SJVIA
San Joaquin Valley Insurance Authority

AGENDA

Meeting Location:
Fresno County Employees' Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
March 18, 2016 9:00 AM

1. Call to Order
2. Pledge of Allegiance
3. Roll Call and Election of President and Vice President of the SJVIA Board of Directors (A)
4. Approval of Agenda (A)
5. 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.
6. Approval of Minutes – Board Meeting of November 6, 2015 (A)

6A. Brief Overview of the SJVIA Since Inception (I)

7. Receive and File SJVIA Executive Claims Summary Through December 2015 (I)
8. Receive and File Quarterly Financial Report (I)
9. Receive Update on Cash Flow Projections and Mitigation Efforts (I)
10. Receive and File Aon Actuarial Review of Rate Development & Reserve Adequacy and Funding Projections and SJVIA Strategic Observations (I)
11. Receive Revised Fiscal Year Budget for the 2015-16 Plan Year (A)
12. Authorize Execution of Loan Agreement Between County of Fresno and SJVIA of up to $2 Million (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 636-4900 or the Assistant SJVIA Manager at 600-1810. 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.

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March 18, 2016 9:00 AM

13. Authorization and Execution of Anthem Blue Cross Administrative Service Agreement (PPO), Anthem Blue Cross Group Benefit Agreement (HMO) and Funding Provision Minimum Premium Agreements (HMO) (A)

14. Execution of Confidentiality Agreement with Anthem Blue Cross Regarding Sutter Health (A)

15. Authorization and Execution of Blue Shield of California Agreement Effective January 1, 2016 for the City of Tulare (A)

16. Receive and File Open Enrollment Migration Report for the 2016 Plan Year (A)

17. Authorization and Execution of Participation Agreements by the City of Tulare, County of Fresno and County of Tulare and Authorization and Execution of Amendments by the Cities of Ceres, Clovis, Escalon, Farmersville, Gustine, Hanford, Hughson, Marysville, Modesto, Oakdale, Reedley, Riverbank, San Joaquin, Sanger, Shafter, Wasco, Waterford, County of Sutter, Superior Court of Kings County and San Joaquin Valley Air Pollution Control District (A)

18. Authorize Execution of the Agreement with Pacific Coast Medical Services Effective January 1, 2016 (A)

19. Adjournment

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MINUTES

Meeting Location:
Fresno County Employees' Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
November 06, 2015

1. Call to Order

   Meeting was called to order by Director Poochigian at 9:00am

2. Pledge of Allegiance

3. Roll Call

   Roll called by Lisa Carrington, Gallagher Benefit Services.

   In attendance: Director Borgeas, Director Ennis, Director Pacheco, Director Vander Poel, Director Worthley, Director Mendes, and Director Poochigian.

4. Approval of Agenda (A)

   Item 20 moved to item 13. Motion approved.

5. 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.

   No Public Comment offered

6. Approval of Minutes – Board Meeting of August 28, 2015 and October 15, 2015 (A)

   Updated minutes distributed by Larry Gomez, County of Fresno. Director Borgeas requested narratives be removed from future meeting minutes. Motion approved.

7. Approve Proposed 2016 Board Meeting Calendar (A)

   July meeting replaced on calendar with June 24. Motion approved.

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MINUTES

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8. Receive Update on Cash Flow and Projections and Mitigation Efforts (I)

   Vicki Crow, County of Fresno appeared via phone; Lawrence Seymour, County of Fresno presented.

   Mitigation efforts discussed including: $1 Million paid towards arrears from County of Fresno, moved from 30 days in arrears to 20 days, County of Fresno considering options to advance premiums; will be proposing creating Line of credit and are scheduled to meet with Debt Advisory Committee and County of Fresno Board of Supervisors on 11/20/15 and 12/8/15, County of Fresno and County of Tulare to each request up to $2M loan to the SJVIA.

   Any loans or lines of credit would require an amendment to the JPA agreement to authorize borrowing.

   Rhonda Sjostrom requested GBS work with Anthem to adjust claims withdrawal timing and provide an update at the next scheduled SJVIA Board Meeting.

9. Receive and File Fourth Quarter 2014-15 Financial Report (A)

   Presented by Lawrence Seymour, County of Fresno. Fiscal update will be provided at every Board Meeting going forward including cash projections. Motion approved.

10. Receive and File First Quarter 2015-2016 Financial Report (A)

    Presented by Lawrence Seymour, County of Fresno. Motion approved.

11. Adopt Resolution to Deallocate Funds from the Viverae Agreement and Authorize SJVIA Manager to give Notice of Termination for Viverae Agreement (A)

    Presented by Rhonda Sjostrom, County of Tulare. Replacement recommendations to be added to the agenda for the next scheduled SJVIA Board Meeting. Motion approved.

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November 06, 2015

12. Adopt Revised Budget for the 2015-16 Fiscal Year (A)

    Presented by Rhonda Sjostrom, County of Tulare. Director Poochigian requested the following be added to the next scheduled SJVIA Board Meeting agenda: further details on the 8/13 County of Fresno labor billing increase, SJVIA staffing with a recommendation to review the Kings/Fresno/Madera health authority staffing model, estimates of financial impact to accounting fees if withdrawals are reduced by Anthem. Motion approved.

13. Receive and File SJVIA Executive Claims Summary through August 2015 (I)

    Presented by Alan Thaxter, Gallagher Benefit Services.

14. Approve Proposal to Amend and Restate Joint Powers Agreement to Address Operational and Administrative Matters and Direct Staff to Present to Member Entities (A)

    Presented by Paul Nerland, County of Fresno. Director Poochigian requested language be added to address staffing and requested that all changes be reflected in another color in the future. Motion approved.

15. Approve Staff Recommendation for Consultant to Review SJVIA Rates for Plan Years 2014-2016 and Authorize President to Execute Agreement with Consultant Subject to the Approval of SJVIA Counsel and Staff (A)

    Presented by Paul Nerland, County of Fresno. Motion approved.

16. Review and Discuss Potential Changes in Composition of SJVIA Board of Directors (I)

    Presented by Rhonda Sjostrom, County of Tulare. Board directed SJVIA staff to provide an option in a future change to the SJVIA JPA Agreement maintaining current status quo with chairman only voting in the event of a tie and chairman rotating every year between County of Fresno and County of Tulare and subcommittee option.

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17. Authorize President to Execute Amendments to SJVIA Participation Agreements Effective January 1, 2016 (A)

    Presented by Larry Gomez, County of Fresno. Motion approved.

18. Approve Amendment to the Administrative Service Agreement with Chimienti & Associates Effective January 1, 2016 (A)

    Presented by Larry Gomez and Hollis Magill, County of Fresno. Motion approved. Director Pachoogian abstained.

19. Approve Amendment to Health Now Administrative Services Agreement Effective January 1, 2016 (A)

    Presented by Larry Gomez, County of Fresno. Motion approved.

20. Receive and File Report from Anthem Blue Cross Regarding the HMO Claims and Disease Management (I)

    Presented by Dan Saeger, Anthem Blue Cross. PPO reports requested by Board to be presented in a future meeting.

21. Adjournment

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Insurance Authority

Meeting Location:
Fresno County Employees' Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
March 18, 2016 9:00 AM

AGENDA DATE:	March 18, 2016
ITEM NUMBER:	Item 7
SUBJECT:	Receive and File SJVIA Executive Claims Summary through December 31, 2015 (I)
REQUEST(S):	That the Board Receive and File SJVIA Executive Claims Summary through December 31, 2015

DESCRIPTION:

The attached SJVIA Executive Claims Summary is in a new format designed to give staff and the SJVIA Board the most relevant information as it relates to plan cost vs. budget in 2015. Pages 1 and 2 provide an overview of the HMO and PPO respectively and page 3 combines the plans total cost summary.

Page 4 of the report provides an explanation of the dramatic increase in large claim (over $25,000) activity that occurred during the 2015 policy period. Increases in specific diagnostic categories are shown for comparison purposes.

AGENDA: San Joaquin Valley Insurance Authority

DATE: March 18, 2016

FISCAL IMPACT/FINANCING:

Informational only.

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

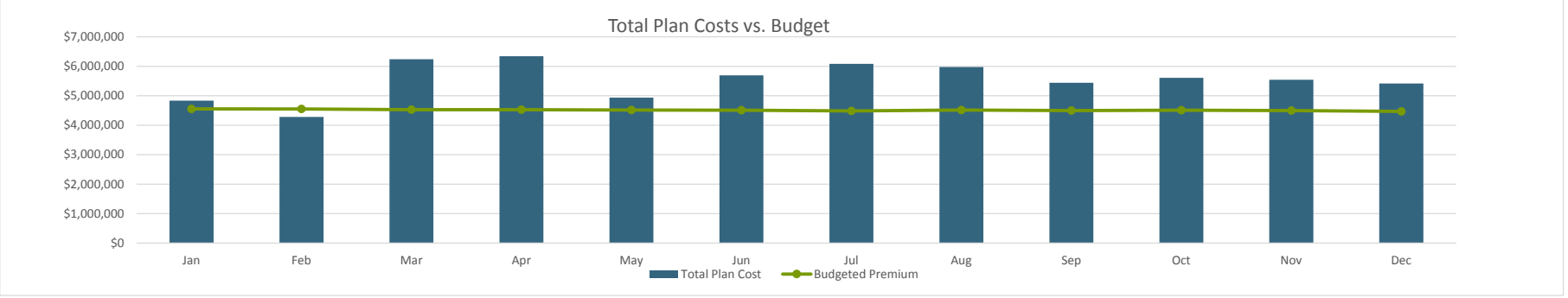
Paul Nerland
SJVIA Assistant Manager

SJVIA

HMO Cost Sumary

Plan Year January 1, 2015 through December 31, 2015

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Average / Total
Enrollment													
Employee Only	2,391	2,373	2,365	2,365	2,354	2,365	2,357	2,360	2,360	2,379	2,365	2,369	2,367
Employee + Spouse	667	662	650	650	647	642	641	648	637	635	632	634	645
Employee + Child(ren)	1,338	1,355	1,353	1,348	1,344	1,337	1,338	1,354	1,347	1,344	1,352	1,336	1,346
Employee + Family	820	818	817	818	819	820	804	810	811	816	810	796	813
Total Employees	**5,216**	**5,208**	**5,185**	**5,181**	**5,164**	**5,164**	**5,140**	**5,172**	**5,155**	**5,174**	**5,159**	**5,135**	**5,171**
Paid Claims													
Medical	$1,999,134	$1,384,373	$3,184,968	$3,153,567	$1,989,123	$2,648,991	$3,001,583	$2,899,663	$2,283,593	$2,528,014	$2,595,865	$2,345,831	$30,014,705
Prescription Drug	$882,719	$953,926	$1,114,536	$1,253,903	$1,013,996	$1,110,971	$1,162,856	$1,142,044	$1,231,172	$1,148,679	$1,021,988	$1,154,620	$13,191,410
Capitation	$1,439,877	$1,437,668	$1,431,319	$1,430,215	$1,425,522	$1,425,522	$1,418,897	$1,427,731	$1,423,038	$1,428,283	$1,424,142	$1,417,517	$17,129,731
Total Gross Paid Claims	**$4,321,730**	**$3,775,967**	**$5,730,823**	**$5,837,685**	**$4,428,641**	**$5,185,484**	**$5,583,336**	**$5,469,438**	**$4,937,803**	**$5,104,976**	**$5,041,995**	**$4,917,968**	**$60,335,846**
Total Pooled Claims / Rx Rebates	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$871,495**
Total Net Paid Claims	**$4,321,730**	**$3,775,967**	**$5,730,823**	**$5,837,685**	**$4,428,641**	**$5,185,484**	**$5,583,336**	**$5,469,438**	**$4,937,803**	**$5,104,976**	**$5,041,995**	**$4,917,968**	**$59,464,351**
Average Med Claims Per EE	$383.27	$265.82	$614.27	$608.68	$385.19	$512.97	$583.97	$560.65	$442.99	$488.60	$503.17	$456.83	$483.69
Average Drug Claims Per EE	$169.23	$183.17	$214.95	$242.02	$196.36	$215.14	$226.24	$220.81	$238.83	$222.01	$198.10	$224.85	$212.58
Total Fixed Costs	**$508,862**	**$506,710**	**$505,608**	**$505,231**	**$504,414**	**$503,872**	**$500,986**	**$504,102**	**$502,727**	**$504,291**	**$502,848**	**$498,768**	**$6,048,419**
Total Costs (Claims + Fixed)	**$4,830,592**	**$4,282,677**	**$6,236,431**	**$6,342,916**	**$4,933,055**	**$5,689,356**	**$6,084,322**	**$5,973,540**	**$5,440,530**	**$5,609,267**	**$5,544,843**	**$5,416,736**	**$65,512,770**
Total Premium	**$4,553,576**	**$4,550,160**	**$4,529,396**	**$4,525,347**	**$4,513,247**	**$4,510,083**	**$4,482,703**	**$4,514,695**	**$4,498,314**	**$4,511,086**	**$4,497,812**	**$4,468,317**	**$54,154,736**
Total Costs vs. Premium													
$ Variance	**($277,016)**	**$267,483**	**($1,707,035)**	**($1,817,569)**	**($419,808)**	**($1,179,273)**	**($1,601,619)**	**($1,458,845)**	**($942,216)**	**($1,098,181)**	**($1,047,031)**	**($948,419)**	**($11,358,034)**
% Variance	**106.1%**	**94.1%**	**137.7%**	**140.2%**	**109.3%**	**126.1%**	**135.7%**	**132.3%**	**120.9%**	**124.3%**	**123.3%**	**121.2%**	**121.0%**



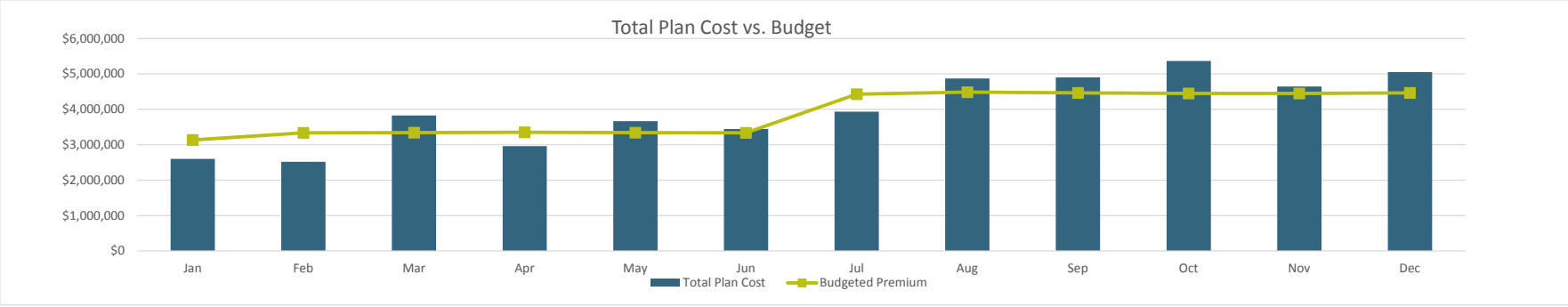
This analysis is for illustrative purposes only, and is not a guarantee of future expenses, claims costs, managed care savings, etc. There are many variables that can affect future health care costs including utilization patterns, catastrophic claims, changes in plan design, health care trend increases, 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

PPO Cost Sumary

Plan Year January 1, 2015 through December 31, 2015

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Average / Total
Enrollment													
Employee Only	3,112	3,316	3,303	3,309	3,297	3,305	3,548	3,582	3,553	3,542	3,551	3,575	3,416
Employee + Spouse	461	497	490	492	482	486	730	753	745	740	736	737	612
Employee + Child(ren)	179	179	189	188	191	191	191	191	195	191	197	202	190
Employee + Family	562	609	620	626	632	622	1,047	1,058	1,061	1,062	1,062	1,066	836
Total Employees	**4,314**	**4,601**	**4,602**	**4,615**	**4,602**	**4,604**	**5,516**	**5,584**	**5,554**	**5,535**	**5,546**	**5,580**	**5,054**
Paid Claims													
Medical	$1,572,126	$1,553,486	$2,678,918	$1,827,950	$2,521,542	$2,194,570	$2,502,257	$3,184,139	$3,397,840	$3,689,425	$3,193,780	$3,512,526	$31,828,559
Prescription Drug	$724,155	$640,866	$822,748	$807,079	$822,696	$926,195	$986,914	$1,236,596	$1,117,037	$1,291,890	$1,065,109	$1,152,116	$11,593,401
Total Gross Paid Claims	**$2,296,281**	**$2,194,352**	**$3,501,666**	**$2,635,029**	**$3,344,238**	**$3,120,765**	**$3,489,171**	**$4,420,735**	**$4,514,877**	**$4,981,315**	**$4,258,889**	**$4,664,642**	**$43,421,960**
Total Pooled Claims / Rx Rebates	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$719,248**
Total Net Paid Claims	**$2,296,281**	**$2,194,352**	**$3,501,666**	**$2,635,029**	**$3,344,238**	**$3,120,765**	**$3,489,171**	**$4,420,735**	**$4,514,877**	**$4,981,315**	**$4,258,889**	**$4,664,642**	**$42,702,712**
Average Med Claims Per EE	$364.42	$337.64	$582.12	$396.09	$547.92	$476.67	$453.64	$570.23	$611.78	$666.56	$575.87	$629.48	$524.76
Average Drug Claims Per EE	$167.86	$139.29	$178.78	$174.88	$178.77	$201.17	$178.92	$221.45	$201.12	$233.40	$192.05	$206.47	$191.14
Total Fixed Costs	**$303,482**	**$324,090**	**$324,175**	**$325,099**	**$324,216**	**$324,335**	**$445,220**	**$451,216**	**$385,307**	**$383,543**	**$384,381**	**$386,910**	**$4,361,974**
Total Costs (Claims + Fixed)	**$2,599,763**	**$2,518,442**	**$3,825,841**	**$2,960,128**	**$3,668,454**	**$3,445,100**	**$3,934,391**	**$4,871,951**	**$4,900,184**	**$5,364,858**	**$4,643,270**	**$5,051,552**	**$47,064,686**
Total Premium	**$3,134,954**	**$3,334,858**	**$3,340,799**	**$3,353,326**	**$3,343,240**	**$3,337,901**	**$4,429,562**	**$4,486,695**	**$4,465,213**	**$4,450,089**	**$4,450,674**	**$4,467,021**	**$46,594,332**
Total Costs vs. Premium													
$ Variance	**$535,191**	**$816,416**	**($485,042)**	**$393,198**	**($325,214)**	**($107,199)**	**$495,171**	**($385,256)**	**($434,971)**	**($914,769)**	**($192,596)**	**($584,531)**	**($470,354)**
% Variance	**82.9%**	**75.5%**	**114.5%**	**88.3%**	**109.7%**	**103.2%**	**88.8%**	**108.6%**	**109.7%**	**120.6%**	**104.3%**	**113.1%**	**101.0%**



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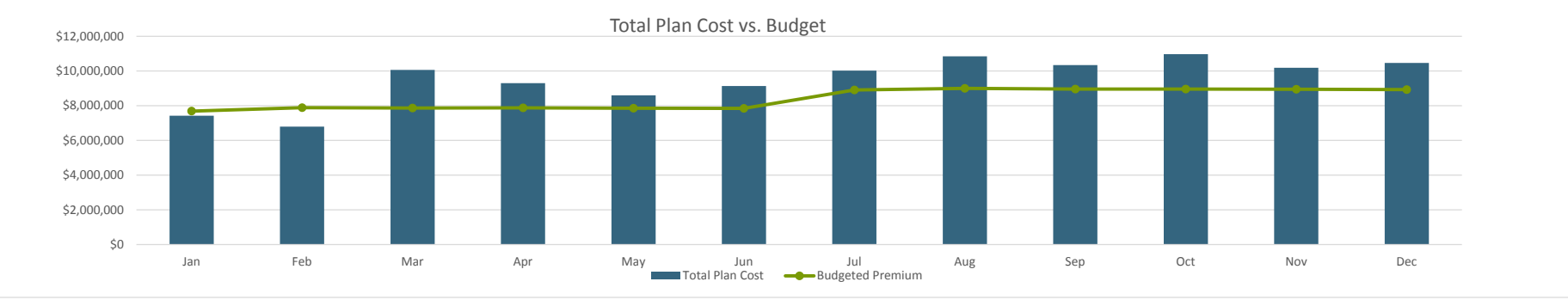
SJVIA

Total Cost Summary

Plan Year January 1, 2015 through December 31, 2015

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Average / Total
Enrollment													
Employee Only	5,503	5,689	5,668	5,674	5,651	5,670	5,905	5,942	5,913	5,921	5,916	5,944	5,783
Employee + Spouse	1,128	1,159	1,140	1,142	1,129	1,128	1,371	1,401	1,382	1,375	1,368	1,371	1,258
Employee + Child(ren)	1,517	1,534	1,542	1,536	1,535	1,528	1,529	1,545	1,542	1,535	1,549	1,538	1,536
Employee + Family	1,382	1,427	1,437	1,444	1,451	1,442	1,851	1,868	1,872	1,878	1,872	1,862	1,649
Total Employees	**9,530**	**9,809**	**9,787**	**9,796**	**9,766**	**9,768**	**10,656**	**10,756**	**10,709**	**10,709**	**10,705**	**10,715**	**10,226**
Paid Claims													
Medical	$3,571,260	$2,937,859	$5,863,886	$4,981,517	$4,510,665	$4,843,561	$5,503,840	$6,083,802	$5,681,433	$6,217,439	$5,789,645	$5,858,357	$61,843,264
Prescription Drug	$1,606,874	$1,594,792	$1,937,284	$2,060,982	$1,836,692	$2,037,166	$2,149,770	$2,378,640	$2,348,209	$2,440,569	$2,087,097	$2,306,736	$24,784,811
Capitation	$1,439,877	$1,437,668	$1,431,319	$1,430,215	$1,425,522	$1,425,522	$1,418,897	$1,427,731	$1,423,038	$1,428,283	$1,424,142	$1,417,517	$17,129,731
Total Gross Paid Claims	**$6,618,011**	**$5,970,319**	**$9,232,489**	**$8,472,714**	**$7,772,879**	**$8,306,249**	**$9,072,507**	**$9,890,173**	**$9,452,680**	**$10,086,291**	**$9,300,884**	**$9,582,610**	**$103,757,806**
Total Pooled Claims	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$1,590,743**
Total Net Paid Claims	**$6,618,011**	**$5,970,319**	**$9,232,489**	**$8,472,714**	**$7,772,879**	**$8,306,249**	**$9,072,507**	**$9,890,173**	**$9,452,680**	**$10,086,291**	**$9,300,884**	**$9,582,610**	**$102,167,063**
Average Cost Per Employee	$694.44	$608.66	$943.34	$864.92	$795.91	$850.35	$851.40	$919.50	$882.69	$941.85	$868.84	$894.32	$832.62
Total Fixed Costs	**$812,344**	**$830,800**	**$829,783**	**$830,330**	**$828,630**	**$828,207**	**$946,206**	**$955,318**	**$888,034**	**$887,834**	**$887,229**	**$885,678**	**$10,410,393**
Total Costs (Claims + Fixed)	**$7,430,355**	**$6,801,119**	**$10,062,272**	**$9,303,044**	**$8,601,509**	**$9,134,456**	**$10,018,713**	**$10,845,491**	**$10,340,714**	**$10,974,125**	**$10,188,113**	**$10,468,288**	**$112,577,456**
Total Premium	**$7,688,530**	**$7,885,018**	**$7,870,195**	**$7,878,673**	**$7,856,487**	**$7,847,984**	**$8,912,265**	**$9,001,390**	**$8,963,527**	**$8,961,175**	**$8,948,486**	**$8,935,338**	**$100,749,068**
Total Costs vs. Premium													
$ Variance	**$258,175**	**$1,083,899**	**($2,192,077)**	**($1,424,371)**	**($745,022)**	**($1,286,472)**	**($1,106,448)**	**($1,844,101)**	**($1,377,187)**	**($2,012,950)**	**($1,239,627)**	**($1,532,950)**	**($11,828,388)**
% Variance	**96.6%**	**86.3%**	**127.9%**	**118.1%**	**109.5%**	**116.4%**	**112.4%**	**120.5%**	**115.4%**	**122.5%**	**113.9%**	**117.2%**	**111.7%**



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

Large Claim Analysis

2015 Policy Period

HMO

	2014	2015 @ trend	2015 actual
Claimants Over $25K	165	165	216
Average / Claim	$75,044	$80,297	$76,987
Annual Cost	$12,382,260	$13,249,018	$16,629,192
		IMPACT DUE TO INCREASED UTILIZATION	$3,380,174

PPO

	2014	2015 @ trend	2015 actual
Claimants Over $25K	144	144	239
Average / Claim	$84,706	$90,635	$68,467
Annual Cost	$12,197,664	$13,051,500	$16,363,613
		IMPACT DUE TO INCREASED UTILIZATION	$3,312,113
		TOTAL HMO / PPO IMPACT DUE TO INCREASED UTILIZATION	***$6,692,286***

Renewal projections are completed by looking at past behavior and applying trend factors to estimate future costs. As can be seen above, the severity of large claims in both the HMO and PPO changed at rates below the trend factors used in the analysis. However, the utilization increased significantly.
The increased utilization "created" nearly $6.7 million in claim activity, that through evaluating historical performance, could not have been predicted. In fact, the HMO had 170 large claimants in 2013, while the PPO had 127. These changes are far from the percentage increase seen in 2015. We would conclude that the "experience deficit" would have been closer to $5 million without
We would conclude that the "experience deficit" would have been closer to $5 million without this dramatic increase in utilization.

WHERE DID THE CLAIMS COME FROM?

HMO

2014	04Respiratory System	14	$980,465	1 Claim over $125K - Staph bacteria infection ($320,161)
2015	04Respiratory System	14	$1,919,289	5 Claims over $125K - Including 2 Resp failures and Valley Fever ($1,547,650)
2014	06Digestive System	11	$653,836	2 Claims over $100,000 - Nothing "abnormal" ($313,707)
2015	06Digestive System	25	$1,836,439	4 Claims over $100,00 - Enteritis (over $462K), Bariatric Comp ($114K)
2014	17Myeloid Disorders	4	$568,912	1 Claim over $300K - Chemotherapy ($442,946)
2015	17Myeloid Disorders	9	$1,630,360	4 Claims over $300K - All four cancer or leukemia ($1,413,557)

PPO

2014	09Skin Disorders	3	$128,502	2 Breast cancers - $82,692
2015	09Skin Disorders	13	$996,385	7 Breast cancers - $777,786
2014	17Myeloid Disorders	2	$309,439	1 Therapy Treatment - $268,430
2015	17Myeloid Disorders	17	$1,767,256	11 Therapy Treatments - $1,025,392

SJVIA

San Joaquin Valley Insurance Authority

Meeting Location:
Fresno County Employee Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
March 18, 2016
9:00 AM

AGENDA DATE: March 18, 2016

ITEM NUMBER: 8

SUBJECT: Quarterly SJVIA financial update

REQUEST(S): That the Board receives the financial update through 2nd quarter, 2015-16

DESCRIPTION: Informational item. Please see attached report.

FISCAL IMPACT/FINANCING: None.

ADMINISTRATIVE SIGN-OFF:

Vicki Crow

Vicki Crow
SJVIA Auditor-Treasurer

SAN JOAQUIN VALLEY INSURANCE AUTHORITY
ACTUALS VS. BUDGETED RECEIPTS & DISBURSEMENTS
FOR THE THREE AND SIX MONTHS ENDED DECEMBER 31, 2015

	Current Quarter				Year-To-Date			
	BUDGET*	ACTUALS	FAVORABLE/ (UNFAVORABLE)	% VARIANCE	BUDGET*	ACTUALS	FAVORABLE/ (UNFAVORABLE)	% VARIANCE
RECEIPTS								
TOTAL RECEIPTS	**$36,183,822**	**$40,244,943**	**$4,061,121**	**11%**	**$72,367,644**	**$75,529,373**	**$3,161,729**	**4%**
DISBURSEMENTS: Fixed								
1 Specific & Aggregate Stop Loss Insurance (PPO)	273,116	270,767	2,349	1%	546,232	522,428	23,804	4%
2 Anthem ASO Administration & Network Fees (PPO)	459,806	539,568	(79,762)	(17%)	919,611	1,044,252	(124,641)	(14%)
3 Chimenti Associates/Hourglass Administration(PPO & Anthem HMO)	195,843	205,567	(9,724)	(5%)	391,685	394,284	(2,599)	(1%)
4 GBS Consulting	139,076	151,959	(12,883)	(9%)	278,153	291,744	(13,591)	(5%)
5 SJVIA Administration	98,430	42,262	56,168	57%	196,860	144,917	51,943	26%
6 Wellness	311,109	177,442	133,667	43%	622,218	427,877	194,341	31%
7 Communications	18,831	0	18,831	100%	37,662	0	37,662	100%
8 Anthem HMO Pooling	404,462	442,434	(37,972)	(9%)	808,924	871,890	(62,966)	(8%)
9 Anthem HMO Administration/Retention	603,033	613,389	(10,356)	(2%)	1,206,065	1,208,829	(2,764)	(0%)
10 ACA Reinsurance (PPO & HMO)	178,561	173,172	5,389	3%	357,122	208,422	148,700	42%
TOTAL FIXED DISBURSEMENTS	**2,682,267**	**2,616,560**	**65,707**	**2%**	**5,364,532**	**5,114,643**	**249,889**	**5%**
DISBURSEMENTS: Claims								
11 Projected Paid Medical & Rx Claims-PPO and Non-Cap HMO	20,360,469	26,281,498	(5,921,029)	(29%)	40,720,938	49,075,342	(8,354,404)	(21%)
12 Anthem MMP HMO Capitation	4,434,901	4,538,667	(103,766)	(2%)	8,869,801	8,944,252	(74,451)	(1%)
TOTAL CLAIMS DISBURSEMENTS	**24,795,370**	**30,820,165**	**(6,024,795)**	**(24%)**	**49,590,739**	**58,019,594**	**(8,428,855)**	**(17%)**
DISBURSEMENTS: Premiums								
13 Delta Dental	1,692,664	1,919,197	(226,533)	(13%)	3,385,327	3,686,606	(301,279)	(9%)
14 Vision Service Plan	330,107	295,649	34,458	10%	660,215	571,157	89,058	13%
15 Kaiser Permanente	5,899,185	6,206,995	(307,810)	(5%)	11,798,370	10,901,323	897,047	8%
TOTAL PREMIUM DISBURSEMENTS	**7,921,956**	**8,421,841**	**(499,885)**	**(6%)**	**15,843,912**	**15,159,086**	**684,826**	**4%**
TOTAL DISBURSEMENTS	**35,399,593**	**41,858,566**	**(6,458,973)**	**(18%)**	**70,799,183**	**78,293,323**	**(7,494,140)**	**(11%)**
16 **Change in Reserve**	784,229	(1,613,623)	(2,397,852)	306%	1,568,461	(2,763,950)	(4,332,411)	276%
COMBINED DISBURSEMENTS & CHANGES IN RESERVES	**$36,183,822**	**$40,244,943**	**$4,061,121**	**11%**	**$72,367,644**	**$75,529,373**	**$3,161,729**	**4%**

*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.

Note: These schedules are on the cash basis and have not been audited.

SAN JOAQUIN VALLEY INSURANCE AUTHORITY

ANALYSIS OF ADMINISTRATION, WELLNESS & COMMUNICATIONS (FEES) - RECEIPTS & DISBURSEMENTS

FOR THE THREE AND SIX MONTHS ENDED DECEMBER 31, 2015

	Current Quarter			Year-To-Date		
	SJVIA FEES			SJVIA FEES		
	Administration (*Line 5)	Wellness (*Line 6)	Communications (*Line 7)	Administration (*Line 5)	Wellness (*Line 6)	Communications (*Line 7)
FY15-16						
Receipts**	$116,247	$429,018	$22,301	$226,698	$751,155	$49,964
Disbursements:						
Auditor-Treasurer Services				8,551		
County Counsel Services				1,636		
Personnel Services	6,720			57,457		
Membership Fees						
Insurance (Liability, Bond, Etc)	30,115			66,719		
Audit Fees						
Bank Service Fees	5,427			10,553		
Wellness		177,442			427,877	
Communications						
Total Disbursements	42,262	177,442		144,917	427,877	
Change in Administration, Wellness & Communications Reserve	$73,985	$251,576	$22,301	$81,781	$323,278	$49,964

*Total disbursements for each column correspond to the line number shown on the "ACTUALS VS. BUDGETED RECEIPTS & DISBURSEMENTS" report.

**Receipts consist of fees collected from relevant enrollees at the following rates per employee per month: Various rates for administration($2.00 for SJVIA administration fees & various rates for non-founding member fees depending upon a participant's enrollment), $9.30 for wellness($2.50 for wellness fees & $6.80 for Viverae wellness fees) & $.50 for communications fees.

Note: These schedules are on the cash basis and have not been audited.

San Joaquin Valley Insurance Authority
Schedule of Cash Flow by Month
For the Six Months Ended December 31, 2015

	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
BEGINNING CASH BALANCES:							
Claims Funding Account	$ 255,518	$ 358,018	$ 725,672	$ 701,149	$ 173,361	$ 451,022	$ 255,518
Fixed Cost Account	962,479	1,084,176	1,188,032	1,878,492	247,705	627,123	962,479
Claims Reserve Account	726,791	2,019,732	889,905	1,067,064	300,837	621,538	726,791
Investment Pool-Note 1	3,111,190	3,113,257	3,113,257	1,123,875	1,126,093	126,093	3,111,190
Total Beginning Balances	5,055,978	6,575,183	5,916,866	4,770,580	1,847,996	1,825,776	5,055,978
RECEIPTS:							
Claims Funding Account	5,458,470	6,197,585	5,777,556	6,256,995	6,237,840	6,488,465	36,416,911
Fixed Cost Account	5,476,988	5,056,322	4,467,807	4,701,234	6,645,574	3,937,764	30,285,689
Claims Reserve Account	10,537,501	8,604,557	10,352,117	10,904,299	11,726,242	13,613,566	65,738,282
Investment Pool	2,067		10,618	2,218		9,780	24,683
	21,475,026	19,858,464	20,608,098	21,864,746	24,609,656	24,049,575	132,465,565
DISBURSEMENTS:							
Claims Funding Account	5,355,970	5,829,931	5,802,079	6,784,783	5,960,179	6,230,296	35,963,238
Fixed Cost Account	5,355,291	4,952,466	3,777,347	6,332,021	6,266,156	3,817,772	30,501,053
Claims Reserve Account	9,244,560	9,734,384	10,174,958	11,670,526	11,405,541	10,079,881	62,309,850
Investment Pool		-	2,000,000		1,000,000		3,000,000
TOTAL DISBURSEMENTS	19,955,821	20,516,781	21,754,384	24,787,330	24,631,876	20,127,949	131,774,141
ENDING CASH BALANCES:							
Claims Funding Account	358,018	725,672	701,149	173,361	451,022	709,191	709,191
Fixed Cost Account	1,084,176	1,188,032	1,878,492	247,705	627,123	747,115	747,115
Claims Reserve Account	2,019,732	889,905	1,067,064	300,837	621,538	4,155,223	4,155,223
Investment Pool	3,113,257	3,113,257	1,123,875	1,126,093	126,093	135,873	135,873
Total Ending Balances	$ 6,575,183	$ 5,916,866	$ 4,770,580	$ 1,847,996	$ 1,825,776	$ 5,747,402	$ 5,747,402

Note 1: The County of Fresno investment pool yield paid during the quarter ended 9/30/15 was 1.412% with quarterly earnings of $11,998.

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 **Administration & Network Fees (Anthem & Blue Shield PPO)**

ASO is "Administrative Services Only". This definition includes Anthem Blue Cross & Blue Shield administration fees and includes access fees to use the Blue Cross & Blue Shield 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 health plans excluding HealthNow/Blue Shield.

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. This category includes charges for Viverae which is an independent vendor providing wellness and disease management services. These services include disease management, health coaching, challenges, website portal, and wellness resources for participants in the SJVIA health plans.

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 & HMO)**

The Affordable Care Act (ACA) includes the following fees on insurance plans: 1) Patient Centered Outcomes Research Institute (PCORI)-this fee is $2.00 per covered member per year. 2) Transitional Reinsurance Fee-this fee is $63.00 per covered member per year.

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 **Change in Reserve**

Excess receipts over claims, premiums and fixed costs.

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Fresno County Employees' Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
March 18, 2016 9:00 AM

AGENDA DATE: March 18, 2016

ITEM NUMBER: 10

SUBJECT: Receive Actuarial Review from Aon Hewitt regarding Rate Development, Reserve Adequacy, and Fund Projections for 2015 & 2016 (A)

REQUEST(S): That the Board receive and provide direction to SJVIA staff on recommendations contained in report

DESCRIPTION:

On October 15, 2015 the SJVIA Board authorized staff to request quotations for an independent review of rates and methodology for pricing, as well as reserve projections and funding adequacy. At the November 6, 2015 meeting the Board approved the selection of Aon Hewitt to perform those services. Staff engaged Aon and after providing the consultant with data and information, Aon has completed the actuarial review and has provided findings and recommendations contained in the Attached report. Representatives from Aon will be in attendance at the March 18, 2016 meeting to present and discuss their findings and recommendations, as well as their strategic observations also contained in the Attached report.

FISCAL IMPACT/FINANCING:

The cost for the preparation, analysis, and finalization of the report is $25,000 and has been included in the amended 2015-16 budget for adoption.

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

Aon Hewitt
San Francisco, CA | Health & Benefits

SJVIA

Actuarial Review

Rate Development & Reserve Adequacy and Fund Projections

February 29, 2016

Table of Contents

Executive Summary

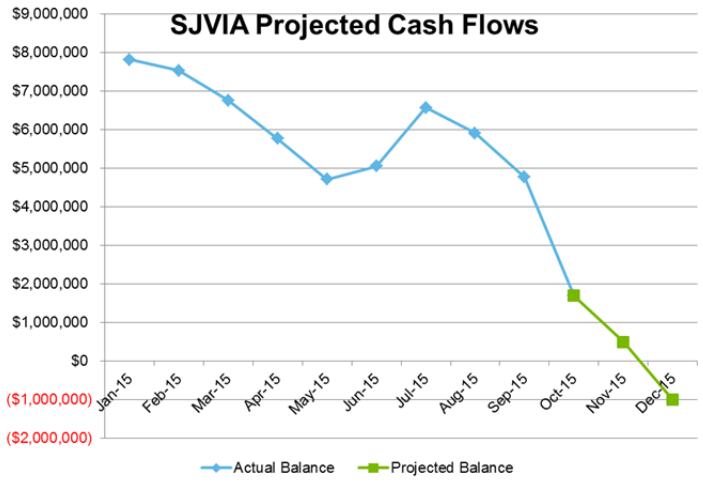
Background

At the request of the SJVIA, Aon Hewitt reviewed the 2015 and 2016 pricing and reserving practices for the Pool. This report contains a written analysis of our findings. Our report includes a review of the adequacy of the 2015-2016 rate development; the IBNR reserve adequacy; and, the 2016 fund projections. A summary of our review including conclusions, recommendations, and observations is provided.

The data used for this analysis was provided by SJVIA. Aon Hewitt relied upon data distributed to the Board and reports from Anthem, US Script, and AdminDirect. Aon Hewitt reviewed this data for reasonableness but has not audited it. Aon Hewitt relied upon the data from SJVIA and its carriers while performing this analysis. The data that was provided was generally accepted as accurate. Aon Hewitt made additional inquiries where the data provided did not meet expectations. This review does not constitute an actual audit of the data provided in the reports.

Rate Development Adequacy Overview

Throughout 2015, SJVIA experienced deterioration of its financial health as illustrated by the graph below (Cash Flows as of 11/06/15).



Aon Hewitt actuaries reviewed the 2015 and 2016 rate development with the data that was available at the time the pricing was developed. The 2015 pricing was approved at the August 2014 Board Meeting using data through June 2014. The 2015 pricing followed a similar schedule. While reviewing the pricing work that was initially done for SJVIA, we performed our analysis using the data that was available at the time that the original work was produced (June 2014 data for the 2015 pricing). Aon Hewitt also reviewed the pricing work that was completed using the chosen underwriting style, with consideration given to the strategic decisions that were made. Strategically, Aon Hewitt has concerns with the practice of using all reserves in excess of the IBNR to reduce the necessary renewal rates.

Aon Hewitt's review resulted in several minor changes in the 2015 pricing that resulted in a pricing increase of 2.85% compared to the implemented 1.13%. An increase of 2.85% would have still resulted in a deficit position for the SJVIA in 2015. The 2.85% reflects our review of the status quo pricing, which

based on the factors that follow, would have been inadequate. This “status quo” pricing should have, at minimum, been adjusted for the SJVIA Growth and the Fresno County Migration to the extent that they were expected. Aon Hewitt was not provided with the circumstances behind these two factors. If they were foreseeable, then the pricing should have been adjusted or should have included some margin. Aon Hewitt expects that the following factors contributed to the underfunded status for 2015:

- Claim Volatility and High Rx Trends – Rx trends increased significantly in late 2014 and 2015 primarily due to the arrival of high cost specialty medications. Additionally, the High Cost Claims (>$50,000) in the Anthem HMO plan has increased significantly.

- SJVIA Growth – SJVIA net enrollment increased by 1,391 subscribers or by15% between July 2014 and July 2015. 75% of the net increase in enrollment came from entities that were unable to provide past claims experience. New business underwriting, especially without historical claims, adds potential volatility to the Pool. Fresno County Migration – In December 2014 over 400 employees from Fresno County migrated from the Anthem HMO plan to the Kaiser HMO plan. These employees had an Age/Gender Factor that was 18% below the rest of the SJVIA HMO population. If this migration was not adjusted for in the pricing, it may have caused the Anthem HMO plan to be underfunded.

- Compared to 2015, Aon Hewitt observed more substantial necessary changes during the review of the 2016 pricing. These observations included changing the experience period from 18 months to 12 months and increasing the trend assumptions. These changes resulted in a required increase of 11.58% as compared to the 8.76% increase that was recommended. Aon Hewitt also recalculated the pricing using our recommended Incurred Claims approach. This approach indicated a rate increase of 16.5% (including 2% margin and no planned reserve release).

Aon Hewitt reviewed the New Business Underwriting Methodology (updated April 19, 2013) and found it to contain technically sound recommendations. Aon Hewitt believes that strict observance of these policies should produce viable long term rates for new entities in SJVIA. However, Aon Hewitt points out that this policy does create a short term deficit exposure, which should be paired with an offsetting excess reserve policy in order to preserve the financial stability of the SJVIA.

IBNR & Excess Reserve Adequacy

Aon Hewitt reviewed the IBNR percent of claims method that SJVIA uses and found the reserves on average to be adequate. However, an actuarially certified reserve will normally utilize more accurate reserve forecasting methods such as the Development and Projection methods. Aon Hewitt recommends that the SJVIA consider adopting policies for reserves in excess of the IBNR such as Contingency and/or Stabilization reserves. These excess reserves will reduce insolvency risk for the SJVIA and add additional controls around surplus cash use. Aon Hewitt also recommends that actuarially certified reserves be calculated, at a minimum, on an annual basis.

2016 Fund Projections

As mentioned above, Aon Hewitt’s recommended 2016 pricing was not aligned with pricing that was developed previously. Aon Hewitt expects a funding deficit of 2.0%-3.5% or approximately $2.2M-$4.0M due to the differences between the 16.5% renewal and the in-force rates. No migration was assumed and the Pool was generally assumed to be in a steady state. This estimate includes eliminating the Viverae contract and the 13.15% HMO and 4.9% PPO renewal for Fresno County and the County of Tulare. This

does not include the Kaiser migration in 2016 (400+)[1]. Although we have included 2.0% claims pricing margin that may absorb some of these unplanned events, if the continued Kaiser migration again resulted in a worse Anthem HMO risk pool (relatively health risk left Anthem and went to Kaiser) then the Anthem HMO premiums may be underpriced. The extent of this deficit will depend on the estimated change in the self-funded risk pool.

Further, our projections do not factor in potential loans from the members or the interest costs on those loans. This projection is the difference between our recommended rates (+16.5% renewal) and the in-force rates. The data that we received and this analysis indicate that the incurred claims for the year (paid + change in IBNR) will exceed the premium collected by $2.2M-$4.0M.

2015 Pricing

For the review of the 2015 pricing, Aon Hewitt performed a technical review of the current underwriting guidelines used by SJVIA by utilizing the data available at the time the underwriting was performed. The 2015 pricing was approved at the August 2014 Board Meeting using data through June 2014. The 2015 pricing followed a similar schedule. While reviewing the pricing work that was initially done for SJVIA, we performed our analysis using the data that was available at the time that the original work was produced (June 2014 data for the 2015 pricing).

Throughout this analysis, there are both technical recommendations (changes that should have been made within the current style) and strategic recommendations (comments regarding the approach taken to perform the underwriting). The majority of the 2015 comments were related to strategic decisions rather than the technical methodology.

2015 Pricing Method Overview

Aon Hewitt opines that from an overall technical perspective, Gallagher's 2015 pricing is not unreasonable. However, Aon Hewitt has a different opinion on some of the strategic decisions made in the 2015 pricing.

Gallagher used an industry accepted "Paid Claims" pricing methodology to calculate the necessary rate increase for the SJVIA program. This "Paid Claims" method works well for stable pools and requires less data than alternative methods such as the "Incurred Claims" method.

For the Paid Claims methodology, Gallagher used the most recent 12 months of paid claims experience (offset by stop loss reimbursements and Rx rebates) in conjunction with 12 months of enrollment data (lagged 2 months) to create the per employee per month (PEPM) claims basis. The enrollment is lagged 2 months in order to create a proxy for incurred claims. The 2 month lag seeks to account for the fact that medical claims typically experience a lag between the date of service (or incurred date) and the date claims are paid. The PEPM claims basis was then adjusted for Medical/Rx trend at 7.5%/4.5%, respectively, for 19 months to produce the 2015 PEPM claims target. Next, non-claims costs (i.e. administration costs, SJVIA fee, stop loss premium) are added to the cost of coverage. Finally, the total SJVIA cost estimate for 2015 is reduced by the entire balance of the excess reserves estimate. This cost is compared to the in-force premium to calculate the necessary renewal increase for the Pool.

[1] Aon Hewitt does not have the 2016 census data that would be necessary to estimate the impact of this migration.

In the Incurred Claims method, incurred claims by month are used as the claims basis in the pricing. The most recent months of incurred claims are "completed", meaning that the total run-out is estimated. This is typically done using the same methods that are used for estimating IBNR reserves. Once the incurred claims are estimated, the pricing follows the same steps as above including trend adjustments and adding non-claims costs. The benefit of the Incurred Claims method for SJVIA is a more accurate claims projection. The 2 month enrollment lag in the Paid Claims method may not create an accurate estimate of incurred claims since the Pool's self-funded enrollment has grown so quickly.

Observations

It appears that Gallagher consistently applied the trend rates over too short of a time period. When utilizing the "Paid Claims" method, an underwriter must consider that the midpoint of their data is based on where the enrollment data time periods. Hence, paid claims data from July 2013 – June 2014 with a 2 month enrollment lag is actually trended as if it were incurred claims data from May 2013 – April 2014 (the 2 month lag creates an estimate of incurred claims). Aon Hewitt also has a different perspective regarding Medical/Rx trends at the time of this pricing.

Pricing Comparison

Consideration:	Gallagher Pricing	Aon Hewitt Review
Experience Period	7/1/13 – 6/30/14 (12 mo.)	7/1/13 – 6/30/14 (12 mo.)
Claims Base	Paid Claims (enrollment lag)	Paid Claims (enrollment lag)
Rx Rebates	Included	Included
Stop Loss Reimbursement	Included	Included
Annual Leveraged Trend (Medical/Rx)	7.5%/4.5%	7.0%/7.4%
Trend Time Period (Months)	19	20
Demographic Adjustment	None	None
Margin	None	None
Excess Reserves Used (planned)	$5.37M	$5.37M
Rate Impact	+1.13%	+2.85%

As shown in the table above, this pricing ignores any adjustments for demographic changes within the population. Based on industry standards, a demographic adjustment is typically used to account for change in the Age/Gender Factor[2] and number of members per employee for the Pool.

A plan value adjustment is also typically included in pricing to reflect changes in the overall actuarial value of the plan. Employee buy-ups or buy-downs should be accounted for in order to ensure that the historical experience properly represents the projected state of the Pool.

The trend numbers are built from Aon Hewitt's proprietary internal trend guidance. This guidance is developed by leveraging multiple industry data sources; Aon Hewitt's own book of business; and, industry experts.

Aon Hewitt would not expect a difference in the calculation of the months of trend. Contrary to some other "judgment calls," calculating the months of trend is an exact formula. We expected that there would be no difference in our calculation. This impact may be small, but it was not expected to differ at all. For

[2] A common proxy for claims cost based on an individual's Age/Gender. See glossary.

example, using a 7% annual trend, a one month difference equates to about a 0.6% difference in estimated claims.

Recommendations

Aon Hewitt recommends that SJVIA consider adding margin to their rates. Margin helps absorb any unplanned deviations from the projected claims costs. For a group of SJVIA's size, margin may be excluded if the Pool is in a predictable steady state. However, at this time Aon Hewitt believes that some margin may be prudent given the level of growth that SJVIA has been experiencing.

Aon Hewitt also questions the practice of using the entire reserve surplus in excess of the IBNR to reduce the required renewal. Instead, Aon Hewitt recommends holding additional reserves in excess of the IBNR (as discussed in the Excess Reserves section below) before using excess funds to reduce the necessary renewal.

2015 Underfunding

The SJVIA Projected Cash Flows as of 11/6/15 distributed to the Board indicated that reserves were estimated to be reduced by $9M in 2015, 67% more than the planned $5.4M reserve release in 2015. Based on the data and information provided, Aon Hewitt expects several factors were key to the underfunding of the SJVIA plans in 2015: (1) Claim Volatility and High Rx trends (2) SJVIA growth (3) Fresno County HMO Migration.

Claim Volatility and High Rx Trends

In late 2014, prescription drug claim cost trends began to spike, in part, due to the entry of the highly publicized expensive specialty medications. The rampant cost increase to plans that occurred in late 2014 and 2015 caught many plan sponsors off guard. Aon Hewitt internal trend guidance published in early 2014 expected a 7.4% pharmacy trend for SJVIA for 2014-2015, but 10.8% for 2014-2015 in the guidance published in early 2015. This same phenomenon is also reflected in SJVIA's case specific data. When rating for 2015, SJVIA's case specific data indicated a prescription drug trend of 4.5-5.5% was used. However, pricing for 2016 SJVIA's case specific trend spiked to 11.5-13.5%. SJVIA medical trends also exhibited a similar increase. Financial Dashboards provided by Anthem also indicate a 54.7% increase in the High Cost Claimant (>$50,000) PEPM between the periods of 8/2014-7/2015 and 8/2013-7/2014 for the HMO plan.

SJVIA Growth

Any material change in the Pool must be properly accounted for in order for the funding to be adequate. Making the proper adjustments is especially challenging when writing new business. In most instances, the Pool will be forced to make a decision to accept/reject the new entities without perfect information. This issue is compounded when the new entity is unable to provide any historical claims experience. From July 2014 to July 2015, SJVIA's self-funded plan enrollment had a net increase of 1,391 subscribers or 15% (HMO: -122 or -2.3%, PPO: +1,513 or +38%). Of the new enrollment in this time period, 1,050 or 75% of the net increase in subscribers came from entities that were unable to provide prior claims experience. Aon Hewitt was not provided with adequately granular data to assess the accuracy of the rates that were developed for these new entities, but recognizes that any time new risk is introduced to the Pool there is a margin for error. The potential volatility introduced by growth is further addressed in the New Business Rates section.

Fresno County HMO Migration

In December 2014, over 400 employees from Fresno County migrated from the Anthem HMO plan to the Kaiser HMO. This migration represented a 7% decrease in total HMO enrollment. In Aon Hewitt's experience, the employees who migrate to Kaiser are typically in better health than those remaining on the plans with broader provider networks. We expect that the employees who migrated were some of the best risk from the Fresno County HMO population. To help validate this theory, Aon Hewitt calculated the Age/Gender factor of the SJVIA HMO population and of the Fresno County employees who migrated to Kaiser. The Age/Gender Factor for the migrating employees was 18% below the rest of the SJVIA HMO population. If this migration was not properly planned for, then the 2016 HMO premiums would be insufficient to cover the expected HMO claims.

Shortly after the employee migration from Fresno County, the HMO plan received offsetting new enrollment from the City of Clovis, City of Hanford, and City of Oakdale totaling 367 subscribers. The Age/Gender Factor of this new population was 32% greater than the existing HMO Pool and 61% higher than the migrating Fresno County population. The Anthem HMO risk pool was not only deteriorated by the migration of the Fresno County employees, but also by the new enrollment.

When underwriting the self-funded plans for SJVIA, the goal is to accurately predict the risk of the Pool in the following year using prior experience. As we demonstrated, the migration from the Anthem HMO to the Kaiser HMO resulted in relatively good risk leaving the Anthem HMO. This change in the risk composition of the self-funded plan would need to be adjusted for. Otherwise favorable past experience (which includes the good risk that migrated to Kaiser) would be used as the cost basis for the future (which post-migration has a relatively worse set of risk). Sometimes this migration is unexpected and the plan would need adequate margin to absorb this change.

If Kaiser's relative competitive position changed significantly (through a lower premium or a lower employee contribution), then it could reasonably be predicted that there would be some employee migration. This migration in the very least would cause additional uncertainty that should be offset with additional reserves or adding margin to the premiums.

Recommendation

Aon Hewitt expects that these factors contributed funding deficit that SJVIA experienced in 2015. We recommend further investigation of these factors and the circumstances surrounding them in order to better prepare for similar circumstances in the future.

2016 Pricing

Aon Hewitt reviewed the 2016 underwriting performed by Gallagher using the data provided to the Board. For the 2016 pricing, Gallagher deviated from the typical 12 months of historical experience that had been used in prior years and instead used 18 months. It appears that this alteration was made to smooth out some of the poor experience that was being observed from January-June 2015. However, smoothing out poor claims experience may not be prudent if the increase in observed claims is not temporary (such as deterioration of the risk pool). Treating an actual increase in costs as a temporary deviation from expectations may cause future premiums to be inadequate.

Aon Hewitt disagrees with the choice of trends that were used for the 2016 pricing. At the time this pricing was developed, industry trend sources were indicating 2015-2016 trends of 5-7% medical and 10-12% prescription drug. Further, Gallagher's own PEPM growth calculations for SJVIA indicated double digit prescription drug trends. Despite these factors, Gallagher used 4.5% prescription drug trends in the pricing for 2016. In Aon Hewitt's opinion, this deviation is outside the range of the underwriter's discretion

and would only be appropriate if properly justified by thorough supporting analysis. As in 2015, Aon Hewitt believes that Gallagher continued to trend the data over too short of a time period. Aon Hewitt's updates to the Gallagher underwriting indicate the following:

Pricing Comparison

Consideration:	Gallagher Pricing	Aon Hewitt Review
Experience Period	1/1/14 – 6/30/15 (18 mo.)	1/1/14 – 6/30/15 (18 mo.)
Claims Base	Paid Claims (enrollment lag)	Paid Claims (enrollment lag)
Rx Rebates	Included	Included
Stop Loss Reimbursement	Included	Included
Annual Trend (Medical/Rx)	7.5%/4.5%	5.5%/11.3%
Trend Time Period (Months)	21	23
Demographic Adjustment	None	None
Margin	None	None
Excess Reserves Used (planned)	$1.15M	$1.05M
Rate Impact	+8.76%	+11.58%

The most important considerations are the trends and the trend period. The Excess Reserve difference is due to the higher estimated costs (therefore less excess reserves that can be used to reduce the rate impact). The 2 months of trend would impact the estimated claims by about 1.2%.

If the typical 12 months of experience (7/1/14-6/30/15) had been used in the current methodology, the recommended rate impact would be 12.6% for the Pool (with a $1.2M planned reserve release). Using 18 months instead of the usual 12 months reduced the necessary renewal by 1.0%.

Aon Hewitt also performed recommended Incurred Claims underwriting for 2016 (with data through June 2016) based on the data provided for the Reserve Adequacy testing. This pricing indicates a necessary increase of 7.9% PPO and 22.6% for the HMO, combining to be 16.5% (without any planned reserve release). In addition to using incurred claims, this method has also built in 2% margin into the 2016 claims projection.

Recommendations

Additional adjustments are needed for any expected changes in the Pool, such as migration between self-funded plans and/or migration to the Kaiser HMO[3].

Aon Hewitt also recommends that the most recent industry standard trend rates be used in the annual renewal. As in the 2015 pricing, Aon Hewitt recommends adding margin to the pricing and questions the practice of using the entire reserve surplus in excess of the IBNR to reduce the necessary renewal.

[3] Recent conversations with the SJVIA have indicated that there was additional migration from the Anthem HMO to the Kaiser HMO in 2016. However, Aon Hewitt does not have the 2016 census data that would be necessary to estimate the impact of this migration.

Risk Pool Deterioration

Aon Hewitt is concerned with the possible deterioration of the SJVIA self-funded risk pool. Migration over the last year indicates:

- Relatively good risk is exiting the Pool by migrating from the Anthem HMO to the Kaiser HMO
- New entities in the self-funded plans primarily have PPO enrollment

In general, HMO enrollment is less risky than PPO enrollment due to the capitated portion of the HMO premium. This capitation provides financial protection to SJVIA against high utilization of the capitated services.

It is common for public entities in California to have a form of fixed-dollar employer subsidy for Medical benefits. This policy creates a competitive advantage to plans with low total premiums because employees will have a lower required contribution. Through Kaiser's care delivery system they can generally offer richer benefits for lower premiums than their competitors with broader provider networks. If healthy employees migrate from the self-funded plans to the Kaiser plan, it will likely result in a deterioration of the self-funded Pool. This deterioration will require a complementary premium increase, which will further exacerbate the premium differential between the Kaiser and non-Kaiser plans. As this cycle continues, the non-Kaiser plans may become unstable or too expensive to maintain. Certainly there are offsetting considerations such as the Kaiser service area and employee preferences.

Recommendations

SJVIA should be conscious of these factors when adding new entities. SJVIA may also consider building a back-end risk adjustment to surcharge the Kaiser premiums/employee contributions if the self-funded risk Pool deteriorates past a given threshold or maintaining a strict Kaiser enrollment percentage requirement. These considerations will be more important if Kaiser ever makes a strategic decision to "invest[4]" in the SJVIA business, or to issue premiums that the underwriting cannot support.

New Business Rates

Aon Hewitt reviewed the New Member Underwriting Methodology document (revised April 19, 2013) and found it to be a technically sound document. If followed correctly, this methodology should produce viable long term rates for new members in the Pool. However, this methodology does contain a short term exposure as illustrated by a simple example.

Consider an entity, City X, with 1001 employees is joining SJVIA without claims experience (perhaps from CalPERS):

[4] There are times when an insurer will offer rates that are lower than presently justified by their underwriting. This is typically a business decision to gain market share. For example an insurer may offer to reduce premiums by 20% in order to cause a large migration. This scenario may cause the incumbent plan funding to be inadequate.

	Initial Entry Period		Renewal	Optional
	Year 1	Year 2	Year 3	Year 4[5]
SJVIA Premium[6]	$86,644,000	$90,837,000	$94,016,000	$96,502,000
SJVIA Status Quo Claims	$86,644,000	$89,677,000	$92,815,000	$96,064,000
Loss Ratio	100%	99%	99%	100%
City X Premium	$8,179,000	$8,575,000	$9,733,000	$10,963,000
City X Claims	$9,406,000	$9,735,000	$10,076,000	$10,429,000
Loss Ratio[7]	115%	114%	104%	95%
Total Premium	$94,482,000	$99,412,000	$103,717,000	$107,209,000
Total Claims	$96,050,000	$99,412,000	$102,892,000	$106,494,000
Loss Ratio	101%	100%	99%	99%
Total Surplus/Deficit	**($1,227,000)**	**$0**	**$858,000**	**$972,000**
		Year 1- Year 2	Year 2 - Year 3	Year 3 - Year 4
SJVIA Claims Trend (Status Quo Renewal)		3.5%	3.5%	3.5%
SJVIA Renewal with City X		4.8%	3.5%	2.6%
Excess Renewal		1.3%	0.0%	-0.9%
City X Renewal[8]		4.8%	13.5%	12.6%
Experience Modification Factor		114%	110%	103%

Suppose that City X's initial rates are underpriced by 15% due to a lack of claims experience and a risk profile that exceeds the demographic adjustment. This entity will create an unplanned budget deficit in Year 1 of $1.2M. In Year 2, this entity will receive the pooled rate increase (which will be adjusted upward from 3.5% to 4.8% to reflect the poor experience of City X). The SJVIA rates will now be stable in Year 2, but higher than they would've been without City X (excess renewal of +1.3%). In Year 3 and Year 4, City X's subsidy will decrease as their renewal is impacted by their Experience Modification Factor (EMF). Additionally, a surplus should be created each year that City X's renewal is greater than the overall SJVIA renewal. By Year 3, the majority of the 15% underpricing should be corrected for City X. This simple example illustrates the long term viability of the methodology (removing the 15% underpricing over 4 years), but also shows the short term volatility of underwriting new business ($1.2M deficit in Year 1).

Based on our simplified example, the SJVIA may not recoup deficit funds until Years 3 and 4 when the individual entity's renewal is influenced by the Experience Modification Factor. However, entities only

[5] Assuming City X remains a member of the SJVIA after year 3
[6] Simplified example: Claims Premium only, ignores expenses for now. Most volatility in budgeting comes from claims.
[7] Credibility Adjusted Loss Ratio
[8] City X Renewal = SJVIA Renewal (Revised) in Year 2. In Years 3-5: SJVIA Renewal (Revised) + Experience Modification Factor (from the prior year, up to 10% per year)

agree to a 3 year commitment, so it may be that for a grossly underpriced entity the deficit funds are never recouped.

Aon Hewitt does not have data that is granular enough to assess the actual impact of SJVIA's new business underwriting. This hypothetical example is meant to illustrate the short term funding volatility that new business can create and illustrate that it would be in the best interest of the SJVIA to carry adequate reserves to offset this volatility.

Recommendations

Aon Hewitt recommends establishing a reserve policy to ensure that sufficient funds are on hand for the Pool to absorb the short term volatility of their New Member Underwriting Methodology. Adequate reserves in excess of the IBNR can be used to cover short term deficits, and recovered in later years (assuming the entity remains with SJVIA) once the Experience Modification Factor begins to correct any underpricing. SJVIA's board can work towards establishing a minimum level of capital needed to underwrite new business. This would be especially prudent when the proposed new entity does not have prior claims experience.

Aon Hewitt recognizes that a minimum reserve policy may limit the amount of new business sold to the available reserve funds. However, a minimum reserve policy would further the SJVIA expansion goal to "benefit from stability and rate advantages typically associated with very large accounts." When establishing the required reserve level, the Board could strike a balance between stability and growth.

IBNR & Excess Reserve Adequacy

IBNR Reserves

Based on information reported to the SJVIA Board, the IBNR reserve methodology for SJVIA from inception has been a percent of annual paid claims. Specifically, from inception to 2015, SJVIA has held 16% of annual medical paid claims and 5% of annual prescription drug paid claims. In the 2016 pricing SJVIA reduced their IBNR factors to 14% of annual medical paid claims and 5% of annual prescription drug paid claims. Aon Hewitt reviewed the adequacy of this methodology be examining the historical run-out patterns of SJVIA's medical and prescription drug claims.

Analysis of the run-out pattern of the medical and prescription drug claims indicate that the IBNR reserve factors used by SJVIA have been adequate on average between July 2014 and June 2015[9]. This time period was chosen in order to allow for five months of run-out data, which reduces the IBNR estimation errors.

Recommendations

Aon Hewitt recommends that SJVIA receive an actuarially certified IBNR estimate, at a minimum, on an annual basis. An estimate built using a percent of paid claims may ignore recent trends in the processing

[9] IBNR estimates developed in the graph above are built using Aon Hewitt's proprietary IBNR model. This model builds upon actuarial methods commonly accepted by the Society of Actuaries and American Academy of Actuaries as valid methods to estimated incurred claims for the purpose of determining an IBNR. All healthcare actuaries in the US are expected to be familiar with these methods and use them. See the glossary for explanations on these methods.
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speeds of the claims data and could possibly underestimate the reserve as SJVIA grows. Further, a more exact estimate, such as using the Development and Projection methods[10], would be beneficial when assessing the level of capital in excess of the IBNR. Aon Hewitt also recommends including margin in the IBNR estimate and a provision for claims expenses, as is commonly accepted in the industry.

Excess Reserves

Aon Hewitt's review of the current SJVIA reserving policies indicates that there are no formal policies in place for reserves in excess of the IBNR. Underwriting documents indicate that any funds in excess of the IBNR are routinely used to reduce the required rate increase of the next renewal. While this practice benefits SJVIA entities by immediately returning any excess surplus (in the form of reduced renewals), it introduces significant cash flow risk to SJVIA. It is prudent for pools such as SJVIA to establish additional reserves as a provision for adverse deviation in the projected claims. A level of capital can be established as a contingency reserve in order to ensure that sufficient funds are available for expected claims for the given year up to a chosen confidence interval (i.e. 80th, 95th, 99th). Funds in excess of the IBNR and contingency reserves could then be used to reduce the SJVIA renewal (all at once or amortized over several years) or invest in new business. A formal stabilization reserve could be established with the purpose of distributing funds in excess of the reserves in a purposeful manner.

Recommendations

Aon Hewitt recommends that additional reserves such as a contingency and/or stabilization reserve be developed to further accomplish the SJVIA's goals. Further Aon Hewitt recommends that the Board formally approve all reserve policies and any changes to these policies.

SJVIA 2016 Fund Projections

After reviewing the 2015 and 2016 plan year pricing, Aon Hewitt developed 2016 budget projections for SJVIA. Aon Hewitt expects the costs to the SJVIA in calendar year 2016 to run 2.0%-3.5% over total budgeted premiums. At the time this analysis was conducted, the budget deficit was estimated to be between $2.2M - $4.0M.

This assessment is based on claims data through November 2015 and enrollment through October 2015. No migration was assumed and the Pool was generally assumed to be in a steady state. This estimate includes eliminating the Viverae contract and the 13.15% HMO and 4.9% PPO renewal for Fresno County and the County of Tulare.

Recommendations

Aon Hewitt recommends that the board develop a funding and underwriting policy geared towards bringing SJVIA back to a sound fiscal position and to ensure long-term financial stability. Aon Hewitt opines that conservative pricing assumptions and oversight; creating reserves in excess of the IBNR; and, more selective new business underwriting are all necessary in order to help improve the financial position of the Pool increasing the chances that the Pool can be sustained.

[10] See Glossary for an overview of these methods

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About Aon

Aon plc (NYSE:AON) is a leading global provider of risk management, insurance brokerage and reinsurance brokerage, and human resources solutions and outsourcing services. Through its more than 69,000 colleagues worldwide, Aon unites to empower results for clients in over 120 countries via innovative risk and people solutions. For further information on our capabilities and to learn how we empower results for clients, please visit: http://aon.mediaroom.com.

Appendix: Glossary

Age/Gender Factors – On average Medical/Rx costs vary significantly by Age/Gender. The difference in cost by Age/Gender can be reduced to standardized factors (Male 65+ Factor =2.5, meaning that costs for males ages 65+ are 2.5 more than the average member). Each age range and gender has a cost factor.

In order to calculate the risk status of a group, the aggregate Age/Gender factor can be calculated. This aggregate factor can also be calculated at several points in time to estimate how the risk of the group has changed over time. Age/Gender factor analysis has its drawbacks, but requires significantly less data and is less costly than the more accurate methods (such as Risk Scores). Age/Gender factors are a useful way to quickly estimate the risk of a population based solely on each subscriber's age and gender.

Completed – Completed is a term used to refer to the calculation of Incurred Claims. For example, consider there is $300,000 in claims incurred in January 2016 (members received medical services in January 2016) and paid in January 2016 (the insurer paid the medical service providers in January). Based on prior experience the actuaries estimate that only 30% of total incurred claims are paid within the same month. So the total incurred claims for January 2016 = $300,000/30% = $1,000,000. This process of estimating the remaining claims is called "Completing" the claims.

Employee buy-ups or buy-downs – This term references changes in employee plan selection during open enrollment. Specifically to "buy-up" means that an employee migrates to a higher value (and generally higher cost) plan. Conversely a "buy-down" means that an employee selects a less rich plan (an generally less costly).

Incurred Claims – Medical Claims typically experience a period of time (or lag) between the date that services are provided and the date that the claims are paid. For example a member may have a hospital stay in January, but the insurance company does not receive the claim until March. Some claims may take up to 12-18 months before they are fully paid (or **completed)**. The actual incurred claims for January 2015 may not be known with certainty until January – June 2016. The majority of the claims for a given incurred month are paid within the first 4-6 months. Actuaries have developed models that help estimate the final incurred claims for any given month at a point in time.

Medical Premiums are set to the level of expected incurred claims for a given time period. It is necessary to estimate historical incurred claims in order to calculate future premiums and set current IBNR reserves.

Impact on Pricing:

- **Paid Claims Pricing** – this method technically still estimates incurred claims. However, this estimate is done by mismatching the paid claims and enrollment of a particular time period. For example paid claims from January –December 2015 would be matched with enrollment from November 2014 –October 2015 (2 month offset or lag). The theory is that the majority of claims that are paid in January 2015 are really incurred by the enrollment in November 2014. This 2 month lag creates an estimate of incurred claims and shifts the claims experience to the enrollment's time period.
- **Incurred Claims Pricing** – in this pricing method, estimates of incurred claims are produced in a separate model (using the same methods as an IBNR calculation – see below).

IBNR Reserve Methods – Overview

The IBNR reserve seeks to quantify the amount of claims that have been incurred but not reported as of a particular point in time. In other words, if the plan was to terminate all coverage as of a point in time, how much would they continue to pay in claims over the next 18 months? At its core, the answer to this question generally reduces down to creating an estimate of ultimate incurred claims and comparing that to what has been paid to date. A detailed exhibit would look like:

Month	Incurred Estimate	Paid to Date	Estimated IBNR
October 2015	$1,000,000	$890,000	$110,000
November 2015	$1,000,000	$780,000	$220,000
December 2015	$1,000,000	$350,000	$650,000
Total IBNR as of 12/31/15			**$980,000**

As seen in the table above, the IBNR is really just the aggregate value of the difference between the Paid to Date and Incurred Estimate for each month. The key assumption in setting the IBNR is the Incurred Estimate. There are multiple methodologies to estimate incurred claims and below we describe two of the most popular methods:

- **Development Method** – In the development method claims data is summarized by paid date and incurred date in the form of a lag triangle. The lag triangle data is analyzed and adjusted to produce Completion Factors such as:

Month	Completion Factor
4	94%
3	89%
2	78%
1	35%

  These completion factors establish a typical run-out pattern that is expected for all months of data. For example in Month 1 (regardless of what month) this method assumes that the paid amount is equal to exactly 35% of the ultimate incurred claims for Month 1. This method can produces unstable results in Month 1 & Month 2 due to the variation in paid claims and the low completion factors. Typically a different method such as the Projection method will be used where the development method produces unstable results.

- **Projection Method** – this method is often used in conjunction with the Development Method. In this method incurred claims are estimated by trending historical data forward and applying any necessary adjustments (i.e. seasonality, plan changes). This method is more stable, but is also not sensitive to the most recent data observations.

Generally, an actuary may use multiple methods together to produce their estimate of incurred claims and subsequently their IBNR reserve estimate. In contrast to these complex methods, a common short-cut is to use a multiple of paid claims (Factor Method). This method can be valid, as long as it consistently produces adequate IBNR reserves.

Paid Claims – Paid Claims refer to the actual amounts paid out for claims incurred each month. For example the plan may pay $1,000,000 in claims in January 2015. This amount is not the same as the claims incurred in January. The majority of the claims paid in January 2015 were really incurred in 2014.

Pool/JPA – A group of entities that join together to obtain or provide services. With insurance pools specifically, members may risk share and retain/pool a portion of the risk and/or purchase insurance/reinsurance as a means of risk transfer.

Run-out Pattern - a run-out pattern in this context is the pattern in which a month of incurred claims becomes completed. For example a run out pattern may look like the following:

Month	Completion Factor
4	94%
3	89%
2	78%
1	35%

In the first month, say January, 35% of that month's incurred claims are also paid. In February, 43% of the ultimate incurred claims for January are paid. By April, 94% of the incurred claims for January have been paid.

Aon Hewitt
San Francisco, CA | Health & Benefits

SJVIA

Strategic Observations

February 29, 2016

General Observations

In addition to the actuarial analysis we completed, we would also like to offer some observations and commentary based on our experience consulting for other large self-funded public sector risk pools and public entities.

Growth Strategy

We recommend that SJVIA consider establishing objective growth goals and targets for the coming years. As part of that growth strategy, SJVIA may wish to place a temporary moratorium on adding new members until the Pool is stable; has accumulated sufficient reserves; and, has implemented other changes they chose to adopt. Further, SJVIA may want to consider establishing underwriting policies regarding underwriting entities with valid historical claims experience and those without claims experience.

Checks and Balances

The addition of new members can have a profound impact on the Pool's financial position, especially those new members that don't come with claims experience. It is recommended that the Pool consider adding a second layer of analysis when underwriting a new member. For example, if you are relying on your consultant to conduct underwriting and provide a recommendation regarding admission of prospective members, consider training someone in one of your finance departments to be able to review and validate the consultant's recommendation.

Consultant Incentives

SJVIA compensates their consultant on a "per employee per month" basis or PEPM. For small entities, it is not uncommon to pay a consultant on a PEPM basis. However as groups get larger, a fixed fee is generally established as opposed to a PEPM. A PEPM fee arrangement creates an incentive for the consultant to increase the number of employees participating in the Pool. Conversely, if the pool decreases in size then the consultant's fees would decrease. This incentive could be useful if the Pool is aggressively trying to grow. But, it can also create a situation where the consultant's desire to increase the population of the Pool may not be aligned with the Pool's goals and strategic direction creating a potential conflict of interest. Also, as the Pool's underwriter, there is motivation to provide a competitive annual renewal to existing members as an incentive to stay in the Pool which may also create an inherent conflict of interest.

We recommend compensating your consultant on a flat fee basis. One method of establishing a fee-basis is to convert the current PEPM to a flat fee (PEPM x # of employees). Consider re-evaluating the consultant's compensation annually to account for any major growth (or decline in enrollment).

In addition to converting the consultant's compensation to a flat fee, consider requiring the consultant to place a portion of their fee "at risk" which would be linked directly to performance objectives established mutually by the pool and consultant.

Employer Contribution Strategy

Our report indicates that there appears to be migration of better risk employees from the Anthem self-funded plan to the Kaiser plan. Unchecked migration can create a death spiral of the Anthem plan. Aon Hewitt recommends that SJVIA review its policies pertaining to member entities contributions strategies.

Contact Information

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About Aon

Aon plc (NYSE:AON) is a leading global provider of risk management, insurance brokerage and reinsurance brokerage, and human resources solutions and outsourcing services. Through its more than 69,000 colleagues worldwide, Aon unites to empower results for clients in over 120 countries via innovative risk and people solutions. For further information on our capabilities and to learn how we empower results for clients, please visit: http://aon.mediaroom.com.

Meeting Location:
Fresno County Employees' Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
March 18, 2016 9:00 AM

AGENDA DATE: March 18, 2016

ITEM NUMBER: 11

SUBJECT: Receive Revised Fiscal Year Budget for the 2015-16 Plan Year (A)

REQUEST(S): That the Board adopt the revised fiscal year budget for the 2015-2016 plan year

DESCRIPTION:

On November 6, 2015 your Board approved the revised budget for the 2015-16 fiscal year commencing July 1, 2015. This budget included the final renewal decisions for the 2016 plan year as well as the removal of the contract with Viverae.

Each year the budget is revised following open enrollment and the finalization of the stop loss premium which is typically not final or "locked" until claims data through October is reviewed by the carrier.

The budget before you for approval at this meeting includes the open enrollment migration as well as the final stop loss rates. No new entities were added in January and a report on open enrollment migration for the participating entities is included as a separate item on this agenda.

The budget previously approved included a projected $17.35 PEPM for specific and aggregate stop loss insurance. The updated budget includes the final rates of $17.58 for these policies.

FISCAL IMPACT/FINANCING:

The impact to the fiscal budget from the prior approved version is revenue of $142,692,795 down from $144,501,209 and expenses to balance revenue including line item 17 as "Discretionary Unallocated Claims Expense".

AGENDA: San Joaquin Valley Insurance Authority

DATE: March 18, 2016

The impact of the updated stop loss rates is $.23 PEPM which is $12,980 (calculated with post open enrollment data).

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

SJVIA 2015-16 FISCAL BUDGET

Revised March 18 - Post Open Enrollment

REVENUE

SJVIA Health Plan Revenue		
Medical & Rx	$	108,445,515
Dental	$	7,152,588
Vision	$	1,124,718
Kaiser Premium	$	25,969,974
TOTAL REVENUE	**$**	**142,692,795**

EXPENSES: Fixed

1	Specific & Aggregate Stop Loss Insurance (PPO)	$	1,125,074
2	Administration & Network Fees (Anthem PPO)	$	1,728,227
2	Administration & Network Fees (Blue Shield PPO)	$	143,656
3	Chimienti Associates/Hourglass Administration (Anthem & Kaiser)	$	788,861
4	GBS Consulting	$	559,256
5	SJVIA Association Fee	$	303,408
6	SJVIA Non-Founding Member Fee	$	94,692
7	Wellness/Communications	$	455,112
8	Anthem HMO Pooling	$	1,513,018
9	Anthem HMO Administration/Retention	$	2,246,287
10	ACA Reinsurance/PCORI (PPO)	$	303,689
10	ACA Reinsurance/PCORI (HMO)	$	394,581
	TOTAL FIXED EXPENSES	**$**	**9,655,861**

EXPENSES: Claims

11	Projected Paid Claims PPO	$	47,071,243
12	Projected Non-Cap HMO Claims	$	35,311,759
13	Anthem MMP HMO Capitation (Fixed Claims Cost)	$	16,525,803
	TOTAL CLAIMS EXPENSES	**$**	**98,908,804**
14	Delta Dental	$	6,202,588
15	VSP	$	1,124,718
16	Kaiser Permanente	$	25,804,830
		$	**33,132,136**
17	Discretionary Unallocated Claims Expense	$	995,994

TOTAL PROJECTED EXPENSES **$ 142,692,795**

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 **Administration & Network Fees (Anthem and Blue Shield PPO):**

Administrative services for the PPO plans. This definition includes Anthem Blue Cross and Health Now Administrative Services administration fees and includes access fees to use the Anthem Blue Cross and Blue Shield networks of providers. These services do not include the Anthem HMO plan.

3 **Chimienti Associates/Hourglass Administration (Anthem and Kaiser)**

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 heatlh plans excluding HealthNow/Blue Shield.

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 Association Fee**

The association fee will be used by SJVIA for administrative, management, legal, accounting and other services needed to effectively establish and maintain proper functioning of the Joint Powers Authority.

6 **SJVIA Non-Founding Member Fee**

This additional fee will be assessed to non-founding member entities and be used to offset administrative, management, legal, accounting and other services needed to effectively establish and maintain proper functioning of the Joint Powers Authority.

7 **Wellness**

This rate category is earmarked 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 earmarked 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/PCORI (PPO)**

The Affordable Care Act (ACA) includes the following fees on insurance plans: 1) Patient Centered Outcomes Research Institute (PCORI) - this fee is $2.00 per covered member per year. 2) Transitional Reinsurance Fee - this fee is $44.00 per covered memebr per year for the 2015 calendar year and $26.00 for the 2016 calendar year.

10 **ACA Reinsurance/PCORI (HMO)**

The Affordable Care Act (ACA) includes the following fees on insurance plans: 1) Patient Centered Outcomes Research Institute (PCORI) - this fee is $2.08 per covered member per year. 2) Transitional Reinsurance Fee - this fee is $44.00 per covered member per year for the 2015 calendar year and $26 for the 2016 calendar year.

11 **Projected Paid Claims PPO**

Projected self-insured PPO claims for medical and Rx and non-capitated HMO claims (hospital)

12 **Projected Non-Cap HMO Claims**

Projected self-insured PPO claims for medical and Rx and non-capitated HMO claims (hospital)

13 **Anthem MMP 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

14 **Delta Dental**

Premium for entities covered under the SJVIA Delta Dental program

15 **VSP**

Premium for entities covered under the SJVIA VSP Vision program

16 **Kaiser Permanente**

Premium for entities covered under the SJVIA Kaiser HMO program less fixed costs including items 6,7

17 **Discretionary Unallocated Claims Expense**

Net of premium less expenses to be added to reserve if not expended.

SJVIA 2015-16 FISCAL BUDGET

Revised November 6, 2015 - Viverae Costs Removed

REVENUE

SJVIA Health Plan Revenue		
Medical & Rx	$	112,697,450
Dental	$	6,770,654
Vision	$	1,297,719
Kaiser Premium	$	23,735,387
TOTAL REVENUE	**$**	**144,501,209**

EXPENSES: Fixed

1	Specific & Aggregate Stop Loss Insurance (PPO)	$	1,092,464
2	Administration & Network Fees (Anthem PPO)	$	1,688,679
2	Administration & Network Fees (Blue Shield PPO)	$	142,793
3	Chimienti Associates/Hourglass Administration (Anthem & Kaiser)	$	783,370
4	GBS Consulting	$	556,305
5	SJVIA Association Fee	$	301,296
6	SJVIA Non-Founding Member Fee	$	92,424
7	Wellness/Communications	$	451,944
8	Anthem HMO Pooling	$	1,617,847
9	Anthem HMO Administration/Retention	$	2,412,130
10	ACA Reinsurance/PCORI (PPO)	$	297,222
10	ACA Reinsurance/PCORI (HMO)	$	417,022
	TOTAL FIXED EXPENSES	**$**	**9,853,495**

EXPENSES: Claims

11	Projected Paid Claims PPO	$	44,425,269
12	Projected Non-Cap HMO Claims	$	37,016,606
13	Anthem MMP HMO Capitation (Fixed Claims Cost)	$	17,739,602
	TOTAL CLAIMS EXPENSES	**$**	**99,181,477**
14	Delta Dental	$	6,770,654
15	VSP	$	1,297,719
16	Kaiser Permanente	$	23,596,739
		$	**31,665,112**

TOTAL PROJECTED EXPENSES **$ 140,700,083**

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

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The association fee will be used by SJVIA for administrative, management, legal, accounting and other services needed to effectively establish and maintain proper functioning of the Joint Powers Authority.

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This rate category is earmarked 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.

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Premium for entities covered under the SJVIA Delta Dental program

15 **VSP**

Premium for entities covered under the SJVIA VSP Vision program

16 **Kaiser Permanente**

Premium for entities covered under the SJVIA Kaiser HMO program less fixed costs including items 6,7

Meeting Location:
Fresno County Employees' Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
March 18, 2016 9:00 AM

AGENDA DATE: March 18, 2016

ITEM NUMBER: 12

SUBJECT: Authorize Execution of Agreement between SJVIA and County of Fresno for Cash Advances and Repayment of Cash Advances of up to $2,000,000 (A)

REQUEST(S): That the Board authorize Chair to execute agreement between SJVIA and County of Fresno for Cash Advances and Repayment of up to $2,000,000

DESCRIPTION:

On November 6, 2015 your Board approved a plan by which Fresno and Tulare Counties would each advance and be repaid up to $2,000,000, as needed, to assist the SJVIA in managing its cash flow. On January 26, 2016 the Fresno County Board of Supervisors approved an agreement between the SJVIA and Fresno County for Cash Advances and Repayment of Cash Advances. The agreement provides the terms and conditions pursuant to which Fresno County and the SJVIA will implement the SJVIA's use of Fresno County's advance and the repayment transaction.

If approved, the agreement would apply retroactively to December 23, 2015, which is when Fresno County first advanced funds to the SJVIA in the amount of $1,500,000. The agreement would remain in effect through December 30, 2017, except that SJVIA's obligation to repay all advances, plus interest, continues after that date.

FISCAL IMPACT/FINANCING:

To date, the total amount advanced by Fresno County to the SJVIA is $1,500,000 and was completed on December 23, 2015. The total cash advance balance shall be repaid to the County at the County of Fresno Treasury Pool interest rate, at the earlier of:

AGENDA: San Joaquin Valley Insurance Authority

DATE: March 18, 2016

(a) when there is sufficient cash balance in SJVIA's bank account to cover regular SJVIA cash flow needs, as determined by the SJVIA Manager and SJVIA Auditor-Treasurer, or (b) December 30, 2017.

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

AGREEMENT FOR CASH ADVANCES AND REPAYMENT

This Agreement for Cash Advances and Repayment ("Agreement") is made and entered into by and between the COUNTY OF FRESNO, a political subdivision of the State of California ("Fresno") and the San Joaquin Valley Insurance Authority ("SJVIA," or "the Authority"). Fresno and SJVIA each are a "Party" to this Agreement; and Fresno and SJVIA collectively are the "Parties" to this Agreement.

WHEREAS, Fresno, the County of Tulare ("Tulare"), and the Central San Joaquin Valley Risk Management Authority, a joint powers authority ("CSJVRMA"), are the members of the SJVIA, a joint powers agency separate and apart from such members and created by such members pursuant to Title 1, Division 7, Chapter 5, Article 1 (beginning with section 6500) of the California Government Code (the "Joint Powers Law") under that certain "Amended and Restated Joint Exercise Of Powers Agreement Creating The San Joaquin Valley Insurance Authority (SJVIA)," effective as of January 1, 2016 (the "SJVIA Joint Powers Agreement"); and

WHEREAS, under the Joint Powers Agreement, the SJVIA negotiates, purchases or otherwise funds health, pharmacy, vision, dental, and life insurance for the employees of Fresno, certain employees of Tulare, and employees of certain approved public agencies, known as participating entities, under certain conditions, in all instances subject to obtaining a financial commitment by the parties to the SJVIA Joint Powers Agreement and such other participating public agencies to pay for their respective costs of that insurance as provided in the SJVIA Joint Powers Agreement; and

WHEREAS, both Fresno and Tulare have, under Government Code section 6504, subdivision (c), the authority to provide advances of public funds to the SJVIA for the purposes set forth in SJVIA Joint Powers Agreement; specifically, Article 5 of the SJVIA Joint Powers Agreement provides that the SJVIA shall have all powers set forth in the Joint Powers Law, and is authorized to do all acts necessary for the exercise of those powers, and that such powers include, but are not limited to, receiving and using contributions and advances from any party or parties to the SJVIA Joint Powers Agreement, or participating entity or entities in the SJVIA as provided in Government Code section 6504; and

WHEREAS, Article 5, paragraph (f), of the SJVIA Joint Powers Agreement also provides that the SJVIA has the authority to repay advances made on or after December 15, 2015, by any party to the SJVIA Joint Powers Agreement on terms established in that paragraph or by separate written agreement; and

WHEREAS, the SJVIA has requested that Fresno and Tulare each make available for advance up to $2,000,000, as needed by the SJVIA to temporarily assist the SJVIA in managing its cash flow needs; and

WHEREAS, the use of a short-term cash advance and repayment is the most cost effective method to ensure that the SJVIA has sufficient cash to pay its costs for the purposes of the SJVIA Joint Powers Agreement; and

WHEREAS, the Fresno County Auditor-Controller/Treasurer-Tax Collector has recommended to the Board of Supervisors of the County of Fresno, and by its adoption

on December 15, 2015 of Resolution No. 15-608, the Board of Supervisors of the County of Fresno has approved, the making of a short-term cash advance or advances up to the maximum amount of $2,000,000, by Fresno to the SJVIA, and, as requested by such Resolution, to be repaid in full by the SJVIA, plus accrued interest thereon at the then-current County of Fresno Treasury Pool interest rate, at the earlier of: (a) when there is sufficient cash balance in SJVIA's Chase Bank account or accounts to cover regular SJVIA cash flow needs, as determined by SJVIA Manager or the SJVIA Manager (or both of them) and the SJVIA Auditor-Treasurer; or (b) December 30, 2017, and as more thoroughly specified herein in Article III, below; and

WHEREAS, Fresno is informed that the Board of Supervisors of the County of Tulare desires to authorize an advance or advances to the SJVIA after December 15, 2015 and on or before June 30, 2016, up to the maximum amount of $2,000,000 to be provided by Tulare to the SJVIA, and will request repayment thereof by the SJVIA, as provided in accordance with its own resolution and/or a separate agreement between Tulare and the SJVIA; and

WHEREAS, on December 23, 2015, the SJVIA Manager requested and Fresno, under the authority provided by Resolution No. 15-608, advanced $1,500,000 to the SJVIA.

NOW THEREFORE, in consideration of their mutual promises, covenants and conditions, hereinafter set forth, the sufficiency of which is acknowledged, the Parties hereto agree as follows.

ARTICLE I
DEFINITIONS

For purposes of this Agreement, the following words or phrases shall be deemed to have the following meanings:

A. "SJVIA Auditor-Treasurer" has the same meaning as the term "Auditor-Treasurer" in the SJVIA Joint Powers Agreement.

B. "Fresno Auditor-Controller" means the Auditor-Controller of the Office of the Fresno County Auditor-Controller/Treasurer-Tax Collector, which acts as the chief financial officer for Fresno.

C. "SJVIA Manager" means the "Manager" or the "Assistant Manager," as those terms are defined in the SJVIA Joint Powers Agreement, or both of them acting together.

D. "The County of Fresno Treasury Pool interest rate" shall mean the weighted average of the interest rate, if such rate is modified during the interval between the time of the advance and the time of its repayment, as applied to the funds advanced during each period, or portion thereof, that such interest rate is in effect. If such rate is modified during the interval between the time of the advance and the time of its repayment, Fresno shall give to the SJVIA Manager prompt written notice of that change.

ARTICLE II
PURPOSES OF THIS AGREEMENT

A. This Agreement is made in furtherance of the determination by the SJVIA Board to request that Fresno and Tulare, which are two of the members of the SJVIA, each make available up to $2,000,000 to the SJVIA, to temporarily assist the SJVIA in managing its cash flow. To that end, the purpose of this Agreement is to provide the terms and conditions pursuant to which Fresno and the SJVIA will implement the SJVIA's use of Fresno's advance and the repayment transaction. It is anticipated by the Parties hereto that a separate agreement between Tulare and the SJVIA will provide the terms and conditions pursuant to which Tulare and the SJVIA will implement the SJVIA's use of Tulare's advance and the repayment transaction (the "Tulare-SJVIA Cash Advance and Repayment Agreement").

B. The legal authority for this Agreement is provided by Government Code Section 6504, subdivision (c), which authorizes the County to provide advances of public funds to the SJVIA for the purposes set forth in SJVIA Joint Powers Agreement, and Article 5, paragraph (f), of the SJVIA Joint Powers Agreement, which authorizes the SJVIA to repay such advances on terms provided in that paragraph or by separate written agreement.

ARTICLE III

ADVANCE AND REPAYMENT

A. Fresno has made or will make available up to $2,000,000 to the SJVIA under the terms and conditions of this Agreement.

B. The SJVIA Auditor-Treasurer shall diligently monitor the SJVIA's Chase Bank cash flow daily reports on-line, including but not limited to, keeping daily records of such bank account information. Such information shall be available, upon request, to the Fresno Auditor-Controller.

C. The Parties hereto desire for the SJVIA Auditor-Treasurer to have the flexibility to match the SJVIA's need for funds to the amount of the request for such funds, up to the maximum amount of the available funds under this Agreement. To that end, from time to time as the need arises during the term of this Agreement, the SJVIA Auditor-Treasurer may, with the written concurrence of the SJVIA Manager, make a written request to the Fresno Auditor-Controller for a cash advance to the SJVIA up to the maximum amount of the funds made available by Fresno, under this Agreement. Such written request and written concurrence made on behalf of the SJVIA may be transmitted by email to the Fresno Auditor-Controller.

In case any SJVIA officer who made such request, or gave such concurrence, as applicable, shall cease to be such officer before the SJVIA's full repayment of all advances, plus accrued interest thereon, under this Agreement, such request or concurrence, as applicable, shall nevertheless be valid and sufficient for all purposes of this Agreement as if such officer had remained in office until the full repayment of all advances, plus accrued interest thereon, under this Agreement.

D. The Fresno Auditor-Controller shall have the right to request information from the SJVIA Auditor-Treasurer with respect to the SJVIA's need for the requested advance of funds, and shall promptly either approve or disapprove the SJVIA's request for an advance of funds up to the maximum amount of Fresno's available funds under this Agreement. Such approval or disapproval made by the Fresno Auditor-Controller may be transmitted by email to the SJVIA Auditor-Treasurer. If the Fresno Auditor-Controller informs the SJVIA Auditor-Treasurer of Fresno's approval of the requested advance, then Fresno shall, not later than 2:00 PM of the immediately following Fresno business day, make available to the SJVIA 100 percent of the requested advance, up to the maximum amount of Fresno's available funds under this Agreement.

E. Fresno will undertake its cash advance(s) to the SJVIA by making a journal entry in its accounting system, and Fresno will wire the funds from Fresno's bank accounts at Bank of the West to the SJVIA's Claims Reserve # 819 bank account at Chase Bank, or, upon written request of the SJVIA Auditor-Treasurer, to such other SJVIA bank account at Chase Bank for the purposes of this Agreement.

F. The SJVIA shall repay in full to Fresno the amount or amounts advanced by Fresno to the SJVIA under this Agreement, plus accrued interest at the County of Fresno Treasury Pool interest rate on the unpaid balance advanced by Fresno to the SJVIA, until all such amounts are fully paid by SJVIA to Fresno, which shall in any event be at the earlier of:

1. When there is sufficient cash balance in SJVIA's Chase Bank to cover regular SJVIA cash flow needs, as determined by SJVIA Manager and SJVIA Auditor-Treasurer; or

2. December 30, 2017.

If Tulare provides any amount of funds to SJVIA, as its own separate advance pursuant to the Tulare-SJVIA Cash Advance and Repayment Agreement referenced in the preceding Paragraph II.A, then Fresno and Tulare shall be repaid simultaneously and pro-rata based on the principal amount advanced by each of them to the SJVIA.

To avoid unnecessary amounts advanced by Fresno and Tulare, the SJVIA may repay a portion of any advance, subject to the terms and conditions of this Agreement, without affecting the SJVIA's right to request an advance under this Agreement, provided that such repayment complies with the foregoing provisions of this Section III.F.

G. The principal amount of funds repaid by the SJVIA to Fresno under the preceding Paragraph III.F shall be available to the SJVIA, up to the maximum amount of Fresno's available funds under this Agreement, for an additional request or requests during the term of this Agreement, to be repaid according to the terms provided in this Agreement.

H. The SJVIA Auditor-Treasurer will charge the SJVIA, under the SJVIA Joint Powers Agreement, an hourly rate for treasury and accounting services provided to SJVIA in relation to this Agreement.

I. In addition to any other bank records to be kept and provided to Fresno under this Agreement, the SJVIA Auditor-Treasurer will prepare and provide quarterly financial

reports, including cash flow projections, of the SJVIA to the Fresno Auditor-Controller not later than thirty (30) days following the relevant quarter.

ARTICLE IV
GENERAL PROVISIONS

A. TERM: This Agreement is effective retroactive to December 23, 2015, which is the date that Fresno first advanced funds to the SJVIA under this Agreement, and this Agreement shall continue in full force and effect through and including December 30, 2017; provided, that SJVIA's obligation to repay all advances, plus accrued interest at the County of Fresno Treasury Pool interest rate on the unpaid balance advanced by Fresno to the SJVIA, until all such amounts are fully repaid by SJVIA, and to perform any other obligations of SJVIA under this Agreement, shall survive the termination of this Agreement. Any action taken by any of the officers or employees of the Parties hereto prior to the Parties' approval and execution of this Agreement is hereby affirmed, approved, and ratified.

B. DEFAULT AND MATERIAL BREACH:

1. Default. The failure by SJVIA to timely meet its obligation under Article III, Section F, to repay in full, any and all advances made by Fresno to SJVIA hereunder, plus accrued interest at the County of Fresno Treasury Pool interest rate on the unpaid balance advanced by Fresno to the SJVIA until all such amounts are fully repaid by SJVIA, or to perform any other obligation hereunder, shall constitute a default under this Agreement by SJVIA.

2. Material Breach. In the event of a default by SJVIA, as provided in the preceding Paragraph IV.B.1, Fresno may, at Fresno's election, immediately declare that SJVIA is in material breach of this Agreement, and provide to SJVIA written notice of SVJIA's material breach of this Agreement; such written notice shall provide for a reasonable period not to exceed 30 days in which the SJVIA may cure the breach; and if the SJVIA fails to cure the breach within the reasonable period not to exceed 30 days as stated in the notice, all amounts due and owing to Fresno pursuant to the terms of this Agreement, shall become immediately due and payable in full, plus accrued interest at the County of Fresno Treasury Pool interest rate on the unpaid balance advanced by Fresno to the SJVIA until all such amounts are fully repaid by SJVIA, and Fresno may exercise its rights and remedies under this Agreement, and as they may otherwise be available in law or equity.

C. INDEPENDENT RELATIONSHIP: Nothing contained in this Agreement shall create, or be deemed to create, any relationship of principal-agent, master-servant, employer-employee, partnership, joint venture, or association between any one or more of the Parties to this Agreement. The relationship between the Parties hereto is that of independent contractors, with each Party at all times acting in an independent capacity from the other.

D. INTERPRETATION: The Parties hereto acknowledge that this Agreement in its final form is the result of the combined efforts of the Parties and that, should any provision of this Agreement be found to be ambiguous in any way, such ambiguity shall not be resolved by construing this Agreement in favor of or against either Party, but rather by construing the terms in accordance with their generally accepted meaning.

E. TIME OF ESSENCE: Time is of the essence with respect to the performance of all obligations to be performed or observed by the Parties hereto, respectively, under this Agreement.

F. GOVERNING LAW; VENUE: Venue for any action arising out of or related to this Agreement shall only be in Fresno County, California. The rights and obligations of the Parties hereto and all interpretation and performance of this Agreement shall be governed in all respects by the laws of the State of California.

G. AUDITS AND INSPECTIONS: SJVIA shall at any time during business hours, and as often as Fresno may deem necessary, make available to Fresno for examination all of SJVIA's records and data with respect to the matters covered by this Agreement. SJVIA shall, upon request by Fresno, permit such Party's representatives to audit and inspect all of such records and data necessary to ensure SJVIA's compliance with the terms of this Agreement.

If this Agreement exceeds ten thousand dollars ($10,000.00), SJVIA shall be subject to the examination and audit of the Auditor General for a period of three (3) years after final payment under contract (Government Code Section 8546.7).

H. NOTICES: The identity and addresses of the persons authorized to give and receive notices under this Agreement include the following:

FRESNO	SJVIA
Auditor-Controller/Treasurer-Tax Collector Hall of Records, Room 5 2281 Tulare St Fresno, CA 93721	SJVIA Manager/Assistant Manager 2220 Tulare St, 14th Floor Fresno, CA 93721
	AND
Director of Personnel Services 2220 Tulare St, 14th Floor Fresno, CA 93721	2900 West Burrell Ave Visalia, CA 93291

Any and all notices between the Parties hereto provided for or permitted under this Agreement shall be in writing and shall be deemed duly served when personally delivered to one of the Parties, or in lieu of such personal service, when deposited in the United States Mail, postage prepaid, addressed to such Party, or as of one business day after

receipt by email.

I. NON-ASSIGNMENT: It is understood that SJVIA shall not assign, sublet, subcontract, or transfer any of SJVIA's rights, duties, or obligations under this Agreement, without the prior express, written consent of Fresno. Such consent and approval may be given only by the Fresno County Board of Supervisors.

J. NO THIRD PARTY BENEFICIARIES: Nothing in this Agreement expressed or implied is intended or shall be construed to confer upon, or to give or grant to, any person or entity, other than Fresno and Tulare and the SJVIA, any right, remedy or claim under or by reason of this Agreement or any term, covenant, or condition hereof, and all terms, covenants, promises and agreements in this Agreement made by and on behalf of the SJVIA shall be for the sole and exclusive benefit of Fresno and Tulare.

K. INDEMNIFICATION:

Subject to Article 15, paragraph (b), of the SJVIA Joint Powers Agreement, the SJVIA agrees to indemnify, save, hold harmless, and at Fresno's request, defend Fresno and its officers, agents, and employees, from any and all costs and expenses, damages, liabilities, claims, and losses occurring or resulting to Fresno as a direct result of willful misconduct by SJVIA, its officers, agents, or employees in performance of this Agreement, and from any and all costs and expenses, damages, liabilities, claims, and losses occurring or resulting to any person, firm, or corporation who may be injured or damaged as a direct result of the willful misconduct of SJVIA, its officers, agents, or employees in performance of this Agreement.

It is further provided that SJVIA's obligations under the provisions of this Section IV.K. shall survive one year after the termination or expiration of this Agreement.

L. AMENDMENTS: Any changes to this Agreement requested by any Party shall be effective only if mutually agreed upon in writing by duly authorized representatives of each of the Parties hereto. This Agreement shall not be modified or amended, nor shall any rights of a party hereto be waived, except by such a written instrument approved by each of the Parties hereto in the manner provided herein.

M. WAIVER: The waiver, if any, by Fresno of any breach of violation of any provision of this Agreement by the SJVIA shall not be deemed to be a waiver by Fresno of any breach or violation by SJVIA of any other provision, nor of any subsequent breach or violation by SJVIA of the same or any other provision. Fresno's acceptance of any partial payment by SJVIA of any repayment obligation arising hereunder, including but not limited to a payment of only the principal amount due and payable, shall not be deemed a waiver by Fresno of the right to full repayment by SJVIA of the remaining amount due and payable by SJVIA to Fresno pursuant to the terms hereof, including but not limited to accrued interest at the County of Fresno Treasury Pool interest rate on the unpaid balance advanced by Fresno to the SJVIA.

N. LIMITATION ON LIABILITY OF SJVIA OFFICERS AND EMPLOYEES: No officer or employee of the SJVIA shall be individually or personally liable for the repayment of the interest on or principal with respect to any advance made hereunder by Fresno, but nothing herein contained shall relieve any officer or employee of the SJVIA from the performance of any official duty necessary to cause the SJVIA to repay such amounts to

Fresno.

O. COUNTERPARTS: This Agreement may be executed in one or more original counterparts, all of which together constitute one and the same agreement.

P. ENTIRE AGREEMENT: This Agreement constitutes the entire agreement between SJVIA and Fresno with respect to the subject matter hereof and supersedes all previous negotiations, proposals, commitments, writings, advertisements, publications, and understandings of any nature whatsoever unless expressly included in this Agreement.

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IN WITNESS WHEREOF, the Parties hereto have executed this AGREEMENT FOR CASH ADVANCES AND REPAYMENT as of the date and year first written above.

COUNTY OF FRESNO

ATTEST:
BERNICE E. SEIDEL, Clerk
Board of Supervisors
By Susan Bishop
Deputy

Ernest Buddy Mendes,
Chairman, Board of Supervisors

REVIEWED & RECOMMENDED
FOR APPROVAL

Jean Rousseau, County Administrative Officer

APPROVED AS TO LEGAL FORM
Daniel C. Cederborg,
County Counsel

By: Deputy

APPROVED AS TO ACCOUNTING FORM
Vicki Crow, C.P.A., Auditor-Controller/Treasurer-Tax Collector

By: Vicki Crow

SAN JOAQUIN VALLEY INSURANCE AUTHORITY

By: _____

REVIEWED & RECOMMENDED
FOR APPROVAL

By: _____
Rhonda Sjostrom, Manager

APPROVED AS TO LEGAL FORM

Daniel C. Cederborg,
County Counsel

BY: _____
Deputy

Meeting Location:
Fresno County Employees' Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
March 18, 2016 9:00 AM

AGENDA DATE: March 18, 2016

ITEM NUMBER: 13

SUBJECT: Authorization and Execution of Anthem Blue Cross Administrative Service Agreement (PPO), Anthem Blue Cross Group Benefit Agreement (HMO) and Funding Provision Minimum Premium Agreements (HMO) (A)

REQUEST(S): That the Board authorize the execution of Anthem Blue Cross Administrative Service Agreement (PPO), Anthem Blue Cross Group Benefit Agreement (HMO) and Funding Provision Minimum Premium Agreements (HMO)

DESCRIPTION:

The 2016 Anthem Blue Cross Contracts for Administrative services for the PPO plans as well as the 2016 Minimum Premium Agreement for the HMO plan have been reviewed and approved by SJVIA Counsel, SJVIA Staff and Gallagher Benefit Services. These contracts are ready for approval by the SJVIA Board and execution by the SJVIA Board President. The primary difference between the 2015 and 2016 agreements is the addition of new groups to the HMO and PPO plans has resulted in additional funding provisions to recognize the demographic and geographical impacts for each group.

FISCAL IMPACT/FINANCING:

The prior PPO Administration fee was $28.39. The prior HMO Pooling fee was $26.91, Retention fee was $40.96 and Capitation was $299.50. The impact to the budget is a 6.9% decrease for PPO and 7% for the HMO on a calendar year basis. The total dollar amount this contract covers is approximately $1,407,893.40 for the PPO and $19,810,084.80 for HMO.

ADMINISTRATIVE SIGN-OFF:

AGENDA: San Joaquin Valley Insurance Authority

DATE: March 18, 2016

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

AMENDMENT 6 TO THE
ADMINISTRATIVE SERVICES AGREEMENT
WITH
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

This is an Amendment to the Administrative Services Agreement as of January 1, 2016. This Amendment shall supplement and amend the Agreement between Plan Sponsor and Anthem Blue Cross Life and Health Insurance Company ("Anthem"). If there are any inconsistencies between the terms of the Agreement and this Amendment, the terms of this Amendment shall control.

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

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

3. Schedule C is added as attached.

4. Banking Arrangement Schedule is replaced by the attached Banking Arrangement Schedule.

Anthem Blue Cross Life and Health Insurance Company

By: J. Brian Ternan
Title: President CA Commercial
Date: December 7, 2015

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

This Schedule A shall govern the Agreement Period from January 1, 2016 through December 31, 2016. For purposes of this Agreement Period, this Schedule shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules, and this Schedule A, the terms of this Schedule A shall control.

Section 1. Effective Date and Renewal Notice

This Agreement Period shall be from 12:01 a.m. January 1, 2016 to the end of the day of December 31, 2016.

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

Incurred from December 1, 2009 through December 31, 2016 and
Paid from January 1, 2016 through December 31, 2016.

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

Section 2. Broker or Consultant Base Compensation

Not Applicable

Section 3. Administrative Services Fees

A. Base Administrative Services Fee

Plan 1 SJVIA PPO Composite (No prescription drug Claim administration)	$26.55 per Subscriber per month
Plan 2 SJVIA HSA Composite (Includes prescription drug Claim administration)	$26.55 per Subscriber per month
Plan 3 Sutter County PPO Composite (No prescription drug Claim administration)	$44.98 per Subscriber per month
Plan 4 Sutter County HSA Composite (Includes prescription drug Claim administration)	$44.98 per Subscriber per month

EAP Enhanced (6 visits)* $1.67 per Subscriber* per month
*SJVIA County of Tulare only (2753410800)

Article 3(a) Retroactive Adjustments to Enrollment.

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

B. Health and Wellness Program Fees

Not applicable

C. Other Fees or Credits

Fee for Subrogation Services. The charge to Plan Sponsor is 25% of gross subrogation recovery, or, if outside counsel is retained, 15% of the net recovery after a deduction for outside counsel fees.

Fee for Provider Audit Performed by External Vendors. The charge to Plan Sponsor is 25% of the amount recovered from Vendor audits of Provider activity, including but not limited to credit balance, hospital bill audits, DRG readmissions and high-cost drug audits.

Fee for Overpayment Identification Provided by External Vendors. The charge to Plan Sponsor is 25% of the amount recovered from review of Claims and membership data to identify overpayments, including but not limited to COB, duplicates, contract compliance and eligibility.

Fee for Collection Services Provided by External Vendors. The charge to Plan Sponsor is 25% of the amount recovered by a Vendor in collecting receivables.

Independent Claims Review Fee. Not Applicable; Plan is grandfathered

NCN Fee. When Anthem forwards a non-Network Provider Claim to NCN to negotiate with the non-Network Provider, the Plan Sponsor will pay a fee equal to 25% of the difference between the non-Network Provider's Billed Charges and NCN's negotiated amount. In the absence of successfully negotiated Claims, there will be no fee charged as the amount will be determined by the local Blue plan.

External Stop Loss Carrier Fee. Plan Sponsor shall pay a $0.50 per Subscriber per month fee* if it utilizes an external stop loss carrier.
*Included in Base Administrative Services Fee

Fee for Integration Services with Pharmacy Carve-out Vendor. Plan Sponsor has carved-out Prescription Drug management services for the PPO plans, and Anthem shall provide integration services. The charge to Plan Sponsor is $2.09 per PPO Subscriber per month and is included in the Base Administrative Services Fee.

Section 4. Paid Claims, Billing Cycle and Payment Method

A. Paid Claims

Paid Claims are described in Article 1-Paid Claims Definition of the Agreement.

B. Billing Cycle

Refer to the Banking Arrangement Schedule of this Agreement.

Anthem shall notify Plan Sponsor of the amount due to Anthem as a result of Claims processed and paid by Anthem according to the billing cycle described above. The actual date of notification of Paid Claims and the Invoice Due Date will be determined according to Anthem's regular business practices and systems capabilities.

C. Payment Method

Refer to the Banking Arrangement Schedule of this Agreement.

Section 5. Administrative Services Fee Billing Cycle and Payment Method

A. Billing Cycle

Monthly List Bill (pay as billed)

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

B. Payment Method

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

Section 6. Claims Runout Services

A. Claims Runout Period

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

B. Claims Runout Administrative Services Fees

A separate Claims Runout Administrative Services Fee will not be charged.

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

Inter-Plan Programs Fees

As described in Article 15, certain fees and compensation may be charged each time a Claim is processed through Inter-Plan Programs, which include the BlueCard Program, Negotiated National Account Arrangements, and non-Network Provider Claims pricing arrangements. (Non-Network Provider Claims fees include, but are not limited to administrative expense allowance fees, Central Financial Agency fee and ITS transaction fee). The extent to which these fees and compensation are (i) included in the Base Administrative Services Fee; or (ii) included in Paid Claims or separately billed to Plan Sponsor is as follows:

Included in Base Administrative Services Fee:

BlueCard Program toll-free number fee

BlueCard Program PPO health care provider directory fee. If Plan Sponsor requests paper copies of PPO directories from a non-Anthem state, a fee may be charged by the Host Blue for those directories and charged to the Plan Sponsor. All other fees related to PPO directories are included in the Administrative Services Fee.

Included in Paid Claims or separately billed to Plan Sponsor:

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

Administrative expense allowance fee ("AEA")

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

Central Financial Agency fee

ITS transaction fee

Notice of Loss of Grandfathering Status

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

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

If Plan Sponsor loses grandfathered Plan status under PPACA and notifies Anthem of such loss no fewer than 90 days before the effective date of the change, Anthem will implement the additional group market (insurance) reforms that apply to non-grandfathered health Plans subject to the provisions of Article 18 of this Agreement.

Anthem Blue Cross Life and Health Insurance Company

By: J. Brian Ternan
Title: President CA Commercial
Date: December 7, 2015

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

This Schedule B shall govern the Agreement Period from January 1, 2016 through December 31, 2016. For purposes of this Agreement Period, this Schedule B shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules and this Schedule B, the terms of this Schedule B shall control.

The following is a list of services that Anthem will provide under this Agreement for the Base Administrative Services Fee listed in Section 3(A) of Schedule A. These services will be furnished to Plan Sponsor in a manner consistent with Anthem's standard policies and procedures for self-funded plans. Anthem may also offer services to Plan Sponsor that have an additional fee. If Plan Sponsor has purchased such services, those services and any additional fees are also listed in Schedule A.

SERVICES INCLUDED IN THE BASE ADMINISTRATIVE SERVICES FEE IN SECTION 3A OF SCHEDULE A

Management Services

- Anthem Benefits and administration, unless otherwise noted below:

  - Anthem definitions and exclusions
    --group specific exclusions
  - Anthem complaint and appeals process
  - Claims incurred and paid as provided in Schedule A
  - Accumulation toward plan maximums beginning at zero on effective date
    --Deductible accumulation (calendar year basis)
    --Out of pocket maximum accumulation (calendar year basis)
  - Anthem Claim forms
  -Personalized ID card overprinted with name and logo
  - Explanation of Benefits (Non-customized)

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

- Preparation of Benefits Booklet (accessible via internet)

- Account reporting - standard data reports

•Billing and Banking Services

- Plan Design consultation

- Employer eServices

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

Claims and Customer Services

- Claims processing services

- Coordination of Benefits

- Recovery services performed internally by Anthem

• Medicare crossover processing

• Complaint and appeals processing

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

• Employer customer service, standard business hours

• Member customer service, standard business hours

• 1099s prepared and delivered to Providers

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

• Member eServices

Prescription Benefit Services (HSA Plans only)

• Home delivery pharmacy

• Specialty Pharmacy Services

• Prescription eServices

- Pharmacy locator
- Online formulary

• Point of sale claims processing

• Home delivery claims processing

• Home delivery call center with toll free number

• Home delivery regular shipping and handling

• Standard management reports

• Ad hoc reports (subject to additional programming charge if required)

• Concurrent Drug Utilization Review (DUR) programs

• Retrospective DURs

• Administrative override (i.e., vacation, lost, stolen or spilled medications)

• Clinical review

• Pharmacy help desk with toll free number

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

Health Care Management

• Health Care Management

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

• SpecialOffers

• HealthCare Advisor

• Care Comparison (where available)

• Transplant services - Blues Distinction

• Healthy Solutions Newsletter (available online)

• MyHealth (Member Portal)

- Electronic Health Risk Assessment
- Personal Health Record
- Online Communities
- Member Alerts

• Health and Wellness Services (PPO/HSA Plans)
  • ConditionCare
    - Asthma
    - Pulmonary disease
    - Congestive heart failure
    - Coronary artery disease
    - Diabetes
  • Anthem Health Guide

Networks

• Access to networks

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

• Network Management

• Anthem.com Provider directory

Anthem Blue Cross Life and Health Insurance Company

By: J. Brian Ternan
Title: President CA Commercial
Date: December 7, 2015

SCHEDULE C
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

This Schedule C provides certain guarantees pertaining to Anthem Blue Cross Life and Health's performance under the Agreement between the Parties ("Performance Guarantees") and shall be effective for the period from January 1, 2016 through December 31, 2016 (the "Performance Period"). Descriptions of the terms of each Performance Guarantee applicable to the Parties are set forth in the Attachments (the "Attachments") to this Schedule C and made a part of this Schedule C. This Schedule shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules and this Schedule C, the terms of this Schedule C shall control.

Section 1. General Conditions

A. The Performance Guarantees described in the Attachments to this Schedule C shall be in effect only for the Performance Period indicated above, unless specifically indicated otherwise in the Attachments. The Performance Guarantees shall also contain a measurement period (the "Measurement Period") for which any Performance Guarantee will be calculated. If there are any inconsistencies between the terms contained in this Schedule, and the terms contained in any of the Attachments to this Schedule C, the terms of the Attachments to this Schedule C. shall control.

B. Anthem Blue Cross Life and Health shall conduct an analysis of the data necessary to calculate any one of the Performance Guarantees within the timeframes provided in the Attachments to this Schedule C. In addition, any calculation of Performance Guarantees, reports provided, or analysis performed by Anthem Blue Cross Life and Health shall be based on Anthem Blue Cross Life and Health's then current measurement methodology.

C. Any audits performed by Anthem Blue Cross Life and Health to test compliance with any of the Performance Guarantees shall be based on a statistically valid sample size with a 95% confidence level.

D. If the Parties do not execute the Agreement and any Amendment thereto, including this Schedule C, Anthem Blue Cross Life and Health shall have no obligation to make payment under these Performance Guarantees.

E. Unless otherwise specified in the Attachments to this Schedule C, the measurement of the Performance Guarantee shall be based on: (1) the performance of any service team, business unit, or measurement group assigned by Anthem Blue Cross Life and Health; and (2) data that is maintained and stored by Anthem Blue Cross Life and Health or its Vendors.

F. If Plan Sponsor terminates the Agreement between the Parties prior to the end of the Performance Period, or if the Agreement is terminated for non-payment, then Plan Sponsor shall forfeit any right to collect any further payments under any outstanding Performance Guarantees, whether such Performance Guarantees are for a prior or current Measurement Period or Performance Period.

G. Anthem Blue Cross Life and Health reserves the right to make changes to any of the Performance Guarantees provided in the Attachments to this Schedule C upon the occurrence, in Anthem Blue Cross Life and Health's determination, of either:

1. a change to the Plan benefits or the administration of the Plan initiated by Plan Sponsor that results in a substantial change in the services to be performed by Anthem Blue Cross Life and Health or the measurement of a Performance Guarantee; or

2. an increase or decrease of 10% or more of the number of Members that were enrolled for coverage on the latter of the effective date or renewal date of this Agreement.

Should there be a change in occurrence as indicated above and these changes negatively impact Anthem Blue Cross Life and Health's ability to meet the Performance Guarantees, Anthem Blue Cross Life and Health shall have the right to modify the Performance Guarantees contained in the Attachments.

H. For the purposes of calculating compliance with the Performance Guarantees contained in the Attachments to this Schedule C, if a delay in performance of, or inability to perform, a service underlying any of the Performance Guarantees is due to circumstances which are beyond the control of Anthem Blue Cross Life and Health, including but not limited to any act of God, civil riot, floods, fire, acts of terrorists, acts of war, or power outage, such delayed or non-performed service will not count towards the measurement of the applicable Performance Guarantee.

Section 2. Payment

A. If Anthem Blue Cross Life and Health fails to meet any of the obligations specifically described in a Performance Guarantee, Anthem Blue Cross Life and Health shall pay Plan Sponsor the amount set forth in the Attachment describing the Performance Guarantee. Payment shall be in the form of a credit on Plan Sponsor's invoice for Administrative Services Fees which will occur annually unless otherwise stated in the Performance Guarantee.

B. Notwithstanding the above, Anthem Blue Cross Life and Health has the right to offset any amounts owed to Plan Sponsor under any of the Performance Guarantees contained in the Attachments to this Schedule C against any amounts owed by Plan Sponsor to Anthem Blue Cross Life and Health under: (1) any Performance Guarantees contained in the Attachments to this Schedule C; (2) the Agreement, or (3) any applicable Stop Loss Policy.

C. Notwithstanding the foregoing, Anthem Blue Cross Life and Health's obligation to make payment under the Performance Guarantees is conditioned upon Plan Sponsor's timely performance of its obligations provided in the Agreement in this Schedule C and the Attachments, including providing Anthem Blue Cross Life and Health with the information required by Anthem Blue Cross Life and Health in the Attachments. Anthem Blue Cross Life and Health shall not be obligated to make payment under the Performance Guarantee if Plan Sponsor fails to meet any of its obligations provided in the Attachments related to such Performance Guarantee.

Section 3. Maximum Amount Payable Under the Performance Guarantees

Notwithstanding any other provision contained in this Schedule or the Attachments to this Schedule, the maximum amount Anthem Blue Cross Life and Health shall be obligated to pay to Plan Sponsor is:

15% of the base medical Administrative Services Fee for Operational Performance Guarantees.

Anthem Blue Cross Life and Health Insurance Company

By: J. Brian Ternan
Title: President CA Commercial
Date: December 7, 2015

ATTACHMENT TO SCHEDULE C
Performance Guarantees
TO ADMINISTRATIVE SERVICES AGREEMENT
WITH
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

Operational Performance Guarantees

This Attachment is made part of Schedule C and will be effective for the Performance Period from January 1, 2016 through December 31, 2016. This Attachment is intended to supplement and amend the Agreement between the Parties.

Operations Guarantees

Performance Category	Year 1	Year 2,3
Claims Timeliness - (14 Calendar Days)	2.0% of Admin. Services Fees	2.0% of Admin. Services Fees
Claim Timeliness - (30 Calendar Days)	2.0% of Admin. Services Fees	2.0% of Admin. Services Fees
Claims Financial Accuracy	2.0% of Admin. Services Fees	2.0% of Admin. Services Fees
Claims Accuracy	2.0% of Admin. Services Fees	2.0% of Admin. Services Fees
Open Enrollment ID Card Issuance	2.0% of Admin. Services Fees	2.0% of Admin. Services Fees
Processing of Ongoing Eligibility Information	2.0% of Admin. Services Fees	2.0% of Admin. Services Fees
Average Speed to Answer	1.0% of Admin. Services Fees	1.0% of Admin. Services Fees
Call Abandonment Rate	1.0% of Admin. Services Fees	1.0% of Admin. Services Fees
First Call Resolution	1.0% of Admin. Services Fees	1.0% of Admin. Services Fees
Total Amount At Risk – Operations	**15.0%**	**15.0%**

Additional Terms and Conditions:

- Performance will be based on the results of a designated service team/business unit assigned to San Joaquin Valley Insurance Authority, unless the guarantee is noted as measured with Employer-specific Data.

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Claims Timeliness (14 Calendar Days)	Year 1: 2.0% of Admin. Services Fees Year 2, 3: 2.0% of Admin. Services Fees	A minimum of 90% of Non-investigated medical Claims will be processed timely. Non-investigated Claims are defined as medical Claims that process through the system without the need to obtain additional information from the Provider, Subscriber or other external sources. Processed Timely is defined as Non-investigated medical Claims that have been finalized within 14 calendar days of receipt. This Guarantee will be calculated based on the number of Non-investigated Claims that Processed Timely divided by the total number of Non-investigated Claims. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter, Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented. This will be measured with Employer-specific Data.	Result / Penalty 90.0% or Greater: None 88.0% to 89.9. %: 25% 86.0% to 87.9%: 50% 85.0% to 85.9%: 75% Less than 85.0%: 100%	**Measurement Period** Annual **Reporting Period** Annual

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Claim Timeliness (30 Calendar Days)	Year 1: 2.0% of Admin. Services Fees Year 2, 3: 2.0% of Admin. Services Fees	A minimum of 98% of Non-investigated medical Claims will be processed timely. Non-investigated medical Claims are defined as Claims that process through the system without the need to obtain additional information from the Provider, Subscriber, or other external sources. Processed Timely is defined as Non-investigated medical Claims that have been finalized within 30 calendar days of receipt. This Guarantee will be calculated based on the number of Non-investigated Claims that Processed Timely divided by the total number of in-investigated Claims. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter, Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented. This will be measured with Employer-specific Data.	Result / Penalty 98.0% or Greater: None 96.0% to 97.9%: 25% 94.0% to 95.9%: 50% 92.0% to 93.9%: 75% Less than 92.0%: 100%	**Measurement Period** Annual **Reporting Period** Annual
Claims Financial Accuracy	Year 1: 2.0% of Admin. Services Fees Year 2, 3: 2.0% of Admin. Services Fees	A minimum of 99% of medical Claim dollars will be processed accurately. This Guarantee will be calculated based on the total dollar amount of audited medical Claims paid correctly divided by the total dollar amount of audited medical Paid Claims. The calculation of this Guarantee includes both underpayments and overpayments. The calculation of this Guarantee does not include Claim adjustments or Claims in any quarter in which an Employer requests changes to Plan benefits, until all such changes have been implemented.	Result / Penalty 99.0% or Greater: None 98.0% to 98.9%: 25% 97.0% to 97.9%: 50% 96.0% to 96.9%: 75% Less than 96.0%: 100%	**Measurement Period** Annual **Reporting Period** Annual
Claims Accuracy	Year 1: 2.0% of Admin. Services Fees Year 2, 3: 2.0% of Admin. Services Fees	A minimum of 97% of medical Claims will be paid or denied correctly. This Guarantee will be calculated based on the number of audited medical Claims paid and denied correctly divided by the total number of audited medical Claims paid and denied. The calculation of this Guarantee excludes in any quarter Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented.	Result / Penalty 97.0% or Greater: None 96.0% to 96.9%: 25% 95.0% to 95.9%: 50% 94.0% to 94.9%: 75% Less than 94.0%: 100%	**Measurement Period** Annual **Reporting Period** Annual
Open Enrollment ID Card Issuance	Year 1: 2.0% of Admin. Services Fees Year 2, 3: 2.0% of Admin. Services Fees	100% of ID cards will be mailed to Open Enrollment participants no later than the Employer's effective date provided that Anthem receives an accurate eligibility file. An Accurate Eligibility File is defined as (1) an electronic eligibility file formatted in a mutually agreed upon manner; (2) received by Anthem no later than 30 calendar days prior to the Employer's effective date; and, (3) contains an error rate of less than 1%. This will be measured with Employer-specific Data.	Result / Penalty 100%: None 99.0% to 99.9%: $100 per ID Card not to exceed 25% of amount at risk for this measure 98.0% to 98.9%: 50% 97.0% to 97.9%: 75% Less than 97.0%: 100%	**Measurement Period** Employer's effective date **Reporting Period** 60 days following the Employer's effective date.

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Processing of Ongoing Eligibility Information	Year 1: 2.0% of Admin. Services Fees Year 2, 3: 2.0% of Admin. Services Fees	100% of Employer's ongoing electronic eligibility files will be processed timely. Timely Processing is defined as electronic eligibility files processed and updated on the eligibility database within 7 business days of receipt of an eligibility file. This Guarantee only applies to the processing of eligibility files submitted by Employer outside of an open enrollment period. This Guarantee does not apply to a defective eligibility file. A defective Eligibility File is defined as an eligibility file that has issues that prevent Anthem's processing of the file. Anthem's payment of this Guarantee is conditioned upon receipt of eligibility files in a format mutually agreed upon by the Parties. This Guarantee will be calculated by (1) dividing the total number of eligibility files processed within the timeframe set forth above by (2) the number of Employer's eligibility files processed. This will be measured with Employer-specific Data.	Result 100% 98.0% to 99.9% 96.0% to 97.9% 94.0% to 95.9% Less than 94.0%	Penalty None 25% 50% 75% 100%	**Measurement Period** Annual **Reporting Period** Annual
Average Speed to Answer	Year 1: 1.0% of Admin. Services Fees Year 2, 3: 1.0% of Admin. Services Fees	The average speed to answer (ASA) will be 45 seconds or less. ASA is defined as the average number of whole seconds members wait and/or are in the telephone system before receiving a response from a customer service representative (CSR) or an interactive voice response (IVR) unit. This Guarantee will be calculated based on the total number of calls received in the customer service telephone system.	Result 45 seconds or less 46 to 48 seconds 49 to 51 seconds 52 to 54 seconds 55 or more seconds	Penalty None 25% 50% 75% 100%	**Measurement Period** Annual **Reporting Period** Annual
Call Abandonment Rate	Year 1: 1.0% of Admin. Services Fees Year 2, 3: 1.0% of Admin. Services Fees	A maximum of 5.0% of member calls will be abandoned. Abandoned Calls are defined as member calls that are waiting for a customer service representative (CSR), but are abandoned before connecting with a CSR. This Guarantee will be calculated based on the number of calls abandoned divided by the total number of calls received in the customer service telephone system. Calls that are abandoned in less than 5 seconds will not be included in this calculation.	Result 5.0% or Less 5.01% to 5.40% 5.41% to 5.70% 5.71% to 5.99% 6.0% or Greater	Penalty None 25% 50% 75% 100%	**Measurement Period** Annual **Reporting Period** Annual
First Call Resolution	Year 1: 1.0% of Admin. Services Fees Year 2, 3: 1.0% of Admin. Services Fees	A minimum of 85% of member calls will be resolved during the initial contact with no further follow up required. First Call Resolution is defined as member callers receiving a response to their inquiry during an initial contact with no further follow-up required. This Guarantee will be calculated based on the total number of members who receive a First Call Resolution divided by the total number of calls received into the customer service telephone system.	Result 85.0% or Greater 83.0% to 84.9% 81.5% to 82.9% 80.0% to 81.4% Less than 80.0%	Penalty None 25% 50% 75% 100%	**Measurement Period** Annual **Reporting Period** Annual

BANKING ARRANGEMENT SCHEDULE
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
San Joaquin Valley Insurance Authority

This Banking Arrangement Schedule, which describes the bank account method by which Plan Sponsor will fund Paid Claims and other charges agreed to by the Parties under this Agreement. For purposes of this Agreement Period, this Schedule shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement, including any prior Schedules and this Banking Arrangement Schedule, the terms of this Banking Arrangement Schedule shall control.

Plan Sponsor shall open and maintain, at its cost, a demand deposit bank account ("Account") in a bank mutually acceptable to the Parties to this Agreement. Plan Sponsor agrees to execute all documents necessary for Anthem to access the Account, including the authority to issue stop payment on checks or other payments. The Account shall be at all times in compliance with the following:

Unless otherwise agreed to by the Parties, all Paid Claims, and other charges consistent with the terms of the Agreement shall be paid from the designated Account.

Plan Sponsor authorizes Anthem, as Plan Sponsor's disbursing agent, to:

Issue payments on a daily basis from the Account. Such payment shall be in a form mutually agreed to by the Parties.

Use Plan Sponsor's signature on all checks issued for the payment of Claims.

Initiate ACH demand debit transactions to withdraw any other amounts due under this Agreement by the Invoice Due Date.

Anthem or the designated bank shall provide Plan Sponsor daily notice of the total dollar amount of payments issued. Anthem shall provide an itemization of the charges deducted from the Account and any credits to the Account.

Plan Sponsor agrees that it will, at all times, have sufficient funds available in the Account to satisfy its obligations under this Agreement. Should Plan Sponsor fail to provide sufficient funds to satisfy its obligations, Anthem shall not have an obligation to make its own funds available for such payments.

Billing and Banking

Billing and Banking

Anthem shall provide the Plan Sponsor:

• An estimate of Claims incurred but not paid within an Agreement Period

• An annual settlement report no later than 4 months following the end of an Agreement Period

If the annual settlement report indicates that Anthem owes Plan Sponsor money, Anthem shall pay or credit the Plan Sponsor immediately following the reconciliation. If the annual settlement report indicates that Plan Sponsor owes Anthem money, Anthem shall provide Plan Sponsor with an invoice and Plan Sponsor shall pay any amounts due by the Invoice Due Date.

Banking Fees

Plan Sponsor shall pay Anthem the following banking fees:

Change of designated Account $1,500
Change to check signature, check name, or check logo $250 for each
Plan Sponsor reinstates Account after such Account has been terminated $3,000
Election of positive pay file transmission to verify valid checks $150 per month
Election of positive pay file transmission after Plan Sponsor effective date $750

Anthem Blue Cross Life and Health Insurance Company

By: J. Brian Ternan
Title: President CA Commercial
Date: December 7, 2015

ANTHEM BLUE CROSS HMO

GROUP BENEFIT AGREEMENT

(the *agreement*)

for

SAN JOAQUIN VALLEY INSURANCE AUTHORITY

(the *group*)

AGREEMENT EFFECTIVE DATE: December 7, 2015

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

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

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

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

President

Secretary

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

GENERAL PROVISIONS

AGREEMENT COMPONENTS

The entire *agreement* consists of:

1. this *agreement*, including any endorsements;
2. all Combined Evidence of Coverage and Disclosure Forms, including any amendments;
3. the application of the *group*; and
4. the individual applications of eligible persons.

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

LIABILITY FOR STATEMENTS

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

ENROLLMENT REQUIREMENTS

All of the persons eligible to be employees, who are not enrolled under another group-sponsored plan, must be enrolled as employees under this *agreement*. If the number of employees enrolled falls below either: (1) **75%** of the persons eligible to enroll as employees; or (2) **40** employees, Anthem may cancel or decline to renew this *agreement*. Anthem may also cancel or decline to renew this *agreement* if the *group* has less than **101** employees.

AGREEMENT CHANGES

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

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

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

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

CONTRACT LANGUAGE

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

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

INTERPRETATION OF PROVIDER CONTRACTS

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

CLERICAL ERRORS

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

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

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

AGREEMENT EFFECTIVE DATE

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

AGREEMENT ANNIVERSARY DATE

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

AGREEMENT RENEWAL

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

MAILING ADDRESSES

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

GENERAL PROVISIONS

ENROLLMENT APPLICATIONS

The *group* is responsible for determining initial and ongoing eligibility of *subscribers* and *family members* and advising Anthem in a timely manner, through a method agreed upon by Anthem and the *group*, as to which eligible *subscribers* and their *family members* are to be enrolled. The *group* agrees to obtain a completed and signed application from each eligible *subscriber* prior to them and any of their *family members* becoming enrolled for benefits under this *agreement*. All applications must be in a form required and acceptable to Anthem. If this *agreement* replaces a prior Anthem *agreement* issued to the same *group,* new applications will not be required for any *members* enrolled immediately before termination of the prior *agreement*. Except as provided in the section "Electronic Submission of Enrollment and Eligibility Data," the *group* agrees to promptly forward all completed and signed applications for eligible *subscribers* and their *family members* to Anthem.

ELECTRONIC SUBMISSION OF ENROLLMENT AND ELIGIBILITY DATA

1. The *group* may submit initial and ongoing eligibility data in a format defined by Anthem and compatible with the Anthem's system or *group* may contract with a Third Party Vendor (Vendor) to capture initial and ongoing eligibility data in order to electronically send such data to Anthem. The *group* or its authorized Vendor will administer and maintain and administer all electronic eligibility in accordance with the provisions of this *agreement* and the *group* shall be responsible for the performance and activities of the Vendor. The *group* must obtain Anthem's approval in writing prior to initiating the submission of electronic eligibility data to Anthem. Anthem will not be responsible for any fees or administrative charges associated with any Vendor services purchased by the *group*. All fees or administrative charges will be the sole responsibility of the *group*.

2. If the *group* uses electronic enrollment applications in place of paper enrollment application forms provided by Anthem, the *group* warrants and agrees that the electronic enrollment processes and media will: (a) include an arbitration disclosure provision with language acceptable to Anthem and be located immediately before the electronic signature; and (b) be maintained in a secure manner, which can be retrieved, and be reproduced with the enrollment form and signature linked with the process or media. In addition, the *group* warrants that the manner of electronic signature satisfies all legal requirements for an electronic signature. The *group* agrees to procure Anthem's prior approval for any non-standard application forms prior to use. The *group* shall maintain the signed arbitration provisions for the duration of this contract plus four years.

3. On or before the end of each month, the *group* or its Vendor will electronically transmit to Anthem the eligibility information using software mutually acceptable to both Anthem and the *group*. The transmission must contain a listing for the current month of all *subscribers* and *family members* enrolled under the *agreement* as of the Subscription Charge Due Date. The listing will also include newly enrolled *members*, deleted *members* who are no longer eligible, and any other changes related to eligibility.

4. Upon receipt of the information from the *group*, Anthem will update its membership data with the current enrollment information contained therein.

5. **Establishment and Retention of Membership Information.** The *group* will provide for the establishment and ongoing retention of membership information. This will include obtaining and maintaining applications from eligible *subscribers* or *family members* who might otherwise qualify for coverage separate from the primary *subscriber,* and the handling of ongoing additions, deletions and changes to the membership list on a timely basis. The *group* will likewise be responsible for retaining, in auditable form, the complete enrollment and eligibility documentation, whether written or in electronic form, including, but not limited to, all electronic or written enrollment applications, any electronic or written confirmation forms or media, and any electronic or written correspondence related to the enrollment, eligibility and waiver or declination forms. The *group* must procure Anthem's prior approval for any non-standard forms to be used in securing enrollment and eligibility information. The *group* agrees to maintain all membership information in a secure manner, retrievable and reproducible, including all signed enrollment applications linked with the process or media. The *group* will furnish to Anthem, immediately upon Anthem's demand, and at no expense to Anthem,

copies of such forms and correspondence, whether written or electronic. Eligibility guidelines based upon criteria set forth in this *agreement* must be adhered to.

The *group* and Anthem shall comply with all applicable requirements of HIPAA and the *group* and Anthem shall require any of their respective agents, subcontractors and vendors to comply with all applicable requirements of HIPAA.

INDEMNIFICATION

The *group* agrees to indemnify and hold Anthem harmless against any claim, demand, loss, lawsuit, settlement, judgment, other liability, and all related expenses which may accrue, arising from or related to the *group*'s failure to provide timely, accurate and complete eligibility information in accordance with the terms of this *agreement*. If Anthem is required to provide membership coverage because of the *group*'s failure to fully and faithfully perform under this *agreement*, in addition to any other remedy Anthem may have against the *group* for such failure, the *group* will, at Anthem's option, pay all prepaid/premium charges due for such coverage or reimburse Anthem for all claims paid as a result of the *group*'s failure, at Anthem's option.

CONFIDENTIALITY

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

DECLINATION FORMS

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

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

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

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

GROUP RECORDS

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

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORMS

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

SUMMARY OF BENEFITS AND COVERAGE

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

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

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

CANCELLATION

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

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

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

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

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

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

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

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

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

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

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

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

COBRA ADMINISTRATION

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

CALCOBRA NOTIFICATION REQUIREMENTS

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

BLUE CROSS AND BLUE SHIELD ASSOCIATION DISCLOSURE

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

INTER-PLAN PROGRAM DISCLOSURE

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

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

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

BlueCard® Program

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

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

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

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

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

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

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

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

NON-NETWORK PROVIDERS OUTSIDE ANTHEM'S SERVICE AREA

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

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

MISCELLANEOUS PROVISIONS

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

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

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

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

ASSIGNMENT

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

SUBSCRIPTION CHARGE SCHEDULE

PAYMENT DATES

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

GRACE PERIOD

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

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

SUBSCRIPTION CHARGE CHANGE

The subscription charges in effect on the Agreement Effective Date are shown in the *agreement's* Subscription Charge Schedule. Anthem has the right to change the subscription charges as of any of these dates by giving the *group* written notice at least 60 days prior notice. The written notice will disclose the reason or reasons for the change in subscription charges.

1. The Agreement Effective Date, or if later, any subsequent Agreement Anniversary Date, if:

    a. It is discovered that the *group* is offering employees alternate health care benefits with an insurance company(ies) and/or health care service plan(s) other than Anthem or Anthem Blue Cross Life and Health & Health Insurance Company (Anthem Blue Cross Life and Health) without the written concurrence of Anthem;

    b. It is determined that the facts used to determine subscription charges for the Agreement Effective Date or Agreement Anniversary Date, during the underwriting process, are incorrect, even if the *group* did not know they were incorrect. Facts which may affect the rates include, but, are not limited to:

        i. There are disabled employees that were not disclosed or discovered;

        ii. There are *members* with serious medical conditions that were not disclosed or discovered;

        iii. There are *members* with large on-going claims that were not disclosed or discovered;

    c. The actual enrollment on the Agreement Effective Date varies from the total enrollment used to determine the rates for the Agreement Effective Date or Agreement Anniversary Date, during the underwriting process, by 10 % or more;

    d. The actual proportion of *subscribers,* for each medical care benefit plan provided by Anthem or Anthem Blue Cross Life and Health (an affiliate of Anthem), who are enrolled on the Agreement Effective Date varies from the assumed proportion of *subscribers* used to determine the subscription charges for the Agreement Effective Date or Agreement Anniversary Date, during the underwriting process, by 10 % or more;

e. With regard to the subscription charges applicable to *subscribers*, the actual enrollment of the *subscribers* is less than 75% of the total number of employees eligible; and/or

f. With regard to the subscription charges applicable to the dependents of *subscribers*, the actual proportion of employees electing dependent coverage differs from the proportion used to determine the subscription charges for the Agreement Effective Date or Agreement Anniversary Date, during the underwriting process, by 10% or more; and

g. The *group's* actual contribution toward the cost of the subscription charge(s), separately for each product, and, under each product, separately for *subscribers* and insured *family members*, is different than what the group indicated to Anthem during the underwriting process.

h. The *group's* emerging claim experience indicates that the subscription charge(s) is/are insufficient to cover the claim costs.

In the event that Anthem determines that a, b, c, d, e, f, and/or g above apply, it will give the *group* written notification of the change in subscription charges and the reason or reasons that it is changing the subscription charges at least 60 days in advance of the Agreement Effective Date or Agreement Anniversary Date.

2. Any Subscription Due Date unless the Subscription Rate Schedule, or an endorsement to the *agreement*, states otherwise.

3. Any date that the number of *subscribers* changes, due to acquisition, divestiture, merger, or similar transaction, by 20% or more, or by 200 *subscribers*, whichever is less.

4. Any date that Anthem determines that the *group* is modifying, or has modified, *plan* benefits, by changing a *subscriber's* financial liability under the *plan,* by it paying a part of the *member's* deductibles, coinsurance, co-payments, out-of-pocket maximums, or for *non-participating providers*, the balance-billed charges, if any. The *group* may not partially pay, reimburse, or otherwise reduce, the *member's* financial responsibility under the *plan* without first notifying Anthem in writing in at least 30-days advance of implementing such a practice and Anthem agreeing, in writing, to that practice. In the absence of Anthem agreeing to such a practice, the *group* must communicate the plan benefits to the subscribers without modification.

5. Any date the extent or nature of the risk under the *agreement* is changed: (a) by an endorsement to the *agreement*, or (b) by the addition or deletion of coverage whether under an Anthem plan or a plan provided by an affiliate of Anthem or (c) by reason of any provision of law or any governmental program or regulation.

Except for item 1 above, Anthem may not increase premium rates without first providing written notification to the *group* at least 60 days prior to the date the increase is to take effect.

ACCURACY OF INFORMATION

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

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

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

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

TAX LIABILITY

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

REFUNDS OF UNEARNED SUBSCRIPTION CHARGES

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

MEDICAL LOSS RATIO REBATE

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

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

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

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORMS INCLUDED IN THIS AGREEMENT

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

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

PLAN DESCRIPTION	FORM NUMBER	EFFECTIVE DATE
Anthem Blue Cross HMO Plan (County of Fresno)	RT275341-1 0215	December 7, 2015
Anthem Blue Cross HMO Plan (County of Tulare)	RT275341-2 0215	January 1, 2016
Anthem Blue Cross HMO Plan (City of Ceres)	RT275341-3 0215	January 1, 2016
Anthem Blue Cross HMO Plan (City of Waterford)	RT275341-4 0215	January 1, 2016
Anthem Blue Cross HMO Plan (City of San Joaquin)	RT275341-5 0215	January 1, 2016
Anthem Blue Cross HMO Plan (City of San Shafter)	RT275341-6 0215	January 1, 2016
Anthem Blue Cross HMO Plan (City of Gustine)	RT275341-7 0215	January 1, 2016
Anthem Blue Cross HMO Plan (City of Reedley)	RT275341-8 0215	January 1, 2016
Anthem Blue Cross HMO Plan (City of Newman)	RT275341-9 0215	January 1, 2016
Anthem Blue Cross HMO Plan (City of Farmersville)	RT275341-10 0215	January 1, 2016
Anthem Blue Cross HMO Plan (City of Riverbank)	RT275341-11 0215	January 1, 2016
Anthem Blue Cross HMO Plan (City of Clovis)	RT275341-12 0215	January 1, 2015
Anthem Blue Cross HMO Plan (City of Hanford)	RT275341-13 0215	January 1, 2015
Anthem Blue Cross HMO Plan (City of Oakdale)	RT275341-14 0215	January 1, 2015

SJVIA
San Joaquin Valley
Insurance Authority

Meeting Location:
Fresno County Employees' Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
March 18, 2016 9:00 AM

AGENDA DATE: March 18, 2016

ITEM NUMBER: 14

SUBJECT: Execution of Confidentiality Agreement with Anthem Blue Cross Regarding Sutter Health (A)

REQUEST(S): That the Board authorize and execution of the Confidentiality Agreement with Anthem Blue Cross

DESCRIPTION:

Effective January 1, 2016 Anthem Blue Cross (Anthem) has renewed their provider contract with Sutter Health (Sutter). The new contract requires Anthem to seek from its self-funded customers, including the SJVIA, a signed attestation that those self-funded customers, even though they are not parties to the agreement between Anthem and Sutter, will comply with a number of provisions relating to dispute resolution, claims payment, utilization management, coordination of benefits and other items. The attestation is a document establishing that the SJVIA has reviewed the new Sutter contract with Anthem and agrees to be bound by those provisions.

Anthem cannot provide a copy of the Sutter contract until the SJVIA signs a confidentiality agreement. That means the SJVIA cannot review the Sutter agreement to see what obligations the attestation might cover until the SJVIA enters into a confidentiality agreement.

For that reason, SJVIA staff recommends that the SJVIA Board approve and authorize its President to sign a Confidentiality Agreement with Anthem. The Confidentiality Agreement requires the SJVIA to maintain the confidentiality of the agreement between Anthem and Sutter Health, unless ordered by a court to disclose the agreement. This Confidentiality Agreement will allow Anthem to provide the SJVIA with a copy of its agreement with Sutter to review. After review of the contract between Anthem and Sutter, SJVIA Staff and Council will make a recommendation to the Board to approve or reject the attestation.

AGENDA: San Joaquin Valley Insurance Authority

DATE: March 18, 2016

FISCAL IMPACT/FINANCING:

No Financial Impact at this time. Failure to sign the attestation will result in Sutter Health claims being processed as non-participating out of network claims.

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

SJVIA
San Joaquin Valley
Insurance Authority

Meeting Location:
Fresno County Employees' Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
March 18, 2016 9:00 AM

AGENDA DATE: March 18, 2016

ITEM NUMBER: 15

SUBJECT: Authorization and Execution of Blue Shield of California Agreement Effective January 1, 2016 (A)

REQUEST(S): That the Board authorize the execution of Blue Shield of California Agreement Effective January 1, 2016

DESCRIPTION:

The Agreement between the SJVIA and Blue Shield of California provides network access for the City of Tulare's health plans through the SJVIA. The per employee per month fee (PEPM) of $20.07 included access to the Blue Shield network of providers and disease management and was approved as part of the renewal for the 2016 calendar year.

FISCAL IMPACT/FINANCING:

The prior fee was $19.11 PEPM. The impact to the budget is 5% on a calendar year basis for the enrollment in the City of Tulare Plans. The total dollar amount this contract covers is approximately $81,000 for the 2016 calendar year and approximately half of that for the current fiscal year.

AGENDA: San Joaquin Valley Insurance Authority

DATE: March 18, 2016

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

SHARED ADVANTAGE PLUS AGREEMENT

BY AND BETWEEN

CALIFORNIA PHYSICIANS' SERVICE D/B/A

BLUE SHIELD OF CALIFORNIA

AND

SAN JOAQUIN VALLEY INSURANCE AUTHORITY

Effective: January 1, 2016

SHARED ADVANTAGE PLUS AGREEMENT

This **SHARED ADVANTAGE PLUS AGREEMENT** (this "**Agreement**"), effective January 1, 2016 (the "**Effective Date**"), is made and entered into by and between **CALIFORNIA PHYSICIANS' SERVICE, d/b/a BLUE SHIELD OF CALIFORNIA**, a California nonprofit mutual benefit corporation ("**Blue Shield**") and **SAN JOAQUIN VALLEY INSURANCE AUTHORITY**, a corporation doing business in California (**"Client"**).

WHEREAS, Blue Shield is licensed as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975, and the regulations promulgated thereunder, each as amended (the **"Knox-Keene Act"**), and provides the Shared Advantage Plus Product (as defined below) to customers in the State of California; and

WHEREAS, Client is headquartered in California and sponsors a health benefits plan named SJVIA Benefit Plan, a copy of which is attached hereto as Attachment A (the **"Plan"**); and

WHEREAS, HealthNow Administrators ("**HealthNow Administrators** ") is a TPA (as defined below); and

WHEREAS, HealthNow Administrators and Blue Shield are parties to that certain Master Services Agreement, effective as of February 1, 2012 (the **"MSA"**), pursuant to which HealthNow Administrators and Blue Shield have agreed to provide certain administrative services to each other and to customers who have purchased the Shared Advantage Plus Product; and

WHEREAS, HealthNow Administrators and Client are parties to that certain Administrative Services Agreement effective as of January 1, 2016 (the **"TPA Agreement"**) pursuant to which HealthNow Administrators has agreed to provide certain administrative services to Client supporting the provision of the Shared Advantage Plus Product and the administration of the Plan; and

WHEREAS, Client and Blue Shield desire to enter into a contract pursuant to which Blue Shield will provide certain other administrative services to Client supporting the provision of the Shared Advantage Plus Product and the administration of the Plan.

NOW, THEREFORE, the parties hereto, in consideration of the premises and covenants herein contained, and intending to be legally bound hereby, agree as follows:

1 DEFINITIONS AND CONSTRUCTION.

1.1 Definitions. The following capitalized terms, when used in this Agreement and the Attachments hereto, shall have the meanings set forth in this Section.

(a) **"Affiliate"** means, with respect to any Person, any other Person Controlling, Controlled by, or under common Control with, such Person at the time in question.

(b) "**Agreement"** is defined in the preamble.

(c) **"At-Risk Party"** is defined in Section 8.2(d)(i).

(d) **"BCBSA"** is defined in Section 9.2.

(e) **"Blue Shield"** is defined in the preamble.

(f) "**Blue Shield Fees"** is defined in Attachment E, Section 1.1(b)(i).

(g) **"Blue Shield Services"** is defined in Section 2.1(a).

(h) **"Books and Records"** is defined in Section 5.2.

(i) **"Business Day"** means any day other than a Saturday or a Sunday or other day on which commercial banks are authorized or required to close in the State of California.

(j) **"Change in Law"** means (i) the passage of any change in a Law in effect as of the Effective Date or any new Law, or a written change in the formal interpretation of a Law that is held, or is reasonably likely to be held, by a Governmental Entity having jurisdiction over a party with respect thereto, to be applicable to such party, or (ii) a change in the applicable requirements of BCBSA in effect as of the Effective Date or any new requirement of BCBSA imposed after the Effective Date.

(k) **"Change Order"** is defined in Section 2.1(d).

(l) **"Change Request"** is defined in Section 2.1(d).

(m) **"Client"** is defined in the preamble.

(n) **"Client Services"** is defined in Section 2.2.

(o) **"Compensation**" is defined in Section 3.

(p) **"Confidential Information"** is defined in Section 7.2(a).

(q) "**Contracting Providers"** means those health care providers with whom/which Blue Shield has entered into contracts to provide health care services to Participants in exchange for negotiated rates.

(r) **"Control"** means (i) the legal, beneficial or equitable ownership, directly or indirectly, of more than fifty percent (50%) of the voting capital stock (or other voting interests) of an entity; or (ii) the possession, directly or indirectly, of the power to direct or cause the direction of the management policies or operation of an entity through ownership of voting securities, by contract, or otherwise.

(s) **"Damages"** is defined in Section 10.1

(t) **"Dispute Date"** is defined in Section 11.10

(u) **"Effective Date"** is defined in the preamble.

(v) **"Encumbrances"** means any mortgage, pledge, security interest, encumbrance, lien or charge of any kind (including any conditional sale or other title retention agreement or lease in the nature thereof), any sale of receivables with recourse, any filing or agreement to file a financing statement as debtor under the Uniform Commercial Code or any similar statute, or any subordination arrangement in favor of another Person.

(w) **"Force Majeure Event"** means any contingency beyond the reasonable control of a party, including acts of God, fires, wars, riots, civil disorders, accidents, labor disputes or shortages, and

governmental Laws (regardless of whether such Laws are valid or invalid).

(x) **"GAAP"** means generally accepted accounting principles as in effect in the United States from time to time.

(y) **"Governmental Entity"** means any foreign, federal, state or local governmental, regulatory or other administrative body, court, tribunal, authority, department, commission, board, bureau, agency or instrumentality.

(z) "**HealthNow Administrators** " is defined in the third recital.

(aa) **"TPA Agreement"** is defined in the fifth recital.

(bb) **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder, each as amended and in effect from time to time.

(cc) **"Indemnified Party"** is defined in Section 10.1.

(dd) **"Indemnifying Party"** is defined in Section 10.1.

(ee) **"Intellectual Property"** means all: (i) patents, patent applications, patent disclosures and inventions; (ii) trademarks, service marks, trade dress, trade names, logos and corporate names and registrations and applications for registration thereof together with all of the goodwill associated therewith; (iii) copyrights (registered or unregistered) and copyrightable works and registrations and applications for registration thereof; (iv) mask works and registrations and applications for registration thereof; (v) computer software, (vi) electronic and non-electronic data, data bases and documentation thereof; (vii) trade secrets and other confidential information (including ideas, formulas, compositions, inventions (whether patentable or unpatentable and whether or not reduced to practice), know-how, manufacturing and production processes and techniques, research and development information, drawings, specifications, designs,

plans, proposals, technical data, copyrightable works, financial and marketing plans and customer and supplier lists and information); (viii) other intellectual property rights; and (ix) copies and tangible embodiments thereof (in whatever form or medium).

(ff) **"Knox-Keene Act"** is defined in the first recital.

(gg) **"Law"** means any federal, state, local, or other constitution, charter, act, statute, law, ordinance, code, rule, regulation, order, specified standards or objective criteria contained in any applicable permit or approval, or other legislative or administrative action of the United States of America, or any state or any agency, department, authority, political subdivision or other instrumentality thereof, or a decree or judgment or order of a court.

(hh) **"Licensee"** is defined in Section 6.1(a).

(ii) **"Licensor"** is defined in Section 6.1(a).

(jj) **"Material Adverse Effect"** means, with respect to a party (other than a natural person), any change or effect that would or would reasonably be expected to materially and adversely affect the financial condition or performance, results of operations, the assets, liabilities, the business, or the party, taken as a whole, as the case may be.

(kk) **"Modifications"** is defined in Section 6.2.

(ll) "**MSA**" is defined in the fourth recital.

(mm) **"Participant"** means each union member, employee, retiree or other individual who is a resident of California and is eligible to enroll in, and is enrolled the Plan and each enrolled dependent of such enrolled union member, employee, retiree or other individual.

(nn) **"Person"** means an individual, trust, estate, partnership, or any incorporated or unincorporated organization.

(oo) **"Plan"** is defined in the second recital.

(pp) **"Proceeding"** is defined in Section 10.2.

(qq) **"Shared Advantage Plus Product"** means an arrangement pursuant to which Blue Shield and a TPA jointly administer the self-funded health care benefit plan(s) of a customer headquartered in the State of California and in which: (i) Blue Shield provides certain administrative services, including claims adjudication services, and access to Blue Shield's network of contracted health care providers (as well as access to the applicable rates contracted for by Blue Shield with such providers); (ii) the TPA provides certain customer support and other administrative services; and (iii) the customer assumes the obligation to pay for the costs of health care benefits for which participants in the self-funded health care benefit plan(s) are eligible.

(rr) **"TPA"** means a third party administrator, where "administrator" has the meaning set forth in Section 1759 of the California Insurance Code.

1.2 **Capitalized Terms.** Other specific capitalized terms in this Agreement are defined where used and have the meanings there indicated. Further, any terms, acronyms, and phrases of general custom or use in the health insurance and/or information services industry, if and to the extent not specifically defined herein, shall be interpreted in accordance with such custom and usage.

1.3 **Rules of Construction.** The following rules of construction shall apply to this Agreement.

(a) Each term defined in the singular form in Section 1.1 or elsewhere in this Agreement means the plural thereof whenever

the plural form is used, and each term defined in the plural form means the singular thereof whenever the singular form is used. The use of a pronoun of any gender is applicable to all genders.

(b) Unless otherwise specified therein, all terms defined in this Agreement have the meanings as so defined herein when used in any other certificate, report or document made or delivered pursuant hereto.

(c) The words “hereof,” “herein,” “hereunder” and similar terms when used in this Agreement refer to this Agreement as a whole and not to any particular provision of this Agreement, and article, section, subsection, schedule and exhibit references herein are references to articles, sections, subsections, schedules and exhibits to this Agreement unless otherwise specified.

(d) A reference to any agreement, document or instrument refers to the agreement, document or instrument as amended or modified and in effect from time to time in accordance with the terms thereof and as permitted therein.

(e) Except as otherwise specified, a reference to any applicable law or section thereof refers to the law as amended, modified, codified, replaced or reenacted, in whole or in part, and in effect from time to time, and to any rules and regulations promulgated thereunder;

(f) The words “including” and “include” mean including without limiting the generality of any description preceding such term, the phrase “may not” is prohibitive and not permissive, and the word “or” is not exclusive.

(g) All accounting terms not specifically defined herein shall be construed in accordance with GAAP.

(h) Unless otherwise stated in this Agreement, in the computation of a period of time from a specified date to a later specified date, the

word “from” means “from but excluding” and the words “to” and “until” each means “to and including.”

1.4 Headings. The headings preceding the text of the sections of this Agreement and the exhibits hereto are for convenience only and shall not be deemed any part of the terms or construction of this Agreement.

1.5 No Presumption. The language used in this Agreement shall be deemed to be the language chosen by the parties to express their mutual intent, and no rule of strict construction shall be applied against any party.

2 THE SERVICES.

2.1 Blue Shield Services.

(a) General. Commencing on the Effective Date, Blue Shield shall provide Participants with access to the Contracting Providers and shall provide those administrative services supporting the Plan set forth in Attachment B hereto (the **“Blue Shield Services”**), in accordance with the terms and conditions of this Agreement.

(b) Resources. Except as otherwise expressly provided in this Agreement, Blue Shield shall be responsible for providing the personnel, facilities, equipment, software, technical knowledge, expertise and other resources necessary to provide the Blue Shield Services.

(c) Limit on Blue Shield Services. Client shall be solely responsible for the performance of all Plan management and administrative functions except those functions specifically identified in this Agreement as the responsibility of Blue Shield. Identification in this Agreement of specific Client responsibilities shall not be deemed or interpreted to limit Client’s other responsibilities for management and administration of the Plan. Blue Shield is not responsible for coordination of benefits or Medicare Crossover services.

(d) **Change Order.** Client may request a change to the scope of the Blue Shield Services, including additional or new services, by written request to Blue Shield (a **"Change Request"**). Blue Shield shall use commercially reasonable efforts to accommodate each Change Request; provided that if such accommodation will require Blue Shield to dedicate resources in addition to those already dedicated to the provision of the Blue Shield Services, Blue Shield may require a reasonable increase in the Compensation for accommodating the Change Request. Within ten (10) Business Days of receipt of a Change Request, Blue Shield notify Client of Blue Shield's ability to accommodate the Change Request, including an estimate of Compensation increases, if any, required by Blue Shield. If the parties agree upon the terms (including any Compensation increases) applicable to any Change Request, the parties shall enter into a change order in substantially the form attached hereto as Attachment C (**"Change Order"**). Each Change Order shall be deemed an amendment to this Agreement.

2.2 Client Services

(a) **General.** Commencing on the Effective Date, Client shall provide the services described in Attachment D hereto (the **"Client Services"**), in accordance with the terms and conditions of this Agreement. The Client Services shall be provided either directly by Client or through HealthNow Administrators , as specified in Attachment D.

(b) **Resources.** Except as otherwise expressly provided in this Agreement, and notwithstanding any delegation to HealthNow Administrators , Client shall be responsible for providing the personnel, facilities, equipment, software, technical knowledge, expertise and other resources necessary to provide the Client Services.

3 THE COMPENSATION.

In exchange for the provision of the Blue Shield Services, Client shall pay Blue Shield the compensation set forth in Attachment E (the **"Compensation"**).

4 PUBLICITY.

Neither party shall issue a press release announcing or describing their relationship contemplated by this Agreement without the prior written consent of the other party, which consent shall not be unreasonably withheld or delayed. Except as otherwise agreed to by the parties, all media releases, public announcements, and public disclosures by either party relating to this Agreement or the subject matter of this Agreement, including promotional or marketing material, but not including announcements intended solely for internal distribution or disclosures to the extent required to satisfy legal or regulatory requirements, shall be coordinated with and approved by the other party prior to release, which approval shall not be unreasonably withheld or delayed. *[Notwithstanding the foregoing, Client's compliance with the applicable provisions of California Government Code §54950 et. seq. (the **"Brown Act"**) shall not be deemed to be in violation of the terms of this Section.]*

5 COVENANTS.

5.1 **Work Standards.** Blue Shield shall perform the Blue Shield Services with reasonable and ordinary care, and with the skill, prudence and diligence of a prudent health care benefits administrator acting under the circumstances then prevailing. Client shall perform the Client Services with reasonable and ordinary care, prudence and diligence acting under the circumstances then prevailing.

5.2 **Books and Records.** Blue Shield shall keep and maintain books of account and other records on a current basis relating to the Blue Shield Services and other performance under this Agreement and Client shall keep and maintain books of account and other records on a current basis relating to the Client Services, the determination of who are Participants and the payment of claims (collectively, the **"Books and Records"**).

Each party agrees to preserve its Books and Records for at least seven (7) years.

5.3 Audit.

(a) During the term of this Agreement and for a period of one (1) year after the termination of this Agreement, Client may inspect and audit Books and Records maintained by Blue Shield in performing the Blue Shield Services by giving Blue Shield thirty (30) days advance written notice and a request for such Books and Records. The notice shall state the purpose for the audit. Any examination of individual benefit payment records shall be carried out in a manner agreed to by the parties and designed to protect the confidentiality of individual medical information. Audits shall be limited to not more than one (1) during any twelve (12) month period.

(b) During the term of this Agreement and for a period of one (1) year after the termination of this Agreement, Blue Shield may inspect and audit the Books and Records maintained by Client respecting the eligible Participants and the payment of claims by giving Client thirty (30) days advance written notice and a request for such Books and Records. The notice shall state the purpose for the audit. Any examination of individual benefit payment records shall be carried out in a manner agreed to by the parties and designed to protect the confidentiality of individual medical information.

(c) Any audits shall be conducted at the auditing party's expense by such party's audit staff or by an independent contractor employed by such party who shall be either a Certified Public Accountant or who shall be otherwise professionally qualified to perform such audit services. A party may refuse access to records and information to any Person who such party believes is reasonably likely to misuse or misappropriate information as a result of a

conflict of interest or otherwise, or whose compensation in connection with any audit is contingent or otherwise wholly or partially based on the audit findings. Any Person who performs an audit hereunder shall use generally accepted auditing standards. Any independent contractor employed by a party to perform an audit shall agree in writing to maintain the confidentiality of all information of which it becomes aware in the course of the audit*[; provided, however, that such requirement of confidentiality shall be subject to Client's obligations under the Brown Act]*. At the conclusion of any audit and prior to drafting the audit report, the auditor shall meet with the audited party for an exit conference. Prior to the release of any final audit report, the audited party shall be provided with a copy of the audit report and be given an opportunity to comment. Such party's comments, if any, shall be made a part of the final audit report. The auditing party shall reimburse the audited party for all reasonable costs incurred by the audited party in support of the audit.

(d) In the event that a party or party's auditors request individually identifiable medical information, the party desiring such records shall provide the other party with a written representation and warranty stating that the party requesting the records has established procedures that ensure appropriate safeguards against unauthorized disclosure or use of such information and that the information will be used solely for the purposes allowed by California Civil Code §§ 56.10-56.16 (the California Confidentiality of Medical Information Act), California Insurance Code §§ 791-791.27 (the California Insurance Information and Privacy Protection Act), HIPAA, Title 42 of the U.S. Code (the U.S. Public Health Service Act), and other applicable privacy Laws.

5.4 Compliance with Laws.

Each party shall comply with all applicable Laws in connection with its performance hereunder.

5.5 TPA Agreements. Client covenants and agrees that any agreements it enters into or maintains with HealthNow Administrators or any other TPA, including the TPA Agreement, and Client's performance of such agreements, shall not conflict with, result in a material breach of, constitute a material default under this Agreement.

6 INTELLECTUAL PROPERTY.

6.1 Existing Intellectual Property.

(a) In the event that either Blue Shield or Client (the **"Licensor"**) licenses or otherwise permits the other party (the **"Licensee"**) to utilize or access certain Intellectual Property of the Licensor, whether pursuant to a separate license agreement or otherwise, in connection with this Agreement, then, following the termination of this Agreement, or at any time the Licensor notifies the Licensee, all license or other rights to the Intellectual Property provided shall terminate and revert back to the Licensor.

(b) The Licensee shall not create or permit any Encumbrances to any Intellectual Property of the Licensor or any Modifications thereto without the prior written consent of the Licensor. The Licensee shall execute such instruments and agreements as may be reasonably requested by the Licensor to evidence the Licensor's rights to the Intellectual Property and any Modifications thereto.

6.2 Modifications. In the event that the parties jointly develop, or cause the development of any modifications, enhancements and adaptations (collectively, any **"Modifications"**) to any Intellectual Property, all right, title and interest to such Modifications shall be deemed to belong to the Licensor whose Intellectual Property such Modifications relate, and the Licensee shall be deemed to have a non-exclusive license, without any

right to sublicense, to use such Modifications in furtherance of its obligations pursuant to this Agreement. Following the termination of this Agreement, all rights to any Modifications shall terminate and revert back to the licensing party.

6.3 **New Intellectual Property.** In the event that the parties jointly develop, or cause the development of any new Intellectual Property, such Intellectual Property shall be deemed to be jointly owned by both parties during the term of this Agreement and thereafter, and each party shall have the unfettered right to exploit such Intellectual Property for its benefit without being obligated to pay any royalties or other sums to, obtain the consent of, or provide any notice to the other party.

7 HIPAA; CONFIDENTIALITY.

7.1 **Protected Health Information.** Blue Shield and Client shall develop and implement policies and procedures to ensure that Participants' information is not disclosed in violation of any applicable Law relating to protection of such information. The parties shall execute, concurrently with this Agreement, a HIPAA Business Associate Agreement, substantially in the form attached hereto as Attachment F, the terms of which are incorporated herein by reference. Client may instruct Blue Shield to transmit reports and information to HealthNow Administrators in connection with Blue Shield's performance of this Agreement. Client may also instruct HealthNow Administrators to send reports and information to Blue Shield in connection with HealthNow Administrators 's performance of the TPA Agreement. Client represents and warrants to Blue Shield that Client has entered into a HIPAA business associate agreement with HealthNow Administrators and that such agreement shall remain in effect during the term of this Agreement. Client understands and agrees that HealthNow Administrators will participate in the exchange of information described herein and that Client nevertheless remains responsible for Client's performance under this Agreement. Client shall notify Blue Shield promptly in the event that its HIPAA business associate agreement with

HealthNow Administrators ceases to be in effect, in which event (notwithstanding anything to the contrary in this Agreement) Blue Shield shall not be required to transmit information to or receive information from HealthNow Administrators . Notwithstanding anything to the contrary in this Agreement, no attorney-client privilege, attorney work product protection, accountant-client privilege, or other similar legal privilege or protection shall be deemed waived by Client or Blue Shield by virtue of this Section 7.1.

7.2 Confidential Information.

(a) Definition. Client and Blue Shield each acknowledges that it may be furnished with, receive or otherwise have access to information of or concerning the other party that such party considers to be confidential, a trade secret, or otherwise restricted. **"Confidential Information"** shall mean all information, in any form, furnished or made available directly or indirectly by one party, or to which either party gains access in the course of or incidental to the performance of this Agreement, and that reasonably should have been understood by the recipient (because of legends or other markings, the circumstances of disclosure, or the nature of the information itself) to be confidential, to the furnishing party, an Affiliate of the furnishing party, or a third party. Confidential Information shall include, whether or not designated "Confidential Information," all non-public information concerning: (i) the identities and related information regarding contracting providers of Blue Shield or its Affiliates, (ii) contract reimbursement rates and related information for such contracting providers, (iii) proprietary claims adjudication rules and procedures, and (iv) other proprietary rules, procedures and methodologies used by Blue Shield or its Affiliates to create and maintain their provider networks and to adjudicate claims. The terms and conditions of this Agreement shall also be deemed Confidential Information. Notwithstanding the foregoing,

Confidential Information shall not include information that the receiving party can demonstrate to the reasonable satisfaction of the disclosing party (A) was rightfully in the possession of the receiving party without any obligation of confidence before receipt thereof from the disclosing party, (B) was independently developed by the receiving party without the use of or reference to any of the disclosing party's Confidential Information, (C) is or has become available to the public without fault of the receiving party or (D) is disclosed to the receiving party, without restriction, by a third party with the right to so disclose.

(b) **Non-Disclosure.** Each party agrees to maintain the Confidential Information of the other party in confidence using at least the same degree of care as it uses for its own Confidential Information and not use the other party's Confidential Information for any purpose other than the purposes contemplated by this Agreement. Each party may disclose the other party's Confidential Information only to (i) officers, directors, employees or Affiliates of the receiving party who have a need to know such information to accomplish the purposes of this Agreement or (ii) third parties upon the prior written approval of the other party. Notwithstanding the foregoing, a party may use or disclose the other party's Confidential Information to the extent that, based upon the advice of the party's legal counsel, such use or disclosure is reasonably necessary to comply with applicable governmental regulations or court order; provided that the party provides reasonable advance written notice to the other party of any such disclosure and uses its reasonable efforts to secure confidential treatment of the other party's Confidential Information prior to its disclosure (whether through protective orders or otherwise) and discloses only the minimum amount of information necessary to comply with such requirements.

(c) **Return of Materials.** As requested by either party during the term, upon expiration or any termination of this Agreement, or upon completion of either party's obligations under this Agreement, the receiving party shall return or destroy, as the furnishing party may direct, all material in any medium that contains, refers to, or relates to Confidential Information of the furnishing party, and retain no copies; provided that the receiving party may retain such archival copies as may be necessary to comply with document retention laws and regulations applicable to the receiving party's business operations.

(d) **Mitigation.** In the event of any actual or suspected misuse, disclosure or loss of, or inability to account for, any Confidential Information of the disclosing party, the receiving party promptly shall (i) notify the disclosing party upon becoming aware thereof; (ii) promptly furnish to the disclosing party full details of the unauthorized possession, use, or knowledge, or attempt thereof, and use reasonable efforts to assist the disclosing party in investigating or preventing the reoccurrence of any unauthorized possession, use, or knowledge, or attempt thereof, of Confidential Information; (iii) take such actions as may be necessary or reasonably requested by the disclosing party to minimize the violation; and (iv) cooperate in all reasonable respects with the furnishing party to remedy, terminate or discontinue the violation and any damage resulting therefrom.

(e) **Duration.** The parties' obligations respecting Confidential Information shall continue for a period of five (5) years following expiration or termination of this Agreement unless a longer period is required by this Agreement or by Law.

(f) **Ownership of Records.** All business records and claims data relating to the Blue Shield Services shall constitute Confidential Information under the terms of this Agreement and shall be and

remain the sole property of Blue Shield. As may be requested by Blue Shield at reasonable intervals, Client shall transfer a complete copy of all Blue Shield data to Blue Shield and shall provide such data within not more than fifteen (15) Business Days after the request.

(g) **Remedies.** The parties agree that any violation of this Section 7 would cause immediate and irreparable injury or loss to the affected party. Accordingly, in the event of any violation of any of the provisions of this Section 7 by a party, or any explicit threat thereof, the other party shall be entitled to an injunction or other decree of specific performance with respect to such violation or threatened violation, without any bond or other security being required and without the necessity of demonstrating actual damages. Such remedies shall be in addition to any other remedies provided by Law.

8 TERM AND TERMINATION.

8.1 **Term.** Unless sooner terminated as provided herein, this Agreement shall remain in effect through December 31, 2016. Thereafter, this Agreement shall automatically renew each year for a one year term unless sooner terminated as set forth in Section 8.2

8.2 **Termination.**

(a) **Without Cause**. Either party may terminate this Agreement without cause by providing the other party with no fewer than ninety (90) days prior written notice.

(b) **For Cause.**

(i) for breach of any other material obligation under this agreement (including timely payment of Service Charges) provided that, the terminating party shall have delivered to the defaulting party written notice thereof specifying the matters in default and the defaulting party shall not have

cured the default within thirty (30) days thereafter (or commenced diligent efforts to cure with respect to any default that by its nature cannot be cured within thirty (30) days, in which case the terminating party may terminate the Agreement if a cure of such default is not completed within sixty (60) days from the notice of default);

(ii) Either party may terminate this Agreement immediately upon written notice delivered to the other party in the event such other party is the subject of any voluntary or involuntary bankruptcy or insolvency proceeding that remains undismissed for a period of sixty (60) days or makes a general assignment for the benefit of its creditors.

(iii) Blue Shield may terminate this Agreement as provided in Section 9.2.

(c) **Force Majeure Event.** This Agreement may be terminated as provided in Section 11.7.

(d) **Change in Law.**

(i) If a party (an **"At-Risk Party"**) receives a final non-appealable determination by a Governmental Entity having jurisdiction with respect thereto, or there is a Change in Law, which determination or Change in Law as applied does, or is likely to, based upon the written opinion of legal counsel to the At-Risk Party:

(A) prohibit the execution, implementation or continuance of this Agreement; or

(B) by virtue of this Agreement or performance thereunder, result in:

(1) the revocation of any material state and/or federal general operating license, permit or certificate of the At-Risk Party;

(2) the subjection of the At-Risk Party to a significant level of governmental scrutiny or reporting requirements; or

(3) a Material Adverse Effect on the business or operations of the At-Risk Party; and if

(ii) the parties, using commercially reasonable efforts and acting in good faith to preserve the relationship and the expectations and intent of the parties hereto, are unable to reach a mutual agreement to amend this Agreement sufficiently to meet the requirements of the determination or Change in Law on or prior to the earlier of (A) the thirtieth (30th) day following the Change in Law, or (B) the effective date, if any, of such Change in Law, then

(iii) the At-Risk Party shall be entitled to elect to terminate this Agreement effective immediately upon notice of such termination from the At-Risk Party to the other party.

(e) **Confidentiality.** Either party may terminate this Agreement immediately upon written notice to the other party in the event that the other party breaches the confidentiality requirements set forth in Section 7.

(f) **Failure to Fund.** Blue Shield may terminate this Agreement upon no fewer than five (5) days prior written notice to Client in the event that Client fails to provide sufficient funds for claim payments under the Plan.

(g) **Discontinuance of the Plan.** Either party may terminate this Agreement upon the effective date of discontinuance of the Plan

by providing the other party with no fewer than thirty (30) days advance written notice.

8.3 **Effect of Termination.** Except for duties and obligations expressly defined herein to survive, or to be created upon, termination of this Agreement, neither party shall have any further duties of performance hereunder as of and after the effective date of any termination, but shall remain obligated as to all obligations accrued prior to such date.

8.4 **Transfer of Records Upon Termination.** Upon expiration or termination of this Agreement for any reason, each party shall transfer to the other party all records and reports, including computer records, which are the properties of the other party as provided herein. Both parties agree to cooperate fully in all such matters.

8.5 **Provision of Services Upon Termination.** Blue Shield Services regarding claims shall be performed only with respect to claims received by Blue Shield or HealthNow Administrators during the term of this Agreement. Blue Shield shall complete the Blue Shield Services regarding all claims in its possession as of the effective date of termination of this Agreement, provided that Client has made sufficient funds available to pay such claims. If this Agreement was terminated other than pursuant to Section 8.2(b), (d), (e), (f), or (g), then for a period of twelve (12) months following termination, Blue Shield shall reprice and finalize adjudication of claims incurred during the term of this Agreement but received after termination of this Agreement, in exchange for fees to be determined as follows: (the Claims Run-out Charge specified in Attachment I) x (the average monthly employee count for the three (3) month period immediately preceding to the effective date of termination) x (three (3)) (the **"Claims Run-out Fee"**). The Claims Run-out Fee will be remitted to Blue Shield by Client upon receipt of Blue Shield's monthly invoice, with payment due within thirty (30) days of the invoice date.

8.6 **Notice to Participants.** Client shall promptly notify Participants of the termination of the Shared Advantage Plus Product.

9 CERTAIN MARKETING AND OPERATIONAL RESTRICTIONS.

9.1 Marketing Materials; Trademarks and Service Marks.

(a) Client and Blue Shield shall not use any advertisement or marketing materials that contain any of the other's names, logos, trademarks, service marks or any variation of the aforementioned without the prior written consent of the other.

(b) Client acknowledges that all printed materials, as well as any other tangible and electronic forms of advertising and marketing materials provided by Blue Shield to Client in connection with this Agreement belong to Blue Shield, and agrees to return such materials to Blue Shield promptly upon demand.

9.2 BCBSA Requirements. Each party shall adhere in good faith to all requirements of the Blue Cross and Blue Shield Association ("Association") in connection with its performance under this Agreement, provided, however, that Client shall only be responsible to comply with those Association requirements Blue Shield communicates to Client in writing in advance. In the event that either (a) Client fails to adhere strictly to all such Association requirements, or (b) Blue Shield receives any notice from the Association that the Association believes this Agreement or any portion of this Agreement violates any Association requirement, Blue Shield may terminate this Agreement by providing either (x) the same notice period and opportunity to cure as required in Section 8.2(b)(i) hereof, or (y) such notice period and opportunity to cure as is provided to Blue Shield by the Association, whichever is shorter.

9.3 Provider Contracts. Client understands and agrees that certain of the Client Services and other obligations of Client in connection with the Plan require Client to perform specific obligations of Blue Shield set forth in the contracts between Blue Shield and Contracting Providers. Client covenants and agrees to perform such Client Services and other obligations of Client and to administer the Plan in accordance with the applicable terms of the contracts between Blue Shield and its Contracting

Providers. Client represents and warrants to Blue Shield that the Plan design is compatible with the obligations of Blue Shield set forth in the contracts between Blue Shield and its Contracting Providers. Except as otherwise specifically permitted in this Section 9.3, Client shall not offer or provide, or assist any other Person in offering or providing, to Participants the benefits of any negotiated or contracted payment rates or terms with any provider of health care services in the State of California other than those rates and terms set forth in a contract between Blue Shield and the Contracting Provider. Client shall not offer or provide, or assist any other Person in offering or providing, the benefits of negotiated or contracted payment rates or terms set forth in a contract between Blue Shield and a Contracting Provider to any Person other than a Participant. Client may, without violating this Section, offer or provide, and assist any other Person in offering or providing, to Participants the benefits of payment rates and terms other than those set forth in a contract between Blue Shield and a provider if the provider is a pharmacy, dentist, or vision services provider, or such other type of ancillary provider designated by Blue Shield from time to time.

10 INDEMNIFICATION.

10.1 **Right to Indemnification.** The parties hereto (each, an **"Indemnifying Party"**) shall indemnify, defend and hold harmless the other party and its directors, managers, officers, employees, successors, assigns and agents (each, an **"Indemnified Party"**) from and against any and all liabilities, obligations, losses, damages, taxes, claims, actions and suits and any and all reasonable costs, expenses and disbursements (including reasonable legal fees and expenses) of any kind and nature whatsoever (collectively, **"Damages"**) which may at any time be imposed on, incurred by, or asserted against any Indemnified Party by any Person in any way relating to or arising out of (a) the breach of any representation or warranty of the Indemnifying Party in this Agreement, (b) the failure of the Indemnifying Party to perform any obligation or covenant to be performed by the Indemnifying Party pursuant to this Agreement, or (c) any wrongful

conduct of the Indemnifying Party. Any right of an Indemnified Party accrued pursuant to this Section 10.1 shall survive the termination of this Agreement.

10.2 **Procedure.** Any Indemnified Party seeking indemnity under this Section 10 shall promptly notify the Indemnifying Party as to: (a) the nature of any Damages asserted against or suffered by the Indemnified Party for which the Indemnified Party intends to seek indemnity hereunder, and (b) the commencement of any claim, litigation, investigation, audit or other proceeding (any **"Proceeding"**) brought to enforce any such matters. Failure of timely notice shall reduce the Indemnified Party's rights only to the extent that such delay or failure of notice actually prejudiced the defense of the claim by the Indemnifying Party. Upon acknowledging the right to indemnity, the Indemnifying Party shall be entitled to assume the defense of any such Proceeding other than a Proceeding brought by a Governmental Entity and the Indemnified Party shall cooperate and shall be entitled to consult with the Indemnifying Party with respect to such defense.

10.3 **Limits of Liability.** Notwithstanding anything to the contrary in this Agreement, Blue Shield shall not be liable for any of the following:

(a) claims for health care benefits incurred by Participants;

(b) costs of compliance by the Plan with applicable Laws, including filing, reporting and disclosure requirements applicable to the Plan; or

(c) Damages arising from the failure of HealthNow Administrators to properly and adequately perform any of its duties under the TPA Agreement.

11 MISCELLANEOUS.

11.1 **Relationship of Parties.** Client is the Plan Sponsor and Plan Administrator of the Plan. Except to the limited extent that Blue Shield performs certain administrative and ministerial functions as a benefits

administrator for the Plan pursuant to this Agreement, this Agreement shall not be deemed to confer upon or delegate to Blue Shield any responsibility for the control, administration or management of the Plan or any assets of the Plan. Except as otherwise explicitly stated in this Agreement, Client, and not Blue Shield, is responsible for all Plan eligibility and final coverage determinations, and all Plan operations, policy, interpretation, practices and procedures. With respect to all performance of this Agreement by each party, including all of the services to be provided by Client on behalf of Blue Shield, each party, including its employees and agents, shall be considered an independent contractor, and not an employee, agent, partner, or joint venturer of the other party. Neither party shall have any right to act for or make commitments on behalf of the other. The parties further agree that Client's employees are not employees of Blue Shield or any Affiliate of Blue Shield and are not, therefore, entitled to any pension, insurance or other employee benefit plan of Blue Shield or any Affiliate of Blue Shield, and Client, on its own behalf, and on behalf of its employees, hereby waives any and all rights and interests in and under any employee medical, insurance, retirement, bonus, benefit, vacation or other similar plan of Blue Shield or any Affiliate of Blue Shield existing on the Effective Date or at any time during or after the term of this Agreement.

11.2 **BCBSA Disclosure.** Client hereby expressly acknowledges its understanding that this Agreement constitutes a contract between Client and Blue Shield, that Blue Shield is an independent corporation operating under a license from the BCBSA, an association of independent Blue Cross and Blue Shield plans, permitting Blue Shield to use the Blue Shield Service Mark in the State of California, and that Blue Shield is not contracting as an agent of BCBSA. Client further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Blue Shield and that no person, entity or organization other than Blue Shield shall be held accountable or liable for any of Blue Shield's obligations to Client created under this

Agreement. This Section 11.2 does not create additional obligations whatsoever on the part of Blue Shield other than those obligations created under other provisions of this Agreement.

11.3 **Use Incentives.** Client shall include incentives in the Plan to actively encourage the use by Participants of Contracting Providers (rather than other providers), including financial incentives directly related to the use of Contracting Providers. Client shall comply with the requirements applicable to payors set forth in California Business and Professions Code §§511.1 *et seq*.

11.4 **Waivers.** No course of dealing or failure of a party to strictly enforce any term, right or condition of this Agreement shall be construed as a general waiver or relinquishment of such (or any other) term, right or condition. Waiver by a party of any default shall not be deemed a waiver of any other default.

11.5 **Amendment.** This Agreement may only be amended by a written instrument signed by the duly authorized representatives of each party.

11.6 **Severability.** If any provision of this Agreement shall be held unlawful, invalid, or unenforceable by any court or administrative agency, such provision shall be deemed modified to the minimum extent necessary to restore the validity and enforceability of all provisions hereof, and, to the extent such provision cannot be so modified, it shall be deemed severable and the remainder of this Agreement shall remain in full force and effect and be interpreted so as to carry out the intent of the parties in an equitable manner.

11.7 **Force Majeure.** Neither party shall be liable for any default or delay in the performance of its obligations under this Agreement if and to the extent such default or delay is caused, directly or indirectly, by a Force Majeure Event; *provided* that: (a) the non-performing party is without fault in causing such default or delay, (b) such default or delay could not have been prevented by reasonable precautions; and (c) such default or delay could not reasonably be circumvented by the non-performing party

through the use of alternate sources, workaround plans, or other means. In the case of any Force Majeure Event, the non-performing party shall be excused from further performance or observance of the obligations so affected for as long as such circumstances prevail and such party continues to use commercially reasonable efforts to recommence performance or observance without delay. Any party so delayed in its performance shall immediately notify the party to whom performance is due by telephone (to be confirmed in writing within twenty-four (24) hours of the inception of such delay) and describe at a reasonable level of detail the circumstances causing such delay. If any Force Majeure Event substantially prevents, hinders, or delays performance of Client Services and performance is not materially restored within thirty (30) days, Blue Shield may terminate this Agreement upon notice to Client.

11.8 **Assignment and Subcontracting.** Except as otherwise expressly contemplated by this Agreement: (a) Client may not assign or subcontract any right, interest, or obligation hereunder without the express written consent of Blue Shield; and (b) Blue Shield may not assign or subcontract any rights, interest, or obligation hereunder without the express written consent of Client.

11.9 **Notices.** All notices which any party is required, or may desire, to give another party, shall be given in writing by addressing the communication to the address herein set forth below, or to such other address as a party may designate. Notices may be sent: (a) postage prepaid by registered or certified mail, return receipt requested and will be deemed effective five (5) days after the date of mailing, (b) by overnight courier and shall be deemed effective on the next Business Day, (c) by fax and shall be deemed effective upon receipt. All notices pertaining to this Agreement are to be sent to:

To Blue Shield:

California Physicians' Service d/b/a Blue Shield of California
50 Beale Street
San Francisco, CA 94105
Attention: Daphne Lewis

To Client:

San Joaquin Valley Insurance Authority
Gallagher Benefits Services of California
45 E. River Park Place West
Fresno CA 93720
Attention: Michelle Mills

The address to which notices or communications may be given by a party may be changed by written notice given by such party pursuant to this Section 11.9.

11.10 **Disputes.** Any dispute between the parties arising out of or relating to this Agreement, including disputes regarding the interpretation of any provision of this Agreement and disputes regarding the performance of HealthNow Administrators or Blue Shield, shall be resolved as provided in this Section 11.10. The parties initially shall attempt to resolve their dispute informally, in accordance with the following: Upon the written notice by a party to another party of a dispute (the date on which such notice is provided being the **"Dispute Date"**), each party shall appoint a designated representative whose primary responsibility is not related to performance under this Agreement. The designated representatives shall meet in good faith and as often as the parties reasonably deem necessary to discuss the problem and attempt to resolve the dispute without the necessity of any formal proceeding. During the course of discussion, all reasonable requests made by a party to the other for non-privileged information, reasonably related to this Agreement, shall be honored in order that a party may be fully advised of the facts and the other party's

position. The specific format for the discussions shall be left to the discretion of the designated representatives. If the dispute is not resolved according to the foregoing process within thirty (30) days after the Dispute Date, either party may commence alternate dispute resolution proceedings in accordance with Section 11.12 to resolve such dispute.

11.11 Applicable Law. This Agreement and the rights and obligations of the parties hereunder shall be construed in accordance with and be governed by the laws of the State of California (without giving effect to the principles thereof relating to conflicts of law). Subject to Section 11.12, any legal action or proceeding pursuant to this Agreement may be brought in the state courts of the State of California or the federal courts located in, or having jurisdiction with respect to the State of California, and, by execution and delivery of this Agreement, each of the parties hereby accepts for itself and in respect of its property, generally and unconditionally, the non-exclusive jurisdiction of the aforesaid courts.

11.12 Alternative Dispute Resolution. If either party determines that the parties are not able to resolve the dispute through negotiation (including non-binding mediation if the parties desire) as provided in Section 11.10 above, then the dispute shall be submitted to, and resolved by, final and binding arbitration in accordance with this Agreement and the CPR Institute for Dispute Resolution Rules for Non-Administered Arbitration then currently in effect by three (3) independent and impartial arbitrators, none of whom shall be appointed by either party. The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§1 et seq., and judgment upon the award rendered by the arbitrators may be entered by any court having jurisdiction thereof. The place of arbitration shall be Sacramento, California. Either party may apply to the arbitrator seeking injunctive relief until the arbitration award is rendered or the controversy is otherwise resolved. Either party also may, without waiving any remedy under this Agreement, seek from any court having jurisdiction any interim or provisional relief that is necessary to protect the rights or property of that party, pending the establishment of the arbitral tribunal (or pending

the arbitral tribunal's determination of the merits of the controversy). The arbitrators shall apply California substantive law and shall accompany the award with a reasoned opinion. The arbitrator shall have no authority to award punitive or other damages not measured by the prevailing party's actual damages.

11.13 **Survival of Provisions.** The provisions of Sections 1, 5.2, 5.3, 7, 8.3, 8.5, 10 and 11 (and any other section providing expressly for survival) shall survive the termination of this Agreement.

11.14 **No Presumption Against Drafter.** This Agreement was fully negotiated between the parties and it shall not be interpreted or construed in favor or against either party on the grounds that such party was principally responsible for drafting the Agreement.

11.15 **Entire Contract.** This Agreement, together with any Attachments, Exhibits, and Amendments appended hereto, constitute the entire agreement and understanding between the parties regarding this subject matter, and replace and supersede any prior understandings or agreements, whether written or verbal, between the parties regarding this subject matter. Neither party is relying on any representation, understanding, or agreement not expressly contained herein or therein, and no such representation, understanding, or agreement shall be binding or enforceable.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective as of the Effective Date.

CALIFORNIA PHYSICIANS' SERVICE, d/b/a BLUE SHIELD OF CALIFORNIA	**San Joaquin Valley Insurance Authority**
By: _____	**By:** _____
Title: _____	**Title:** _____

Date:	**Date:**

Attachment A

San Joaquin Valley Insurance Authority

Health Benefits Plan

On File with BSC

Attachment B

Blue Shield Services

The Blue Shield Services shall consist of the following:

1 ACCESS TO CONTRACTING PROVIDERS

Blue Shield shall enter into and maintain contracts with health care providers that enable Client and Participants to access and receive services from such Contracting Providers on the terms and conditions set forth in such contracts, including negotiated rates. Blue Shield shall communicate with Contracting Providers as necessary to ensure that Contracting Providers are able to identify and provide access to Participants.

2 BLUE SHIELD ADMINISTRATIVE SERVICES

The Blue Shield Administrative Services shall include:

2.1 provider network maintenance in accordance with applicable regulatory requirements;

2.2 provider servicing, including quoting eligibility and responding to benefit inquiries, based on information provided by Client;

2.3 issuing payment to providers for medically necessary covered services including providing explanation of benefit, and payment remittance advice in accordance with regulatory requirements;

2.4 utilization management for outpatient services and inpatient hospitalizations, including pre-service review, pre-certification, concurrent review, retrospective review, in accordance with BSC utilization management programs and medical policies;

2.5 provide Participants information regarding contracting providers and other content on its website www.blueshieldca.com, or such other website designated by Blue Shield;

2.6 account management support on an as needed basis;

2.7 provide Participants access to the BlueCard Program as further described Attachment H; [and]

2.8 provide Client the option to purchase stop loss coverage (through Blue Shield of California Life and Health Insurance Company, a California corporation, an Affiliate of Blue Shield), pharmacy, dental, vision, disease management and complex case management services from Blue Shield in connection with the Shared Advantage Plus Product;

2.9 *Disease Management services;*

2.10 *High Risk Case Management (Complex, NICU, Catastrophic Injury) services;*

2.11 *Chronic Complex Case Management;*

2.12 *High Risk Maternity Case Management;*

2.13 *Musculoskeletal Case Management;*

2.14 *Case Management Bundle (High Risk CM, Chronic Complex CM, High Risk Maternity CM and Musculoskeletal CM);*

2.15 *Health Advocate – Comprehensive;*

2.16 *Health Advocate – Acute Care;*

2.17 *Healthy Lifestyle Rewards – BSC Members (Admin Only/No Rewards);*

2.18 *Healthy Lifestyle Rewards – Wrap Non-BSC Members (Admin Only/No Rewards);*

2.19 *Health Coach;*

2.20 *Health Coach – Incentive;*

2.21 *Health Coach – Wrap;*

2.22 *Managed Behavioral Health Benefit;*

2.23 *LifeReferrals 24/7;*

2.24 *NurseHelp 24/7;*

2.25 *CareTips;*

2.26 *Tobacco Cessation; and*

2.27 *Shield Wellcheck.*

3 BLUE SHIELD SERVICES TO HEALTHNOW ADMINISTRATORS

The Blue Shield Services to HealthNow Administrators in connection with the Shared Advantage Plus Product for Client shall consist of:

3.1 receiving claims from Contracting Providers and non-contracted providers;

3.2 pricing claims from Contracting Providers by applying the terms of the applicable contract to the services billed on the claim;

3.3 pricing claims from providers who are not contracted with Blue Shield as follows:

(a) claims from California professional providers shall be priced by applying the Blue Shield allowed amount to such claims;

(b) claims from California hospital providers shall be priced at the billed amount for such claims. Client will apply its non-network reimbursement structure for payment of such claims;

(c) claims from non-California providers (BlueCard claims) shall be priced pursuant to the host plan allowed amount'

3.4 making initial benefit determination for submitted claims, based on Client's summary of Plan benefits, and forwarding the claim to HealthNow Administrators for review;

3.5 electronically transmitting the claim with the pricing information for contracted providers or billed charges for non-contracting facility providers and allowed amounts for professional providers to HealthNow Administrators for determination of eligibility and application of the benefits covered by the Plan;

3.6 receiving returned claims electronically from HealthNow Administrators with eligibility and benefit verification and closing out the claim in the Blue Shield system;

3.7 finalizing claims adjudication and issuing provider checks and explanation of benefits notices; and

3.8 receiving, investigating and responding to inquiries and appeals from providers in accordance with Blue Shield's standard provider appeals protocols.

Attachment C

Change Order Form

Requested By:					**Request Date:**		
Organization:					**Phone:**		
Requester Priority:		**Emergency**		**Urgent**		**Routine**	
Received By:					**Received Date:**		
Organization:					**Phone:**		
Impacted Agreement Sections:							
Description of Change:							
Reason for Change Request:							
Supporting Documentation:							

Approvals-

CALIFORNIA PHYSICIANS' SERVICE, d/b/a BLUE SHIELD OF CALIFORNIA	**San Joaquin Valley Insurance Authority**
By:	**By:**
Title:	**Title:**
Date:	**Date:**

Attachment D

Client Services

1. CLIENT SERVICES.

The Client Services shall consist of:

1.1 **Eligibility Determinations**. Client shall determine eligibility of Persons for Plan benefits. Client shall provide HealthNow Administrators with accurate eligibility information to enable HealthNow Administrators to perform the services set forth in the TPA Agreement. Client shall, or shall cause HealthNow Administrators to, provide Blue Shield with such eligibility information and the information necessary to determine the Blue Shield Fee.

1.2 **Benefit Determinations**. Client shall, or shall cause HealthNow Administrators to, apply the terms of the Plan to claims for Plan benefits and make all Plan benefit determinations.

1.3 **Coordination of Benefits**. Client shall, or shall cause HealthNow Administrators to, make and perform all coordination of benefits services, procedures and investigations, including for Medicare services. Medicare Crossover shall not be performed by Client, HealthNow Administrators or Blue Shield.

1.4 **Plan Documents**. Client shall, or shall cause HealthNow Administrators to prepare and distribute to Participants summary plan descriptions and other communications regarding the Plan (including notices required by the Consolidated Omnibus Budget Reconciliation Act). Client shall furnish promptly to Blue Shield drafts of changes to the Plan and all summary plan descriptions, Participant booklets, and other documents by which the Plan is established, for review and comment by Blue Shield prior to finalization. Client shall furnish promptly to Blue Shield all such final documents.

1.5 **Benefit Changes**. Client shall provide Blue Shield or HealthNow Administrators with ninety (90) days advance written notice of and detailed information regarding any change in the Plan benefits or design.

1.6 **Participant Inquiries and Appeals**. Client shall, or shall cause HealthNow Administrators to, respond to all Participant inquiries and appeals.

1.7 **Plan Interpretation**. Client shall make and perform all Plan interpretation.

1.8 **Participant Communications**. Except as otherwise specifically set forth in this Agreement, Client shall be solely responsible for the provision of any notices required to be provided to Participants, including certificates of creditable coverage.

1.9 **Identification Cards**. Client shall, or shall cause HealthNow Administrators to, design, produce and issue identification cards to Participants complying with BCBSA requirements.

1.10 **Plan Benefit Design**. Client shall be responsible for the design of the Plan.

1.11 **Application of Benefits to Claims.** Client shall verify the terms of the Plan on claims submitted to HealthNow Administrators by Blue Shield and return such claim to Blue Shield, in the agreed upon file format and with the agreed upon frequency, for final adjudication by Blue Shield;

1.11 **Claim Funding**. Client shall be responsible for funding all claims determined to be payable by the Plan in accordance with the following:

(a) Blue Shield has established an account with Bank of America (Account # 1499-9-05524) which can receive electronic fund transfers via automated clearing house (ACH) transactions.

(b) Client, or HealthNow Administrators on behalf of Client, will establish an account with a bank acceptable to Blue Shield which: (i) can transmit ACH-enabled payments, and, (ii) operates in accordance with the NACHA operating rules as they currently exist and as modified in the future.

(c) Client, or HealthNow Administrators on behalf of Client, will provide its bank with the appropriate authorization which permits Blue Shield to initiate transfer electronically of benefit claims amounts from Client or HealthNow Administrators 's account and into Blue Shield's bank account, following notice from Blue Shield to Client or HealthNow Administrators of the amount to be transferred electronically.

(d) Blue Shield will notify Client or HealthNow Administrators of the dollar amount of benefit claims which have been paid and/or finalized and then will initiate the electronic transfer of this amount from Client or HealthNow Administrators 's account to Blue Shield's account by an ACH transaction. When Client or HealthNow Administrators is notified before 11:30 a.m. (Pacific time), the transaction will be initiated on the same day. If the notification is received after 11:30 a.m. (Pacific time), the transaction will be initiated on the next working day. Blue Shield will follow the initial notification with written confirmation by mail.

Attachment E

Compensation

1 PAYMENTS.

1.1 Blue Shield Fees.

(a) Methodology. Client shall pay to Blue Shield the Blue Shield Fees identified in Attachment I to this Agreement. The Blue Shield Fees shall be separate from and in addition to the charges payable to HealthNow Administrators pursuant to the TPA Agreement.

(i)

(b) Calculation and Collection. Blue Shield shall, or shall cause HealthNow Administrators to, calculate the Blue Shield Fees payable for each month. Blue Shield shall, or shall cause HealthNow Administrators to, invoice Client for the applicable Blue Shield Fees on the first (1st) day of the month. Client shall pay the Blue Shield Fees to Blue Shield within fifteen (15) days after the date of such invoice. If Client pays an amount other than the amount invoiced by Blue Shield, Client shall include a detailed description of the calculation of the payment made and the parties shall promptly discuss in good faith what the correct applicable Blue Shield Fees should be for the subject month. Retroactive corrections and adjustments to reflect changes in enrollment not known on the date a particular month's Blue Shield Fees is calculated shall be included in the Blue Shield Fees in the month in which the need for such correction or adjustment becomes known.

3 Taxes and Other Fees.

The Blue Shield Fees and its components do not contemplate any taxes, fees, assessments, other charges or offsets imposed by any Governmental Entity which may be imposed or assessed against Blue Shield or HealthNow Administrators on

the basis of benefit payments made on Client's behalf under this Agreement or the TPA Agreement. In the event that Blue Shield or HealthNow Administrators becomes liable for any such taxes, fees, assessments, other charges or offsets, Client agrees to reimburse Blue Shield or HealthNow Administrators , as applicable, in full. This provision shall survive the termination of this Agreement.

Attachment F

Business Associate Addendum

I. GENERAL PROVISIONS

1. Purpose and Effect. This Business Associate Agreement is an addendum ("**Addendum**") to the Shared Advantage or Shared Advantage Plus Agreement ("**Client Agreement**") to which it is appended and is entered into by and between San Joaquin Valley Insurance Authority for and on behalf of its sponsored group health plan (a HIPAA Covered Entity) to which the Client Agreement pertains (the "**Plan**"), and **California Physicians' Service, d/b/a Blue Shield of California**, for and on behalf of itself and its operating subsidiaries and affiliates, (hereinafter collectively referred to as "**Business Associate**") As of the Effective Date of the Client Agreement, the terms and provisions of this Addendum, including the attached "Standard Business Associate Processes and Procedures," are incorporated into and shall supersede any conflicting or inconsistent terms and provisions of the Client Agreement, including all exhibits or other attachments to, and all documents incorporated by reference into such agreement. This Addendum sets out terms and provisions relating to the use and disclosure of Protected Health Information ("**PHI**") without written authorization from the individual.

2. Amendment to Comply with Law. Business Associate the Plan agree to amend this Addendum to the extent necessary to allow either party to comply with applicable laws and regulations including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 and its implementing Administrative Simplification regulations (45 C.F.R. Parts 142, 160, 162 and 164) ("**HIPAA**"); the Health Information Technology for Economic and Clinical Health Act and its implementing guidance and regulations ("**HITECH**"); and other applicable federal laws and regulations.

3. Definitions. For purposes of this Addendum, capitalized terms used or defined herein shall supersede any definition ascribed to such terms in the Client Agreement. Unless otherwise provided herein, capitalized terms used in this Addendum shall have

the meanings ascribed to them by HIPAA and HITECH. If the meaning of any term defined herein is changed by regulatory or legislative amendment, then this Addendum will be modified automatically to correspond to the amended definition. All capitalized terms used herein that are not otherwise defined have the meanings ascribed to them under in HIPAA and HITECH. A reference in this Addendum to a section in the HIPAA Privacy Rule, HIPAA Security Rule, or HITECH means the section then in effect, as amended.

a. "**Protected Health Information**" **or** "**PHI**" has the meaning ascribed to such term under HIPAA at 45 C.F.R. §160.103, as amended, and includes individually identifiable health information, including genetic information, maintained or transmitted in any form or medium that one Party hereto creates or receives from or on behalf of another Party hereto in the course of fulfilling such Party's obligations under this Agreement or the ACO Agreement. PHI shall not include (i) education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. §1232g, (ii) records described in 20 U.S.C. §1232g(a)(4)(B)(iv), and (iii) employment records held by any Party hereto in its role as employer. .

II. OBLIGATIONS OF BUSINESS ASSOCIATE

1. Use and Disclosure of PHI. Business Associate may use and disclose PHI only if such use or disclosure is permitted or required by the HIPAA Privacy Rule, including the applicable provisions of 45 C.F.R. §164.504(e); is required to satisfy its obligations, or is permitted, under the Client Agreement; and/or is permitted or required by law, but shall not otherwise use or disclose any PHI.

a. Business Associate shall not use or disclose, and shall ensure that its directors, officers and employees do not use or disclose, PHI in any manner that would constitute a violation of the HIPAA Privacy Rule or HITECH if done by the Plan, except that Business Associate may use and disclose PHI as permitted under the HIPAA Privacy Rule (i) for the proper management and administration of

Business Associate, (ii) to carry out the legal responsibilities of Business Associate, or (iii) to provide Data Aggregation services relating to the health care operations of the Plan if such services are required under the Client Agreement.

b. To the extent that, pursuant to this Addendum or the Client Agreement, Business Associate is required to carry out any obligation of Plan which is addressed by Subpart E of the HIPAA Privacy Rule – Privacy of Individually Identifiable Health Information, then in the performance of such obligations Business Associate shall comply with the requirements of Subpart E that apply to Plan as a HIPAA Covered Entity.

2. Minimum Necessary Standard and Determination. Business Associate shall limit its use, disclosure, or request of individuals' PHI to the minimum necessary amount of required to accomplish the intended purpose of such use, disclosure, or request and to perform its obligations under the Client Agreement and this Addendum. Business Associate shall determine what constitutes the minimum necessary to accomplish the intended purpose of such disclosure.

3. Safeguards Against Misuse of Information. Business Associate shall comply with all applicable requirements of HIPAA and HITECH relating to Business Associates and shall implement appropriate safeguards to prevent the use or disclosure of PHI in any manner other than pursuant to the terms and conditions of the Client Agreement and this Addendum. Business Associate shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that it creates, receives, maintains, or transmits on behalf of Plan.

a. Business Associate and its subcontractors with access to PHI shall comply in full with the applicable provisions of the HIPAA Security Rule and the HIPAA Privacy Rule, including the Security Standards for the Protection of Electronic PHI and Privacy of Individually Identifiable Health Information.

4. Reporting of Violations. Business Associate shall report to the Plan any Security Incident and any use or disclosure of PHI not provided for by this Addendum of which it becomes aware. Business Associate agrees to mitigate, to the extent practicable, any harmful effect from a use or disclosure of PHI in violation of this Addendum of which it is aware.

5. Security Breach Notification. Business Associate will notify the Plan of a Breach (including privacy related incidents that might, upon further investigation, be deemed to be a Breach) without unreasonable delay and, in any event, within ten business days after Business Associate's discovery of same. This notification will include, to the extent known:

i. the names of the individuals whose PHI was involved in the Breach;
ii. the circumstances surrounding the Breach;
iii. the date of the Breach and the date of its discovery;
iv. the information Breached;
v. any steps the impacted individuals should take to protect themselves;
vi. the steps Business Associate is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and,
vii. a contact person who can provide additional information about the Breach.

Business Associate will investigate Breaches, assess their impact under applicable and federal law, including HITECH, and make a recommendation to the Plan as to whether notification is required pursuant to 45 C.F.R. §§164.404-408. With the Plan's prior approval, Business Associate will issue notices to such individuals, federal agencies - including the Department of Health and Human Services, and/or the media as the Plan is required to notify pursuant to, and in accordance with the requirements of applicable law (including 45 C.F.R. §§164.404-408). Business Associate will pay the costs of issuing notices required by law and other remediation and mitigation which, in Business Associate's discretion, are appropriate and necessary to address the Breach. Business Associate will not be required to issue notifications that are not mandated by applicable law. Business

Associate shall provide the Plan with information necessary for the Plan to fulfill its obligation to report Breaches affecting fewer than 500 individuals to the Secretary as required by C.F.R. §164.408(c).

6. Disclosures to and Agreements with Third Parties. Business Associate shall ensure that any subcontractor to whom it provides PHI agrees to the same restrictions and conditions with respect to such PHI that apply to Business Associate pursuant to this Addendum and shall enter into Business Associate contracts with such subcontractors as required by HIPAA

7. Access to PHI. Business Associate shall provide an individual with access to such individual's PHI contained in a Designated Record Set in response to such individual's request in the manner and time required in 45 C.F.R. §164.524.

8. Availability of PHI for Amendment. Business Associate shall respond to a request by an individual for amendment to such individual's PHI contained in a Designated Record Set in the manner and time required in 45 C.F.R. §164.526, except that the Plan shall handle any requests for amendment of PHI originated by the Plan, Plan Sponsor or the Plan's other business associates, such as enrollment information.

9. Modifications to Individual Rights and Accounting of Disclosures. Business Associate shall comply with, and shall assist the Plan in complying with, responding to individuals' requests to restrict the uses and disclosures of their PHI under 45 C.F.R. §164.522. As required by HIPAA, Business Associate shall, upon request, provide individuals with access to certain PHI in electronic form. Business Associate shall provide an accounting of disclosures of PHI to an individual who requests such accounting in the manner and time required in 45 C.F.R. §164.528.

10. Requests for Privacy Protection. Business Associate shall handle requests by an individual for privacy protection for such individual's PHI pursuant to the requirements of 45 C.F.R. §164.522.

11. Processes and Procedures. In carrying out its duties set forth in Article II, Sections 7 – 10, above, Business Associate will implement the Standard Business Associate Processes and Procedures (the "Processes and Procedures") attached hereto for requests from individuals, including the requirement that requests be made in writing, the creation of forms for use by individuals in making such requests, and the setting of time periods for the Plan to forward to Business Associate any such requests made directly to the Plan or Plan Sponsor. In addition, Business Associate will implement the Processes and Procedures relating to disclosure of PHI to Plan Sponsor or designated third parties.

12. Availability of Books and Records. Business Associate hereby agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of the Plan, available to the Secretary for purposes of determining the Plan's compliance with the Privacy Rule.

III. OBLIGATIONS OF THE PLAN

1. The Plan will:

a. Not request Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA or HITECH if done by the Plan.

b. Advise Business Associate of any specific limitations in the Plan's Notice of Privacy Practices, to the extent that such limitations may affect Business Associate's use or disclosure of PHI.

c. Promptly notify Business Associate of any changes in, or revocation of, permission by individuals to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

d. Promptly notify Business Associate of any restriction to the use or disclosure of PHI that Plan has agreed to, to the extent that such restriction may affect

Business Associate's use or disclosure of PHI.

2. Plan HIPAA Compliance. The Plan confirms that it is in compliance with the provisions of HIPAA applicable to Covered Entities, including designating a privacy official, establishing policies and procedures concerning PHI, implementing administrative, technical, and physical safeguards, providing a notice of privacy practices to individuals in the Group Health Plan, and other administrative and organizational requirements.

IV. TERMINATION OF AGREEMENT WITH BUSINESS ASSOCIATE

1. Termination Upon Breach of Provisions Applicable to PHI. Any other provision of the Client Agreement notwithstanding, the Client Agreement may be terminated by the Plan upon prior written notice to Business Associate in the event that Business Associate materially breaches any obligation of this Addendum and fails to cure the breach within such reasonable time as the Plan may provide for in such notice; provided that in the event that termination of the Client Agreement is not feasible, in the Plan's sole discretion, the Plan shall have the right to report the breach to the Secretary.

If Business Associate knows of a pattern of activity or practice of the Plan that constitutes a material breach or violation of the Plan's duties and obligations under this Addendum, Business Associate shall provide a reasonable period of time, as agreed upon by the parties, for the Plan to cure the material breach or violation. Provided, however, that, if the Plan does not cure the material breach or violation within such agreed upon time period, Business Associate may terminate the Client Agreement at the end of such period.

2. Use of PHI upon Termination. The parties hereto agree that it is not feasible for Business Associate to return or destroy PHI at termination of the Client Agreement; therefore, the protections of this Addendum for PHI shall survive termination or expiration of the Client Agreement, and Business Associate shall limit any further uses

and disclosures of such PHI to the purpose or purposes which make the return or destruction of such PHI infeasible.

Privacy and Security Contact Information.

1. Privacy

a) Covered Entity: San Joaquin Valley Insurance Authority
Attn: Michele Mills
Mailing Address: 45 E. River Park Place West
City, State Zip: Fresno CA 93720
Phone: (559) 436-0833
Email: Michele_mills@ajg.com

b) Business Associate: Blue Shield of California
Attn: Chief Privacy Official
50 Beale Street
San Francisco, CA 94105
Phone: 888-266-8080
Email: blueshieldca_privacy@blueshieldca.com

2. Security.

a) Covered Entity: San Joaquin Valley Insurance Authority
Attn: Michele Mills
Mailing Address: 45 E. River Park Place West
City, State Zip: Fresno CA 93720
Phone: (559) 436-0833
Email: Michele_mills@ajg.com

b) Business Associate: Blue Shield of California
Attn: Chief Security Official
50 Beale Street
San Francisco, CA 94105
Phone: 800-642-5599
Email: informationsecurity@blueshieldca.com

Except as set forth in this Addendum, all other provisions of this Agreement shall remain unchanged and in effect.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date(s) set forth below, effective as of the Effective Date.

California Physicians' Service d/b/a Blue Shield of California	**San Joaquin Valley Insurance Authority**
By: _____	**By:** _____
Title: _____	**Title:** **HIPAA Compliance Officer**
Date: _____	**Date:** _____

Attachment F

Standard Business Associate Processes and Procedures

1. Access to PHI. When an individual requests access to PHI contained in a Designated Record Set and such request is made directly to the Plan or Plan Sponsor, the Plan shall forward the request to Business Associate within five (5) business days of such receipt. Upon receipt of such request from the Plan, or upon receipt of such a request directly from an individual, Business Associate shall make such PHI available directly to the individual within the time and manner required in 45 C.F.R. §164.524. The Plan delegates to Business Associate the duty to determine, on behalf of the Plan, whether to deny access to PHI requested by an individual and the duty to provide any required notices and review in accordance with the HIPAA Privacy Rule.

2. Availability of PHI for Amendment.

a. When an individual requests amendment to PHI contained in a Designated Record Set, and such request is made directly to the Plan or Plan Sponsor, within five (5) business days of such receipt, the Plan shall forward such request to Business Associate for handling, except that the Plan shall retain and handle all such requests to the extent that they pertain to Individually Identifiable Health Information (such as enrollment information) originated by the Plan, Plan Sponsor, or the Plan's other business associates. Business Associate shall respond to such forwarded requests as well as to any such requests that it receives directly from individuals as required by 45 C.F.R. §164.526, except that Business Associate shall forward to the Plan for handling any requests for amendment of PHI originated by the Plan, Plan Sponsor, or the Plan's other business associates.

b. With respect to those requests handled by Business Associate under subparagraph (a) above, the Plan delegates to Business Associate the duty to determine, on behalf of the Plan, whether to deny a request for amendment of PHI and the duty to provide any required notices and review as well as, in the case of its determination to grant such a request, the duty to make any amendments in accordance with the terms of the HIPAA Privacy Rule. In all other instances, the Plan retains all responsibility for handling such requests, including any denials, in accordance with the HIPAA Privacy Rule.

c. Whenever Business Associate is notified by the Plan that the Plan has agreed to make an amendment pursuant to a request that it handles under subparagraph (a) above, Business Associate shall incorporate any such amendments in accordance with 45 C.F.R. §164.526.

3. Accounting of Disclosures. When an individual requests an accounting of disclosures of PHI held by Business Associate directly to the Plan or Plan Sponsor, the Plan shall within five (5) business days of such receipt forward the request to Business Associate to handle. Business Associate shall handle such requests, and any such

requests for an accounting of disclosures received directly from individuals, in the time and manner as required in 45 C.F.R. §164.528.

4. Requests for Privacy Protection. Business Associate shall handle individuals' requests made to it for privacy protection for PHI in Business Associate's possession pursuant to the requirements of 45 C.F.R. §164.522. The Plan shall forward to Business Associate to handle any such requests the Plan receives from individuals that affect PHI held by Business Associate.

5. General Provisions Regarding Requests. Business Associate may require that requests pursuant to Sections 1 through 4 above be made in writing and may create forms for use by individuals in making such requests. When responding to an individual's request as provided above, Business Associate may inform the individual that there may be other "protected health information" created or maintained by the Plan and/or the Plan's other business associates and not included in the Business Associate's response. Business Associate shall not be responsible for performing any duties described in the Business Associate Agreement with respect to any such other "protected health information." In carrying out its duties set forth herein, Business Associate may establish such additional processes and procedures for requests from individuals as permitted by the HIPAA Privacy Rule.

6. Disclosure of Health Information and/or PHI to the Plan Sponsor. As otherwise permitted by applicable federal law, including HIPAA, Business Associate shall:

a. Upon the Plan Sponsor's written request, disclose to any employee or other person under the control or direction of Plan Sponsor:

i. information about whether an individual is participating in the Group Health Plan, or is enrolled in or disenrolled from coverage offered by the Plan; and/or

ii. Summary Health Information, for purposes of obtaining premium bids from health plans for providing health insurance coverage under the Group Health Plan, or modifying, amending or terminating the Plan;

b. At the written direction of the Plan, disclose PHI (other than Summary Health Information) to those employees or other persons under the control of Plan Sponsor identified in the Plan documents, solely for the purpose of carrying out Plan administration functions that Plan Sponsor performs for the Plan. Such authorized PHI recipients must be identified to Business Associate in writing by the Plan by name, title, or other appropriate designation as a condition of disclosure of PHI pursuant to this Section 6(b). The Plan may modify such list from time to time by written notice to Business Associate.

7. Disclosures of PHI to the Plan and/or a Business Associates of the Plan. Upon the Plan's written request, and as otherwise permitted by applicable federal law, including HIPAA, Business Associate will disclose PHI for the Plan's Payment and Health Care Operations purposes:

a. To representatives of the Plan, and/or

b. To a Business Associate of the Plan ("Designated Third Party") including, but not limited to, the Plan's third-party administrators, consultants, brokers, auditors, successor administrators or insurers, and stop-loss carriers.

The Plan must identify authorized PHI recipients to Business Associate by name, function, or job title, and must confirm that, when required by HIPAA, the Plan has entered into a Business Associate agreement with any Designated Third Party to whom PHI is to be disclosed. Business Associate may condition its release of PHI to a Designated Third Party upon such party's execution of a non-disclosure agreement with Business Associate, the terms of which will be made available to the Plan upon request.

Attachment H

BlueCard Program

I. Out-of-Area Services

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever a Plan Participant accesses Covered Services outside California, the claim for those services may be processed through one of these Inter-Plan Programs and presented to Blue Shield for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Plan Participants under this agreement are described generally below.

When a Plan Participant accesses Covered Services outside of California, such Plan Participant may obtain care from health care providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (a "Host Blue"). In some instances, Plan Participants may obtain care from non-participating health care providers. Blue Shield's payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when Plan Participants access covered health care services within the geographic area served by a Host Blue, Blue Shield will remain responsible for fulfilling our contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating health care providers.

The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our actions will be consistent with the spirit of this description.

(i) Liability Calculation Method Per Claim

The calculation of the Plan Participant liability on claims for covered health care services processed through the BlueCard Program, if not a flat dollar copayment, will be based on the lower of the participating health care provider's billed covered charges or the negotiated price made available to Blue Shield by the Host Blue.

The calculation of Client liability on claims for covered health care services processed through the BlueCard Program will be based on the negotiated price made available to Blue Shield by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating health care provider(s) an inclusive allowance (e.g., per case or per day amount) for specific health care services.

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

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

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

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

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., a prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid to providers or

anticipated to be paid to or received from providers). However, the amount paid by the Plan Participant and Client is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to Blue Shield is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

If a Host Blue uses either an estimated price or an average price on a claim, it may also hold some portion of the amount that Client pays in a variance account, pending settlement with its participating health care providers. Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from Client. Such payable or receivable would be eventually exhausted by health care provider settlements and/or through prospective adjustment to the negotiated prices. *Some Host Blues may retain interest earned, if any, on funds held in variance accounts.*

A small number of states require a Host Blue either (i) to use a basis for determining a Plan Participant's liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Blue Shield would then calculate the Plan Participant liability and Client liability in accordance with applicable law.

BlueCard Program Fees and Compensation

Client agrees (a) to reimburse Blue Shield for certain fees and compensation which we are obligated under the BlueCard Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association ("BCBSA"), and/or to BlueCard Program vendors, as described below and (b) that fees and compensation under the BlueCard Program may be revised without Client's prior approval in accordance with the program's standard procedures for revising such fees and compensation. Revisions to fees and compensation under the BlueCard Program typically are made annually as a result of program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with Client's benefit period under this agreement.

BlueCard Program fees include access fees, administrative expense allowance ("AEA") fees, Central Financial Agency ("CFA") fees and Inter-Plan Teleprocessing Services ("ITS") fees.

The BlueCard Program access fee may be charged separately each time a claim is processed through the BlueCard Program. If one is charged, it will be a percentage of the discount/differential Blue Shield receives from the Host Blue, based on the current rate in accordance with the program's standard procedures for establishing the access fee rate. The access fee will not exceed $2,000 for any claim. All other BlueCard Program related fees are included in Blue Shield's general administrative fee.

Special Cases: Value-Based Programs

Value-Based Programs Overview

Client's Plan Participants may access covered services from providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

<u>Value-Based Programs under the BlueCard Program</u>

Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay providers for reaching agreed-upon cost/quality goals in the following ways:

- Retrospective settlements;
- Provider incentives;
- Share of target savings;
- Care Coordinator Fees; and/or

- Other allowed amounts.

The Host Blue may pass these provider payments to Blue Shield, which we will pass directly on to Client as either an amount included in the price of the claim or an amount charged separately in addition to the claim.

When such amounts are included in the price of the claim, the claim may be billed using one of the following pricing methods, as determined by the Host Blue:

(i) Actual Pricing: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the claim. These charges are passed to Client via an enhanced provider fee schedule.

(ii) Supplemental Factor: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the claim amount). The supplemental factor may be adjusted from time to time.

When such amounts are billed separately from the price of the claim, they may be billed as follows:

- Per Member Per Month (PMPM) Billings: Per Member Per Month billings for Value- Based Programs incentives/Shared Savings settlements to accounts are outside of the claim system. Blue Shield will pass these Host Blue charges directly through to Client as a separately identified amount on the group billings.

The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the

measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.

- Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from how estimated, average or PMPM price methods, described above, are calculated. If Client terminates, you will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of this agreement.

Variance account balances are small amounts relative to the overall paid claims amounts and will be drawn down over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

Note: Plan Participants will not bear any portion of the cost of Value-Based Programs except when a Host Blue uses either average pricing or actual pricing to pay providers under Value-Based Programs.

Care Coordinator Fees

Host Blues may also bill Blue Shield for Care Coordinator Fees for provider services which we will pass on to Client as follows:

1. PMPM billings; or

2. Individual claim billings through applicable care coordination codes from the most current editions of either Current Procedural Terminology (CPT) published by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) published by the U.S. Centers for Medicare and Medicaid Services (CMS).

Value-Based Programs under Negotiated Arrangements

If Blue Shield has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Client's Plan Participants, Blue Shield will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted in the BlueCard Program section.

Return of Overpayments

Under Inter-Plan Programs, recoveries from a Host Blue or its participating health care providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. Recovery amounts determined in these ways will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by claim or prospective basis.

B. Non-Participating Health Care Providers Outside of the Blue Shield Service Area

Plan Participant Liability Calculation

Claims for Covered Services received from Non-Participating Health Care Providers Outside of the Blue Shield Service Area are paid based on the Allowable Amount as defined in the Benefits Booklet.

Fees and Compensation

Client agrees (a) to reimburse Blue Shield for certain fees and compensation which we are obligated to pay to Host Blues, to the BCBSA, and/or to Inter-Plan

Programs vendors for the processing of non-participating provider claims and (b) that fees and compensation assessed in connection with such claims may be revised without Client's prior approval in accordance with standard procedures for revising such fees and compensation. Revisions to fees and compensation for the processing of non-participating provider claims typically are made annually as a result of policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with Client's benefit period under this agreement.

Non-participating health care provider claims fees include AEA fees, which are included in Blue Shield's general administrative fee.

Definitions:

a. **Accountable Care Organization (ACO):** A group of healthcare providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.

b. **Care Coordination:** Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Participant's healthcare needs across the continuum of care.

c. **Care Coordinator:** An individual within a provider organization who facilitates Care Coordination for patients.

d. **Care Coordinator Fee:** A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

e. **Global Payment/Total Cost of Care**: A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and prescription drugs.

f. **Negotiated Arrangement [a.k.a., Negotiated National Account Arrangement]:** An agreement negotiated between a Control/Home Licensee

and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

g. **Patient Centered Medical Home (PCMH):** A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

h. **Provider Incentive:** An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

i. **Shared Savings:** A payment mechanism in which the provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

j. **Value-Based Program (VBP):** An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

Attachment I

Blue Shield Fees

Type	Per Employee Per Month (pepm) Amount
Basic Fees:	
Shared Advantage Plus Base Fee	$16.96 pepm
Claims Run-out Charge	$16.96 pepm
Optional Service Fees:	
Case Management Bundle (High Risk CM, Chronic Complex CM, High Risk Maternity CM and Musculoskeletal CM)	$3.11 pepm

Meeting Location:
Fresno County Employees' Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
March 18, 2016 9:00 AM

AGENDA DATE: March 18, 2016

ITEM NUMBER: 16

SUBJECT: Receive and File Open Enrollment Report for the 2016 Plan Year (A)

REQUEST(S): That the Board receive and file open enrollment report for the 2016 plan year

DESCRIPTION:

Open Enrollment for 2016 resulted in changes to the SJVIA plan enrollments:

- Total membership dropped slightly from 12,613 members to 12,510; a decrease of 0.82%
- Kaiser membership increased 17.44% from 2,053 to 2,411
- HMO membership decreased 9.67% from 4,993 to 4,510
- PPO membership remained relatively stable with a slight increase of 0.40% from 5,567 to 5,589

The SJVIA 2016 Enrollment Report by entity has been attached for your reference.

FISCAL IMPACT/FINANCING:

Projected claims runout for the 358 members moving from Anthem to Kaiser has not been accounted for in the premium rates adopted by the SJVIA Board for the HMO plan.

AGENDA: San Joaquin Valley Insurance Authority

DATE: March 18, 2016

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

San Joaquin Valley Insurance Authority

Enrollment Totals

Entity Name	2014 Enrollment			2015 Enrollment			2016 Enrollment			Totals		
	HMO	PPO	Kaiser	HMO	PPO	Kaiser	HMO	PPO	Kaiser	2014	2015	2016
County of Fresno	4,700	792	284	4,027	743	876	3,595	758	1,293	5,776	5,646	5,646
County of Tulare	290	2,466	204	329	2,446	201	286	2,476	202	2,960	2,976	2,964
City of Ceres	85	3	19	77	3	21	73	4	22	107	101	99
City of Clovis				200	81	157	196	79	150	0	438	425
City of Escalon				0	17	0	0	17	0	0	17	17
City of Farmersville	4	26	0	4	28	0	4	29	0	30	32	33
City of Gustine	19	2	0	16	3	0	17	3	0	21	19	20
City of Hanford				134	51	11	127	56	11	0	196	194
City of Hughson				0	15	0	0	16	0	0	15	16
City of Marysville				0	52	1	0	50	1	0	53	51
City of Modesto				0	222	680	0	244	641	0	902	885
City of Newman	1	24	0	2	23	0	1	24	0	25	25	25
City of Oakdale				41	16	20	42	17	17	0	77	76
City of Reedley	96	18	10	87	16	10	90	20	8	124	113	118
City of Riverbank	14	30	0	15	29	0	17	27	0	44	44	44
City of San Joaquin	12	2	0	17	0	0	17	0	0	14	17	17
City of Sanger	0	98	0	0	94	3	0	93	5	98	97	98
City of Shafter	24	95	35	29	99	33	31	107	19	154	161	157
City of Tulare	0	326	0	0	333	0	0	333	0	326	333	333
City of Wasco	0	53	0	0	57	0	0	56	0	53	57	56
City of Waterford	13	0	0	15	0	0	14	0	0	13	15	14
County of Sutter				0	863	36	0	837	42	0	899	879
San Joaquin Valley Air Pollution Control District				0	287	0	0	275	0	0	287	275
Superior Court of Kings County				0	36	0	0	34	0	0	36	34
Superior Court of Sutter County				0	53	4	0	34	0	0	57	34
Total Enrollment	**5,258**	**3,935**	**552**	**4,993**	**5,567**	**2,053**	**4,510**	**5,589**	**2,411**	**9,745**	**12,613**	**12,510**

SJVIA
San Joaquin Valley
Insurance Authority

Meeting Location:
Fresno County Employees' Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
March 18, 2016 9:00 AM

AGENDA DATE: March 18, 2016

ITEM NUMBER: 17

SUBJECT: Authorization and Execution of Participation Agreements by the City of Tulare, County of Fresno and County of Tulare and Authorization and Execution of Amendments by the Cities of Ceres, Clovis, Escalon, Farmersville, Gustine, Hanford, Hughson, Marysville, Modesto, Oakdale, Reedley, Riverbank, San Joaquin, Sanger, Shafter, Wasco, Waterford, County of Sutter, Superior Court of Kings County and San Joaquin Valley Air Pollution Control District (A)

REQUEST(S): That the Board authorize the execution of Participation Agreements

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 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.

AGENDA: San Joaquin Valley Insurance Authority

DATE: March 18, 2016

For entities currently participating in programs under the SJVIA with standing participation agreements, staff will request an amendment to the agreement allowing for the updating of these exhibits on an annual basis.

FISCAL IMPACT/FINANCING:

There is no financial impact as a result of executing the Participation Agreements as projected fixed and claims costs are already included in the FY 15-16 Budget.

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Fresno County Employees' Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
March 18, 2016 9:00 AM

AGENDA DATE: March 18, 2016

ITEM NUMBER: 18

SUBJECT: Authorization and Execution of the Agreement with Pacific Coast Medical Services Effective March 18, 2016(A)

REQUEST(S): That the Board authorize the execution of Agreement with Pacific Coast Medical Services Effective March 18, 2016

DESCRIPTION:

For the last four years, the SJVIA has offered onsite mammography screenings to its health plan participants through the SJVIA wellness program. Offering the screenings as an onsite service is of great benefit to both the SJVIA and the employee. Currently, under the Anthem Blue Cross health plans, a mammogram costs the plan around $300 and is covered as a preventive care benefit. Each exam through the recommended vendor costs $95, a discount of almost 70%. In addition, the employees that participate in this event are spending much less time away from work, thus improving efficiency while providing a heightened awareness of health behavior. Therefore, staff is requesting that the SJVIA contract with Pacific Coast Medical Services to again offer these screenings. The contract would allow for multiple days of onsite screenings with a guarantee of 30 exams conducted per day.

This item requests the authority of the Chair to execute a one year agreement with Pacific Coast Medical Services effective March 18, 2016.

AGENDA: San Joaquin Valley Insurance Authority

DATE: March 18, 2016

FISCAL IMPACT/FINANCING:

Under the prior agreements, the SJVIA entities have contracted for approximately 6 days of mammography services. Under the proposed agreement, the cost remains $95 per mammogram and the total cost will be determined by the number of days scheduled and will be treated as medical claims, paid through the SJVIA budget. The cost of mammograms is still lower through Pacific Coast Medical Services ($95) compared to Anthem Blue Cross (approximately $300).

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

A G R E E M E N T

THIS AGREEMENT is made and entered into this 1st Day of January 2016, by and between the San Joaquin Valley Insurance Authority, a Joint Powers Authority within the State of California, (hereinafter “SJVIA”),and Pacific Coast Medical Services, a California Corporation, whose address is 1440 S. State College Blvd., Suite 3-K, Anaheim, Ca. 92806, hereinafter referred to as "CONTRACTOR".

RECITALS

Whereas, the SJVIA desires to enter into a medical management relationship with CONTRACTOR with the terms and conditions set forth in this Agreement; and

Whereas, the CONTRACTOR represents that it is willing and able to provide the medical management services as set forth in this Agreement.

NOW, THEREFORE, the parties hereto agree as follows:

SJVIA hereby engages CONTRACTOR, and CONTRACTOR hereby accepts such engagement, to perform medical management services as specified in this Agreement.

DEFINITIONS

For purposes of this agreement, the following words have the meanings given to them here:

1. Participant means a person deemed eligible by SJVIA to participate in the services listed in Attachment A.
2. Participating Entity means a County, City, Special District or other Joint Powers Authority that has been approved by the SJVIA Board of Directors to participate in the SJVIA.
3. Plan means the SJVIA’s self-funded medical plan.
4. Plan Sponsor means the SJVIA or any of its member entities.
5. Provider means any person or entity who proposes to provide, or does provide, health care services covered under the Plan to a Participant.
6. Health Educator means a health care professional having at least a Master’s

degree in Diagnostic Medical Sonography who is employed by CONTRACTOR.

7. Nurse Health Coach means a Registered Nurse licensed in the state of CA.

1. OBLIGATIONS OF THE CONTRACTOR

A. The CONTRACTOR will provide the medical management services described in Exhibit "A."

2. OBLIGATIONS OF THE SJVIA

A. Each Participating Entity that receives medical management services from CONTRACTOR shall provide access to adequate facilities for CONTRACTOR to perform those services on dates agreed upon by SJVIA and CONTRACTOR.

3. TERM

This Agreement shall become effective on the 1st day of January 2016, and shall terminate on the 31st day of December 2016.

4. TERMINATION

A. Non-Allocation of Funds - The terms of this Agreement, and the services to be provided thereunder, are contingent on the approval of funds by the appropriating government agency. Should sufficient funds not be allocated, the services provided may be modified, or this Agreement terminated, at any time by giving the CONTRACTOR thirty (30) days advance written notice.

B. Breach of Contract - The SJVIA may immediately suspend or terminate this Agreement in whole or in part, where in the determination of the SJVIA there is:

1) An illegal or improper use of funds;

2) A failure to comply with any term of this Agreement;

3) A substantially incorrect or incomplete report submitted to the SJVIA;

4) Improperly performed service.

In no event shall any payment by the SJVIA constitute a waiver by the SJVIA of any breach of this Agreement or any default which may then exist on the part of the CONTRACTOR. Neither shall such payment impair or prejudice any remedy available to the SJVIA with respect to

the breach or default. The SJVIA shall have the right to demand of the CONTRACTOR the repayment to the SJVIA of any funds disbursed to the CONTRACTOR under this Agreement, which in the judgment of the SJVIA were not expended in accordance with the terms of this Agreement. The CONTRACTOR shall promptly refund any such funds upon demand.

C. Without Cause - Under circumstances other than those set forth above, this Agreement may be terminated by SJVIA upon the giving of sixty (60) days advance written notice of an intention to terminate to CONTRACTOR.

5. COMPENSATION/INVOICING

SJVIA agrees to pay CONTRACTOR and CONTRACTOR agrees to receive compensation as detailed in Exhibit B. Payment under Exhibit B shall be due no earlier than thirty (30) business days after SJVIA's receipt of an accurate and complete invoice from CONTRACTOR. SJVIA shall have no obligation to pay any invoice from CONTRACTOR which SJVIA reasonably disputes until such dispute is resolved to SJVIA's satisfaction.

6. OWNERSHIP OF DATA

All data delivered by the SJVIA or its Participating Entities to CONTRACTOR, or which is created by either party for the SJVIA in connection with the performance of this Agreement shall be the exclusive property of the SJVIA. Provider shall be the custodian of such data and will immediately make such data available to the SJVIA upon request during normal working hours. CONTRACTOR shall return all personnel/payroll raw data collected or generated in connection with the performance of the Agreement within thirty (30) days of the termination of this Agreement and shall not access said data for any purpose other than in connection with the performance of this Agreement.

7. CONFIDENTIALITY

All data, programs and other materials provided to CONTRACTOR by SJVIA Participating Entities, Eligible Employees and/or Participants in connection with this Agreement shall be deemed confidential as to the SJVIA and/or such Eligible Employees and/or Participants. Neither the CONTRACTOR, its officers, agents nor employees shall disclose such data to any third party without the express prior written consent of the SJVIA, the affected

Eligible Employees and/or Participants.

A. CONTRACTOR shall protect confidential information from inadvertent disclosure to any third party in the same manner that they protect their own confidential information, unless such disclosure is required in response to a validly issued subpoena or other process of law. The provisions of this section shall continue to survive, upon completion of this Agreement.

B. The SJVIA agrees to provide CONTRACTOR (or its authorized agents or subcontractors), personnel information including, but not limited to employee names who have elected to receive a Bilateral Screening Mammography Exam, for the sole and exclusive purpose of performing services as detailed in Exhibit A..

C. CONTRACTOR agrees to keep in confidence all information provided by SJVIA and its clients. Provider shall treat such information with at least the same degree of care as CONTRACTOR exercises toward its own employees' personnel and payroll information.

8. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

A. The parties to this Agreement shall be in strict conformance with all applicable Federal and State of California laws and regulations, including but not limited to Sections 5328, 10850, and 14100.2 *et seq.* of the Welfare and Institutions Code, Sections 2.1 and 431.300 *et seq*. of Title 42, Code of Federal Regulations (CFR), Section 56 *et seq.* of the California Civil Code, Sections 11977 and 11812 of Title 22 of the California Code of Regulations, and the Health Insurance Portability and Accountability Act (HIPAA), including but not limited to Section 1320 D *et seq.* of Title 42, United States Code (USC) and its implementing regulations, including, but not limited to Title 45, CFR, Parts 142, 160, 162, and 164, The Health Information Technology for Economic and Clinical Health Act (HITECH) regarding the confidentiality and security of patient information, and the Genetic Information Nondiscrimination Act (GINA) of 2008 regarding the confidentiality of genetic information.

Except as otherwise provided in this Agreement, CONTRACTOR, as a Business Associate of SJVIA, may use or disclose Protected Health Information (PHI) to perform functions, activities or services for or on behalf of SJVIA, as specified in this Agreement, provided

that such use or disclosure shall not violate the Health Insurance Portability and Accountability Act (HIPAA), 42 USC 1320d *et seq*. The uses and disclosures of PHI may not be more expansive than those applicable to SJVIA, as the "Covered Entity" under the HIPAA Privacy Rule (45 CFR 164.500 *et seq.*), except as authorized for management, administrative or legal responsibilities of the Business Associate.

B. CONTRACTOR, including its subcontractors and employees, shall protect, from unauthorized access, use, or disclosure of names and other identifying information, including genetic information, concerning persons receiving services pursuant to this Agreement, except where permitted in order to carry out data aggregation purposes for health care operations [45 CFR Sections 164.504 (e)(2)(i), 164.504 (3)(2)(ii)(A), and 164.504 (e)(4)(i)] This pertains to any and all persons receiving services pursuant to a SJVIA funded program. This requirement applies to electronic PHI. CONTRACTOR shall not use such identifying information or genetic information for any purpose other than carrying out CONTRACTOR's obligations under this Agreement.

C. CONTRACTOR, including its subcontractors and employees, shall not disclose any such identifying information or genetic information to any person or entity, except as otherwise specifically permitted by this Agreement, authorized by Subpart E of 45 CFR Part 164 or other law, required by the Secretary, or authorized by the client/patient in writing. In using or disclosing PHI that is permitted by this Agreement or authorized by law, CONTRACTOR shall make reasonable efforts to limit PHI to the minimum necessary to accomplish intended purpose of use, disclosure or request.

D. For purposes of the above sections, identifying information shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print, or photograph.

E. For purposes of the above sections, genetic information shall include genetic tests of family members of an individual or individual, manifestation of disease or disorder of family members of an individual, or any request for or receipt of, genetic services by individual

or family members. Family member means a dependent or any person who is first, second, third, or fourth degree relative.

F. CONTRACTOR shall provide access, at the request of SJVIA, and in the time and manner designated by SJVIA, to PHI in a designated record set (as defined in 45 CFR Section 164.501), to an individual or to SJVIA in order to meet the requirements of 45 CFR Section 164.524 regarding access by individuals to their PHI. With respect to individual requests, access shall be provided within thirty (30) days from request. Access may be extended if CONTRACTOR cannot provide access and provides individual with the reasons for the delay and the date when access may be granted. PHI shall be provided in the form and format requested by the individual or SJVIA.

CONTRACTOR shall make any amendment(s) to PHI in a designated record set at the request of SJVIA or individual, and in the time and manner designated by SJVIA in accordance with 45 CFR Section 164.526.

CONTRACTOR shall provide to SJVIA or to an individual, in a time and manner designated by SJVIA, information collected in accordance with 45 CFR Section 164.528, to permit SJVIA to respond to a request by the individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

G. CONTRACTOR shall report to SJVIA, in writing, any knowledge or reasonable belief that there has been unauthorized access, viewing, use, disclosure, security incident, or breach of unsecured PHI not permitted by this Agreement of which it becomes aware, immediately and without reasonable delay and in no case later than two (2) business days of discovery. Immediate notification shall be made to SJVIA's Privacy Officer within two (2) business days of discovery. The notification shall include, to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, used, disclosed, or breached. CONTRACTOR shall take prompt corrective action to cure any deficiencies and any action pertaining to such unauthorized disclosure required by applicable Federal and State Laws and regulations. CONTRACTOR shall investigate such breach and is responsible for all notifications required by law and regulation or deemed necessary

by SJVIA and shall provide a written report of the investigation and reporting required to SJVIA's Privacy Officer. This written investigation and description of any reporting necessary shall be postmarked within the thirty (30) working days of the discovery of the breach to the address below:

Rhonda Sjostrom
SJVIA Privacy Officer
2900 W. Burrel Ave.
Visalia, CA 93291

H. CONTRACTOR shall make its internal practices, books, and records relating to the use and disclosure of PHI received from SJVIA, or created or received by the CONTRACTOR on behalf of SJVIA, in compliance with HIPAA's Privacy Rule, including, but not limited to the requirements set forth in Title 45, CFR, Parts 160 and 164. CONTRACTOR shall make its internal practices, books, and records relating to the use and disclosure of PHI received from SJVIA, or created or received by the CONTRACTOR on behalf of SJVIA, available to the United States Department of Health and Human Services (Secretary) upon demand.

CONTRACTOR shall cooperate with the compliance and investigation reviews conducted by the Secretary. PHI access to the Secretary must be provided during the CONTRACTOR's normal business hours, however, upon exigent circumstances access at any time must be granted. Upon the Secretary's compliance or investigation review, if PHI is unavailable to CONTRACTOR and in possession of a Subcontractor, it must certify efforts to obtain the information to the Secretary.

I. Safeguards

CONTRACTOR shall implement administrative, physical, and technical safeguards as required by the HIPAA Security Rule, Subpart C of 45 CFR Part 164, that reasonably and appropriately protects the confidentiality, integrity, and availability of PHI, including electronic PHI, that it creates, receives, maintains or transmits on behalf of SJVIA and to prevent unauthorized access, viewing, use, disclosure, or breach of PHI other than as provided for by this Agreement. CONTRACTOR shall conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity and availability of electronic PHI.

CONTRACTOR shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of CONTRACTOR's operations and the nature and scope of its activities. Upon SJVIA's request, CONTRACTOR shall provide SJVIA with information concerning such safeguards.

CONTRACTOR shall implement strong access controls and other security safeguards and precautions in order to restrict logical and physical access to confidential, personal (e.g., PHI) or sensitive data to authorized users only. Said safeguards and precautions shall include the following administrative and technical password controls for all systems used to process or store confidential, personal, or sensitive data:

1. Passwords must **not** be:
    a. Shared or written down where they are accessible or recognizable by anyone else; such as taped to computer screens, stored under keyboards, or visible in a work area;
    b. A dictionary word; or
    c. Stored in clear text
2. Passwords must be:
    a. Eight (8) characters or more in length;
    b. Changed every ninety (90) days;
    c. Changed immediately if revealed or compromised; and
    d. Composed of characters from at least three (3) of the following four (4) groups from the standard keyboard:
        1) Upper case letters (A-Z);
        2) Lowercase letters (a-z);
        3) Arabic numerals (0 through 9); and
        4) Non-alphanumeric characters (punctuation symbols).

CONTRACTOR shall implement the following security controls on each workstation or portable computing device (e.g., laptop computer) containing confidential, personal, or sensitive data:

1. Network-based firewall and/or personal firewall;
2. Continuously updated anti-virus software; and
3. Patch management process including installation of all operating system/software vendor security patches.

CONTRACTOR shall utilize a commercial encryption solution that has received FIPS 140-2 validation to encrypt all confidential, personal, or sensitive data stored on portable electronic media (including, but not limited to, compact disks and thumb drives) and on portable computing devices (including, but not limited to, laptop and notebook computers). CONTRACTOR shall not transmit confidential, personal, or sensitive data via e-mail or other internet transport protocol unless the data is encrypted by a solution that has been validated by the National Institute of Standards and Technology (NIST) as conforming to the Advanced Encryption Standard (AES) Algorithm. CONTRACTOR must apply appropriate sanctions against its employees who fail to comply with these safeguards. CONTRACTOR must adopt procedures for terminating access to PHI when employment of employee ends.

J. Mitigation of Harmful Effects

CONTRACTOR shall mitigate, to the extent practicable, any harmful effect that is suspected or known to CONTRACTOR of an unauthorized access, viewing, use, disclosure, or breach of PHI by CONTRACTOR or its subcontractors in violation of the requirements of these provisions. CONTRACTOR must document suspected or known harmful effects and the outcome.

K. CONTRACTOR's Subcontractors

CONTRACTOR shall ensure that any of its contractors, including subcontractors, if applicable, to whom CONTRACTOR provides PHI received from or created or received by CONTRACTOR on behalf of SJVIA, agree to the same restrictions, safeguards, and conditions that apply to CONTRACTOR with respect to such PHI and to incorporate, when

applicable, the relevant provisions of these provisions into each subcontract or sub-award to such agents or subcontractors.

L. Employee Training and Discipline

CONTRACTOR shall train and use reasonable measures to ensure compliance with the requirements of these provisions by employees who assist in the performance of functions or activities on behalf of SJVIA under this Agreement and use or disclose PHI and discipline such employees who intentionally violate any provisions of these provisions, including termination of employment.

M. Termination for Cause

Upon SJVIA's knowledge of a material breach of these provisions by CONTRACTOR, SJVIA shall either:

1. Provide an opportunity for CONTRACTOR to cure the breach or end the violation and terminate this Agreement if CONTRACTOR does not cure the breach or end the violation within the time specified by SJVIA; or

2. Immediately terminate this Agreement if CONTRACTOR has breached a material term of these provisions and cure is not possible.

3. If neither cure nor termination is feasible, the SJVIA's Privacy Officer shall report the violation to the Secretary of the U.S. Department of Health and Human Services.

N. Judicial or Administrative Proceedings

SJVIA may terminate this Agreement in accordance with the terms and conditions of this Agreement as written hereinabove, if: (1) CONTRACTOR is found guilty in a criminal proceeding for a violation of the HIPAA Privacy or Security Laws or the HITECH Act; or (2) there is a finding or stipulation that the CONTRACTOR has violated a privacy or security standard or requirement of the HITECH Act, HIPAA or other security or privacy laws in an administrative or civil proceeding in which the CONTRACTOR is a party.

O. Effect of Termination

Upon termination or expiration of this Agreement for any reason, CONTRACTOR shall return or destroy all PHI received from SJVIA (or created or received by

CONTRACTOR on behalf of SJVIA) that CONTRACTOR still maintains in any form, and shall retain no copies of such PHI. If return or destruction of PHI is not feasible, it shall continue to extend the protections of these provisions to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. This provision shall apply to PHI that is in the possession of subcontractors or agents, if applicable, of CONTRACTOR. If CONTRACTOR destroys the PHI data, a certification of date and time of destruction shall be provided to the SJVIA by CONTRACTOR.

P. Disclaimer

SJVIA makes no warranty or representation that compliance by CONTRACTOR with these provisions, the HITECH Act, HIPAA or the HIPAA regulations will be adequate or satisfactory for CONTRACTOR's own purposes or that any information in CONTRACTOR's possession or control, or transmitted or received by CONTRACTOR, is or will be secure from unauthorized access, viewing, use, disclosure, or breach. CONTRACTOR is solely responsible for all decisions made by CONTRACTOR regarding the safeguarding of PHI.

Q. Amendment

The parties acknowledge that Federal and State laws relating to electronic data security and privacy are rapidly evolving and that amendment of these provisions may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to amend this agreement in order to implement the standards and requirements of HIPAA, the HIPAA regulations, the HITECH Act and other applicable laws relating to the security or privacy of PHI. SJVIA may terminate this Agreement upon thirty (30) days written notice in the event that CONTRACTOR does not enter into an amendment providing assurances regarding the safeguarding of PHI that SJVIA in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA, the HIPAA regulations and the HITECH Act.

R. No Third-Party Beneficiaries

Nothing express or implied in the terms and conditions of these provisions is intended to confer, nor shall anything herein confer, upon any person other than SJVIA or

CONTRACTOR and their respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.

S. Interpretation

The terms and conditions in these provisions shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HIPAA regulations and applicable State laws. The parties agree that any ambiguity in the terms and conditions of these provisions shall be resolved in favor of a meaning that complies and is consistent with HlPAA and the HIPAA regulations.

T. Regulatory References

A reference in the terms and conditions of these provisions to a section in the HIPAA regulations means the section as in effect or as amended.

U. Survival

The respective rights and obligations of CONTRACTOR as stated in this Section shall survive the termination or expiration of this Agreement.

V. No Waiver of Obligations

No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation on any other occasion.

9. INDEPENDENT CONTRACTOR

In performance of the work, duties and obligations assumed by CONTRACTOR under this Agreement, it is mutually understood and agreed that CONTRACTOR, including any and all of the CONTRACTOR'S officers, agents, and employees will at all times be acting and performing as an independent contractor, and shall act in an independent capacity and not as an officer, agent, servant, employee, joint venturer, partner, or associate of the SJVIA. Furthermore, SJVIA shall have no right to control or supervise or direct the manner or method by which CONTRACTOR shall perform its work and function. However, SJVIA shall retain the right to administer this Agreement so as to verify that CONTRACTOR is performing its obligations in accordance with the terms and conditions thereof.

CONTRACTOR and SJVIA shall comply with all applicable provisions of law and the rules and regulations, if any, of governmental authorities having jurisdiction over matters the subject thereof.

Because of its status as an independent contractor, CONTRACTOR shall have absolutely no right to employment rights and benefits available to SJVIA employees. CONTRACTOR shall be solely liable and responsible for providing to, or on behalf of, its employees all legally-required employee benefits. In addition, CONTRACTOR shall be solely responsible and save SJVIA harmless from all matters relating to payment of CONTRACTOR'S employees, including compliance with Social Security withholding and all other regulations governing such matters. It is acknowledged that during the term of this Agreement, CONTRACTOR may be providing services to others unrelated to the SJVIA or to this Agreement.

10. MODIFICATION

Any matters of this Agreement may be modified from time to time by the written consent of all the parties without, in any way, affecting the remainder.

11. NON-ASSIGNMENT

Contractor currently sub-contracts Fullerton Radiology Group for some services provided through this agreement. This is agreed upon by CONTRACTOR and SJVIA and incorporated into this Agreement. SJVIA is an express third party beneficiary of services provided by Pacific Coast Medical Services. Neither party shall further assign, transfer or sub-contract this Agreement nor their rights or duties under this Agreement without the prior written consent of the other party.

12. HOLD HARMLESS

CONTRACTOR agrees to indemnify, save, hold harmless, and at SJVIA'S request, defend the SJVIA, its officers, agents, and employees from any and all costs and expenses, damages, liabilities, claims, and losses occurring or resulting to SJVIA in connection with the performance, or failure to perform, by CONTRACTOR, its officers, agents, or employees under this Agreement, and from any and all costs and expenses, damages, liabilities, claims, and losses occurring or resulting to any person, firm, or corporation who may be injured or damaged

by the performance, or failure to perform, of CONTRACTOR, its officers, agents, or employees under this Agreement.

13. INSURANCE

A. Without limiting the SJVIA's right to obtain indemnification from CONTRACTOR or any third parties, CONTRACTOR, at its sole expense, shall maintain in full force and effect, the following insurance policies or a program of self-insurance, including but not limited to, an insurance pooling arrangement or Joint Powers Agreement (JPA) throughout the term of the Agreement:

B. Commercial General Liability

Commercial General Liability Insurance with limits of not less than One Million Dollars ($1,000,000) per occurrence and an annual aggregate of Two Million Dollars ($2,000,000). This policy shall be issued on a per occurrence basis.

C. Automobile Liability

Comprehensive Automobile Liability Insurance with limits for bodily injury of not less than Two Hundred Fifty Thousand Dollars ($250,000.00) per person, Five Hundred Thousand Dollars ($500,000.00) per accident and for property damages of not less than Fifty Thousand Dollars ($50,000.00), or such coverage with a combined single limit of Five Hundred Thousand Dollars ($500,000.00). Coverage should include owned and non-owned vehicles used in connection with this Agreement.

D. Professional Liability

If CONTRACTOR employs licensed professional staff, (e.g., Ph.D., R.N., L.C.S.W., M.F.C.C.) in providing services, Professional Liability Insurance with limits of not less than One Million Dollars ($1,000,000.00) per occurrence, Three Million Dollars ($3,000,000.00) annual aggregate.

E. Worker's Compensation

A policy of Worker's Compensation insurance as may be required by the California Labor Code.

CONTRACTOR shall obtain endorsements to the Commercial General Liability

insurance naming the San Joaquin Valley Insurance Authority, its officers, agents, and employees, individually and collectively, as additional insured, but only insofar as the operations under this Agreement are concerned. Such coverage for additional insured shall apply as primary insurance and any other insurance, or self-insurance, maintained by SJVIA, its officers, agents and employees shall be excess only and not contributing with insurance provided under CONTRACTOR's policies herein. This insurance shall not be cancelled or changed without a minimum of thirty (30) days advance written notice given to SJVIA.

Within Thirty (30) days from the date CONTRACTOR signs and executes this Agreement, CONTRACTOR shall provide certificates of insurance and endorsement as stated above for all of the foregoing policies, as required herein, to the SJVIA, (**Rhonda Sjostrom, SJVIA Manager, 2900 W. Burrel Ave., Visalia, CA 93291**), stating that such insurance coverage have been obtained and are in full force; that the San Joaquin Valley Insurance Authority, its officers, agents and employees will not be responsible for any premiums on the policies; that such Commercial General Liability insurance names the San Joaquin Valley Insurance Authority, its officers, agents and employees, individually and collectively, as additional insured, but only insofar as the operations under this Agreement are concerned; that such coverage for additional insured shall apply as primary insurance and any other insurance, or self-insurance, maintained by SJVIA, its officers, agents and employees, shall be excess only and not contributing with insurance provided under CONTRACTOR's policies herein; and that this insurance shall not be cancelled or changed without a minimum of thirty (30) days advance, written notice given to SJVIA.

In the event CONTRACTOR fails to keep in effect at all times insurance coverage as herein provided, the SJVIA may, in addition to other remedies it may have, suspend or terminate this Agreement upon the occurrence of such event.

All policies shall be with admitted insurers licensed to do business in the State of California. Insurance purchased shall be purchased from companies possessing a current A.M. Best, Inc. rating of A FSC VII or better.

14. AUDITS AND INSPECTIONS

The CONTRACTOR shall at any time during business hours, and as often as

the SJVIA may deem necessary, make available to the SJVIA for examination all of its records and data with respect to the matters covered by this Agreement. The CONTRACTOR shall, upon request by the SJVIA, permit the SJVIA to audit and inspect all of such records and data necessary to ensure CONTRACTOR'S compliance with the terms of this Agreement.

If this Agreement exceeds ten thousand dollars ($10,000.00), CONTRACTOR shall be subject to the examination and audit of the Auditor General for a period of three (3) years after final payment under contract (Government Code Section 8546.7).

15. NOTICES

The persons and their addresses having authority to give and receive notices under this Agreement include the following:

SJVIA	CONTRACTOR
Rhonda Sjostrom, SJVIA Manager	Pacific Coast Medical Services
2900 W. Burrel Ave.	1440 S. State College Blvd., Suite 3-K
Visalia, CA 93291	Anaheim, CA. 92806

Any and all notices between the SJVIA and the CONTRACTOR provided for or permitted under this Agreement shall be in writing and shall be deemed duly served when personally delivered to one of the parties, or in lieu of such personal services, when deposited in the United States Mail, postage prepaid, addressed to such party.

16. VENUE AND GOVERNING LAW

Venue for any action arising out of or related to this Agreement shall only be in Fresno County, California. The rights and obligations of the parties and all interpretation and performance of this Agreement shall be governed in all respects by the laws of the State of California.

17. ENTIRE AGREEMENT

This Agreement constitutes the entire agreement between the CONTRACTOR and SJVIA with respect to the subject matter hereof and supersedes all previous Agreement negotiations, proposals, commitments, writings, advertisements, publications, and understanding of any nature whatsoever unless expressly included in this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement:

SAN JOAQUIN VALLEY INSURANCE AUTHORITY	PACIFIC COAST MEDICAL
_____	_____
Deborah Poochigian, President SJVIA Board of Directors	Reyna R. Chavez, Owner Pacific Coast Medical
DATE: _____	DATE: _____

REVIEWED & RECOMMENDED FOR APPROVAL

_____

Rhonda Sjostrom, SJVIA Manager

EXHIBIT "A"

Mammography Services:

CONTRACTOR will conduct on-site bilateral screening mammography exams to participants of the SJVIA at various locations and over multiple days for Participating Entities as mutually agreed upon between CONTRACTOR and Participating Entity.

CONTRACTOR may only schedule mammography services with a Participating Entity after receiving written approval from the SJVIA Manager, SJVIA Assistant Manager, or designee to ensure that the Participating Entity is able to schedule the minimum number of required exams as set forth in Exhibit B. Such services should be scheduled by the Participating Entity at least 45 days in advance of services unless mutually agreed upon by Participating Entity and CONTRACTOR. Upon receiving SJVIA approval, CONTRACTOR shall work directly with Participating Entity to schedule actual dates and locations of mammography services.

CONTRACTOR shall provide a notice of privacy practices to each participant before conducting the bilateral screening mammography exam.

The bilateral screening mammography exam shall result in a written report, including interpretation, by the radiologist who performed the exam. The report shall be sent to the participant's designated physician within 5-7 working days after the day of service. CONTRACTOR shall provide to each participant either a normal or an abnormal results letter within 7-9 working days after the day of service. CONTRACTOR shall provide a generic outcome report that does not contain unique identifiers pursuant to HIPAA will be sent to the SJVIA no later than 9 days after the last day of service for each Participating Entity.

EXHIBIT "B"

CONTRACTOR will be compensated for providing mammography services for the SJVIA as detailed below:

<u>Pricing</u>:

- The fee for services defined in Exhibit A shall be $95.00 per exam with a guarantee that the Participating Entity will pay for a minimum of 30 exams per scheduled day.

- The minimum fee for services provided by CONTRACTOR to a Participating Entity for a scheduled day of service is $2,850.00 ($95.00 x 30 exams).

- A 50% deposit ($1,425.00) is due 30 days prior to day of service for each Participating Entity. CONTRACTOR will invoice SJVIA for the deposit.

- Any exams completed after 30 exams per day will be paid for by Participating Entity to CONTRACTOR at the rate of $95.00 per exam.

- CONTRACTOR will invoice SJVIA for the balance based on actual exams performed.