2,678,747	2,600,291	3,974,737	3,355,440	5,380,340	4,389,538	43,633,900
Fixed Cost Account-844535120	2,244,415	2,348,918	2,300,236	3,425,918	3,067,577	2,320,277	4,268,308	4,522,568	5,654,974	4,511,174	5,715,101	4,640,545	45,020,011
Claims Reserve Account-428255819	4,916,508	4,427,610	5,206,785	4,900,900	5,328,350	5,626,514	3,439,500	5,033,656	5,830,753	5,021,662	4,795,143	5,571,245	60,098,626
TOTAL RECEIPTS	9,834,730	11,171,952	10,780,165	12,023,306	11,909,571	11,649,091	10,386,555	12,156,515	15,460,464	12,888,276	15,890,584	14,601,328	148,752,537
DISBURSEMENTS:													
Claims Funding Account-844535294	2,855,428	3,979,905	3,533,239	3,797,923	3,307,718	3,762,344	3,026,479	2,114,169	4,374,200	3,588,350	4,615,769	4,660,095	43,615,619
Fixed Cost Account-844535120	1,953,114	2,658,248	2,255,508	3,740,366	2,769,728	2,316,333	2,261,304	4,432,149	5,635,857	5,638,027	3,072,940	7,231,444	43,965,018
Claims Reserve Account-428255819	4,350,038	5,926,705	4,633,530	6,236,465	4,369,895	5,183,971	4,111,070	4,152,503	6,374,329	5,063,087	7,000,545	6,773,047	64,175,185
TOTAL DISBURSEMENTS	9,158,580	12,564,858	10,422,277	13,774,754	10,447,341	11,262,648	9,398,853	10,698,821	16,384,386	14,289,464	14,689,254	18,664,586	151,755,822
ENDING CASH BALANCES:													
Claims Funding Account-844535294	369,448	784,967	524,872	423,437	629,363	569,319	221,587	707,709	308,246	75,336	839,907	569,350	569,350
Fixed Cost Account-844535120	613,622	304,292	349,020	34,572	332,421	336,365	2,343,369	2,433,788	2,452,905	1,326,052	3,968,213	1,377,314	1,377,314
Claims Reserve Account-428255819	4,832,847	3,333,752	3,907,007	2,571,442	3,529,897	3,972,440	3,300,870	4,182,023	3,638,447	3,597,022	1,391,620	189,818	189,818
Total Ending Balances	$5,815,917	$4,423,011	$4,780,899	$3,029,451	$4,491,681	$4,878,124	$5,865,826	$7,323,520	$6,399,598	$4,998,410	$6,199,740	$2,136,482	$2,136,482
Investments:													
Total Ending Balances	$5,027,974	$5,027,974	$5,039,948	$5,039,948	$5,039,948	$5,053,890	$5,053,890	$5,053,890	$5,065,073	$5,065,073	$5,065,073	$5,078,099	$5,078,099

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 6/30/14 was 1.03% with quarterly earnings of $13,026.

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 **ACA Reinsurance (PPO)**

The Affordable Care Act (ACA) includes the following fees on insurance plans: 1) Patient Centered Outcomes Research Institute (PCORI) 2) Transitional Reinsurance Fee

11 **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).

12 **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.

13 **Delta Dental**

Premium for entities covered under the SJVIA Delta Dental program.

14 **Vision Service Plan**

Premium for entities covered under the SJVIA VSP Vision program.

15 **Kaiser Permanente**

Premium for entities covered under the SJVIA Kaiser HMO program

16 **Reserve Surplus/Deficit**

Excess revenue over claims, premiums and fixed costs.

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employees' Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93291
July 25, 2014 9:00 AM

AGENDA DATE: July 25, 2014

ITEM NUMBER: 7

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

REQUEST(S): That the Board of Directors approve the release of proposals for the Cities of Taft, Oakdale, Hanford, Mendota, Firebaugh, Selma and Modesto

DESCRIPTION:

On November 5, 2010, 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.

The Underwriting Committee is in the process of reviewing these proposals and upon approval seeks authority to release illustrative proposals to the Cities of Taft (100), Oakdale (81), Hanford (225), Mendota (46), Firebaugh (16), Selma (110) and Modesto (900).

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).

AGENDA: San Joaquin Valley Insurance Authority

DATE: July 25, 2014

FISCAL IMPACT/FINANCING:

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

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
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, Oakdale, Hanford, Mendota, Firebaugh, Selma and Modesto, and authorized the Board President to execute related participation agreements

SJVIA
San Joaquin Valley
Insurance Authority

New Member Activity

CURRENT NON-FOUNDING MEMBER GROUPS:

	City:	Status to Date:	Effective	EE's
1	**Ceres**	SJVIA Member	Jan-13	115
2	**Sanger**	SJVIA Member	Jul-13	105
3	**Shafter**	SJVIA Member	Jul-13	111
4	**Tulare**	SJVIA Member	Jul-12	334
5	**Waterford**	SJVIA Member	Jun-13	12
6	**San Joaquin**	SJVIA Member	Jul-13	15
7	**Gustine**	SJVIA Member	Oct-13	17
8	**Reedley**	SJVIA Member	Jan-14	93
9	**Riverbank**	SJVIA Member	Feb-14	37
10	**Newman**	SJVIA Member	Mar-14	24
11	**Wasco**	SJVIA Member	Apr-14	59
12	**Farmersville**	SJVIA Member	May-14	63
			TOTAL	**985**

ACTIVE IN PROPOSAL PROCESS:

	City:	Status to Date:	Effective	EE's
1	**City of Taft**	**In process**	September	100
2	**City of Oakdale**	**In process**	January	81
3	**City of Hanford**	**In process**	January	225
4	**City of Mendota**	**In process**	January	30
5	**City of Firebaugh**	**In process**	January	16
6	**City of Selma**	**In process**	January	110
7	**City of Modesto**	**In process**	January	917
			TOTAL	**1479**

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employees' Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93291
July 25, 2014 9:00 AM

AGENDA DATE: July 25, 2014

ITEM NUMBER: 8

SUBJECT: Staff Report on Request for Proposal Process for Wellness/Disease Management Vendors Effective January 1, 2015

REQUEST(S): That the Board receive and file the update on Request for Proposal for Wellness vendors effective January 1, 2015

DESCRIPTION:

At the February 21, 2014 meeting, your Board directed staff to request proposals for integrated wellness and disease management vendors capable of handling the complexities, goals, and expectations of the SJVIA programs. Specifically, SJVIA staff recommended requesting proposals that consider an integrated lifestyle and disease management program that allows flexibility for targeted efforts. Currently, the SJVIA contracts with Delta Team Care for Wellness (onsite health screenings, health coaching and education) and Anthem Blue Cross for Disease Management (Anthem 360 Program). The focus of this process is to consider a more integrated approach to wellness and disease management that may provide a more measurable return on investment.

SJVIA Staff, along with the local consultant team at Gallagher Benefit Services and their national Wellness Practice Leader, Ali Payne have gone through the first few stages of the RFP process and are prepared to recommend vendors for finalist interviews and potential contract award.

Ali Payne performed the preliminary RFP requesting proposals from a number of vendors that aligned with the requirements and objectives of the SJVIA according to an extensive Request for Information or Market Scan she performs with hundreds of vendors across the US on a quarterly basis. From this detailed information, she is able to align vendors with the needs of the client that can best respond to her request for comprehensive proposals.

Proposals were received from the following vendors:

- Anthem Blue Cross
- Humana Vitality
- Viverae
- TriWellness
- Optum
- Delta Team Care

The proposals received by the interested vendors varied greatly in scope, pricing, resources, onsite capabilities, and software platform. Each vendor proposed their own unique focus and combination of recommended solutions for the SJVIA. However, most proposals demonstrate an integrated approach to wellness/disease management, tools to increase and maintain employee engagement and measurable savings. The results of the RFP have been reviewed with Ali, SJVIA staff, and Gallagher. SJVIA staff is recommending finalist interviews in early August with Humana Vitality, Viverae, TriWellness, Optum, and Delta Team Care. The SJVIA's current vendors (Anthem Blue Cross and Delta Team Care) do not offer the integrated approach and/or measurable results. Delta Team Care does, however, offer additional on-site services; therefore, they are being included as a finalist. Staff will continue to analyze the vendor proposals and the options available to the SJVIA and come back to your Board with a recommended vendor for contract award at the next Board Meeting.

FISCAL IMPACT/FINANCING:

The SJVIA currently pays $2.10 (PPO) and $3.38 (HMO) per employee for month for disease management programs through Anthem 360 (approximately $340,000) per year. Health Risk Assessments and Biometric Screening through Delta TeamCare are offered at $195 per employee that participates. The SJVIA has budgeted $2.50 per employee per month or $325,800 annually for Wellness efforts.

AGENDA: San Joaquin Valley Insurance Authority

DATE: July 25, 2014

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Update on Request for Proposal for Wellness Vendors Effective January 1, 2015

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 the update on Request for Proposal for Wellness vendors effective January 1, 2015

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employees' Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93291
July 25, 2014 9:00 AM

AGENDA DATE: July 25, 2014

ITEM NUMBER: 9

SUBJECT: Update on Request for Proposal for Administrative Services Vendors Effective January 1, 2015

REQUEST(S): That the Board receive and file the update on Request for Proposal for Administrative Services vendors effective January 1, 2015

DESCRIPTION:

At the July 26, 2013 meeting, your Board directed staff to execute an amendment to the in force contract with Chimienti and Associates for their administrative services extending it for one year. This action also directed staff to perform an RFP for these services during the 2014 year for a new contract to go into effect January 1, 2015.

Over the last few months staff has been working with Gallagher to request and review proposals from interested vendors for the services currently performed by Chimienti & Associates. While this RFP was not the result of dissatisfaction with current services, it is of utmost importance for the SJVIA to analyze all components of the health plan to remain competitive and efficient.

Proposals were received from the following vendors:

- Secova
- BenefitFocus
- Next Generation Enrollment

- Businesssolver
- Chimienti & Associates

Similar to the Wellness RFP, the services of these vendors varies in pricing structure, services offered, required implementation timing, etc. Each vendor proposed their own unique focus and combination of recommended solutions for the SJVIA. The results of the RFP are under review by SJVIA staff and Gallagher. SJVIA staff is recommending finalist interviews in early August with vendors to be determined who provide the most competitive options for the SJVIA.

Staff will continue to analyze the vendor proposals and the options available to the SJVIA and come back to your Board with a recommended vendor for contract award at the next Board Meeting.

FISCAL IMPACT/FINANCING:

None.

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Update on Request for Proposal for Administrative Services Vendors Effective January 1, 2015

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 the update on the Request for Proposal for administrative services vendors effective January 1, 2015

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employees' Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93291
July 25, 2014 9:00 AM

AGENDA DATE: July 25, 2014

ITEM NUMBER: 10

SUBJECT: Receive and File SJVIA Executive Claims Summary through May 2014

REQUEST(S): That the Board Receive and File SJVIA Executive Claims Summary through May 2014

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 Claims Report" has been included in the Monthly Claims Report (page 3). This summary details on-going claims that are over $100,000 paid-to-date. The "pooling point" is the maximum amount the SJVIA could pay in a plan year for each individual on the plan. 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. When claims reach the pooling point the SJVIA is no longer liable for the payment of further eligible claims within the policy year.

In addition to the founding Counties (Fresno and Tulare), this report includes data for:

- City of Tulare, which began participating in the SJVIA effective July, 2012
- City of Ceres, which joined SJVIA effective January 2013
- City of Waterford, which joined the SJVIA effective June 2013
- City of San Joaquin, which joined the SJVIA effective July 2013
- City of Shafter, which joined the SJVIA effective July 2013
- City of Sanger, which joined the SJVIA effective July 2013
- City of Gustine, which joined the SJVIA effective October 2013
- City of Riverbank, which joined the SJVIA effective January 1, 2014
- City of Newman, which joined the SJVIA effective January 1, 2014
- City of Reedley, which joined the SJVIA effective January 1, 2014
- City of Wasco, which joined the SJVIA effective January 1, 2014
- City of Farmersville, which joined the SJVIA effective January 1, 2014

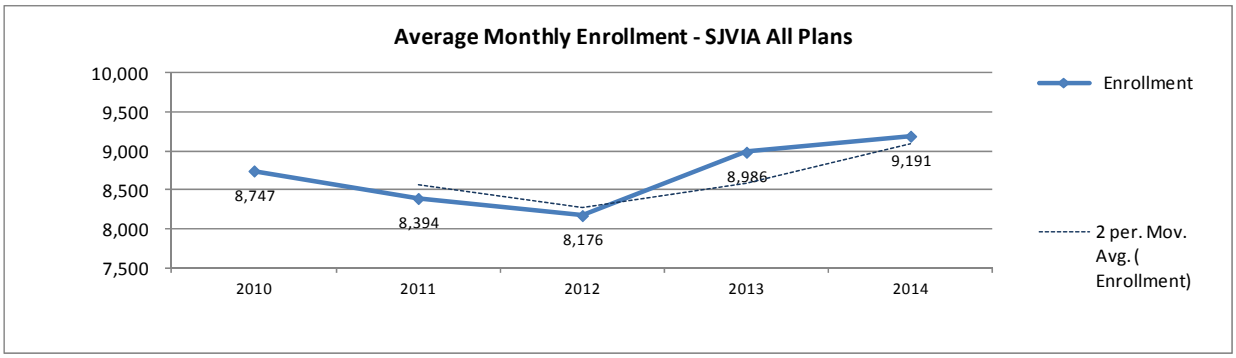
Comparing claims "Per Employee Per Month" (PEPM) can be a good indicator of overall medical inflationary trends. The overall yearly averages are below:

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	$783.07 PEPM	$517.95 PEPM	$667.02 PEPM
2014 (through May)	$757.86 PEPM	$600.60 PEPM	$690.30 PEPM

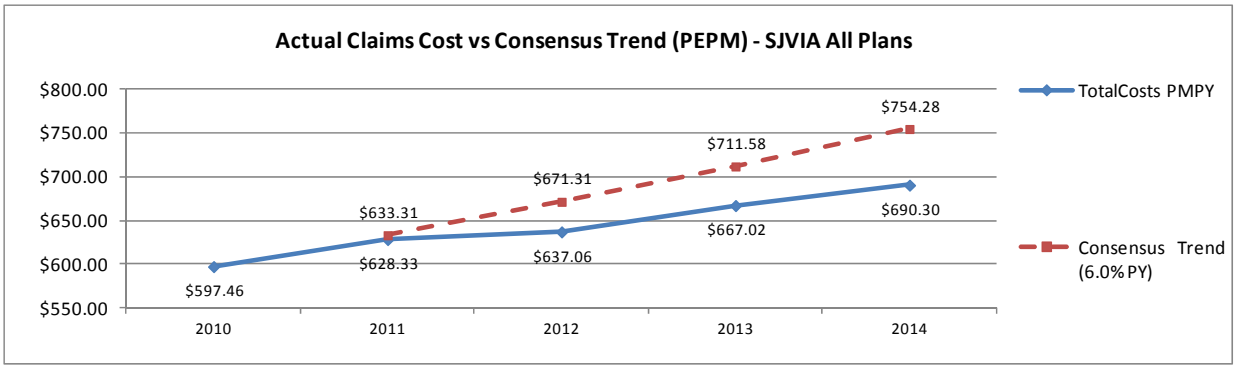
AGENDA: San Joaquin Valley Insurance Authority

DATE: July 25, 2014

The chart below shows average monthly enrollment in all SJVIA plans since inception. Enrollment dropped slightly in 2011 and 2012 but increased 9.9% in 2013 due to increased participation in the founding members' population as well as the addition of the new entities mentioned above. Membership continues to grow in 2014 as a result of new entities joining the SJVIA.



The chart below shows actual claims costs (Per Employee Per Month) for all of the SJVIA plans. These values are represented by the blue line with corresponding average claims from the table above. For illustrative purposes, we have included a consensus trend line (red line) that represents a level, year over year, 6% medical inflationary trend assumption. The differential between these two lines demonstrates the savings the SJVIA has realized over a normal, consensus medical trend assumption.



Overall weighted medical trend since inception of the SJVIA has been 3.68%

AGENDA: San Joaquin Valley Insurance Authority

DATE: July 25, 2014

FISCAL IMPACT/FINANCING:

Informational Only

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
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 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 received and filed SJVIA Executive Claims Summary through May 2014

Arthur J. Gallagher & Co.
BUSINESS WITHOUT BARRIERS™

Executive Claims Report

Data through May 2014

GALLAGHER BENEFIT SERVICES | JULY 21, 2014

SJVIA
San Joaquin Valley Insurance Authority

Large Claim Report - 2014 YTD

San Joaquin Valley Insurance Authority

Potential Large Dollar Claimants >$200,000

HMO Plan

January 1, 2014 through December 31, 2014 as of July 21, 2014

Pooling Point $400,000

Relationship	Paid	Diagnosis	Reimbursment
Sub	$ 402,821	Hepatobiliary (07)	$ 2,821

Total HMO Pooling Reimbursements **$ 2,821**

PPO Plan

January 1, 2014 through December 31, 2014 as of July 21, 2014

Stop Loss Deductible $450,000

Relationship	Paid	Diagnosis	Reimbursment
Dep	$ 802,466	Newborns (15)	$ 352,466

Total PPO Stop Loss Reimbursements **$ 352,466**

Total SJVIA Pooling and Stop Loss Reimbursements **$ 355,287**

Large Claim Report - 2013

Potential Large Dollar Claimants >$200,000

January 1, 2013 through December 31, 2013 as of February 2014

HMO Plan

Pooling Point $400,000

Relationship	Paid	Diagnosis	Reimbursment
Dependent	$ 392,339	Circulatory System (05)	$ -
Dependent	$ 340,656	Myeloid Disorders (17)	$ -
Dependent	$ 322,211	Injuries/Poisonings (21)	$ -
Subscriber	$ 285,910	Myeloid Disorders (17)	$ -
Subscriber	$ 273,662	Nervous System (01)	$ -
Dependent	$ 215,661	Hepatobiliary (07)	$ -
Subscriber	$ 213,456	Ear/Nose/Throat Disorders (08)	$ -
Dependent	$ 202,454	Newborns (15)	$ -
Total HMO Pooling Reimbursements			**$ -**

PPO Plan

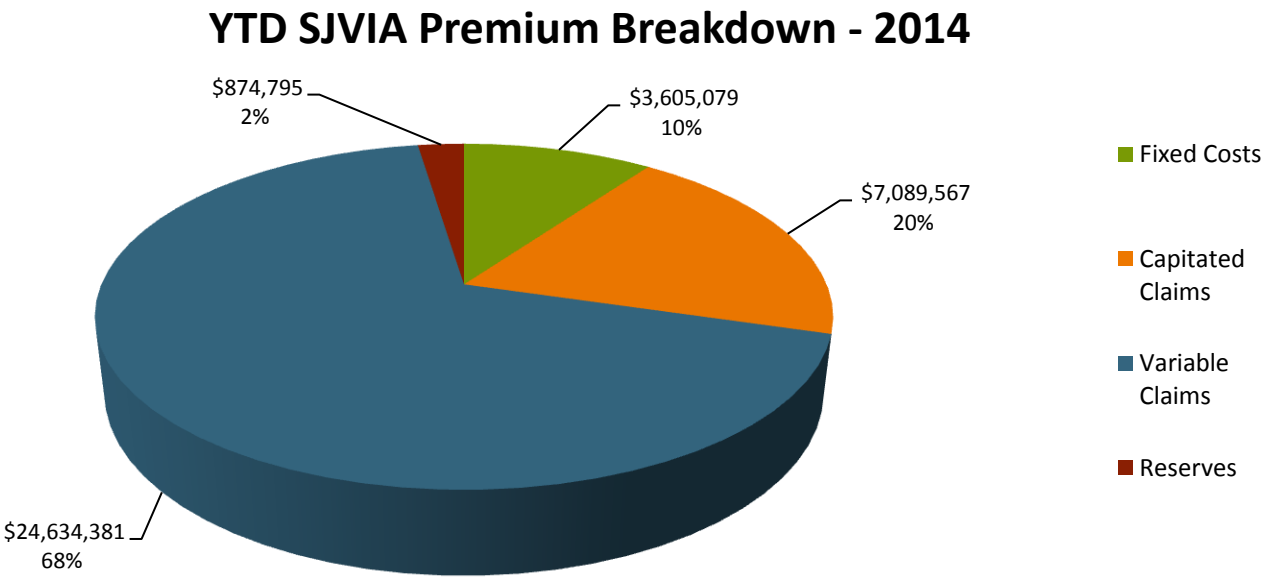
Stop Loss Deductible $450,000

Relationship	Paid	Diagnosis	Reimbursment
Subscriber	$ 479,395	Injuries/Poisonings (21)	$ 29,395
Dependent	$ 223,672	Circulatory System (05)	$ -
Subscriber	$ 203,726	Nervous System (01)	$ -
Total PPO Stop Loss Reimbursements			**$ 29,395**

Total SJVIA Pooling and Stop Loss Reimbursements	**$ 29,395.00**

ALL PLANS

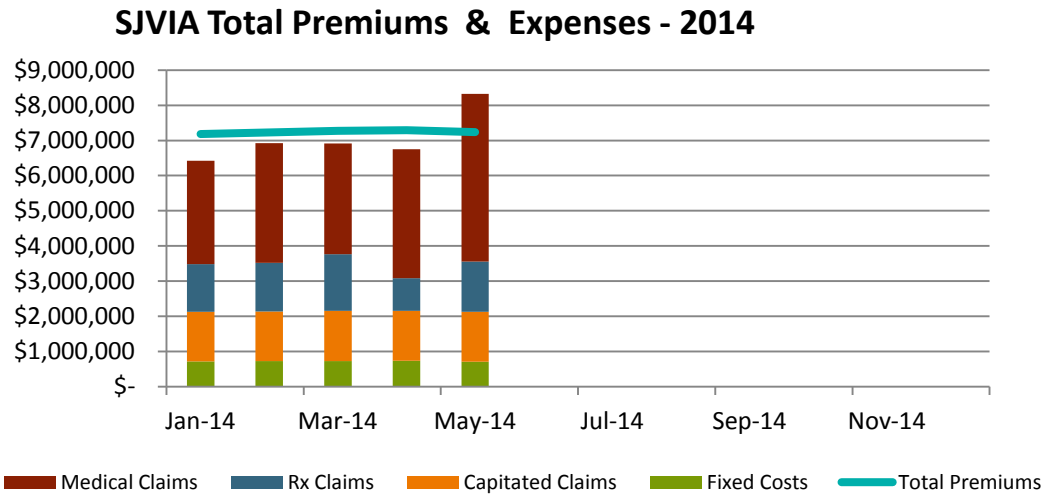
All Plans

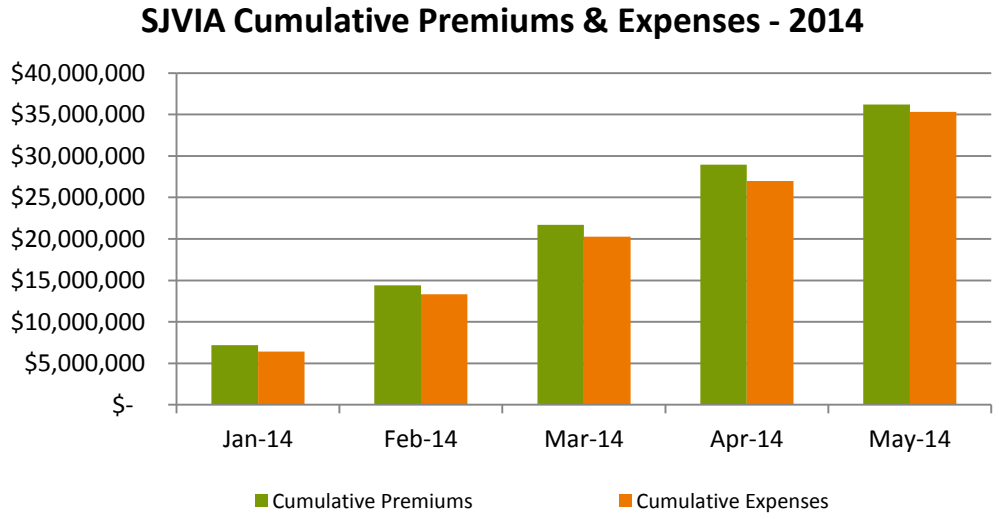


2014 Premium Breakdown - All Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
Fixed Costs	$ 719,083	$ 721,157	$ 726,947	$ 729,268	$ 708,624	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,605,079
Capitated Claims	$1,410,719	$1,411,801	$1,424,242	$1,423,431	$ 1,419,374	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,089,567
Variable Claims	$4,288,528	$4,788,239	$4,761,438	$4,596,484	$ 6,199,691	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$24,634,381
Reserves	$ 766,642	$ 302,799	$ 356,912	$ 540,530	$(1,092,088)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 874,795
Total	**$7,184,973**	**$7,223,996**	**$7,269,539**	**$7,289,713**	**$ 7,235,601**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$36,203,822**

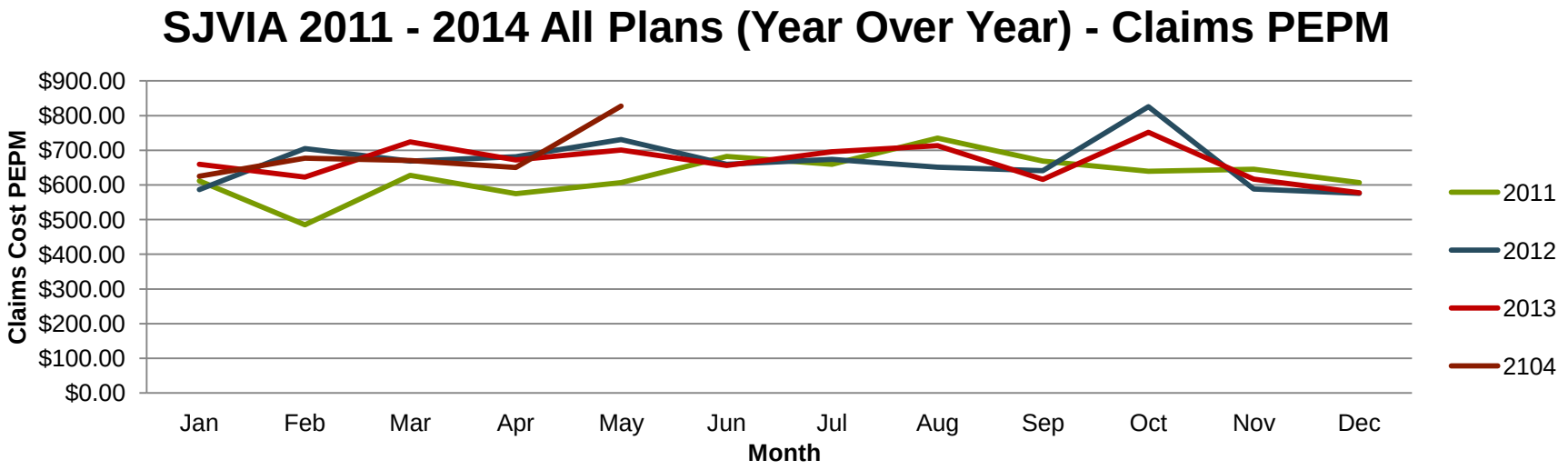
2013 Premium Breakdown - All Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
Fixed Costs	$ 583,834	$ 586,580	$ 587,395	$ 588,830	$ 571,851	$ 590,070	$ 600,266	$ 599,320	$ 598,739	$ 597,696	$ 597,801	$ 598,073	$ 7,100,456
Capitated Claims	$1,282,850	$1,290,885	$1,298,101	$1,305,832	$ 1,297,722	$1,311,837	$1,321,827	$ 1,318,659	$1,321,540	$ 1,317,492	$1,317,159	$1,321,465	$15,705,371
Variable Claims	$4,405,587	$4,100,037	$4,977,785	$4,528,889	$ 4,764,080	$4,401,965	$5,173,542	$ 5,333,286	$4,410,735	$ 5,671,241	$4,409,107	$4,007,898	$56,184,152
Reserves	$ 148,703	$ 468,101	$ (408,902)	$ 28,446	$ (199,305)	$ 172,246	$ (431,708)	$ (590,151)	$ 271,269	$(1,003,337)	$ 249,080	$ 653,418	$ (642,140)
Total	**$6,420,974**	**$6,445,603**	**$6,454,378**	**$6,451,998**	**$ 6,434,347**	**$6,476,118**	**$6,663,927**	**$ 6,661,115**	**$6,602,284**	**$ 6,583,092**	**$6,573,148**	**$6,580,855**	**$78,347,839**

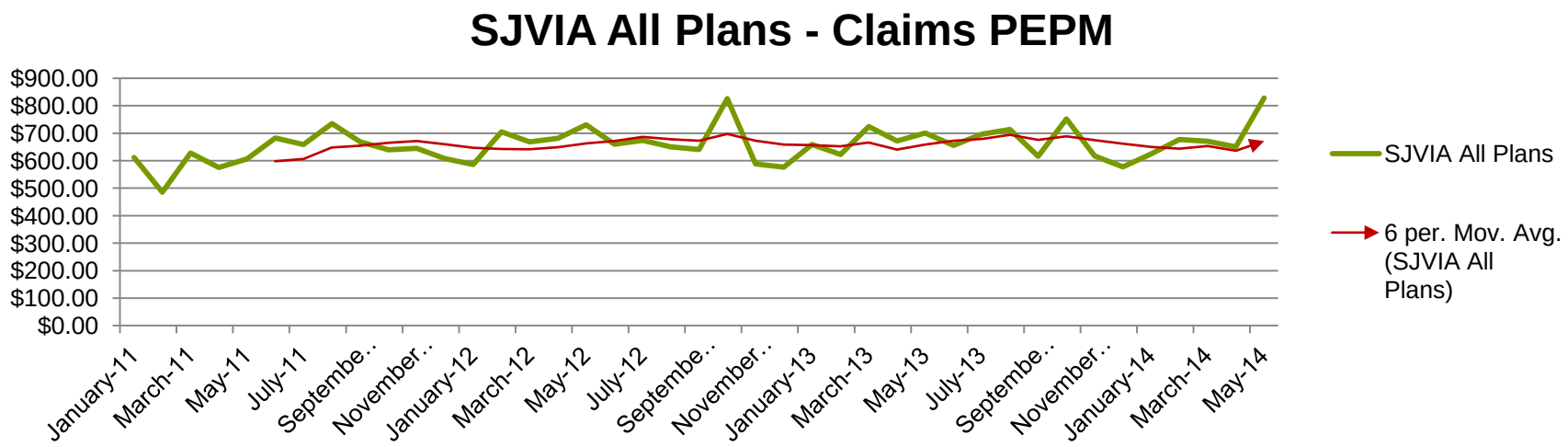
All Plans





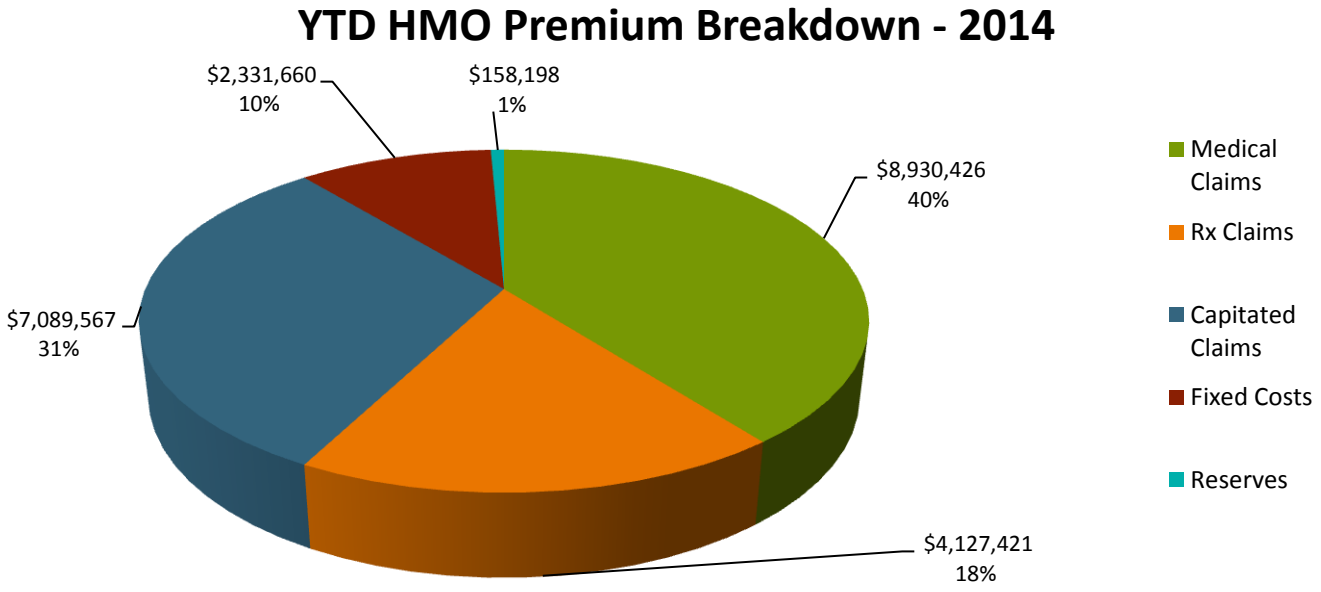
All Plans





HMO PLAN

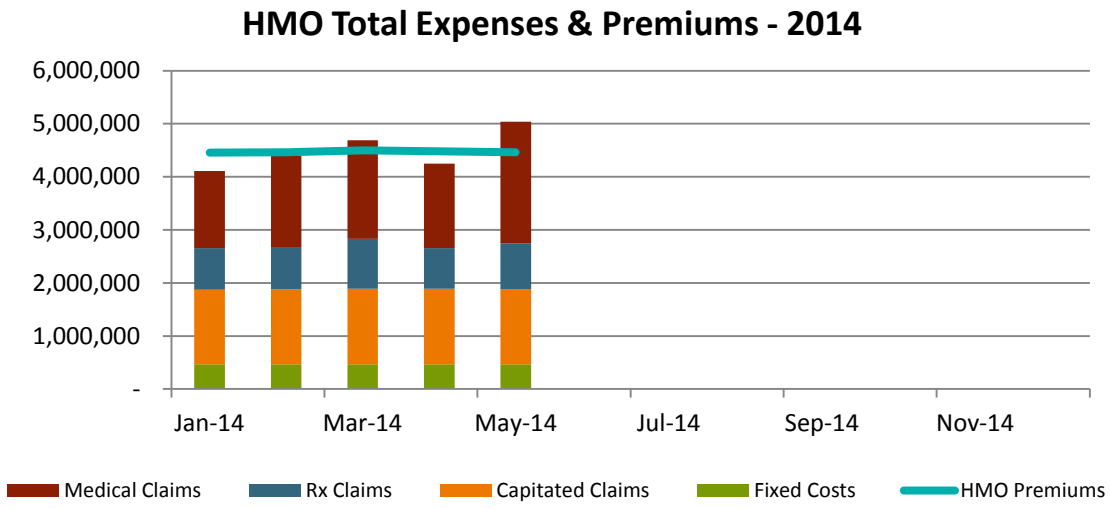
HMO Plan

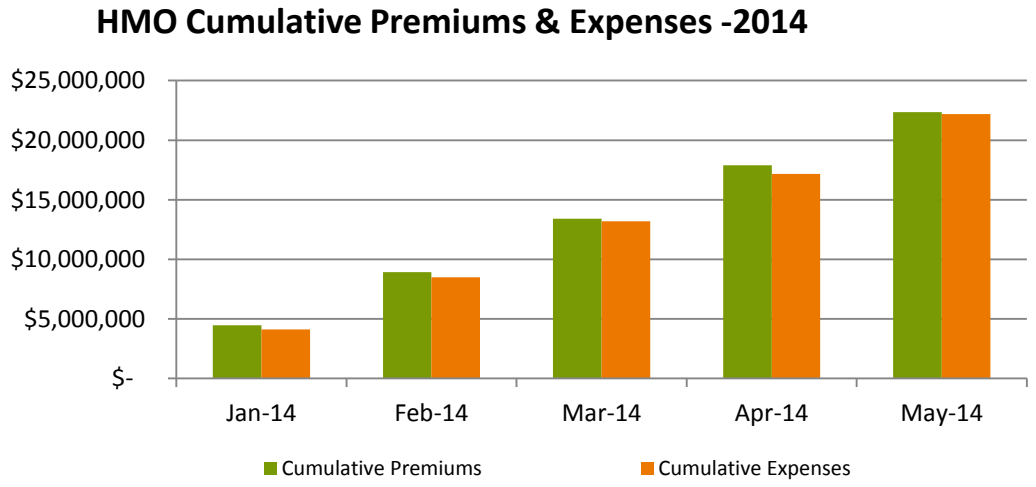


2014 Premium Breakdown - HMO	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
Fixed Costs	$ 463,958	$ 464,335	$ 468,422	$ 468,134	$ 466,811	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,331,660
Capitated Claims	$1,410,719	$1,411,801	$1,424,242	$1,423,431	$ 1,419,374	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,089,567
Medical Claims	$1,453,837	$1,730,599	$1,861,318	$1,594,709	$ 2,289,963	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,930,426
Rx Claims	$ 782,651	$ 783,486	$ 936,204	$ 764,169	$ 860,911	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,127,421
Reserves	$ 346,519	$ 69,204	$ (190,488)	$ 510,597	$ (577,634)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 158,198
Total	**$4,457,684**	**$4,459,425**	**$4,499,698**	**$4,761,040**	**$ 4,459,425**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$22,637,272**

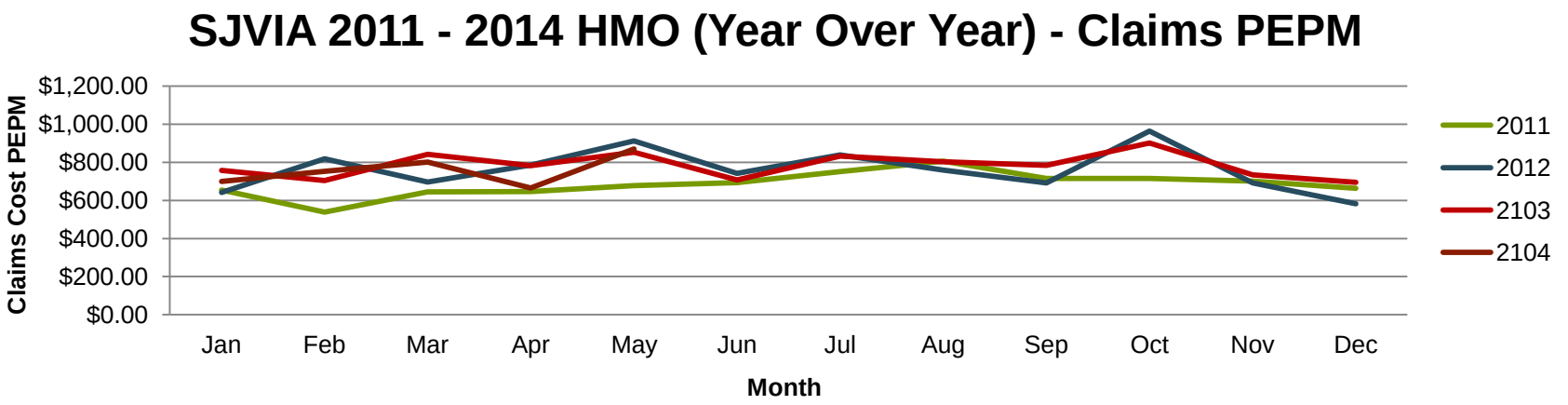
2013 Premium Breakdown - HMO	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
Fixed Costs	$ 377,213	$ 379,829	$ 381,908	$ 384,137	$ 381,549	$ 384,799	$ 386,766	$ 385,862	$ 386,775	$ 385,639	$ 385,905	$ 386,884	$ 4,607,267
Capitated Claims	$1,282,850	$1,290,885	$1,298,101	$1,305,832	$ 1,297,722	$1,311,837	$1,321,827	$ 1,318,659	$1,321,540	$ 1,317,492	$1,317,159	$ 1,321,465	$15,705,371
Medical Claims	$1,758,813	$1,553,541	$2,201,042	$1,884,434	$ 2,236,723	$1,588,607	$2,184,670	$ 2,006,960	$1,907,913	$ 2,557,500	$1,744,290	$ 1,529,322	$23,153,816
Rx Claims	$ 713,502	$ 664,853	$ 721,627	$ 757,054	$ 741,845	$ 683,590	$ 742,765	$ 758,755	$ 766,216	$ 706,425	$ 665,364	$ 692,614	$ 8,614,610
Reserves	$ (113,573)	$ 153,590	$ (542,626)	$ (261,435)	$ (604,013)	$ 126,718	$ (512,265)	$ (354,353)	$ (262,372)	$ (861,614)	$ (13,160)	$ 181,196	$ (3,063,907)
Total	**$4,018,805**	**$4,042,699**	**$4,060,052**	**$4,070,023**	**$ 4,053,826**	**$4,095,550**	**$4,123,763**	**$ 4,115,884**	**$4,120,072**	**$ 4,105,442**	**$4,099,559**	**$ 4,111,482**	**$49,017,156**

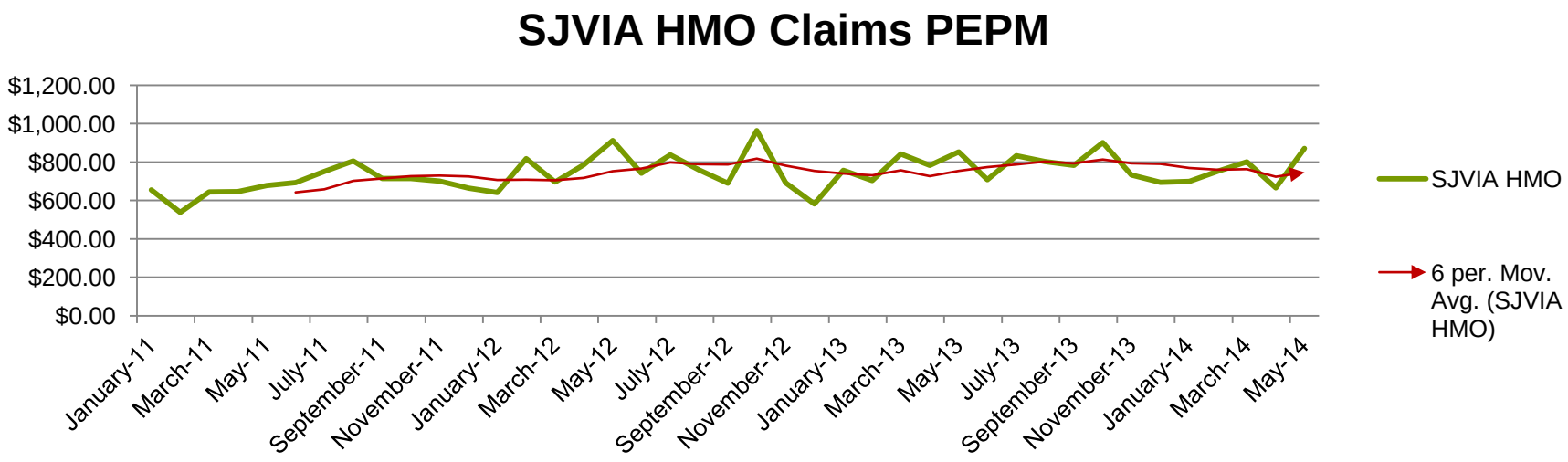
HMO Plan





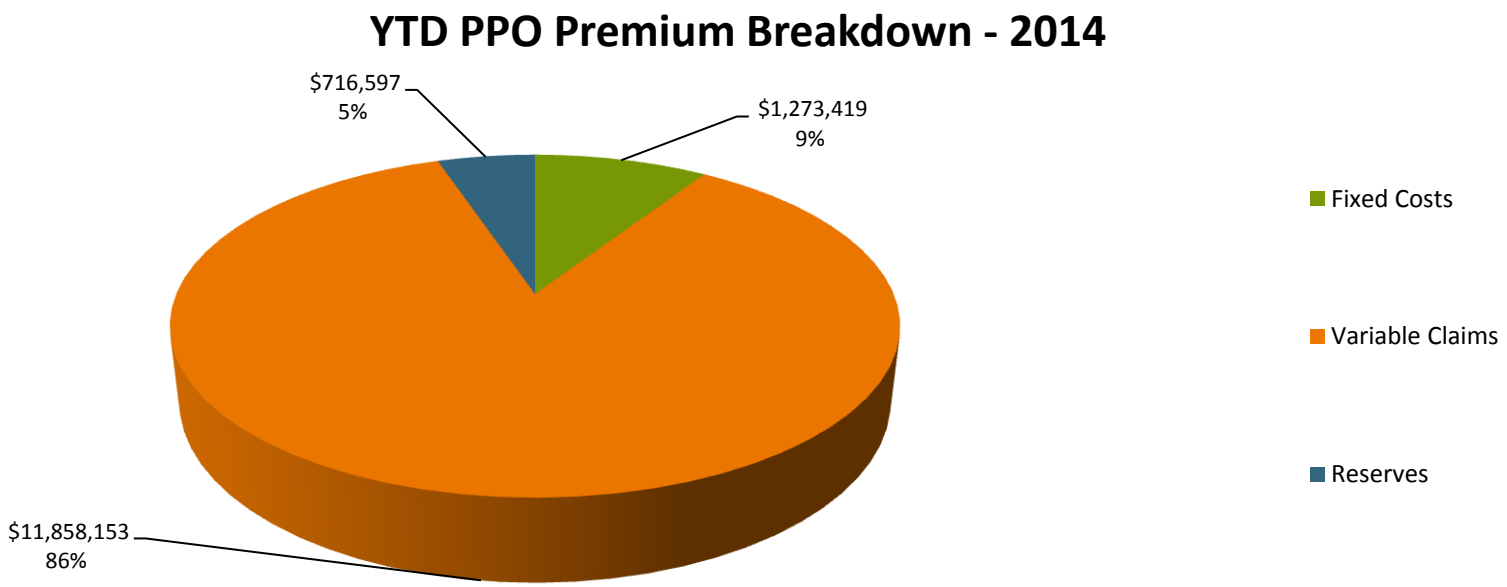
HMO Plan





PPO PLANS

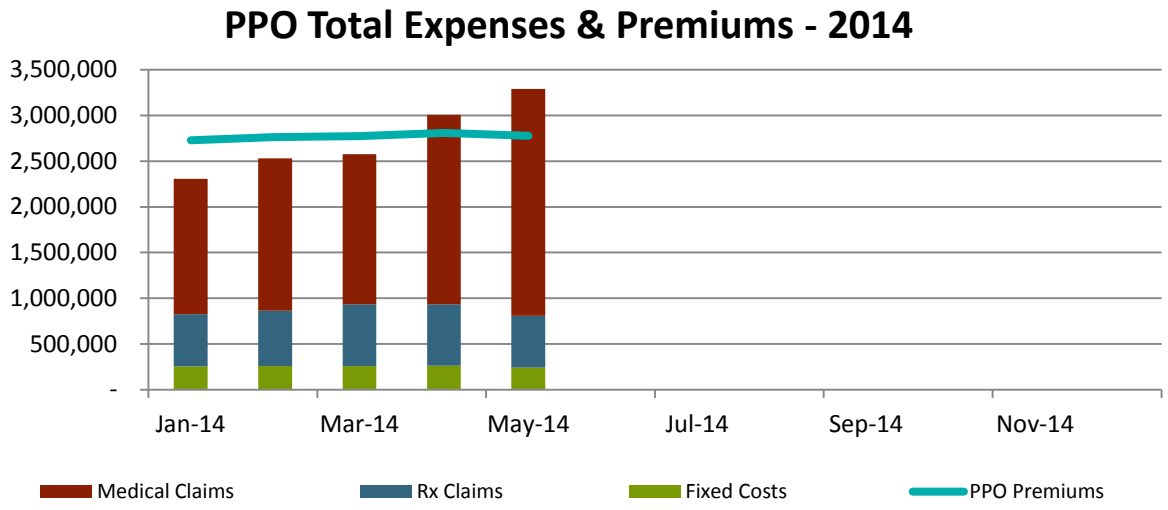
PPO Plans

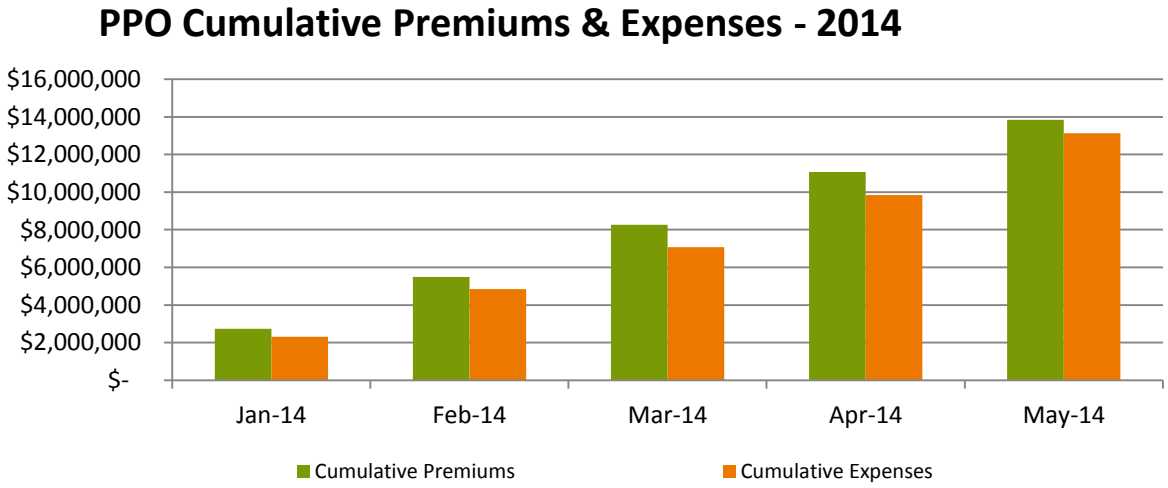


2014 Premium Breakdown - PPO	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
Fixed Costs	$ 255,125	$ 256,822	$ 258,525	$ 261,134	$ 241,813	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,273,419
Variable Claims	$ 2,052,040	$ 2,274,155	$ 1,966,737	$ 2,516,404	$ 3,048,817	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,858,153
Reserves	$ 420,124	$ 233,594	$ 547,400	$ 29,933	$ (514,454)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 716,597
Total	**$ 2,727,289**	**$ 2,764,571**	**$ 2,772,662**	**$ 2,807,471**	**$ 2,776,176**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 13,848,169**

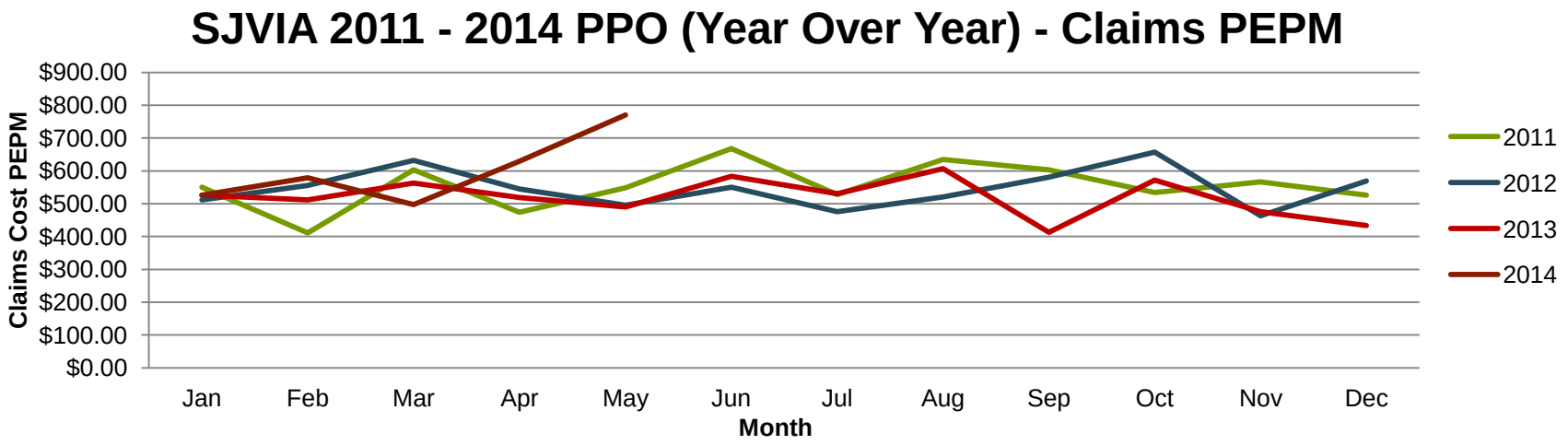
2013 Premium Breakdown - PPO	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
Fixed Costs	$ 206,621	$ 206,752	$ 205,486	$ 204,694	$ 190,302	$ 205,271	$ 213,500	$ 213,458	$ 211,964	$ 212,057	$ 211,896	$ 211,189	$ 2,493,189
Variable Claims	$ 1,933,272	$ 1,881,643	$ 2,055,116	$ 1,887,401	$ 1,785,512	$ 2,129,769	$ 2,246,107	$ 2,567,571	$ 1,736,607	$ 2,407,316	$ 1,999,453	$ 1,785,962	$ 24,415,727
Reserves	$ 262,276	$ 314,510	$ 133,725	$ 289,881	$ 404,708	$ 45,528	$ 80,557	$ (235,798)	$ 533,641	$ (141,723)	$ 262,240	$ 472,222	$ 2,421,768
Total	**$ 2,402,169**	**$ 2,402,904**	**$ 2,394,326**	**$ 2,381,975**	**$ 2,380,522**	**$ 2,380,568**	**$ 2,540,165**	**$ 2,545,231**	**$ 2,482,212**	**$ 2,477,650**	**$ 2,473,589**	**$ 2,469,373**	**$ 29,330,683**

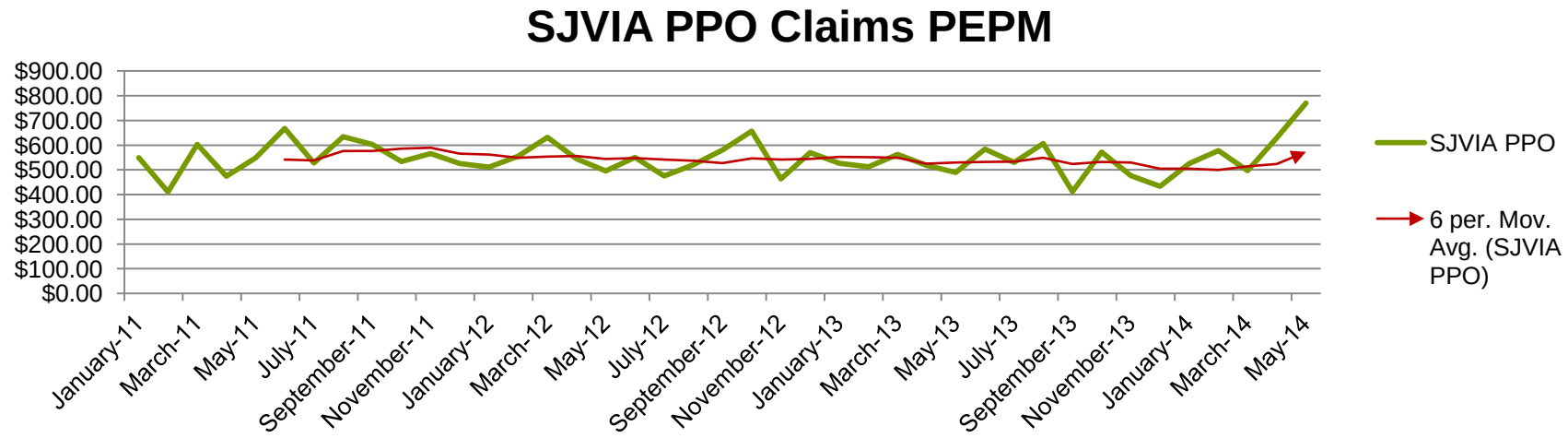
PPO Plans





PPO Plans – PEPM





MONTHLY DATA

All Plans Combined

2014 SJVIA Enrollment - All Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
- Employee Only	5,341	5,324	5,386	5,422	5,412	0	0	0	0	0	0	0	26,885
- Employee + Spouse	1,058	1,062	1,070	1,068	1,050	0	0	0	0	0	0	0	5,308
- Employee + Child(ren)	1,579	1,594	1,609	1,612	1,595	0	0	0	0	0	0	0	7,989
- Employee + Family	1,142	1,170	1,157	1,157	1,149	0	0	0	0	0	0	0	5,775
SJVIA Total Enrollment	**9,120**	**9,150**	**9,222**	**9,259**	**9,206**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	45,957
SJVIA Total Premiums	**$7,184,973**	**$7,223,996**	**$7,269,539**	**$7,289,713**	**$ 7,235,601**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$36,203,822**
SJVIA Premiums PEPM	$ 787.83	$ 789.51	$ 788.28	$ 787.31	$ 785.97								$ 787.78
SJVIA Total Claims	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**YTD Totals**
- Medical Claims	$2,934,309	$3,399,334	$3,505,706	$3,667,851	$ 4,774,159	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$18,281,360
- Rx Claims	$1,354,219	$1,388,905	$1,611,019	$1,435,538	$ 1,425,532	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,215,213
- Rx Rebates	$ -	$ -	$ -	$ (506,905)	$ -								$ (506,905)
- Stop-Loss Refunds	$ -	$ -	$ (355,287)	$ -	$ -							$ -	$ (355,287)
- Capitated Claims (HMO)	$1,410,719	$1,411,801	$1,424,242	$1,423,431	$ 1,419,374	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,089,567
SJVIA Total Claims	**$5,699,247**	**$6,200,041**	**$6,185,680**	**$6,019,915**	**$ 7,619,065**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$31,723,948**
SJVIA Claims PEPM	$ 624.92	$ 677.60	$ 670.75	$ 650.17	$ 827.62								$ 690.30
SJVIA Fixed Costs	**$ 719,083**	**$ 721,157**	**$ 726,947**	**$ 729,268**	**$ 708,624**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 3,605,079**
SJVIA Total Costs	**$6,418,330**	**$6,921,198**	**$6,912,627**	**$6,749,183**	**$ 8,327,689**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$35,329,027**
SJVIA Cost PEPM	$ 703.76	$ 756.42	$ 749.58	$ 728.93	$ 904.59								$ 768.74
SJVIA Total Reserve - Increase/(Decrease)	**$ 766,642**	**$ 302,799**	**$ 356,912**	**$ 540,530**	**$(1,092,088)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 874,795**
Reserve % of Non Cap. Claims	**17.9%**	**6.3%**	**7.5%**	**10.6%**	**-17.6%**								**3.5%**

HMO Plan

2014 HMO Enrollment	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
- Employee Only	2,402	2,406	2,426	2,446	2,461								12,141
- Employee + Spouse	640	638	648	639	629								3,194
- Employee + Child(ren)	1,435	1,434	1,452	1,448	1,432								7,201
- Employee + Family	739	742	740	730	726								3,677
HMO Total Enroll.	**5,216**	**5,220**	**5,266**	**5,263**	**5,248**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**26,213**
HMO Premiums	**4,457,684**	**4,459,425**	**4,496,877**	**4,482,242**	**4,459,425**								**$ 22,355,653**
HMO Premiums PEPM	$ 854.62	$ 854.30	$ 853.95	$ 851.65	$ 849.74								$ 852.85
HMO Claims	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**YTD Totals**
- Medical Claims	1,453,837	1,730,599	1,861,318	1,594,709	2,289,963								$ 8,930,426
- Rx Claims	782,651	783,486	936,204	764,169	860,911								$ 4,127,421
- Rx Rebates				(278,798)									$ (278,798)
- Capitated Claims	1,410,719	1,411,801	1,424,242	1,423,431	1,419,374								$ 7,089,567
Pooling Reimbursements			$ (2,821)										$ (2,821)
HMO Total Claims	**$ 3,647,207**	**$ 3,925,886**	**$ 4,218,943**	**$ 3,503,511**	**$ 4,570,248**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 19,865,795**
HMO Claims PEPM	$ 699.23	$ 752.09	$ 801.17	$ 665.69	$ 870.86								$ 757.86
HMO Fixed Costs	**463,958**	**464,335**	**468,422**	**468,134**	**466,811**								**$ 2,331,660**
HMO Total Costs	**$ 4,111,165**	**$ 4,390,221**	**$ 4,687,365**	**$ 3,971,645**	**$ 5,037,059**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 22,197,455**
HMO Costs PEPM	$ 788.18	$ 841.04	$ 890.12	$ 754.64	$ 959.81								$ 846.81
HMO Plan Reserve - Increase/(Decrease)	**$ 346,519**	**$ 69,204**	**$ (190,488)**	**$ 510,597**	**$ (577,634)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 158,198**
Reserve % of Non Cap. Claims	**15.5%**	**2.8%**	**-6.8%**	**21.6%**	**-18.3%**								**1.2%**

PPO Plans

2014 PPO Enrollment - All Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
- Employee Only	2,939	2,918	2,960	2,976	2,951								14,744
- Employee + Spouse	418	424	422	429	421								2,114
- Employee + Child(ren)	144	160	157	164	163								788
- Employee + Family	403	428	417	427	423								2,098
PPO Plans Total Enrollment	**3,904**	**3,930**	**3,956**	**3,996**	**3,958**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**19,744**
PPO Plans Total Premiums	**2,727,289**	**2,764,571**	**2,772,662**	**2,807,471**	**2,776,176**								**$ 13,848,169**
PPO Premiums PEPM	$ 698.59	$ 703.45	$ 700.88	$ 702.57	$ 701.41								$ 701.39
PPO Plans Total Claims	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**YTD Totals**
- Medical Claims	1,480,472	1,668,736	1,644,388	2,073,142	2,484,196								$ 9,350,934
- Rx Claims	571,568	605,419	674,815	671,369	564,621								$ 3,087,792
- Rx Rebates				(228,107)									$ (228,107)
- Stop-Loss Refunds			$ (352,466)										$ (352,466)
PPO Plans Net Claims	**$ 2,052,040**	**$ 2,274,155**	**$ 1,966,737**	**$ 2,516,404**	**$ 3,048,817**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 11,858,153**
PPO Plans Claims PEPM	$ 525.63	$ 578.67	$ 497.15	$ 629.73	$ 770.29								$ 600.60
PPO Plans Fixed Costs	**255,125**	**256,822**	**258,525**	**261,134**	**241,813**								**$ 1,273,419**
PPO Plans Total Costs	**$ 2,307,165**	**$ 2,530,977**	**$ 2,225,262**	**$ 2,777,538**	**$ 3,290,630**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 13,131,572**
PPO Plans Cost PEPM	$ 590.97	$ 644.01	$ 562.50	$ 695.08	$ 831.39								$ 665.09
PPO Plans Total Reserve - Increase/(Decrease)	**$ 420,124**	**$ 233,594**	**$ 547,400**	**$ 29,933**	**$ (514,454)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 716,597**
Reserve % of Net Claims	**20.5%**	**10.3%**	**27.8%**	**1.2%**	**-16.9%**								**6.0%**

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.

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employees' Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93291
July 25, 2014 9:00 AM

AGENDA DATE: July 25, 2014

ITEM NUMBER: 11

SUBJECT: Approve Recommended Annual Out-of-Pocket Maximum Change as Required by the Affordable Care Act Effective January 1, 2015

REQUEST(S): That the Board approve the recommended Annual Out-of-Pocket Maximum Change as required by the Affordable Care Act Effective January 1, 2015

DESCRIPTION:

As part of the renewal underwriting process, any changes to the health plan necessitated by regulation or cost are evaluated by SJVIA staff in cooperation with the Gallagher consulting team. As part of this year's renewal for January 1, 2015, member cost share provisions for all essential health benefits cannot exceed the maximum out-of-pocket amount set by the Affordable Care Act (ACA). For the SJVIA, effective January 1, 2015 this will now include all copay amounts for both medical and prescription, which do not currently credit to the maximum out-of-pocket limit on the traditional PPO and HMO plan options. This change does not apply to the three high deductible PPO plan options offered through the Anthem program as all medical and prescription costs are subject to the deductible and out-of-pocket maximum amounts.

This change will most impact the prescription benefit plans administered by US Script as the member copay amounts are not tracked by Anthem Blue Cross, therefore creating a need to amend the plan to comply with this requirement. There are several ways this requirement can be met:

1. Move all prescription administration from the current US Script contract to Anthem Blue Cross.
2. Establish data sharing for member copay amounts between US Script and Anthem Blue Cross for additional administrative costs to the SJVIA.
3. Implement a separate maximum out-of-pocket for the medical and pharmacy benefits for the traditional PPO and HMO plans.

Currently, the SJVIA plans that have the prescription benefit managed by US Script have benefit amounts as follows:

	HMO	PPO $0	PPO $250	PPO $500	PPO $1000
Benefits:	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
DEDUCTIBLE					
Per Individual	$0	$0	$250	$500	$1,000
Per Family	$0	$0	$500	$1,000	$2,000
OUT OF POCKET MAX					
Per Individual	$1,000	$2,000	$3,000	$3,000	$4,000
Per Family	$2,000	$4,000	$5,000	$6,000	$8,000
PHYSICIAN SERVICES					
Office Visits	$45	$35	$15	$20	$20
PRESCRIPTON DRUG					
Generic	$10	$10	$10	$10	$10
Brand	$20	$20	$20	$20	$20
Non-Formulary	$35	$35	$35	$35	$35

The maximum allowed out-of pocket limitations set by the ACA for 2015 are $6,600 for an individual and $13,200 for a family. The SJVIA plans can remain compliant by setting a separate out-of-pocket maximum for each of these plans up to an amount that when added to the medical maximum does not exceed the limitations of the ACA maximums. Given the structure of the current medical plans, a $2,000 individual and $4,000 family out-of-pocket maximum could be set for the prescription plans. According to US Script data, during the last plan year, the majority (86%) of those that used the prescription benefit had a total out-of-pocket cost of under $500, while only 3 members incurred over $3,000 in employee expenses. While this new requirement would add a level of benefit to those very high utilizers of the plan that would cap their prescription copay expenses for the year, it will not have any impact to the underwriting of the plan.

Staff's recommendation for the SJVIA health plan benefits to comply with this ACA requirement would be to implement a separate out-of-pocket maximum for the prescription plans at $2,000 for an individual and $4,000 for a family unit.

AGENDA: San Joaquin Valley Insurance Authority

DATE: July 25, 2014

FISCAL IMPACT/FINANCING:

None at this time.

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Approve Recommended Annual Out-of-Pocket Maximum Change as Required by the Affordable Care Act Effective January 1, 2015

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 the recommended Annual Out-of-Pocket Maximum Change as required by the Affordable Care Act effective January 1, 2015

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employees' Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93291
July 25, 2014 9:00 AM

AGENDA DATE: July 25, 2014

ITEM NUMBER: 12

SUBJECT: Receive and File Updated Anthem HMO Administrative Fees Effective July 1, 2014

REQUEST(S): That the Board Receive and File updated Anthem HMO Administrative Fees effective July 1, 2014

DESCRIPTION:

As part of the January 1, 2014 renewal process, your Board approved the fixed costs components of the Anthem HMO plan which included fees required by the Affordable Care Act (ACA).

For the HMO plan, there were three fees required to be paid to the IRS as a fully insured plan through Anthem Blue Cross. Those fees were as follows:

- ACA Reinsurance: $11.37 PEPM
- ACA Insurer: $22.22 PEPM
- ACA PCORI: $.36 PEPM

Of these fees, the Reinsurance and PCORI fee apply to all medical plans, whether fully insured or self funded. The ACA Insurer fee is a tax that is only imposed on plans that are considered fully insured. These fees were paid to Anthem who then submitted them to the IRS on behalf of the SJVIA for the HMO plan.

AGENDA: San Joaquin Valley Insurance Authority

DATE: July 25, 2014

In June, the SJVIA was notified that the Minimum Premium HMO plan with Anthem had been re-categorized as an "alternatively funded" plan and thus not subject to the requirement to pay the ACA Insurer fee of $22.22 PEPM. Also, even though the Reinsurance and the PCORI fee would still apply and be payable to the IRS, it would not need to be remitted to Anthem but retained by the SJVIA until payable. This change has resulted in revised fixed costs invoiced to the SJVIA from Anthem effective July 1, 2014 as follows:

Policy Year 1/1/2014 - 1/1/2015	*(Current Rates)*	*(The rates with the ACA Insurer, Reinsurance fees and PCORI removed)*
Effective Date	**1/1/2014**	**7/1/2014**
MPP - Premium Rate Components (by LOC)	PCPM	PCPM
901 - Admin Fee	$69.47	$35.52
910 - Capitation Revenue	$270.46	$270.46
913 - 360 Health	$3.38	$3.38
984 - $400K Stop Loss Charge	$22.72	$22.72
Total	**$366.03**	**$332.08**
Admin Fee Components		
General Office & Admin	$35.52	$35.52
ACA - Reinsurance	$11.37	$0.00
ACA Insurer	$22.22	$0.00
ACA - PCORI	$0.36	$0.00
Admin Fee Total	$69.47	$35.52
Retention changes from Prior period		
General Office & Admin		-> no change
ACA - Reinsurance		-> removed
ACA Insurer		-> removed
ACA - PCORI		-> removed
Admin Fee Total		-48.87%

This represents a significant change in administrative fees and an estimated savings to the SJVIA of $1.3 million. Prior to this notification, estimated fees allocated for the HMO plan due to ACA requirements were approximately $2,065,000. The total ACA fees for the HMO plan is now approximately $713,000.

AGENDA: San Joaquin Valley Insurance Authority

DATE: July 25, 2014

FISCAL IMPACT/FINANCING:

Refund approximating $1.3 million to be received from Anthem Blue Cross in addition in PEPM fixed costs from $366.03 to $332.08.

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Receive and File Updated Anthem HMO Administrative Fees Effective July 1, 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 received and filed updated Anthem HMO Administrative fees effective July 1, 2014

Meeting Location:
Tulare County Employees' Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93291
July 25, 2014 9:00 AM

AGENDA DATE: July 25, 2014

ITEM NUMBER: 13

SUBJECT: Receive and File Update Regarding US Script Guaranteed Pricing

REQUEST(S): That the Board Receive and File an update regarding US Script guaranteed pricing

DESCRIPTION:

As the Pharmacy Benefit Manager (PBM) for the SJVIA, US Script guarantees that on an annual basis, the total amount paid to US Script by the SJVIA for all Covered Pharmacy Services (including dispensing fees) by all Network Pharmacies to all Covered Persons in the aggregate shall not exceed: (i) the sum of the Average Wholesale Price (AWP) for each Covered Pharmacy Service dispensed by Network Pharmacies to Covered Persons during the same period less the applicable Discount for such Covered Pharmacy Service; and (ii) the Retail dispensing fee multiplied by the total number of paid applicable paid Claims for Covered Persons during the same period (the "Annual Guarantee Amount").

US Script routinely reconciles pass-through cost outcomes to Annual Guaranteed Amounts. In the event that the total amount paid to US Script by the SJVIA for all Covered Pharmacy Services (including dispensing fees) exceeds the Annual Guaranteed Amount as calculated by US Script for that year, then US Script shall pay the SJVIA the difference between such total amount paid to US Script by Client and the Annual Guaranteed Amount. This

reimbursement will be paid within ninety (90) days of the close of the measured year.

Per the contract, US Script performed the annual reconciliation to determine how actual, passed-through costs compared to what was contracted. To calculate the amount due to SJVIA, if any, US Script aggregated SJVIA claims for the period, based on the dispensing channel, and compared actual discounts to guaranteed discounts. US Script then subtracted the amounts actually paid from what US Script guaranteed. The results follow:

Client: SJVIA		
Litigation (Settlement Basis): Post AWP		
Contract Period: Ending 12/31/2013		
	Contracted AWP%	Due To (From)
Retail 30 Brand	15.0%	39,470.61
Retail 30 Generic	74.0%	(94,726.90)
Retail 90 Generic	23.0%	189,497.12
Retail 90 Generic	74.0%	259,347.89
Mail Order Generic	23.0%	3,853.46
Mail Order Generic	75.0%	(58.39)
Dispense Fees	$ 1.30	67,577.64
Total		464,961.43

FISCAL IMPACT/FINANCING:

Refund of $464,961.43 received.

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Receive and File Update Regarding US Script Guaranteed Pricing

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 an update regarding US Script Guaranteed Pricing

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employees' Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93291
July 25, 2014 9:00 AM

AGENDA DATE: July 25, 2014

ITEM NUMBER: 14

SUBJECT: Approve the Participation Agreement Amendments for Non-founding Entities

REQUEST(S): That the Board approve the Participation Agreement Amendments for non-founding entities

DESCRIPTION:

Each entity that participates in the SJVIA's program offerings currently executes a Participation Agreement with the SJVIA. Participating Entities may participate in a variety of SJVIA programs including medical HMO and/or PPO options through Anthem Blue Cross, Blue Shield, and Kaiser; dental options through Delta Dental of California; and vision options through Vision Service Plan (VSP). The current Participation Agreement that is signed by non-founding entities is for a minimum term of 3 years, which is their required commitment to the SJVIA. This agreement includes exhibits that cover the programs the entity has chosen and the benefits and rates that apply to those programs.

Each year at renewal, all SJVIA plans are reviewed and underwritten to cover anticipated costs for the upcoming plan year. Also at renewal, all participating entities have the opportunity to elect or opt out of ancillary programs, which, along with rate changes, create the need to amend the exhibits that accompany their respective participation agreements. As part of the January 1, 2014 renewal process and with the addition of multiple new entities, it became apparent that the current participation agreement and process needs to be revised to account for changes in rates and programs for each entity.

AGENDA: San Joaquin Valley Insurance Authority

DATE: July 25, 2014

On April 25, 2014 your Board approved Staff's request to draft an amendment to the agreement for entities currently participating in programs under the SJVIA with standing participation agreements that have since added plans and/or had rate revisions.

Staff is requesting that the Board approve the Participation Agreement Amendments for City of Tulare, City of Ceres and City of Shafter.

FISCAL IMPACT/FINANCING:

None.

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Approve the Revisions to the Participation Agreement for Non-founding Entities

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 the recommended revisions to the Participation Agreement for non-founding entities

AMENDMENT 1 TO SJVIA PARTICIPATION AGREEMENT

This Amendment 1 to the SJVIA Participation Agreement (Amendment 1) is effective July 1, 2014, and is between the City of Shafter, a municipal corporation (CITY OF SHAFTER), and the San Joaquin Valley Insurance Authority, a joint powers agency (SJVIA).

The parties previously entered into an agreement dated July 1, 2013, and titled "SJVIA PARTICIPATION AGREEMENT" (Agreement), to allow CITY OF SHAFTER to participate in certain insurance programs through SJVIA.

The parties now desire to amend the Agreement to revise the insurance programs available to CITY OF SHAFTER through SJVIA, and the rates for benefits under those programs.

The parties therefore agree as follows:

1. The Agreement is amended, effective July 1, 2014, as follows:

    a. The Exhibit A that is attached to this Amendment 1 replaces and supersedes any and all documents previously identified as Exhibit A to the Agreement.

    b. The Exhibit B that is attached to this Amendment 1 replaces and supersedes any and all documents previously identified as Exhibit B to the Agreement.

2. Except as modified by this Amendment 1, the Agreement remains in full force and effect.

The parties are signing this agreement on the date first written above.

SAN JOAQUIN VALLEY INSURANCE AUTHORITY

By _____
Deborah Poochigian
SJVIA Board President

Date: _____

REVIEWED & RECOMMENDED FOR APPROVAL

By _____
Paul Nerland
SJVIA Manager

CITY OF SHAFTER

By _____
Scott Hurlbert
City Manager

Date: _____

ATTEST:

By _____

APPROVED AS TO LEGAL FORM:

By _____

Anthem Blue Cross

San Joaquin Valley Insurance Authority Modified Premier PPO (250/20/100/50)

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This proposed benefit summary is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care.

In addition to dollar and percentage copays, members are responsible for deductibles, as described below.

Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Maximum Allowed Amount

Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.

PPO Providers—The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.

Non-PPO Providers—For non-emergency care, reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. Members are responsible for the difference between the provider's usual charges & the maximum allowed amount.

For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Benefit year deductible for all providers	$250/member maximum of two separate deductibles/family
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	$500/admission *(waived for emergency admission)*
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	$500/admission *(waived for emergency admission)*
Deductible for emergency room services	$100/visit *(waived if admitted directly from ER)*
Annual Out-of-Pocket Maximums	
PPO Providers & Other Health Care Providers	$3,000/member/year; $5,000/family/year
Non-PPO Providers	$10,000/member/year; $15,000/family/year

The following do not apply to out-of-pocket maximums: deductibles listed above; dollar copays; non-covered expense. After a member reaches the out-of-pocket maximum, the member no longer pays percentage copays for the remainder of the year. However, member remains responsible for dollar copays; and for non-PPO providers & other health care providers, costs in excess of the covered expense.

Lifetime Maximum	Unlimited	
Covered Services	**PPO: Per Member Copay**	**Non-PPO: Per Member Copay**
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	No copay	50%[1]
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	No copay	50%[1]
Hospice Care		
➢ Inpatient or outpatient services ; family bereavement services	No copay[2]	
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to 100 visits/benefit year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	No copay	50%

[1] For California facilities, a discount will be applied if the facility has a contract with Anthem Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher costs for members.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Home Infusion Therapy *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	No copay	50% *(benefit limited to $600/day)*
Physician Medical Services		
➢ Office & home visits	$20/visit[1] *(deductible waived)*	50%
➢ Hospital & skilled nursing facility visits	No copay	50%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	No copay	50%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	No copay	50%
➢ Other diagnostic x-ray & lab	No copay	50%
Preventive Care services		
Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.		
➢ Routine physical examinations *(birth through age six)*	No copay/exam *(deductible waived)*	50% *(benefit limited to $20/exam)*
➢ Immunizations *(birth through age six)*	No copay *(deductible waived)*	50% *(benefit limited to $12/immunization)*
➢ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam *(members 7 years old and older)*	No copay/exam *(deductible waived)*	50%
➢ Adult preventive services *(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings)*	No copay *(deductible waived)*	50% *(deductible waived)*
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(limited to 24 visits/benefit year; additional visits may be authorized)*	No copay	50% *(benefit limited to $25/visit)*
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	No copay	50%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to $30/visit & 12 visits/benefit year)*	No copay[2]	50%[2]
Pregnancy & Maternity Care		
➢ Physician office visits	$20/visit[1] *(deductible waived)*	50%
➢ Prescription drug for elective abortion *(mifepristone)*	No copay	50%
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	No copay	50%
➢ Hospital & ancillary services	No copay	50%[3]
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at Center of Expertise [COE])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	No copay	
➢ Transplant travel expense for an authorized, specified transplant at a *COE* *(recipient & companion transportation limited to 6trips/episode & $250/person/trip for round-trip coach airfare, 21 days/trip, other expenses limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days)*	No copay *(deductible waived)*	

[1] The dollar copay applies only to the visit itself. An additional No copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[2] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

[3] For California facilities, a discount will be applied if the facility has a contract with Anthem Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher costs for members.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	No copay	50%
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	No copay	
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest bariatric *COE (member's transportation to & from COE limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from COE limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*	No copay *(deductible waived)*	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$20/visit *(deductible waived)*	50%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for members with diabetes	No copay	50%
Durable Medical Equipment		
➢ Rental or purchase of DME including hearing aids, dialysis equipment & supplies *(hearing aids benefit is available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	No copay	50%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	No copay[1]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	No copay[1]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	No copay[1]	
Specialty Pharmacy Drugs *(utilization review may be required)*		
➢ Specialty pharmacy drugs filled through the specialty pharmacy program *(limited to 30-day supply; not covered if benefits are provided through prescription drug benefits, if applicable)*	No copay	Not covered[2]
If member does not get specialty pharmacy drugs from the specialty pharmacy program, member will not receive any specialty pharmacy drug benefits under this plan, unless the member qualifies for an exception as specified in the EOC.		

[1] These providers are not represented in the Anthem Blue Cross PPO network.

[2] No copay if member or non-PPO physician obtains drug from Specialty Pharmacy Program; otherwise, not covered.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	No copay	50% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/benefit year)*	No copay	50%
Emergency Care		
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	No copay	No copay
➢ Inpatient hospital services	No copay	No copay
➢ Physician services	No copay	No copay
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	30%[1]
➢ Inpatient physician visits	10%	30%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	30%[1]
➢ Outpatient physician visits *(Behavioral Health Treatment will be subject to pre-service review)*	$20/visit[2] *(deductible waived)*	30%

[1] For California facilities, a discount applies if the facility has a contract with Anthem Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for members.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Premier Plan Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Evidence of Coverage (EOC).

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.

Excess Amounts. Any amounts in excess of covered expense or the lifetime maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the insured person for free.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders and alcohol or drug dependence, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. Hearing aids and routine hearing tests, except as specified as covered in the EOC.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or infusion therapy provider, except as specified as covered in the EOC.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related feet complications , except as specified as covered in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Chronic Pain. Treatment of chronic pain, except as specified as covered in the EOC.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the EOC.

Acupuncture. Acupuncture treatment, as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. **Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.**

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Wigs.

Pre-Existing Condition Exclusion — No payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six months following either (a) member's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to a child born to or newly adopted by an enrolled subscriber or spouse/domestic partner, or to conditions of pregnancy. Also, if member was covered under creditable coverage, as outlined in the member's EOC, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

Third Party Liability — Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination Of Benefits — The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

SJVIA
San Joaquin Valley
Insurance Authority

USscript
Integrity. Innovation. Outcomes.

Prescription Drug Copays

30 Day Supply:		**Mail**	
Generic	$10	Generic	$20
Formulary	$20	Formulary	$40
Non-Formulary	$35	Non-Formulary	$60
Retail 90 Day Supply:		**Specialty Medication copays:**	
Generic	$20	30% ($100.00 max.)	
Formulary	$40	** Specialty medications are covered at a 30-day	
Non-Formulary	$60	supply only.**	

Exclusions

Hair Treatments
Pigmenting/Depigmenting
Anti-wrinkle
OTC Medications
Fertility Drugs
Miscellaneous Injectables

US Script Helpdesk: 1(866)264-4161

This is not a complete summary of benefits further limitations and exclusions may apply.

Your Summary of Benefits

Anthem Blue Cross

Custom Premier HMO 15

This Summary of Benefits is a brief overview of your plan's benefits only. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA), except services provided under the "ReadyAccess" program, OB/GYN services received within the member's medical group/IPA, and services for all mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Annual copay maximum: Individual $1,000; Family $2,000

The following copay does not apply to the annual copay maximum: for infertility services

Covered Services	Per Member Copay
Preventive Care Services	
Preventive Care Services including*, physical exams, preventive screenings *(including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing),* and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay
Smoking Cessation Program	No copay
Physician Medical Services	
• Office & home visits	$15/visit
• Specialists	$15/visit
• Skilled nursing facility visits	No copay
• Hospital visits	No copay
• Injectable medications in physician's office *(excluding allergy serum and immunization)*	20%/up to $150 maximum copay
• Surgeon & Surgical assistant	No copay
• Anesthesiologist or anesthetist	No copay
Acupuncture	$15/visit
Outpatient Medical Services (*Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital***)**	
• Outpatient surgery & supplies	No copay
• Advanced Imaging	No copay
• All other X-ray & laboratory tests (*including genetic testing*)	No copay
• Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	No copay
• Other Outpatient Medical Services including: Rehabilitation Therapy *(Physical, Occupational, or Speech Therapy, limited to a 60-day period of care)*	No copay
General Medical Services (*when performed in non-hospital-based facility***)**	
• Advanced Imaging	No copay
• All other X-ray & laboratory tests (*including genetic testing*)	No copay
• Allergy testing & treatment *(including serums)*	No copay
• Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	No copay
• Rehabilitation Therapy *(Physical, Occupational, or Speech Therapy or Chiropractic Care, limited to 60-days period of care)*	$15/visit
Emergency Care	
• Physician & medical services	No copay

CONTINUED ON NEXT PAGE

Covered Services	Per Member Copay
• Outpatient hospital emergency room services	$100/visit (*waived if admitted inpatient*)
Inpatient Medical Services Semi-private room or private room, medically necessary services & supplies	No copay
Urgent Care *(out of service area)*	$15/visit *(copay waived if admitted inpatient or outpatient ER. For in area, contact your PCP or medical group)*
Skilled Nursing Facility (*limited to 100 days/calendar year*) • All necessary services & supplies (*excluding take-home drugs*)	 No copay
Ambulance Services • Transportation when medically necessary	No copay
Ambulatory Surgical Center • Outpatient surgery & supplies	No copay
Pregnancy and Maternity Care Prenatal & postnatal Professional *(physician)* services *(For your Inpatient copay, see Inpatient Medical Services. For your Outpatient Services copay, see Outpatient Medical Services)* **Elective Abortions** *(including prescription drug for abortion, mifepristone)*	No copay $100
Prosthetic devices *(including Orthotics)*	No copay
Durable medical equipment • Rental and Purchase of DME *(hearing aids benefit available for one hearing aid per ear every three years;breast pump and supplies are covered under preventive care at no charge)*	No copay
Family Planning and Infertility Services • Infertility studies & tests, Including treatment • Female Sterilization *(including tubal ligation and counseling/consultation)* • Male Sterilization • Counseling & consultation	 $15/visit No copay $15/visit $15/visit
Mental or Nervous Disorders and Substance Abuse **Inpatient Care** • Facility-based care (*pre-authorization required*) • Physician hospital visits **Outpatient Care** • Facility-based care (*pre-authorization required*) • Outpatient physician visits *(Behavioral Health treatment will be subject to pre-service review)*	 No copay No copay No copay $15/visit
Home Health Care (*limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less*)	$15/visit
Hospice Care (*Inpatient or outpatient services; family bereavement services*)	No copay
Organ and Tissue Transplant • Inpatient Care • Physician office visits • Specialist office visits	 No copay $15/visit $15/visit

This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).

Premier HMO - Exclusions and Limitations

Care Not Approved. Care from a health care provider without the OK of primary care doctor, except for emergency services or urgent care.

Care Not Covered. Services before the member was on the plan, or after coverage ended.

Care Not Listed. Services not listed as being covered by this plan.

Care Not Needed. Any services or supplies that are not medically necessary.

Crime or Nuclear Energy. Any health problem caused: (1) while committing or trying to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) by nuclear energy, when the government can pay for treatment.

Experimental or Investigative. Any experimental or investigative procedure or medication.
But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may ask that the denial be reviewed by an external independent medical review organization, as described in the Evidence of Coverage (EOC).

Government Treatment. Any services the member actually received that were given by a local, state or federal government agency, except when this plan's benefits, must be provided by law.
We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services Given by Providers Who Are Not With Anthem Blue Cross HMO. We will not cover these services unless primary care doctor refers the member, except for emergencies or urgent care.

Services Not Needing Payment. Services the member is not required to pay for or are given to the member at no charge, except services the member got at a charitable research hospital (not with the government). This hospital must:1. Be known throughout the world as devoted to medical research.2. Have at least 10% of its yearly budget spent on research not directly related to patient care.3. Have 1/3 of its income from donations or grants (not gifts or payments for patient care).4. Accept patients who are not able to pay.5. Serve patients with conditions directly related to the hospital's research (at least 2/3 of their patients).

Work-Related. Care for health problems that are work-related if such health problems are or can be covered by workers' compensation, an employer's liability law, or a similar law. We will provide care for a work-related health problem, but, we have the right to be paid back for that care. See "Third Party Liability" below.

Acupressure. Acupressure, or massage to help pain, treat illness or promote health by putting pressure to one or more areas of the body.**Air Conditioners.** Air purifiers, air conditioners, or humidifiers.

Birth Control Devices. Any devices needed for birth control which can be obtained without a doctor's prescription such as condoms.

Blood. Benefits are not provided for the collection, processing and storage of self-donated blood unless it is specifically collected for a planned and covered surgical procedure.

Braces or Other Appliances or Services for straightening the teeth (orthodontic services).

Chronic Pain Treatment. Treatment of frequent recurrences of pain, over a long period of time, that is not related to an active medical condition currently being treated.

Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Evidence of Coverage (EOC).

Commercial weight loss programs. Weight loss programs, whether or not they are pursued under medical or doctor supervision, except as specified as covered in the EOC. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or for treatment of anorexia nervosa or bulimia nervosa.

Consultations given by telephone or fax.

Cosmetic Surgery. Surgery or other services done only to make the member: look beautiful; to improve appearance; or to change or reshape normal parts or tissues of the body. This does not apply to reconstructive surgery the member might need to: get back the use of a body part; have for breast reconstruction after a mastectomy; correct or repair a deformity caused by birth defects, abnormal development, injury or illness in order to improve function, symptomatology or create a normal appearance. Cosmetic surgery does not become reconstructive because of psychological or psychiatric reasons.

Custodial Care or Rest Cures. Room and board charges for a hospital stay mostly for a change of scene or to make the member feel good. Services given by a rest home, a home for the aged, or any place like that.

Dental Services or Supplies. Dentures, bridges, crowns, caps, or dental prostheses, dental implants, dental services, tooth extraction, or treatment to the teeth or gums. Cosmetic dental surgery or other dental services for beauty purposes.

Diabetic Supplies. Prescription and non-prescription diabetic supplies, except as specified as covered in the EOC.

Eye Exercises or Services and Supplies for Correcting Vision. Optometry services, eye exercises, and orthoptics, except for eye exams to find out if the member's vision needs to be corrected. Eyeglasses or contact lenses are not covered. Contact lens fitting is not covered.

Eye Surgery for Refractive Defects. Any eye surgery just for correcting vision (like nearsightedness and/or astigmatism). Contact lenses and eyeglasses needed after this surgery.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as specified as covered in the EOC or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

Health Club Membership. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a doctor. This exclusion also applies to health spas.

Immunizations. Immunizations needed to travel outside the USA.

Infertility Treatment. Any infertility treatment including artificial insemination or in vitro fertilization & sperm bank.

Lifestyle Programs. Programs to help member change how one lives, like fitness clubs, or dieting programs. This does not apply to cardiac rehabilitation programs approved by the medical group.

Mental or nervous disorders. Academic or educational testing, counseling. Remedying an academic or education problem, except as stated as covered in the EOC.

Non-Prescription Drugs. Non-prescription, over-the-counter drugs or medicines.

Orthopedic Shoes. Orthopedic shoes (except when joined to braces) or shoe inserts (except custom molded orthotics). This does not apply to shoes and inserts designed to prevent or treat foot complications due to diabetes.

Outpatient Drugs. Outpatient prescription drugs or medications including insulin.

Personal Care and Supplies. Services for personal care, such as: help in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beauty purposes.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Routine Exams. Routine physical or psychological exams or tests asked for by a job or other group, such as a school, camp, or sports program.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement.

Sex Change. Sex change surgery or treatments.

Sexual Problems. Treatment of any sexual problems unless due to a medical problem, physical defect, or disease.

Sterilization Reversal. Surgery done to reverse a sterilization.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Third Party Liability – Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Coordination of Benefits – The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

SJVIA
Modified Chiropractic Care and Acupuncture Rider Plan 10/40

The benefits described in this Rider are provided through an agreement between Anthem Blue Cross and American Specialty Health Plans of California (ASH Plans). The services listed below are covered only if provided by an ASH Plans Chiropractor and/or ASH Plans Acupuncturist. These benefits are provided in addition to the benefits described in the Anthem Blue Cross HMO Evidence of Coverage (EOC) document. However, when expenses are incurred for treatment received from an ASH Plans Chiropractor or ASH Plans Acupuncturist, no other benefits other than the benefits described in this Rider will be paid.

Covered Services	Member's Copayment
Office Visit to a Chiropractor	$10/visit
Office Visit to an Acupuncturist	$10/visit
Maximum Benefits	
Office visits to a Chiropractor or Acupuncturist	40 visits per calendar year (chiropractic and acupuncture visits combined)
Chiropractic appliances	$50 per calendar year

Covered Services

Chiropractor Services: Member has up to 30 visits, combined with visits for acupuncture services, in a calendar year for chiropractor care services that are determined by ASH PLANS to be medically/clinically necessary. All visits to an ASH Plans chiropractor or ASH Plans acupuncturist will be applied towards the maximum number of visits in a calendar year. The ASH Plans chiropractor is responsible for submitting a treatment plan to ASH Plans for prior approval.

Covered services include:

- An initial new patient exam by an ASH Plans chiropractor to determine the appropriateness of chiropractic services.
- Follow-up office visits as set forth in a treatment plan approved by ASH Plans and provided by an ASH Plans chiropractor
- An established patient exam performed by an ASH Plans chiropractor to assess the need to continue, extend or change a treatment plan approved by ASH Plans.
- Adjunctive physiotherapy modalities and procedures as set forth in a treatment plan approved by ASH Plans and provided by ASH Plans chiropractor.
- Radiological x-rays and laboratory tests when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered services include radiological consultations when determined by ASH Plans to be medically/clinically necessary and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which has contracted with ASH Plans to provide those services.
- Chiropractic Appliances: Up to $50 per calendar year when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered chiropractic appliances are limited to:
  - elbow supports, back supports (thoracic), lumbar braces and supports, rib supports, or wrist supports;
  - cervical collars or cervical pillows;
  - ankle braces, knee braces, or wrist braces;
  - heel lifts;
  - hot or cold packs;
  - lumbar cushions;
  - rib belts or orthotics; and
  - home traction units for treatment of the cervical or lumbar regions.

Acupuncture Services. Member has up to 30 visits, combined with visits for chiropractic care, in a calendar year for acupuncture services that are determined by ASH Plans to be medically/clinically necessary. All visits to an ASH Plans chiropractor or ASH Plans acupuncturist will be applied towards the maximum number of visits in a calendar year. The ASH Plans acupuncturist is responsible for submitting a treatment plan to ASH Plans for prior approval.

Covered services include:

- An initial new patient exam by an ASH Plans acupuncturist to determine the appropriateness of acupuncture services.
- Follow-up office visits as set forth in a treatment plan approved by ASH Plans and provided by an ASH Plans acupuncturist
- An established patient exam performed by an ASH Plans acupuncturist to assess the need to continue, extend or change a treatment plan approved by ASH Plans.
- Adjunctive physiotherapy modalities and procedures as set forth in a treatment plan approved by ASH Plans and provided by ASH Plans acupuncturist.

Chiropractic Care and Acupuncture Rider Exclusions & Limitations

Care Not Approved: Any services provided by an ASH Plans chiropractor or an ASH Plans acupuncturist that are not approved by ASH Plans except as specified as covered in the Evidence of Coverage (EOC). An ASH Plans chiropractor or ASH Plans acupuncturist is responsible for submitting a treatment plan to ASH Plans for prior approval.

Care Not Covered: In addition to any service or supply specifically excluded in the EOC, no benefits will be provided for chiropractic or acupuncture services or supplies in connection with:

- Diagnostic scanning, such as magnetic resonance imaging (MRI) or computerized axial tomography (CAT) scans. Diagnostic services for acupuncture.
- Thermography.
- Hypnotherapy.
- Behavior training.
- Sleep therapy.
- Weight programs.
- Any non-medical program or service.
- Pre-employment examinations, any chiropractic or acupuncture services required by an employer that are not medically/clinically necessary, or vocational rehabilitation.
- Services and/or treatments which are not documented as medically/clinically necessary.
- Massage therapy.
- Acupuncture performed with reusable needles.
- Acupuncture services benefits are not provided for magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacement products, acupuncture point or trigger-point injections (including injectable substances), laser/laser biostim, colorpuncture, NAET diagnosis and/or treatment, and direct moxibustion.
- Any service or supply for the exam and/or treatment by an ASH chiropractor for conditions other than those related to neuromusculoskeletal disorders.
- Services from an ASH Plans acupuncturist for exam and/or treatment for conditions not related to neuromusculoskeletal disorders, nausea or pain, incluing, without limitation, asthma or addictions such as nicotine addiction.
- Transportation costs including local ambulance charges.
- Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services, or other related services;
- All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephone compatible with hearing aids;
- Adjunctive therapy not associated with spinal, muscle or joint manipulation.
- Laboratory and diagnostic x-ray studies, except as specified as covered in the EOC.

Non-ASH Plans Chiropractors or non-ASH Plans Acupuncturists: Services and supplies provided by a chiropractor or an acupuncturists who does not have an agreement with ASH Plans to provide covered services under this plan.

Work Related: Care for health problems that are work-related if such health problems are covered by workers' compensation, an employer's liability law or similar law. We will provide care for a work-related health problem, but we have the right to be paid back for that care as described in the EOC.

Government Treatment: Any services actually given to the member by a local, state or federal government agency, except when this plan's benefits, must be provided by law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Drugs: Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription.

Supplement. Vitamins, minerals, dietary and nutritional supplements or other similar products and any herbal supplements.

Air Conditioners: Air purifiers, air conditioners, humidifiers, supplies or any other similar devices or appliances. All appliances or durable medical equipment, except as specified as covered in the EOC..

Personal Items: Any supplies for comfort, hygiene or beauty purposes, including therapeutic mattresses.

Out-Of-Area and Emergency Care: Out-of-area care is not covered under this Chiropractic and Acupuncture Care benefit, except for emergency services. The member should follow the procedures specified by their Anthem Blue Cross HMO plan to obtain emergency or out-of-area care.

Third Party Liability

Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

SJVIA
San Joaquin Valley
Insurance Authority

USscript
Integrity. Innovation. Outcomes.

Prescription Drug Copays

30 Day Supply:		**Mail**	
Generic	$10	Generic	$20
Formulary	$20	Formulary	$40
Non-Formulary	$35	Non-Formulary	$60
Retail 90 Day Supply:		**Specialty Medication copays:**	
Generic	$20	30% ($100.00 max.)	
Formulary	$40	** Specialty medications are covered at a 30-day	
Non-Formulary	$60	supply only.**	

Exclusions

Hair Treatments
Pigmenting/Depigmenting
Anti-wrinkle
OTC Medications
Fertility Drugs
Miscellaneous Injectables

US Script Helpdesk: 1(866)264-4161

This is not a complete summary of benefits further limitations and exclusions may apply.

Disclosure Form

231107 CITY OF SHAFTER

Principal benefits for Kaiser Permanente Traditional Plan

(7/1/14—12/31/14)

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Southern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Share during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$3,000 per calendar year
For any one Member in a Family of two or more Members	$3,000 per calendar year
For an entire Family of two or more Members	$6,000 per calendar year
Plan Deductible	None
Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, evaluations, and treatment	$10 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Urgent care consultations, exams, and treatment	$10 per visit
Most physical, occupational, and speech therapy	$10 per visit

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$10 per procedure
Allergy injections (including allergy serum)	$5 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Covered individual health education counseling	No charge
Covered health education programs	No charge

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge

Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit

Note: This Cost Share does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	**You Pay**
Ambulance Services	$50 per trip

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply
Most generic refills through our mail-order service	$20 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy	$20 for up to a 30-day supply
Most brand-name refills through our mail-order service	$40 for up to a 100-day supply

Durable Medical Equipment	**You Pay**
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	20% Coinsurance

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	$10 per visit

(continues)

Disclosure Form *(continued)*

Group outpatient mental health treatment	$5 per visit
Chemical Dependency Services	**You Pay**
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	$10 per visit
Group outpatient chemical dependency treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

VSP
Vision care for life

Your Vision Benefit Summary

Keep your eyes healthy with
City of Shafter and VSP® Vision Care.

Using your VSP benefit is easy.

- **Find an eyecare provider who's right for you.** You can choose to see any eyecare provider—your local VSP doctor, a retail chain affiliate, or any other provider. To find a VSP doctor or retail chain affiliate, visit **vsp.com** or call **800.877.7195**.
- **Review your benefit information.** Visit **vsp.com** to review your plan coverage before your appointment.
- **At your appointment, tell them you have VSP.** There's no ID card necessary.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP doctor or retail chain affiliate.

Primary EyeCare

As a VSP member, you can visit your VSP doctor for medical and urgent eyecare. Your VSP doctor can diagnose, treat, and monitor common eye conditions like pink eye, and more serious conditions like sudden vision loss, glaucoma, diabetic eye disease, and cataracts. Ask your VSP doctor for details.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options for you and your family. You'll have access to great brands, like bebe®, Calvin Klein, Disney, FENDI, Nike, and Tommy Bahama®.

Plan Information

VSP Coverage Effective Date: 07/01/2013
VSP Doctor Network: VSP Choice

Primary EyeCare Copay: $20

Benefit	Description	Copay
Your Coverage with VSP Doctors and Affiliate Providers*		
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$10 for exam and glasses
Prescription Glasses		
Frame	• $150 allowance for a wide selection of frames • 20% off amount over your allowance • $80 allowance at Costco® Optical • Every 24 months	Combined with exam
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months	Combined with exam
Lens Options	• Tints/Photochromic lenses-Transitions • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 20-25% off other lens options • Every 12 months	$0 $55 $95 - $105 $150 - $175
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60
Additional Coverage	• Primary Eyecare	
Extra Savings and Discounts	**Glasses and Sunglasses** • 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam. **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	
Your Coverage with Other Providers		

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.

Exam.....up to $45	Lined Trifocal Lenses.....up to $65
Frame.....up to $70	Progressive Lenses.....up to $50
Single Vision Lenses.....up to $30	Contacts.....up to $105
Lined Bifocal Lenses.....up to $50	Tints.....up to $5

***Coverage with a retail chain affiliate may be different. Once your benefit is effective, visit vsp.com for details.**
Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

Visit **vsp.com** or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

City of Shafter
2014 SJVIA Benefit and Rate Summary

	SJVIA/Anthem PPO $250		SJVIA/Anthem HMO	SJVIA/Kaiser HMO
	In-Network	**Non-Network**	**In-Network**	**In-Network**
Coinsurance	100%	50%	100%	100%
Deductible				
Individual	$250		$0	$0
Family	$500		$0	$0
Out of Pocket Maximum				
Individual	$3,000	$10,000	$1,000	$3,000
Family	$5,000	$15,000	$2,000	$6,000
Office Visit	$20 Copay	50%	$15	$10
Preventive Care	100%	50%	No Charge	No Charge
Inpatient Services	100%	50%	No Charge	No Charge
Outpatient Services	100%	50%	No Charge	$10/procedure
Emergency Room	$100/visit (waived if admitted)		$100/visit	$50/visit
Chiropractic	100%	50%	$10 Copay	Not Covered
	24 visits/year		40 visits/year	
Prescription Drugs				
Generic	$10		$10	$10
Preferred Brand	$20		$20	$20
Non-Preferred Brand	$35		$35	n/a
Rates				
EE	$552.45		$490.67	$370.74
EE+Sp	$976.79		$867.57	$946.24
EE+Ch	$862.14		$765.73	$814.91
EE+Family	$1,285.36		$1,141.63	$1,262.95

Note: This summary of benefits serves as a brief overview of benefits. A full description of benefits, including limitations/exclusions and a full range of covered services can be found in the Evidence of Coverage.

City of Shafter
2014 SJVIA Benefit and Rate Summary

	VSP Vision Plan	
	In-Network	**Out-of Network**
Frequency	12 / 12 / 24	
Copays		
Exams	$10	Up to $45
Materials - Standard Lenses	$0	Scheduled
Lenses	$0	$30
Single Vision	$0	$50
Lined Bifocal	$0	$65
Lined Trifocal		
Frames	$150	Up to $70
Contacts		
Medically Necessary	$0	Up to $210
Cosmetic - Elective	$130	Up to $105
MONTHLY RATES		
EE	$6.18	
EE+Sp	$12.34	
EE+Ch	$13.20	
EE+Family	$21.12	

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employees' Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93291
July 25, 2014 9:00 AM

AGENDA DATE: July 25, 2014

ITEM NUMBER: 15

SUBJECT: Preliminary 2015 Health Plan Renewal

REQUEST(S): That the Board receive a report projecting the 2015 renewal rate action

DESCRIPTION:

For the fourth 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 2015 would require an increase between 6% and 8%. This initial renewal projection is based on claims data through May 2014 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.

AGENDA: San Joaquin Valley Insurance Authority

DATE: July 25, 2014

The final rate recommendation will be completed using claims data updated through June 2014 and presented at the August 22, 2014 SJVIA Board of Directors meeting. The presentation at that time will have the 2015 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:

None.

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Preliminary 2015 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 the 2015 renewal rate action

Arthur J. Gallagher & Co.
BUSINESS WITHOUT BARRIERS™

2015 Preliminary Renewal

SJVIA
San Joaquin Valley Insurance Authority

Plan Year: January 1, 2015 - December 31, 2015

Presented By:

Gallagher Benefit Services

CA License #: 0D36879

July 25, 2014

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		Medical	Rx	Total
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	**42,120**	**$16,784,754**	**$6,260,546**	**$23,045,300**
Average per Employee (Enrollment lagged 2 months)		**$398.50**	**$148.64**	**$547.13**
Percentage Change from Prior Year		**2.92%**	**24.30%**	**7.96%**
2012 Plan Year				
Totals	**42,630**	**$17,271,644**	**$6,651,370**	**$23,923,014**
Average per Employee (Enrollment lagged 2 months)		**$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	554,202	1,933,272
Feb-13	2,914	385	132	244	3,675	1,355,513	526,129	1,881,643
Mar-13	2,891	384	129	248	3,652	1,521,017	534,099	2,055,116
Apr-13	2,884	378	130	246	3,638	1,329,384	558,016	1,887,401
May-13	2,892	369	131	252	3,644	1,190,872	594,640	1,785,512
Jun-13	2,899	366	130	253	3,648	1,601,788	527,981	2,129,769
Jul-13	2,929	399	136	328	3,792	1,506,432	739,675	2,246,107
Aug-13	2,919	401	136	335	3,791	1,995,618	571,953	2,567,571
Sep-13	2,898	399	136	331	3,764	1,125,764	610,843	1,736,607
Oct-13	2,909	392	134	331	3,766	1,821,267	586,049	2,407,316
Nov-13	2,911	388	131	333	3,763	1,441,710	557,743	1,999,453
Dec-13	2,896	387	132	335	3,750	1,224,187	591,170	1,815,357
Sub Total	34,856	4,630	1,590	3,480	44,556	17,492,621	6,952,501	24,445,122
Rolling 12 month Stop Loss Reimbursement						-	-	-
City of Tulare Run-Out Claims						10,586	-	10,586
Totals						**$17,503,207**	**$6,952,501**	**$24,455,708**
Average per Employee (Enrollment lagged 2 months)					**44,666**	**$391.87**	**$155.66**	**$547.53**
Percentage Change from Prior Year						**-3.28%**	**-0.24%**	**-2.43%**

2014 Plan Year

	Enrollment					Paid Claims		
Month-Year	**EE**	**ES**	**EC**	**EF**	**Total EE's**	**Medical**	**Rx**	**Combined**
Jan-14	2,939	418	144	403	3,904	1,480,472	571,568	2,052,040
Feb-14	2,918	424	160	428	3,930	1,668,736	605,419	2,274,155
Mar-14	2,960	422	157	417	3,956	1,644,388	674,815	2,319,203
Apr-14	2,976	429	164	427	3,996	2,073,142	671,369	2,744,511
May-14	2,951	421	163	423	3,958	2,484,196	564,621	3,048,817
Sub Total	14,744	2,114	788	2,098	19,744	9,350,934	3,087,792	12,438,727
Rolling 12 month Stop Loss Reimbursement						352,466	-	-
Totals						**$8,998,468**	**$3,087,792**	**$12,086,261**
Average per Employee (Enrollment lagged 2 months)					**19,303**	**$466.17**	**$159.96**	**$626.13**
Percentage Change from Prior Year						**18.96%**	**2.77%**	**14.36%**
Rolling 12 Month Totals (Enrollment lagged 2 months)					**45,346**	**$19,715,234**	**$7,273,207**	**$26,988,440**
Average per Employee (Enrollment lagged 2 months)						**$434.77**	**$160.39**	**$595.17**
Percentage Change from Prior Year						**10.95%**	**3.04%**	**8.70%**
4 Year Average Claims Trend						**3.06%**	**8.02%**	**4.20%**

SJVIA PPO

2015 Claims Projection

Paid Claims Period: June 2013 through May 2014

		Medical		Rx		Total
Total Paid Claims	$	20,067,700	$	7,273,207	$	27,340,906
Claims in Excess of Pooling + Rx Rebates	$	352,466	$	660,781	$	1,013,247
Total Paid Claims Net of Pooling	$	19,715,234	$	6,612,425	$	26,327,659
Enrollment lagged 2 months		45,346		45,346		45,346
Average Paid Claim for Period	$	434.77	$	145.82	$	580.59
Trend (Med.- 7.5%, Rx - 4.5%)		1.1281		1.0761		1.1150
Projected Paid Claim	**$**	**490.47**	**$**	**156.92**	**$**	**647.39**
Current Monthly Enrollment (May 2014)		3,958		3,958		3,958
Monthly Projected Paid Claims	$	1,941,271	$	621,095	$	2,562,366
2015 Annual Projected Paid Claims	**$**	**23,295,252**	**$**	**7,453,141**	**$**	**30,748,393**
Projected Required Reserve (16%Med/5% Rx)	**$**	**3,727,240**	**$**	**372,657**	**$**	**4,099,897**
Current Reserve*					**$**	**9,724,949**
Contingent Reserve					**$**	**5,625,052**

**Calculated from May 2014 Claims Data - represents all premiums paid from inception less all costs from inception*

SJVIA 2014 PPO Cost Worksheet: Combined - Anthem Blue Cross

Enrollment	Single	EE +Sp	EE + Ch	Family	Total
Anthem Blue Cross PPO	2,797	416	163	248	3,624
BSC/HNAS PPO	154	5	-	175	334
Total PPO - May 2014	**2,951**	**421**	**163**	**423**	**3,958**
				Total Members	**5,735**
				Non Founding Member Employees	**694**

2014 Fixed Costs:	Single	EE +Sp	EE + Ch	Family	Totals
PPO - Specific Stop Loss (HM Life $450,000 ded. 12/15)	$ 12.92	$ 12.92	$ 12.92	$ 12.92	$ 613,648
PPO - Aggregate Stop Loss (HM Life 12/15)	$ 0.85	$ 0.85	$ 0.85	$ 0.85	$ 40,372
PPO - Blue Cross Core Administration	$ 26.57	$ 26.57	$ 26.57	$ 26.57	$ 1,261,969
PPO - Blue Cross 360 Claims Management	$ 2.10	$ 2.10	$ 2.10	$ 2.10	$ 99,742
Claims Management/Communication	$ 3.00	$ 3.00	$ 3.00	$ 3.00	$ 142,488
JPA Consulting	$ 4.00	$ 4.00	$ 4.00	$ 4.00	$ 189,984
SJVIA Fee	$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 94,992
SJVIA Non Founding Member Fee	$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 94,992
Hourglass (Consolidated Billing, COBRA, Flex Admin)	$ 6.50	$ 6.50	$ 6.50	$ 6.50	$ 308,724
PCORI Fee	$ 0.26	$ 0.26	$ 0.26	$ 0.26	$ 12,349
Transitional Reinsurance Fee	$ 8.33	$ 8.33	$ 8.33	$ 8.33	$ 395,642
Total Fixed Cost	**$ 68.53**	**$ 68.53**	**$ 68.53**	**$ 68.53**	**$ 3,254,901**
2014 Claims Costs:					
PPO - Medical Claims	$ 434.77	$ 434.77	$ 434.77	$ 434.77	$ 20,649,996
PPO - Rx Claims	$ 145.82	$ 145.82	$ 145.82	$ 145.82	$ 6,925,942
Total Claims	**$ 580.59**	**$ 580.59**	**$ 580.59**	**$ 580.59**	**$ 27,575,938**
Aggregate Attachment Factors	*$ 803.33*	*$ 803.33*	*$ 803.33*	*$ 803.33*	*$ 38,154,962*
Projected Total PPO Cost - 2014					**$ 30,830,839**
Current PPO Plan Rates/Funding					**$ 33,314,116**

2015 Fixed Costs: *(Projected)*	Single	EE +Sp	EE + Ch	Family	Totals	Increase
PPO - Specific Stop Loss (HM Life $450,000 ded. 12/15)	$ 14.21	$ 14.21	$ 14.21	$ 14.21	$ 675,013	10%
PPO - Aggregate Stop Loss (HM Life 12/15)	$ 0.94	$ 0.94	$ 0.94	$ 0.94	$ 44,409	10%
PPO - Blue Cross Core Administration	$ 27.92	$ 27.92	$ 27.92	$ 27.92	$ 1,214,185	5%
PPO - Blue Cross 360 Claims Management	$ 2.21	$ 2.21	$ 2.21	$ 2.21	$ 96,108	5%
PPO - Blue Shield / HNAS Administration	$ 34.11	$ 34.11	$ 34.11	$ 34.11	$ 136,713	
Claims Management/Communication	$ 3.00	$ 3.00	$ 3.00	$ 3.00	$ 142,488	0%
JPA Consulting	$ 4.00	$ 4.00	$ 4.00	$ 4.00	$ 189,984	0%
SJVIA Fee	$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 94,992	0%
SJVIA Non Founding Member Fee	$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 16,656	0%
Hourglass (Consolidated Billing, COBRA, Flex Admin)	$ 6.50	$ 6.50	$ 6.50	$ 6.50	$ 308,724	0%
PCORI Fee	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 11,470	-7%
Transitional Reinsurance Fee	$ 5.19	$ 5.19	$ 5.19	$ 5.19	$ 246,605	-38%
Total Fixed Cost Anthem Blue Cross	**$ 66.21**	**$ 66.21**	**$ 66.21**	**$ 66.21**		
Total Fixed Cost BSC/HNAS	**$ 70.19**	**$ 70.19**	**$ 70.19**	**$ 70.19**		
Total PPO Fixed Costs					**$ 3,177,347**	-2.4%
2015 Claims Costs: *(Projected)*						
PPO - Projected Claims	$ 490.47	$ 490.47	$ 490.47	$ 490.47	$ 23,295,252	12.8%
PPO - Projected Rx Claims	$ 156.92	$ 156.92	$ 156.92	$ 156.92	$ 7,453,141	7.6%
Total Claims	**$ 647.39**	**$ 647.39**	**$ 647.39**	**$ 647.39**	**$ 30,748,393**	11.5%
Aggregate Attachment Factors	*$ 803.33*	*$ 803.33*	*$ 803.33*	*$ 803.33*	*$ 38,154,962*	0%
Projected Total PPO Cost					**$ 33,925,740**	
Current PPO Plan Rates/Funding					**$ 33,314,116**	
Rate Action					1.8%	

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						**$240.97**	**$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

Totals	**11,764**	**3,738**	**8,088**	**3,625**	**55,289**	**13,589,192**	**19,668,689**	**7,179,142**	**40,437,022**
Average per Employee (Enrollment lagged 2 months)						**$248.07**	**$355.75**	**$129.85**	**$731.38**
Percentage Change from Prior Year						**2.95%**	**17.96%**	**6.26%**	**13.18%**

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	1,413	655	4,955	1,282,850	1,758,813	713,502	3,755,165
Feb-13	2,265	644	1,412	664	4,985	1,290,885	1,553,541	664,853	3,509,280
Mar-13	2,289	640	1,418	666	5,013	1,298,101	2,201,042	721,627	4,220,770
Apr-13	2,327	639	1,418	659	5,043	1,305,832	1,884,434	757,054	3,947,321
May-13	2,296	634	1,416	666	5,012	1,297,722	2,236,723	741,845	4,276,290
Jun-13	2,322	636	1,425	680	5,063	1,311,837	1,588,607	683,590	3,584,034
Jul-13	2,356	636	1,422	688	5,102	1,321,827	2,184,670	742,765	4,249,262
Aug-13	2,344	632	1,425	688	5,089	1,318,659	2,006,960	758,755	4,084,375
Sep-13	2,358	621	1,426	694	5,099	1,321,540	1,907,913	766,216	3,995,669
Oct-13	2,363	622	1,405	694	5,084	1,317,492	2,557,500	706,425	4,581,417
Nov-13	2,370	615	1,412	685	5,082	1,317,159	1,744,290	665,364	3,726,814
Dec-13	2,377	618	1,415	688	5,098	1,321,465	1,529,322	692,614	3,543,401
Sub Total	27,908	7,583	17,007	8,127	60,625	15,705,371	23,153,816	8,614,610	47,473,796
Rolling 12 month Large Claim Credit (Pooling Limit @ $400K)							-	n/a	-
Totals					**60,625**	**$15,705,371**	**$23,153,816**	**$8,614,610**	**$47,473,796**
Average per Employee (Enrollment lagged 2 months)					**59,690**	**$259.06**	**$387.90**	**$144.32**	**$795.34**
Percentage Change from Prior Year						**4.43%**	**9.04%**	**11.15%**	**8.75%**

2014 Plan Year

	Enrollment					Non Capitated Paid Claims			
Month-Year	EE	ES	EC	EF	Total EE's	Capitation	Medical	Rx	Combined
Jan-14	2,402	640	1,435	739	5,216	1,410,719	1,453,837	782,651	3,647,207
Feb-14	2,406	638	1,434	742	5,220	1,411,801	1,730,599	783,486	3,925,885
Mar-14	2,426	648	1,452	740	5,266	1,424,242	1,861,318	936,204	4,221,764
Apr-14	2,446	639	1,448	730	5,263	1,423,431	1,594,709	764,169	3,782,309
May-14	2,461	629	1,432	726	5,248	1,419,374	2,289,963	860,911	4,570,248
Sub Total	12,141	3,194	7,201	3,677	26,213	7,089,568	8,930,426	4,127,421	20,147,414
Rolling 12 month Large Claim Credit (Pooling Limit @ $400K)							2,821	n/a	2,821
Totals					**26,213**	**$7,089,568**	**$8,927,605**	**$4,127,421**	**$20,144,593**
Average per Employee (Enrollment lagged 2 months)					**25,882**	**$273.92**	**$340.58**	**$159.47**	**$778.32**
Percentage Change from Prior Year						**5.74%**	**-12.20%**	**10.50%**	**-2.14%**
Rolling 12 Month Totals (Enrollment lagged 2 months)					**61,374**	**$16,319,549**	**22,449,687**	**$9,143,149**	**$47,912,386**
Average per Employee (Enrollment lagged 2 months)						**$265.90**	**$351.61**	**$148.97**	**$766.49**
Percentage Change from Prior Year							**-9.35%**	**3.22%**	**-3.63%**
4 Year Average Claims Trend							**4.74%**	**10.03%**	**5.11%**

SJVIA HMO
2015 Claims Projection - All HMO Plans
Paid Claims Period: June 2013 through May 2014

	Non Capitated	Capitation	Rx	Total
Total Paid Claims	$ 22,449,687	$ 16,319,549	$ 9,143,149	$ 47,912,386
Claims in Excess of Pooling + Rx Rebates	$ 2,821	-	807,622	810,443
Total Paid Claims Net of Pooling	$ 22,446,866	$ 16,319,549	$ 8,335,528	$ 47,101,943
Enrollment lagged 2 months	61,374	61,374	61,374	61,374
Average Paid Claim for Period (Non-Cap)	$ 365.74	$ 259.06	$ 135.82	$ 760.61
Trend (Med.- 7.5%, Rx -4.5%)	1.1281	1.0656	1.0761	1.0975
Projected Paid Claim	**$ 412.59**	**$ 276.05**	**$ 146.15**	**$ 834.79**
Current Monthly Enrollment (May 2014)	5,248	5,248	5,248	5,248
Monthly Projected Paid Claims	2,165,272	1,448,710	767,013	4,380,996
2014 Annual Projected Paid Claim Reserves needed for 16% Me	**$ 25,983,270**	**$ 17,384,525**	**$ 9,204,161**	**$ 52,571,956**

Projected Required Reserve (16% Medical/5% Rx)	**$4,157,323**	**N/A**	**$460,208**	**$4,617,531**
Current Reserve*				**$4,175,469**
Reserves Held by Anthem Blue Cross				**$1,065,596**
Contingent Reserve				**$623,534**

**Calculated from May 2014 Claims Data - represents all premiums paid from inception less all costs from inception*

SJVIA 2014 HMO Cost Worksheet: Combined - Anthem Blue Cross

Enrollment	Single	EE +Sp	EE + Ch	Family	Total
Total HMO - May 2014	**2,461**	**629**	**1,432**	**726**	**5,248**
				Non Founding Member Employees	**263**

2014 Fixed Costs:	Single	EE +Sp	EE + Ch	Family	Totals
HMO - Pooling ($400,000)	$ 22.72	$ 22.72	$ 22.72	$ 22.72	$ 1,430,815
HMO - Blue Cross MPP Retention (incl 360 Health)	$ 39.27	$ 39.27	$ 39.27	$ 39.27	$ 2,473,068
ACA Reinsurance	$ 11.37	$ 11.37	$ 11.37	$ 11.37	$ 716,037
Claims Management/Communication	$ 3.00	$ 3.00	$ 3.00	$ 3.00	$ 188,928
JPA Consulting	$ 4.00	$ 4.00	$ 4.00	$ 4.00	$ 251,904
SJVIA Fee	$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 125,952
SJVIA Non Founding Member Fee	$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 6,312
Hourglass (Consolidated Billing, COBRA, Flex Admin)	$ 6.50	$ 6.50	$ 6.50	$ 6.50	$ 409,344
Total Fixed Cost	$ 90.86	$ 90.86	$ 90.86	$ 90.86	**$ 5,602,359**
2014 Claims Costs:					
HMO - Capitation	$ 270.46	$ 270.46	$ 270.46	$ 270.46	$ 17,032,489
HMO - Medical Claims	$ 365.74	$ 365.74	$ 365.74	$ 365.74	$ 23,032,780
HMO - Rx Claims	$ 135.82	$ 135.82	$ 135.82	$ 135.82	$ 8,553,104
Total Claims	$ 772.01	$ 772.01	$ 772.01	$ 772.01	**$ 48,618,373**
Aggregate Factors	*$ 509.37*	*$ 509.37*	*$ 509.37*	*$ 509.37*	*$ 32,078,085*
Projected Total HMO Costs - 2014					**$ 54,220,732**
Current HMO Plan Rates/Funding					**$ 53,513,101**

2015 Fixed Costs: *(Projected)*	Single	EE +Sp	EE + Ch	Family	Totals	Increase
HMO - Pooling ($400,000)	$ 29.76	$ 29.76	$ 29.76	$ 29.76	$ 1,874,166	31%
HMO - Blue Cross MPP Retention (incl 360 Health)	$ 41.10	$ 41.10	$ 41.10	$ 41.10	$ 2,588,314	5%
ACA Reinsurance/PCORI	$ 8.29	$ 8.29	$ 8.29	$ 8.29	$ 522,071	-27%
Claims Management/Communication	$ 3.00	$ 3.00	$ 3.00	$ 3.00	$ 188,928	0%
JPA Consulting	$ 4.00	$ 4.00	$ 4.00	$ 4.00	$ 251,904	0%
SJVIA Fee	$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 125,952	0%
SJVIA Non Founding Member Fee	$ 2.00	$ 2.00	$ 2.00	$ 2.00	$ 6,312	0%
Hourglass (Consolidated Billing, COBRA, Flex Admin)	$ 6.50	$ 6.50	$ 6.50	$ 6.50	$ 409,344	0%
Total Fixed Cost	**$ 96.65**	**$ 96.65**	**$ 96.65**	**$ 96.65**	**$ 5,966,990**	7%
2015 Claims Costs: *(Projected)*						
HMO - Capitation	$ 276.05	$ 276.05	$ 276.05	$ 276.05	$ 17,384,525	2%
HMO - Projected Medical Claims	$ 412.59	$ 412.59	$ 412.59	$ 412.59	$ 25,983,270	13%
HMO - Projected Rx Claims	$ 146.15	$ 146.15	$ 146.15	$ 146.15	$ 9,204,161	7.6%
Total Claims	**$ 834.79**	**$ 834.79**	**$ 834.79**	**$ 834.79**	**$ 52,571,956**	8%
Aggregate Factors	*$ 548.65*	*$ 548.65*	*$ 548.65*	*$ 548.65*	*$ 34,551,782*	
Projected Total HMO Cost - 2015					**$ 58,538,946**	
Current HMO Plan Rates/Funding					**$ 53,513,101**	
Rate Action					9.39%	

San Joaquin Valley Insurance Authority

2015 Renewal Summary

Effective January 1, 2015

Cost Recap

	PPO	HMO	SJVIA Total
2014 Premium Funding	$33,314,116	$53,513,101	$86,827,217
2015 Projected Costs	$33,925,740	$58,538,946	$92,464,686
Change	**1.84%**	**9.39%**	**6.49%**

Reserve Recap - All Plans

	Medical	Rx	Total
Projected Required Reserve (16% Medical/5% Rx)	**$7,884,564**	**$832,865**	**$8,717,429**
Current Reserve*			**$14,966,014**
Contingent Reserve			**$6,248,586**

**Calculated from May 2014 Claims Data - represents all premiums paid from inception less all costs from inception*

San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employees' Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93291
July 25, 2014 9:00 AM

AGENDA DATE: July 25, 2014

ITEM NUMBER: 16

SUBJECT: Approve and Authorize Sending the 2014 Multi-County Biennial Notice to the California Fair Political Practices Commission (FPPC)

REQUEST(S): That the Board approve and authorize the SJVIA Manager to submit the 2014 Multi-County Biennial Notice to the FPPC indicating that no amendment is required at this time

DESCRIPTION:

The Political Reform Act requires every government agency to review its conflict of interest code biennially to determine if it is accurate or, alternatively, that the code must be amended. The biennial review examines current programs to ensure that the agency's code requires disclosure by agency officials who make or participate in making governmental decisions.

According to the FPPC guidelines, points to consider when determining if changes must be made to the Conflict of Interest Code include:

1. Is the current code more than 5 years old? (No)
2. Have there been any substantial changes to the organizational structure since the last code was approved by the FPPC? (No)
3. Have any positions been eliminated or renamed, or have any new positions been added since the last code was approved? (No)
4. Have there been any substantial changes in duties/responsibilities for any positions since the last code was approved? (No)

Because those four questions may be answered in the negative, as indicated above, SJVIA staff recommends submission of the 2014 Multi-County Biennial

AGENDA: San Joaquin Valley Insurance Authority

DATE: July 25, 2014

Notice to the FPPC indicating that no amendment is required at this time. The original SJVIA conflict of interest code was approved in 2010 and updated in 2012 to designate positions that had a title change. The code accurately reflects designated positions and disclosure categories. The approved 2014 Multi-County Biennial Notice, which is attached for your reference, must be returned to the FPPC no later than October 1, 2014.

FISCAL IMPACT/FINANCING:

None.

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Approve and Authorize sending the 2014 Multi-County Biennial Notice to the California Fair Political Practices Commission (FPPC)

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 and authorized the SJVIA Manager to submit the 2014 Multi-County Biennial Notice to the FPPC indicating that no amendment is required at this time

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employees' Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93291
July 25, 2014 9:00 AM

AGENDA DATE: July 25, 2014

ITEM NUMBER: 17

SUBJECT: Appoint the SJVIA Manager as the HIPAA Privacy Officer for the SJVIA effective immediately

REQUEST(S): That the Board of Directors Appoint the SJVIA Manager as the HIPAA Privacy Officer for the SJVIA effective immediately

DESCRIPTION:

With the continued growth of the SJVIA through the addition of new member entities, the need for an appointed HIPAA Privacy Officer is essential. When the SJVIA formed, a Privacy Officer from both the County of Tulare and the County of Fresno were appointed but those individuals are no longer employed with the Counties.

HIPAA requires that all health care organizations that transmit or maintain protected health information (PHI) designate a Privacy Officer. This individual should be of a high-level Management or Officer Position and will be the focal point for privacy compliance-related activities. The role of this position is to implement policies and procedures to ensure that PHI is kept secure. Also, as claims and eligibility issues arise within the SJVIA from either the two founding Counties or other participating member entities, there is a need to have an appointed person with access to potential PHI. This access is needed to assist with eligibility, claims, and other issues that may come up for SJVIA participants from any entity. All vendor partners of the SJVIA will be notified of the access granted to the HIPAA Privacy Officer and will be instructed to work through him/her as needed in situations where the privacy of information must be protected.

Staff recognizes the sensitivity of this information and is recommending that the Board appoint the SJVIA Manager as the HIPAA Privacy Officer effective immediately.

FISCAL IMPACT/FINANCING:

None.

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Appoint the SJVIA Manager as the HIPAA Privacy Officer for the SJVIA Effective Immediately

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 the SJVIA Manager as the HIPAA Privacy Officer for the SJVIA effective immediately