REMIF
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MUNICIPAL
INSURANCE
FUND

414 W. Napa Street | 2nd Floor, Suite C | Sonoma, CA 95476
Phone (707) 938-2388 | Fax (707) 938-0374 | www.remif.com

Member Cities: Arcata, Cloverdale, Cotati, Eureka, Ft. Bragg, Fortuna, Healdsburg, Lakeport, Rohnert Park, St. Helena, Sebastopol, Sonoma, Ukiah, Willits, Windsor

AGENDA
REMIF ANNUAL MEMBERSHIP MEETING

Friday, January 22, 2021 – 9:00 a.m. – 12:00 p.m.

1. City of Arcata
2. City of Cloverdale
3. City of Cotati
4. City of Eureka
5. City of Fortuna
6. City of Fort Bragg
7. City of Healdsburg
8. City of Lakeport
9. City of Rohnert Park
10. City of Sebastopol
11. City of Sonoma
12. City of St. Helena
13. City of Ukiah
14. City of Willits
15. Town of Windsor
16. REMIF

Members of the public have the option of commenting and/or attending this meeting telephonically by dialing +1 669 900 9128 (Meeting ID: 861 6503 8455, Passcode: 491632).

CALL TO ORDER

ROLL CALL

PUBLIC COMMENT

TIME RESERVED FOR THE PUBLIC TO OFFER COMMENTS REGARDING CONSENT CALENDAR OR BOARD BUSINESS NOT LISTED ON THE AGENDA. THE PUBLIC COMMENT PERIOD IS LIMITED TO FIVE MINUTES PER SPEAKER UNLESS ADDITIONAL TIME HAS BEEN ALLOWED BY THE CHAIRPERSON. STATE LAW PROHIBITS ACTION BY THE BOARD ON NON-AGENDA ITEMS.

COMMUNICATIONS – None

PRESENTATIONS – None

Page:	**CONSENT CALENDAR – (I) Information Item (A) Action Item**
3	1. Receipt and approval of minutes of the REMIF Board meeting on September 24, 2020 (A) and November 16, 2020 (A)
11	2. Receipt of minutes from the REMIF Executive Committee meetings on April 23, 2020, June 29, 2020, August 13, 2020, and October 27, 2020 (I)
15	3. Receipt of minutes from the REMIF Self-Insured Health Committee meetings on August 27, 2020, October 8, 2020, and November 12, 2020 (I)
23	4. Receipt and approval of REMIF check register (A); receipt and approval of Treasurer's Report (A), and receipt and approval of REMIF financials (including budget to actuals) for quarters ending June 30, 2020 and September 30, 2020 (A)

96 5. Receipt of report out after closed session (I)
98 6. Receipt of General Manager's activities (I)

ACTION (A) AND INFORMATION (I) CALENDAR

99 7. Finance: discussion and possible action on Financial Audit FY 19-20 (A), presentation by REMIF's financial auditor, Jesse Deol from James Marta Company
195 8. Finance: discussion and possible action on changes to Investment Policy (A)
210 9. Finance: discussion and possible action to approve OPEB actuarial report (A)
252 10. REMIF/PARSAC Strategic Partnership: discussion, direction to staff and possible action on CIRA Transition Committee's recommendations (A)
477 11. Health Plan: discussion and possible action on REMIF Health Care Committee recommendations on Self-Insured Health Plan (A)
619 12. Administrative: discussion and possible action on changes, adds and deletes to the Covered Party list attached to the Memorandum of Coverage (Liability Program) (A)

ADJOURNMENT OF MEETING

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MINUTES
REMIF BOARD OF DIRECTORS' TELEPHONIC MEETING
September 24, 2020 – 10:30 a.m.

CALL TO ORDER
President McLaughlin called the meeting to order at 10:34 a.m.

ROLL CALL
PRESENT
1. Danette Demello, *Arcata*
2. Susie Holmes, *Cloverdale*
3. Pam Powell, *Eureka*
4. Tabatha Miller, *Fort Bragg*
5. Heather Ippoliti, *Healdsburg*
6. Kelly Buendia, *Lakeport*
7. Larry McLaughlin, *Sebastopol*
8. Cathy Lanning, *Sonoma*
9. Kathy Robinson, *St. Helena*
10. Sheri Mannion, *Ukiah*
11. Stephanie Garrabrant-Sierra, *Willits*
12. Jeneen Peterson, *Windsor*

ABSENT
1. John Moore, *Cotati*
2. Siana Emmons, *Fortuna*
3. Darrin Jenkins, *Rohnert Park*

OTHERS PRESENT
1. Amy Northam, *REMIF*
2. Carmela Beckman-Spector, *REMIF*
3. Heather McGroarty, *REMIF*
4. Doug Alliston, *Alliston & Quinn*
5. Carlos Oblites, *Chandler Asset Management*
6. Tom Baber, *George Hills*
7. Rose Melchor, *George Hills*
8. Parmit Randhawa, *George Hills*
9. Dana Calkins, *George Hills*
10. Pat O'Brien, *Real Care*
11. Royann Franchini, *Real Care*
12. Carol Reid, *Real Care*
13. Yahaira Martinez, *PARSAC*
14. Ritesh Sharma, *Sedgwick*

TIME RESERVED FOR THE PUBLIC TO OFFER COMMENTS REGARDING CONSENT CALENDAR AND/OR CLOSED SESSION ITEMS, OR BOARD BUSINESS NOT LISTED ON THE AGENDA. THE PUBLIC COMMENT PERIOD IS LIMITED TO FIVE MINUTES PER SPEAKER UNLESS ADDITIONAL TIME HAS BEEN ALLOWED BY THE CHAIRPERSON. STATE LAW PROHIBITS ACTION BY THE BOARD ON NON-AGENDA ITEMS. **None**

COMMUNICATIONS
GM Amy Northam pointed out that Margaret Silveira, Lake Port, sent a thank you note included in the agenda packet after her retirement ceremony.

PRESENTATIONS – None

CONSENT CALENDAR – (I) Information Item (A) Action Item
1. Approval of Board of Directors Meeting Minutes: 6/18/20 and 7/20/20 (A)
2. Minutes from Health Committee Meeting: 6/25/20, 7/23/20 and 8/27/20 (A)

3. Receipt and Approval of REMIF Check Register (A)
4. Receipt and Approval of REMIF Treasurer's Report (A)
5. Report out of closed session (A)
6. Approval of changes to board representation (A)
7. General Manager's Activities (I)

- A motion was made by Director Demello, seconded by Director Garrabrandt-Sierra to approve the consent calendar with the exception of item 4. The motion carried by the following roll call vote:
- Aye: Directors: Demello, Holmes, Powell, Ippoliti, Buendia, McLaughlin, Lanning, Robinson, Mannion, Garrabrandt-Sierra, and Peterson.
- No: None
- Absent: Moore, Miller, Emmons, Jenkins

Item 4. REMIF Treasurer's Report was pulled and upon discussion was approved.

- A motion was made by Director Demello, seconded by Director Holmes to approve the REMIF Treasurer's Report. The motion carried by the following roll call vote:
- Aye: Directors: Demello, Holmes, Powell, Miller Ippoliti, Buendia, McLaughlin, Lanning, Robinson, Mannion, Garrabrandt-Sierra, and Peterson.
- No: None
- Absent: Moore, Emmons, Jenkins

ADJOURN INTO CLOSED SESSION

Government Code Section 54956.95 – Conference regarding a claim for the payment of tort liability losses, public liability losses, or workers' compensation liability incurred by the joint powers' agency or a local agency member of the joint powers' agency.

Claimant: P. Rilla
Agency claimed against: City of Healdsburg

Claimant: J. Fitzhugh
Agency claimed against: City of Eureka

ACTION (A) AND INFORMATION (I) CALENDAR

8. Investments/investment policy: discussion and possible action on: (A)

a. Review of assets/investments from investment manager Carlos Oblites, Chandler Asset Management (I)

Mr. Oblites provided an economic update to the Board as well provided the status of REMIF's portfolio and investments. He noted REMIF's portfolio was designed for safety and liquidity and is performing as designed.

b. Review of recommended changes to investment policy (A)

Upon review of the REMIF investment policy, Mr. Oblites recommended the following changes:

- A change to the concentration limit language on callable securities which makes a new concentration limit of 20% and is applicable to agency callable securities;
- Updated language outlining the requirements for commercial paper, which makes the policy language more in line with language used in Code to avoid any ambiguity; and
- Updated language addressing credit risk mitigation, which places a duty on REMIF's investment advisor to notify the finance director in a timely manner of any actions taken related to securities downgraded below the minimum credit requirement. It was noted this is current practice, but adding it to the policy to makes it explicit.

- A motion was made by Director Holmes, seconded by Director Powell to approve the changes to the REMIF investment policy as presented. The motion carried by the following roll call vote:
- Aye: Directors: Demello, Holmes, Powell, Ippoliti, Buendia, McLaughlin, Lanning, Robinson, Mannion, Garrabrandt-Sierra, and Peterson.
- No: None
- Absent: Moore, Emmons, Jenkins

- A motion was made by Director Peterson, seconded by Director Powell to direct staff to bring back options and suggested changes regarding investments in environmental and fossil fuel as well as extending the length of investments from five to ten years. The motion carried by the following roll call vote:
- Aye: Directors: Demello, Holmes, Powell, Ippoliti, Buendia, McLaughlin, Lanning, Robinson, Mannion, Garrabrandt-Sierra, and Peterson.
- No: None
- Absent: Moore, Emmons, Jenkins

9. Health Program: discussion and possible action on:

1. Renewal of over age 65 retiree medical plan (A)

A proposal from United American was presented that would reduce the medical increase with no change to the medical benefits and the Health Care Committee recommended the Board approve moving from Transamerica plan to the United American plan for 2020.

2. Elimination of prior authorization for durable medical equipment
During a medical claims audit, a problem was identified with DME claims in that the plan language requires prior authorization, yet no authorization process currently exists, so the Health Care Committee recommended removing the requirement rather than obtaining costly prior authorizations.

3. Continuation of waiver of copay for Live-Health Online (A)
To encourage the use of the Live Health platform, the Health Care Committee recommended the Board allow the waiver of the co-pay for the Live Health Online visits to continue through 12/31/20.

4. Continuation of expansion of telemedicine option (A)
The Health Care Committee recommended the Board allow the expansion of telemedicine permanently as there has been a significant increase in the demand for patients to be seen virtually due to the pandemic.

5. Receipt of audit of health care program/administration (I)
The Health Care Committee recommended the Board adopt the claims audit report of HealthComp for medical claims.

- A motion was made by Director Buendia, seconded by Director Mannion to approve all five of the recommendations of the Health Care Committee as presented. The motion carried by the following roll call vote:
- Aye: Directors: Demello, Holmes, Powell, Ippoliti, Buendia, McLaughlin, Lanning, Robinson, Mannion, Garrabrandt-Sierra, and Peterson.
- No: None
- Absent: Moore, Emmons, Jenkins

10. Finance: discussion and possible action on general liability and automobile liability actuarial report, to record outstanding liabilities as of 6/30/20 (A)

The general and auto liability actuarial report was completed for the purposes of booking the outstanding financial liability on the 6/30/20 financial statement. Overall, the report showed and increase of over 47% in liability claims. Claims are discounted 2.5%, which resulted in the value of the estimated outstanding claims to be $8,039,211. Upon adding the 5% ULAE of $401,961, the total claims liabilities to be recorded as of 6/30/20 is $8,441,172.

- A motion was made by Director Holmes, seconded by Director Buendia to approve the actuarial report and allow staff to book the outstanding financial liability of $8,441,172 on the financial statement as of June 30, 2020. The motion carried by the following roll call vote:
- Aye: Directors: Demello, Holmes, Powell, Ippoliti, Buendia, McLaughlin, Lanning, Robinson, Mannion, Garrabrandt-Sierra, and Peterson.
- No: None
- Absent: Moore, Emmons, Jenkins

11. Finance: discussion and possible action workers' compensation actuarial report, to record outstanding liabilities as of 6/30/20 (A)

The workers' compensation actuarial report was completed for the purpose of booking outstanding liabilities on the 6/30/20 financial statement. Overall, there was a decrease in losses in this program of almost one million dollars. The claims are also discounted at 2.5% resulting in the present value of the claims to be $17,969,446. Upon adding the 5% ULAE of $898,472, the outstanding liability to be recorded on the 6/30/20 statement is $18,867,918.

- A motion was made by Director Demello, seconded by Director Holmes to approve the actuarial report and allow staff to book the outstanding financial liability of $18,867,918 on the financial statement as of June 30, 2020. The motion carried by the following roll call vote:
- Aye: Directors: Demello, Holmes, Powell, Ippoliti, Buendia, McLaughlin, Lanning, Robinson, Mannion, Garrabrandt-Sierra, and Peterson.
- No: None
- Absent: Moore, Emmons, Jenkins

12. Property renewal: discussion and possible action on property renewals (A)

At the July 2020 Board meeting, staff reported the final property renewals were slightly below initial projections provided in June by about $78,000. Unfortunately, there was a significant increase to the flood deductible, which went from $250K to $1 million. Upon discussing, the Board agreed the individual member deductibles should increase to $500K and that REMIF should self-fund from $500K to $1 million.

Further, the Board requested this issue be brought back for discussion in September once final quotes are received for the buy down policy option and to allow members more time to think about how to fund this exposure. Since quotes for a deductible buy down came in at $750,000, staff recommended the Board not purchase the commercial policy and self-fund as previously established.

No action was taken on this item.

13. PARSAC/REMIF strategic partnership: discussion and direction to staff and possible action on Transition Committee's recommendations (I) and (A); discussion and possible action on REMIF JPA and Bylaws

The Transition Committee, which includes REMIF's Executive Committee, previously met and discussed the following issues and is recommending Board approval of the following:

The recommended changes to the CIRA JPA and bylaws to reflect PARSAC as the successor agency;

The recommended changes to the CIRA JPA and bylaws to reflect a staggered election cycle for the first election;

A $500K pool SIR for the workers compensation program, a $1 million SIR pool layer for the general liability program, and a $250K SIR for employment practices liability, subject to options with the excess carrier/JPA and rates;

The creation of a Transition Finance Committee that includes REMIF members: Aaron Felmlee, Fortuna; Nicholas Walker, Lakeport; Daniel Buffalo, Ukiah; and PARSAC members: Chuck Dantuono, Highland; Amber Johnson, Belvedere; Dave Warren, Placerville; and Noah Daniels, Rancho Cucamonga;

The staggered election procedures for the CIRA Executive Committee outlined in the CIRA governing documents presented; and

The first CIRA Board meeting to be held on May 26, 2021 with the location to be determined.

Additionally, staff presented language changes to the REMIF JPA and bylaws that allow the REMIF health care program to remain with REMIF.

- A motion was made by Director Buendia, seconded by Director Ippoliti to approve all the recommendations of the Transition Committee as presented as well as approve the changes to the REMIF JPA and bylaws as presented. The motion carried by the following roll call vote:
- Aye: Directors: Demello, Holmes, Powell, Ippoliti, Buendia, McLaughlin, Lanning, Robinson, Mannion, Garrabrandt-Sierra, and Peterson.
- No: None
- Absent: Moore, Miller, Emmons, Jenkins

14. Administrative: discussion and action on date for REMIF Annual Membership Meeting (A)

At the January 31, 2020, Board meeting, dates for the 2020/21 program year meetings were selected except for the annual meeting. Due to the pandemic, staff recommended the annual meeting be scheduled virtually as two half days on January 21 and 22, 2021, at 9:00 a.m. each day. The other dates selected were: September 24, 2020; April 22, 2021; and June 17, 2021.

- A motion was made by Director Demello, seconded by Director Holmes to approve the 2020/21 meeting dates as presented. The motion carried by the following roll call vote:
- Aye: Directors: Demello, Holmes, Powell, Ippoliti, Buendia, McLaughlin, Lanning, Robinson, Mannion, Garrabrandt-Sierra, and Peterson.
- No: None
- Absent: Moore, Miller, Emmons, Jenkins

15. Administrative: discussion and possible action on First Amendment to Employment Agreement with General Manager Implementing a Salary Increase to $175,000 Annually (A)

At the January meeting, the Board met in closed session to review the performance evaluation of the General Manager and recommended her salary be increased $15,000. At the time, the General Manager elected to defer her increase in compensation for eight months due to the pandemic. The draft amendment to the General Manager's contract reflecting the salary increase was brought forth for consideration.

- A motion was made by Director McLaughlin, seconded by Director Holmes to give authority to the REMIF President to execute the Amendment to the General Manager's Contract reflecting a $15,000 salary increase, from $160,000 to $175,000. The motion carried by the following roll call vote:
- Aye: Directors: Demello, Holmes, Powell, Ippoliti, Buendia, McLaughlin, Lanning, Robinson, Mannion, Garrabrandt-Sierra, and Peterson.
- No: None
- Absent: Moore, Miller, Emmons, Jenkins

16. Administrative: discussion and direction to staff on services provided to members by REMIF (I)

REMIF service providers were asked to provide staff with utilization reports so the Board can determine whether it would like to continue utilizing the services. Upon discussion and review of the utilization reports, the Board determined they do not wish to continue using the online training services provided by DFK/My Safety Officer. The Board also determined they wish to eliminate providing MSDS safety data sheets.

No action was taken on this item.

17. Workers' Compensation: receipt of audit report of administration of workers' compensation program (I)

As required by Board Policy, a claims audit of the administration of the workers' compensation claims is to be completed every two years. As such, Athens Administrators was audited by ABD Insurance and Financial Services. Upon review of 50 claims, the report found Athens scored 93% overall, which is very commendable.

No action was taken on this item.

18. Risk Management roundtable (I)

This item was reserved for the discussion of risk management issues that are of concern to members. Topics discussed were:

- The handling of traffic signals during power shut offs by different cities;
- The virtual CAJPA/AGRiP conference;
- SB1159 requirements and how staff will work with Athens to implement changes and satisfy requirements; and
- Stephanie Garrabrandt-Sierra, Willits, was congratulated on her upcoming retirement.

ADJOURNMENT
The Board adjourned at: 2:04 p.m.

Respectfully Submitted by:

/s/ Yahaira Martinez
Yahaira Martinez, Acting Board Secretary

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MINUTES

REMIF BOARD OF DIRECTORS' MEETING (TELEPHONIC)
Monday, November 16, 2020 at 11:00 a.m.

CALL TO ORDER:

President McLaughlin called the meeting to order at 11:04 a.m.

ROLL CALL

PRESENT:

1. Danette Demello, Arcata
2. Susie Holmes, Cloverdale
3. Damien O'Bid, Cotati
4. Pam Powell, Eureka
5. Tabatha Miller, Ft. Bragg
6. Siana Emmons, Fortuna
7. Heather Ippoliti, Healdsburg
8. Kelly Buendia, Lakeport
9. Larry McLaughlin, Sebastopol
10. Kathy Robinson, St. Helena
11. Jeneen Peterson, Windsor
12. Stephanie Garrabrant-Sierra, Willits

ABSENT:

1. Darrin Jenkins, Rohnert Park
2. Sue Casey, Sonoma

OTHERS PRESENT:

Mary Gourley, Sebastopol; Amy Northam, REMIF; Patrick Moriarty; Parmit Randhawa

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COMMUNICATIONS:

1. REMIF website
2. Expect increases in liability
3. Changes in deductible due 12/31
4. Underwriting for CIRA
5. CIRA adoption by City Council

PRESENTATIONS:

None.

CONSENT CALENDAR:

None.

ADJOURN INTO CLOSED SESSION:

Government Code Section 54956.95 – Conference regarding a claim for the payment of tort liability losses, public liability losses, or workers' compensation liability incurred by the joint powers' agency or a local agency member of the joint powers' agency.

Claimant: M. Lawson

Agency claimed against: City of Arcata

REPORT OUT OF CLOSED SESSION:

None. Staff will proceed as directed.

ADJOURNMENT OF REGULAR MEETING:

Meeting was adjourned at 11:34 a.m.

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MINUTES

REMIF EXECUTIVE COMMITTEE MEETING (TELEPHONIC)

Thursday, April 23, 2020 9:00 a.m.

CALL TO ORDER:
The meeting was called to order at 9:04 a.m.

ROLL CALL:
Present:

PRESENT:
Larry McLaughlin, City of Sebastopol
Darrin Jenkins, City of Rohnert Park
Pam Powell, City of Eureka
Damien O'Bid, City of Cotati
Margaret Silveira, City of Lakeport

ABSENT:
None

OTHERS PRESENT:
Amy Northam, REMIF

PUBLIC COMMENT:
There was no public comment.

COMMUNICATIONS – None
PRESENTATIONS - None
CONSENT CALENDAR – None

ACTION (A) AND INFORMATION (I) CALENDAR
Discussion on Strategic Partnership between REMIF and PARSAC.
Staff will proceed as directed.

ADJOURNMENT OF REGULAR MEETING
The meeting adjourned at 9:34 a.m.

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MINUTES

REMIF EXECUTIVE COMMITTEE MEETING (TELEPHONIC)

Monday, June 29, 2020 2:00 p.m.

CALL TO ORDER:
The meeting was called to order at 2:05 p.m.

ROLL CALL:
PRESENT:
Larry McLaughlin, City of Sebastopol
Darrin Jenkins, City of Rohnert Park
Damien O'Bid, City of Cotati
Margaret Silveira, City of Lakeport

ABSENT:
Pam Powell, City of Eureka

OTHERS PRESENT: Amy Northam, REMIF

PUBLIC COMMENT:
No public comments.

COMMUNICATIONS – None
PRESENTATIONS - None
CONSENT CALENDAR – None
ACTION (A) AND INFORMATION (I) CALENDAR - None

ADJOURN INTO CLOSED SESSION

At 2:08 p.m.

Government Code Section 54956.95 – Conference regarding a claim for the payment of tort liability losses, public liability losses, or workers' compensation liability incurred by the joint powers' agency or a local agency member of the joint powers' agency.

Claimant: S. Wiley

Agency claimed against: Town of Windsor

REPORT OUT OF CLOSED SESSION

At 2:21 p.m.

Staff will proceed as directed.

ADJOURNMENT OF REGULAR MEETING
The meeting was adjourned at 2:24 p.m.

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MINUTES

REMIF EXECUTIVE COMMITTEE MEETING (TELEPHONIC)

Thursday, August 13, 3:00 p.m.

CALL TO ORDER:
The meeting was called to order at 3:01 p.m.

ROLL CALL:
PRESENT:
Larry McLaughlin, City of Sebastopol
Darrin Jenkins, City of Rohnert Park
Damien O'Bid, City of Cotati
Kelly Buendia, City of Lakeport
Pam Powell, City of Eureka

ABSENT:
None.

ALSO PRESENT: Amy Northam, General Manager; Kristina Palomo, Athens Administrators; Lakisha Jones-Bishop, Athens Administrators; Michael Ash, Attorney at Law.

PUBLIC COMMENT - None.

COMMUNICATIONS – None
PRESENTATIONS - None
CONSENT CALENDAR – None
ACTION (A) AND INFORMATION (I) CALENDAR - None

ADJOURN INTO CLOSED SESSION

At 3:03 p.m.

Government Code Section 54956.95 – Conference regarding a claim for the payment of tort liability losses, public liability losses, or workers' compensation liability incurred by the joint powers' agency or a local agency member of the joint powers' agency.

Claimant: S. Magill

Agency claimed against: City of St. Helena

REPORT OUT OF CLOSED SESSION

At 3:15
Staff will proceed as directed.

ADJOURNMENT OF REGULAR MEETING
The meeting was adjourned at 3:15 p.m.

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MINUTES

REMIF EXECUTIVE COMMITTEE MEETING (TELEPHONIC)

Tuesday, October 27, 2020 at 11:00 a.m.

CALL TO ORDER:
The meeting was called to order at 11:00 a.m.

ROLL CALL:
PRESENT:
Larry McLaughlin, City of Sebastopol
Darrin Jenkins, City of Rohnert Park
Damien O'Bid, City of Cotati
Kelly Buendia, City of Lakeport
Pam Powell, City of Eureka

ABSENT:
None.

ALSO, PRESENT: Amy Northam, General Manager; Parmit Randhawa, George Hills Company.

PUBLIC COMMENT - None.

COMMUNICATIONS – REMIF/PARSAC strategic partnership: communication on brokers, REMIF/PARSAC strategic partnership: communication on CIRA Executive Committee

PRESENTATIONS - None

CONSENT CALENDAR – None

ACTION (A) AND INFORMATION (I) CALENDAR - None

ADJOURN INTO CLOSED SESSION

At 11:06 a.m.

Government Code Section 54956.95 – Conference regarding a claim for the payment of tort liability losses, public liability losses, or workers' compensation liability incurred by the joint powers' agency or a local agency member of the joint powers' agency.

Claimant: T. May

Agency claimed against: City of Arcata

REPORT OUT OF CLOSED SESSION

Staff will proceed as directed.

ADJOURNMENT OF REGULAR MEETING
The meeting was adjourned at 11:11 a.m.

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REMIF Self-Insurance Committee Minutes

Date: August 27, 2020

Time: 2:00 p.m.

Telephonic Committee Meeting
Dial In: (646) 664-4400/ Conference ID: 17171#

AGENDA

Call to Order: 2:01 p.m.

I. ROLL CALL
   - A. Present:
     - i. Amy Northam, REMIF
     - ii. Danette Demello, Arcata
     - iii. James Leon, Windsor
     - iv. Kelly Buendia, Lakeport
     - v. Sheri Mannion, Ukiah
   - B. Also in attendance:
     - i. Carol Reid, RealCare
     - ii. Pat O'Brien, RealCare
     - iii. Royann Franchini, RealCare
   - C. Absent:
     - i. Stephanie Garrabrant-Sierra, Willits

II. APPROVAL OF MINUTES
   - A. Meeting of July 23, 2020

Danette Demello, Arcata, moves to approve the July 23, 2020, Minutes: Kelly Buendia, Lakeport, seconds the motion. Motion carries.

III. ITEMS FOR DISCUSSION
   - A. **Transamerica/Express Scripts Retiree Medical Renewal – Action**

AmWINS presented the 1-1-21 renewal for the Transamerica Medicare Supplement plan and Express Scripts Rx plan. The rate increase for the current benefit package is between +5.48% and +6.46%, depending on the Rx plan each city has chosen.

AmWINS presented 3 options to help reduce the requested increase. Two of the options would keep the Medical portion of the coverage with Transamerica but change the Supplement plan design from a Plan F

to a Plan G plan design. There would be no change to the Express Scripts Rx plan design. The increases in cost would be between +0.98% and +2.96%, depending on the Rx plan each city has chosen.

The third option presented would keep the plan design unchanged for medical and Rx coverage but change the Medicare Supplement vendor from Transamerica to United American. The Express Scripts Rx plan design would remain unchanged. The requested renewal would be from -0.31% to -0.97%.

Changing the medical portion of the coverage to United American would be seamless to current participants. The transition would be completed through a file transfer from one company to the other. AmWINS is required to notify participants of the change. Participants would get new medical ID cards. Current Rx ID cards would remain valid and unchanged. The current AmWINS Billing and Administrative procedures would remain unchanged.

Sheri Mannion, Ukiah, motions to recommend that the Board approve the change to United American; Danette Demello, Arcata, seconds the motion. Motion carries.

Should the Board approve the move to United American, the Committee would like RealCare to research the following:

1. If a Prior Authorization is required and has been approved for a procedure, would the PA transfer from one medical carrier to the other?
2. The Committee would like to know when AmWINS would be sending the announcement letters to the participants so that the cities can give advance notification to their members.
3. Can the name of the company (United American Insurance Company) be bolded on the announcement letter?

B. **LiveHealth Online** – **Update**

i. LHO copay waiver is effective through 9-13-20.

ii. We have now been informed that due to State Legislation, the waiver of the LHO copays is now open-ended. **NEEDS CLARIFICATION! State legislation referred to non-LHO Telemedicine that mirrors an office visit copay.**

iii. If an LHO visist results in a COVID test, the copay is waived indefinitely.

iv. If we want to extend $10 copay waiver, HealthComp needs to know by Monday, August 31, 2020, at the latest.

Danette Demello, Arcta, motions to extend the $10 copay waiver through 12-31-20; Kelly Buendia, Lakeport, seconds the motion. Motion carries.

Committee is in favor for the waiver being granted through the 12-31-20. Because a decision is needed by 8-31-20, Amy Northam has authorized the waiver of the $10 LHO copay through 12-31-20.

C. **Telemedicine Expansion** – **Update**

i. Coverage for this expanded benefit is in effect until September 1, 2020.

ii. We have now been informed that due to State Legislation, coverage for telemedicine benefits must be covered with no end date.

iii. At the July 23, 2020, Health Care Committee meeting, there was a motion to recommend to the Board that Telemedicine benefits become a permanent benefit.

D. **EnvisionRx soon to become Elixir – Informational**

i. No change in group or phone numbers.

ii. Newly printed HealthComp ID cards will reflect the Elixir name once the transition has been completed.

E. **Income and Expense – Informational**

Pat O'Brien, RealCare, noted that we are still awaiting Stop Loss reimbursements.

Next meeting: September 10, 2020; 2:00 p.m.

Meeting adjourned: 2:53 p.m.

Health Insurance Committee Members:

Danette Demello – City of Arcata – 736 F Street, Arcata, CA 95521; 707-825-2120; ddemello@cityofarcata.org
James Leon – Town of Windsor – 9291 Old Redwood Highway, Windsor, CA 95492; 707-838-5379; jleon@townofwindsor.com
Kelly Buendia – City of Lakeport – 255 Park Street, Lakeport, CA 95453; 707-263-5613 x30; kbuendia@cityoflakeport.com
Sheri Mannion—City of Ukiah –300 Seminary Drive, Ukiah, CA 95482; 707-463-6244; smannion@cityofukiah.com
Stephanie Garrabrant-Sierra – City of Willits—111 E. Commercial, Willits, CA 95490; 707-459-4601; sgsierra@cityofwillits.org

REMIF
REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

REMIF Self-Insurance Committee Minutes

Date: October 8, 2020

Time: 2:00 p.m.

Telephonic Committee Meeting
Dial In: (646) 664-4400/ Conference ID: 17171#

AGENDA

Call to Order: 2:03 pm

I. ROLL CALL
   - A. Present:
     - i. Amy Northam, REMIF
     - ii. Danette Demello, Arcata
     - iii. James Leon, Windsor
     - iv. Kelly Buendia, Lakeport
     - v. Sheri Mannion, Ukiah
   - B. Also in attendance:
     - i. Carol Reid, RealCare
     - ii. Pat O'Brien, RealCare
     - iii. Royann Franchini, RealCare
   - C. Absent:
     - i. Stephanie Garrabrant-Sierra

II. APPROVAL OF MINUTES
   - A. Meeting of September 10, 2020

Sheri Mannion, Ukiah, motioned to approved Minutes of September 10, 2020; Kelly Buendia, Lakeport, seconded motion. Motion carries

III. ITEMS FOR DISCUSSION
   - A. Emergency Protocols – Action Item

Anthem Blue Cross has instituted new emergency protocols due to the numerous wildfires in California for their fully insured plans. Anthem is allowing all members to receive emergency or urgent care from any doctor or hospital, even if they are not in the plan's network. The claims would be paid as if they are in the plan's network.

REMIF is a self-funded plan and is not governed by what Anthem does for their fully insured products. However, RealCare wanted to explore whether or not the Committee would like to pursue expanding coverage during an emergency.

REMIF"s Plan already pays Emergency Room bills at 100% of billed charges at all times, so there would be no change needed in the emergency protocols.

However, the Committee would like to explore the possibility of expanding Urgent Care charges for all providers to be paid at 100% during the duration of the Emergency Protocol.

1. RealCare will confirm that the HealthComp claims system can administer this expanded coverage.
2. RealCare will confirm whether the Stop Loss carrier would approve this expansion.
3. RealCare will request reports on Urgent Care usage currently.

Danette Demello, Arcata, motioned to have RealCare pursue the feasibility of Urgent Care charges being paid at 100% during the duration of an Emergency Protocol; Kelly Buendia, Lakeport, seconded the motion. Motion carries.

B. Truveris Year End Report – Informational

Each year Truveris and Elixir (formerly EnvisionRx) audit the prescription claims data with the REMIF/Elixir contract to ensure that Elixir has met the contract guarantees for the Plan Year. This report, prepared by Truveris and reviewed by Elixir, reflects the claims paid for the 2019/20 Plan Year.

Overall Envision ended the year with a total guarantee deficit which means that the price guarantees were not met overall. A credit in the amount of $20,609 was identified by Truveris and will be reviewed by Elixir. If both parties validate the report, a credit for the amount of the refund will be given.

RealCare will report back to the Health Care Committee as soon as the final refund number has been agreed upon after the Elixir and Truveris review. No other action was necessary as this was an informational item.

C. Anthem/Kaiser/Sutter Participation – Informational

The number of members on the REMIF plan continue to decrease as cities who can offer Kaiser and/or Sutter plans increase in the number of members on those plans.

RealCare continues to monitor these numbers and will provide a graph that shows the rate of decline over past years.

D. Elixir – Informational
    i. Revised cost of Stelara
        1. A medical plan member was receiving a high cost medication as a medical benefit through home health. The initial cost of this medication was over $50K per treatment. The member was directed to obtain future medications through the Elixir pharmacy benefit. The initial report from Elixir was that the new cost for the medication would be approximately $6K. However this was revised based on the actual dosage and is now estimated to be $15K per treatment.
        2.

E. Income and Expense – Informational

Next meeting: Thursday, November 12, 2020; 2:00 p.m.

Meeting adjourned: 2:51 p.m.

Health Insurance Committee Members:

Danette Demello – City of Arcata – 736 F Street, Arcata, CA 95521; 707-825-2120; ddemello@cityofarcata.org
James Leon – Town of Windsor – 9291 Old Redwood Highway, Windsor, CA 95492; 707-838-5379; jleon@townofwindsor.com
Kelly Buendia – City of Lakeport – 255 Park Street, Lakeport, CA 95453; 707-263-5613 x30; kbuendia@cityoflakeport.com
Sheri Mannion—City of Ukiah –300 Seminary Drive, Ukiah, CA 95482; 707-463-6244; smannion@cityofukiah.com
Stephanie Garrabrant-Sierra – City of Willits—111 E. Commercial, Willits, CA 95490; 707-459-4601; sgsierra@cityofwillits.org

REMIF
REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

REMIF Self-Insurance Committee Minutes

Date: November 12, 2020

Time: 2:00 p.m.

Telephonic Committee Meeting
Dial In: (646) 664-4400/ Conference ID: 17171#

AGENDA

Call to Order: 2:04 p.m.

I. ROLL CALL

A. Present:

i. Amy Northam, REMIF
ii. Danette Demello, Arcata
iii. Sheri Mannion, Ukiah

B. Also in attendance:

i. Pat O'Brien, RealCare
ii. Royann Franchini, RealCare

C. Absent:

i. James Leon, Windsor
ii. Kelly Buendia, Lakeport
iii. Stephanie Garrabrant-Sierra, Willits

II. APPROVAL OF MINUTES

A. Meeting of October 8, 2020

There was no quorum so the approval of the minutes will be moved to the next meeting.

III. ITEMS FOR DISCUSSION

A. **City of Lakeport requests the addition of Police members to the REMIF Medical/Dental/Vision plans - Action**

i. Per phone conversation with Kelly Buendia, the Police Department members are young and would like to move away from the OE3 benefits.
ii. Lakeport would like to get them onto the REMIF plan due to being easier to administer 1 plan vs. 2.
iii. The Actuary is running a preliminary surcharge quote. Will need to get a final quote (based on updated data) closer to the requested effective date of 7-1-21 so that it can then be taken to the Board.

There was no quorum.

B. **LiveHealth Online - Copay waiver – Action**
   i. HealthComp advises that Anthem will end the copay waiver for LHO on 01/01/2021. This could change but that is the date as of now.
   ii. 20 members used LHO between 4-1-20 through 7-31-20. 11 used LHO between 8-1-20 and 10-31-20.
   iii. 807 used non-LHO providers between 4-1-20 through 7-31-20. 406 used non-LHO providers between 8-1-20 and 10-31-20.

   Need to table this until we see if Anthem extends the the waiver of the LHO copay waiver.

C. **Truveris Year End Report – Informational**
   i. When is refund coming and how?

   Refund turned out to be $20,521 and will be credited to a future invoice.

D. **Income and Expense – Informational**

Next meeting: Thursday, December 10, 2020; 2:00 p.m.

Meeting adjourned: 2:50 p.m.

Health Insurance Committee Members:

Danette Demello – City of Arcata – 736 F Street, Arcata, CA 95521; 707-825-2120; ddemello@cityofarcata.org
James Leon – Town of Windsor – 9291 Old Redwood Highway, Windsor, CA 95492; 707-838-5379; jleon@townofwindsor.com
Kelly Buendia – City of Lakeport – 255 Park Street, Lakeport, CA 95453; 707-263-5613 x30; kbuendia@cityoflakeport.com
Sheri Mannion—City of Ukiah –300 Seminary Drive, Ukiah, CA 95482; 707-463-6244; smannion@cityofukiah.com
Stephanie Garrabrant-Sierra – City of Willits—111 E. Commercial, Willits, CA 95490; 707-459-4601; sgsierra@cityofwillits.org

Date	Vendor	Check/EFT #	Amount
0157-Bank of America			
9/2/2020	VEN-109--Delta Dental of California	EFT	17,717.45
9/3/2020	VEN-112--Office Information Systems	EFT	227.75
9/3/2020	VEN-107--Athens Insurance Services, Inc.	EFT	43,333.00
9/3/2020	VEN-181--Health Comp-Admin Fee	EFT	176,370.11
9/3/2020	VEN-133--Stanley Convergent Security Solutions, Inc	17911	1,640.16
9/3/2020	VEN-208--Health and Human Resource Center, Inc.	17906	4,808.12
9/3/2020	VEN-154--Pitney Bowes Global	17909	252.91
9/3/2020	VEN-120--City of Rohnert Park	17903	2,270.36
9/3/2020	VEN-131--Vista Landscape	17913	330.00
9/3/2020	VEN-138--Acceptable Risk	17902	62.50
9/3/2020	VEN-127--DKF Solutions Group, LLC	17905	5,250.00
9/3/2020	VEN-229--KBA Document Solutions, LLC	17907	337.46
9/3/2020	VEN-117--Vision Service Plan	17912	11,201.53
9/3/2020	VEN-257--ABD Insurance & Financial Services	17901	13,500.00
9/3/2020	VEN-121--Sonoma Garbage Collectors, Inc	17910	234.28
9/3/2020	VEN-118--Comcast	17904	675.97
9/3/2020	VEN-167--Liebert Cassidy Whitmore	17908	47,431.00
9/9/2020	VEN-109--Delta Dental of California	EFT	21,995.25
9/10/2020	VEN-153--Pacific Gas & Electric	17917	314.68
9/10/2020	VEN-124--Comcast Business	17914	337.74
9/10/2020	VEN-167--Liebert Cassidy Whitmore	17916	380.00
9/10/2020	VEN-123--WM Cleaning of Sonoma	17920	225.00
9/10/2020	VEN-117--Vision Service Plan	17919	2,643.48
9/10/2020	VEN-121--Sonoma Garbage Collectors, Inc	17918	234.28
9/10/2020	VEN-106--Comprehensive Drug Testing, Inc	17915	292.00
9/16/2020	VEN-109--Delta Dental of California	EFT	20,443.97
9/17/2020	VEN-173--SAGE INTACCT	17927	225.00
9/17/2020	VEN-103--City of Sonoma-Water	17924	84.89
9/17/2020	VEN-141--Murphy, Campbell, Alliston & Quinn	17926	5,557.50
9/17/2020	VEN-126--AmWINS	17922	7,009.80
9/17/2020	VEN-114--Best Best & Krieger	17923	1,440.00
9/17/2020	VEN-220--AAA Business Supplies & Interiors	17921	222.06
9/17/2020	VEN-171--Shapiro, Galvin, Shaprio & Moran	17928	822.50
9/17/2020	VEN-146--George Hills	17925	962.50
9/17/2020	VEN-146--George Hills	EFT	10,583.33
9/22/2020	VEN-128--Business Card	EFT	677.52
9/23/2020	VEN-109--Delta Dental of California	EFT	21,179.75
9/30/2020	VEN-109--Delta Dental of California	EFT	9,930.18
9/30/2020	VEN-109--Delta Dental of California	EFT	19,200.70
10/1/2020	VEN-127--DKF Solutions Group, LLC	17932	5,250.00
10/1/2020	VEN-102--Shred-It USA	17938	57.44
10/1/2020	VEN-229--KBA Document Solutions, LLC	17935	449.92
10/1/2020	VEN-124--Comcast Business	17931	337.74
10/1/2020	VEN-108--Alhambra	17929	9.00
10/1/2020	VEN-227--James Marta & Co. LLP	17934	8,000.00
10/1/2020	VEN-255--FOLEY & LARDNER LLP	17933	10,651.50
10/1/2020	VEN-110--Alterity Group	17937	507.95
10/1/2020	VEN-167--Liebert Cassidy Whitmore	17936	304.00
10/1/2020	VEN-222--York Risk Services Group, Inc.	17939	8,125.00
10/1/2020	VEN-125--California Joint Powers Risk Management Au	17930	1,291,954.00

Date	Vendor	Check/EFT #	Amount
10/1/2020	VEN-107--Athens Insurance Services, Inc.	EFT	43,333.00
10/1/2020	VEN-258--THOMPSOM HEALTH & BOND LTD	EFT	150,000.00
10/1/2020	VEN-112--Office Information Systems	EFT	200.00
10/7/2020	VEN-109--Delta Dental of California	EFT	30,202.70
10/8/2020	VEN-141--Murphy, Campbell, Alliston & Quinn	17943	1,620.00
10/8/2020	VEN-123--WM Cleaning of Sonoma	17946	225.00
10/8/2020	VEN-208--Health and Human Resource Center, Inc.	17942	4,825.16
10/8/2020	VEN-117--Vision Service Plan	17944	11,985.16
10/8/2020	VEN-131--Vista Landscape	17945	330.00
10/8/2020	VEN-106--Comprehensive Drug Testing, Inc	17941	292.00
10/8/2020	VEN-120--City of Rohnert Park	17940	32,704.79
10/14/2020	VEN-109--Delta Dental of California	EFT	17,327.80
10/15/2020	VEN-146--George Hills	EFT	10,833.33
10/15/2020	VEN-121--Sonoma Garbage Collectors, Inc	17950	234.38
10/15/2020	VEN-153--Pacific Gas & Electric	17948	247.14
10/15/2020	VEN-117--Vision Service Plan	17951	2,630.88
10/15/2020	VEN-171--Shapiro, Galvin, Shaprio & Moran	17949	317.25
10/15/2020	VEN-126--AmWINS	17947	7,007.64
10/20/2020	VEN-112--Office Information Systems	EFT	2,305.25
10/20/2020	VEN-181--Health Comp-Admin Fee	EFT	179,141.39
10/21/2020	VEN-109--Delta Dental of California	EFT	15,559.10
10/22/2020	VEN-128--Business Card	EFT	4,471.27
10/22/2020	VEN-105--Sonoma County Tax Collector	17958	2,625.60
10/22/2020	VEN-194--MacLeod Watts Inc	17956	1,850.00
10/22/2020	VEN-108--Alhambra	17952	9.00
10/22/2020	VEN-140--Antonio Machuca	17953	225.00
10/22/2020	VEN-222--York Risk Services Group, Inc.	17959	8,125.00
10/22/2020	VEN-255--FOLEY & LARDNER LLP	17955	1,438.50
10/22/2020	VEN-259--Rugworks	17957	7,000.00
10/22/2020	VEN-120--City of Rohnert Park	17954	31,718.20
10/28/2020	VEN-109--Delta Dental of California	EFT	13,224.91
10/28/2020	VEN-109--Delta Dental of California	EFT	17,061.65
10/29/2020	VEN-117--Vision Service Plan	17966	11,019.63
10/29/2020	VEN-109--Delta Dental of California	Voided - 17962	-13,224.91
10/29/2020	VEN-117--Vision Service Plan	Voided - 17965	-24,017.25
10/29/2020	VEN-107--Athens Insurance Services, Inc.	EFT	43,333.00
10/29/2020	VEN-102--Shred-It USA	17964	59.40
10/29/2020	VEN-110--Alterity Group	17963	509.85
10/29/2020	VEN-109--Delta Dental of California	17962	13,224.91
10/29/2020	VEN-103--City of Sonoma-Water	17960	80.10
10/29/2020	VEN-118--Comcast	17961	676.80
10/29/2020	VEN-117--Vision Service Plan	17965	24,017.25
10/29/2020	VEN-117--Vision Service Plan	Voided - 17849	-12,997.62
11/4/2020	VEN-112--Office Information Systems	EFT	125.00
11/4/2020	VEN-181--Health Comp-Admin Fee	EFT	181,453.29
11/4/2020	VEN-109--Delta Dental of California	EFT	21,193.67
11/5/2020	VEN-229--KBA Document Solutions, LLC	17970	337.46
11/5/2020	VEN-208--Health and Human Resource Center, Inc.	17969	4,816.64
11/5/2020	VEN-127--DKF Solutions Group, LLC	17968	5,250.00
11/5/2020	VEN-131--Vista Landscape	17971	330.00
11/5/2020	VEN-138--Acceptable Risk	17967	1,371.13
11/6/2020	VEN-187--CalPERS	EFT	1,228.81
11/6/2020	VEN-187--CalPERS	EFT	700.00
11/10/2020	VEN-128--Business Card	EFT	15,737.20
11/12/2020	VEN-173--SAGE INTACCT	17977	56.25

Date	Vendor	Check/EFT #	Amount
11/12/2020	VEN-121--Sonoma Garbage Collectors, Inc	17979	234.18
11/12/2020	VEN-141--Murphy, Campbell, Alliston & Quinn	17975	1,777.50
11/12/2020	VEN-257--ABD Insurance & Financial Services	17972	12,500.00
11/12/2020	VEN-117--Vision Service Plan	17980	2,608.20
11/12/2020	VEN-171--Shapiro, Galvin, Shaprio & Moran	17978	94.00
11/12/2020	VEN-106--Comprehensive Drug Testing, Inc	17974	2,390.00
11/12/2020	VEN-153--Pacific Gas & Electric	17976	234.06
11/12/2020	VEN-170--Carmela Beckman-Spector	17973	121.78
11/12/2020	VEN-112--Office Information Systems	EFT	58.27
11/12/2020	VEN-109--Delta Dental of California	EFT	21,183.35
11/18/2020	VEN-109--Delta Dental of California	EFT	16,865.40
11/19/2020	VEN-103--City of Sonoma-Water	17984	80.10
11/19/2020	VEN-222--York Risk Services Group, Inc.	17987	8,125.00
11/19/2020	VEN-255--FOLEY & LARDNER LLP	17985	2,574.00
11/19/2020	VEN-173--SAGE INTACCT	17986	9,072.00
11/19/2020	VEN-126--AmWINS	17982	7,009.08
11/19/2020	VEN-108--Alhambra	17981	9.00
11/19/2020	VEN-120--City of Rohnert Park	17983	35,362.42
11/19/2020	VEN-146--George Hills	EFT	10,583.33
11/25/2020	VEN-109--Delta Dental of California	EFT	23,229.75
12/2/2020	VEN-107--Athens Insurance Services, Inc.	EFT	43,333.00
12/2/2020	VEN-181--Health Comp-Admin Fee	EFT	177,015.98
12/2/2020	VEN-112--Office Information Systems	EFT	75.00
12/3/2020	VEN-172--Department Of Industrial Relations	17991	198,867.49
12/3/2020	VEN-102--Shred-It USA	17994	121.22
12/3/2020	VEN-118--Comcast	17989	33.56
12/3/2020	VEN-229--KBA Document Solutions, LLC	17993	337.46
12/3/2020	VEN-124--Comcast Business	17990	698.34
12/3/2020	VEN-127--DKF Solutions Group, LLC	17992	5,250.00
12/3/2020	VEN-117--Vision Service Plan	17995	12,627.49
12/3/2020	VEN-138--Acceptable Risk	17988	1,006.13
12/3/2020	VEN-131--Vista Landscape	17996	330.00
12/3/2020	VEN-109--Delta Dental of California	EFT	13,155.73
12/3/2020	VEN-109--Delta Dental of California	EFT	17,982.35
12/8/2020	VEN-112--Office Information Systems	EFT	54.00
12/9/2020	VEN-109--Delta Dental of California	EFT	17,498.10
12/9/2020	VEN-208--Health and Human Resource Center, Inc.	18002	4,808.12
12/9/2020	VEN-260--CAJPA	18000	1,500.00
12/9/2020	VEN-154--Pitney Bowes Global	18006	252.91
12/9/2020	VEN-112--Office Information Systems	18019	54.00
12/9/2020	VEN-128--Business Card	17999	188.29
12/9/2020	VEN-153--Pacific Gas & Electric	18005	228.21
12/9/2020	VEN-121--Sonoma Garbage Collectors, Inc	18008	234.28
12/9/2020	VEN-141--Murphy, Campbell, Alliston & Quinn	18004	1,462.50
12/9/2020	VEN-110--Alterity Group	17997	508.90
12/9/2020	VEN-123--WM Cleaning of Sonoma	18011	225.00
12/9/2020	VEN-114--Best Best & Krieger	17998	585.00
12/9/2020	VEN-117--Vision Service Plan	18009	2,598.12
12/9/2020	VEN-131--Vista Landscape	18010	330.00
12/9/2020	VEN-106--Comprehensive Drug Testing, Inc	18001	1,099.00
12/9/2020	VEN-171--Shapiro, Galvin, Shaprio & Moran	18007	176.25
12/9/2020	VEN-111--Marsh USA, Inc.	18003	4,609.00
12/16/2020	VEN-109--Delta Dental of California	EFT	18,032.05
12/18/2020	VEN-146--George Hills	EFT	10,583.33
12/29/2020	VEN-109--Delta Dental of California	EFT	27,642.90

Date	Vendor	Check/EFT #	Amount
12/30/2020	VEN-112--Office Information Systems	Voided - 18019	-54.00
12/30/2020	VEN-126--AmWINS	18012	6,987.24
12/30/2020	VEN-111--Marsh USA, Inc.	18018	6,252.00
12/30/2020	VEN-117--Vision Service Plan	18023	11,086.92
12/30/2020	VEN-259--Rugworks	18020	7,233.61
12/30/2020	VEN-103--City of Sonoma-Water	18016	67.36
12/30/2020	VEN-197--Town of Windsor	18022	1,040.00
12/30/2020	VEN-222--York Risk Services Group, Inc.	18025	8,125.00
12/30/2020	VEN-206--Sonoma Valley Pest Control, Inc	18021	75.00
12/30/2020	VEN-120--City of Rohnert Park	18015	33,988.43
12/30/2020	VEN-161--City of Ukiah	18017	1,040.00
12/30/2020	VEN-210--City of Fortuna	18014	1,040.00
12/30/2020	VEN-178--City of Arcata	18013	1,040.00
12/30/2020	VEN-123--WM Cleaning of Sonoma	18024	225.00
Total:			**$3,446,164.68**

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND
Treasurer's Report
As of September 30, 2020

INSTITUTION	COST VALUE	MARKET VALUE	% of Total	Effective Yield
Local Agency Investment Fund (LAIF)	$9,525,518	$9,564,711	31.19%	0.69%
Sonoma County Trust Fund	$244,005	$245,079	0.80%	1.14%
Chandler Asset Management - REMIF Account	$12,264,701	$12,721,105	41.48%	1.86%
Total Investments	**$22,034,224**	**$22,530,895**		
Total Cash with Banks*	$8,136,276	$8,136,276	26.53%	
Petty Cash	$503	$503	0.00%	
TOTAL INVESTMENT & CASH EQUIVALENTS	**$30,171,003**	**$30,667,674**	**100.00%**	

Attached are the Chandler Asset Management, LAIF and Sonoma County Trust Fund statement detailing all investment transactions and balances.

*Cash with Bank is shown based upon reconciled book balance.

This report accurately reflects all cash and investments and is in conformity with California Government Code Section 53646 and REMIF's investment policy. The investment program show herein is sufficient to meet REMIF's expenditure requirement over the next six months.

Respectfully submitted,

Ritesh Sharma
Finance Director

Accepted,

Aaron Felmlee
Treasurer

BETTY T. YEE

California State Controller

LOCAL AGENCY INVESTMENT FUND
REMITTANCE ADVICE

Agency Name: REDWOOD EMPIRE INSURANCE FUND

Account Number: 35-49-001

As of 10/15/2020, your Local Agency Investment Fund account has been directly credited with the interest earned on your deposits for the quarter ending 09/30/2020.

Earnings Ratio		.00002309407394024
Interest Rate		0.84%
Dollar Day Total	$	876,007,090.20
Quarter End Principal Balance	$	9,525,517.60
Quarterly Interest Earned	$	20,230.57

FUND SUMMARY

09/01/20 THROUGH 09/30/20

FUND NUMBER	FUND NAME	BEGINNING BALANCE	TOTAL DEBITS	TOTAL CREDITS	ENDING BALANCE
082120 80040200	LT Disability Clearng TR	.00	.00	.00	.00
082125 80040300	Housing Assistance Progr	640,310.54	29,286.89	.00	669,597.43
082130 80050100	Business Appeals Impound	724,287.78	-261,027.36	.00	463,260.42
082135 80050200	Windsor Redevelopment TR	1,858,986.54	.00	.00	1,858,986.54
082140 80050300	Tax Loss Reserve Trust	17,398,346.60	27,064.19	.00	17,425,410.79
082145 80050400	Auditors Tax Clearing TR	1,437,155.96	169,956.30	.00	1,607,112.26
082150 80050500	Geothermal Impound Trust	.00	.00	.00	.00
082155 80050600	Sebastopol Tax Coll TR	8,674,087.02	3,397.27	.00	8,677,484.29
082160 80050700	Town of Windsor Trust	8,480,577.16	.00	799,012.25	7,681,564.91
082165 80050800	City of Sebastopol Trust	.00	.00	.00	.00
082170 80070100	Tax Collector Trust	-3,732.48	.00	.00	-3,732.48
082171 80071800	Mobile Home Deposit Tr	139,977.49	8,582.00	.00	148,559.49
082174 80071900	Lot Line Adjustment Tr	1,172,957.26	94,700.00	.00	1,267,657.26
082175 80070200	Subdivision Tax Trust	485,916.51	-513,350.00	.00	-27,433.49
082179 80071700	TOT-BIA Clearing Trust	1,014,509.84	-490,389.64	.00	524,120.20
082180 80070300	1911 Clearing Trust	57,302.41	.00	.00	57,302.41
082185 80070400	Collection Officers TR	23,559.71	.00	.00	23,559.71
082190 80070500	Redemption Officers TR	5,374,886.20	1,496,518.04	.00	6,871,404.24
082195 80070600	Transitional Tax Coll TR	2,056,700.78	907,288.63	.00	2,963,989.41
082200 80070700	Spec Assess Inv Earn TR	26,253.10	.00	.00	26,253.10
082205 80080100	Treasurer Holding Trust	21,062.30	.00	.00	21,062.30
082210 80090100	Agricultural Comm Trust	99,094.44	-2,532.27	.00	96,562.17
082215 80100100	Domestic Violence Trust	12,945.34	-11,394.51	.00	1,550.83
082225 80110100	County Counsel I/B Dep	10,318.68	.00	.00	10,318.68
082230 80110200	ERAF Litigation Trust	.00	.00	.00	.00
082235 80120100	DA Donation Trust	9,502.76	.00	.00	9,502.76
082240 80120200	Victim Assistance Trust	49,613.45	-7.62	.00	49,605.83
082245 80120300	JP Revolving Fund	.00	.00	.00	.00
082250 80130100	State Disaster Assistanc	.00	.00	.00	.00
082255 80140100	Public Health Restricted	4,301.04	.00	.00	4,301.04
082260 80140200	Mental Health Restricted	2.39	.00	.00	2.39
082265 80140300	Mental Hlth Crisis Resp	6,309.10	.00	.00	6,309.10
082270 80160100	Welfare Restrictions TR	16,740.93	21.32	.00	16,762.25
082275 80160200	PA/PG/PC Trust	1,884,145.16	.00	.00	1,884,145.16
082285 80270100	NBCLS Equip. Replacemnt	.00	.00	.00	.00
082290 80270200	NBCLS Employee Benefits	.00	.00	.00	.00
082295 80270300	NBCLS Member Libraries	.00	.00	.00	.00
082300 80270400	Office of Communication	169.65	.00	.00	169.65
082305 80270500	Rohnert Park CDA	.00	.00	.00	.00
082310 80270600	Rohnert Park Investment	39,520,176.57	.00	.00	39,520,176.57
082320 80270800	Cloverdale Investment	211,090.60	.00	.00	211,090.60
082325 80270900	REMIF-Cities Ins Invest	244,005.42	.00	.00	244,005.42
082330 80271000	Cotati Investment Trust	419,689.39	.00	.00	419,689.39
082335 80271100	Healdsburg Investment	.00	.00	.00	.00

Redwood Empire Municipal Insurance Fund (REMIF) - Account #10140

MONTHLY ACCOUNT STATEMENT

SEPTEMBER 1, 2020 THROUGH SEPTEMBER 30, 2020

Chandler Team:
For questions about your account, please call (800) 317-4747,
or contact **operations@chandlerasset.com**

Custodian
US Bank
Christopher Isles
(503) 464-3685

CHANDLER ASSET MANAGEMENT
chandlerasset.com

Redwood Empire Municipal Insurance Fund (REMIF)
Account #10140

Portfolio Summary

As of September 30, 2020

PORTFOLIO CHARACTERISTICS

Average Modified Duration	2.51
Average Coupon	1.94%
Average Purchase YTM	1.86%
Average Market YTM	0.28%
Average S&P/Moody Rating	AA/Aa1
Average Final Maturity	2.61 yrs
Average Life	2.58 yrs

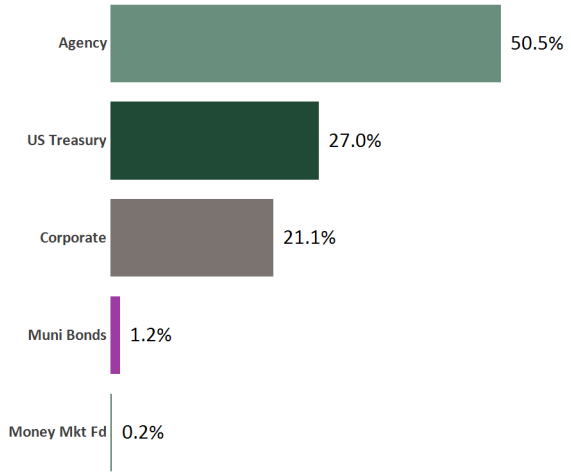
ACCOUNT SUMMARY

	Beg. Values as of 8/31/20	End Values as of 9/30/20
Market Value	12,707,956	12,721,105
Accrued Interest	66,116	54,359
Total Market Value	**12,774,072**	**12,775,464**
Income Earned	20,183	19,749
Cont/WD		-1,277
Par	12,183,165	12,214,681
Book Value	12,230,800	12,264,701
Cost Value	12,230,800	12,264,701

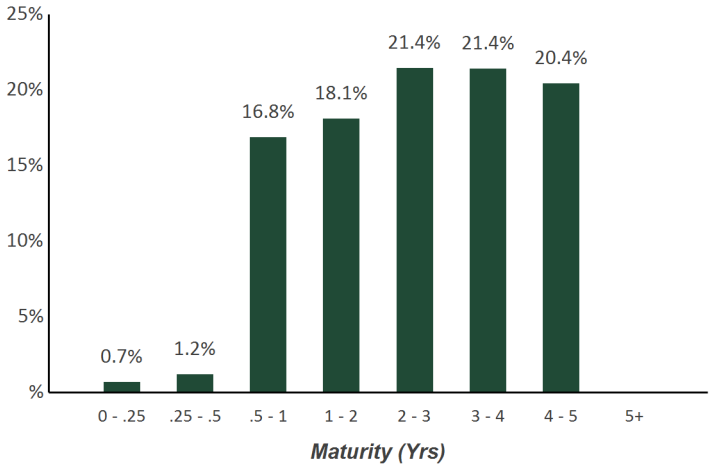
TOP ISSUERS

Government of United States	27.0%
Federal National Mortgage Assoc	24.9%
Federal Home Loan Bank	13.8%
Federal Home Loan Mortgage Corp	11.9%
Paccar Financial	1.4%
Honda Motor Corporation	1.3%
Microsoft	1.3%
Deere & Company	1.3%
Total	**82.9%**

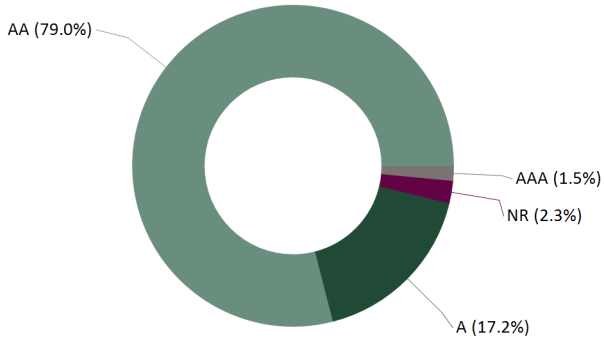
SECTOR ALLOCATION



MATURITY DISTRIBUTION



CREDIT QUALITY (S&P)



PERFORMANCE REVIEW

					Annualized				
TOTAL RATE OF RETURN	**1M**	**3M**	**YTD**	**1YR**	**2YRS**	**3YRS**	**5YRS**	**10YRS**	**12/31/2010**
Redwood Empire Municipal Insurance Fund (REMIF)	0.02%	0.29%	4.20%	4.73%	5.09%	3.27%	2.39%	N/A	2.13%
ICE BAML 1-5 Year US Treasury/Agency Index	0.02%	0.13%	4.20%	4.57%	5.08%	3.17%	2.19%	N/A	1.82%

Statement of Compliance

As of September 30, 2020

Redwood Empire Municipal Insurance Fund - REMIF

Assets managed by Chandler Asset Management are in full compliance with state law and with the investment policy.

Category	Standard	Comment
Treasury Issues	No Limitation	*Complies*
Agency Issues	No Limitation	*Complies*
Local Agency Bonds	California local agencies and national state obligations	*Complies*
Banker's Acceptances	40% maximum; <180 days maturity	*Complies*
Time Deposits	5 years maximum maturity	*Complies*
Negotiable Certificates of Deposit	30% maximum; 5 years maximum maturity	*Complies*
Commercial Paper	25% maximum; <270 days maturity; A-1/P-1/F-1, minimum of two ratings	*Complies*
Medium Term Notes	30% maximum; 5 years maximum maturity; A-rated or better by 2 NRSROs	*Complies*
Money Market Mutual Funds	20% maximum; "AAA" rated or SEC-registered with $500M in assets	*Complies*
Sonoma County Pool	Currently not used by investment adviser	*Complies*
Local Agency Investment Fund - L.A.I.F.	Currently not used by investment adviser	*Complies*
Prohibited Securities	Inverse floaters; Ranges notes, Interest-only strips from mortgaged backed securities; Zero interest accrual securities	*Complies*
Callable Securities	15% maximum	*Complies*
Maximum maturity	5 years	*Complies*

Reconciliation Summary

As of September 30, 2020

BOOK VALUE RECONCILIATION		
BEGINNING BOOK VALUE		**$12,230,800.43**
Acquisition		
+ Security Purchases	$154,533.45	
+ Money Market Fund Purchases	$172,326.75	
+ Money Market Contributions	$0.00	
+ Security Contributions	$0.00	
+ Security Transfers	$0.00	
Total Acquisitions		**$326,860.20**
Dispositions		
- Security Sales	$140,820.31	
- Money Market Fund Sales	$154,533.45	
- MMF Withdrawals	$1,277.27	
- Security Withdrawals	$0.00	
- Security Transfers	$0.00	
- Other Dispositions	$0.00	
- Maturites	$0.00	
- Calls	$0.00	
- Principal Paydowns	$0.00	
Total Dispositions		**$296,631.03**
Amortization/Accretion		
+/- Net Accretion	$0.00	
		$0.00
Gain/Loss on Dispositions		
+/- Realized Gain/Loss	$3,671.41	
		$3,671.41
ENDING BOOK VALUE		**$12,264,701.01**

CASH TRANSACTION SUMMARY		
BEGINNING BALANCE		**$8,165.20**
Acquisition		
Contributions	$0.00	
Security Sale Proceeds	$140,820.31	
Accrued Interest Received	$851.09	
Interest Received	$30,655.27	
Dividend Received	$0.08	
Principal on Maturities	$0.00	
Interest on Maturities	$0.00	
Calls/Redemption (Principal)	$0.00	
Interest from Calls/Redemption	$0.00	
Principal Paydown	$0.00	
Total Acquisitions	**$172,326.75**	
Dispositions		
Withdrawals	$1,277.27	
Security Purchase	$154,533.45	
Accrued Interest Paid	$0.00	
Total Dispositions	**$155,810.72**	
ENDING BOOK VALUE		**$24,681.23**

Holdings Report

As of September 30, 2020

CUSIP	Security Description	Par Value/Units	Purchase Date Book Yield	Cost Value Book Value	Mkt Price Mkt YTM	Market Value Accrued Int.	% of Port. Gain/Loss	Moody/S&P Fitch	Maturity Duration
AGENCY									
3135G0K69	FNMA Note 1.25% Due 5/6/2021	230,000.00	06/29/2016 1.18%	230,782.00 230,782.00	100.66 0.15%	231,514.55 1,157.99	1.82% 732.55	Aaa / AA+ AAA	0.60 0.60
313379RB7	FHLB Note 1.875% Due 6/11/2021	70,000.00	10/17/2017 1.88%	69,993.00 69,993.00	101.21 0.13%	70,849.73 401.04	0.56% 856.73	Aaa / AA+ AAA	0.70 0.69
3135G0U35	FNMA Note 2.75% Due 6/22/2021	160,000.00	06/28/2018 2.70%	160,236.80 160,236.80	101.89 0.15%	163,020.32 1,210.00	1.29% 2,783.52	Aaa / AA+ AAA	0.73 0.72
3130A8QS5	FHLB Note 1.125% Due 7/14/2021	230,000.00	10/04/2016 1.33%	227,874.80 227,874.80	100.79 0.12%	231,817.00 553.44	1.82% 3,942.20	Aaa / AA+ AAA	0.79 0.79
3137EAEC9	FHLMC Note 1.125% Due 8/12/2021	215,000.00	Various 1.29%	213,356.40 213,356.40	100.85 0.15%	216,820.62 329.22	1.70% 3,464.22	Aaa / AA+ AAA	0.87 0.86
3135G0N82	FNMA Note 1.25% Due 8/17/2021	190,000.00	10/04/2016 1.37%	188,972.67 188,972.67	100.98 0.13%	191,864.85 290.28	1.50% 2,892.18	Aaa / AA+ AAA	0.88 0.88
3135G0Q89	FNMA Note 1.375% Due 10/7/2021	60,000.00	10/27/2016 1.50%	59,634.60 59,634.60	101.24 0.16%	60,742.08 398.75	0.48% 1,107.48	Aaa / AA+ AAA	1.02 1.01
3135G0S38	FNMA Note 2% Due 1/5/2022	225,000.00	Various 1.96%	225,389.25 225,389.25	102.38 0.11%	230,363.78 1,075.00	1.81% 4,974.53	Aaa / AA+ AAA	1.27 1.25
3135G0T45	FNMA Note 1.875% Due 4/5/2022	235,000.00	06/19/2017 1.88%	234,964.52 234,964.52	102.63 0.13%	241,188.49 2,154.17	1.90% 6,223.97	Aaa / AA+ AAA	1.51 1.49
3135G0T78	FNMA Note 2% Due 10/5/2022	235,000.00	10/17/2017 2.04%	234,530.00 234,530.00	103.71 0.16%	243,712.86 2,297.78	1.93% 9,182.86	Aaa / AA+ AAA	2.01 1.96
3135G0T94	FNMA Note 2.375% Due 1/19/2023	100,000.00	04/11/2018 2.71%	98,526.00 98,526.00	104.91 0.24%	104,905.30 475.00	0.82% 6,379.30	Aaa / AA+ AAA	2.30 2.24
3137EAER6	FHLMC Note 0.375% Due 5/5/2023	235,000.00	05/05/2020 0.39%	234,901.30 234,901.30	100.43 0.21%	236,008.15 352.50	1.85% 1,106.85	Aaa / AA+ AAA	2.59 2.58
3135G04Q3	FNMA Note 0.25% Due 5/22/2023	235,000.00	05/20/2020 0.35%	234,292.65 234,292.65	100.07 0.22%	235,168.50 210.52	1.84% 875.85	Aaa / AA+ AAA	2.64 2.63
3137EAEN5	FHLMC Note 2.75% Due 6/19/2023	225,000.00	07/20/2018 2.86%	223,870.50 223,870.50	106.76 0.25%	240,210.23 1,753.13	1.89% 16,339.73	Aaa / AA+ AAA	2.72 2.62
3135G05G4	FNMA Note 0.25% Due 7/10/2023	195,000.00	07/08/2020 0.32%	194,580.75 194,580.75	99.98 0.26%	194,959.83 109.69	1.53% 379.08	Aaa / AA+ AAA	2.78 2.76
3137EAEV7	FHLMC Note 0.25% Due 8/24/2023	235,000.00	08/19/2020 0.28%	234,760.30 234,760.30	100.07 0.23%	235,159.33 65.28	1.84% 399.03	Aaa / AA+ AAA	2.90 2.89

Holdings Report

As of September 30, 2020

CUSIP	Security Description	Par Value/Units	Purchase Date Book Yield	Cost Value Book Value	Mkt Price Mkt YTM	Market Value Accrued Int.	% of Port. Gain/Loss	Moody/S&P Fitch	Maturity Duration
AGENCY									
313383YJ4	FHLB Note 3.375% Due 9/8/2023	215,000.00	10/29/2018 3.08%	217,822.95 217,822.95	109.15 0.25%	234,671.64 463.59	1.84% 16,848.69	Aaa / AA+ NR	2.94 2.82
3135G0U43	FNMA Note 2.875% Due 9/12/2023	230,000.00	09/12/2018 2.96%	229,057.00 229,057.00	107.78 0.23%	247,892.39 348.99	1.94% 18,835.39	Aaa / AA+ AAA	2.95 2.85
3130A0F70	FHLB Note 3.375% Due 12/8/2023	225,000.00	Various 2.75%	231,460.50 231,460.50	109.84 0.27%	247,140.00 2,383.59	1.95% 15,679.50	Aaa / AA+ AAA	3.19 3.03
3130A0XE5	FHLB Note 3.25% Due 3/8/2024	200,000.00	03/28/2019 2.27%	209,082.00 209,082.00	110.10 0.30%	220,198.60 415.28	1.73% 11,116.60	Aaa / AA+ NR	3.44 3.28
3130AB3H7	FHLB Note 2.375% Due 3/8/2024	35,000.00	04/29/2019 2.37%	35,002.45 35,002.45	107.06 0.31%	37,469.29 53.11	0.29% 2,466.84	Aaa / AA+ NR	3.44 3.32
3130A1XJ2	FHLB Note 2.875% Due 6/14/2024	225,000.00	06/18/2019 1.96%	234,733.55 234,733.55	109.68 0.25%	246,771.00 1,922.66	1.95% 12,037.45	Aaa / AA+ NR	3.71 3.52
3130A2UW4	FHLB Note 2.875% Due 9/13/2024	200,000.00	09/13/2019 1.79%	210,338.00 210,338.00	110.56 0.19%	221,117.60 287.50	1.73% 10,779.60	Aaa / AA+ AAA	3.96 3.77
3135G0W66	FNMA Note 1.625% Due 10/15/2024	240,000.00	Various 1.17%	244,859.10 244,859.10	105.32 0.30%	252,779.28 1,798.34	1.99% 7,920.18	Aaa / AA+ AAA	4.04 3.90
3135G0X24	FNMA Note 1.625% Due 1/7/2025	240,000.00	Various 1.18%	244,959.90 244,959.90	105.38 0.35%	252,905.52 910.00	1.99% 7,945.62	Aaa / AA+ AAA	4.27 4.12
3137EAEP0	FHLMC Note 1.5% Due 2/12/2025	275,000.00	02/13/2020 1.52%	274,788.25 274,788.25	104.96 0.35%	288,633.68 561.46	2.26% 13,845.43	Aaa / NR AAA	4.37 4.23
3130A4CH3	FHLB Note 2.375% Due 3/14/2025	225,000.00	03/19/2020 1.19%	237,876.75 237,876.75	108.54 0.44%	244,212.75 252.34	1.91% 6,336.00	Aaa / AA+ AAA	4.45 4.25
3135G03U5	FNMA Note 0.625% Due 4/22/2025	215,000.00	04/22/2020 0.67%	214,557.10 214,557.10	101.35 0.33%	217,912.82 586.02	1.71% 3,355.72	Aaa / AA+ AAA	4.56 4.48
3135G04Z3	FNMA Note 0.5% Due 6/17/2025	135,000.00	06/17/2020 0.54%	134,720.55 134,720.55	100.46 0.40%	135,622.49 191.25	1.06% 901.94	Aaa / AA+ AAA	4.72 4.65
3137EAEU9	FHLMC Note 0.375% Due 7/21/2025	145,000.00	07/21/2020 0.48%	144,277.90 144,277.90	100.02 0.37%	145,023.78 102.71	1.14% 745.88	Aaa / AA+ AAA	4.81 4.76
3135G05X7	FNMA Note 0.375% Due 8/25/2025	160,000.00	08/25/2020 0.47%	159,251.20 159,251.20	99.68 0.44%	159,495.84 56.67	1.25% 244.64	Aaa / AA+ AAA	4.90 4.85
3137EAEX3	FHLMC Note 0.375% Due 9/23/2025	155,000.00	09/23/2020 0.44%	154,533.45 154,533.45	99.67 0.44%	154,488.97 9.69	1.21% (44.48)	Aaa / AA+ AAA	4.98 4.93

Holdings Report

As of September 30, 2020

CUSIP	Security Description	Par Value/Units	Purchase Date Book Yield	Cost Value Book Value	Mkt Price Mkt YTM	Market Value Accrued Int.	% of Port. Gain/Loss	Moody/S&P Fitch	Maturity Duration
				6,243,986.19		**6,434,641.27**	**50.55%**	**Aaa / AA+**	**2.89**
Total Agency		**6,195,000.00**	**1.51%**	**6,243,986.19**	**0.25%**	**23,176.99**	**190,655.08**	**AAA**	**2.82**
CORPORATE									
594918BG8	Microsoft Callable Note Cont. 10/3/2020 2% Due 11/3/2020	60,000.00	10/29/2015 2.02%	59,952.00 59,952.00	100.01 1.39%	60,003.00 493.33	0.47% 51.00	Aaa / AAA AA+	0.09 0.01
30231GAV4	Exxon Mobil Corp Callable Note Cont 2/1/2021 2.222% Due 3/1/2021	150,000.00	05/16/2016 1.84%	152,629.50 152,629.50	100.66 0.64%	150,991.65 277.75	1.18% (1,637.85)	Aa1 / AA NR	0.42 0.42
369550BE7	General Dynamics Corp Note 3% Due 5/11/2021	150,000.00	Various 3.25%	148,947.10 148,947.10	101.67 0.27%	152,505.90 1,750.00	1.21% 3,558.80	A2 / A NR	0.61 0.61
857477AV5	State Street Bank Note 1.95% Due 5/19/2021	80,000.00	05/16/2016 1.96%	79,958.40 79,958.40	101.09 0.23%	80,875.52 572.00	0.64% 917.12	A1 / A AA-	0.63 0.63
594918BP8	Microsoft Callable Note Cont 7/8/2021 1.55% Due 8/8/2021	105,000.00	Various 1.57%	104,875.35 104,875.35	101.08 0.15%	106,133.79 239.61	0.83% 1,258.44	Aaa / AAA AA+	0.85 0.77
69371RN44	Paccar Financial Corp Note 1.65% Due 8/11/2021	145,000.00	05/23/2018 3.15%	138,421.35 138,421.35	101.17 0.29%	146,694.33 332.29	1.15% 8,272.98	A1 / A+ NR	0.86 0.86
68389XBK0	Oracle Corp Callable Note Cont 8/15/2021 1.9% Due 9/15/2021	145,000.00	11/29/2016 2.40%	141,753.45 141,753.45	101.42 0.27%	147,066.11 122.44	1.15% 5,312.66	A3 / A A-	0.96 0.87
24422ETL3	John Deere Capital Corp Note 2.65% Due 1/6/2022	160,000.00	01/03/2017 2.66%	159,955.20 159,955.20	102.89 0.36%	164,618.08 1,001.11	1.30% 4,662.88	A2 / A A	1.27 1.25
89236TDP7	Toyota Motor Credit Corp Note 2.6% Due 1/11/2022	145,000.00	03/14/2018 3.04%	142,711.98 142,711.98	102.94 0.30%	149,262.42 837.78	1.17% 6,550.44	A1 / A+ A+	1.28 1.26
91159HHP8	US Bancorp Callable Note Cont 12/23/2021 2.625% Due 1/24/2022	70,000.00	01/19/2017 2.66%	69,879.60 69,879.60	102.83 0.32%	71,980.51 341.98	0.57% 2,100.91	A1 / A+ A+	1.32 1.21
44932HAC7	IBM Credit Corp Note 2.2% Due 9/8/2022	150,000.00	11/29/2017 2.58%	147,462.00 147,462.00	103.84 0.22%	155,755.05 210.83	1.22% 8,293.05	A2 / A NR	1.94 1.91
48128BAB7	JP Morgan Chase & Co Callable Note 1X 1/15/2022 2.972% Due 1/15/2023	125,000.00	02/09/2018 3.19%	123,793.75 123,793.75	103.26 0.44%	129,077.38 784.28	1.02% 5,283.63	A2 / A- AA-	2.29 1.27

Holdings Report

As of September 30, 2020

CUSIP	Security Description	Par Value/Units	Purchase Date Book Yield	Cost Value Book Value	Mkt Price Mkt YTM	Market Value Accrued Int.	% of Port. Gain/Loss	Moody/S&P Fitch	Maturity Duration
CORPORATE									
084670BR8	Berkshire Hathaway Callable Note Cont 1/15/2023 2.75% Due 3/15/2023	100,000.00	11/26/2018 3.51%	97,009.00 97,009.00	105.34 0.41%	105,339.20 122.22	0.83% 8,330.20	Aa2 / AA A+	2.45 2.23
037833AK6	Apple Inc Note 2.4% Due 5/3/2023	60,000.00	11/28/2018 3.54%	57,227.40 57,227.40	105.29 0.35%	63,172.62 592.00	0.50% 5,945.22	Aa1 / AA+ NR	2.59 2.50
02665WCJ8	American Honda Finance Note 3.45% Due 7/14/2023	45,000.00	07/11/2018 3.49%	44,922.15 44,922.15	107.81 0.62%	48,514.95 332.06	0.38% 3,592.80	A3 / A- NR	2.79 2.66
06406RAJ6	Bank of NY Mellon Corp Note 3.45% Due 8/11/2023	150,000.00	05/16/2019 2.79%	153,945.00 153,945.00	108.63 0.42%	162,937.95 718.75	1.28% 8,992.95	A1 / A AA-	2.86 2.74
02665WCQ2	American Honda Finance Note 3.625% Due 10/10/2023	110,000.00	10/03/2018 3.64%	109,909.80 109,909.80	108.91 0.65%	119,801.77 1,894.06	0.95% 9,891.97	A3 / A- NR	3.03 2.85
06051GHF9	Bank of America Corp Callable Note 1X 3/5/2023 3.55% Due 3/5/2024	145,000.00	03/06/2019 3.01%	145,594.50 145,594.50	106.50 0.84%	154,419.20 371.76	1.21% 8,824.70	A2 / A- A+	3.43 2.34
89114QCB2	Toronto Dominion Bank Note 3.25% Due 3/11/2024	145,000.00	03/26/2019 2.97%	146,835.70 146,835.70	108.41 0.77%	157,189.43 261.81	1.23% 10,353.73	Aa3 / A AA-	3.45 3.28
69371RQ25	Paccar Financial Corp Note 2.15% Due 8/15/2024	30,000.00	08/08/2019 2.20%	29,933.70 29,933.70	105.66 0.67%	31,697.73 82.42	0.25% 1,764.03	A1 / A+ NR	3.88 3.72
78015K7C2	Royal Bank of Canada Note 2.25% Due 11/1/2024	150,000.00	12/05/2019 2.26%	149,922.00 149,922.00	106.00 0.76%	158,997.75 1,406.25	1.26% 9,075.75	A2 / A AA	4.09 3.88
14913Q3B3	Caterpillar Finl Service Note 2.15% Due 11/8/2024	150,000.00	01/28/2020 1.91%	151,605.00 151,605.00	106.34 0.59%	159,508.65 1,281.04	1.26% 7,903.65	A3 / A A	4.11 3.91
Total Corporate		**2,570,000.00**	**2.70%**	**2,557,243.93** **2,557,243.93**	**0.48%**	**2,676,542.99** **14,025.77**	**21.06%** **119,299.06**	**A1 / A+** **A+**	**2.07** **1.88**
MONEY MARKET FUND FI									
31846V203	First American Govt Obligation Fund Class Y	24,681.23	Various 0.01%	24,681.23 24,681.23	1.00 0.01%	24,681.23 0.00	0.19% 0.00	Aaa / AAA AAA	0.00 0.00
Total Money Market Fund FI		**24,681.23**	**0.01%**	**24,681.23** **24,681.23**	**0.01%**	**24,681.23** **0.00**	**0.19%** **0.00**	**Aaa / AAA** **AAA**	**0.00** **0.00**

Holdings Report

As of September 30, 2020

CUSIP	Security Description	Par Value/Units	Purchase Date Book Yield	Cost Value Book Value	Mkt Price Mkt YTM	Market Value Accrued Int.	% of Port. Gain/Loss	Moody/S&P Fitch	Maturity Duration
MUNICIPAL BONDS									
13063DRK6	California St Taxable GO 2.4% Due 10/1/2024	145,000.00	10/16/2019 1.91%	148,330.65 148,330.65	106.99 0.63%	155,138.40 1,740.00	1.23% 6,807.75	Aa2 / AA- AA	4.01 3.79
Total Municipal Bonds		**145,000.00**	**1.91%**	**148,330.65** **148,330.65**	**0.63%**	**155,138.40** **1,740.00**	**1.23%** **6,807.75**	**Aa2 / AA-** **AA**	**4.01** **3.79**
US TREASURY									
912828S27	US Treasury Note 1.125% Due 6/30/2021	165,000.00	12/13/2016 1.87%	159,676.72 159,676.72	100.75 0.12%	166,237.50 469.11	1.30% 6,560.78	Aaa / AA+ AAA	0.75 0.75
912828T34	US Treasury Note 1.125% Due 9/30/2021	235,000.00	11/09/2016 1.48%	231,025.99 231,025.99	100.98 0.15%	237,295.01 7.26	1.86% 6,269.02	Aaa / AA+ AAA	1.00 1.00
912828F96	US Treasury Note 2% Due 10/31/2021	245,000.00	08/15/2017 1.73%	247,642.23 247,642.23	102.01 0.15%	249,919.11 2,050.54	1.97% 2,276.88	Aaa / AA+ AAA	1.08 1.07
912828G87	US Treasury Note 2.125% Due 12/31/2021	245,000.00	08/15/2017 1.75%	248,809.81 248,809.81	102.48 0.14%	251,067.67 1,315.71	1.98% 2,257.86	Aaa / AA+ AAA	1.25 1.23
912828J43	US Treasury Note 1.75% Due 2/28/2022	245,000.00	03/13/2017 2.14%	240,569.77 240,569.77	102.29 0.13%	250,608.30 367.16	1.96% 10,038.53	Aaa / AA+ AAA	1.41 1.40
912828XG0	US Treasury Note 2.125% Due 6/30/2022	210,000.00	07/31/2017 1.84%	212,789.77 212,789.77	103.48 0.13%	217,309.05 1,127.75	1.71% 4,519.28	Aaa / AA+ AAA	1.75 1.72
912828L57	US Treasury Note 1.75% Due 9/30/2022	250,000.00	10/17/2017 1.99%	247,226.56 247,226.56	103.23 0.13%	258,086.00 12.02	2.02% 10,859.44	Aaa / AA+ AAA	2.00 1.97
912828N30	US Treasury Note 2.125% Due 12/31/2022	235,000.00	01/25/2018 2.46%	231,346.48 231,346.48	104.47 0.14%	245,501.68 1,262.01	1.93% 14,155.20	Aaa / AA+ AAA	2.25 2.20
912828T91	US Treasury Note 1.625% Due 10/31/2023	235,000.00	04/29/2019 2.31%	228,161.13 228,161.13	104.52 0.16%	245,620.83 1,598.06	1.94% 17,459.70	Aaa / AA+ AAA	3.08 3.00
912828B66	US Treasury Note 2.75% Due 2/15/2024	235,000.00	04/29/2019 2.31%	239,644.92 239,644.92	108.68 0.17%	255,388.13 825.37	2.01% 15,743.21	Aaa / AA+ AAA	3.38 3.24
912828X70	US Treasury Note 2% Due 4/30/2024	245,000.00	Various 1.58%	249,631.05 249,631.05	106.47 0.19%	260,848.56 2,050.54	2.06% 11,217.51	Aaa / AA+ AAA	3.58 3.45
912828XX3	US Treasury Note 2% Due 6/30/2024	250,000.00	12/12/2019 1.74%	252,861.33 252,861.33	106.74 0.19%	266,855.50 1,263.59	2.10% 13,994.17	Aaa / AA+ AAA	3.75 3.62

Holdings Report

As of September 30, 2020

CUSIP	Security Description	Par Value/Units	Purchase Date Book Yield	Cost Value Book Value	Mkt Price Mkt YTM	Market Value Accrued Int.	% of Port. Gain/Loss	Moody/S&P Fitch	Maturity Duration
US TREASURY									
912828D56	US Treasury Note 2.375% Due 8/15/2024	235,000.00	08/29/2019 1.45%	245,418.95 245,418.95	108.38 0.20%	254,690.42 712.82	2.00% 9,271.47	Aaa / AA+ AAA	3.88 3.72
9128283D0	US Treasury Note 2.25% Due 10/31/2024	250,000.00	11/07/2019 1.77%	255,654.30 255,654.30	108.27 0.22%	270,673.75 2,353.94	2.14% 15,019.45	Aaa / AA+ AAA	4.09 3.89
Total US Treasury		**3,280,000.00**	**1.88%**	**3,290,459.01** **3,290,459.01**	**0.16%**	**3,430,101.51** **15,415.88**	**26.97%** **139,642.50**	**Aaa / AA+** **AAA**	**2.45** **2.37**
TOTAL PORTFOLIO		**12,214,681.23**	**1.86%**	**12,264,701.01** **12,264,701.01**	**0.28%**	**12,721,105.40** **54,358.64**	**100.00%** **456,404.39**	**Aa1 / AA** **AAA**	**2.61** **2.51**
TOTAL MARKET VALUE PLUS ACCRUED						**12,775,464.04**			

Transaction Ledger

As of September 30, 2020

Transaction Type	Settlement Date	CUSIP	Quantity	Security Description	Price	Acq/Disp Yield	Amount	Interest Pur/Sold	Total Amount	Gain/Loss
ACQUISITIONS										
Purchase	09/01/2020	31846V203	1,666.50	First American Govt Obligation Fund Class Y	1.000	0.01%	1,666.50	0.00	1,666.50	0.00
Purchase	09/01/2020	31846V203	0.08	First American Govt Obligation Fund Class Y	1.000	0.01%	0.08	0.00	0.08	0.00
Purchase	09/05/2020	31846V203	2,573.75	First American Govt Obligation Fund Class Y	1.000	0.01%	2,573.75	0.00	2,573.75	0.00
Purchase	09/08/2020	31846V203	8,943.76	First American Govt Obligation Fund Class Y	1.000	0.01%	8,943.76	0.00	8,943.76	0.00
Purchase	09/11/2020	31846V203	2,356.25	First American Govt Obligation Fund Class Y	1.000	0.01%	2,356.25	0.00	2,356.25	0.00
Purchase	09/12/2020	31846V203	3,306.25	First American Govt Obligation Fund Class Y	1.000	0.01%	3,306.25	0.00	3,306.25	0.00
Purchase	09/13/2020	31846V203	2,875.00	First American Govt Obligation Fund Class Y	1.000	0.01%	2,875.00	0.00	2,875.00	0.00
Purchase	09/14/2020	31846V203	2,671.88	First American Govt Obligation Fund Class Y	1.000	0.01%	2,671.88	0.00	2,671.88	0.00
Purchase	09/15/2020	31846V203	2,752.50	First American Govt Obligation Fund Class Y	1.000	0.01%	2,752.50	0.00	2,752.50	0.00
Purchase	09/25/2020	3137EAEX3	155,000.00	FHLMC Note 0.375% Due 9/23/2025	99.699	0.44%	154,533.45	0.00	154,533.45	0.00
Purchase	09/25/2020	31846V203	141,671.40	First American Govt Obligation Fund Class Y	1.000	0.01%	141,671.40	0.00	141,671.40	0.00
Purchase	09/30/2020	31846V203	3,509.38	First American Govt Obligation Fund Class Y	1.000	0.01%	3,509.38	0.00	3,509.38	0.00
Subtotal			**327,326.75**				**326,860.20**	**0.00**	**326,860.20**	**0.00**
Short Sale	09/25/2020	31846V203	-154,533.45	First American Govt Obligation Fund Class Y	1.000		-154,533.45	0.00	-154,533.45	0.00
Subtotal			**-154,533.45**				**-154,533.45**	**0.00**	**-154,533.45**	**0.00**
TOTAL ACQUISITIONS			**172,793.30**				**172,326.75**	**0.00**	**172,326.75**	**0.00**

Transaction Ledger

As of September 30, 2020

Transaction Type	Settlement Date	CUSIP	Quantity	Security Description	Price	Acq/Disp Yield	Amount	Interest Pur/Sold	Total Amount	Gain/Loss
DISPOSITIONS										
Closing Purchase	09/25/2020	31846V203	-154,533.45	First American Govt Obligation Fund Class Y	1.000		-154,533.45	0.00	-154,533.45	0.00
Subtotal			**-154,533.45**				**-154,533.45**	**0.00**	**-154,533.45**	**0.00**
Sale	09/25/2020	31846V203	154,533.45	First American Govt Obligation Fund Class Y	1.000	0.01%	154,533.45	0.00	154,533.45	0.00
Sale	09/25/2020	912828Q37	140,000.00	US Treasury Note 1.25% Due 3/31/2021	100.586	0.11%	140,820.31	851.09	141,671.40	3,671.41
Subtotal			**294,533.45**				**295,353.76**	**851.09**	**296,204.85**	**3,671.41**
Security Withdrawal	09/03/2020	31846V203	1,277.27	First American Govt Obligation Fund Class Y	1.000		1,277.27	0.00	1,277.27	0.00
Subtotal			**1,277.27**				**1,277.27**	**0.00**	**1,277.27**	**0.00**
TOTAL DISPOSITIONS			**141,277.27**				**142,097.58**	**851.09**	**142,948.67**	**3,671.41**
OTHER TRANSACTIONS										
Interest	09/01/2020	30231GAV4	150,000.00	Exxon Mobil Corp Callable Note Cont 2/1/2021 2.222% Due 3/1/2021	0.000		1,666.50	0.00	1,666.50	0.00
Interest	09/05/2020	06051GHF9	145,000.00	Bank of America Corp Callable Note 1X 3/5/2023 3.55% Due 3/5/2024	0.000		2,573.75	0.00	2,573.75	0.00
Interest	09/08/2020	3130A0XE5	200,000.00	FHLB Note 3.25% Due 3/8/2024	0.000		3,250.00	0.00	3,250.00	0.00
Interest	09/08/2020	3130AB3H7	35,000.00	FHLB Note 2.375% Due 3/8/2024	0.000		415.63	0.00	415.63	0.00
Interest	09/08/2020	313383YJ4	215,000.00	FHLB Note 3.375% Due 9/8/2023	0.000		3,628.13	0.00	3,628.13	0.00
Interest	09/08/2020	44932HAC7	150,000.00	IBM Credit Corp Note 2.2% Due 9/8/2022	0.000		1,650.00	0.00	1,650.00	0.00

Transaction Ledger

As of September 30, 2020

Transaction Type	Settlement Date	CUSIP	Quantity	Security Description	Price	Acq/Disp Yield	Amount	Interest Pur/Sold	Total Amount	Gain/Loss
OTHER TRANSACTIONS										
Interest	09/11/2020	89114QCB2	145,000.00	Toronto Dominion Bank Note 3.25% Due 3/11/2024	0.000		2,356.25	0.00	2,356.25	0.00
Interest	09/12/2020	3135G0U43	230,000.00	FNMA Note 2.875% Due 9/12/2023	0.000		3,306.25	0.00	3,306.25	0.00
Interest	09/13/2020	3130A2UW4	200,000.00	FHLB Note 2.875% Due 9/13/2024	0.000		2,875.00	0.00	2,875.00	0.00
Interest	09/14/2020	3130A4CH3	225,000.00	FHLB Note 2.375% Due 3/14/2025	0.000		2,671.88	0.00	2,671.88	0.00
Interest	09/15/2020	084670BR8	100,000.00	Berkshire Hathaway Callable Note Cont 1/15/2023 2.75% Due 3/15/2023	0.000		1,375.00	0.00	1,375.00	0.00
Interest	09/15/2020	68389XBK0	145,000.00	Oracle Corp Callable Note Cont 8/15/2021 1.9% Due 9/15/2021	0.000		1,377.50	0.00	1,377.50	0.00
Interest	09/30/2020	912828L57	250,000.00	US Treasury Note 1.75% Due 9/30/2022	0.000		2,187.50	0.00	2,187.50	0.00
Interest	09/30/2020	912828T34	235,000.00	US Treasury Note 1.125% Due 9/30/2021	0.000		1,321.88	0.00	1,321.88	0.00
Subtotal			**2,425,000.00**				**30,655.27**	**0.00**	**30,655.27**	**0.00**
Dividend	09/01/2020	31846V203	9,831.70	First American Govt Obligation Fund Class Y	0.000		0.08	0.00	0.08	0.00
Subtotal			**9,831.70**				**0.08**	**0.00**	**0.08**	**0.00**
TOTAL OTHER TRANSACTIONS			**2,434,831.70**				**30,655.35**	**0.00**	**30,655.35**	**0.00**

Income Earned

As of September 30, 2020

CUSIP	Security Description	Trade Date Settle Date Units	Book Value: Begin Book Value: Acq Book Value: Disp Book Value: End	Prior Accrued Inc. Received Ending Accrued Total Interest	Accr. Of Discount Amort. Of Premium Net Accret/Amort Income Earned	Total Income
FIXED INCOME						
02665WCJ8	American Honda Finance Note 3.45% Due 07/14/2023	07/11/2018 07/16/2018 45,000.00	44,922.15 0.00 0.00 44,922.15	202.69 0.00 332.06 129.37	0.00 0.00 0.00 129.37	129.37
02665WCQ2	American Honda Finance Note 3.625% Due 10/10/2023	10/03/2018 10/10/2018 110,000.00	109,909.80 0.00 0.00 109,909.80	1,561.77 0.00 1,894.06 332.29	0.00 0.00 0.00 332.29	332.29
037833AK6	Apple Inc Note 2.4% Due 05/03/2023	11/28/2018 11/30/2018 60,000.00	57,227.40 0.00 0.00 57,227.40	472.00 0.00 592.00 120.00	0.00 0.00 0.00 120.00	120.00
06051GHF9	Bank of America Corp Callable Note 1X 3/5/2023 3.55% Due 03/05/2024	03/06/2019 03/08/2019 145,000.00	145,594.50 0.00 0.00 145,594.50	2,516.56 2,573.75 371.76 428.95	0.00 0.00 0.00 428.95	428.95
06406RAJ6	Bank of NY Mellon Corp Note 3.45% Due 08/11/2023	05/16/2019 05/20/2019 150,000.00	153,945.00 0.00 0.00 153,945.00	287.50 0.00 718.75 431.25	0.00 0.00 0.00 431.25	431.25
084670BR8	Berkshire Hathaway Callable Note Cont 1/15/2023 2.75% Due 03/15/2023	11/26/2018 11/28/2018 100,000.00	97,009.00 0.00 0.00 97,009.00	1,268.06 1,375.00 122.22 229.16	0.00 0.00 0.00 229.16	229.16
13063DRK6	California St Taxable GO 2.4% Due 10/01/2024	10/16/2019 10/24/2019 145,000.00	148,330.65 0.00 0.00 148,330.65	1,450.00 0.00 1,740.00 290.00	0.00 0.00 0.00 290.00	290.00
14913Q3B3	Caterpillar Finl Service Note 2.15% Due 11/08/2024	01/28/2020 01/30/2020 150,000.00	151,605.00 0.00 0.00 151,605.00	1,012.29 0.00 1,281.04 268.75	0.00 0.00 0.00 268.75	268.75
24422ETL3	John Deere Capital Corp Note 2.65% Due 01/06/2022	01/03/2017 01/06/2017 160,000.00	159,955.20 0.00 0.00 159,955.20	647.78 0.00 1,001.11 353.33	0.00 0.00 0.00 353.33	353.33

Income Earned

As of September 30, 2020

CUSIP	Security Description	Trade Date Settle Date Units	Book Value: Begin Book Value: Acq Book Value: Disp Book Value: End	Prior Accrued Inc. Received Ending Accrued Total Interest	Accr. Of Discount Amort. Of Premium Net Accret/Amort Income Earned	Total Income
30231GAV4	Exxon Mobil Corp Callable Note Cont 2/1/2021 2.222% Due 03/01/2021	05/16/2016 05/19/2016 150,000.00	152,629.50 0.00 0.00 152,629.50	1,666.50 1,666.50 277.75 277.75	0.00 0.00 0.00 277.75	277.75
3130A0F70	FHLB Note 3.375% Due 12/08/2023	Various Various 225,000.00	231,460.50 0.00 0.00 231,460.50	1,750.78 0.00 2,383.59 632.81	0.00 0.00 0.00 632.81	632.81
3130A0XE5	FHLB Note 3.25% Due 03/08/2024	03/28/2019 03/29/2019 200,000.00	209,082.00 0.00 0.00 209,082.00	3,123.61 3,250.00 415.28 541.67	0.00 0.00 0.00 541.67	541.67
3130A1XJ2	FHLB Note 2.875% Due 06/14/2024	06/18/2019 06/19/2019 225,000.00	234,733.55 0.00 0.00 234,733.55	1,383.59 0.00 1,922.66 539.07	0.00 0.00 0.00 539.07	539.07
3130A2UW4	FHLB Note 2.875% Due 09/13/2024	09/13/2019 09/16/2019 200,000.00	210,338.00 0.00 0.00 210,338.00	2,683.33 2,875.00 287.50 479.17	0.00 0.00 0.00 479.17	479.17
3130A4CH3	FHLB Note 2.375% Due 03/14/2025	03/19/2020 03/23/2020 225,000.00	237,876.75 0.00 0.00 237,876.75	2,478.91 2,671.88 252.34 445.31	0.00 0.00 0.00 445.31	445.31
3130A8QS5	FHLB Note 1.125% Due 07/14/2021	10/04/2016 10/06/2016 230,000.00	227,874.80 0.00 0.00 227,874.80	337.81 0.00 553.44 215.63	0.00 0.00 0.00 215.63	215.63
3130AB3H7	FHLB Note 2.375% Due 03/08/2024	04/29/2019 04/30/2019 35,000.00	35,002.45 0.00 0.00 35,002.45	399.46 415.63 53.11 69.28	0.00 0.00 0.00 69.28	69.28
313379RB7	FHLB Note 1.875% Due 06/11/2021	10/17/2017 10/18/2017 70,000.00	69,993.00 0.00 0.00 69,993.00	291.67 0.00 401.04 109.37	0.00 0.00 0.00 109.37	109.37

Income Earned

As of September 30, 2020

CUSIP	Security Description	Trade Date Settle Date Units	Book Value: Begin Book Value: Acq Book Value: Disp Book Value: End	Prior Accrued Inc. Received Ending Accrued Total Interest	Accr. Of Discount Amort. Of Premium Net Accret/Amort Income Earned	Total Income
313383YJ4	FHLB Note 3.375% Due 09/08/2023	10/29/2018 10/31/2018 215,000.00	217,822.95 0.00 0.00 217,822.95	3,487.03 3,628.13 463.59 604.69	0.00 0.00 0.00 604.69	604.69
3135G03U5	FNMA Note 0.625% Due 04/22/2025	04/22/2020 04/24/2020 215,000.00	214,557.10 0.00 0.00 214,557.10	474.05 0.00 586.02 111.97	0.00 0.00 0.00 111.97	111.97
3135G04Q3	FNMA Note 0.25% Due 05/22/2023	05/20/2020 05/22/2020 235,000.00	234,292.65 0.00 0.00 234,292.65	161.56 0.00 210.52 48.96	0.00 0.00 0.00 48.96	48.96
3135G04Z3	FNMA Note 0.5% Due 06/17/2025	06/17/2020 06/19/2020 135,000.00	134,720.55 0.00 0.00 134,720.55	135.00 0.00 191.25 56.25	0.00 0.00 0.00 56.25	56.25
3135G05G4	FNMA Note 0.25% Due 07/10/2023	07/08/2020 07/10/2020 195,000.00	194,580.75 0.00 0.00 194,580.75	69.06 0.00 109.69 40.63	0.00 0.00 0.00 40.63	40.63
3135G05X7	FNMA Note 0.375% Due 08/25/2025	08/25/2020 08/27/2020 160,000.00	159,251.20 0.00 0.00 159,251.20	6.67 0.00 56.67 50.00	0.00 0.00 0.00 50.00	50.00
3135G0K69	FNMA Note 1.25% Due 05/06/2021	06/29/2016 06/30/2016 230,000.00	230,782.00 0.00 0.00 230,782.00	918.40 0.00 1,157.99 239.59	0.00 0.00 0.00 239.59	239.59
3135G0N82	FNMA Note 1.25% Due 08/17/2021	10/04/2016 10/06/2016 190,000.00	188,972.67 0.00 0.00 188,972.67	92.36 0.00 290.28 197.92	0.00 0.00 0.00 197.92	197.92
3135G0Q89	FNMA Note 1.375% Due 10/07/2021	10/27/2016 10/28/2016 60,000.00	59,634.60 0.00 0.00 59,634.60	330.00 0.00 398.75 68.75	0.00 0.00 0.00 68.75	68.75

Income Earned

As of September 30, 2020

CUSIP	Security Description	Trade Date Settle Date Units	Book Value: Begin Book Value: Acq Book Value: Disp Book Value: End	Prior Accrued Inc. Received Ending Accrued Total Interest	Accr. Of Discount Amort. Of Premium Net Accret/Amort Income Earned	Total Income
3135G0S38	FNMA Note 2% Due 01/05/2022	Various Various 225,000.00	225,389.25 0.00 0.00 225,389.25	700.00 0.00 1,075.00 375.00	0.00 0.00 0.00 375.00	375.00
3135G0T45	FNMA Note 1.875% Due 04/05/2022	06/19/2017 06/20/2017 235,000.00	234,964.52 0.00 0.00 234,964.52	1,786.98 0.00 2,154.17 367.19	0.00 0.00 0.00 367.19	367.19
3135G0T78	FNMA Note 2% Due 10/05/2022	10/17/2017 10/18/2017 235,000.00	234,530.00 0.00 0.00 234,530.00	1,906.11 0.00 2,297.78 391.67	0.00 0.00 0.00 391.67	391.67
3135G0T94	FNMA Note 2.375% Due 01/19/2023	04/11/2018 04/12/2018 100,000.00	98,526.00 0.00 0.00 98,526.00	277.08 0.00 475.00 197.92	0.00 0.00 0.00 197.92	197.92
3135G0U35	FNMA Note 2.75% Due 06/22/2021	06/28/2018 06/29/2018 160,000.00	160,236.80 0.00 0.00 160,236.80	843.33 0.00 1,210.00 366.67	0.00 0.00 0.00 366.67	366.67
3135G0U43	FNMA Note 2.875% Due 09/12/2023	09/12/2018 09/14/2018 230,000.00	229,057.00 0.00 0.00 229,057.00	3,104.20 3,306.25 348.99 551.04	0.00 0.00 0.00 551.04	551.04
3135G0W66	FNMA Note 1.625% Due 10/15/2024	Various Various 240,000.00	244,859.10 0.00 0.00 244,859.10	1,473.33 0.00 1,798.34 325.01	0.00 0.00 0.00 325.01	325.01
3135G0X24	FNMA Note 1.625% Due 01/07/2025	Various Various 240,000.00	244,959.90 0.00 0.00 244,959.90	585.01 0.00 910.00 324.99	0.00 0.00 0.00 324.99	324.99
3137EAEC9	FHLMC Note 1.125% Due 08/12/2021	Various Various 215,000.00	213,356.40 0.00 0.00 213,356.40	127.66 0.00 329.22 201.56	0.00 0.00 0.00 201.56	201.56

Income Earned

As of September 30, 2020

CUSIP	Security Description	Trade Date Settle Date Units	Book Value: Begin Book Value: Acq Book Value: Disp Book Value: End	Prior Accrued Inc. Received Ending Accrued Total Interest	Accr. Of Discount Amort. Of Premium Net Accret/Amort Income Earned	Total Income
3137EAEN5	FHLMC Note 2.75% Due 06/19/2023	07/20/2018 07/23/2018 225,000.00	223,870.50 0.00 0.00 223,870.50	1,237.50 0.00 1,753.13 515.63	0.00 0.00 0.00 515.63	515.63
3137EAEP0	FHLMC Note 1.5% Due 02/12/2025	02/13/2020 02/14/2020 275,000.00	274,788.25 0.00 0.00 274,788.25	217.71 0.00 561.46 343.75	0.00 0.00 0.00 343.75	343.75
3137EAER6	FHLMC Note 0.375% Due 05/05/2023	05/05/2020 05/07/2020 235,000.00	234,901.30 0.00 0.00 234,901.30	279.06 0.00 352.50 73.44	0.00 0.00 0.00 73.44	73.44
3137EAEU9	FHLMC Note 0.375% Due 07/21/2025	07/21/2020 07/23/2020 145,000.00	144,277.90 0.00 0.00 144,277.90	57.40 0.00 102.71 45.31	0.00 0.00 0.00 45.31	45.31
3137EAEV7	FHLMC Note 0.25% Due 08/24/2023	08/19/2020 08/21/2020 235,000.00	234,760.30 0.00 0.00 234,760.30	16.32 0.00 65.28 48.96	0.00 0.00 0.00 48.96	48.96
3137EAEX3	FHLMC Note 0.375% Due 09/23/2025	09/23/2020 09/25/2020 155,000.00	0.00 154,533.45 0.00 154,533.45	0.00 0.00 9.69 9.69	0.00 0.00 0.00 9.69	9.69
369550BE7	General Dynamics Corp Note 3% Due 05/11/2021	Various Various 150,000.00	148,947.10 0.00 0.00 148,947.10	1,375.00 0.00 1,750.00 375.00	0.00 0.00 0.00 375.00	375.00
44932HAC7	IBM Credit Corp Note 2.2% Due 09/08/2022	11/29/2017 12/01/2017 150,000.00	147,462.00 0.00 0.00 147,462.00	1,585.83 1,650.00 210.83 275.00	0.00 0.00 0.00 275.00	275.00
48128BAB7	JP Morgan Chase & Co Callable Note 1X 1/15/2022 2.972% Due 01/15/2023	02/09/2018 02/13/2018 125,000.00	123,793.75 0.00 0.00 123,793.75	474.69 0.00 784.28 309.59	0.00 0.00 0.00 309.59	309.59

Income Earned

As of September 30, 2020

CUSIP	Security Description	Trade Date Settle Date Units	Book Value: Begin Book Value: Acq Book Value: Disp Book Value: End	Prior Accrued Inc. Received Ending Accrued Total Interest	Accr. Of Discount Amort. Of Premium Net Accret/Amort Income Earned	Total Income
594918BG8	Microsoft Callable Note Cont. 10/3/2020 2% Due 11/03/2020	10/29/2015 11/03/2015 60,000.00	59,952.00 0.00 0.00 59,952.00	393.33 0.00 493.33 100.00	0.00 0.00 0.00 100.00	100.00
594918BP8	Microsoft Callable Note Cont 7/8/2021 1.55% Due 08/08/2021	Various 08/08/2016 105,000.00	104,875.35 0.00 0.00 104,875.35	103.98 0.00 239.61 135.63	0.00 0.00 0.00 135.63	135.63
68389XBK0	Oracle Corp Callable Note Cont 8/15/2021 1.9% Due 09/15/2021	11/29/2016 12/02/2016 145,000.00	141,753.45 0.00 0.00 141,753.45	1,270.36 1,377.50 122.44 229.58	0.00 0.00 0.00 229.58	229.58
69371RN44	Paccar Financial Corp Note 1.65% Due 08/11/2021	05/23/2018 05/25/2018 145,000.00	138,421.35 0.00 0.00 138,421.35	132.92 0.00 332.29 199.37	0.00 0.00 0.00 199.37	199.37
69371RQ25	Paccar Financial Corp Note 2.15% Due 08/15/2024	08/08/2019 08/15/2019 30,000.00	29,933.70 0.00 0.00 29,933.70	28.67 0.00 82.42 53.75	0.00 0.00 0.00 53.75	53.75
78015K7C2	Royal Bank of Canada Note 2.25% Due 11/01/2024	12/05/2019 12/09/2019 150,000.00	149,922.00 0.00 0.00 149,922.00	1,125.00 0.00 1,406.25 281.25	0.00 0.00 0.00 281.25	281.25
857477AV5	State Street Bank Note 1.95% Due 05/19/2021	05/16/2016 05/19/2016 80,000.00	79,958.40 0.00 0.00 79,958.40	442.00 0.00 572.00 130.00	0.00 0.00 0.00 130.00	130.00
89114QCB2	Toronto Dominion Bank Note 3.25% Due 03/11/2024	03/26/2019 03/28/2019 145,000.00	146,835.70 0.00 0.00 146,835.70	2,225.35 2,356.25 261.81 392.71	0.00 0.00 0.00 392.71	392.71
89236TDP7	Toyota Motor Credit Corp Note 2.6% Due 01/11/2022	03/14/2018 03/16/2018 145,000.00	142,711.98 0.00 0.00 142,711.98	523.61 0.00 837.78 314.17	0.00 0.00 0.00 314.17	314.17

Income Earned

As of September 30, 2020

CUSIP	Security Description	Trade Date Settle Date Units	Book Value: Begin Book Value: Acq Book Value: Disp Book Value: End	Prior Accrued Inc. Received Ending Accrued Total Interest	Accr. Of Discount Amort. Of Premium Net Accret/Amort Income Earned	Total Income
91159HHP8	US Bancorp Callable Note Cont 12/23/2021 2.625% Due 01/24/2022	01/19/2017 01/24/2017 70,000.00	69,879.60 0.00 0.00 69,879.60	188.85 0.00 341.98 153.13	0.00 0.00 0.00 153.13	153.13
9128283D0	US Treasury Note 2.25% Due 10/31/2024	11/07/2019 11/08/2019 250,000.00	255,654.30 0.00 0.00 255,654.30	1,895.38 0.00 2,353.94 458.56	0.00 0.00 0.00 458.56	458.56
912828B66	US Treasury Note 2.75% Due 02/15/2024	04/29/2019 04/30/2019 235,000.00	239,644.92 0.00 0.00 239,644.92	298.54 0.00 825.37 526.83	0.00 0.00 0.00 526.83	526.83
912828D56	US Treasury Note 2.375% Due 08/15/2024	08/29/2019 08/30/2019 235,000.00	245,418.95 0.00 0.00 245,418.95	257.83 0.00 712.82 454.99	0.00 0.00 0.00 454.99	454.99
912828F96	US Treasury Note 2% Due 10/31/2021	08/15/2017 08/16/2017 245,000.00	247,642.23 0.00 0.00 247,642.23	1,651.09 0.00 2,050.54 399.45	0.00 0.00 0.00 399.45	399.45
912828G87	US Treasury Note 2.125% Due 12/31/2021	08/15/2017 08/16/2017 245,000.00	248,809.81 0.00 0.00 248,809.81	891.29 0.00 1,315.71 424.42	0.00 0.00 0.00 424.42	424.42
912828J43	US Treasury Note 1.75% Due 02/28/2022	03/13/2017 03/15/2017 245,000.00	240,569.77 0.00 0.00 240,569.77	11.84 0.00 367.16 355.32	0.00 0.00 0.00 355.32	355.32
912828L57	US Treasury Note 1.75% Due 09/30/2022	10/17/2017 10/18/2017 250,000.00	247,226.56 0.00 0.00 247,226.56	1,840.85 2,187.50 12.02 358.67	0.00 0.00 0.00 358.67	358.67
912828N30	US Treasury Note 2.125% Due 12/31/2022	01/25/2018 01/26/2018 235,000.00	231,346.48 0.00 0.00 231,346.48	854.91 0.00 1,262.01 407.10	0.00 0.00 0.00 407.10	407.10

Income Earned

As of September 30, 2020

CUSIP	Security Description	Trade Date Settle Date Units	Book Value: Begin Book Value: Acq Book Value: Disp Book Value: End	Prior Accrued Inc. Received Ending Accrued Total Interest	Accr. Of Discount Amort. Of Premium Net Accret/Amort Income Earned	Total Income
912828Q37	US Treasury Note Due 03/31/2021	Various Various 0.00	137,148.90 0.00 137,148.90 0.00	736.34 851.09 0.00 114.75	0.00 0.00 0.00 114.75	114.75
912828S27	US Treasury Note 1.125% Due 06/30/2021	12/13/2016 12/14/2016 165,000.00	159,676.72 0.00 0.00 159,676.72	317.78 0.00 469.11 151.33	0.00 0.00 0.00 151.33	151.33
912828T34	US Treasury Note 1.125% Due 09/30/2021	11/09/2016 11/10/2016 235,000.00	231,025.99 0.00 0.00 231,025.99	1,112.40 1,321.88 7.26 216.74	0.00 0.00 0.00 216.74	216.74
912828T91	US Treasury Note 1.625% Due 10/31/2023	04/29/2019 04/30/2019 235,000.00	228,161.13 0.00 0.00 228,161.13	1,286.75 0.00 1,598.06 311.31	0.00 0.00 0.00 311.31	311.31
912828X70	US Treasury Note 2% Due 04/30/2024	Various Various 245,000.00	249,631.05 0.00 0.00 249,631.05	1,651.09 0.00 2,050.54 399.45	0.00 0.00 0.00 399.45	399.45
912828XG0	US Treasury Note 2.125% Due 06/30/2022	07/31/2017 07/31/2017 210,000.00	212,789.77 0.00 0.00 212,789.77	763.96 0.00 1,127.75 363.79	0.00 0.00 0.00 363.79	363.79
912828XX3	US Treasury Note 2% Due 06/30/2024	12/12/2019 12/13/2019 250,000.00	252,861.33 0.00 0.00 252,861.33	855.98 0.00 1,263.59 407.61	0.00 0.00 0.00 407.61	407.61
			12,222,635.23 **154,533.45** **137,148.90**	**66,115.75** **31,506.36** **54,358.64**	**0.00** **0.00** **0.00**	
Total Fixed Income		**12,190,000.00**	**12,240,019.78**	**19,749.25**	**19,749.25**	**19,749.25**

Income Earned

As of September 30, 2020

CUSIP	Security Description	Trade Date Settle Date Units	Book Value: Begin Book Value: Acq Book Value: Disp Book Value: End	Prior Accrued Inc. Received Ending Accrued Total Interest	Accr. Of Discount Amort. Of Premium Net Accret/Amort Income Earned	Total Income
CASH & EQUIVALENT						
31846V203	First American	Various	8,165.20	0.00	0.00	0.08
	Govt Obligation Fund Class Y	Various	17,793.30	0.08	0.00	
		24,681.23	1,277.27	0.00	0.00	
			24,681.23	0.08	0.08	
			8,165.20	**0.00**	**0.00**	
			17,793.30	**0.08**	**0.00**	
			1,277.27	**0.00**	**0.00**	
Total Cash & Equivalent		**24,681.23**	**24,681.23**	**0.08**	**0.08**	**0.08**
			12,230,800.43	**66,115.75**	**0.00**	
			172,326.75	**31,506.44**	**0.00**	
			138,426.17	**54,358.64**	**0.00**	
TOTAL PORTFOLIO		**12,214,681.23**	**12,264,701.01**	**19,749.33**	**19,749.33**	**19,749.33**

Cash Flow Report

As of September 30, 2020

Payment Date	Transaction Type	CUSIP	Quantity	Security Description	Principal Amount	Income	Total Amount
10/01/2020	Interest	13063DRK6	145,000.00	California St Taxable GO 2.4% Due 10/1/2024	0.00	1,740.00	1,740.00
10/05/2020	Interest	3135G0T78	235,000.00	FNMA Note 2% Due 10/5/2022	0.00	2,350.00	2,350.00
10/05/2020	Interest	3135G0T45	235,000.00	FNMA Note 1.875% Due 4/5/2022	0.00	2,203.13	2,203.13
10/07/2020	Interest	3135G0Q89	60,000.00	FNMA Note 1.375% Due 10/7/2021	0.00	412.50	412.50
10/10/2020	Interest	02665WCQ2	110,000.00	American Honda Finance Note 3.625% Due 10/10/2023	0.00	1,993.75	1,993.75
10/15/2020	Interest	3135G0W66	240,000.00	FNMA Note 1.625% Due 10/15/2024	0.00	1,950.00	1,950.00
10/22/2020	Interest	3135G03U5	215,000.00	FNMA Note 0.625% Due 4/22/2025	0.00	664.41	664.41
10/31/2020	Interest	912828F96	245,000.00	US Treasury Note 2% Due 10/31/2021	0.00	2,450.00	2,450.00
10/31/2020	Interest	912828T91	235,000.00	US Treasury Note 1.625% Due 10/31/2023	0.00	1,909.38	1,909.38
10/31/2020	Interest	912828X70	245,000.00	US Treasury Note 2% Due 4/30/2024	0.00	2,450.00	2,450.00
10/31/2020	Interest	9128283D0	250,000.00	US Treasury Note 2.25% Due 10/31/2024	0.00	2,812.50	2,812.50
OCT 2020					**0.00**	**20,935.67**	**20,935.67**
11/01/2020	Interest	78015K7C2	150,000.00	Royal Bank of Canada Note 2.25% Due 11/1/2024	0.00	1,687.50	1,687.50
11/03/2020	Interest	037833AK6	60,000.00	Apple Inc Note 2.4% Due 5/3/2023	0.00	720.00	720.00
11/03/2020	Maturity	594918BG8	60,000.00	Microsoft Callable Note Cont. 10/3/2020 2% Due 11/3/2020	60,000.00	600.00	60,600.00
11/05/2020	Interest	3137EAER6	235,000.00	FHLMC Note 0.375% Due 5/5/2023	0.00	435.73	435.73
11/06/2020	Interest	3135G0K69	230,000.00	FNMA Note 1.25% Due 5/6/2021	0.00	1,437.50	1,437.50

Cash Flow Report

As of September 30, 2020

Payment Date	Transaction Type	CUSIP	Quantity	Security Description	Principal Amount	Income	Total Amount
11/08/2020	Interest	14913Q3B3	150,000.00	Caterpillar Finl Service Note 2.15% Due 11/8/2024	0.00	1,612.50	1,612.50
11/11/2020	Interest	369550BE7	150,000.00	General Dynamics Corp Note 3% Due 5/11/2021	0.00	2,250.00	2,250.00
11/19/2020	Interest	857477AV5	80,000.00	State Street Bank Note 1.95% Due 5/19/2021	0.00	780.00	780.00
11/22/2020	Interest	3135G04Q3	235,000.00	FNMA Note 0.25% Due 5/22/2023	0.00	293.75	293.75
NOV 2020					**60,000.00**	**9,816.98**	**69,816.98**
12/08/2020	Interest	3130A0F70	225,000.00	FHLB Note 3.375% Due 12/8/2023	0.00	3,796.88	3,796.88
12/11/2020	Interest	313379RB7	70,000.00	FHLB Note 1.875% Due 6/11/2021	0.00	656.25	656.25
12/14/2020	Interest	3130A1XJ2	225,000.00	FHLB Note 2.875% Due 6/14/2024	0.00	3,234.38	3,234.38
12/17/2020	Interest	3135G04Z3	135,000.00	FNMA Note 0.5% Due 6/17/2025	0.00	333.75	333.75
12/19/2020	Interest	3137EAEN5	225,000.00	FHLMC Note 2.75% Due 6/19/2023	0.00	3,093.75	3,093.75
12/22/2020	Interest	3135G0U35	160,000.00	FNMA Note 2.75% Due 6/22/2021	0.00	2,200.00	2,200.00
12/31/2020	Interest	912828S27	165,000.00	US Treasury Note 1.125% Due 6/30/2021	0.00	928.13	928.13
12/31/2020	Interest	912828XG0	210,000.00	US Treasury Note 2.125% Due 6/30/2022	0.00	2,231.25	2,231.25
12/31/2020	Interest	912828N30	235,000.00	US Treasury Note 2.125% Due 12/31/2022	0.00	2,496.88	2,496.88
12/31/2020	Interest	912828XX3	250,000.00	US Treasury Note 2% Due 6/30/2024	0.00	2,500.00	2,500.00
12/31/2020	Interest	912828G87	245,000.00	US Treasury Note 2.125% Due 12/31/2021	0.00	2,603.13	2,603.13
DEC 2020					**0.00**	**24,074.40**	**24,074.40**
01/05/2021	Interest	3135G0S38	225,000.00	FNMA Note 2% Due 1/5/2022	0.00	2,250.00	2,250.00

Payment Date	Transaction Type	CUSIP	Quantity	Security Description	Principal Amount	Income	Total Amount
01/06/2021	Interest	24422ETL3	160,000.00	John Deere Capital Corp Note 2.65% Due 1/6/2022	0.00	2,120.00	2,120.00
01/07/2021	Interest	3135G0X24	240,000.00	FNMA Note 1.625% Due 1/7/2025	0.00	1,950.00	1,950.00
01/10/2021	Interest	3135G05G4	195,000.00	FNMA Note 0.25% Due 7/10/2023	0.00	243.75	243.75
01/11/2021	Interest	89236TDP7	145,000.00	Toyota Motor Credit Corp Note 2.6% Due 1/11/2022	0.00	1,885.00	1,885.00
01/14/2021	Interest	02665WCJ8	45,000.00	American Honda Finance Note 3.45% Due 7/14/2023	0.00	776.25	776.25
01/14/2021	Interest	3130A8QS5	230,000.00	FHLB Note 1.125% Due 7/14/2021	0.00	1,293.75	1,293.75
01/15/2021	Interest	48128BAB7	125,000.00	JP Morgan Chase & Co Callable Note 1X 1/15/2022 2.972% Due 1/15/2023	0.00	1,857.50	1,857.50
01/19/2021	Interest	3135G0T94	100,000.00	FNMA Note 2.375% Due 1/19/2023	0.00	1,187.50	1,187.50
01/21/2021	Interest	3137EAEU9	145,000.00	FHLMC Note 0.375% Due 7/21/2025	0.00	268.85	268.85
01/24/2021	Interest	91159HHP8	70,000.00	US Bancorp Callable Note Cont 12/23/2021 2.625% Due 1/24/2022	0.00	918.75	918.75
JAN 2021					**0.00**	**14,751.35**	**14,751.35**
02/08/2021	Interest	594918BP8	105,000.00	Microsoft Callable Note Cont 7/8/2021 1.55% Due 8/8/2021	0.00	813.75	813.75
02/11/2021	Interest	06406RAJ6	150,000.00	Bank of NY Mellon Corp Note 3.45% Due 8/11/2023	0.00	2,587.50	2,587.50
02/11/2021	Interest	69371RN44	145,000.00	Paccar Financial Corp Note 1.65% Due 8/11/2021	0.00	1,196.25	1,196.25
02/12/2021	Interest	3137EAEP0	275,000.00	FHLMC Note 1.5% Due 2/12/2025	0.00	2,062.50	2,062.50
02/12/2021	Interest	3137EAEC9	215,000.00	FHLMC Note 1.125% Due 8/12/2021	0.00	1,209.38	1,209.38
02/15/2021	Interest	69371RQ25	30,000.00	Paccar Financial Corp Note 2.15% Due 8/15/2024	0.00	322.50	322.50

Payment Date	Transaction Type	CUSIP	Quantity	Security Description	Principal Amount	Income	Total Amount
02/15/2021	Interest	912828B66	235,000.00	US Treasury Note 2.75% Due 2/15/2024	0.00	3,231.25	3,231.25
02/15/2021	Interest	912828D56	235,000.00	US Treasury Note 2.375% Due 8/15/2024	0.00	2,790.63	2,790.63
02/17/2021	Interest	3135G0N82	190,000.00	FNMA Note 1.25% Due 8/17/2021	0.00	1,187.50	1,187.50
02/24/2021	Interest	3137EAEV7	235,000.00	FHLMC Note 0.25% Due 8/24/2023	0.00	298.65	298.65
02/25/2021	Interest	3135G05X7	160,000.00	FNMA Note 0.375% Due 8/25/2025	0.00	296.67	296.67
02/28/2021	Interest	912828J43	245,000.00	US Treasury Note 1.75% Due 2/28/2022	0.00	2,143.75	2,143.75
FEB 2021					**0.00**	**18,140.33**	**18,140.33**
03/01/2021	Maturity	30231GAV4	150,000.00	Exxon Mobil Corp Callable Note Cont 2/1/2021 2.222% Due 3/1/2021	150,000.00	1,666.50	151,666.50
03/05/2021	Interest	06051GHF9	145,000.00	Bank of America Corp Callable Note 1X 3/5/2023 3.55% Due 3/5/2024	0.00	2,573.75	2,573.75
03/08/2021	Interest	313383YJ4	215,000.00	FHLB Note 3.375% Due 9/8/2023	0.00	3,628.13	3,628.13
03/08/2021	Interest	44932HAC7	150,000.00	IBM Credit Corp Note 2.2% Due 9/8/2022	0.00	1,650.00	1,650.00
03/08/2021	Interest	3130A0XE5	200,000.00	FHLB Note 3.25% Due 3/8/2024	0.00	3,250.00	3,250.00
03/08/2021	Interest	3130AB3H7	35,000.00	FHLB Note 2.375% Due 3/8/2024	0.00	415.63	415.63
03/11/2021	Interest	89114QCB2	145,000.00	Toronto Dominion Bank Note 3.25% Due 3/11/2024	0.00	2,356.25	2,356.25
03/12/2021	Interest	3135G0U43	230,000.00	FNMA Note 2.875% Due 9/12/2023	0.00	3,306.25	3,306.25
03/13/2021	Interest	3130A2UW4	200,000.00	FHLB Note 2.875% Due 9/13/2024	0.00	2,875.00	2,875.00
03/14/2021	Interest	3130A4CH3	225,000.00	FHLB Note 2.375% Due 3/14/2025	0.00	2,671.88	2,671.88

Payment Date	Transaction Type	CUSIP	Quantity	Security Description	Principal Amount	Income	Total Amount
03/15/2021	Interest	68389XBK0	145,000.00	Oracle Corp Callable Note Cont 8/15/2021 1.9% Due 9/15/2021	0.00	1,377.50	1,377.50
03/15/2021	Interest	084670BR8	100,000.00	Berkshire Hathaway Callable Note Cont 1/15/2023 2.75% Due 3/15/2023	0.00	1,375.00	1,375.00
03/23/2021	Interest	3137EAEX3	155,000.00	FHLMC Note 0.375% Due 9/23/2025	0.00	287.40	287.40
03/31/2021	Interest	912828L57	250,000.00	US Treasury Note 1.75% Due 9/30/2022	0.00	2,187.50	2,187.50
03/31/2021	Interest	912828T34	235,000.00	US Treasury Note 1.125% Due 9/30/2021	0.00	1,321.88	1,321.88
MAR 2021					**150,000.00**	**30,942.67**	**180,942.67**
04/01/2021	Interest	13063DRK6	145,000.00	California St Taxable GO 2.4% Due 10/1/2024	0.00	1,740.00	1,740.00
04/05/2021	Interest	3135G0T78	235,000.00	FNMA Note 2% Due 10/5/2022	0.00	2,350.00	2,350.00
04/05/2021	Interest	3135G0T45	235,000.00	FNMA Note 1.875% Due 4/5/2022	0.00	2,203.13	2,203.13
04/07/2021	Interest	3135G0Q89	60,000.00	FNMA Note 1.375% Due 10/7/2021	0.00	412.50	412.50
04/10/2021	Interest	02665WCQ2	110,000.00	American Honda Finance Note 3.625% Due 10/10/2023	0.00	1,993.75	1,993.75
04/15/2021	Interest	3135G0W66	240,000.00	FNMA Note 1.625% Due 10/15/2024	0.00	1,950.00	1,950.00
04/22/2021	Interest	3135G03U5	215,000.00	FNMA Note 0.625% Due 4/22/2025	0.00	671.88	671.88
04/30/2021	Interest	912828F96	245,000.00	US Treasury Note 2% Due 10/31/2021	0.00	2,450.00	2,450.00
04/30/2021	Interest	912828T91	235,000.00	US Treasury Note 1.625% Due 10/31/2023	0.00	1,909.38	1,909.38
04/30/2021	Interest	912828X70	245,000.00	US Treasury Note 2% Due 4/30/2024	0.00	2,450.00	2,450.00
04/30/2021	Interest	9128283D0	250,000.00	US Treasury Note 2.25% Due 10/31/2024	0.00	2,812.50	2,812.50
APR 2021					**0.00**	**20,943.14**	**20,943.14**

Cash Flow Report

As of September 30, 2020

Payment Date	Transaction Type	CUSIP	Quantity	Security Description	Principal Amount	Income	Total Amount
05/01/2021	Interest	78015K7C2	150,000.00	Royal Bank of Canada Note 2.25% Due 11/1/2024	0.00	1,687.50	1,687.50
05/03/2021	Interest	037833AK6	60,000.00	Apple Inc Note 2.4% Due 5/3/2023	0.00	720.00	720.00
05/05/2021	Interest	3137EAER6	235,000.00	FHLMC Note 0.375% Due 5/5/2023	0.00	440.63	440.63
05/06/2021	Maturity	3135G0K69	230,000.00	FNMA Note 1.25% Due 5/6/2021	230,000.00	1,437.50	231,437.50
05/08/2021	Interest	14913Q3B3	150,000.00	Caterpillar Finl Service Note 2.15% Due 11/8/2024	0.00	1,612.50	1,612.50
05/11/2021	Maturity	369550BE7	150,000.00	General Dynamics Corp Note 3% Due 5/11/2021	150,000.00	2,250.00	152,250.00
05/19/2021	Maturity	857477AV5	80,000.00	State Street Bank Note 1.95% Due 5/19/2021	80,000.00	780.00	80,780.00
05/22/2021	Interest	3135G04Q3	235,000.00	FNMA Note 0.25% Due 5/22/2023	0.00	293.75	293.75
MAY 2021					**460,000.00**	**9,221.88**	**469,221.88**
06/08/2021	Interest	3130A0F70	225,000.00	FHLB Note 3.375% Due 12/8/2023	0.00	3,796.88	3,796.88
06/11/2021	Maturity	313379RB7	70,000.00	FHLB Note 1.875% Due 6/11/2021	70,000.00	656.25	70,656.25
06/14/2021	Interest	3130A1XJ2	225,000.00	FHLB Note 2.875% Due 6/14/2024	0.00	3,234.38	3,234.38
06/17/2021	Interest	3135G04Z3	135,000.00	FNMA Note 0.5% Due 6/17/2025	0.00	337.50	337.50
06/19/2021	Interest	3137EAEN5	225,000.00	FHLMC Note 2.75% Due 6/19/2023	0.00	3,093.75	3,093.75
06/22/2021	Maturity	3135G0U35	160,000.00	FNMA Note 2.75% Due 6/22/2021	160,000.00	2,200.00	162,200.00
06/30/2021	Interest	912828G87	245,000.00	US Treasury Note 2.125% Due 12/31/2021	0.00	2,603.13	2,603.13
06/30/2021	Interest	912828N30	235,000.00	US Treasury Note 2.125% Due 12/31/2022	0.00	2,496.88	2,496.88

Payment Date	Transaction Type	CUSIP	Quantity	Security Description	Principal Amount	Income	Total Amount
06/30/2021	Interest	912828XX3	250,000.00	US Treasury Note 2% Due 6/30/2024	0.00	2,500.00	2,500.00
06/30/2021	Interest	912828XG0	210,000.00	US Treasury Note 2.125% Due 6/30/2022	0.00	2,231.25	2,231.25
06/30/2021	Maturity	912828S27	165,000.00	US Treasury Note 1.125% Due 6/30/2021	165,000.00	928.13	165,928.13
JUN 2021					**395,000.00**	**24,078.15**	**419,078.15**
07/05/2021	Interest	3135G0S38	225,000.00	FNMA Note 2% Due 1/5/2022	0.00	2,250.00	2,250.00
07/06/2021	Interest	24422ETL3	160,000.00	John Deere Capital Corp Note 2.65% Due 1/6/2022	0.00	2,120.00	2,120.00
07/07/2021	Interest	3135G0X24	240,000.00	FNMA Note 1.625% Due 1/7/2025	0.00	1,950.00	1,950.00
07/10/2021	Interest	3135G05G4	195,000.00	FNMA Note 0.25% Due 7/10/2023	0.00	243.75	243.75
07/11/2021	Interest	89236TDP7	145,000.00	Toyota Motor Credit Corp Note 2.6% Due 1/11/2022	0.00	1,885.00	1,885.00
07/14/2021	Interest	02665WCJ8	45,000.00	American Honda Finance Note 3.45% Due 7/14/2023	0.00	776.25	776.25
07/14/2021	Maturity	3130A8QS5	230,000.00	FHLB Note 1.125% Due 7/14/2021	230,000.00	1,293.75	231,293.75
07/15/2021	Interest	48128BAB7	125,000.00	JP Morgan Chase & Co Callable Note 1X 1/15/2022 2.972% Due 1/15/2023	0.00	1,857.50	1,857.50
07/19/2021	Interest	3135G0T94	100,000.00	FNMA Note 2.375% Due 1/19/2023	0.00	1,187.50	1,187.50
07/21/2021	Interest	3137EAEU9	145,000.00	FHLMC Note 0.375% Due 7/21/2025	0.00	271.88	271.88
07/24/2021	Interest	91159HHP8	70,000.00	US Bancorp Callable Note Cont 12/23/2021 2.625% Due 1/24/2022	0.00	918.75	918.75
JUL 2021					**230,000.00**	**14,754.38**	**244,754.38**
08/08/2021	Maturity	594918BP8	105,000.00	Microsoft Callable Note Cont 7/8/2021 1.55% Due 8/8/2021	105,000.00	813.75	105,813.75
08/11/2021	Interest	06406RAJ6	150,000.00	Bank of NY Mellon Corp Note 3.45% Due 8/11/2023	0.00	2,587.50	2,587.50

Cash Flow Report

As of September 30, 2020

Payment Date	Transaction Type	CUSIP	Quantity	Security Description	Principal Amount	Income	Total Amount
08/11/2021	Maturity	69371RN44	145,000.00	Paccar Financial Corp Note 1.65% Due 8/11/2021	145,000.00	1,196.25	146,196.25
08/12/2021	Interest	3137EAEP0	275,000.00	FHLMC Note 1.5% Due 2/12/2025	0.00	2,062.50	2,062.50
08/12/2021	Maturity	3137EAEC9	215,000.00	FHLMC Note 1.125% Due 8/12/2021	215,000.00	1,209.38	216,209.38
08/15/2021	Interest	912828D56	235,000.00	US Treasury Note 2.375% Due 8/15/2024	0.00	2,790.63	2,790.63
08/15/2021	Interest	912828B66	235,000.00	US Treasury Note 2.75% Due 2/15/2024	0.00	3,231.25	3,231.25
08/15/2021	Interest	69371RQ25	30,000.00	Paccar Financial Corp Note 2.15% Due 8/15/2024	0.00	322.50	322.50
08/17/2021	Maturity	3135G0N82	190,000.00	FNMA Note 1.25% Due 8/17/2021	190,000.00	1,187.50	191,187.50
08/24/2021	Interest	3137EAEV7	235,000.00	FHLMC Note 0.25% Due 8/24/2023	0.00	293.75	293.75
08/25/2021	Interest	3135G05X7	160,000.00	FNMA Note 0.375% Due 8/25/2025	0.00	300.00	300.00
08/31/2021	Interest	912828J43	245,000.00	US Treasury Note 1.75% Due 2/28/2022	0.00	2,143.75	2,143.75
AUG 2021					**655,000.00**	**18,138.76**	**673,138.76**
09/05/2021	Interest	06051GHF9	145,000.00	Bank of America Corp Callable Note 1X 3/5/2023 3.55% Due 3/5/2024	0.00	2,573.75	2,573.75
09/08/2021	Interest	3130AB3H7	35,000.00	FHLB Note 2.375% Due 3/8/2024	0.00	415.63	415.63
09/08/2021	Interest	313383YJ4	215,000.00	FHLB Note 3.375% Due 9/8/2023	0.00	3,628.13	3,628.13
09/08/2021	Interest	3130A0XE5	200,000.00	FHLB Note 3.25% Due 3/8/2024	0.00	3,250.00	3,250.00
09/08/2021	Interest	44932HAC7	150,000.00	IBM Credit Corp Note 2.2% Due 9/8/2022	0.00	1,650.00	1,650.00
09/11/2021	Interest	89114QCB2	145,000.00	Toronto Dominion Bank Note 3.25% Due 3/11/2024	0.00	2,356.25	2,356.25

Cash Flow Report

As of September 30, 2020

Payment Date	Transaction Type	CUSIP	Quantity	Security Description	Principal Amount	Income	Total Amount
09/12/2021	Interest	3135G0U43	230,000.00	FNMA Note 2.875% Due 9/12/2023	0.00	3,306.25	3,306.25
09/13/2021	Interest	3130A2UW4	200,000.00	FHLB Note 2.875% Due 9/13/2024	0.00	2,875.00	2,875.00
09/14/2021	Interest	3130A4CH3	225,000.00	FHLB Note 2.375% Due 3/14/2025	0.00	2,671.88	2,671.88
09/15/2021	Interest	084670BR8	100,000.00	Berkshire Hathaway Callable Note Cont 1/15/2023 2.75% Due 3/15/2023	0.00	1,375.00	1,375.00
09/15/2021	Maturity	68389XBK0	145,000.00	Oracle Corp Callable Note Cont 8/15/2021 1.9% Due 9/15/2021	145,000.00	1,377.50	146,377.50
09/23/2021	Interest	3137EAEX3	155,000.00	FHLMC Note 0.375% Due 9/23/2025	0.00	290.63	290.63
09/30/2021	Interest	912828L57	250,000.00	US Treasury Note 1.75% Due 9/30/2022	0.00	2,187.50	2,187.50
09/30/2021	Maturity	912828T34	235,000.00	US Treasury Note 1.125% Due 9/30/2021	235,000.00	1,321.88	236,321.88
SEP 2021					**380,000.00**	**29,279.40**	**409,279.40**
TOTAL					**2,330,000.00**	**235,077.11**	**2,565,077.11**

Important Disclosures

Chandler Asset Management, Inc. (“Chandler”) is an SEC registered investment adviser. For additional information about our firm, please see our current disclosures (Form ADV). To obtain a copy of our current disclosures, you may contact your client service representative by calling the number on the front of this statement or you may visit our website at www.chandlerasset.com.

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Valuation: Prices are provided by IDC, an independent pricing source. In the event IDC does not provide a price or if the price provided is not reflective of fair market value, Chandler will obtain pricing from an alternative approved third party pricing source in accordance with our written valuation policy and procedures. Our valuation procedures are also disclosed in Item 5 of our Form ADV Part 2A.

Performance: Performance results are presented gross-of-advisory fees and represent the client’s Total Return. The deduction of advisory fees lowers performance results. These results include the reinvestment of dividends and other earnings. Past performance may not be indicative of future results. Therefore, clients should not assume that future performance of any specific investment or investment strategy will be profitable or equal to past performance levels. All investment strategies have the potential for profit or loss. Economic factors, market conditions or changes in investment strategies, contributions or withdrawals may materially alter the performance and results of your portfolio.

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Ratings: Ratings information have been provided by Moody’s, S&P and Fitch through data feeds we believe to be reliable as of the date of this statement, however we cannot guarantee its accuracy.

Security level ratings for U.S. Agency issued mortgage-backed securities (“MBS”) reflect the issuer rating because the securities themselves are not rated. The issuing U.S. Agency guarantees the full and timely payment of both principal and interest and carries a AA+/Aaa/AAA by S&P, Moody’s and Fitch respectively.

Benchmark Index & Disclosures

Benchmark Index	Disclosure
ICE BAML 1-5 Year US Treasury/Agency Index	The ICE BAML 1-5 Year US Treasury & Agency Index tracks the performance of US dollar denominated US Treasury and nonsubordinated US agency debt issued in the US domestic market. Qualifying securities must have an investment grade rating (based on an average of Moody's, S&P and Fitch). Qualifying securities must have at least one year remaining term to final maturity and less than five years remaining term to final maturity, at least 18 months to maturity at time of issuance, a fixed coupon schedule and a minimum amount outstanding of $1 billion for sovereigns and $250 million for agencies. (Index: GVA0. Please visit www.mlindex.ml.com for more information)

Transaction Ledger

As of September 30, 2020

Transaction Type	Settlement Date	CUSIP	Quantity	Security Description	Price	Acq/Disp Yield	Amount	Interest Pur/Sold	Total Amount	Gain/Loss
ACQUISITIONS										
Purchase	09/01/2020	31846V203	1,666.50	First American Govt Obligation Fund Class Y	1.000	0.01%	1,666.50	0.00	1,666.50	0.00
Purchase	09/01/2020	31846V203	0.08	First American Govt Obligation Fund Class Y	1.000	0.01%	0.08	0.00	0.08	0.00
Purchase	09/05/2020	31846V203	2,573.75	First American Govt Obligation Fund Class Y	1.000	0.01%	2,573.75	0.00	2,573.75	0.00
Purchase	09/08/2020	31846V203	8,943.76	First American Govt Obligation Fund Class Y	1.000	0.01%	8,943.76	0.00	8,943.76	0.00
Purchase	09/11/2020	31846V203	2,356.25	First American Govt Obligation Fund Class Y	1.000	0.01%	2,356.25	0.00	2,356.25	0.00
Purchase	09/12/2020	31846V203	3,306.25	First American Govt Obligation Fund Class Y	1.000	0.01%	3,306.25	0.00	3,306.25	0.00
Purchase	09/13/2020	31846V203	2,875.00	First American Govt Obligation Fund Class Y	1.000	0.01%	2,875.00	0.00	2,875.00	0.00
Purchase	09/14/2020	31846V203	2,671.88	First American Govt Obligation Fund Class Y	1.000	0.01%	2,671.88	0.00	2,671.88	0.00
Purchase	09/15/2020	31846V203	2,752.50	First American Govt Obligation Fund Class Y	1.000	0.01%	2,752.50	0.00	2,752.50	0.00
Purchase	09/25/2020	3137EAEX3	155,000.00	FHLMC Note 0.375% Due 9/23/2025	99.699	0.44%	154,533.45	0.00	154,533.45	0.00
Purchase	09/25/2020	31846V203	141,671.40	First American Govt Obligation Fund Class Y	1.000	0.01%	141,671.40	0.00	141,671.40	0.00
Purchase	09/30/2020	31846V203	3,509.38	First American Govt Obligation Fund Class Y	1.000	0.01%	3,509.38	0.00	3,509.38	0.00
Subtotal			**327,326.75**				**326,860.20**	**0.00**	**326,860.20**	**0.00**
Short Sale	09/25/2020	31846V203	-154,533.45	First American Govt Obligation Fund Class Y	1.000		-154,533.45	0.00	-154,533.45	0.00
Subtotal			**-154,533.45**				**-154,533.45**	**0.00**	**-154,533.45**	**0.00**
TOTAL ACQUISITIONS			**172,793.30**				**172,326.75**	**0.00**	**172,326.75**	**0.00**

Transaction Ledger

As of September 30, 2020

Transaction Type	Settlement Date	CUSIP	Quantity	Security Description	Price	Acq/Disp Yield	Amount	Interest Pur/Sold	Total Amount	Gain/Loss
DISPOSITIONS										
Closing Purchase	09/25/2020	31846V203	-154,533.45	First American Govt Obligation Fund Class Y	1.000		-154,533.45	0.00	-154,533.45	0.00
Subtotal			**-154,533.45**				**-154,533.45**	**0.00**	**-154,533.45**	**0.00**
Sale	09/25/2020	31846V203	154,533.45	First American Govt Obligation Fund Class Y	1.000	0.01%	154,533.45	0.00	154,533.45	0.00
Sale	09/25/2020	912828Q37	140,000.00	US Treasury Note 1.25% Due 3/31/2021	100.586	0.11%	140,820.31	851.09	141,671.40	3,671.41
Subtotal			**294,533.45**				**295,353.76**	**851.09**	**296,204.85**	**3,671.41**
Security Withdrawal	09/03/2020	31846V203	1,277.27	First American Govt Obligation Fund Class Y	1.000		1,277.27	0.00	1,277.27	0.00
Subtotal			**1,277.27**				**1,277.27**	**0.00**	**1,277.27**	**0.00**
TOTAL DISPOSITIONS			**141,277.27**				**142,097.58**	**851.09**	**142,948.67**	**3,671.41**
OTHER TRANSACTIONS										
Interest	09/01/2020	30231GAV4	150,000.00	Exxon Mobil Corp Callable Note Cont 2/1/2021 2.222% Due 3/1/2021	0.000		1,666.50	0.00	1,666.50	0.00
Interest	09/05/2020	06051GHF9	145,000.00	Bank of America Corp Callable Note 1X 3/5/2023 3.55% Due 3/5/2024	0.000		2,573.75	0.00	2,573.75	0.00
Interest	09/08/2020	3130A0XE5	200,000.00	FHLB Note 3.25% Due 3/8/2024	0.000		3,250.00	0.00	3,250.00	0.00
Interest	09/08/2020	3130AB3H7	35,000.00	FHLB Note 2.375% Due 3/8/2024	0.000		415.63	0.00	415.63	0.00
Interest	09/08/2020	313383YJ4	215,000.00	FHLB Note 3.375% Due 9/8/2023	0.000		3,628.13	0.00	3,628.13	0.00
Interest	09/08/2020	44932HAC7	150,000.00	IBM Credit Corp Note 2.2% Due 9/8/2022	0.000		1,650.00	0.00	1,650.00	0.00

Transaction Type	Settlement Date	CUSIP	Quantity	Security Description	Price	Acq/Disp Yield	Amount	Interest Pur/Sold	Total Amount	Gain/Loss
OTHER TRANSACTIONS										
Interest	09/11/2020	89114QCB2	145,000.00	Toronto Dominion Bank Note 3.25% Due 3/11/2024	0.000		2,356.25	0.00	2,356.25	0.00
Interest	09/12/2020	3135G0U43	230,000.00	FNMA Note 2.875% Due 9/12/2023	0.000		3,306.25	0.00	3,306.25	0.00
Interest	09/13/2020	3130A2UW4	200,000.00	FHLB Note 2.875% Due 9/13/2024	0.000		2,875.00	0.00	2,875.00	0.00
Interest	09/14/2020	3130A4CH3	225,000.00	FHLB Note 2.375% Due 3/14/2025	0.000		2,671.88	0.00	2,671.88	0.00
Interest	09/15/2020	084670BR8	100,000.00	Berkshire Hathaway Callable Note Cont 1/15/2023 2.75% Due 3/15/2023	0.000		1,375.00	0.00	1,375.00	0.00
Interest	09/15/2020	68389XBK0	145,000.00	Oracle Corp Callable Note Cont 8/15/2021 1.9% Due 9/15/2021	0.000		1,377.50	0.00	1,377.50	0.00
Interest	09/30/2020	912828L57	250,000.00	US Treasury Note 1.75% Due 9/30/2022	0.000		2,187.50	0.00	2,187.50	0.00
Interest	09/30/2020	912828T34	235,000.00	US Treasury Note 1.125% Due 9/30/2021	0.000		1,321.88	0.00	1,321.88	0.00
Subtotal			**2,425,000.00**				**30,655.27**	**0.00**	**30,655.27**	**0.00**
Dividend	09/01/2020	31846V203	9,831.70	First American Govt Obligation Fund Class Y	0.000		0.08	0.00	0.08	0.00
Subtotal			**9,831.70**				**0.08**	**0.00**	**0.08**	**0.00**
TOTAL OTHER TRANSACTIONS			**2,434,831.70**				**30,655.35**	**0.00**	**30,655.35**	**0.00**

Transaction Ledger

As of July 31, 2020

Transaction Type	Settlement Date	CUSIP	Quantity	Security Description	Price	Acq/Disp Yield	Amount	Interest Pur/Sold	Total Amount	Gain/Loss
ACQUISITIONS										
Purchase	07/01/2020	31846V203	0.07	First American Govt Obligation Fund Class Y	1.000	0.01%	0.07	0.00	0.07	0.00
Purchase	07/05/2020	31846V203	2,250.00	First American Govt Obligation Fund Class Y	1.000	0.01%	2,250.00	0.00	2,250.00	0.00
Purchase	07/06/2020	31846V203	2,120.00	First American Govt Obligation Fund Class Y	1.000	0.01%	2,120.00	0.00	2,120.00	0.00
Purchase	07/07/2020	31846V203	1,917.50	First American Govt Obligation Fund Class Y	1.000	0.01%	1,917.50	0.00	1,917.50	0.00
Purchase	07/10/2020	3135G05G4	195,000.00	FNMA Note 0.25% Due 7/10/2023	99.785	0.32%	194,580.75	0.00	194,580.75	0.00
Purchase	07/10/2020	31846V203	208,881.00	First American Govt Obligation Fund Class Y	1.000	0.01%	208,881.00	0.00	208,881.00	0.00
Purchase	07/11/2020	31846V203	1,885.00	First American Govt Obligation Fund Class Y	1.000	0.01%	1,885.00	0.00	1,885.00	0.00
Purchase	07/14/2020	31846V203	2,070.00	First American Govt Obligation Fund Class Y	1.000	0.01%	2,070.00	0.00	2,070.00	0.00
Purchase	07/15/2020	31846V203	1,857.50	First American Govt Obligation Fund Class Y	1.000	0.01%	1,857.50	0.00	1,857.50	0.00
Purchase	07/19/2020	31846V203	1,187.50	First American Govt Obligation Fund Class Y	1.000	0.01%	1,187.50	0.00	1,187.50	0.00
Purchase	07/23/2020	3137EAEU9	145,000.00	FHLMC Note 0.375% Due 7/21/2025	99.502	0.48%	144,277.90	0.00	144,277.90	0.00
Purchase	07/23/2020	31846V203	101,170.59	First American Govt Obligation Fund Class Y	1.000	0.01%	101,170.59	0.00	101,170.59	0.00
Purchase	07/24/2020	31846V203	918.75	First American Govt Obligation Fund Class Y	1.000	0.01%	918.75	0.00	918.75	0.00
Subtotal			**664,257.91**				**663,116.56**	**0.00**	**663,116.56**	**0.00**
Short Sale	07/10/2020	31846V203	-194,580.75	First American Govt Obligation Fund Class Y	1.000		-194,580.75	0.00	-194,580.75	0.00

Transaction Ledger

As of July 31, 2020

Transaction Type	Settlement Date	CUSIP	Quantity	Security Description	Price	Acq/Disp Yield	Amount	Interest Pur/Sold	Total Amount	Gain/Loss
ACQUISITIONS										
Short Sale	07/23/2020	31846V203	-144,277.90	First American Govt Obligation Fund Class Y	1.000		-144,277.90	0.00	-144,277.90	0.00
Subtotal			**-338,858.65**				**-338,858.65**	**0.00**	**-338,858.65**	**0.00**
TOTAL ACQUISITIONS			**325,399.26**				**324,257.91**	**0.00**	**324,257.91**	**0.00**
DISPOSITIONS										
Closing Purchase	07/10/2020	31846V203	-194,580.75	First American Govt Obligation Fund Class Y	1.000		-194,580.75	0.00	-194,580.75	0.00
Closing Purchase	07/23/2020	31846V203	-144,277.90	First American Govt Obligation Fund Class Y	1.000		-144,277.90	0.00	-144,277.90	0.00
Subtotal			**-338,858.65**				**-338,858.65**	**0.00**	**-338,858.65**	**0.00**
Sale	07/10/2020	31846V203	194,580.75	First American Govt Obligation Fund Class Y	1.000	0.01%	194,580.75	0.00	194,580.75	0.00
Sale	07/10/2020	912828B90	205,000.00	US Treasury Note 2% Due 2/28/2021	101.176	0.16%	207,410.35	1,470.65	208,881.00	-3,347.96
Sale	07/23/2020	31846V203	144,277.90	First American Govt Obligation Fund Class Y	1.000	0.01%	144,277.90	0.00	144,277.90	0.00
Sale	07/23/2020	912828Q37	100,000.00	US Treasury Note 1.25% Due 3/31/2021	100.781	0.11%	100,781.25	389.34	101,170.59	1,140.29
Subtotal			**643,858.65**				**647,050.25**	**1,859.99**	**648,910.24**	**-2,207.67**
Security Withdrawal	07/06/2020	31846V203	1,273.04	First American Govt Obligation Fund Class Y	1.000		1,273.04	0.00	1,273.04	0.00
Subtotal			**1,273.04**				**1,273.04**	**0.00**	**1,273.04**	**0.00**
TOTAL DISPOSITIONS			**306,273.04**				**309,464.64**	**1,859.99**	**311,324.63**	**-2,207.67**

Transaction Ledger

As of July 31, 2020

Transaction Type	Settlement Date	CUSIP	Quantity	Security Description	Price	Acq/Disp Yield	Amount	Interest Pur/Sold	Total Amount	Gain/Loss
OTHER TRANSACTIONS										
Interest	07/05/2020	3135G0S38	225,000.00	FNMA Note 2% Due 1/5/2022	0.000		2,250.00	0.00	2,250.00	0.00
Interest	07/06/2020	24422ETL3	160,000.00	John Deere Capital Corp Note 2.65% Due 1/6/2022	0.000		2,120.00	0.00	2,120.00	0.00
Interest	07/07/2020	3135G0X24	240,000.00	FNMA Note 1.625% Due 1/7/2025	0.000		1,917.50	0.00	1,917.50	0.00
Interest	07/11/2020	89236TDP7	145,000.00	Toyota Motor Credit Corp Note 2.6% Due 1/11/2022	0.000		1,885.00	0.00	1,885.00	0.00
Interest	07/14/2020	02665WCJ8	45,000.00	American Honda Finance Note 3.45% Due 7/14/2023	0.000		776.25	0.00	776.25	0.00
Interest	07/14/2020	3130A8QS5	230,000.00	FHLB Note 1.125% Due 7/14/2021	0.000		1,293.75	0.00	1,293.75	0.00
Interest	07/15/2020	48128BAB7	125,000.00	JP Morgan Chase & Co Callable Note 1X 1/15/2022 2.972% Due 1/15/2023	0.000		1,857.50	0.00	1,857.50	0.00
Interest	07/19/2020	3135G0T94	100,000.00	FNMA Note 2.375% Due 1/19/2023	0.000		1,187.50	0.00	1,187.50	0.00
Interest	07/24/2020	91159HHP8	70,000.00	US Bancorp Callable Note Cont 12/23/2021 2.625% Due 1/24/2022	0.000		918.75	0.00	918.75	0.00
Subtotal			**1,340,000.00**				**14,206.25**	**0.00**	**14,206.25**	**0.00**
Dividend	07/01/2020	31846V203	22,289.22	First American Govt Obligation Fund Class Y	0.000		0.07	0.00	0.07	0.00
Subtotal			**22,289.22**				**0.07**	**0.00**	**0.07**	**0.00**
TOTAL OTHER TRANSACTIONS			**1,362,289.22**				**14,206.32**	**0.00**	**14,206.32**	**0.00**

Redwood Empire Municipal Insurance Fund
Statement of Net Position by Fund
As of June 30, 2020
Unaudited

	Workers' Compensation	Liability	Property	Medical	Dental	Vision	Auto	Post Retirement Benefits	All Programs
ASSETS									
CURRENT ASSETS									
Cash & Cash Equivalents	9,662,286	18,534	267,357	2,908,124	168,128	83,884	100,867	0	13,209,178
Receivables	5,094,683	1,758,354	37,446	(16,752)	(4,591)	(720)	617	0	6,869,039
Prepaid Expense	45,004	83,701	997	38,878	406	409	614	0	170,008
Deposits	0	320,684	19,451	0	0	0	0	0	340,136
TOTAL CURRENT ASSETS	14,801,973	2,181,273	325,251	2,930,250	163,943	83,573	102,098	0	20,588,361
NONCURRENT ASSETS									
Investments	3,651,328	2,285,637	816,009	4,341,813	735,787	129,020	721,679	0	12,681,273
Capital Assets, Net of Accumulated Depreciation	473,778	0	0	0	0	0	0	0	473,778
Net Pension Asset	0	0	0	0	0	0	0	568,145	568,145
TOTAL NONCURRENT ASSETS	4,125,106	2,285,637	816,009	4,341,813	735,787	129,020	721,679	568,145	13,723,196
TOTAL ASSETS	**18,927,079**	**4,466,910**	**1,141,260**	**7,272,063**	**899,730**	**212,593**	**823,777**	**568,145**	**34,311,557**
DEFERRED OUTFLOWS OF RESOURCES	**549,945**	**0**	**0**	**0**	**0**	**0**	**0**	**109,994**	**659,939**
LIABILITIES									
CURRENT LIABILITIES									
Accounts Payable	107,307	35,240	151,156	235,991	32,546	12,427	3,196	0	577,863
Unearned Revenue	259	307	155	3,350	25	3	96	0	4,195
Tenant and Other Deposits	10,346	0	0	0	0	0	0	0	10,346
TOTAL CURRENT LIABILITIES	117,912	35,547	151,311	239,341	32,571	12,430	3,292	0	592,404
NONCURRENT LIABILITIES									
Reserve for Losses and Claims	18,867,919	8,441,173	200,000	1,250,000	55,000	9,999	0	0	28,824,092
Net Pension Liability	2,256,336	0	0	0	0	0	0	0	2,256,336
TOTAL NONCURRENT LIABILITIES	21,124,255	8,441,173	200,000	1,250,000	55,000	9,999	0	0	31,080,428
TOTAL LIABILITIES	**21,242,167**	**8,476,720**	**351,311**	**1,489,341**	**87,571**	**22,429**	**3,292**	**0**	**31,672,832**
DEFERRED INFLOWS OF RESOURCES	**185,787**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**185,787**
ENDING NET POSITION									
NET POSITION - ENDING									
Net Position Unrestricted	(1,950,930)	(4,009,811)	789,948	5,782,722	812,160	190,163	820,486	678,139	3,112,877
TOTAL NET POSITION - ENDING	(1,950,930)	(4,009,811)	789,948	5,782,722	812,160	190,163	820,486	678,139	3,112,877
TOTAL ENDING NET POSITION	**(1,950,930)**	**(4,009,811)**	**789,948**	**5,782,722**	**812,160**	**190,163**	**820,486**	**678,139**	**3,112,877**

Redwood Empire Municipal Insurance Fund
Statement of Revenues, Expenses and Changes in Net Position
As of June 30, 2020
Unaudited

	Workers' Compensation Year To Date 06/30/2020 Actual	Liability Year To Date 06/30/2020 Actual	Property Year To Date 06/30/2020 Actual	Medical Year To Date 06/30/2020 Actual	Dental Year To Date 06/30/2020 Actual	Vision Year To Date 06/30/2020 Actual	Auto Year To Date 06/30/2020 Actual	Post Retirement Benefits Year To Date 06/30/2020 Actual	All Programs Year To Date 06/30/2020 Actual
OPERATING INCOME (LOSS)									
OPERATING REVENUE									
Member Contributions	7,035,266	4,542,038	2,333,301	13,674,420	1,413,445	218,649	224,632	0	29,441,751
Fees Earned	97,450	7,200	750	136,677	14,020	12,618	0	0	268,715
TOTAL OPERATING REVENUE	7,132,716	4,549,238	2,334,051	13,811,097	1,427,465	231,267	224,632	0	29,710,466
OPERATING EXPENSES									
Claims Paid, Net	3,668,515	2,594,175	(57,725)	11,435,044	929,143	126,767	26	0	18,695,945
Claims Adjustment Expense	(817,052)	2,702,624	100,000	0	5,000	(4,227)	0	0	1,986,345
Excess Insurance	395,768	1,032,867	1,780,964	55,539	0	0	215,011	0	3,480,149
Claims Administration	579,964	124,625	0	2,342,945	161,708	32,344	0	0	3,241,586
Professional Services	128,144	49,685	3,749	45,382	2,528	2,528	3,750	0	235,766
Risk Management Expense	33,363	191,230	1,033	696	696	696	1,032	0	228,746
Salaries, Wages and Benefits	343,649	88,417	10,637	7,169	7,171	7,170	10,637	0	474,851
Administrative Expenses	146,951	35,327	4,147	7,330	2,794	2,795	4,147	0	203,491
Pension Expenses	347,285	37,119	4,465	3,011	3,011	3,010	4,465	(148,316)	254,049
TOTAL OPERATING EXPENSES	4,826,587	6,856,069	1,847,270	13,897,116	1,112,051	171,083	239,068	(148,316)	28,800,928
OPERATING INCOME (LOSS)	2,306,129	(2,306,831)	486,781	(86,019)	315,414	60,184	(14,436)	148,316	909,538
NONOPERATING REVENUE (EXPENSE)									
Rental Income	61,920	0	0	0	0	0	0	0	61,920
Investment Income	190,344	37,263	9,032	88,789	7,895	2,134	9,672	0	345,129
Unrealized Gains (Losses) on Investments	134,628	61,868	16,193	147,478	13,185	3,616	15,823	0	392,791
TOTAL NONOPERATING REVENUE (EXPENSE)	386,892	99,131	25,225	236,267	21,080	5,750	25,495	0	799,840
CHANGE IN NET POSITION	2,693,021	(2,207,700)	512,006	150,249	336,494	65,934	11,059	148,316	1,709,378
NET POSITION - BEGINNING	(4,643,951)	(1,802,111)	277,943	5,632,474	475,665	124,230	809,427	529,823	1,403,499
NET POSITION - ENDING	(1,950,930)	(4,009,811)	789,948	5,782,722	812,160	190,163	820,486	678,139	3,112,877

Redwood Empire Municipal Insurance Fund
Statement of Cash Flows By Fund
Unaudited

	Workers' Compensation Year To Date 06/30/2020	Liability Year To Date 06/30/2020	Property Year To Date 06/30/2020	Medical Year To Date 06/30/2020	Dental Year To Date 06/30/2020	Vision Year To Date 06/30/2020	Auto Year To Date 06/30/2020	Post Retirement Benefits Year To Date 06/30/2020	All Programs Year To Date 06/30/2020
Net Increase (Decrease) in Cash									
Cash Flows From Operating Activities									
Cash received from members	7,688,548	5,079,637	2,362,570	13,834,053	1,432,293	232,069	224,561	0	30,853,730
Payments for excess insurance	(395,769)	(1,032,867)	(1,780,964)	(55,539)	0	0	(215,011)	0	(3,480,150)
Payments for claims, claims consultants and claims administration	(4,248,478)	(2,784,545)	38,273	(13,777,989)	(1,090,851)	(159,112)	(26)	0	(22,022,727)
Payments to Vendors	(256,051)	(331,662)	(84,604)	(792,359)	12,504	(7,925)	(7,181)	0	(1,467,278)
Payments to or on behalf of employees	(487,918)	(125,536)	(15,103)	(10,180)	(10,181)	(10,181)	(15,102)	0	(674,200)
Total Cash Provided (Used) by Operating Activities	2,300,332	805,027	520,172	(802,014)	343,765	54,851	(12,759)	0	3,209,375
Cash Flows from Noncapital Financing Activities									
Rents received	61,920	0	0	0	0	0	0	0	61,920
Total Cash Provided (Used) by Noncapital Financing Activities	61,920	0	0	0	0	0	0	0	61,920
Cash Flows from Investing Activities									
Interest received (paid), net of fair value adjustment	168,481	37,001	8,824	88,456	7,889	2,127	9,602	0	322,380
(Purchase) sale of investments	2,242,767	185,178	(352,690)	(2,088,456)	(207,889)	(2,127)	(9,602)	0	(232,819)
Total Cash Provided (Used) by Investing Activities	2,411,248	222,179	(343,866)	(2,000,000)	(200,000)	0	0	0	89,561
Cash Flows from Capital and Related Financing Activities									
Sale (Acquisition) of capital assets	(117,152)	0	0	0	0	0	0	0	(117,152)
Total Cash Provided (Used) by Capital and Related Financing Activities	(117,152)	0	0	0	0	0	0	0	(117,152)
Net Increase (Decrease) in Cash	4,656,348	1,027,206	176,306	(2,802,014)	143,765	54,851	(12,759)	0	3,243,704
Cash, Beginning of Year	5,005,938	(1,008,673)	91,051	5,710,137	24,363	29,032	113,626	0	9,965,475
Cash, End of Year	9,662,286	18,534	267,357	2,908,124	168,128	83,884	100,867	0	13,209,178
Reconciliation of Operating Income to Net Cash Provided (Used) by Ops. Activity									
OPERATING INCOME (LOSS)	2,306,129	(2,306,831)	486,781	(86,019)	315,414	60,184	(14,436)	148,316	909,538
Depreciation Expense	17,063	0	0	0	0	0	0	0	17,063
(Increase) Decrease in Receivables	555,573	530,092	28,363	19,606	4,803	798	(167)	0	1,139,068
(Increase) Decrease in Prepaid Expenses	(43,615)	(83,344)	(954)	(38,849)	(377)	(380)	(570)	0	(168,088)
(Increase) Decrease in Deposits	0	(65,744)	(19,451)	0	0	0	0	0	(85,196)
(Increase) Decrease in Deferred Outflows of Resources	109,820	0	0	0	0	0	0	(109,994)	(174)
Increase (Decrease) in Accounts Payable	78,958	27,923	(74,722)	(700,102)	18,900	(1,527)	2,318	0	(648,250)
Increase (Decrease) in Unearned Revenue	260	307	155	3,350	25	3	96	0	4,195
Increase (Decrease) in Reserve for Losses and Claims	(817,052)	2,702,624	100,000	0	5,000	(4,227)	0	0	1,986,345
Increase (Decrease) in Net Pension Liability	100,998	0	0	0	0	0	0	(15,539)	85,459
Increase (Decrease) in Deferred Inflows of Resources	(7,802)	0	0	0	0	0	0	(22,783)	(30,585)
Net Cash Provided (Used) by Operating Activities	2,300,332	805,027	520,172	(802,014)	343,765	54,851	(12,759)	0	3,209,375

Redwood Empire Municipal Insurance Fund
Budget vs Actual
As of June 30, 2020

	Year Ending 06/30/2020 Annual Budget	Year To Date 06/30/2020 Budget YTD	Year To Date 06/30/2020 Actual	Budget YTD $ Var.	Budget YTD % Var.
Net Income (Loss)					
Revenues					
Contributions	$ 29,161,948	$ 29,161,948	$ 29,441,751	279,803	100.96 %
Fees Earned	491,300	491,300	268,715	(222,585) A	54.69 %
Rental Income	62,720	62,720	61,920	(800)	98.72 %
Investment Income	75,000	75,000	737,920	662,920	983.89 %
Total Revenues	29,790,968	29,790,968	30,510,306	719,338	102.41 %
Operating Expenses					
Claims Expense	19,617,805	19,617,805	20,682,290	1,064,485 B	105.43 %
Excess Insurance	3,133,026	3,133,026	3,480,149	347,124 C	111.08 %
Claims Administration	3,078,720	3,078,720	3,241,587	162,866 D	105.29 %
Professional Services	222,751	222,751	235,765	13,015	105.84 %
Risk Management Expense	234,237	234,237	228,746	(5,491)	97.66 %
Total Operating Expenses	26,286,539	26,286,539	27,868,537	1,581,999	106.02 %
General and Administrative Expenses					
Salaries, Wages and Benefits	682,164	682,164	474,851	(207,314)	69.61 %
Administrative Expenses	281,041	281,041	203,491	(77,550)	72.41 %
Pension Expenses	191,999	191,999	254,049	62,050 E	132.32 %
Total General and Administrative Expenses	1,155,204	1,155,204	932,391	(222,814)	80.71 %
Total Net Income (Loss)	2,349,225	2,349,225	1,709,378	(639,847)	72.76 %
NET POSITION - BEGINNING	0	0	1,403,499	1,403,499	0.00 %
ENDING NET POSITION	$ 2,349,225	$ 2,349,225	$ 3,112,877	763,652	132.51 %

Redwood Empire Municipal Insurance Fund

Notes to the Budget vs Actual

Expectation: The budget year to date (YTD) is 100% completed. The Budget YTD variance column on the Budget vs Actual report will show 100% if the actuals match the budget YTD. Any significant budget overages are explained below.

A. Fees Earned: Actual fees are calculated on a semi-annual basis. The budget for 19-20 year was overstated and less claims have been processed through REMIF.

B. Claims Expense: exceeded 5% ($1.1 million) above the budgeted amount. The claims expense includes current policy year ultimate loss and revision to ultimate losses for the older policy years. Overall, the current year ultimate loss exceeded the budgeted amount by $1.3M which was offset by decrease in the older policy years ultimate's of $380K. The workers' compensation claims have developed favorably leading to a decrease in prior policy ultimate losses of $2M while the Liability program has experienced unfavorable claims development leading to an increase in ultimate losses of $2.4M.

C. Excess Insurance: is up 11% from the budget due to the pass-through coverages being budgeted lower than the actual cost. While majority of increases are isolated to the Property program, APD was budgeted lower than expected due to fund balance in the APD program. And, the Workers' Compensation program received a payroll true-up bill from it's excess carrier which was not budgeted for.

D. Claims Administration: is up 5% from the budget due to timing the monthly bills received and recorded as well as the recording of the medical program cost. In the prior years, the claims administration cost were recorded net of available bank balance. The budget for FY 19-20 was compiled using the net of claims administration cost. In order to ensure that the cost is being recorded correctly, the claims administration expense is being recorded at the full gross amount.

E. Pension Expenses: is above budget by 32% due to recording of the pension liability at the end of the year. The recognition of the liability is based upon actuarial report provided by CalPERS.

Redwood Empire Municipal Insurance Fund
Budget vs Actual
As of June 30, 2020

	Workers' Compensation Year Ending 06/30/2020 Annual Budget	Workers' Compensation Year To Date 06/30/2020 Budget YTD	Workers' Compensation Year To Date 06/30/2020 Actual	Budget YTD $ Var.	Budget YTD % Var.
Net Income (Loss)					
Revenues					
Contributions	$ 7,027,600	$ 7,027,600	$ 7,035,266	7,666	100.11 %
Fees Earned	301,000	301,000	97,450	(203,551)	32.38 %
Rental Income	62,720	62,720	61,919	(800)	98.72 %
Investment Income	35,250	35,250	324,972	289,722	921.91 %
Total Revenues	7,426,570	7,426,570	7,519,607	93,037	101.25 %
Operating Expenses					
Claims Expense	4,606,330	4,606,330	2,851,462	(1,754,868)	61.90 %
Excess Insurance	350,000	350,000	395,768	45,769	113.08 %
Claims Administration	613,000	613,000	579,964	(33,036)	94.61 %
Professional Services	146,174	146,174	128,144	(18,030)	87.67 %
Risk Management Expense	5,460	5,460	33,363	27,903	611.05 %
Total Operating Expenses	5,720,964	5,720,964	3,988,701	(1,732,262)	69.72 %
General and Administrative Expenses					
Salaries, Wages and Benefits	493,698	493,698	343,650	(150,049)	69.61 %
Administrative Expenses	203,401	203,401	146,950	(56,450)	72.25 %
Pension Expenses	138,955	138,955	347,285	208,329	249.93 %
Total General and Administrative Expenses	836,054	836,054	837,885	1,830	100.22 %
Total Net Income (Loss)	869,552	869,552	2,693,021	1,823,469	309.70 %
NET POSITION - BEGINNING	0	0	(4,643,951)	(4,643,951)	0.00 %
ENDING NET POSITION	$ 869,552	$ 869,552	$ (1,950,930)	(2,820,482)	(224.36) %

Redwood Empire Municipal Insurance Fund
Budget vs Actual
As of June 30, 2020

	Liability Year Ending 06/30/2020 Annual Budget	Liability Year To Date 06/30/2020 Budget YTD	Liability Year To Date 06/30/2020 Actual	Budget YTD $ Var.	Budget YTD % Var.
Net Income (Loss)					
Revenues					
Contributions	$ 4,552,032	$ 4,552,032	$ 4,542,038	(9,994)	99.78 %
Fees Earned	5,500	5,500	7,200	1,700	130.91 %
Investment Income	17,250	17,250	99,131	81,881	574.67 %
Total Revenues	4,574,782	4,574,782	4,648,369	73,587	101.61 %
Operating Expenses					
Claims Expense	2,332,175	2,332,175	5,296,799	2,964,625	227.12 %
Excess Insurance	1,078,420	1,078,420	1,032,867	(45,553)	95.78 %
Claims Administration	123,500	123,500	124,625	1,125	100.91 %
Professional Services	43,753	43,753	49,685	5,932	113.56 %
Risk Management Expense	228,777	228,777	191,230	(37,548)	83.59 %
Total Operating Expenses	3,806,625	3,806,625	6,695,206	2,888,581	175.88 %
General and Administrative Expenses					
Salaries, Wages and Benefits	127,033	127,033	88,417	(38,616)	69.60 %
Administrative Expenses	52,336	52,336	35,327	(17,008)	67.50 %
Pension Expenses	35,754	35,754	37,119	1,365	103.82 %
Total General and Administrative Expenses	215,123	215,123	160,863	(54,259)	74.78 %
Total Net Income (Loss)	553,034	553,034	(2,207,700)	(2,760,734)	(399.20) %
NET POSITION - BEGINNING	0	0	(1,802,111)	(1,802,111)	0.00 %
ENDING NET POSITION	$ 553,034	$ 553,034	$ (4,009,811)	(4,562,845)	(725.06) %

Redwood Empire Municipal Insurance Fund
Budget vs Actual
As of June 30, 2020

	Property Year Ending 06/30/2020 Annual Budget	Property Year To Date 06/30/2020 Budget YTD	Property Year To Date 06/30/2020 Actual	Budget YTD $ Var.	Budget YTD % Var.
Net Income (Loss)					
Revenues					
Contributions	$ 1,483,550	$ 1,483,550	$ 2,333,301	849,751	157.28 %
Fees Earned	0	0	750	750	0.00 %
Investment Income	3,000	3,000	25,225	22,225	840.83 %
Total Revenues	1,486,550	1,486,550	2,359,276	872,726	158.71 %
Operating Expenses					
Claims Expense	0	0	42,275	42,275	0.00 %
Excess Insurance	1,453,550	1,453,550	1,780,964	327,414	122.53 %
Professional Services	4,058	4,058	3,749	(309)	92.40 %
Risk Management Expense	0	0	1,033	1,033	0.00 %
Total Operating Expenses	1,457,608	1,457,608	1,828,021	370,413	125.41 %
General and Administrative Expenses					
Salaries, Wages and Benefits	15,271	15,271	10,637	(4,634)	69.66 %
Administrative Expenses	6,292	6,292	4,147	(2,145)	65.91 %
Pension Expenses	4,298	4,298	4,465	167	103.90 %
Total General and Administrative Expenses	25,861	25,861	19,249	(6,612)	74.43 %
Total Net Income (Loss)	3,081	3,081	512,006	508,925	16,618.16 %
NET POSITION - BEGINNING	0	0	277,943	277,943	0.00 %
ENDING NET POSITION	$ 3,081	$ 3,081	$ 789,948	786,867	25,639.35 %

Redwood Empire Municipal Insurance Fund
Budget vs Actual
As of June 30, 2020

	Medical Year Ending 06/30/2020 Annual Budget	Medical Year To Date 06/30/2020 Budget YTD	Medical Year To Date 06/30/2020 Actual	Budget YTD $ Var.	Budget YTD % Var.
Net Income (Loss)					
Revenues					
Contributions	$ 14,270,430	$ 14,270,430	$ 13,674,420	(596,010)	95.82 %
Fees Earned	159,600	159,600	136,677	(22,923)	85.64 %
Investment Income	5,850	5,850	236,267	230,417	4,038.75 %
Total Revenues	14,435,880	14,435,880	14,047,364	(388,516)	97.31 %
Operating Expenses					
Claims Expense	11,245,540	11,245,540	11,435,044	189,505	101.69 %
Excess Insurance	54,370	54,370	55,539	1,169	102.15 %
Claims Administration	2,121,800	2,121,800	2,342,945	221,145	110.42 %
Professional Services	19,236	19,236	45,382	26,146	235.92 %
Risk Management Expense	0	0	696	696	0.00 %
Total Operating Expenses	13,440,946	13,440,946	13,879,606	438,661	103.26 %
General and Administrative Expenses					
Salaries, Wages and Benefits	10,297	10,297	7,169	(3,128)	69.62 %
Administrative Expenses	4,240	4,240	7,330	3,090	172.88 %
Pension Expenses	2,898	2,898	3,011	112	103.87 %
Total General and Administrative Expenses	17,435	17,435	17,510	74	100.43 %
Total Net Income (Loss)	977,499	977,499	150,249	(827,251)	15.37 %
NET POSITION - BEGINNING	0	0	5,632,474	5,632,474	0.00 %
ENDING NET POSITION	$ 977,499	$ 977,499	$ 5,782,722	4,805,223	591.58 %

Redwood Empire Municipal Insurance Fund
Budget vs Actual
As of June 30, 2020

	Dental Year Ending 06/30/2020 Annual Budget	Dental Year To Date 06/30/2020 Budget YTD	Dental Year To Date 06/30/2020 Actual	Budget YTD $ Var.	Budget YTD % Var.
Net Income (Loss)					
Revenues					
Contributions	$ 1,339,000	$ 1,339,000	$ 1,413,445	74,445	105.56 %
Fees Earned	13,200	13,200	14,020	820	106.21 %
Investment Income	5,700	5,700	21,080	15,380	369.82 %
Total Revenues	1,357,900	1,357,900	1,448,545	90,645	106.68 %
Operating Expenses					
Claims Expense	1,273,080	1,273,080	934,143	(338,937)	73.38 %
Claims Administration	175,100	175,100	161,708	(13,392)	92.35 %
Professional Services	2,736	2,736	2,528	(208)	92.38 %
Risk Management Expense	0	0	696	696	0.00 %
Total Operating Expenses	1,450,916	1,450,916	1,099,075	(351,841)	75.75 %
General and Administrative Expenses					
Salaries, Wages and Benefits	10,297	10,297	7,171	(3,127)	69.63 %
Administrative Expenses	4,240	4,240	2,794	(1,445)	65.92 %
Pension Expenses	2,898	2,898	3,011	112	103.87 %
Total General and Administrative Expenses	17,435	17,435	12,976	(4,460)	74.42 %
Total Net Income (Loss)	(110,451)	(110,451)	336,494	446,945	(304.65) %
NET POSITION - BEGINNING	0	0	475,665	475,665	0.00 %
ENDING NET POSITION	$ (110,451)	$ (110,451)	$ 812,160	922,611	(735.31) %

Redwood Empire Municipal Insurance Fund
Budget vs Actual
As of June 30, 2020

	Vision Year Ending 06/30/2020 Annual Budget	Vision Year To Date 06/30/2020 Budget YTD	Vision Year To Date 06/30/2020 Actual	Budget YTD $ Var.	Budget YTD % Var.
Net Income (Loss)					
Revenues					
Contributions	$ 262,650	$ 262,650	$ 218,649	(44,001)	83.25 %
Fees Earned	12,000	12,000	12,618	618	105.15 %
Investment Income	5,700	5,700	5,750	50	100.88 %
Total Revenues	280,350	280,350	237,017	(43,333)	84.54 %
Operating Expenses					
Claims Expense	160,680	160,680	122,540	(38,139)	76.26 %
Claims Administration	45,320	45,320	32,344	(12,976)	71.37 %
Professional Services	2,736	2,736	2,528	(208)	92.38 %
Risk Management Expense	0	0	696	696	0.00 %
Total Operating Expenses	208,736	208,736	158,108	(50,627)	75.75 %
General and Administrative Expenses					
Salaries, Wages and Benefits	10,297	10,297	7,170	(3,127)	69.63 %
Administrative Expenses	4,240	4,240	2,795	(1,445)	65.92 %
Pension Expenses	2,898	2,898	3,010	112	103.87 %
Total General and Administrative Expenses	17,435	17,435	12,975	(4,460)	74.42 %
Total Net Income (Loss)	54,179	54,179	65,934	11,755	121.70 %
NET POSITION - BEGINNING	0	0	124,230	124,230	0.00 %
ENDING NET POSITION	$ 54,179	$ 54,179	$ 190,163	135,984	350.99 %

Redwood Empire Municipal Insurance Fund
Budget vs Actual
As of June 30, 2020

	Auto Year Ending 06/30/2020 Annual Budget	Auto Year To Date 06/30/2020 Budget YTD	Auto Year To Date 06/30/2020 Actual	Budget YTD $ Var.	Budget YTD % Var.
Net Income (Loss)					
Revenues					
Contributions	$ 226,686	$ 226,686	$ 224,632	(2,054)	99.09 %
Investment Income	2,250	2,250	25,495	23,245	1,133.11 %
Total Revenues	228,936	228,936	250,127	21,191	109.26 %
Operating Expenses					
Claims Expense	0	0	26	26	0.00 %
Excess Insurance	196,686	196,686	215,011	18,325	109.32 %
Professional Services	4,058	4,058	3,750	(308)	92.40 %
Risk Management Expense	0	0	1,032	1,032	0.00 %
Total Operating Expenses	200,744	200,744	219,819	19,075	109.50 %
General and Administrative Expenses					
Salaries, Wages and Benefits	15,271	15,271	10,637	(4,634)	69.65 %
Administrative Expenses	6,292	6,292	4,147	(2,145)	65.90 %
Pension Expenses	4,298	4,298	4,465	167	103.90 %
Total General and Administrative Expenses	25,861	25,861	19,249	(6,612)	74.43 %
Total Net Income (Loss)	2,331	2,331	11,059	8,728	474.41 %
NET POSITION - BEGINNING	0	0	809,427	809,427	0.00 %
ENDING NET POSITION	$ 2,331	$ 2,331	$ 820,486	818,155	35,198.87 %

REMIF
Statement of Fiduciary Net Position
OPEB Trust Fund

	Year To Date 06/30/2020 Current Year Balance	Year Ending 06/30/2019 Prior Year
Assets		
Investments	$ 2,795,935	$ 2,922,246
Total Assets	**2,795,935**	**2,922,246**
Liabilities		
Other Payables	59,760	46,193
Total Liabilities	**59,760**	**46,193**
Net Position restricted for OPEB - End of year	**$ 2,736,175**	**$ 2,876,053**

Redwood Empire Municipal Insurance Fund
Statement of Changes in Fiduciary Net Position
OPEB Trust Fund
As of June 30, 2020

	Year To Date 06/30/2020 Actual	Year Ending 06/30/2019 Prior Year
Additions		
Contributions to OPEB Plan	$ 4,705	$ 16,442
Investment Income		
Interest and Dividends	(8,276)	146,442
Less: investment expenses	7,208	7,158
Total Additions	(10,779)	155,726
Deductions		
Benefits	129,099	258,703
Total Deductions	129,099	258,703
Total Change in net position	(139,878)	(102,977)
Net Position restricted for OPEB - Beginning of year	2,876,053	2,979,030
Total Net Position restricted for OPEB - End of year	$ 2,736,175	$ 2,876,053

Redwood Empire Municipal Insurance Fund
Statement of Net Position by Fund
As of September 30, 2020
Unaudited

	Workers' Compensation	Liability	Property	Medical	Dental	Vision	Auto	Post Retirement Benefits	All Programs
ASSETS									
CURRENT ASSETS									
Cash & Cash Equivalents	11,055,304	3,064,193	82,832	3,724,674	146,168	48,124	198,668	0	18,319,965
Receivables	4,089,576	3,083,608	898,792	127,290	10,184	2,116	59,577	0	8,271,142
Prepaid Expense	309,487	1,052,667	1,920,567	38,878	406	409	186,325	0	3,508,738
Deposits	0	424,217	(78,582)	0	0	0	(46,814)	0	298,822
TOTAL CURRENT ASSETS	15,454,367	7,624,685	2,823,609	3,890,842	156,758	50,649	397,756	0	30,398,667
NONCURRENT ASSETS									
Investments	3,698,776	2,299,076	817,019	4,367,636	738,744	129,632	724,582	0	12,775,464
Capital Assets, Net of Accumulated Depreciation	473,777	0	0	0	0	0	0	0	473,777
Net Pension Asset	0	0	0	0	0	0	0	568,145	568,145
TOTAL NONCURRENT ASSETS	4,172,553	2,299,076	817,019	4,367,636	738,744	129,632	724,582	568,145	13,817,386
TOTAL ASSETS	**19,626,920**	**9,923,761**	**3,640,628**	**8,258,478**	**895,502**	**180,281**	**1,122,338**	**568,145**	**44,216,053**
DEFERRED OUTFLOWS OF RESOURCES	**549,945**	**0**	**0**	**0**	**0**	**0**	**0**	**109,994**	**659,939**
LIABILITIES									
CURRENT LIABILITIES									
Accounts Payable	32,882	1,314,851	56,335	20,991	2,777	2,794	4,473	0	1,435,104
Unearned Revenue	0	4,230,107	2,387,074	0	0	0	270,701	0	6,887,882
Tenant and Other Deposits	10,346	0	0	0	0	0	0	0	10,345
TOTAL CURRENT LIABILITIES	43,228	5,544,958	2,443,409	20,991	2,777	2,794	275,174	0	8,333,331
NONCURRENT LIABILITIES									
Reserve for Losses and Claims	19,283,400	8,154,011	265,490	1,250,000	55,000	10,000	0	0	29,017,901
Net Pension Liability	2,256,336	0	0	0	0	0	0	0	2,256,336
TOTAL NONCURRENT LIABILITIES	21,539,736	8,154,011	265,490	1,250,000	55,000	10,000	0	0	31,274,237
TOTAL LIABILITIES	**21,582,964**	**13,698,969**	**2,708,899**	**1,270,991**	**57,777**	**12,794**	**275,174**	**0**	**39,607,568**
DEFERRED INFLOWS OF RESOURCES	**185,787**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**185,787**
ENDING NET POSITION									
NET POSITION - ENDING									
Net Position Unrestricted	(1,591,886)	(3,775,208)	931,729	6,987,486	837,725	167,487	847,164	678,139	5,082,637
TOTAL NET POSITION - ENDING	(1,591,886)	(3,775,208)	931,729	6,987,486	837,725	167,487	847,164	678,139	5,082,637
TOTAL ENDING NET POSITION	**(1,591,886)**	**(3,775,208)**	**931,729**	**6,987,486**	**837,725**	**167,487**	**847,164**	**678,139**	**5,082,637**

Redwood Empire Municipal Insurance Fund
Statement of Revenues, Expenses and Changes in Net Position
As of September 30, 2020
Unaudited

	Workers' Compensation Year To Date 09/30/2020 Actual	Liability Year To Date 09/30/2020 Actual	Property Year To Date 09/30/2020 Actual	Medical Year To Date 09/30/2020 Actual	Dental Year To Date 09/30/2020 Actual	Vision Year To Date 09/30/2020 Actual	Auto Year To Date 09/30/2020 Actual	Post Retirement Benefits Year To Date 09/30/2020 Actual	All Programs Year To Date 09/30/2020 Actual
OPERATING INCOME (LOSS)									
OPERATING REVENUE									
Member Contributions	1,777,099	1,450,388	893,521	3,714,525	348,721	53,764	97,447	0	8,335,466
Fees Earned	0	0	0	33,182	3,465	3,147	0	0	39,794
TOTAL OPERATING REVENUE	1,777,099	1,450,388	893,521	3,747,707	352,186	56,911	97,447	0	8,375,260
OPERATING EXPENSES									
Claims Paid, Net	822,515	1,041,486	0	1,883,532	275,359	53,260	(19,405)	0	4,056,748
Claims Adjustment Expense	415,481	(287,162)	65,490	0	0	0	0	0	193,809
Excess Insurance	88,168	322,874	639,858	5,256	0	0	63,764	0	1,119,920
Claims Administration	85,666	32,000	0	587,049	35,946	7,961	0	0	748,621
Professional Services	29,409	16,013	4,295	22,991	1,750	1,763	2,643	0	78,865
Risk Management Expense	0	23,233	0	0	0	0	0	0	23,233
Salaries, Wages and Benefits	2,898	21,822	12,976	23,482	5,122	5,164	7,749	0	79,212
Administrative Expenses	3,019	4,420	2,101	3,692	856	863	1,293	0	16,247
Pension Expenses	46,362	54,831	27,665	48,642	11,270	11,357	17,025	0	217,151
TOTAL OPERATING EXPENSES	1,493,518	1,229,517	752,385	2,574,644	330,303	80,368	73,069	0	6,533,806
OPERATING INCOME (LOSS)	283,581	220,871	141,136	1,173,063	21,883	(23,457)	24,378	0	1,841,454
NONOPERATING REVENUE (EXPENSE)									
Rental Income	17,158	0	0	0	0	0	0	0	17,158
Investment Income	43,419	8,693	(205)	23,720	2,780	595	1,343	0	80,345
Unrealized Gains (Losses) on Investments	14,886	5,039	850	7,981	903	186	958	0	30,803
TOTAL NONOPERATING REVENUE (EXPENSE)	75,463	13,732	645	31,701	3,683	781	2,301	0	128,306
CHANGE IN NET POSITION	359,045	234,603	141,781	1,204,764	25,566	(22,676)	26,678	0	1,969,760
NET POSITION - BEGINNING	(1,950,930)	(4,009,811)	789,948	5,782,722	812,160	190,163	820,486	678,139	3,112,877
NET POSITION - ENDING	(1,591,886)	(3,775,208)	931,729	6,987,486	837,725	167,487	847,164	678,139	5,082,637

Redwood Empire Municipal Insurance Fund
Statement of Cash Flows By Fund
Unaudited

	Workers' Compensation Year To Date 09/30/2020	Liability Year To Date 09/30/2020	Property Year To Date 09/30/2020	Medical Year To Date 09/30/2020	Dental Year To Date 09/30/2020	Vision Year To Date 09/30/2020	Auto Year To Date 09/30/2020	All Programs Year To Date 09/30/2020
Net Increase (Decrease) in Cash								
Cash Flows From Operating Activities								
Cash received from members	2,778,633	4,353,334	2,418,861	3,598,648	337,210	54,041	308,871	13,849,597
Payments for excess insurance	(352,671)	(1,291,841)	(2,559,427)	(5,256)	0	0	(249,475)	(4,458,670)
Payments for claims, claims consultants and claims administration	(908,182)	(1,177,018)	98,033	(2,470,581)	(311,306)	(61,221)	66,219	(4,764,055)
Payments to Vendors	(106,832)	1,235,945	(101,218)	(241,683)	(32,375)	(12,259)	(2,660)	738,918
Payments to or on behalf of employees	(49,260)	(76,653)	(40,641)	(72,124)	(16,392)	(16,521)	(24,773)	(296,364)
Total Cash Provided (Used) by Operating Activities	1,361,688	3,043,767	(184,392)	809,004	(22,863)	(35,960)	98,182	5,069,426
Cash Flows from Noncapital Financing Activities								
Rents received	17,158	0	0	0	0	0	0	17,158
Total Cash Provided (Used) by Noncapital Financing Activities	17,158	0	0	0	0	0	0	17,158
Cash Flows from Investing Activities								
Interest received (paid), net of fair value adjustment	46,734	10,294	28	25,387	2,957	627	1,564	87,591
(Purchase) sale of investments	(32,561)	(8,401)	(160)	(17,841)	(2,054)	(426)	(1,945)	(63,388)
Total Cash Provided (Used) by Investing Activities	14,173	1,893	(132)	7,546	903	201	(381)	24,203
Net Increase (Decrease) in Cash	1,393,019	3,045,660	(184,524)	816,550	(21,960)	(35,759)	97,801	5,110,787
Cash, Beginning of Year	9,662,286	18,534	267,357	2,908,124	168,128	83,884	100,867	13,209,178
Cash, End of Year	11,055,304	3,064,193	82,832	3,724,674	146,168	48,124	198,668	18,319,965
Reconciliation of Operating Income to Net Cash Provided (Used) by Ops. Activity								
OPERATING INCOME (LOSS)	283,581	220,871	141,136	1,173,063	21,883	(23,457)	24,378	1,841,454
(Increase) Decrease in Receivables	1,001,793	(1,326,854)	(861,579)	(145,708)	(14,952)	(2,868)	(59,182)	(1,409,349)
(Increase) Decrease in Prepaid Expenses	(264,483)	(968,966)	(1,919,570)	0	0	0	(185,711)	(3,338,730)
(Increase) Decrease in Deposits	0	(103,533)	98,033	0	0	0	46,814	41,315
Increase (Decrease) in Accounts Payable	(74,424)	1,279,611	(94,821)	(215,000)	(29,769)	(9,632)	1,277	857,241
Increase (Decrease) in Unearned Revenue	(260)	4,229,800	2,386,919	(3,351)	(25)	(3)	270,606	6,883,686
Increase (Decrease) in Reserve for Losses and Claims	415,481	(287,162)	65,490	0	0	0	0	193,809
Net Cash Provided (Used) by Operating Activities	1,361,688	3,043,767	(184,392)	809,004	(22,863)	(35,960)	98,182	5,069,426

Redwood Empire Municipal Insurance Fund
Budget vs Actual
As of September 30, 2020

	Year Ending 06/30/2021 Annual Budget	Year To Date 09/30/2020 Budget YTD	Year To Date 09/30/2020 Actual	Budget YTD $ Var.	Budget YTD % Var.
Net Income (Loss)					
Revenues					
Contributions	$ 32,144,372	$ 8,102,143	$ 8,335,466	233,323	102.88 %
Fees Earned	273,600	68,962	39,794	(29,168)	57.70 %
Rental Income	71,300	17,972	17,158	(814)	95.47 %
Investment Income	75,000	18,904	111,148	92,244	587.96 %
Total Revenues	32,564,272	8,207,981	8,503,566	295,585	103.60 %
Operating Expenses					
Claims Expense	21,192,821	5,341,752	4,250,557	(1,091,195)	79.57 %
Excess Insurance	5,040,783	1,270,554	1,119,920	(150,634)	88.14 %
Claims Administration	3,288,060	828,771	748,621	(80,150)	90.33 %
Professional Services	220,247	55,514	78,865	23,351	142.06 %
Risk Management Expense	245,949	61,993	23,233	(38,760)	37.48 %
Total Operating Expenses	29,987,860	7,558,584	6,221,196	(1,337,388)	82.31 %
General and Administrative Expenses					
Salaries, Wages and Benefits	753,577	189,943	79,212	(110,730)	41.70 %
Administrative Expenses	288,375	72,686	16,247	(56,440)	22.35 %
Pension Expenses	230,000	57,973	217,151	159,178	374.58 %
Total General and Administrative Expenses	1,271,952	320,602	312,610	(7,992)	97.51 %
Total Net Income (Loss)	1,304,460	328,795	1,969,760	1,640,965	599.08 %
NET POSITION - BEGINNING	0	0	3,112,877	3,112,877	0.00 %
ENDING NET POSITION	$ 1,304,460	$ 328,795	$ 5,082,637	4,753,842	1,545.84 %

Redwood Empire Municipal Insurance Fund
Budget vs Actual
As of September 30, 2020

	Workers' Compensation Year Ending 06/30/2021 Annual Budget	Workers' Compensation Year To Date 09/30/2020 Budget YTD	Workers' Compensation Year To Date 09/30/2020 Actual	Budget YTD $ Var.	Budget YTD % Var.
Net Income (Loss)					
Revenues					
Contributions	$ 7,362,265	$ 1,855,694	$ 1,777,099	(78,595)	95.76 %
Fees Earned	100,000	25,206	0	(25,205)	0.00 %
Rental Income	71,300	17,971	17,159	(814)	95.47 %
Investment Income	35,250	8,885	58,305	49,421	656.23 %
Total Revenues	7,568,815	1,907,756	1,852,563	(55,193)	97.11 %
Operating Expenses					
Claims Expense	5,134,690	1,294,223	1,237,997	(56,227)	95.66 %
Excess Insurance	656,367	165,441	88,168	(77,272)	53.29 %
Claims Administration	570,000	143,671	85,666	(58,005)	59.63 %
Professional Services	53,163	13,400	29,408	16,008	219.47 %
Risk Management Expense	5,733	1,445	0	(1,445)	0.00 %
Total Operating Expenses	6,419,953	1,618,180	1,441,239	(176,941)	89.07 %
General and Administrative Expenses					
Salaries, Wages and Benefits	160,889	40,553	2,899	(37,655)	7.15 %
Administrative Expenses	61,566	15,518	3,019	(12,499)	19.46 %
Pension Expenses	49,105	12,377	46,361	33,985	374.58 %
Total General and Administrative Expenses	271,560	68,448	52,279	(16,169)	76.38 %
Total Net Income (Loss)	877,302	221,128	359,045	137,916	162.37 %
NET POSITION - BEGINNING	0	0	(1,950,930)	(1,950,930)	0.00 %
ENDING NET POSITION	$ 877,302	$ 221,128	$ (1,591,886)	(1,813,014)	(719.89) %

Redwood Empire Municipal Insurance Fund
Budget vs Actual
As of September 30, 2020

	Liability Year Ending 06/30/2021 Annual Budget	Liability Year To Date 09/30/2020 Budget YTD	Liability Year To Date 09/30/2020 Actual	Budget YTD $ Var.	Budget YTD % Var.
Net Income (Loss)					
Revenues					
Contributions	$ 5,592,039	$ 1,409,500	$ 1,450,388	40,888	102.90 %
Fees Earned	4,400	1,109	0	(1,109)	0.00 %
Investment Income	17,250	4,348	13,732	9,384	315.83 %
Total Revenues	5,613,689	1,414,957	1,464,120	49,163	103.47 %
Operating Expenses					
Claims Expense	2,998,451	755,774	754,324	(1,450)	99.81 %
Excess Insurance	1,243,900	313,531	322,874	9,343	102.98 %
Claims Administration	127,000	32,011	32,000	(11)	99.97 %
Professional Services	55,134	13,896	16,013	2,117	115.23 %
Risk Management Expense	240,216	60,548	23,233	(37,315)	38.37 %
Total Operating Expenses	4,664,701	1,175,760	1,148,444	(27,316)	97.68 %
General and Administrative Expenses					
Salaries, Wages and Benefits	190,278	47,961	21,822	(26,139)	45.50 %
Administrative Expenses	72,815	18,353	4,420	(13,933)	24.08 %
Pension Expenses	58,075	14,638	54,831	40,193	374.58 %
Total General and Administrative Expenses	321,168	80,952	81,073	121	100.15 %
Total Net Income (Loss)	627,820	158,245	234,603	76,358	148.25 %
NET POSITION - BEGINNING	0	0	(4,009,811)	(4,009,811)	0.00 %
ENDING NET POSITION	$ 627,820	$ 158,245	$ (3,775,208)	(3,933,453)	(2,385.67) %

Redwood Empire Municipal Insurance Fund
Budget vs Actual
As of September 30, 2020

	Property Year Ending 06/30/2021 Annual Budget	Property Year To Date 09/30/2020 Budget YTD	Property Year To Date 09/30/2020 Actual	Budget YTD $ Var.	Budget YTD % Var.
Net Income (Loss)					
Revenues					
Contributions	$ 3,307,316	$ 833,625	$ 893,521	59,896	107.19 %
Investment Income	3,000	756	645	(111)	85.30 %
Total Revenues	3,310,316	834,381	894,166	59,785	107.17 %
Operating Expenses					
Claims Expense	0	0	65,490	65,490	0.00 %
Excess Insurance	2,823,997	711,802	639,858	(71,944)	89.89 %
Professional Services	22,772	5,740	4,295	(1,445)	74.83 %
Total Operating Expenses	2,846,769	717,542	709,643	(7,899)	98.90 %
General and Administrative Expenses					
Salaries, Wages and Benefits	96,006	24,199	12,976	(11,222)	53.62 %
Administrative Expenses	36,739	9,260	2,101	(7,159)	22.69 %
Pension Expenses	29,302	7,386	27,665	20,279	374.58 %
Total General and Administrative Expenses	162,047	40,845	42,742	1,898	104.65 %
Total Net Income (Loss)	301,500	75,994	141,781	65,786	186.57 %
NET POSITION - BEGINNING	0	0	789,948	789,948	0.00 %
ENDING NET POSITION	$ 301,500	$ 75,994	$ 931,729	855,735	1,226.05 %

Redwood Empire Municipal Insurance Fund
Budget vs Actual
As of September 30, 2020

	Medical Year Ending 06/30/2021 Annual Budget	Medical Year To Date 09/30/2020 Budget YTD	Medical Year To Date 09/30/2020 Actual	Budget YTD $ Var.	Budget YTD % Var.
Net Income (Loss)					
Revenues					
Contributions	$ 13,879,872	$ 3,498,488	$ 3,714,525	216,037	106.18 %
Fees Earned	141,600	35,691	33,182	(2,510)	92.97 %
Investment Income	5,850	1,475	31,701	30,227	2,149.92 %
Total Revenues	14,027,322	3,535,654	3,779,408	243,754	106.89 %
Operating Expenses					
Claims Expense	11,582,906	2,919,527	1,883,532	(1,035,996)	64.51 %
Excess Insurance	57,090	14,390	5,256	(9,133)	36.53 %
Claims Administration	2,370,640	597,531	587,049	(10,483)	98.25 %
Professional Services	56,539	14,251	22,991	8,741	161.33 %
Total Operating Expenses	14,067,175	3,545,699	2,498,828	(1,046,871)	70.47 %
General and Administrative Expenses					
Salaries, Wages and Benefits	168,801	42,547	23,482	(19,066)	55.19 %
Administrative Expenses	64,596	16,282	3,692	(12,589)	22.68 %
Pension Expenses	51,520	12,986	48,642	35,656	374.58 %
Total General and Administrative Expenses	284,917	71,815	75,816	4,001	105.57 %
Total Net Income (Loss)	(324,770)	(81,860)	1,204,764	1,286,624	(1,471.74) %
NET POSITION - BEGINNING	0	0	5,782,722	5,782,722	0.00 %
ENDING NET POSITION	$ (324,770)	$ (81,860)	$ 6,987,486	7,069,346	(8,535.91) %

Redwood Empire Municipal Insurance Fund
Budget vs Actual
As of September 30, 2020

	Dental Year Ending 06/30/2021 Annual Budget	Dental Year To Date 09/30/2020 Budget YTD	Dental Year To Date 09/30/2020 Actual	Budget YTD $ Var.	Budget YTD % Var.
Net Income (Loss)					
Revenues					
Contributions	$ 1,411,998	$ 355,901	$ 348,721	(7,180)	97.98 %
Fees Earned	14,400	3,629	3,465	(164)	95.47 %
Investment Income	5,700	1,437	3,683	2,246	256.35 %
Total Revenues	1,432,098	360,967	355,869	(5,098)	98.59 %
Operating Expenses					
Claims Expense	1,311,272	330,512	275,359	(55,153)	83.31 %
Claims Administration	175,100	44,135	35,946	(8,189)	81.45 %
Professional Services	9,277	2,338	1,750	(588)	74.84 %
Total Operating Expenses	1,495,649	376,985	313,055	(63,930)	83.04 %
General and Administrative Expenses					
Salaries, Wages and Benefits	39,111	9,858	5,122	(4,736)	51.96 %
Administrative Expenses	14,967	3,773	856	(2,916)	22.70 %
Pension Expenses	11,937	3,009	11,270	8,261	374.58 %
Total General and Administrative Expenses	66,015	16,640	17,248	609	103.66 %
Total Net Income (Loss)	(129,566)	(32,658)	25,566	58,223	(78.28) %
NET POSITION - BEGINNING	0	0	812,160	812,160	0.00 %
ENDING NET POSITION	$ (129,566)	$ (32,658)	$ 837,725	870,383	(2,565.17) %

Redwood Empire Municipal Insurance Fund
Budget vs Actual
As of September 30, 2020

	Vision Year Ending 06/30/2021 Annual Budget	Vision Year To Date 09/30/2020 Budget YTD	Vision Year To Date 09/30/2020 Actual	Budget YTD $ Var.	Budget YTD % Var.
Net Income (Loss)					
Revenues					
Contributions	$ 218,518	$ 55,079	$ 53,764	(1,314)	97.61 %
Fees Earned	13,200	3,327	3,147	(180)	94.59 %
Investment Income	5,700	1,436	781	(656)	54.36 %
Total Revenues	237,418	59,842	57,692	(2,150)	96.41 %
Operating Expenses					
Claims Expense	165,500	41,715	53,260	11,545	127.68 %
Claims Administration	45,320	11,423	7,961	(3,462)	69.69 %
Professional Services	9,349	2,356	1,763	(593)	74.83 %
Total Operating Expenses	220,169	55,494	62,984	7,490	113.50 %
General and Administrative Expenses					
Salaries, Wages and Benefits	39,412	9,934	5,164	(4,770)	51.99 %
Administrative Expenses	15,082	3,802	863	(2,938)	22.70 %
Pension Expenses	12,029	3,032	11,357	8,325	374.57 %
Total General and Administrative Expenses	66,523	16,768	17,384	617	103.68 %
Total Net Income (Loss)	(49,274)	(12,420)	(22,676)	(10,257)	182.58 %
NET POSITION - BEGINNING	0	0	190,163	190,163	0.00 %
ENDING NET POSITION	$ (49,274)	$ (12,420)	$ 167,487	179,907	(1,348.55) %

Redwood Empire Municipal Insurance Fund
Budget vs Actual
As of September 30, 2020

	Auto Year Ending 06/30/2021 Annual Budget	Auto Year To Date 09/30/2020 Budget YTD	Auto Year To Date 09/30/2020 Actual	Budget YTD $ Var.	Budget YTD % Var.
Net Income (Loss)					
Revenues					
Contributions	$ 372,364	$ 93,856	$ 97,447	3,591	103.83 %
Investment Income	2,250	567	2,301	1,733	405.65 %
Total Revenues	374,614	94,423	99,748	5,324	105.64 %
Operating Expenses					
Claims Expense	0	0	(19,405)	(19,405)	0.00 %
Excess Insurance	259,430	65,390	63,764	(1,627)	97.51 %
Professional Services	14,014	3,533	2,644	(889)	74.83 %
Total Operating Expenses	273,444	68,923	47,003	(21,921)	68.20 %
General and Administrative Expenses					
Salaries, Wages and Benefits	59,080	14,891	7,748	(7,142)	52.03 %
Administrative Expenses	22,609	5,699	1,294	(4,405)	22.70 %
Pension Expenses	18,032	4,545	17,025	12,479	374.58 %
Total General and Administrative Expenses	99,721	25,135	26,067	932	103.71 %
Total Net Income (Loss)	1,449	365	26,678	26,313	7,305.95 %
NET POSITION - BEGINNING	0	0	820,486	820,486	0.00 %
ENDING NET POSITION	$ 1,449	$ 365	$ 847,164	846,799	231,998.07 %

REMIF
Statement of Fiduciary Net Position
OPEB Trust Fund

	Year To Date 09/30/2020 Current Year Balance	Year Ending 06/30/2020 Prior Year
Assets		
Investments	$ 2,855,649	$ 2,795,935
Total Assets	**2,855,649**	**2,795,935**
Liabilities		
Other Payables	59,760	59,760
Total Liabilities	**59,760**	**59,760**
Net Position restricted for OPEB - End of year	**$ 2,795,889**	**$ 2,736,175**

Redwood Empire Municipal Insurance Fund
Statement of Changes in Fiduciary Net Position
OPEB Trust Fund
As of September 30, 2020

	Year To Date 09/30/2020 Actual	Year Ending 06/30/2020 Prior Year
Additions		
Contributions to OPEB Plan	$ 0	$ 4,705
Investment Income		
Interest and Dividends	121,269	(8,276)
Less: investment expenses	1,795	7,208
Total Additions	119,474	(10,779)
Deductions		
Benefits	59,760	129,099
Total Deductions	59,760	129,099
Total Change in net position	59,714	(139,878)
Net Position restricted for OPEB - Beginning of year	2,736,175	2,876,053
Total Net Position restricted for OPEB - End of year	$ 2,795,889	$ 2,736,175

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ITEM 5.0

AGENDA ITEM SUMMARY

TITLE: REPORT OUT AFTER CLOSED SESSION
PRESENTED BY: AMY NORTHAM, GENERAL MANAGER

ISSUE
Pursuant to the Government Code Section 54957.1, this will serve as a report out of closed session items.

BACKGROUND
Pursuant to California Government Code Section 54957.1, approval by either the Executive Committee or the Board of Directors to accept a settlement offer signed by the opposing party was obtained in the following matters. The terms of the agreement include that the plaintiff/applicant will dismiss the case in exchange for payments as outlined below.

A. Government Code Section 54956.95:
Conference regarding a claim for the payment of tort liability losses, public liability losses, or workers' compensation liability incurred by the joint powers' agency or a local agency member of the joint powers' agency.

Date of meeting: 10/27/20
Claimant: T. May
Agency claimed against: City of Arcata
Settlement: $125,808.42

B. Government Code Section 54956.95:
Conference regarding a claim for the payment of tort liability losses, public liability losses, or workers' compensation liability incurred by the joint powers' agency or a local agency member of the joint powers' agency.

Date of meeting: 11/23/20
Claimant: Mendocino Christadelphian Ecclesia
Agency claimed against: City of Ukiah
Settlement: $43,441.51

C. Government Code Section 54956.95:
Conference regarding a claim for the payment of tort liability losses, public liability losses, or workers' compensation liability incurred by the joint powers' agency or a local agency member of the joint powers' agency.

Date of meeting: 11/23/20
Claimant: J. Thompson, R. Thompson
Agency claimed against: City of Healdsburg
Settlement: $49,750

FISCAL IMPACT
Payment of settlements as outlined above.

RECOMMENDED ACTION
None

ATTACHMENT
None

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St. Helena, Sebastopol, Sonoma, Ukiah, Willits, Windsor

ITEM 6.0

AGENDA ITEM SUMMARY

TITLE: GENERAL MANAGER'S COMMUNICATION AND ACTIVITIES
PRESENTED BY: AMY NORTHAM, GENERAL MANAGER

ISSUE
The General Manager is responsible for the planning and direction of REMIF's day-to-day operations to meet the organization's fiscal and service goals. The General Manager will routinely report on her activities to the Governing Board. No action is required by the Board. This is informational only.

BACKGROUND
Below, please find a summary of my activities since last report to the Board of Directors (September 24, 2020):
1. Plan, prepare for and attend REMIF Health Care Committee meetings;
2. Plan, prepare for and attend REMIF Board of Directors meeting (November);
3. Plan, prepare for and attend REMIF Executive Committee meeting (October, November, December);
4. Plan, prepare for and attend CJPRMA Board of Directors meeting, Executive Committee meeting and Finance Committee meeting (October, November, December);
5. Plan, prepare for and attend REMIF/PARSAC transition committee meetings (includes numerous meetings in preparation for);
6. Health care plan – review claims issue, work on plan documents;
7. Meetings with liability, property and workers' comp carriers regard strategic partnership with PARSAC, meetings with PARSAC regarding same;
8. Discussions regarding settlement in various liability matters;
9. Discussions regarding settlement in various workers' compensation matters;
10. Plan, prepare for and attend REMIF liability file reviews;
11. Plan, prepare for and attend REMIF future medical (workers' compensation file reviews);
12. Plan, prepare for and attend REMIF members' city council meetings;
13. Attend CAJPA (virtual event).

FISCAL IMPACT
None

RECOMMENDED ACTION
None

ATTACHMENT
None

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St. Helena, Sebastopol, Sonoma, Ukiah, Willits, Windsor

ITEM 7.0

AGENDA ITEM SUMMARY

TITLE: FINANCIAL AUDIT
PRESENTED BY: JESSE DEOL OF JAMES MARTA & COMPANY, LLP

ISSUE
The audit report (attached) requires ratification by the Board.

BACKGROUND
Pursuant to Board policy #16.0, the REMIF financial records are audited by a third-party auditor annually. Jesse Deol of James Marta & Company completed the financial audit for fiscal year 2019/2020. The draft audited financial statements with the required communication letters are included in the agenda for the Board's review. Mr. Deol will present the findings of the financial audit to the Board.

FISCAL IMPACT
None

RECOMMENDED ACTION
Approve attached financial audit reports.

ATTACHMENT
7.1 –Financial Statement with Independent Auditor's Report for the Fiscal Years Ended June 30, 2020
7.2 – Draft Report on Internal Control over Financial Reporting and Compliance and Other Matters
7.3 – Communication with Those Charged with Governance

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

FINANCIAL STATEMENTS
WITH
INDEPENDENT AUDITOR'S REPORT
FOR THE FISCAL YEARS ENDED

JUNE 30, 2020 AND 2019

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

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James Marta & Company LLP
Certified Public Accountants

Accounting, Auditing, Consulting, and Tax

INDEPENDENT AUDITOR'S REPORT

Board of Directors
Redwood Empire Municipal Insurance Fund
Sonoma, California

Report on the Financial Statements

We have audited the accompanying Statement of Net Position of Redwood Empire Municipal Insurance Fund (Authority) as of June 30, 2020 and 2019 and the related Statement of Revenues, Expenses and Changes in Net Position, Statement of Cash Flows as of and for the years then ended and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America, the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and the State Controller's *Minimum Audit Requirements for California Special Districts*. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Redwood Empire Municipal Insurance Fund as of June 30, 2020 and 2019 and the results of its operations and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America, as well as accounting systems prescribed by the State Controller's Office and state regulations governing special districts.

Other Matters

Required Supplementary Information

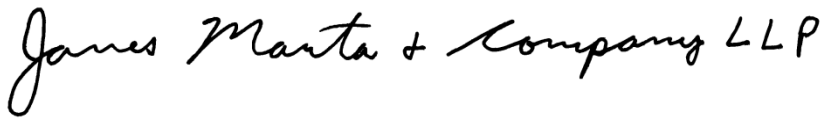
Accounting principles generally accepted in the United States of America require that Management's Discussion and Analysis, the Reconciliation of Claims Liabilities by Program, Claims Development Information, the Schedule of the Proportionate Share of the Net Pension Liability and Related Ratios, the Schedule of Pension Contributions, Schedule of Changes in Net OPEB Liability and Related Ratios, Schedule of OPEB Contributions, and Notes to the Required Supplementary Information be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board (GASB) who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted principally of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Information

Our audit was conducted for the purpose of forming an opinion on the basic financials statements of the Authority. The Combining Statement of Net Position, Combining Statement of Revenues, Expenses and Changes in Net Position, and Graphical Summary of Claims are presented for purposes of additional analysis and are not required parts of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the Combining Statement of Net Position, Combining Statement of Revenues, Expenses and Changes in Net Position, and Graphical Summary of Claims are fairly stated in all material respects in relation to the financial statements as a whole.

Report on Other Legal and Regulatory Requirements

In accordance with *Government Auditing Standards*, we have also issued our report dated January 13, 2021 on our consideration of Redwood Empire Municipal Insurance Fund's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts, grant agreements, and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and in considering Redwood Empire Municipal Insurance Fund's internal control over financial reporting and compliance.



James Marta & Company LLP
Certified Public Accountants
Sacramento, California
January 13, 2021

MANAGEMENT'S DISCUSSION AND ANALYSIS

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

MANAGEMENT'S DISCUSSION AND ANALYSIS

JUNE 30, 2020 AND 2019

This section of the Redwood Empire Municipal Insurance Fund annual financial report presents management's discussion and analysis of its financial performance during the fiscal year that ended June 30, 2020. We encourage readers to evaluate the information presented here along with the additional information included in the financial statements.

The Redwood Empire Municipal Insurance Fund (**REMIF**) is a Joint Powers Authority (**JPA**) created in 1976 through the provisions in the Labor and Government Codes that oversee a risk sharing, risk financing, and risk management program for fifteen participating public entities. REMIF is located in Sonoma, California, is a separate public entity, and has a governing board comprised of fifteen voting members (listed below), seven of whom represent the original seven members that created the JPA in 1976.

City of Arcata
City of Cloverdale
City of Cotati
City of Eureka
City of Fort Bragg
City of Fortuna
City of Healdsburg
City of Lakeport
City of Rohnert Park
City of Sebastopol
City of Sonoma
City of St. Helena
City of Ukiah
City of Willits
Town of Windsor

Primary coverage for REMIF currently includes workers' compensation, general/auto liability, property, auto physical damage, fidelity employee bonding, medical, dental, and vision insurance. There are a number of programs that are funded on a pass-through basis including employee assistance plan coverage, life and long-term disability insurance, Difference in Condition (**DIC**) (earthquake) coverage and pollution coverage. Medical coverage, which is self-funded program, is paid by each member that participates in the medical coverage program.

The Executive Committee is composed of the President, Vice-President and one representative from each of three regions (north/middle/south). The Board appoints a General Manager to handle the day-to-day business operations of REMIF. As of fiscal year-end, the General Manager is assisted by an Administrative Assistant who coordinates training, risk transference, general/auto liability claims handling, acts as a receptionist, performs other clerical functions and is the JPA's confidential Board Assistant. In addition, there are two staff who perform day to day accounting activities. REMIF contracts with the following service providers: Athens Administrators to provide claims administration over workers' compensation program; George Hills & Company to provide claims administration over the liability/property/APD programs; York Risk Services/Sedgwick to provide high level finance. In addition, other service providers were contracted by REMIF to conduct annual financial audits and actuarial studies, provide payroll services, safety training, and perform workers' compensation and liability claims audits.

REMIF acted as a contract third party claims administrator for handling the workers' compensation claims of two cities: Petaluma (since 1987) and San Rafael (since 2004). These two cities are not members of REMIF. However, effective May 1, 2018, the claims administrator services were terminated. Previously, REMIF also acted as a contract third party administrator for handling the workers' compensation claims of Santa Rosa, but that contract was terminated as of June 20, 2017.

REMIF's goal is to protect the member's assets by helping moderate the effects of claims, lawsuits and losses through the use of education, prevention, training, advocacy, and insurance/self-insurance programs. In addition, REMIF helps provide cost effective employee benefit programs through the use of group coverage purchasing or self-insurance. Members are assessed contributions for participation in REMIF's programs.

DESCRIPTION OF BASIC FINANCIAL STATEMENTS AND FINANCIAL REPORTING

All of the activities of REMIF are classified as "business-type activities." These activities include the development and operation of public entity risk pools and the purchase of insurance-related services for members. These financial statements consist of three parts – management's discussion and analysis, the basic financial statements and supplementary information. The statement of net position and statement of revenues, expenses and changes in net position provide an indication of REMIF's financial health as well as an indication of the net position available for various future purposes. The statement of net position includes all of REMIF's assets, deferred outflows of resources, liabilities and deferred inflows of resources and net position using the accrual basis of accounting. The statement of revenues, expenses and changes in net position reports all of the revenues and expenses during the fiscal years indicated. The statement of cash flows reports the cash provided and used by operating activities, as well as other cash sources such as investment income. The basic financial statements also include the notes to the financial statements section, which provides more detailed data for selected information in the financial statements.

This report contains other required supplementary information and supplementary information in addition to the basic financial statements. As a public entity risk pool, under government accounting standards, a reconciliation of claims liabilities by type of contract and claims development information are required elements of supplemental information.

ANALYSIS OF OVERALL FINANCIAL POSITION AND RESULTS OF OPERATIONS

Condensed Statement of Net Position

	6/30/2020	6/30/2019	6/30/2018
Total capital	$ 473,777	$ 373,688	$ 331,394
Total other	33,837,779	30,815,962	26,973,890
Total assets	34,311,556	31,189,650	27,305,284
Total deferred outflows of resources	659,939	659,765	884,139
Total long-term liabilities	24,015,428	21,928,858	20,126,661
Total short-term liabilities	7,657,403	8,300,687	7,122,386
Total liabilities	31,672,831	30,229,545	27,249,047
Total deferred inflows of resources	185,787	216,372	318,912
Total net position	$ 3,112,877	$ 1,403,498	$ 621,464

Condensed Statement of Revenues, Expenses, and Changes in Net Position

	6/30/2020	6/30/2019	6/30/2018
Total operating revenues	$ 29,710,466	$ 26,012,592	$ 32,694,595
Total non-operating revenues	799,840	430,948	225,356
Total revenues	30,510,306	26,443,540	32,919,951
Net losses and claims incurred	20,682,291	18,469,028	21,659,181
Premium and/or contribution for excess	3,480,149	3,046,907	1,674,580
Claims consultants and administration	3,266,586	2,787,150	2,383,512
Other operating expenses/Change in OPEB	(148,316)	(54,538)	(602,250)
General and administrative	1,520,217	1,412,959	2,316,895
Total expenses	28,800,927	25,661,506	27,431,918
Change in net position	1,709,379	782,034	5,488,033
Net position, beginning of year	1,403,498	621,464	(4,866,569) *
Net position, end of year	$ 3,112,877	$ 1,403,498	$ 621,464

*Restated for the provisions of GASB Statement No. 75

ANALYSIS OF CURRENT YEAR RESULTS COMPARED TO PRIOR YEARS

There was a net gain in FY 19/20 of $1.7 million, which in comparison to FY 18/19 also had a net gain of $782 thousand. Overall financial highlights include the following:

Total Assets increased by $3.1 million from FY 18/19. Cash and cash equivalents increased by $3.2 million due to contributions received in the current year will be used to pay claims in the future years. Receivables decreased $1.1 million from FY 18/19 partially due to payment of $1.5 million for the assessment and contribution billing on timely fashion. Long-term investments increased by $625 thousand from FY 18/19.

Total Liabilities increased $1.4 million from FY 18/19. Accounts Payable decreased by $648 thousand from FY 18/19 due to timing of medical payment made in the prior year. This was offset by increase of $2 million in Claims Liabilities. Claims Reserves increased by $100 thousand, Claims Incurred But Not Reported (IBNR) increased by $1.8 million and Unallocated Loss Adjustment Expense (ULAE) increased $90 thousand from FY 18/19. Pension liability increased by $101 thousand when compared to FY 18/19.

Total Net Position increased $1.7 million from FY 18/19. The total net position is $3.1 million. Steps were taken during FY 17/18 to rebuild deficit fund balance in the liability program and workers' compensation program. During FY 17/18, the Board of Directors declared assessments of $2.5M in the liability program and $6M in the workers' compensation program to be paid over 5 year and 6 years, respectively. The assessment collection started in FY 18/19.

Total Revenues increased $4.1 million from FY 18/19. Member Contributions increased $3.6 million from FY 18/19. Investment income also increased $325 thousand from FY 18/19.

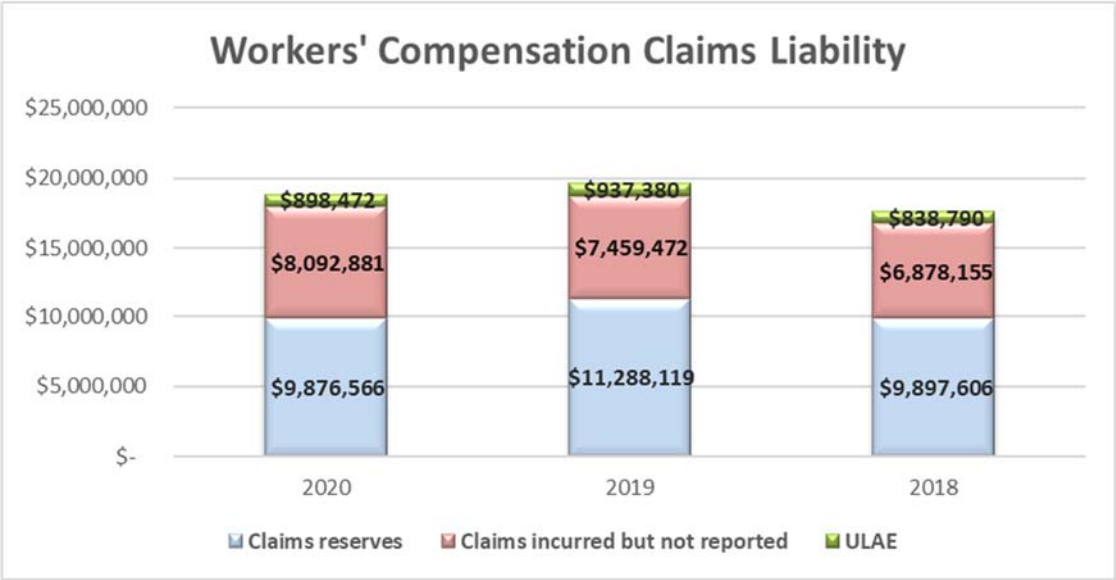
Total Expenses increased $3.1 million from FY 18/19. Net losses and claims incurred (claims expense) increased $2.2 million from FY 18/19. The current year ultimate losses increased by $7.2 million when compared to FY 18/19 which was offset by adjustments to ultimate losses for older years that decreased by $5.1 million when compared to FY 18/19. Premium and/or contributions for excess increased by $433 thousand from FY 18/19 due to rise in liability and property rates. Claims consultants and administration increased $480 thousand from FY 18/19; most of the increases were in the medical and dental programs.

The general and administration expenses increased $107 thousand from FY 18/19. The overall increase is due to the changes in recognition of the pension liability.

Workers' Compensation

The Workers' Compensation program saw an increase in net position of $2.7 million in FY 19/20. The Workers' Compensation program ended FY 19/20 with a deficit position of $2 million.

Total Revenues increased $1.6 million from FY 18/19. Member contributions increased $1.5 million from FY 18/19 to due increase in estimated payroll of 7% and self-insured retention rate of 21%. Additionally, budgeted expenditures increased 25% over the prior year. The member contributions were funded at 75% confidence level, undiscounted.



Total Expenses decreased $3.3 million from FY 18/19. Net losses and claim incurred and change in reserves for ULAE are considered claims expense. Claims expense decreased $3.4 million from FY 18/19. Claims Liabilities (as shown above) also decreased by $817 thousand from prior year mainly due to decrease in claims reserves. The decrease in a result of hard work by claims administrator, REMIF staff and REMIF members. REMIF hired Athens to administer claims and REMIF staff working with REMIF members have been involved in oversight of claims with the Athens.

Excess insurance increased $42 thousand from FY 18/19. Excess insurance carriers continued to reimburse payments to injured employees due to workers' compensation injuries when their expenses exceeded their self-insured retention level (**SIR**).

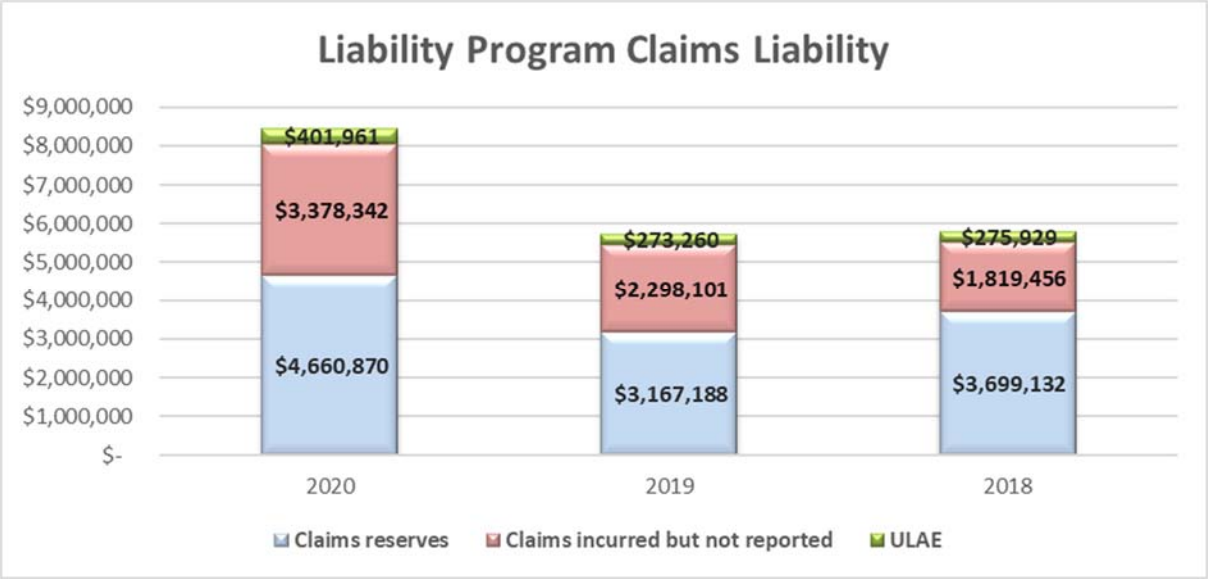
Claims administration expense decreased $16 thousand from prior year due to the renegotiation to the contract halfway through the year.

The general and administrative expense increased by $83 thousand from FY 18/19.

Liability

The Liability program saw a decrease in net position of $2.2 million in FY 19/20. The Liability program ended FY 19/20 with a deficit net position of $4 million.

Total Revenues increased $795 thousand from FY 18/19. Member contributions increased $759 thousand from FY 18/19 due to rising cost of the excess insurance, increase in payroll of 7% and increase in self-insured rate of 12%. Additionally, budgeted expenditure increased 20% from prior year. Member contribution were funded at 75% confidence level, undiscounted.



Total expense increased $1.8 million from FY 18/19. Net losses and claim incurred and change in reserves for ULAE are considered claims expense. Claims expense increased by $1.6 million from FY 18/19. The actuary increased FY 19/20 ultimate losses by $1.2 million when compared to FY 18/19 and the older year ultimate losses were increased by $380 thousand. Claims Liabilities (as shown above) increased by $2.7 million from the prior year. Claims Reserves increased by $1.5 million and Claims IBNR increased $1.1 million. The increases in the Liability program are due to unfavorable development in claims which is what we seen it in insurance market.

The excess insurance increased by $190 thousand (23%) from FY 18/19. The increase is a result of continuing increase of rates in the marketplace as well the liability program experiencing unfavorable claims development in prior years.

The general and administrative expense increased by $13 thousand from FY 18/19.

Property

The Property program showed a net income in FY 19/20 of $512 thousand, increasing the net position to $790 thousand.

Total Revenues increased $1 million from FY 18/19. As coverage deductibles increased, the REMIF Board elected to self-fund for two claims on the Property coverage. The pass-through coverages (Difference in Condition and High Flood Zone) that REMIF obtains for its members, also increased as the rates for these coverages have been increasing state wide.

REMIF obtains Property coverage through California Joint Powers Risk Management Authority (CJPRMA). Excess insurance increased $160 thousand of which is a result of the pass-through coverage as mentioned above.

Auto Physical Damage

The Auto Physical Damage program had net income in the amount $11 thousand, increasing the net position to $820 thousand as of June 30, 2020.

For the FY 19/20, REMIF opted to be fully insured through its insurance provider, CJPRMA. A total of 1,356 vehicles were covered for all REMIF cities with the vehicles valued at $79 million. With member deductible at $10 thousand, the insurance cost was $215 thousand, resulting in saving of $50 thousand in member contribution funding.

Dental

Dental premiums exceeded claims paid in FY 19/20, which resulted in a change in net position of $336 thousand. The fund balance at end of the fiscal year is $812 thousand and claims liability is recorded at $55 thousand.

Dental	6/30/2020	6/30/2019	6/30/2018
Net premiums (cumulative from inception)	$479,302	$170,569	$352,343
Employees enrolled	1,159	1,148	1,121
Net income (loss)	$336,494	$24,646	$28,972

Vision

Vision premiums exceeded claims payments in FY 19/20, which resulted in a net income of $66 thousand. The fund balance at FYE is $190 thousand and claims liability is recorded at $10 thousand.

Vision	6/30/2020	6/30/2019	6/30/2018
Net premiums (cumulative from inception)	$96,109	$49,863	$38,250
Employees enrolled	1,056	1,045	1,042
Net income (loss)	$65,934	$19,224	$17,830

Health

A self-funded health plan was established on July 1, 2015 for the REMIF medical program. Claims payments exceeded premiums collected in FY 19/20, which resulted in a net gain of $150 thousand. The fund balance at FYE is $5.8 million and claims liability is recorded at $1.25 million.

Health	6/30/2020	6/30/2019	6/30/2018
Net premiums (cumulative from inception)	$2,239,375	$2,495,736	$3,311,181
Employees enrolled	797	798	799
Net income (loss)	$150,248	$4,586,968	($617,950)

Post-Retirement Benefits

While health benefits are no longer offered to newer REMIF employees, REMIF offered future health benefits for retired employees that worked for REMIF for at least ten years. The funds are held in an irrevocable trust under Chandler Asset Management and are used to pay on going health benefits for the retired employees.

With an updated actuarial valuation as of June 30, 2020, the OPEB Liability is $2.2 million and the trust fund balance is $2.7 million resulting in an asset of $568 thousand. Because these funds are held in an irrevocable trust, OPEB transactions are shown in separate fiduciary fund statements and footnotes in the Financial Statement.

Transference of Risk for Members

Insurance was provided for all programs as follows:

In the **Liability** program the California Joint Powers Risk Management Authority provided $39.50 million of coverage in excess of $500,000, through both pooled funds, insurance and reinsurance. Covered items included general liability, automobile liability and employment practices liability. It should be noted that there are sub-limits in some specified areas.

In the **Workers' Compensation** program Safety National Casualty provided statutory coverage in excess of a $1 million self-insured retention.

In the **Property** program there was coverage up to $400 million per incident, through a CJPRMA purchase program, with a $100,000 self-insured retention. This did not include earthquake coverage which was billed separately to each city. Four insurance companies provided earthquake coverage up to $20 million for replacement value. The cost of the earthquake coverage was $46,440 less than the previous year. Pollution was covered for $5 million with a $100,000 self-insured retention.

Boiler and Machinery coverage was provided up to $21.25 million, with a self-insured retention of $25,000.

Automobile Physical Damage coverage was up to $10 million through CJPRMA. Each city has a deductible of $10,000 per vehicle. There is a fully insured program through REMIF.

Bonds and Fidelity Insurance were provided in the form of **Public Employee Blanket Bonds** for loss of money, securities and other property through employee dishonesty up to $2 million with an SIR of $10,000 which includes a faithful performance component. There was also a **Depositors Forgery Bond** up to $2 million with an SIR of $10,000 for coverage due to forgery or alteration. **Computer Fraud** provided up to $2 million with an SIR of $10,000 and covered a loss of money, securities and other property through failure to properly supervise. In addition, there was coverage against **Funds Transfer Fraud** and **Public Official Faithful Performance** which provided up to $2 million with an SIR of $10,000 and covered against the fraudulent transfer of funds from the agency transfer account and faithful performance of public officials.

Employee Assistance Plan benefits include financial counseling, budgeting strategies, credit management, legal referrals, and counseling for stress management, family support, smoking cessation and weight management (eight visits per incident).

PROGRAM SERVICES

Program Services provided to the member entities are intended to help them manage risk or transfer risk when it is appropriate.

Risk Transference

REMIF maintains a strong risk transference program by requiring the entities to be named as an additional insured on contractors', facility users' and permitees' insurance policies. The members are given training as needed to effectively administer their risk transference programs. In addition, the General Manager and Administrative Assistant, on an almost daily basis, field inquiries about proper documentation needed to ensure that the cities are protected. At the end of FY 19/20, there were active litigation cases being handled by contractors' insurance companies at no expense to REMIF and the entities because of this highly effective program.

Training

Training is a strong component of any risk management program and one that REMIF is heavily engaged in. Each year, a special two-day training seminar is conducted for all police chiefs and are POST certified. In addition, each year the Board has a full day of training as part of its annual meeting in January. Other members of the entities' staff, as well as Board members, are invited to attend this training.

There is an annual full day Public Works training seminar for the member's Public Works Directors and other supervisory staff. The training provides information concerning risk reduction, personnel practices and other relevant subjects designed to avoid or reduce the costs of claims and lawsuits.

REMIF has a policy of reimbursing the attendance of up to six members from each entity to attend the following conferences: CAJPA, CALPELRA, PARMA and LCW. In addition to the above specific training sessions, REMIF hosts or conducts numerous training activities throughout the year at various sites as requested by the entities.

As an adjunct to the Police Daily Training Bulletin program, REMIF has a policy of providing access to Lexipol, to help the members establish and maintain current procedure manuals. This effort reduces exposure and litigation costs when claims/lawsuits are filed against police agencies.

On January 1, 2006, REMIF set up a consultation program with a contracted outside law firm for personnel legal advice services at no cost to the cities.

Drug and Alcohol Detection

The entities are required to have a substance abuse testing and treatment program for all drivers who have commercial licenses as part of their job requirements. This is a federally mandated program through the Department of Transportation. REMIF coordinates this program through a private provider. The various drug tests are administered in accordance with federal law and the costs are passed through to the entities.

DESCRIPTION OF FACTS OR CONDITIONS THAT ARE EXPECTED TO HAVE A SIGNIFICANT EFFECT ON FINANCIAL POSITION OR RESULTS OF OPERATIONS

Investment Arena

The U.S. economy closed out calendar year 2019 with strong underlying fundamentals, capping off the longest period of consecutive gross domestic product ("GDP") growth in recent history as the domestic unemployment rate registered at just 4.1%, while GDP for the fourth quarter of the year came in at 2.1%, well above the Federal Reserve's ("Fed") longer-run estimate of 1.9%.

By March 2020, however, the economic landscape had changed entirely as the COVID-19 pandemic spread rapidly across the globe, disrupting economies and financial markets worldwide. In an effort to provide stability to the markets, the Fed intervened cutting overnight rates to near zero and committing to a virtually unlimited amount of asset purchases. For its part, Congress authorized nearly $3 trillion in stimulus packages to bolster the U.S. economy and to help mitigate the effects of the pandemic.

As "stay-at-home" lockdown orders were imposed across the United States, businesses were confronted with a dramatic slackening in consumer demand. April's unemployment rate of 14.7% was the highest on record since 1948, and retail sales dropped over 20% from the previous year's results. Meanwhile, first quarter 2020 GDP growth came in at -5.0%, but the advanced reading of second quarter 2020 GDP growth was even more dire, registering a decline of 32.9%, the worst reading on record as personal consumption dropped by over 25%.

In the months following the initial reaction to the pandemic, we observe the beginnings or foundation of an economic recovery. Evidence of this may be found in June's unemployment rate, which had fallen to 11.1%. However, it is also important to note that headwinds remain and economic datapoints are likely to remain volatile in the near term. To that end, despite the June unemployment numbers, U.S. consumers have in fact been fiscally cautious throughout the second and into the third quarter of 2020.

Markets remain volatile as numerous uncertainties surrounding the pandemic persist, including the ability to contain the spread and the timeline for a viable vaccine or treatment. Not surprisingly, the yields available on high-quality fixed income securities have plummeted and remain near historic lows as investors brace for an extended period of near-zero interest rates. As of June 30, 2020, the yield on the 2-year U.S. Treasury note stood at 0.15%, while the yield on 10-year U.S. Treasury obligations was only slightly higher at 0.66%.

REMIF's fixed income investment portfolio has benefitted from the strong market value appreciation that occurs when interest rates in the marketplace decrease. The portfolio is currently being managed to a neutral duration position relative to the benchmark in order to minimize risk and optimize relative performance. REMIF's portfolio remains well diversified across the various investment sectors permitted by California Government Code and the Authority's Investment Policy. Given current market uncertainties and expectations of slowing economic growth in the future, allocations to the U.S. Treasury sector have increased notably over the past year, reflective of a more conservative stance.

REMIF has continued to meet its goals of safety, liquidity, and return through execution of an actively-managed strategy that seeks to identify undervalued securities in order to enhance portfolio earnings while maintaining its foremost focus on safety and liquidity. We anticipate this strategy of active management will continue to be effective and will deliver favorable results in the REMIF portfolio.

Workers' Compensation Arena:

Statewide California experience indicates that costs started to decrease in 2014, and after a period of flattening, decreases were realized into 2019. The WCIRB filed for rate decreases on seven occasions between 7/1/15 to 2019. The decreases were due mostly to lower medical costs, which were affected by a variety of changes associated with the passing of SB 863, including the implementation of Resource-Based Relative Value Scale (RBRVS) and Independent Medical Review (IMR). SB 863 also significantly increased permanent disability benefits, and those increases continue to be implemented as expected. Declining costs were also due to the reduction in claims involving opioid prescriptions. Due to the COVID-19 pandemic, the WCIRB will be filing for the first-rate increase since the rates began falling. It is estimated that the pandemic costs will add six cents per $100 of payroll, which is approximately a 4% increase. From a legislative standpoint, there has been significant activity pertaining to COVID-19. With the passing of SB 1159, AB 685, and AB 1867, additional benefits due as a result of these bills may increase future rates. Since the burden lies with the employee to establish industrial causation of their COVID-19 infection, litigation may be increased to pursue these benefits.

CONTACTING FINANCIAL MANAGEMENT

The Basic Financial Statements are intended to provide REMIF members, citizens, creditors and other interested parties a general financial overview of the REMIF's operation. Questions about these statements should be directed to REMIF, 414 W. Napa Street, 2nd Floor, Suite C, Sonoma, CA 95476.

FINANCIAL SECTION

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

STATEMENT OF NET POSITION

JUNE 30, 2020 AND 2019

	2020	2019
ASSETS		
Current Assets		
Cash and cash equivalents	$ 13,183,261	$ 9,965,475
Investments	4,725,635	1,616,155
Receivables:		
Premiums and fees	283,480	12,725
Reimbursements	471,061	509,819
Member assessments	1,500,000	1,500,000
Excess insurance reimbursement and other	554,576	399,724
Interest	85,838	63,089
Prepaid expenses	170,008	1,921
Deposits	340,137	254,940
Total Current Assets	21,313,996	14,323,848
Noncurrent Assets		
Receivables:		
Member assessments	4,000,000	5,500,000
Investments	7,955,638	10,439,508
Net OPEB asset	568,145	552,606
Capital assets - net	473,777	373,688
Total Noncurrent Assets	12,997,560	16,865,802
Total Assets	34,311,556	31,189,650
DEFERRED OUTFLOWS OF RESOURCES		
Deferred outflows related to OPEB	109,994	-
Deferred outflows related to pensions	549,945	659,765
Total Deferred Outflows of Resources	659,939	659,765
LIABILITIES		
Current Liabilities		
Accounts payable	577,862	1,226,114
Unearned premiums	4,195	-
Tenant and other deposits	10,346	10,346
Claims liabilities	7,065,000	7,064,227
Total Current Liabilities	7,657,403	8,300,687
Noncurrent Liabilities		
Claims liabilities	21,759,092	19,773,520
Net pension liability	2,256,336	2,155,338
Total Noncurrent Liabilities	24,015,428	21,928,858
Total Liabilities	31,672,831	30,229,545
DEFERRED INFLOWS OF RESOURCES		
Deferred inflows related to OPEB	-	22,783
Deferred inflows related to pensions	185,787	193,589
Total Deferred Outflows of Resources	185,787	216,372
NET POSITION		
Net investment in capital assets	473,777	373,688
Unrestricted	2,639,100	1,029,810
Total Net Position	$ 3,112,877	$ 1,403,498

The accompanying notes are an integral part of these financial statements.

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

FOR THE FISCAL YEARS ENDED JUNE 30, 2020 AND 2019

	2020	2019
OPERATING REVENUES		
Member premiums	$ 29,441,751	$ 25,806,822
Fees	268,715	205,770
Total Operating Revenues	29,710,466	26,012,592
OPERATING EXPENSES		
Net losses and claims incurred	20,682,291	18,469,028
Premiums and/or contributions for excess coverage	3,480,149	3,046,907
Claims consultants and administration	3,266,586	2,787,150
General and administrative	1,520,217	1,412,959
Annual OPEB expense	(148,316)	(54,538)
Total Operating Expenses	28,800,927	25,661,506
Net Operating Income/(Loss)	909,539	351,086
Non-operating Revenues (Expenses)		
Rental income	61,920	17,730
Investment income	737,920	413,218
Total Non-operating Revenues (Expenses)	799,840	430,948
Change in Net Position	1,709,379	782,034
Net Position - Beginning of Year	1,403,498	621,464
Net Position - End of Year	$ 3,112,877	$ 1,403,498

The accompanying notes are an integral part of these financial statements.

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

STATEMENT OF CASH FLOWS

FOR THE FISCAL YEARS ENDED JUNE 30, 2020 AND 2019

	2020	2019
Cash Flows from Operating Activities		
Cash received from members	$ 30,982,664	$ 29,057,225
Payments for excess insurance	(3,648,236)	(2,674,672)
Payments for claims, claims consultants and claims administration	(22,177,581)	(19,245,500)
Payments to vendors	(1,855,494)	121,438
Payments to or on behalf of employees	(117,896)	(166,035)
Net Cash Flows Provided/(Used) by Operating Activities	3,183,457	7,092,456
Cash Flows from Noncapital Financing Activities		
Rents received	61,920	25,916
Net Cash Flows Provided/(Used) by Financing Activities	61,920	25,916
Cash Flows from Investing Activities		
Investment income/(loss)	715,171	558,858
(Purchase) sale of investments	(625,610)	(545,334)
Net Cash Flows Provided/(Used) by Investing Activities	89,561	13,524
Cash Flows from Capital and Related Financing Activities		
Acquisition of capital assets	(117,152)	(46,691)
Net Cash Flows Provided/(Used) by Financing Activities	(117,152)	(46,691)
Net Increase/(Decrease) in Cash	3,217,786	7,085,205
Beginning Cash and Equivalents	9,965,475	2,880,270
Ending Cash and Equivalents	$ 13,183,261	$ 9,965,475
Reconciliation of Operating Income to Net Cash Provided by Operating Activities		
Operating income (loss)	$ 909,539	$ 351,086
Depreciation expense	17,063	4,397
Changes in assets and liabilities		
Premiums and fees receivable	(270,755)	1,652,085
Reimbursement receivable	38,758	130,785
Member assessments receivable	1,500,000	1,500,000
Excess insurance reimbursement and other	(154,852)	156,166
Prepaid expenses	(168,087)	372,235
Unearned premiums	4,195	(238,237)
Deposits held to perform claim administration	(85,197)	(254,940)
Net pension liability and deferred outflows/inflows	203,016	177,914
Other postemployment benefits	(148,316)	(54,538)
Accounts payable and other liabilities	(648,252)	1,206,051
Claims liabilities	1,986,345	2,089,452
Net Cash Provided by Operating Activities	$ 3,183,457	$ 7,092,456
Supplementary Information		
Noncash Investing and Financing Transactions		
Change in fair market value of investments	$ 392,791	$ 346,175

The accompanying notes are an integral part of these financial statements.

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

OPEB TRUST FUND

STATEMENT OF FIDUCIARY NET POSITION

JUNE 30, 2020 AND 2019

	2020	2019
ASSETS		
Investments		
Money market	$ 29,375	$ 46,181
Exchange traded funds	2,766,560	2,876,065
Total Assets	2,795,935	2,922,246
LIABILITIES		
Accounts payable	59,760	46,193
Total Liabilities	59,760	46,193
NET POSITION		
Held in trust for investment pool participants	$ 2,736,175	$ 2,876,053

The accompanying notes are an integral part of these financial statements.

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

OPEB TRUST FUND

STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN FIDUCIARY NET POSITION

FOR THE FISCAL YEARS ENDED JUNE 30, 2020 AND 2019

	2020	2019
ADDITIONS		
Contributions to OPEB plan	$ 4,705	$ 16,442
Investment income:		
Interest and dividends	(22,692)	146,442
Less: investment expense	7,208	(7,158)
Total Additions	(10,779)	155,726
DEDUCTIONS		
Benefits	129,099	258,703
Total deductions	129,099	258,703
Change in Net Position	(139,878)	(102,977)
Net Position, Beginning of Year	2,876,053	2,979,030
Net Position, Ending of Year	$ 2,736,175	$ 2,876,053

The accompanying notes are an integral part of these financial statements.

1. GENERAL INFORMATION

Redwood Empire Municipal Insurance Fund (REMIF) is a governmental entity organized under a joint powers agreement by certain California cities to provide various coverage programs to its members as allowed under the California Government Code. REMIF is a "risk sharing pool" which pools risk and funds and which shares in the cost of losses. REMIF provides and administers coverage programs for seven member and eight associate member cities. Members and associate members participate in the workers' compensation and general liability programs and have the option, with approval by the Board of Directors, of participating in any or all of the other coverage programs which provide property, difference in conditions (flood and earthquake), fidelity/faithful performance, dental, vision, employee assistance, auto physical damage and healthcare.

Members consist of those cities which were involved with the formation of REMIF and have representation on the Board of Directors. Associate members consist of additional cities which have been allowed to participate in the programs and are entitled to one vote for every four associate members on the Board of Directors. In June 2014, the Board amended the Governance By-laws effective January 1, 2015 to allow all REMIF members the right to sit on the Board.

The activities of REMIF include setting and collecting contributions for each program, negotiating excess insurance coverage, administering payment of claims and related expenses including maintaining risk management and safety programs, training for the members, and investing each program's assets. REMIF engages the services of independent actuaries and claims administrators to assist in performing some of these activities.

General and administrative expenses are allocated to each fund based on percentages and amounts established annually by the Board of Directors.

For some of the coverage programs REMIF has a risk sharing arrangement. Each member participating in a risk sharing program assumes its own losses up to its retention level. Losses in excess of each member's self-insured retention are paid out of that program's pool. Each program's pool is funded by all of the members participating in that program through cash contributions. Losses and expenses are paid from these pools up to the limit of coverage subject to REMIF's self-insured retention. Losses in excess of each program's coverage level are covered by commercial carriers or other joint power authorities of which REMIF is a member. Losses exceeding the excess coverage limits for each program are the responsibility of the individual member from which the loss or claim originated. Each year REMIF evaluates every program's financial risk position, defined as contributions less projected ultimate loss. If the events of the year result in a negative risk position, the members' annual assessment may be increased in subsequent years.

2. SIGNIFICANT ACCOUNTING POLICIES

A. Basis of Accounting

The financial statements have been prepared on the accrual method of accounting in accordance with accounting principles generally accepted in the United States of America for governmental enterprise funds. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. As a governmental entity, REMIF follows the accounting standard hierarchy established by the GASB.

In addition to REMIF's business-type activities, REMIF maintains a fiduciary fund to account for the assets held in a trustee capacity. Fiduciary funds are also accounted for using the economic resources measurement focus and accrual basis of accounting. REMIF reports the following fiduciary fund:

The Other Postemployment Benefits Trust Fund (OPEB Trust Fund) is an irrevocable trust fund used to account for assets held by REMIF as Trustee for other postemployment benefits as further described in Note 8.

B. Insurance Coverage and Deductibles

REMIF provides the following major insurance coverage and deductibles:

1. Workers Compensation Program

REMIF provides the following insurance coverage and self-insured retention (SIR):

Member Deductible:	$5,000 to $10,000
REMIF SIR:	$750,000 for non-safety coverage as of June 30, 2020
	$1,000,000 for safety coverage as of June 30, 2020

The SIRs for this program by year are as follows:

Year	Amount
7/1/76 - 6/30/81	$ 150,000
7/1/81 - 2/28/82	100,000
3/1/82 - 6/30/86	150,000
7/1/86 - 6/30/87	200,000
7/1/87 - 6/30/90	250,000
7/1/90 - 6/30/03	300,000
7/1/03 - 6/30/20	1,000,000

Excess of: Excess of $1,000,000 to statutory limits for each worker's compensation occurrence through Safety National Casualty.

Excess of $1,000,000 to $2,000,000 for employer's liability through Safety National Casualty.

2. SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

2. Liability Program

REMIF provides the following insurance coverage and self-insured retention (SIR):

Member Deductible: $5,000 to $25,000
REMIF SIR: $500,000 as of June 30, 2020

Excess of: $500,000 to a total of $40,000,000 coverage per occurrence through California Joint Powers Risk Management Authority, Munich Reinsurance America and SCOR Reinsurance Co.

3. Property Program

REMIF provides the following insurance coverage and self-insured retention (SIR):

Member Deductible: $50,000
REMIF SIR: $100,000 with a deductible buydown of $50,000 as of June 30, 2020

Excess of: $250,000 to a total of $400,000,000 ($100,000,000 Boiler/Machinery) coverage per occurrence through Munich Reinsurance America, XL Insurance America Inc., and Hartford Steam Boiler Insurance Company.

4. Auto Physical Damage

REMIF provides the following insurance coverage as a pass through:

Member Deductible: $10,000

Excess of: $10,000 to a total of $10,000,000 coverage per occurrence through The Hanover Insurance Company.

5. Healthcare Program

Beginning July 1, 2015, REMIF provides a self-insured healthcare program. The program is administered by a third-party administrator (TPA) and a pharmacy benefit manager (PBM) and includes stop loss coverage to protect REMIF from large individual or catastrophic losses as follows:

REMIF Deductible: $175,000
Maximum Annual Reimbursement: $1,000,000

2. SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

6. Pass-through Programs

REMIF also provides earthquake and flood (difference in conditions), life, comprehensive drug testing and employee assistance programs which are fully insured by a commercial provider.

C. Contributions from Members

Each member is assessed a premium which is intended to cover REMIF's claims, operating costs and claim settlement expenses for that program. Contributions for all programs, except the Healthcare Programs, are based on an actuarially determined rate for each program, based on an estimate of the probable losses and expenses to be borne by that program, in the year in question. Additional cash contributions may be assessed on the basis of adverse loss experience. Refunds to members may be made if funds are determined to be surplus according to an established policy. General and administrative expenses are allocated on the basis of each participant's share of cash contributions. All contributions are recognized as revenues when earned, based on the period covered by the premium. Contributions received in advance are recorded as unearned premiums and are recognized over the effective coverage period.

For the Healthcare Program, contributions for the medical, dental, and vision plans are based on an estimate determined by the Board, in an amount calculated to be sufficient to provide for all covered expenses. The cash contributions are also calculated to establish a prudent surplus to fund for a contingent risk margin and administrative expenses. Contributions are recognized as revenues when earned, based on the period covered by the premium.

D. Nonoperating Revenue

REMIF does not discount its claims liabilities for all programs. Therefore, investment income is classified as nonoperating income. Additionally, REMIF anticipates investment income in determining if a premium deficiency exists.

E. Unpaid Claims Liabilities (Claims Reserves and Claims IBNR)

REMIF established claims liabilities separately for the worker's compensation and liability programs based on discounted estimates and all other programs based on the undiscounted estimates of the ultimate cost of claims (including future claims settlement expenses) that have been reported but not settled, and based on estimates of claims that have been incurred but not reported (IBNR) by that program. Because actual claims costs depend on such complex factors as inflation, changes in doctrines of legal liability and damage awards, claims liabilities are recomputed periodically using a variety of actuarial and statistical techniques to produce current estimates that reflect recent settlements, claim frequency, and other economic and social factors. A provision for inflation is implicit in the calculation of estimated future claims costs because reliance is placed both on actual historical data that reflect past inflation and other factors that are considered to be appropriate modifiers of past experience. Adjustments to claims liabilities are charged or credited to expense in the periods in which they are made.

2. SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

F. Reserve for Unallocated Loss Adjustment Expense (ULAE)

Amounts have been estimated for the cost of administering claims payable and future claims. These amounts were estimated in connection with other loss development information.

G. Deferred Outflows/Inflows of Resources

In addition to assets, the statement of net position reports a separate section for deferred outflows of resources. This separate financial statement element, deferred outflows of resources, represents a consumption of net position or fund balance that applies to a future period(s) and so will not be recognized as an outflow of resources (expense/expenditure) until then. In addition to liabilities, the statement of net position reports a separate section for deferred inflows of resources. This separate financial statement element, deferred inflows of resources, represents an acquisition of net position or fund balance that applies to a future period(s) and so will not be recognized as an inflow of resources (revenue) until that time.

H. Deferred Compensation Plan

REMIF employees may defer a portion of their compensation under a City of Rohnert Park sponsored Deferred Compensation Plan created in accordance with Internal Revenue Code Section 457. Under this plan, participants are not taxed on the deferred portion of their compensation until distributed to them; distributions may be made only at termination, retirement, death, or in an emergency as defined by the Plan. The laws governing deferred compensation plan assets require plan assets to be held by a trust for the exclusive benefit of plan participants and their beneficiaries. Since the assets held under these new plans are not REMIF's or the property, and are not subject to claims by general creditors of REMIF or the City, they have been excluded from these financial statements.

I. Cash and Equivalents

REMIF considers all highly liquid debt instruments purchased with a maturity of three months or less and its investments in the Local Agency Investment Fund (LAIF) and Sonoma County Trust to be cash equivalents. LAIF is recorded at fair value, which is based on the quoted market prices of its underlying investments.

J. Prepaid Expenses

Prepaid expenses consist of operating expenses for which payment was made in advance and will be expensed when the benefit is realized.

2. SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

K. Capital Assets

Capital assets are stated at cost. Major additions are capitalized and repair and maintenance costs are expensed. Depreciation is provided using the straight-line method which means the cost of the asset is divided by its expected useful life in years and the result is charged to expense each year until the asset is fully depreciated. Depreciation of all capital assets is charged as an expense against operations each year and the total amount of depreciation taken over the years, called accumulated depreciation, is reported on the statement of net position as a reduction in the book value of capital assets. When assets are sold or abandoned, the cost and related accumulated depreciation are removed from the accounts and the resulting gain or loss is recognized in the statement of revenues, expenses, and changes in net position.

REMIF has assigned the useful lives and capitalization thresholds listed below to capital assets, depending upon the year of acquisition:

	Prior to July 1, 2012	On or After July 1, 2012
Capitalization Threshold	$ 1,000	$ 5,000
Useful Lives (Years):		
Buildings	20	50
Building Improvements	10-20	30
Leasehold Improvements	10-20	10
Equipment	5	5
Furniture and Fixtures	7	N/A

L. Fair Value Measurements

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. REMIF categorizes its fair value measurements within the fair value hierarchy established by generally accepted accounting principles. The fair value hierarchy categorizes the inputs to valuation techniques used to measure fair value into three levels based on the extent to which inputs used in measuring fair value are observable in the market.

Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities.

Level 2 inputs are inputs – other than quoted prices included within level 1 – that are observable for an asset or liability, either directly or indirectly.

Level 3 inputs are unobservable inputs for an asset or liability.

If the fair value of an asset or liability is measured using inputs from more than one level of the fair value hierarchy, the measurement is considered to be based on the lowest priority level input that is significant to the entire measurement.

2. SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

M. Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions. REMIF's most significant estimates include estimates for liabilities associated with claims and other post-employment benefits. These estimates and assumptions affect the reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates.

N. Income Taxes

REMIF's income is exempt from federal income taxes under Internal Revenue Code Section 115, which excludes income derived from the exercise of any essential governmental function and accrues to a state political subdivision.

O. Reclassifications

Certain accounts in the prior-year financial statements have been reclassified for comparative purposes to conform with the presentation in the current-year financial statements.

3. CASH, CASH EQUIVALENTS, AND INVESTMENTS

A. CASH AND CASH EQUIVALENTS

Cash and cash equivalents consisted of the following as of June 30:

	2020	2019
Cash in bank and on hand	$ 3,439,072	$ 9,310,847
Sonoma County Tust	242,995	237,860
Local Agency Investment Fund (LAIF)	9,501,194	416,768
Total Cash and Cash Equivalents	$ 13,183,261	$ 9,965,475

The carrying amount of the Authority's cash in bank is covered by federal depository insurance up to $250,000 for each account. Should deposits exceed the insured limits, the balance is covered by collateral held by the bank in accordance with California law requiring the depository bank to hold collateral equal to 110% of the excess government funds on deposit. This collateral must be in the form of government-backed securities. All funds held in banks are collateralized.

Investment Pools

REMIF is a participant in LAIF that is regulated by California Government Code Section 16429 under the oversight of the Treasurer of the State of California and the Sonoma County Trust Fund. The fair value of REMIF's investment in the pools is reported in the accompanying financial statements at amounts based upon REMIF's pro-rata share of the fair value provided by LAIF for the entire LAIF portfolio (in relation to the amortized cost of that portfolio) and Sonoma County Trust Fund. The balance available for withdrawal is based on the accounting records maintained by LAIF and the Sonoma County Trust Fund, which are recorded on an amortized cost basis. Separate complete financial statements for LAIF may be obtained from 915 Capitol Mall, Sacramento, CA 95814 and for Sonoma County Trust Fund from 575 Administration Drive, Santa Rosa, CA 95403.

B. INVESTMENT

Policies

REMIF invests in individual investments and in investment pools. Individual investments are evidenced by specific identifiable pieces of paper called securities instruments, or by an electronic entry registering the owner in the records of the institution issuing the security, called the book entry system. In order to maximize security, REMIF employs the Trust Department of a bank as the custodian of all REMIF managed investments, regardless of their form.

3. CASH, CASH EQUIVALENTS, AND INVESTMENTS (CONTINUED)

The table below identifies the investment types that are authorized for REMIF by the California Government Code and REMIF's investment policy. The table also identifies certain provisions of the California Government Code or REMIF's investment policy, if more restrictive, that address interest rate risk and concentration of credit risk.

Investment Types Authorized by State Law	Maximum Maturity	Minimum Credit Quality	Maximum Percentage of Portfolio	Maximum Investment In One Issuer
U.S. Treasury Obligations	5 years	None	None	None
U.S. Agency Securities	5 years	None	None	25%
Municipal Securities				
State	5 years	None	None	None
Local Agencies within California	5 years	None	None	None
Banker's Acceptances	180 days	A1	40%	5%
Non-Negotiable Certificates (Time Deposits)	5 years	None	30%	None
Negotiable Certificates of Deposit	5 years	A	30%	5%
Commercial Paper	270 days	A/A1	25%	5%
Local Agency Investment Fund (LAIF)	N/A	None	None	LAIF Max
Sonoma County Pooled Investment Fund	N/A	None	10%	None
Medium-Term Notes	5 years	A	30%	5%
Money Market Mutual Funds	N/A	AAA	20%	10%

Interest Rate Risk

Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. One of .the ways that REMIF manages its exposure to interest rate risk is by purchasing a combination of shorter term and longer term investments and by timing cash flows from maturities so that a portion of the portfolio is maturing or coming close to maturity evenly over time as necessary to provide the cash flow and liquidity needed for operations.

Information about the sensitivity of the fair values of REMIF's investments to market interest rate fluctuations is provided by the following tables that show the maturity date of each investment or earliest call date:

		Investment Maturities		
Investment Type	Fair Value	< 1yr	1-3 yrs	>3 yrs
U.S Treasury Obligations	$ 3,891,129	$ 615,934	$ 1,715,784	$ 1,559,411
U.S Agency Securities	5,932,156	844,894	2,237,650	2,849,612
U.S. Corporate Notes	2,681,003	446,579	1,242,136	992,288
Municipal Bonds	154,696	-	-	154,696
Money Market Mutual Funds	22,289	22,289	-	-
Total Investments	$ 12,681,273	$ 1,929,696	$ 5,195,570	$ 5,556,007

3. CASH, CASH EQUIVALENTS, AND INVESTMENTS (CONTINUED)

Credit Risk

Credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of a rating by a nationally recognized statistical rating organization. Presented below is the actual rating as of year-end for each investment type as of June 30, 2020, as provided by Standard and Poor's investment rating system.

		Rating as of Year End		
Investment Type	Amount	AAA	AA+/AA/AA-	A+/A/A-
U.S Treasury Obligations	$ 3,891,129	$ -	$ 3,891,129	$ -
U.S Agency Securities	5,932,155	-	5,932,155	
U.S. Corporate Notes	2,681,003	166,682	321,052	2,193,269
Municipal Bonds	154,696	-	154,696	-
Money Market Mutual Funds	22,289	22,289	-	-
Total	$ 12,681,273	$ 188,971	$ 10,299,033	$ 2,193,269

Fair Value Hierarchy

REMIF categorizes its fair value measurements within the fair value hierarchy established by generally accepted accounting principles. The hierarchy is based on the valuation inputs used to measure fair value of the assets. Level 1 inputs are quoted prices in an active market for identical assets; Level 2 inputs are significant other observable inputs; and Level 3 inputs are significant unobservable inputs.

The following is a summary of the fair value hierarchy of the fair value of investments of REMIF as of June 30, 2020:

		Fair Value Measurements Using			
Investments	**Fair Value**	**Level 1 Inputs**	**Level 2 Inputs**	**Level 3 Inputs**	**N/A**
Debt Securities					
U.S Treasury Obligations	$ 3,891,129	$ 3,891,129	$ -	$ -	$ -
U.S Agency Securities	5,932,155	5,932,155	-	-	-
U.S. Corporate Notes	2,835,699	-	2,835,699	-	-
Money Market Mutual Funds	22,289	-	-	-	22,289
Total Debt Securities	$ 12,681,273	$ 9,823,284	$ 2,835,699	$ -	$ 22,289

3. CASH, CASH EQUIVALENTS, AND INVESTMENTS (CONTINUED)

Debt securities, classified in Level 2 of the fair value hierarchy, are valued using various pricing techniques maintained by Interactive Data Pricing, including benchmark curves, sector groupings and matrix pricing. These prices are obtained from various pricing sources by our investment manager. Fair value is defined as the quoted market value on the last trading day of the period.

Concentration of Credit Risk

The investment policy of REMIF contains no limitations on the amount that can be invested in any one issuer beyond that stipulated by the California Government Code. During fiscal year 2020, REMIF did have more than 5% of total investments in a single issuer (other than U.S. Treasury securities, mutual funds and external investment pools), which are disclosed as follows:

	% of Portfolio
United States Treasury	30.60%
Federal National Mortgage Association	24.20%
Federal Home Loan Banks	14.80%
Federal Home Loan Mortgage Corp	7.70%

4. INVESTMENTS – OPEB TRUST FUND

Composition

Investments of the OPEB Trust Fund at June 30 consisted of the following:

	2020	2019
Money Market	$ 29,375	$ 46,181
Exchange Traded Funds:		
Equities:		
Domestic	1,101,222	1,179,901
Emerging Market	143,586	154,171
International	288,404	310,114
Real Estate:		
Domestic	153,526	170,867
International	54,565	70,203
Commodities	32,035	41,280
Bonds:		
Domestic	915,287	872,174
International	77,935	77,355
Total Investments	$ 2,795,935	$ 2,922,246

4. INVESTMENTS – OPEB TRUST FUND (CONTINUED)

Investments Authorized by OPEB Trust Fund's Investment Policy

The tables below identify the investment types that are authorized by the OPEB Trust Fund's investment policy. The tables also identify certain provisions that address interest rate risk and concentration of credit risk.

Investment Types Authorized by State Law	Maximum Investment In One Issuer
U.S. Treasury and Agency Obligations	None
Money Market Instruments	5%
Fixed Income Securities**	5%
Mortgage-Backed Securities	5%
Asset-Backed Securities	5%
Equity Securities of U.S. and non-U.S.	5%
Real Estate Investment Trusts (REITs	5%
Commingled Funds*	5%
Mutual Funds*	None
Exchange Traded Funds (ETF)*	None

* Must invest in permitted investments.

** Individually purchased fixed income securities must, at the time of purchase, have a credit rating of at least "Investment Grade" by one or more of the Nationally Recognized Statistical Rations Organization (NRSRO).

Asset Class	Acceptable Range of Asset Allocation (within 5%)
Money Market	0%-10%
Exchange Traded Funds:	
Equities:	25%-75%
Domestic	20%-75%
Emerging Market	20%-75%
International	5%-50%
Real Estate:	0%-25%
Domestic	0%-25%
International	0%-10%
Commodities	0%-25%
Bonds:	25%-75%
Domestic	15%-75%
International	0%-35%

4. INVESTMENTS – OPEB TRUST FUND (CONTINUED)

Interest Rate Risk

As of June 30, 2020 and 2019, the OPEB Trust Fund's investments had maturities of 12 months or less.

Fair Value Hierarchy

The OPEB Trust Fund categorizes its fair value measurements within the fair value hierarchy established by generally accepted accounting principles. The hierarchy is based on the valuation inputs used to measure fair value of the assets. Level 1 inputs are quoted prices in an active market for identical assets; Level 2 inputs are significant other observable inputs; and Level 3 inputs are significant unobservable inputs.

The following is a summary of the fair value hierarchy of the *fair* value of investments of the OPEB Trust Fund as of June 30, 2020:

		Fair Value Measurements Using			
Investments	Fair Value	Level 1 Inputs	Level 2 Inputs	Level 3 Inputs	N/A
Money Market	$ 29,375	$ -	$ -	$ -	$ 29,375
Exchange Traded Funds:		.			
Equities:					
Domestic	1,101,222	1,101,222	-	-	-
Emerging Market	143,586	143,586	-	-	-
International	288,404	288,404	-	-	-
Real Estate:					
Domestic	153,526	153,526	-	-	-
International	54,565	54,565	-	-	-
Commodities	32,035	32,035	-	-	-
Bonds:					
Domestic	915,287	915,287	-	-	-
International	77,935	77,935	-	-	-
Total Investments	$ 2,795,935	$ 2,766,560	$ -	$ -	$ 29,375

Investments classified in Level 1 of the fair value hierarchy are valued using quoted prices in active markets. Fair value is defined as the quoted market value on the last trading day of the period. These prices are obtained from various pricing sources by our investment manager.

Disclosures Relating to Credit Risk

The Money Market Fund was rated AAA by Standard and Poor's Investment Rating Service as of June 30, 2020 and 2019. All other holdings were not rated.

4. INVESTMENTS – OPEB TRUST FUND (CONTINUED)

Rate of Return

For the year ended June 30, 2020, the annual money-weighted rate of return on OPEB Trust Fund investments, net of OPEB plan investment expense, was -0.55%. The money-weighted rate of return expresses investment performance, net of investment expense, adjusted for the changing amounts actually invested.

5. CAPITAL ASSETS

Capital assets are comprised of the following:

	June 30, 2019	Additions	Deletions	June 30, 2020
Capital assets not being depreciated				
Land	$ 319,999	$ -	$ -	$ 319,999
Construction in progess	46,691	117,152	(163,843)	-
Total capital assets not being depreciated	366,690	117,152	(163,843)	319,999
Capital assets being depreciated				
Building and improvements	652,273	22,050	-	674,323
Leasehold improvements	-	141,793	-	141,793
Furniture and fixtures	41,981	-	-	41,981
Equipment	28,033	-	-	28,033
Total capital assets being depreciated	722,287	398,147	-	886,130
Less accumulated depreciation	(715,289)	(17,063)	-	(732,352)
Total capital assets being depreciated, net	6,998	-	-	153,778
Total capital assets, net	$ 373,688	$ 117,152	$ (163,843)	$ 473,777

Depreciation expense was $17,063 and $4,397 and of June 30, 2020 and 2019, respectively.

6. RESERVES FOR LOSSES AND CLAIMS

Liabilities for losses and claims are based on discounted estimates of the ultimate net cost of settling all losses and claims which are incurred but unpaid at year end, including claims incurred but not reported. These amounts were computed using a combination of actuarial estimates, case basis estimates and industry guidelines, and are net of any anticipated recoveries from insurers.

The following summarizes for all programs, the changes in losses and claims payable, including claims incurred but not reported (IBNR), and excludes claims and payments at the member deductible level, during the year ended June 30:

	Totals	
	2020	2019
Liability at the beginning of the fiscal year	$ 26,837,747	$ 24,748,295
Incurred claims and claim adjustment expenses:		
Provision for insured events of the current fiscal year	20,963,163	13,764,408
Changes in provision for insured events of prior fiscal years	(378,905)	4,704,620
Total incurred claims and claim adjustment expenses	20,584,258	18,469,028
Payments:		
Claims and claim adjustment expenses attributable to insured events of the current fiscal year	12,314,258	8,489,088
Claims and claim adjustment expenses attributable to insured events of prior fiscal years	6,283,655	7,890,488
Total payments	18,597,913	16,379,576
Liability at the end of the fiscal year	$ 28,824,092	$ 26,837,747
Components of Claims Liabilities		
Claims reserves	$ 14,637,436	$ 14,532,202
Claims incurred but not reported	12,886,223	11,094,905
ULAE	1,300,433	1,210,640
Total Claims Liability	$ 28,824,092	$ 26,837,747
Current portion	$ 7,065,000	$ 7,064,227
Long-term portion	21,759,092	19,773,520
Total	$ 28,824,092	$ 26,837,747

The claims payable at June 30, 2020 and 2019 are reported at their present value using expected future investment yield assumptions of 2.25%. The undiscounted claims totaled $31,157,056 and $29,170,450 at June 30, 2020 and 2019, respectively.

7. NET POSITION

Designated Net Position

The Board has designated a reserve for both the workers' compensation and liability programs of REMIF for future loss development. Any net position in excess of the confidence margin is undesignated.

REMIF's policy is to reserve net position of $1,000,000 in the Workers' Compensation Fund, however the Fund has deficit unrestricted net position of $2,424,708 as of June 30, 2020. REMIF's policy is to also reserve net position of $1,000,000 in the Liability Fund, however the Fund has deficit unrestricted net position of $4,009,810 as of June 30, 2020. REMIF plans to replenish the reserves through future member premiums.

8. OTHER POSTEMPLOYMENT BENEFITS

REMIF sponsors a single-employer postemployment health care benefit plan (The Plan). REMIF provides certain health, dental, vision and life insurance benefits in the form of premium payments for its separated employees with at least 10 years of continuous service. These benefits are paid for life and extend to the retiree's dependents. The benefits provided depend on the employee's length of service and date of hire.

For employees hired before July 1, 1993 (Plan 1), REMIF pays the entire appropriate premium costs.

For employees hired on or after July 1, 1993, but before July 1, 2014 (Plan 2), REMIF pays towards premium costs as follows:

- For retirees having at least 10 years continuous service – 50% of applicable premium costs
- For retirees having at least 15 years of continuous service – 65% of the applicable premium costs
- For retirees having at least 25 years of continuous service – 80% of the applicable premium costs

Employees hired on or after July 1, 2014 are not eligible for any post-employment healthcare benefits, including coverage under the REMIF medical, dental, or vision plans.

During the year-ended June 30, 2011, REMIF established an irrevocable trust. REMIF established the OPEB Trust Fund to account for the Plan assets held by REMIF as Trustee for other postemployment benefits. The Board reserves the authority to review and amend the funding policy from time to time to ensure that the funding policy continues to best suit the circumstances of REMIF. The OPEB Trust Fund does not issue a separate report. Contributions to the OPEB Trust Fund are an irrevocable transfer in which assets are dedicated to providing benefits to retirees and their beneficiaries in accordance with the terms of the Plan and are legally protected from creditors of REMIF.

8. OTHER POSTEMPLOYMENT BENEFITS (CONTINUED)

Actuarial valuations involve estimates of the value of reported amounts and assumptions about the probability of events far into the future and actuarially determined amounts are subject to continual revision as actual results are compared to past expectations and new estimations are made about the future. Projections of benefits are based on the types of benefits provided under the substantive plan at the time of each valuation and on the pattern of sharing of benefit costs between the employer and plan members to that point, and, if applicable, the disclosure that the projections of benefits for financial reporting purposes do not explicitly incorporate the potential effects of legal or contractual funding limitations on the pattern of cost sharing between the employer and plan member in the future.

Plan Administration – REMIF is the Plan administrator.

Employees covered by benefit terms. At June 30, 2020, the following employees were covered by the benefit terms:

Inactive employees or beneficiaries currently receiving benefit payments	14
Inactive employees entitled to but not yet receiving benefit payments	-
Active employees	1
	15

Net OPEB Liability

REMIF's net OPEB liability was measured as of June 30, 2019, and the total OPEB liability used to calculate the net OPEB liability was determined by an actuarial valuation as of June 30, 2018.

Actuarial assumptions. The total OPEB liability in the June 30, 2019 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Salary Increases	3.00%; since benefits do not depend on salary, this is used only to allocate the cost of benefits between service years
Investment Rate of Return	5.00%; net of plan investment expenses and trust administrative expenses
General Inflation Rate	2.5% per year
Healthcare Cost Trend Rates	5.40% in 2021, grades down to 4.00% for year 2076 and thereafter. REMIF EPO premiums change effective July 1 of each year; AmWINS premiums change effective January 1 of each year

The retirement rates and post-retirement mortality rates used in this valuation are based on the 2017 experience study of the California Public Employees Retirement System using data from 1997 to 2015, except for a different basis used to project future mortality improvements. Mortality rates used were the published CalPERS rates, adjusted to back out 15 years of Scale MP 2016 to central year 2015.

8. OTHER POSTEMPLOYMENT BENEFITS (CONTINUED)

Discount rate. The discount rate used to measure the total OPEB liability was 5.00%. The projection of cash flows used to determine the discount rate assumed that the REMIF's contributions will be made at rates equal to the actuarially determined contribution rates. Based on those assumptions, the OPEB plan's fiduciary net position was projected to be available to make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on OPEB plan investments was applied to all periods of projected benefit payments to determine the total OPEB liability.

The long-term expected rate of return on OPEB plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of OPEB plan investment expense) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. The best estimates of arithmetic real rates of return for each major asset class included in the target asset allocation as of June 30, 2020 are summarized in the following table:

Asset Class	Target Allocation	Long-Term Expected Real Rate of Return
Domestic Equity	48%	8.56%
International Equity	11%	8.39%
Fixed Income	31%	3.76%
REIT	8%	6.69%
Commodities	2%	5.00%
Cash	0%	n/a
	100%	

Changes in Assumptions. Below are the changes in assumptions recognized during the current measurement period.

Mortality Improvement	The mortality improvement scale was updated from MacLeod Watts Scale 2018 to MacLeod Watts Scale 2020, reflecting continued updates in available information.
Salary Scale	Decreased from 3.25% per year to 3.0% per year
General Inflation Rate	Decreased from 2.75% to 2.5% per year
Medical Trend	Updated to use the Getzen healthcare trend model sponsored by the Society of Actuaries
Excise Tax Repeal	Excluded the excise tax from the valuation results due to the December 2019 repeal of excise tax on high cost retiree coverage

Changes in Benefit Terms. There were no changes in benefit terms

8. OTHER POSTEMPLOYMENT BENEFITS (CONTINUED)

Changes in the Net OPEB Liability

	Increase (Decrease)		
	Total OPEB Liability (Asset)	Plan Fiduciary Net Position	Net OPEB Liability (Asset)
Balances at June 30, 2019	$ 2,323,447	$ 2,876,053	$ (552,606)
Changes for the year:			
Service cost	27,465	-	27,465
Interest cost	114,363	-	114,363
Expected investment income	-	140,693	(140,693)
Contributions - employer	-	4,705	(4,705)
Actuarial Fees		(1,800)	1,800
Benefit payments	(127,298)	(127,298)	-
Assumption Changes	(116,152)		(116,152)
Plan experience	(53,795)	-	(53,795)
Investment experience	-	(156,178)	156,178
Net changes	(155,417)	(139,878)	(15,539)
Balances at June 30, 2020	$ 2,168,030	$ 2,736,175	$ (568,145)

Sensitivity of the net OPEB liability to changes in the discount rate and healthcare cost trend rates. The following presents the net OPEB liability of REMIF, as well as what REMIF's net OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower (4.0%) or 1-percentage-point higher (6.0%) than the current discount rate:

	1% Decrease (4%)	Discount Rate (5%)	1% Increase (6%)
Net OPEB liability (asset)	$ (309,084)	$ (568,145)	$ (782,871)

Sensitivity of the net OPEB liability to changes in the healthcare cost trend rates. The following presents the net OPEB liability of REMIF, as well as what REMIF's net OPEB liability would be if it were calculated using healthcare cost trend rates that are 1-percentage-point lower or 1-percentage-point higher than the current healthcare cost trend rates:

	1% Decrease	Healthcare Cost Trend Rates (Current Trend)	1% Increase
Net OPEB liability (asset)	$ (768,996)	$ (568,145)	$ (329,463)

8. OTHER POSTEMPLOYMENT BENEFITS (CONTINUED)

OPEB Expense and Deferred Outflows of Resources and Deferred Inflows of Resources Related to OPEB

For the year ended June 30, 2020, REMIF recognized OPEB expense of $148,316. At June 30, 2020, REMIF reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions subsequent to measurement date	$ -	$ -
Changes of assumptions	-	-
Differences between expected and actual experience	-	-
Net difference between projected and actual earnings on	109,994	-
OPEB plan investments	-	-
Total	$ 109,994	$ -

Amounts reported as deferred outflows of resources and deferred inflows of resources related to OPEB will be recognized in OPEB expense as follows:

Year ended June 30	Total Deferred Outflows/(Inflows) of Resources
2021	$ 23,401
2022	23,400
2023	31,959
2024	31,234
2025	-
Thereafter	-
Total	$ 109,994

Payable to the OPEB Plan

At June 30, 2020, REMIF had no outstanding amount of contributions to the OPEB plan required for the year ended June 30, 2020.

9. PENSION PLAN

Plan Description

Substantially all REMIF employees are eligible to participate in REMIF's Miscellaneous Employee Pension Rate Plan. The REMIF Miscellaneous Rate Plan is part of the public agency cost-sharing multiple-employer defined benefit pension plan (PERF C), which is administered by the California Public Employees' Retirement System (CalPERS). PERF C consists of a miscellaneous pool and a safety pool (also referred to as "risk pools"), which are comprised of individual employer miscellaneous and safety rate plans, respectively. Individual employers may sponsor more than one miscellaneous and safety rate plan. The employer participates in one cost-sharing multiple-employer defined benefit pension plan regardless of the number of rate plans the employer sponsors. REMIF sponsors two miscellaneous rate plans. Benefit provisions under the Plan are established by State statute and REMIF ordinance. CalPERS issues publicly available reports that include a full description of the pension plan regarding benefit provisions, assumptions and membership information that can be found on the CalPERS website.

Benefits Provided

CalPERS provides service retirement and disability benefits, annual cost of living adjustments and death benefits to plan members, who must be public employees and beneficiaries. Benefits are based on years of credited service, equal to one year of full time employment. Members with five years of total service are eligible to retire at age 50 with statutorily reduced benefits. All members are eligible for non-duty disability benefits after 10 years of service. The death benefit is one of the following: the Basic Death Benefit, the 1957 Survivor Benefit, or the Optional Settlement 2W Death Benefit. The cost of living adjustments for each plan are applied as specified by the Public Employees' Retirement Law.

REMIF's employees hired on or before December 31, 2012 participate in the Miscellaneous Plan of the Redwood Empire Municipal Insurance Fund (part of CalPERS' Miscellaneous Risk Pool). The Pension Reform Act of 2013 (PEPRA), Assembly Bill 340, is applicable to employees new to CalPERS and hired after December 31, 2012. REMIF's employees hired on or after January 1, 2013 participate in the Miscellaneous Plan of Redwood Empire Municipal Insurance Fund (part of CalPERS' Miscellaneous Risk Pool). Benefit provisions under the Plan were established by State statute and REMIF ordinance. Benefits are based on years of credited service, equal to one year of full-time employment. REMIF employees retiring on or after July 1, 2009 are eligible to receive a benefit of 2.7% per year of credited service. The plan provides retirement and disability benefits, annual cost-of-living adjustments, and death benefits to plan members and beneficiaries. Benefit provisions are established by state statutes, as legislatively amended, within the Public Employees' Retirement Law. CalPERS issues a separate comprehensive annual financial report that includes financial statements and required supplementary information. Copies of the CalPERS annual financial report may be obtained from the CalPERS Executive Office, 400 P Street, Sacramento, California 95814.

9. PENSION PLAN (CONTINUED)

The Plan's provisions and benefits in effect at June 30, 2020, are summarized as follows:

	Classic	PEPRA
Hire date	Prior to January 1, 2013	On or after January 1, 2013
Benefit formula	2% @ 55	2% @ 62
Benefit vesting schedule	5 years service	5 years service
Benefit payments	monthly for life	monthly for life
Retirement age	50-67	52 - 67
Monthly benefits, as a % of eligible compensation	2.0%-2.7%	1.0% to 2.5%
Required employee contribution rates	8.000%	6.500%
Required employer contribution rates	14.334%	7.191%

Beginning in fiscal year 2016, CalPERS collects employer contributions for the Plan as a percentage of payroll for the normal cost portion as noted in the rates above and as a dollar amount for contributions toward the unfunded liability.

Contributions

Section 20814(c) of the California Public Employees' Retirement Law requires that the employer contribution rates for all public employers be determined on an annual basis by the actuary and shall be effective on the July 1 following notice of a change in the rate. Funding contributions for the Plans are determined annually on an actuarial basis as of June 30 by CalPERS. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. Redwood Empire Municipal Insurance Fund is required to contribute the difference between the actuarially determined rate and the contribution rate of employees.

For the year ended June 30, 2020, the contributions recognized as part of pension expense for the Plan were $240,547.

Pension Liabilities, Pension Expenses and Deferred Outflows/Inflows of Resources Related to Pensions

As of June 30, 2020, Redwood Empire Municipal Insurance Fund reported net pension liabilities for its proportionate share of the net pension liability of the Plans' of $2,256,336.

9. PENSION PLAN (CONTINUED)

Redwood Empire Municipal Insurance Fund's net pension liability for the Plan is measured as the proportionate share of the net pension liability. The net pension liability of the Plan is measured as of June 30, 2019, and the total pension liability for the Plan used to calculate the net pension liability was determined by an actuarial valuation as of June 30, 2018 rolled forward to June 30, 2019 using standard update procedures. Redwood Empire Municipal Insurance Fund's proportion of the net pension liability was based on a projection of REMIF's long-term share of contributions to the pension plan relative to the projected contributions of all participating employers, actuarially determined. REMIF's proportionate share of the net pension liability for the Plan as of June 30, 2020 and 2019 was as follows:

	Miscellaneous
Proportion - June 30, 2019	0.05719%
Proportion - June 30, 2020	0.05635%
Change - Increase (Decrease)	-0.00085%

For the year ended June 30, 2020, REMIF recognized pension expense of $443,562. At June 30, 2020, REMIF reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Pension contributions subsequent to measurement date	$ 240,547	$ -
Net differences between projected and actual earnings on plan investments	-	39,448
Change in employer's proportion	13,740	84,864
Adjustment due to differences between actual and proportionate share of contributions	31,354	11,193
Changes in assumptions	107,593	38,141
Difference between expected and actual experience	156,712	12,142
Total	$ 549,945	$ 185,787

9. PENSION PLAN (CONTINUED)

The amounts reported as deferred outflows of resources related to contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability in the year ended June 30, 2021. Other amounts reported as deferred inflows of resources related to pensions will be recognized as pension expense as follows:

Year Ended June 30	Deferred Outflows/(Inflows) of Resources
2021	$ 155,274
2022	(48,952)
2023	9,318
2024	7,971
2025	-
Thereafter	-
Total	$ 123,611

Actuarial Assumptions

The total pension liabilities in the June 30, 2019 actuarial valuations were determined using the following actuarial assumptions for both plans:

	Miscellaneous
Valuation Date	June 30, 2018
Measurement Date	June 30, 2019
Actuarial Cost Method	Entry-Age Normal Cost Method
Actuarial Assumptions	
Discount Rate	7.15%
Payroll Growth	2.75%
Inflation	2.50%
Salary Increases	Varies by Entry Age and Service
Mortality	Derived using CalERS' Membership Data for all Funds
Post-retirement benefit increase	Protection Allowance Floor on Purchasing Power applies

The mortality table used was developed based on CalPERS-specific data. The table includes 15 years of mortality improvements using Society of Actuaries Scale 90% of scale MP 2016. For more details on this table, please refer to the December 2017 experience study report (based on CalPERS demographic data from 1997 to 2015) that can be found on the CalPERS website.

9. PENSION PLAN (CONTINUED)

Changes in Assumptions

There were no changes in assumptions.

Changes in Benefit Terms

There were no changes in benefit terms.

Discount Rate

The discount rate used to measure the total pension liability was 7.15%. The projection of cash flows used to determine the discount rate assumed that contributions from plan members will be made at the current member contribution rates and that contributions from employers will be made at statutorily required rates, actuarially determined. Based on those assumptions, the Plan's fiduciary net position was projected to be available to make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class.

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations as well as the expected pension fund cash flows. Using historical returns of all of the funds' asset classes, expected compound (geometric) returns were calculated over the short-term (first 10 years) and the long-term (11+ years) using a building-block approach. Using the expected nominal returns for both short-term and long-term, the present value of benefits was calculated for each fund. The expected rate of return was set by calculating the rounded single equivalent expected return that arrived at the same present value of benefits for cash flows as the one calculated using both short-term and long-term returns. The expected rate of return was then set equal to the single equivalent rate calculated above and adjusted to account for assumed administrative expenses.

9. PENSION PLAN (CONTINUED)

The expected real rates of return by asset class are as follows:

Asset Class	Assumed Asset Allocation	Real Return Years 1 - 10 (a)	Real Return Years 11+ (b)
Global Equity	50.0%	4.80%	5.98%
Fixed Income	28.0%	1.00%	2.62%
Inflation Assets	0.0%	0.77%	1.81%
Private Equity	8.0%	6.30%	7.23%
Real Assets	13.0%	3.75%	4.93%
Liquidity	1.0%	0.00%	-0.92%

(a) An expected inflation of 2.00% used for this period
(b) An expected inflation of 2.92% used for this period

Sensitivity of the Proportionate Share of the Net Pension Liability to Changes in the Discount Rate

The following presents REMIF's proportionate share of the net pension liability for the Plan, calculated using the discount rate for the Plan, as well as what REMIF's proportionate share of the net pension liability would be if it were calculated using a discount rate that is 1-percentage point lower or 1-percentage point higher than the current rate:

	Discount Rate - 1% (6.15%)	Current Discount Rate (7.15%)	Discount Rate + 1% (8.15%)
Plan's Net Pension Liability	$ 3,338,081	$ 2,256,336	$ 1,363,433

Pension Plan Fiduciary Net Position

Detailed information about each pension plan's fiduciary net position is available in the separately issued CalPERS Miscellaneous and Safety financial reports available on the CalPERS website at www.calpers.ca.gov.

Payable to the Pension Plan

As of June 30, 2020, REMIF had no outstanding required contributions to the pension plans.

10. JOINT VENTURES

REMIF participates in a joint venture under a joint powers agreement with California Joint Powers Risk Management Authority (CJPRMA). The relationship between REMIF and CJPRMA is such that CJPRMA is not a component unit of REMIF for financial reporting purposes.

CJPRMA arranges for and provides excess general liability coverage and property coverage for REMIF. A board consisting of a representative from each member agency governs CJPRMA. The Board controls the operations of CJPRMA including selection of management and approval of operating budgets, independent of any influence by the member agencies beyond their representation on the board. Each member's agency pays a premium commensurate with the level of coverage requested and shares surpluses and deficits proportionate to their participation in CJPRMA.

During the fiscal year ended June 30, 2020, REMIF contributed $1,034,034 for Liability, $812,491 for Property, and $207,628 for Auto Physical Damage current year coverage.

The most recent condensed financial information available is as follows:

	June 30, 2019 CJPRMA
Total Assets	$ 58,064,421
Deferred Outflows	638,415
Total Liabilities	54,471,325
Deferred Inflows	171,555
Net Position	$ 4,059,956
Total Revenues	$ 20,702,993
Total Expenditures	38,695,602
Net Increase (Decrease) in Net Position	$ (17,992,609)

CJPRMA's financial statements may be obtained from CJPRMA at 3201 Doolan Road, Suite 285, Livermore, CA 94551.

11. MEMBER ASSESSMENTS RECEIVABLE

The REMIF Board has the authority to levy a cash assessment on the participating members for any pooled coverage program. Due to unfavorable claims development over the last ten years and underfunding of member premiums during that time, REMIF's overall equity balance reflected a deficit of $4.23 million as of June 30, 2017.

On March 22, 2018, the REMIF Board approved an assessment for the following programs to be collected beginning in the 2018/2019 fiscal year:

* Workers' Compensation program – $6 million to be collected over 6 years
* Liability program – $2.5 million to be collected over 5 years

The assessments will be paid in six or five equal annual installments as noted above, and the unpaid balances of the assessments do not bear interest.

As of June 30, 2020, the amount of outstanding assessments was $4,000,000 and $1,500,000 for the workers' compensation and liability programs, respectively.

12. COMMITMENTS AND CONTINGENCIES

REMIF is subject to litigation arising in the normal course of business. In the opinion of the General Manager, there is no pending litigation which is likely to have a material adverse effect on the financial position of the REMIF.

13. SUBSEQUENT EVENTS

In March 2020, the World Health Organization declared the novel coronavirus ("COVID-19") a global pandemic and recommended containment and mitigation measures worldwide. This contagious disease outbreak, which has continued to spread, and any related adverse public health developments, has adversely affected public education, workforces, economies, and financial markets globally, potentially leading to an economic downturn. It has also disrupted the normal operations of many businesses and organizations. It is not possible for management to predict the duration or magnitude of the adverse results of the outbreak and its disruptive effects on the REMIF's operations and financial results at this time.

Redwood Empire Municipal Insurance Fund's management evaluated its June 30, 2020 financial statements for subsequent events through January 13, 2021, the date the financial statements were available to be issued. Management is not aware of any subsequent events, other than those described above, that would require recognition or disclosure in the financial statements.

REQUIRED SUPPLEMENTARY INFORMATION

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

RECONCILIATION OF CLAIMS LIABILITY BY PROGRAM

JUNE 30, 2020 AND 2019

	Workers' Compensation		Liability		Property		Dental	
	2020	2019	2020	2019	2020	2019	2020	2019
Liability at the beginning of the fiscal year	$ 19,684,971	$ 17,614,551	$ 5,738,549	$ 5,794,517	$ 100,000	$ 25,000	$ 50,000	$ 50,000
Incurred claims and claim adjustment expenses:								
Provision for insured events of the current fiscal year	4,864,210	4,498,440	2,816,424	1,585,474	100,000	176,597	929,330	1,092,550
Changes in provision for insured events of prior fiscal years	(2,012,747)	1,799,062	2,480,375	2,100,662	(57,725)	(172,728)	4,813	(7,161)
Total incurred claims and claim adjustment expenses	2,851,463	6,297,502	5,296,799	3,686,136	42,275	3,869	934,143	1,085,389
Payments:								
Claims and claim adjustment expenses attributable to insured events of the current fiscal year	349,685	337,231	92,044	147,978	-	76,597	874,330	1,042,550
Claims and claim adjustment expenses attributable to insured events of prior fiscal years	3,318,830	3,889,851	2,502,131	3,594,126	(57,725)	(147,728)	54,813	42,839
Total payments	3,668,515	4,227,082	2,594,175	3,742,104	(57,725)	(71,131)	929,143	1,085,389
Liability at the end of the fiscal year	$ 18,867,919	$ 19,684,971	$ 8,441,173	$ 5,738,549	$ 200,000	$ 100,000	$ 55,000	$ 50,000
Components of Claims Liabilities								
Claims reserves	$ 9,876,566	$ 11,288,119	$ 4,660,870	$ 3,167,188	$ 100,000	$ 76,895	$ -	$ -
Claims incurred but not reported	8,092,881	7,459,472	3,378,342	2,298,101	100,000	23,105	55,000	50,000
ULAE	898,472	937,380	401,961	273,260	-	-	-	-
Total Claims Liability	$ 18,867,919	$ 19,684,971	$ 8,441,173	$ 5,738,549	$ 200,000	$ 100,000	$ 55,000	$ 50,000
Current portion	$ 4,000,000	$ 4,000,000	$ 3,000,000	$ 3,000,000	$ -	$ -	$ 55,000	$ 50,000
Long-term portion	14,867,919	15,684,971	5,441,173	2,738,549	200,000	100,000	-	-
Total	$ 18,867,919	$ 19,684,971	$ 8,441,173	$ 5,738,549	$ 200,000	$ 100,000	$ 55,000	$ 50,000

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

RECONCILIATION OF CLAIMS LIABILITY BY PROGRAM

JUNE 30, 2020 AND 2019

	Vision		Auto Physical Damage		Self-Insured		Totals	
	2020	2019	2020	2019	2020	2019	2020	2019
Liability at the beginning of the fiscal year	$ 14,227	$ 14,227	$ -	$ -	$ 1,250,000	$ 1,250,000	$ 26,837,747	$ 24,748,295
Incurred claims and claim adjustment expenses:								
Provision for insured events of the current fiscal year	130,931	177,372	-	5,000	12,122,268	6,228,975	20,963,163	13,764,408
Changes in provision for insured events of prior fiscal years	(8,391)	(14,227)	26	63,511	(687,223)	935,501	(378,905)	4,704,620
Total incurred claims and claim adjustment expenses	122,540	163,145	26	68,511	11,435,045	7,164,476	20,584,258	18,469,028
Payments:								
Claims and claim adjustment expenses attributable to insured events of the current fiscal year	120,931	156,080	5,000	5,000	10,872,268	6,723,652	12,314,258	8,489,088
Claims and claim adjustment expenses attributable to insured events of prior fiscal years	5,836	7,065	(4,974)	63,511	562,777	440,824	6,283,655	7,890,488
Total payments	126,767	163,145	26	68,511	11,435,045	7,164,476	18,597,913	16,379,576
Liability at the end of the fiscal year	$ 10,000	$ 14,227	$ -	$ -	$ 1,250,000	$ 1,250,000	$ 28,824,092	$ 26,837,747
Components of Claims Liabilities								
Claims reserves	$ -	$ -	$ -	$ -	$ -	$ -	$ 14,637,436	$ 14,532,202
Claims incurred but not reported	10,000	14,227	-	-	1,250,000	1,250,000	12,886,223	11,094,905
ULAE	-	-	-	-	-	-	1,300,433	1,210,640
Total Claims Liability	$ 10,000	$ 14,227	$ -	$ -	$ 1,250,000	$ 1,250,000	$ 28,824,092	$ 26,837,747
Current portion	$ 10,000	$ 14,227	$ -	$ -	$ -	$ -	$ 7,065,000	$ 7,064,227
Long-term portion	-	-	-	-	1,250,000	1,250,000	21,759,092	19,773,520
Total	$ 10,000	$ 14,227	$ -	$ -	$ 1,250,000	$ 1,250,000	$ 28,824,092	$ 26,837,747

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

CLAIMS DEVELOPMENT INFORMATION – WORKERS' COMPENSATION
(in thousands)

AS OF JUNE 30, 2020

	For the fiscal year ended June 30,									
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
1) Premium and investment revenues										
Earned	$ 3,376	$ 3,304	$ 3,806	$ 3,579	$ 3,695	$ 4,162	$ 4,862	$ 5,310	$ 5,480	$ 7,035
Ceded	(315)	(282)	(293)	(277)	(291)	(345)	(320)	(333)	(354)	(395)
Net Earned	3,061	3,022	3,513	3,302	3,404	3,817	4,542	4,977	5,126	6,640
2) Unallocated expenses	347	318	338	335	327	212	724	1,217	1,512	1,579
3) Estimated self insured incurred claims and expense, end of program year	2,680	2,195	2,984	3,132	2,906	3,442	3,529	5,351	4,498	4,864
4) Paid (cumulative) as of:										
End of program year	436	313	618	558	418	381	488	722	337	350
One year later	1,224	1,204	1,465	1,618	1,176	1,107	1,138	1,363	1,270	
Two years later	1,893	1,869	2,337	2,412	1,655	1,724	1,535	2,099		
Three years later	2,472	2,278	2,701	3,070	2,127	1,460	1,986			
Four years later	2,788	2,513	3,086	3,625	1,749	1,805				
Five years later	3,086	2,710	3,329	3,351	1,928					
Six years later	3,434	2,934	3,213	3,598						
Seven years later	3,967	2,474	3,476							
Eight years later	3,717	3,489								
Nine years later	3,767									
5) Reestimated ceded claims and expenses	-	-	-	-	-	-	-	-	-	-
6) Reestimated incurred claims and expenses										
End of program year	2,680	2,195	2,984	3,132	2,906	3,442	3,529	5,351	4,498	4,864
One year later	2,824	3,204	3,175	3,633	2,949	3,210	3,897	4,957	4,520	
Two years later	3,783	3,316	3,731	4,189	3,287	3,395	3,652	4,837		
Three years later	4,331	3,498	4,088	4,746	3,659	2,994	3,262			
Four years later	4,423	3,267	4,367	5,760	2,923	3,053				
Five years later	4,568	3,280	4,919	4,673	2,360					
Six years later	4,673	3,520	4,316	4,664						
Seven years later	5,078	2,880	4,048							
Eight years later	4,505	2,736								
Nine years later	4,393									
7) Increase (decrease) in estimated incurred claims and expenses from end of program year	$ 1,713	$ 541	$ 1,064	$ 1,532	$ (546)	$ (389)	$ (267)	$ (514)	$ 22	$ -

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

CLAIMS DEVELOPMENT INFORMATION – LIABILITY
(in thousands)

AS OF JUNE 30, 2020

	For the fiscal year ended June 30,									
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
1) Premium and investment revenues										
Earned	$ 3,023	$ 2,853	$ 2,389	$ 2,271	$ 2,035	$ 2,307	$ 2,518	$ 2,799	$ 3,783	$ 4,542
Ceded	(597)	(633)	(521)	(614)	(609)	(604)	(647)	(759)	(842)	(1,033)
Net Earned	2,426	2,220	1,868	1,657	1,426	1,703	1,871	2,040	2,941	3,509
2) Unallocated expenses	608	569	589	497	637	648	656	516	529	526
3) Estimated self insured incurred claims and expense, end of program year	1,701	1,566	1,211	1,601	2,166	1,883	2,671	1,747	1,585	2,816
4) Paid (cumulative) as of:										
End of program year	416	430	258	471	569	379	328	177	148	92
One year later	1,036	840	515	1,231	1,085	828	737	525	266	
Two years later	1,562	1,680	747	1,705	1,942	1,459	1,521	1,672		
Three years later	1,626	2,320	935	1,845	2,194	1,973	2,264			
Four years later	1,650	2,321	989	2,323	2,476	2,133				
Five years later	1,595	2,387	970	1,623	2,614					
Six years later	1,597	2,550	674	1,804						
Seven years later	1,630	2,231	674							
Eight years later	1,128	2,231								
Nine years later	1,128									
5) Reestimated ceded claims and expenses	-	-	-	-	-	-	-	-	-	-
6) Reestimated incurred claims and expenses										
End of program year	1,701	1,566	1,211	1,601	2,166	1,883	2,671	1,747	1,585	2,816
One year later	1,710	1,600	1,164	2,061	2,124	2,288	2,488	2,560	2,222	
Two years later	1,843	2,003	1,045	1,993	2,758	2,715	2,759	2,812		
Three years later	1,673	2,443	999	2,306	3,017	2,325	3,547			
Four years later	1,688	2,429	1,042	2,608	2,749	3,219				
Five years later	1,614	2,803	1,001	1,829	2,614					
Six years later	1,653	2,602	674	1,807						
Seven years later	1,656	2,278	674							
Eight years later	1,128	2,277								
Nine years later	1,128									
7) Increase (decrease) in estimated incurred claims and expenses from end of program year	$ (573)	$ 711	$ (537)	$ 206	$ 448	$ 1,336	$ 876	$ 1,065	$ 637	$ -

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

CLAIMS DEVELOPMENT INFORMATION – PROPERTY

AS OF JUNE 30, 2020

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Total Required Contribution and Investment Revenue:										
Earned	$ 436,255	$ 451,325	$ 483,499	$ 490,724	$ 492,523	$ 504,961	$ 473,090	$ 507,425	$ 1,342,755	$ 2,358,526
Ceded- Excess Ins.	(379,485)	(363,446)	(387,001)	(396,981)	(395,631)	(290,814)	(338,807)	(478,971)	(1,621,434)	(1,780,964)
(1) Net Earned Required Contribution and Investment Revenues	56,770	87,879	96,498	93,743	96,892	214,147	134,283	28,454	(278,679)	577,562
(2) Unallocated Expenses	15,239	13,930	15,104	15,878	15,823	15,762	45,451	23,308	23,422	24,031
(3) Estimated Incurred Claims and Expenses										
End of Year	380,188	415,917	402,975	472,285	434,790	428,421	388,634	559,949	1,798,031	1,880,964
Ceded	379,485	363,446	387,001	396,981	395,631	290,814	338,807	478,971	1,621,434	1,780,964
Net Incurred	703	52,471	15,974	75,304	39,159	137,607	49,827	80,978	176,597	100,000
(4) Paid (Cumulative)										
End of Year	703	49,155	15,974	75,304	39,159	137,607	49,827	77,296	76,597	-
One Year Later	703	49,155	19,938	77,801	11,223	104,092	84,813	77,296	39,866	
Two Years Later	15,333	49,155	19,938	77,801	11,223	104,093	84,813	77,296		
Three Years Later	15,333	49,155	19,218	77,800	11,223	104,093	84,813			
Four Years Later	16,095	49,155	19,218	77,801	11,223	104,093				
Five Years Later	16,095	49,155	9,744	77,801	39,189					
Six Years Later	16,095	49,155	9,744	77,801						
Seven Years Later	16,095	49,155	9,744							
Eight Years Later	16,095	49,155								
Nine Years Later	16,095									
(5) Reestimated Ceded Claims and Expenses	-	-	-	-	-	-	-	-	-	-
(6) Reestimated Incurred Claims and Expenses										
End of Year	703	52,471	15,974	75,304	39,159	137,607	49,827	80,978	176,597	100,000
One Year Later	703	49,155	19,938	77,801	11,223	104,092	84,813	77,296	139,863	
Two Years Later	15,333	49,155	19,938	77,801	11,223	104,093	84,813	77,296		
Three Years Later	15,333	49,155	19,218	77,801	11,223	104,093	84,813			
Four Years Later	16,095	49,155	19,218	77,801	11,223	104,093				
Five Years Later	16,075	49,155	9,744	77,801	39,189					
Six Years Later	16,095	49,155	9,744	77,801						
Seven Years Later	16,095	49,155	9,744							
Eight Years Later	16,095	49,155								
Nine Years Later	16,095									
(7) Increase (Decrease) in Estimated Incurred Claims Expense from End of Policy Year	$ (15,392)	$ 3,316	$ 6,230	$ (2,497)	$ (30)	$ 33,514	$ (34,986)	$ 3,682	$ 36,734	$ -

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

CLAIMS DEVELOPMENT INFORMATION – DENTAL

AS OF JUNE 30, 2020

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Total Required Contribution and Investment Revenue:										
Earned	$ 1,296,855	$ 1,278,063	$ 1,095,907	$ 1,070,049	$ 1,187,445	$ 1,214,854	$ 1,204,661	$ 1,249,112	$ 1,283,496	$ 1,434,525
Ceded- Excess Ins.	-	-	-	-	-	-	-	-	-	-
(1) Net Earned Required Contribution and Investment Revenues	1,296,855	1,278,063	1,095,907	1,070,049	1,187,445	1,214,854	1,204,661	1,249,112	1,283,496	1,434,525
(2) Unallocated Expenses	133,573	154,387	140,130	142,201	152,789	153,587	166,783	170,857	173,461	177,908
(3) Estimated Incurred Claims and Expenses										
End of Year	1,112,579	1,126,876	1,048,642	1,040,235	1,048,518	1,072,372	1,110,345	1,084,239	1,092,550	929,330
Ceded	-	-	-	-	-	-	-	-	-	-
Net Incurred	1,112,579	1,126,876	1,048,642	1,040,235	1,048,518	1,072,372	1,110,345	1,084,239	1,092,550	929,330
(4) Paid (Cumulative)										
End of Year	1,112,579	1,126,876	1,048,642	1,071,296	982,792	988,517	1,028,211	1,034,239	1,042,550	874,330
One Year Later	1,112,579	1,126,876	1,048,642	1,145,185	1,048,518	1,072,372	1,075,389	1,077,079	1,097,882	
Two Years Later	1,112,579	1,126,876	1,048,642	1,145,185	1,048,518	1,072,372	1,075,389	1,077,079		
Three Years Later	1,112,579	1,126,876	1,048,642	1,145,185	1,048,518	1,072,372	1,075,389			
Four Years Later	1,112,579	1,126,876	1,048,642	1,145,185	1,048,518	1,072,372				
Five Years Later	1,112,579	1,126,876	1,048,642	1,145,185	1,048,518					
Six Years Later	1,112,579	1,126,876	1,048,642	1,145,185						
Seven Years Later	1,112,579	1,126,876	1,048,642							
Eight Years Later	1,112,579	1,126,876								
Nine Years Later	1,112,579									
(5) Reestimated Ceded Claims and Expenses	-	-	-	-	-	-	-	-	-	-
(6) Reestimated Incurred Claims and Expenses										
End of Year	1,112,579	1,126,876	1,048,642	1,040,235	1,048,518	1,072,372	1,110,345	1,084,239	1,092,550	929,330
One Year Later	1,112,579	1,126,876	1,048,642	1,145,185	1,048,518	1,072,372	1,075,389	1,077,079	1,097,882	
Two Years Later	1,112,579	1,126,876	1,048,642	1,145,185	1,048,518	1,072,372	1,075,389	1,077,079		
Three Years Later	1,112,579	1,126,876	1,048,642	1,145,185	1,048,518	1,072,372	1,075,389			
Four Years Later	1,112,579	1,126,876	1,048,642	1,145,185	1,048,518	1,072,372				
Five Years Later	1,112,579	1,126,876	1,048,642	1,145,185	1,048,518					
Six Years Later	1,112,579	1,126,876	1,048,642	1,145,185						
Seven Years Later	1,112,579	1,126,876	1,048,642							
Eight Years Later	1,112,579	1,126,876								
Nine Years Later	1,112,579									
(7) Increase (Decrease) in Estimated Incurred Claims Expense from End of Policy Year	$ -	$ -	$ -	$ (104,950)	$ -	$ -	$ 34,956	$ 7,160	$ (5,332)	$ -

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

CLAIMS DEVELOPMENT INFORMATION – VISION

AS OF JUNE 30, 2020

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Total Required Contribution and Investment Revenue:										
Earned	$ 183,281	$ 185,020	$ 200,435	$ 140,808	$ 183,460	$ 175,360	$ 209,675	$ 228,349	$ 229,120	$ 224,399
Ceded- Excess Ins.	-		-	-	-	-	-	-	-	-
(1) Net Earned Required Contribution and Investment Revenues	183,281	185,020	200,435	140,808	183,460	175,360	209,675	228,349	229,120	224,399
(2) Unallocated Expenses	36,750	33,020	33,856	39,344	41,305	40,976	43,051	51,010	46,751	48,543
(3) Estimated Incurred Claims and Expenses										
End of Year	155,240	167,325	178,473	164,471	158,859	159,163	160,508	159,509	177,372	130,931
Ceded	-	-	-	-	-	-	-	-	-	-
Net Incurred	155,240	167,325	178,473	164,471	158,859	159,163	160,508	159,509	177,372	130,931
(4) Paid (Cumulative)										
End of Year	155,240	167,325	178,473	147,697	143,699	147,524	146,281	143,693	163,145	120,931
One Year Later	155,240	167,325	186,802	162,777	158,859	159,163	162,097	143,693	168,963	
Two Years Later	155,240	167,325	186,802	162,777	158,859	159,163	162,097	143,693		
Three Years Later	155,240	167,325	186,802	162,777	158,859	159,163	162,097			
Four Years Later	155,240	167,325	186,802	162,777	158,859	159,163				
Five Years Later	155,240	167,325	186,802	162,777	158,859					
Six Years Later	155,240	167,325	186,802	162,777						
Seven Years Later	155,240	167,325	186,802							
Eight Years Later	155,240	167,325								
Nine Years Later	155,240									
(5) Reestimated Ceded Claims and Expenses	-	-	-	-	-	-	-	-	-	-
(6) Reestimated Incurred Claims and Expenses										
End of Year	155,240	167,325	178,473	164,471	158,859	159,163	160,508	159,509	177,372	130,931
One Year Later	155,240	167,325	186,802	162,777	158,859	159,163	162,097	143,693	168,963	
Two Years Later	155,240	167,325	186,802	162,777	158,859	159,163	162,097	143,693		
Three Years Later	155,240	167,325	186,802	162,777	158,859	159,163	162,097			
Four Years Later	155,240	167,325	186,802	162,777	158,859	159,163				
Five Years Later	155,240	167,325	186,802	162,777	158,859					
Six Years Later	155,240	167,325	186,802	162,777						
Seven Years Later	155,240	167,325	186,802							
Eight Years Later	155,240	167,325								
Nine Years Later	155,240									
(7) Increase (Decrease) in Estimated Incurred Claims Expense from End of Policy Year	$ -	$ -	$ (8,329)	$ 1,694	$ -	$ -	$ (1,589)	$ 15,816	$ 8,409	$ -

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

CLAIMS DEVELOPMENT INFORMATION – AUTO PHYSICAL DAMAGE

AS OF JUNE 30, 2020

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Total Required Contribution and Investment Revenue:										
Earned	$ 149,767	$ 150,179	$ 144,757	$ 165,102	$ 164,006	$ 201,064	$ 194,779	$ 225,749	$ 330,646	$ 250,127
Ceded- Excess Ins.	(85,110)	(74,196)	(76,623)	(80,792)	(81,515)	(96,137)	(64,262)	(103,948)	(136,295)	(215,011)
(1) Net Earned Required Contribution and Investment Revenues	64,657	75,983	68,134	84,310	82,491	104,927	130,517	121,801	194,351	35,116
(2) Unallocated Expenses	7,620	6,964	7,552	7,939	7,912	7,881	91,352	23,308	23,423	24,031
(3) Estimated Incurred Claims and Expenses										
End of Year	135,560	90,238	80,639	82,170	147,385	134,970	77,042	174,742	204,806	215,011
Ceded	85,110	74,196	76,623	80,792	81,515	96,137	64,262	103,948	136,295	215,011
Net Incurred	50,450	16,042	4,016	1,378	65,870	38,833	12,780	70,794	68,511	-
(4) Paid (Cumulative)										
End of Year	50,450	16,042	3,792	1,378	37,439	31,723	12,780	70,794	68,511	-
One Year Later	51,058	7,731	3,792	1,682	38,511	52,033	15,653	70,794	5,000	
Two Years Later	51,058	7,731	3,792	1,682	38,511	50,494	15,653	99,662		
Three Years Later	51,058	7,731	3,792	1,681	38,511	50,494	15,653			
Four Years Later	51,058	7,731	3,792	1,682	38,511	50,494				
Five Years Later	51,058	7,731	3,792	1,682	38,511					
Six Years Later	51,058	7,731	3,792	1,682						
Seven Years Later	51,058	7,731	3,792							
Eight Years Later	51,058	7,731								
Nine Years Later	51,058									
(5) Reestimated Ceded Claims and Expenses	-	-	-	-	-	-	-	-	-	-
(6) Reestimated Incurred Claims and Expenses										
End of Year	50,450	16,042	4,016	1,378	65,870	38,833	12,780	70,794	68,511	-
One Year Later	51,058	7,731	3,792	1,682	38,511	52,033	15,653	70,794	5,000	
Two Years Later	51,058	7,731	3,792	1,682	38,511	50,494	15,653	99,662		
Three Years Later	51,058	7,731	3,792	1,682	38,511	50,494	15,653			
Four Years Later	51,058	7,731	3,792	1,682	38,511	50,494				
Five Years Later	51,058	7,731	3,792	1,682	38,511					
Six Years Later	51,058	7,731	3,792	1,682						
Seven Years Later	51,058	7,731	3,792							
Eight Years Later	51,058	7,731								
Nine Years Later	51,058									
(7) Increase (Decrease) in Estimated Incurred Claims Expense from End of Policy Year	$ (608)	$ 8,311	$ 224	$ (304)	$ 27,359	$ (11,661)	$ (2,873)	$ (28,868)	$ 63,511	$ -

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

CLAIMS DEVELOPMENT INFORMATION – SELF INSURED HEALTHCARE

AS OF JUNE 30, 2020

	2016	2017	2018	2019	2020
Total Required Contribution and Investment Revenue:					
Earned	$ 14,326,372	$ 13,614,708	$ 13,280,417	$ 13,735,433	$ 13,910,687
Ceded- Excess Ins.	-	-	-	(92,642)	(55,539)
(1) Net Earned Required Contribution and Investment Revenues	14,326,372	13,614,708	13,280,417	13,642,791	13,855,148
(2) Unallocated Expenses	1,711,519	1,911,244	1,825,179	1,891,347	2,406,532
(3) Estimated Incurred Claims and Expenses					
End of Year	12,011,790	10,640,919	10,693,595	12,016,465	12,177,807
Ceded	-	-	-	92,642	55,539
Net Incurred	12,011,790	10,640,919	10,693,595	11,923,823	12,122,268
(4) Paid (Cumulative)					
End of Year	10,806,441	9,711,868	9,443,595	10,673,823	10,872,268
One Year Later	12,011,790	12,020,542	9,884,419	11,987,335	
Two Years Later	12,011,790	12,020,542	10,325,243		
Three Years Later	12,011,790	12,020,542			
Four Years Later	12,011,790				
Five Years Later					
Six Years Later					
Seven Years Later					
Eight Years Later					
Nine Years Later					
(5) Reestimated Ceded Claims and Expenses	-	-	-	-	-
(6) Reestimated Incurred Claims and Expenses					
End of Year	12,011,790	10,640,919	10,693,595	11,923,823	12,122,268
One Year Later	12,011,790	12,020,512	9,884,419	11,987,335	
Two Years Later	12,011,790	12,020,512	9,884,419		
Three Years Later	12,011,790	12,020,512			
Four Years Later	12,011,790				
Five Years Later					
Six Years Later					
Seven Years Later					
Eight Years Later					
Nine Years Later					
(7) Increase (Decrease) in Estimated Incurred Claims Expense from End of Policy Year	$ -	$ (1,379,593)	$ 809,176	$ (63,512)	$ -

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

SCHEDULE OF THE PROPORTIONATE SHARE OF THE NET PENSION LIABILITY

AS OF JUNE 30, 2020

	June 30, 2014	June 30, 2015	June 30, 2016	June 30, 2017	June 30, 2018	June 30, 2019
Proportion of the net pension liability	0.058590%	0.062120%	0.058040%	0.056830%	0.057190%	0.056345%
Proportionate share of the net pension liability	$ 1,448,051	$ 1,704,201	$ 2,016,395	$ 2,240,292	$ 2,155,338	$ 2,256,336
Covered payroll (1)	$ 685,650	$ 756,359	$ 757,350	$ 811,012	$ 782,868	$ 343,521
Proportionate share of the net pension liability as a percentage of covered payroll	211.19%	225.32%	266.24%	276.23%	275.31%	656.83%
Plans fiduciary net position as a percentage of the total pension liability	79.82%	78.40%	74.06%	73.31%	77.69%	77.73%

(1) Covered payroll represented above is the payroll on which contributions to the pension plan are based.

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

SCHEDULE OF PENSION CONTRIBUTIONS

JUNE 30, 2020

	2015	2016	2017	2018	2019	2020
Actuarially determined contribution (1)	$ 259,592	$ 219,744	$ 241,669	$ 242,051	$ 224,566	$ 240,547
Contributions in relation to the actuarially determined contributions (1)	(259,592)	(219,744)	(241,669)	(242,051)	(224,566)	(240,547)
Contribution deficiency (excess)	$ -	$ -	$ -	$ -	$ -	$ -
Covered payroll (2)	$ 756,359	$ 757,350	$ 811,012	$ 782,868	$ 343,521	$ 320,911
Contributions as a percentage of covered payroll (2)	34.32%	29.01%	29.80%	30.92%	65.37%	74.96%

(1) Employers are assumed to make contributions equal to the actuarially determined contributions (which is the actuarially determined contribution). However, some employers may choose to make additional contributions towards their side fund or their unfunded liability. Employer contributions for such plans exceed the actuarially determined contributions. CalPERS has determined that employer obligations referred to as "side funds" do not conform to the circumstances described in paragraph 120 of GASB 68, therefore are not considered separately financed specific liabilities.

(2) Covered payroll represented above is the payroll on which contributions to the pension plan are based.

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

SCHEDULE OF CHANGES IN NET OPEB LIABILITY AND RELATED RATIOS

JUNE 30, 2020

	2020	2019	2018	2017
Total OPEB liability				
Service cost	$ 27,465	$ 26,600	$ 100,153	$ 97,000
Interest	114,363	114,390	190,208	179,000
Changes of benefit terms	-	-	-	-
Differences between expected and actual experience	(53,795)	-	(1,166,627)	-
Changes of assumptions	(116,152)	-	448,000	-
Benefit payments, including refunds of member contributions	(127,298)	(157,471)	(115,806)	(115,159)
Net change in total OPEB liability (asset)	(155,417)	(16,481)	(544,072)	160,841
Total OPEB liability - beginning	2,323,447	2,339,928	2,884,000 *	2,723,000
Total OPEB liability - ending (a)	$ 2,168,030	$ 2,323,447	$ 2,339,928	$ 2,883,841
Plan fiduciary net position				
Contributions - employer	$ 4,705	$ 16,442	$ 115,806	$ 132,253
Net investment income	(15,485)	139,284	221,995	262,639
Benefit payments, including refunds of member contributions	(127,298)	(157,471)	(115,806)	(115,159)
Actuarial fees	(1,800)	-	-	-
Reimbursement to REMIF for prior year retiree benefits paid	-	(101,232)	-	-
Net change in plan fiduciary net position	(139,878)	(102,977)	221,995	279,733
Plan fiduciary net position - beginning	2,876,053	2,979,030	2,757,035	2,477,302
Plan fiduciary net position - ending (b)	$ 2,736,175	$ 2,876,053	$ 2,979,030	$ 2,757,035
REMIF's net OPEB liability (asset) - ending (a) - (b)	$ (568,145)	$ (552,606)	$ (639,102)	$ 126,806
Plan fiduciary net position as a percentage of the total OPEB liability	126.2%	123.8%	127.3%	95.6%
Covered-employee payroll	$ 72,240	$ 122,480	$ 467,743	$ 811,000
REMIF's net OPEB liability as a percentage of covered-employee payroll	-786.5%	-451.2%	-136.6%	15.6%

* REMIF changed actuarial firms in fiscal year 2018, which resulted in a rounding difference between the fiscal year balances.

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

SCHEDULE OF OPEB CONTRIBUTIONS

JUNE 30, 2020

	2020	2019	2018	2017
Actuarially determined contribution	$ -	$ -	$ -	$ -
Contributions in relation to the actuarially determined contribution	(4,705)	(16,442)	(115,806)	(115,159)
Contribution deficiency (excess)	$ (4,705)	$ (16,442)	$ (115,806)	$ (115,159)
Covered-employee payroll	$ 72,240	$ 122,480	$ 467,743	$ 811,000
Contributions as a percentage of covered-employee payroll	6.51%	13.42%	24.76%	14.20%

1. Reconciliation of Claims Liabilities by Program

The schedules represent the changes in claims liabilities for the current and past year for all of the Authority's programs.

2. Claims Development Information

(1) This line shows the total of each fiscal year's gross earned deposit premiums and cumulative investment income less ceded (excess insurance cost) and any dividends or assessments to arrive at net earned contribution and investment revenues.

(2) This line shows other operating costs of the Authority for each fiscal year including overhead and claims administration expenses.

(3) This line shows the Authority's gross estimated ultimate losses, losses assumed by reinsurers and net incurred losses as originally reported at the end of the policy years.

(4) This line shows the cumulative amounts paid as of the end of successive years for each program year.

(5) This line shows the latest reestimated amount of losses assumed by reinsurers for each policy year.

(6) This line shows the reestimated net incurred claims and allocated loss adjustment expenses as calculated by the actuary.

(7) This line compares the latest reestimated net incurred claims amount to the amount originally established (line 3) and shows whether this latest estimate of claims cost is greater than or less than originally projected.

The original and reestimated cost of claims is presented on a net present value basis, the effect of which decreases over time and may cause the appearance of adverse loss development when compared to original estimates. As data for individual accident years mature, the correlation between original estimates and the reestimated amounts is commonly used to evaluate the accuracy of net incurred claims currently recognized in less mature accident years. The columns of the table show data for successive accident years.

3. Schedule of the Proportionate Share of the Net Pension Liability and Schedule of Pension Contributions

This schedule presents information on REMIF's proportionate share of the net pension liability (NPL) and the Plan's fiduciary net position. In the future, as data becomes available, ten years of information will be presented.

	Miscellaneous
Valuation Date	June 30, 2018
Measurement Date	June 30, 2019
Actuarial Cost Method	Entry-Age Normal Cost Method
Actuarial Assumptions	
Discount Rate	7.15%
Payroll Growth	2.75%
Inflation	2.50%
Salary Increases	Varies by Entry Age and Service
Mortality	Derived using CalERS' Membership Data for all Funds
Post-retirement benefit increase	Protection Allowance Floor on Purchasing Power applies

Changes in Assumptions
There were no changes in assumptions.

Changes in Benefit Terms
There were no changes in benefit terms.

4. Schedule of Changes in the Net OPEB Liability and Related Ratios and Schedule of OPEB Contributions

GASB 75 requires presentation of the 10-year history of changes in the Net OPEB Liability and OPEB contributions. However, since this is the fourth year of implementation, only four years are currently available.

Actuarial cost method	Entry age normal (EAN) cost method
Amortization method	Level percentage of pay
Amortization period	5 years for the investment differences 1.22 years for all other deferred resources
Asset valuation method	Market value
Inflation	2.5% per year
Healthcare cost trend rates	Assumed to start at 5.4% (effective 2021) and grade down to 4% for years 2076 and thereafter
Salary increases	3.0% per year
Investment rate of return	5.0% as of June 30, 2020 and June 30, 2019

Changes in Assumptions

Below are the changes in assumptions recognized during the current measurement period.

Mortality Improvement	The mortality improvement scale was updated from MacLeod Watts Scale 2018 to MacLeod Watts Scale 2020, reflecting continued updates in available information.
Salary Scale	Decreased from 3.25% per year to 3.0% per year
General Inflation Rate	Decreased from 2.75% to 2.5% per year
Medical Trend	Updated to use the Getzen healthcare trend model sponsored by the Society of Actuaries
Excise Tax Repeal	Excluded the excise tax from the valuation results due to the December 2019 repeal of excise tax on high cost retiree coverage

Changes in Benefit Terms

There were no changes in benefit terms.

SUPPLEMENTARY INFORMATION

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

COMBINING STATEMENT OF NET POSITION

JUNE 30, 2020

	Workers' Comp.	Liability	Property	Dental	Vision	Auto Physical Damage	Post Retirement Benefits	Self-Funded Healthcare	Total
ASSETS									
Current Assets									
Cash and cash equivalents	$ 9,662,285	$ 18,534	$ 267,357	$ 163,213	$ 82,974	$ 100,867	$ -	$ 2,888,031	$ 13,183,261
Investments, current	1,360,656	851,735	304,083	274,189	48,079	268,932	-	1,617,961	4,725,635
Receivables									
Premiums and fees	280,852	1,520	183	123	123	183	-	496	283,480
Reimbursements	253,879	180,362	36,820	-	-	-	-	-	471,061
Member assessments	1,000,000	500,000	-	-	-	-	-	-	1,500,000
Excess insurance reimbursement and other	479,503	75,073	-	-	-	-	-	-	554,576
Interest	80,449	1,399	443	201	67	434	-	2,845	85,838
Prepaid expenses	45,004	83,701	997	406	409	613	-	38,878	170,008
Deposits	-	320,685	19,452	-	-	-	-	-	340,137
Total Current Assets	13,162,628	2,033,009	629,335	438,132	131,652	371,029	-	4,548,211	21,313,996
Noncurrent assets:									
Receivables									
Member assessments	3,000,000	1,000,000	-	-	-	-	-	-	4,000,000
Investments, noncurrent	2,290,673	1,433,901	511,925	461,598	80,941	452,748	-	2,723,852	7,955,638
Net OPEB asset	-	-	-	-	-	-	568,145	-	568,145
Capital assets - net of accumulated depreciation	473,777	-	-	-	-	-	-	-	473,777
Total Noncurrent Assets	5,764,450	2,433,901	511,925	461,598	80,941	452,748	568,145	2,723,852	12,997,560
Total Assets	18,927,078	4,466,910	1,141,260	899,730	212,593	823,777	568,145	7,272,063	34,311,556
DEFERRED OUTFLOWS OF RESOURCES									
Related to OPEB	-	-	-	-	-	-	109,994	-	109,994
Related to pensions	549,945	-	-	-	-	-	-	-	549,945
Total Deferred Ouflows of Resources	549,945	-	-	-	-	-	109,994	-	659,939

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

COMBINING STATEMENT OF NET POSITION

JUNE 30, 2020

	Workers' Comp.	Liability	Property	Dental	Vision	Auto Physical Damage	Post Retirement Benefits	Self-Funded Healthcare	Total
LIABILITIES									
Current Liabilities									
Accounts payable	$ 107,306	$ 35,240	$ 151,156	$ 32,546	$ 12,427	$ 3,196	$ -	$ 235,991	$ 577,862
Unearned premiums	260	307	155	25	3	95	-	3,350	4,195
Tenant and other deposits	10,346	-	-	-	-	-	-	-	10,346
Claims liabilities	4,000,000	3,000,000	-	55,000	10,000	-	-	-	7,065,000
Total Current Liabilities	4,117,912	3,035,547	151,311	87,571	22,430	3,291	-	239,341	7,657,403
Noncurrent Liabilities									
Claims liabilities	14,867,919	5,441,173	200,000	-	-	-	-	1,250,000	21,759,092
Net pension liability	2,256,336	-	-	-	-	-	-	-	2,256,336
Total Noncurrent Liabilities	17,124,255	5,441,173	200,000	-	-	-	-	1,250,000	24,015,428
Total Liabilities	21,242,167	8,476,720	351,311	87,571	22,430	3,291	-	1,489,341	31,672,831
DEFERRED INFLOWS OF RESOURCES									
Related to pensions	185,787	-	-	-	-	-	-	-	185,787
Total Deferred Inflows of Resources	185,787	-	-	-	-	-	-	-	185,787
NET POSITION									
Net investment in capital assets	473,777	-	-	-	-	-	-	-	473,777
Unrestricted	(2,424,708)	(4,009,810)	789,949	812,159	190,163	820,486	678,139	5,782,722	2,639,100
Total Net Position	$ (1,950,931)	$ (4,009,810)	$ 789,949	$ 812,159	$ 190,163	$ 820,486	$ 678,139	$ 5,782,722	$ 3,112,877

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

COMBINING STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

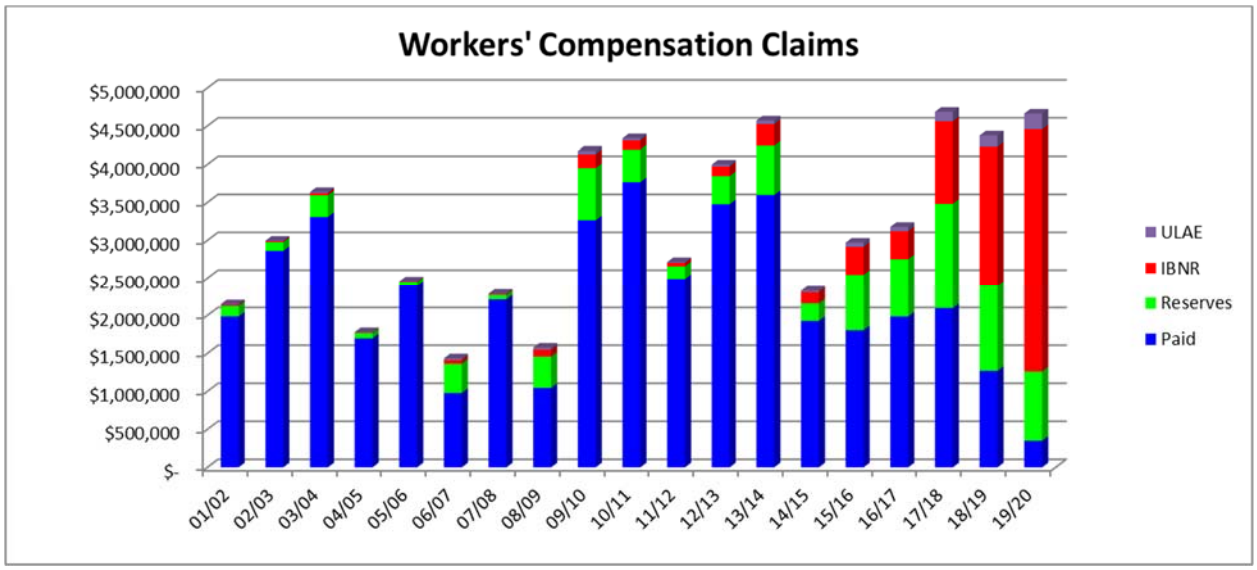
JUNE 30, 2020

	Workers' Comp.	Liability	Property	Dental	Vision	Auto Physical Damage	Post Retirement Benefits	Self-Funded Healthcare	Total
OPERATING REVENUES									
Member premiums	$ 7,035,266	$ 4,542,038	$ 2,333,301	$ 1,413,445	$ 218,649	$ 224,632	$ -	$ 13,674,420	$ 29,441,751
Fees	97,450	7,200	750	14,020	12,618	-	-	136,677	268,715
Total operating revenues	7,132,716	4,549,238	2,334,051	1,427,465	231,267	224,632	-	13,811,097	29,710,466
OPERATING EXPENSES									
Net losses and claims incurred	2,851,463	5,296,799	42,275	934,143	122,540	26	-	11,435,045	20,682,291
Premiums and/or contributions for excess coverage	395,768	1,032,867	1,780,964	-	-	215,011	-	55,539	3,480,149
Claims consultants and administration	579,964	124,625	-	161,708	32,344	-	-	2,367,945	3,266,586
General and administrative	999,392	401,777	24,031	16,200	16,199	24,031	-	38,587	1,520,217
Annual OPEB expense	-	-	-	-	-	-	(148,316)	-	(148,316)
Total operating expenses	4,826,587	6,856,068	1,847,270	1,112,051	171,083	239,068	(148,316)	13,897,116	28,800,927
OPERATING INCOME (LOSS)	2,306,129	(2,306,830)	486,781	315,414	60,184	(14,436)	148,316	(86,019)	909,539
NONOPERATING REVENUE (EXPENSES)									
Rental income	61,920	-	-	-	-	-	-	-	61,920
Investment income	324,972	99,131	25,225	21,080	5,750	25,495	-	236,267	737,920
Total nonoperating revenues (expenses)	386,892	99,131	25,225	21,080	5,750	25,495	-	236,267	799,840
NET CHANGE IN NET POSITION	2,693,021	(2,207,699)	512,006	336,494	65,934	11,059	148,316	150,248	1,709,379
NET POSITION (DEFICIT), Beginning	(4,643,952)	(1,802,111)	277,943	475,665	124,229	809,427	529,823	5,632,474	1,403,498
NET POSITION (DEFICIT), Ending	$ (1,950,931)	$ (4,009,810)	$ 789,949	$ 812,159	$ 190,163	$ 820,486	$ 678,139	$ 5,782,722	$ 3,112,877

REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

GRAPHICAL SUMMARY OF CLAIMS

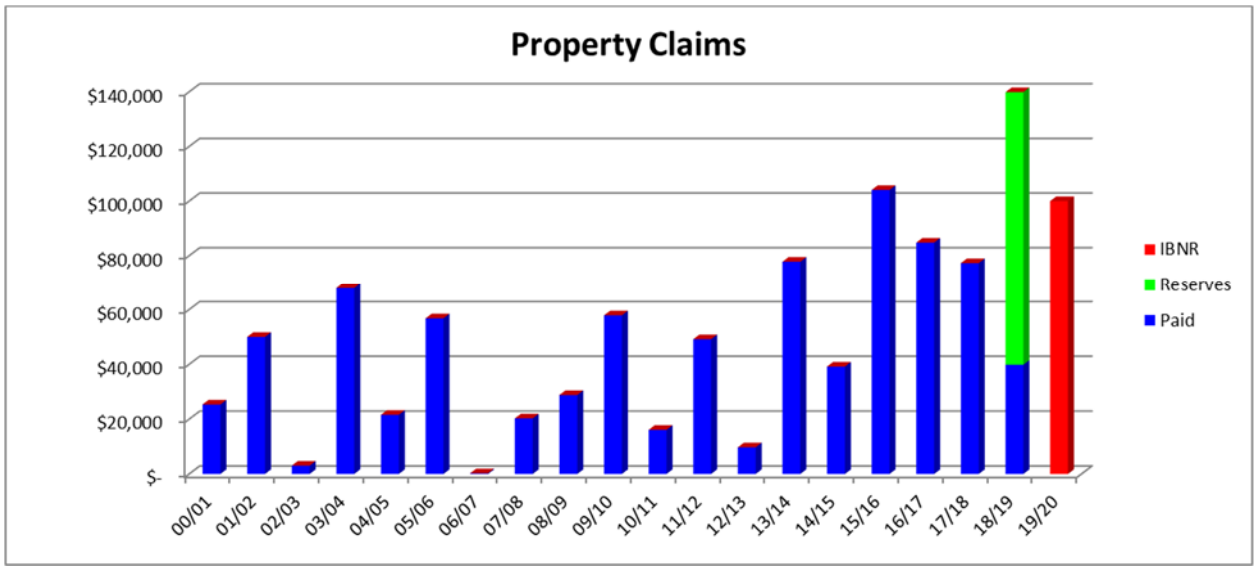
JUNE 30, 2020

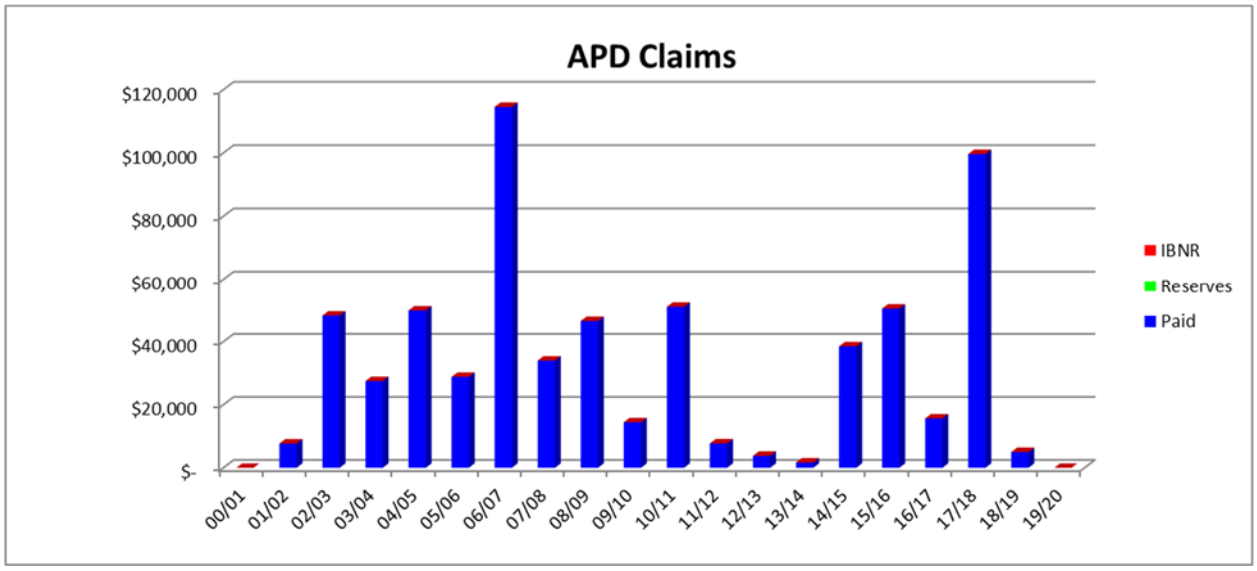


REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

GRAPHICAL SUMMARY OF CLAIMS

JUNE 30, 2020





James Marta & Company LLP
Certified Public Accountants

Accounting, Auditing, Consulting, and Tax

REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

INDEPENDENT AUDITOR'S REPORT

Board of Directors
Redwood Empire Municipal Insurance Fund
Sonoma, California

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Redwood Empire Municipal Insurance Fund, as of and for the years ended June 30, 2020 and 2019, and the related notes to the financial statements, which collectively comprise the Redwood Empire Municipal Insurance Fund's basic financial statements, and have issued our report thereon dated January 13, 2021.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered Redwood Empire Municipal Insurance Fund's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Redwood Empire Municipal Insurance Fund's internal control. Accordingly, we do not express an opinion on the effectiveness of Redwood Empire Municipal Insurance Fund's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

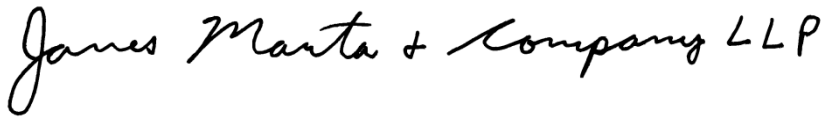
Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Redwood Empire Municipal Insurance Fund's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. This report is intended solely for the information and use of management, board of directors, and others within the entity, and is not intended to be and should not be used by anyone other than these specified parties.



James Marta & Company LLP
Certified Public Accountants
Sacramento, California
January 13, 2021

James Marta & Company LLP
Certified Public Accountants

Accounting, Auditing, Consulting, and Tax

COMMUNICATION WITH THOSE CHARGED WITH GOVERNANCE

Board of Directors of
Redwood Empire Municipal Insurance Fund
P.O. Box 885 Sonoma, California

We have audited the financial statements of Redwood Empire Municipal Insurance Fund as of and for the years ended June 30, 2020 and 2019, and have issued our report thereon dated January 13, 2021. Professional standards require that we advise you of the following matters relating to our audit.

Our Responsibility in Relation to the Financial Statement Audit

As communicated in our engagement letter dated June 26, 2019, our responsibility, as described by professional standards, is to form and express an opinion(s) about whether the financial statements that have been prepared by management with your oversight are presented fairly, in all material respects, in conformity with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your respective responsibilities.

Our responsibility, as prescribed by professional standards, is to plan and perform our audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement. An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control over financial reporting. Accordingly, as part of our audit, we considered the internal control of the Authority solely for the purpose of determining our audit procedures and not to provide any assurance concerning such internal control.

We are also responsible for communicating significant matters related to the audit that are, in our professional judgment, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Other Information in Documents Containing Audited Financial Statements

Pursuant to professional standards, our responsibility as auditors for other information in documents containing the Authority's audited financial statements does not extend beyond the financial information identified in the audit report, and we are not required to perform any procedures to corroborate such other information.

Our responsibility also includes communicating to you any information which we believe is a material misstatement of fact. Nothing came to our attention that caused us to believe that such information, or its manner of presentation, is materially inconsistent with the information, or manner of its presentation, appearing in the financial statements.

Planned Scope and Timing of the Audit

We conducted our audit consistent with the planned scope we previously communicated to you. There was no change in the timing of the audit.

Qualitative Aspects of the Entity's Significant Accounting Practices

Significant Accounting Policies

Management has the responsibility to select and use appropriate accounting policies. A summary of the significant accounting policies adopted by the Authority is included in Note 1 to the financial statements. There have been no initial selection of accounting policies and no changes in significant accounting policies or their application during the fiscal year 2019-2020. No matters have come to our attention that would require us, under professional standards, to inform you about (1) the methods used to account for significant unusual transactions and (2) the effect of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus. However, we have identified new accounting standards that will be applicable in subsequent years and are included in Attachment A.

Significant Accounting Estimates

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's current judgments. Those judgments are normally based on knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ markedly from management's current judgments.

The most sensitive accounting estimates affecting the financial statements are the claim liabilities. Management's estimate of the claim liabilities is based on calculations reported by the actuary and claim administrators. We evaluated the key factors and assumptions used to develop the claim liabilities and determined that it is reasonable in relation to the basic financial statements taken as a whole and in relation to the applicable opinion units.

Financial Statement Disclosures

Certain financial statement disclosures involve significant judgment and are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the Authority's financial statements relate to accounting policies affecting claim liabilities.

Significant Difficulties Encountered during the Audit

We encountered no significant difficulties in dealing with management relating to the performance of the audit.

Uncorrected and Corrected Misstatements

For purposes of this communication, professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that we believe are trivial, and communicate them to the appropriate level of management. There were no misstatment identifed during the audit.

In addition, professional standards require us to communicate to you all material, corrected misstatements that were brought to the attention of management as a result of our audit procedures. See Attachment B for a schedule of correcting entries.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a matter, whether or not resolved to our satisfaction, concerning a financial accounting, reporting, or auditing matter, which could be significant to the Authority's financial statements or the auditor's report. No such disagreements arose during the course of the audit.

Representations Requested from Management

We have requested certain written representations from management, which are included in the attached letter dated January 13, 2021.

Management's Consultations with Other Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters. Management informed us that, and to our knowledge, there were no consultations with other accountants regarding auditing and accounting matters.

Other Significant Matters, Findings, or Issues

In the normal course of our professional association with the Authority, we generally discuss a variety of matters, including the application of accounting principles and auditing standards, operating and regulatory conditions affecting the entity, and operational plans and strategies that may affect the risks of material misstatement. None of the matters discussed resulted in a condition to our retention as the Authority's auditors.

This report is intended solely for the use of the Board of Directors and management of Redwood Empire Municipal Insurance Fund and is not intended to be and should not be used by anyone other than these specified parties. However, this report is a matter of public record and its distribution is not limited.

James Marta & Company LLP

James Marta & Company LLP
Certified Public Accountants
Sacramento, California
January 13, 2021

Attachment A – Upcoming Changes in Accounting Standards

The following pronouncements of the Governmental Accounting Standards Board (GASB) have been released recently and may be applicable to REMIF in the near future. We encourage management to review the following information and determine which standard(s) may be applicable to REMIF. For the complete text of these and other GASB standards, visit www.gasb.org and click on the "Standards & Guidance" tab. If you have questions regarding the applicability, timing, or implementation approach for any of these standards, please contact your audit team.

GASB Statement No. 84, Fiduciary Activities
Effective for the fiscal year ending June 30, 2020

This Statement establishes criteria for identifying fiduciary activities of all state and local governments. The focus of the criteria generally is on (1) whether a government is controlling the assets of the fiduciary activity and (2) the beneficiaries with whom a fiduciary relationship exists. Separate criteria are included to identify fiduciary component units and postemployment benefit arrangements that are fiduciary activities.

An activity meeting the criteria should be reported in a fiduciary fund in the basic financial statements. Governments with activities meeting the criteria should present a statement of fiduciary net position and a statement of changes in fiduciary net position. An exception to that requirement is provided for a business-type activity that normally expects to hold custodial assets for three months or less.

This Statement describes four fiduciary funds that should be reported, if applicable: (1) pension (and other employee benefit) trust funds, (2) investment trust funds, (3) private-purpose trust funds, and (4) custodial funds. Custodial funds generally should report fiduciary activities that are not held in a trust or equivalent arrangement that meets specific criteria. A fiduciary component unit, when reported in the fiduciary fund financial statements of a primary government, should combine its information with its component units that are fiduciary component units and aggregate that combined information with the primary government's fiduciary funds.

This Statement also provides for recognition of a liability to the beneficiaries in a fiduciary fund when an event has occurred that compels the government to disburse fiduciary resources. Events that compel a government to disburse fiduciary resources occur when a demand for the resources has been made or when no further action, approval, or condition is required to be taken or met by the beneficiary to release the assets.

Management is currently assessing the impact of GASB 84 on REMIF at this time.

GASB Statement No. 87, Leases
Effective for the fiscal year ending June 30, 2021

The objective of this Statement is to better meet the information needs of financial statement users by improving accounting and financial reporting for leases by governments. This Statement increases the usefulness of governments' financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. It establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. Under this Statement, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset, and a lessor is required to recognize a lease receivable and a deferred inflow of resources, thereby enhancing the relevance and consistency of information about governments' leasing activities.

Management is currently assessing the impact of GASB 87 on REMIF at this time.

GASB Statement No. 88, Certain Disclosures Related to Debt, Including Direct Borrowings and Direct Placements
Effective for the fiscal year ending June 30, 2020

The primary objective of this Statement is to improve the information that is disclosed in notes to government financial statements related to debt, including direct borrowings and direct placements. It also clarifies which liabilities governments should include when disclosing information related to debt.

This Statement defines debt for purposes of disclosure in notes to financial statements as a liability that arises from a contractual obligation to pay cash (or other assets that may be used in lieu of cash) in one or more payments to settle an amount that is fixed at the date the contractual obligation is established.

This Statement requires that additional essential information related to debt be disclosed in notes to financial statements, including unused lines of credit; assets pledged as collateral for the debt; and terms specified in debt agreements related to significant events of default with finance-related consequences, significant termination events with finance-related consequences, and significant subjective acceleration clauses.

For notes to financial statements related to debt, this Statement also requires that existing and additional information be provided for direct borrowings and direct placements of debt separately from other debt.

We do not expect GASB 88 to have any significant impact on REMIF at this time.

GASB Statement No. 89, Accounting for Interest Cost Incurred Before the End of a Construction Period
Effective for the fiscal year ending June 30, 2021

This Statement establishes accounting requirements for interest cost incurred before the end of a construction period. Such interest cost includes all interest that previously was accounted for in accordance with the requirements of paragraphs 5–22 of Statement No. 62, Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements, which are superseded by this Statement. This Statement requires that interest cost incurred before the end of a construction period be recognized as an expense in the period in which the cost is incurred for financial statements prepared using the economic resources measurement focus. As a result, interest cost incurred before the end of a construction period will not be included in the historical cost of a capital asset reported in a business-type activity or enterprise fund.

This Statement also reiterates that in financial statements prepared using the current financial resources measurement focus, interest cost incurred before the end of a construction period should be recognized as an expenditure on a basis consistent with governmental fund accounting principles.

We do not expect GASB 89 to have any significant impact on REMIF at this time.

GASB Statement No. 90, Majority Equity Interests – An Amendment of GASB Statements No. 14 and No. 61
Effective for the fiscal year ending June 30, 2020

The primary objectives of this Statement are to improve the consistency and comparability of reporting a government's majority equity interest in a legally separate organization and to improve the relevance of financial statement information for certain component units. It defines a majority equity interest and specifies that a majority equity interest in a legally separate organization should be reported as an investment if a government's holding of the equity interest meets the definition of an investment. A majority equity interest that meets the definition of an investment should be measured using the equity method, unless it is held by a special-purpose government engaged only in fiduciary activities, a fiduciary fund, or an endowment (including permanent and term endowments) or permanent fund. Those governments and funds should measure the majority equity interest at fair value.

For all other holdings of a majority equity interest in a legally separate organization, a government should report the legally separate organization as a component unit, and the government or fund that holds the equity interest should report an asset related to the majority equity interest using the equity method. This Statement establishes that ownership of a majority equity interest in a legally separate organization results in the government being financially accountable for the legally separate organization and, therefore, the government should report that organization as a component unit.

This Statement also requires that a component unit in which a government has a 100 percent equity interest account for its assets, deferred outflows of resources, liabilities, and deferred inflows of resources at acquisition value at the date the government acquired a 100 percent equity interest in the component unit. Transactions presented in flows statements of the component unit in that circumstance should include only transactions that occurred subsequent to the acquisition.

We do not expect GASB 90 to have any significant impact on REMIF at this time.

GASB Statement No. 91, Conduit Debt Obligations
Effective for the fiscal year ending June 30, 2022

The primary objectives of this Statement are to provide a single method of reporting conduit debt obligations by issuers and eliminate diversity in practice associated with (1) commitments extended by issuers, (2) arrangements associated with conduit debt obligations, and (3) related note disclosures. This Statement achieves those objectives by clarifying the existing definition of a conduit debt obligation; establishing that a conduit debt obligation is not a liability of the issuer; establishing standards for accounting and financial reporting of additional commitments and voluntary commitments extended by issuers and arrangements associated with conduit debt obligations; and improving required note disclosures.

We do not expect GASB 91 to have any significant impact on REMIF at this time.

GASB Statement No. 92, Omnibus 2020
Effective dates vary

The objectives of this Statement are to enhance comparability in accounting and financial reporting and to improve the consistency of authoritative literature by addressing practice issues that have been identified during implementation and application of certain GASB Statements. This Statement addresses a variety of topics and includes specific provisions about the following:

- The effective date of Statement No. 87, *Leases*, and Implementation Guide No. 2019-3, *Leases*, for interim financial reports – *Effective for the fiscal year ending June 30, 2021*
- Reporting of intra-entity transfers of assets between a primary government employer and a component unit defined benefit pension plan or defined benefit other postemployment benefit (OPEB) plan – *Effective for the fiscal year ending June 30, 2021*
- The applicability of Statements No. 73, *Accounting and Financial Reporting for Pensions and Related Assets That Are Not within the Scope of GASB Statement 68, and Amendments to Certain Provisions of GASB Statements 67 and 68*, as amended, and No. 74, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, as amended, to reporting assets accumulated for postemployment benefits – *Effective for the fiscal year ending June 30, 2021*
- The applicability of certain requirements of Statement No. 84, *Fiduciary Activities*, to postemployment benefit arrangements – *Effective for the fiscal year ending June 30, 2021*
- Measurement of liabilities (and assets, if any) related to asset retirement obligations (AROs) in a government acquisition – *Effective for the government acquisitions occurring in reporting periods beginning after June 15, 2020*
- Reporting by public entity risk pools for amounts that are recoverable from reinsurers or excess insurers – *Effective for the fiscal year ending June 30, 2021*
- Reference to nonrecurring fair value measurements of assets or liabilities in authoritative literature – *Effective for the fiscal year ending June 30, 2021*
- Terminology used to refer to derivative instruments. – *Effective for the fiscal year ending June 30, 2021*

We do not expect GASB 92 to have any significant impact on REMIF at this time.

GASB Statement No. 93, Replacement of Interbank Offered Rates
Effective for the fiscal year ending June 30, 2022

The objective of this Statement is to address those and other accounting and financial reporting implications that result from the replacement of an IBOR. This Statement achieves that objective by:

- Providing exceptions for certain hedging derivative instruments to the hedge accounting termination provisions when an IBOR is replaced as the reference rate of the hedging derivative instrument's variable payment
- Clarifying the hedge accounting termination provisions when a hedged item is amended to replace the reference rate
- Clarifying that the uncertainty related to the continued availability of IBORs does not, by itself, affect the assessment of whether the occurrence of a hedged expected transaction is probable
- Removing LIBOR as an appropriate benchmark interest rate for the qualitative evaluation of the effectiveness of an interest rate swap
- Identifying a Secured Overnight Financing Rate and the Effective Federal Funds Rate as appropriate benchmark interest rates for the qualitative evaluation of the effectiveness of an interest rate swap

- Clarifying the definition of reference rate, as it is used in Statement 53, as amended

Providing an exception to the lease modifications guidance in Statement 87, as amended, for certain lease contracts that are amended solely to replace an IBOR as the rate upon which variable payments depend.

We do not expect GASB 93 to have any significant impact on REMIF at this time.

GASB Statement No. 94, Public-Private and Public-Public Partnerships and Availability Payment Arrangements
Effective for the fiscal year ending June 30, 2023

The primary objective of this Statement is to improve financial reporting by addressing issues related to public-private and public-public partnership arrangements (PPPs). As used in this Statement, a PPP is an arrangement in which a government (the transferor) contracts with an operator (a governmental or nongovernmental entity) to provide public services by conveying control of the right to operate or use a nonfinancial asset, such as infrastructure or other capital asset (the underlying PPP asset), for a period of time in an exchange or exchange-like transaction. Some PPPs meet the definition of a service concession arrangement (SCA), which the Board defines in this Statement as a PPP in which (1) the operator collects and is compensated by fees from third parties; (2) the transferor determines or has the ability to modify or approve which services the operator is required to provide, to whom the operator is required to provide the services, and the prices or rates that can be charged for the services; and (3) the transferor is entitled to significant residual interest in the service utility of the underlying PPP asset at the end of the arrangement.

This Statement also provides guidance for accounting and financial reporting for availability payment arrangements (APAs). As defined in this Statement, an APA is an arrangement in which a government compensates an operator for services that may include designing, constructing, financing, maintaining, or operating an underlying nonfinancial asset for a period of time in an exchange or exchange-like transaction.

We do not expect GASB 94 to have any significant impact on REMIF at this time.

GASB Statement No. 95, Postponement of the Effective Dates of Certain Authoritative Guidance
Effective immediately

The primary objective of this Statement is to provide temporary relief to governments and other stakeholders in light of the COVID-19 pandemic. That objective is accomplished by postponing the effective dates of certain provisions in Statements and Implementation Guides that first became effective or are scheduled to become effective for periods beginning after June 15, 2018, and later.

The effective dates of the preceding statements have been updated to reflect the impact of the issuance of GASB 95.

We do not expect GASB 95 to have any significant impact on REMIF at this time.

GASB Statement No. 96, Subscription-Based Information Technology Arrangements
Effective for the fiscal year ending June 30, 2023

This Statement provides guidance on the accounting and financial reporting for subscription-based information technology arrangements (SBITAs) for government end users (governments). This Statement (1) defines a SBITA; (2) establishes that a SBITA results in a right-to-use subscription asset—an intangible asset—and a corresponding subscription liability; (3) provides the capitalization criteria for outlays other than subscription payments, including implementation costs of a SBITA; and (4) requires note disclosures regarding a SBITA. To the extent relevant, the standards for SBITAs are based on the standards established in Statement No. 87, Leases, as amended.

We do not expect GASB 96 to have any significant impact on REMIF at this time.

GASB Statement No. 97, Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans
Effective for the fiscal year ending June 30, 2021

The primary objectives of this Statement are to (1) increase consistency and comparability related to the reporting of fiduciary component units in circumstances in which a potential component unit does not have a governing board and the primary government performs the duties that a governing board typically would perform; (2) mitigate costs associated with the reporting of certain defined contribution pension plans, defined contribution other postemployment benefit (OPEB) plans, and employee benefit plans other than pension plans or OPEB plans (other employee benefit plans) as fiduciary component units in fiduciary fund financial statements; and (3) enhance the relevance, consistency, and comparability of the accounting and financial reporting for Internal Revenue Code (IRC) Section 457 deferred compensation plans (Section 457 plans) that meet the definition of a pension plan and for benefits provided through those plans.

We do not expect GASB 97 to have any significant impact on REMIF at this time.

Adjusting Journal Entries

Adjusting Journal Entries JE # 2			
PBC To record Anthem claims incurred by 6/30/20 and paid in July 2020			
40-50110	Claims Paid	216,031.00	
40-20410	Other Payables		216,031.00
Total		**216,031.00**	**216,031.00**

Adjusting Journal Entries JE # 3			
PBC To adjust accrued payable for the Property Program			
30-20410	Other Payables	175,000.00	
30-50310	Excess Insurance Premiums		175,000.00
Total		**175,000.00**	**175,000.00**

Adjusting Journal Entries JE # 4			
PBC To adjust the OPEB trust balance for double posting of cash disbursement.			
120-12020	Investments - OPEB	110,827.00	
120-40420	Investment Fees Expense		110,827.00
Total		**110,827.00**	**110,827.00**

Adjusting Journal Entries JE # 5			
PBC To adjust excess receivables			
10-13510	Other Receivables	230,376.00	
20-50130	Subrogation/Refunds	75,524.00	
10-50130	Subrogation/Refunds		230,376.00
20-13510	Other Receivables		75,524.00
Total		**305,900.00**	**305,900.00**

Adjusting Journal Entries JE # 6			
PBC To adjust cliams liabilities based upon claims reconciliation			
10-22010	Claims IBNR Liability	1,017,353.00	
10-23010	ULAE Liability	85,777.00	
20-22010	Claims IBNR Liability	212,086.00	
20-50130	Subrogation/Refunds	5,056.00	
20-50210	Change In Claims Liabilites	1,247,367.00	
30-22010	Claims IBNR Liability	5.00	
30-50210	Change In Claims Liabilites	73,100.00	
70-11010	General Checking - 0157	5,056.00	
10-20210	Claims Reserves		81,829.00
10-50210	Change In Claims Liabilites		1,021,301.00
20-11010	General Checking - 0157		5,056.00
20-20210	Claims Reserves		1,330,752.00
20-23010	ULAE Liability		128,701.00
30-20210	Claims Reserves		73,105.00
70-50130	Subrogation/Refunds		5,056.00
Total		**2,645,800.00**	**2,645,800.00**

Adjusting Journal Entries (continued)

Adjusting Journal Entries JE # 7			
PBC To adjust OPEB balances based on actuarial report.			
120-60000	Pension Expense	13,567.00	
90-11900	Net Pension Obligations	15,539.00	
90-14210	Deferred Pension Outflows	109,994.00	
90-22005	Deferred Pension Inflow	22,783.00	
120-20410	Other Payables		13,567.00
90-60000	Pension Expense		148,316.00
Total		**161,883.00**	**161,883.00**

Adjusting Journal Entries JE # 8			
To record OPEB implicit employer contributions for 19-20.			
120-60000	Pension Expense	4,705.00	
120-40110	Premiums Earned		4,705.00
Total		**4,705.00**	**4,705.00**

Adjusting Journal Entries JE # 10			
To adjust claims recoveries received in advance for property program			
30-50110	Claims Paid	98,033.00	
30-20410	Other Payables		98,033.00
Total		**98,033.00**	**98,033.00**

Reclassifying Journal Entries

Reclassifying Journal Entries JE # 9			
To reclass pension payments into salaries and benefits line item.			
10-51011	Active Employees Benefits	347,285.00	
20-51011	Active Employees Benefits	37,119.00	
30-51011	Active Employees Benefits	4,465.00	
40-51011	Active Employees Benefits	3,010.00	
50-51011	Active Employees Benefits	3,010.00	
60-51011	Active Employees Benefits	3,010.00	
70-51011	Active Employees Benefits	4,465.00	
10-60000	Pension Expense		347,285.00
20-60000	Pension Expense		37,119.00
30-60000	Pension Expense		4,465.00
40-60000	Pension Expense		3,010.00
50-60000	Pension Expense		3,010.00
60-60000	Pension Expense		3,010.00
70-60000	Pension Expense		4,465.00
Total		**402,364.00**	**402,364.00**

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MANAGEMENT REPRESENTATION LETTER

January 13, 2021

James Marta & Company LLP
Certified Public Accountants
701 Howe Avenue, Suite E3
Sacramento, California 95825

This representation letter is provided in connection with your audit of the Statement of Net Position, Statement of Revenues, Expenses and Changes in Net Position, and Statement of Cash Flows of Redwood Empire Municipal Insurance Fund as of June 30, 2020 and 2019 and for the fiscal years then ended, and the related notes to the financial statements, for the purpose of expressing opinions on whether the basic financial statements present fairly, in all material respects, the financial position, results of operations, and cash flows, where applicable, of the various opinion units of Redwood Empire Municipal Insurance Fund in accordance with accounting principles generally accepted for governments in the United States of America (U.S. GAAP).

Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves as of January 13, 2021:

Financial Statements

- We have fulfilled our responsibilities, as set out in the terms of the audit engagement dated June 26, 2019, for the preparation and fair presentation of the financial statements of the various opinion units referred to above in accordance with U.S. GAAP.
- We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.
- We acknowledge our responsibility for the design, implementation, and maintenance of internal control to prevent and detect fraud.

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- We acknowledge our responsibility for compliance with the laws, regulations, and provisions of contracts and grant agreements.
- We acknowledge that we are responsible for distributing the issued report as well as the communication with governance letter and internal control letter to all governing board members.
- We have reviewed, approved, and taken responsibility for the financial statements and related notes.
- We have a process to track the status of audit findings and recommendations.
- We have identified and communicated to you all previous audits, attestation engagements, and other studies related to the audit objectives and whether related recommendations have been implemented.
- Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.
- Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of U.S. GAAP.
- All events subsequent to the date of the financial statements and for which U.S. GAAP requires adjustment or disclosure have been adjusted or disclosed.
- There were no uncorrected misstatements during the current engagement to the applicable opinion units and to the financial statements as a whole.
- We have reviewed and approved the adjusting and reclassifying journal entries reflected in the audit statements and Attachment A.
- The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP.
- All component units, as well as joint ventures with an equity interest, are included and other joint ventures and related organizations are properly disclosed.
- All funds and activities are properly classified.
- All funds that meet the quantitative criteria in GASB Statement No. 34, *Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments*, GASB Statement No. 37, *Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments: Omnibus* as amended, and GASB Statement No. 65, *Items Previously Reported as Assets and Liabilities*, for presentation as major are

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identified and presented as such and all other funds that are presented as major are considered important to financial statement users.

- All components of net position, nonspendable fund balance, and restricted, committed, assigned, and unassigned fund balance are properly classified and, if applicable, approved.
- Our policy regarding whether to first apply restricted or unrestricted resources when an expense is incurred for purposes for which both restricted and unrestricted net position/fund balance are available is appropriately disclosed and net position/fund balance is properly recognized under the policy.
- Special items and extraordinary items have been properly classified and reported.
- Deposit and investment risks have been properly and fully disclosed.
- All required supplementary information is measured and presented within the prescribed guidelines.
- With regard to investments and other instruments reported at fair value:
  - The underlying assumptions are reasonable and they appropriately reflect management's intent and ability to carry out its stated courses of action.
  - The measurement methods and related assumptions used in determining fair value are appropriate in the circumstances and have been consistently applied.
  - The disclosures related to fair values are complete, adequate, and in accordance with U.S. GAAP.
  - There are no subsequent events that require adjustments to the fair value measurements and disclosures included in the financial statements.

Information Provided

- We have provided you with:
  - Access to all information, of which we are aware that is relevant to the preparation and fair presentation of the financial statements of the various opinion units referred to above, such as records, documentation, meeting minutes, and other matters;
  - Additional information that you have requested from us for the purpose of the audit; and
  - Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.

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- All transactions have been recorded in the accounting records and are reflected in the financial statements.
- We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
- We have no knowledge of any fraud or suspected fraud that affects the entity and involves:
  - Management;
  - Employees who have significant roles in internal control; or
  - Others where the fraud could have a material effect on the financial statements.
- We have no knowledge of any allegations of fraud, or suspected fraud, affecting the entity's financial statements communicated by employees, former employees, vendors, regulators, or others.
- We are not aware of any pending or threatened litigation, claims, and assessments whose effects should be considered when preparing the financial statements.
- We have disclosed to you the identity of the entity's related parties and all the related party relationships and transactions of which we are aware.
- There have been no communications from regulatory agencies concerning noncompliance with or deficiencies in accounting, internal control, or financial reporting practices.
- Redwood Empire Municipal Insurance Fund has no plans or intentions that may materially affect the carrying value or classification of assets and liabilities.
- We have disclosed to you all guarantees, whether written or oral, under which Redwood Empire Municipal Insurance Fund is contingently liable.
- We have disclosed to you all significant estimates and material concentrations known to management that are required to be disclosed in accordance with GASB Statement No. 62 (GASB-62), *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*. Significant estimates are estimates at the balance sheet date that could change materially within the next year. Concentrations refer to volumes of business, revenues, available sources of supply, or markets or geographic areas for which events could occur that would significantly disrupt normal finances within the next year.

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Member cities/towns: Arcata, Cloverdale, Cotati, Eureka, Ft. Bragg, Fortuna, Healdsburg, Lakeport, Rohnert Park, St. Helena, Sebastopol, Sonoma, Ukiah, Willits, Windsor

- We have identified and disclosed to you the laws, regulations, and provisions of contracts and grant agreements that could have a direct and material effect on financial statement amounts, including legal and contractual provisions for reporting specific activities in separate funds.
- There are no:
  - Violations or possible violations of laws or regulations, or provisions of contracts or grant agreements whose effects should be considered for disclosure in the financial statements or as a basis for recording a loss contingency, including applicable budget laws and regulations.
  - Unasserted claims or assessments that our lawyer has advised are probable of assertion and must be disclosed in accordance with GASB-62.
  - Other liabilities or gain or loss contingencies that are required to be accrued or disclosed by GASB-62
  - Continuing disclosure consent decree agreements or filings with the Securities and Exchange Commission and we have filed updates on a timely basis in accordance with the agreements (Rule 240, 15c2-12).
- Redwood Empire Municipal Insurance Fund has satisfactory title to all owned assets, and there are no liens or encumbrances on such assets nor has any asset or future revenue been pledged as collateral, except as disclosed to you.
- We have complied with all aspects of grant agreements and other contractual agreements that would have a material effect on the financial statements in the event of noncompliance.

Required Supplementary Information

With respect to the required supplementary information accompanying the financial statements:

a. We acknowledge our responsibility for the presentation of the required supplementary information in accordance with *Government Auditing Standards*.

b. We believe the required supplementary information, including its form and content, is measured and fairly presented in accordance with accounting standards generally accepted in the United States of America.

c. The methods of measurement or presentation have not changed from those used in the prior period.

d. We believe the following significant assumptions or interpretations underlying the measurement or presentation of the required supplementary information, and the basis for our assumptions and interpretations, are reasonable and appropriate in the circumstances:

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Significant Assumption or Interpretation	*Basis for Assumption or Interpretation*
Estimated claims liabilities	Actuarial review

Pension and Postretirement Benefits

- We believe that the actuarial assumptions and methods used to measure pension and other postemployment benefit liabilities and costs for financial accounting purposes are appropriate in the circumstances.
- We are unable to determine the possibility of a withdrawal liability in a multiemployer benefit plan.

Supplementary Information in Relation to the Financial Statements as a Whole

With respect to the supplementary information accompanying the financial statements:

a. We acknowledge our responsibility for the presentation of the supplementary information in accordance with *Government Auditing Standards*.

b. We believe the supplementary information, including its form and content, is fairly presented in accordance with accounting standards generally accepted in the United States of America.

c. The methods of measurement or presentation have not changed from those used in the prior period.

d. We believe the following significant assumptions or interpretations underlying the measurement or presentation of the supplementary information, and the basis for our assumptions and interpretations, are reasonable and appropriate in the circumstances:

Significant Assumption or Interpretation	*Basis for Assumption or Interpretation*
Estimated claims liabilities	Actuarial review

e. When the supplementary information is not presented with the audited financial statements, management will make the audited financial statements readily available to the intended users of the supplementary information no later than the date of issuance by the entity of the supplementary information and the auditor's report thereon.

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f. We acknowledge our responsibility to include the auditor's report on the supplementary information in any document containing the supplementary information and that indicates the auditor reported on such supplementary information.

g. We acknowledge our responsibility to present the supplementary information with the audited financial statements or, if the supplementary information will not be presented with the audited financial statements, to make the audited financial statements readily available to the intended users of the supplementary information no later than the date of issuance by the entity of the supplementary information and the auditor's report thereon.

Use of a Specialist

The work of a specialist has been used by the entity.

We agree with the findings of specialists in evaluating the claims liabilities and have adequately considered the qualifications of the specialist in determining the amounts and disclosures used in the financial statements and underlying accounting records. We did not give or cause any instructions to be given to specialists with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the specialists.

Amy Northam

Digitally signed
by Amy Northam
Date: 2021.01.13
09:25:21 -08'00'

Amy Northam, General Manager

Sharma

Ritesh Sharma, Finance Director

Adjusting Journal Entries

Adjusting Journal Entries JE # 2			
PBC To record Anthem claims incurred by 6/30/20 and paid in July 2020			
40-50110	Claims Paid	216,031.00	
40-20410	Other Payables		216,031.00
Total		**216,031.00**	**216,031.00**

Adjusting Journal Entries JE # 3			
PBC To adjust accrued payable for the Property Program			
30-20410	Other Payables	175,000.00	
30-50310	Excess Insurance Premiums		175,000.00
Total		**175,000.00**	**175,000.00**

Adjusting Journal Entries JE # 4			
PBC To adjust the OPEB trust balance for double posting of cash disbursement.			
120-12020	Investments - OPEB	110,827.00	
120-40420	Investment Fees Expense		110,827.00
Total		**110,827.00**	**110,827.00**

Adjusting Journal Entries JE # 5			
PBC To adjust excess receivables			
10-13510	Other Receivables	230,376.00	
20-50130	Subrogation/Refunds	75,524.00	
10-50130	Subrogation/Refunds		230,376.00
20-13510	Other Receivables		75,524.00
Total		**305,900.00**	**305,900.00**

Adjusting Journal Entries JE # 6			
PBC To adjust cliams liabilities based upon claims reconciliation			
10-22010	Claims IBNR Liability	1,017,353.00	
10-23010	ULAE Liability	85,777.00	
20-22010	Claims IBNR Liability	212,086.00	
20-50130	Subrogation/Refunds	5,056.00	
20-50210	Change In Claims Liabilites	1,247,367.00	
30-22010	Claims IBNR Liability	5.00	
30-50210	Change In Claims Liabilites	73,100.00	
70-11010	General Checking - 0157	5,056.00	
10-20210	Claims Reserves		81,829.00
10-50210	Change In Claims Liabilites		1,021,301.00
20-11010	General Checking - 0157		5,056.00
20-20210	Claims Reserves		1,330,752.00
20-23010	ULAE Liability		128,701.00
30-20210	Claims Reserves		73,105.00
70-50130	Subrogation/Refunds		5,056.00
Total		**2,645,800.00**	**2,645,800.00**

Adjusting Journal Entries (continued)

Adjusting Journal Entries JE # 7			
PBC To adjust OPEB balances based on actuarial report.			
120-60000	Pension Expense	13,567.00	
90-11900	Net Pension Obligations	15,539.00	
90-14210	Deferred Pension Outflows	109,994.00	
90-22005	Deferred Pension Inflow	22,783.00	
120-20410	Other Payables		13,567.00
90-60000	Pension Expense		148,316.00
Total		**161,883.00**	**161,883.00**

Adjusting Journal Entries JE # 8			
To record OPEB implicit employer contributions for 19-20.			
120-60000	Pension Expense	4,705.00	
120-40110	Premiums Earned		4,705.00
Total		**4,705.00**	**4,705.00**

Adjusting Journal Entries JE # 10			
To adjust claims recoveries received in advance for property program			
30-50110	Claims Paid	98,033.00	
30-20410	Other Payables		98,033.00
Total		**98,033.00**	**98,033.00**

Reclassifying Journal Entries

Reclassifying Journal Entries JE # 9			
To reclass pension payments into salaries and benefits line item.			
10-51011	Active Employees Benefits	347,285.00	
20-51011	Active Employees Benefits	37,119.00	
30-51011	Active Employees Benefits	4,465.00	
40-51011	Active Employees Benefits	3,010.00	
50-51011	Active Employees Benefits	3,010.00	
60-51011	Active Employees Benefits	3,010.00	
70-51011	Active Employees Benefits	4,465.00	
10-60000	Pension Expense		347,285.00
20-60000	Pension Expense		37,119.00
30-60000	Pension Expense		4,465.00
40-60000	Pension Expense		3,010.00
50-60000	Pension Expense		3,010.00
60-60000	Pension Expense		3,010.00
70-60000	Pension Expense		4,465.00
Total		**402,364.00**	**402,364.00**

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ITEM 8.0

AGENDA ITEM SUMMARY

TITLE: REVIEW OF RECOMMENDED CHANGES TO INVESTMENT POLICY
PRESENTED BY: AMY NORTHAM, GENERAL MANAGER

ISSUE
Changes to the Investment Policy require ratification by the Board of Directors.

BACKGROUND
At the June 10, 2010, Board of Directors' meeting, the Board of Directors gave the General Manager authority to enter into an agreement with Chandler Investment Management to handle REMIF's investments and to establish an Investment Policy that meets all accounting and State criteria. An Investment Policy was subsequently created and approved by the Board on October 28, 2010, and changes to that policy were made and approved by the Board on September 26, 2019, January 31, 2020, and September 24, 2020. A separate investment policy for OPEB investments was created, updated and approved by the Board on October 31, 2017.

At the September 24, 2020 Board of Directors meeting, staff was directed to provide recommended changes to the policy, with an eye towards a more socially responsible investment policy. As such, updates/changes to the investment policy are being suggested and will be discussed.

The Board of Directors, staff, and the investment manager all have a fiduciary responsibility to follow the requirements of the code and to maintain safety, liquidity and return in the investments. As long as the fiduciary responsibility is met, it is permissible for the Board to adopt a more socially responsible investment platform.

Staff's approach involved putting together a framework for conducting a socially-responsible investment program which addresses Board-directed policy initiatives. Primarily, the language being recommended is designed to include firm guidance on Board direction, while allowing staff to implement staff-directed actions that support the Board's policy. Staff took into account the wishes of the Board, and with input from REMIF's investment manager, wrote language for your approval.

Staff suggests consideration of the following language in the policy:

> In the event all general objectives mandated by state law are met and created equal, investments in corporate securities and depository institutions will be evaluated for social and environmental concerns. Investments are encouraged in entities that support equality of rights regardless of sex, race, age, disability, religion, or sexual orientation, as well as those entities that practice environmentally sound and fair labor practices. Investments are discouraged in entities that receive a significant portion of their revenues from the manufacture of tobacco products, exploration of fossil fuels, firearms, or weapons not used in our national defense.

Staff is seeking feedback on this suggested language and whether it meets the intent of the Board of Directors. No changes to the investment policy that governs REMIF's OPEB assets are being contemplated at this time, as REMIF invests in index and exchange traded funds tied to broad market indexes whose make-up cannot be influenced by REMIF.

FISCAL IMPACT
Unknown

RECOMMENDED ACTION
Review and discuss suggested changes to the REMIF investment policy. Possible adoption of language presented.

ATTACHMENTS
8.1 Investment Policy (recommended changes with track changes)

Policy #13.0
REDWOOD EMPIRE MUNICIPAL INSURANCE FUND
INVESTMENT POLICY

I. Investment Philosophy

A. Policy

1. This Investment Policy is set forth by the Redwood Empire Municipal Insurance Fund (hereinafter referred to as "REMIF" or "Fund"), for the following purposes:

a. To establish a clear understanding for the governing body, management, responsible employees, citizens and third parties of the objectives, policies and guidelines for the investment of REMIF's idle and surplus funds;

b. To offer guidance to the Board, Finance Director and any external investment advisers on the investment of REMIF funds; and

c. To establish a basis for evaluating investment results.

2. REMIF establishes investment policies that meet its current investment goals. The Fund shall review this policy annually and may change its policies as its investment objectives change.

B. Objective

All investment management decisions and activities must assure ongoing compliance with all Federal, State and local laws governing the investment of moneys under the control of the Board. The primary objectives, in priority order, of REMIF's investment activities shall be:

1. Safety: The primary objective of this policy is to protect, preserve and maintain cash and investments of the Fund.

2. Liquidity: An adequate percentage of the portfolio will be maintained in liquid short-term securities which can be converted to cash, as necessary, to meet disbursement requirements. The liquidity percentage will be determined, from time to time, from projected cash flow reports. Investments will be made in securities with active secondary or resale markets. Securities with low market risk will be emphasized.

3. Return: Within the constraints of safety and liquidity and in compliance with state and federal regulations and this investment policy, the portfolio will be designed to attain a "market average rate of return" consistent with the agreed upon benchmark.

4. Diversification: The portfolio will be diversified in order to avoid incurring unreasonable and avoidable risks regarding specific types of securities or individual financial institutions.

5. Public trust: All participants in the investment process shall act as custodians of the public trust and shall recognize that the investment portfolio is subject to public review and evaluation. The overall program shall be designed and managed with the degree of professionalism that is worthy of public trust.

In the event all general objectives mandated by state law are met and created equal, investments in corporate securities and depository institutions will be evaluated for social and environmental concerns. Investments are encouraged in entities that support equality of rights regardless of sex, race, age, disability, religion, or sexual orientation, as well as those entities that practice environmentally sound and fair labor practices. Investments are discouraged in entities that receive a significant portion of their revenues from the manufacture of tobacco products, exploration of fossil fuels, firearms, or weapons not used in our national defense.

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C. Prudence and Indemnification

1. Prudent Investor Standard: Management of REMIF's investments is governed by the Prudent Investor Standard as set forth in the California Government Code 53600.3:

"…all governing bodies of local agencies or persons authorized to make investment decisions on behalf of those local agencies investing public funds pursuant to this chapter are trustees and therefore fiduciaries subject to the prudent investor standard. When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including, but not limited to, the general economic conditions and the anticipated needs of the agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the agency. Within the limitations of this section and considering individual investments as part of an overall strategy, investments may be acquired as authorized by law."

2. Indemnification: Officers and employees of REMIF responsible for managing REMIF funds, acting in accordance with written procedures and the investment policy and exercising due diligence, shall be relieved of personal responsibility for an individual security's credit risk or market price changes,

provided deviations from expectations are reported within 30 days and appropriate action is taken to control adverse developments.

D. Ethics and Conflicts of Interest

Officers and employees of REMIF involved in the investment process shall refrain from personal business activity that could conflict with proper execution of the investment program, or which could impair their ability to make impartial investment decisions.

II. Operational and Procedural matters

A. Scope

This investment policy applies to all financial assets and investment activities under the control of the Fund with the following exceptions:

1. Retirement funds and other post- employment benefits (OPEB) funds that are governed by other investment policies and objectives; and

2. Bond proceeds whose investments shall be governed by the provisions of the related bond indentures.

B. Delegation of Authority

California Government Code Sections 53600 through 53601.6 provide legal authorization for investment of the funds of local agencies. All investments of REMIF shall conform to the restrictions of those laws.

Management responsibility is here by delegated to General Manager and the Finance Director, who shall establish procedures for the operation of the investment program. The Finance Director shall be responsible for all transactions undertaken and shall establish a system of controls to regulate the activities of subordinates. The responsibility for investment transactions may be delegated to staff personnel or an outside professional service.

C. Authorized Financial Dealers and Institutions

1. REMIF's Finance Director shall determine which financial institutions are authorized to provide investment services to the Fund. Institutions eligible to transact investment business with the Fund include:

a. Primary government dealers as designated by the Federal Reserve Bank;

b. Nationally or state-chartered banks;

c. The Federal Reserve Bank; and

d. Direct issuers of securities eligible for purchase by the Fund.

2. Selection of financial institutions and broker/dealers authorized to engage in transactions with the Fund shall be at the sole discretion of REMIF, except where REMIF utilizes an external investment adviser in which case the REMIF may rely on the adviser for selection.

3. All financial institutions that are or desire to become qualified bidders for investment transactions (and which are not dealing only with the investment adviser) must supply the REMIF Finance Director with a statement clarifying that the individual responsible for the account has reviewed and understands the California Government Code Section 53600 et seq. and the Fund's Investment Policy and intends to present only those transactions appropriate under the policy.

4. Selection of broker/dealers used by an external investment adviser retained by the Fund shall be at the sole discretion of the investment adviser. Where possible, transactions with broker/dealers shall be selected on a competitive basis and their bid or offering prices shall be recorded. If there is no other readily available competitive offering, best efforts will be made to document quotations for comparable or alternative securities. When purchasing original issue instrumentality securities, no competitive offerings will be required as all dealers in the selling group offer those securities at the same original issue price.

5. Public deposits shall be made only in qualified public depositories within the State of California as established by State law. Deposits shall be insured by the Federal Deposit Insurance Corporation, or, to the extent the amount exceeds the insured maximum, shall be collateralized with securities in accordance with State law.

D. Delivery vs. payment

Settlement of all investment transactions will be completed using standard delivery-vs.-payment procedures.

E. Safekeeping of securities

All securities owned by REMIF shall be held in safekeeping by a third patty bank trust department, acting as agent for the Fund under the terms of a custody agreement executed by the bank and by REMIF. All investment transactions will require a safekeeping receipt or acknowledgment generated from the trade. A monthly report will be received by REMIF from the custodian listing all securities held in safekeeping with current market data and other information.

III. Permitted investments and portfolio risk management

A. Authorized Investments

All investments shall be made in accordance with Sections 53600 et seq. of the Government Code of California and as described within this Investment Policy. In the event a discrepancy is found between this policy and the Code, the more restrictive parameters will take precedence. Percentage holding limits listed in this section apply at the time the security is purchased.

Any investment currently held at the time the policy is adopted which does not meet the new policy guidelines can be held until maturity and shall be exempt from the current policy. At the time of the investment's maturity or liquidation, such funds shall be reinvested only as provided in the current policy.

An appropriate risk level shall be maintained by primarily purchasing securities that are of high quality, liquid, and marketable. The portfolio shall be diversified by security type and institution to avoid incurring unreasonable and avoidable risks regarding specific security types or individual issuers.

Permitted investments under this policy shall include:

1. U.S. Treasury and other government obligations for which the full faith and credit of the United States are pledged for the payment of principal and interest. There are no limits on the dollar amount or percentage that the Fund may invest in U.S. Treasuries.

2. Federal Agency or United States government-sponsored enterprise obligations, participations, or other instruments, including those issued by or fully guaranteed as to principal and interest by federal agencies or United States government-sponsored enterprises. There are no limits on the dollar amount or percentage that the Fund may invest in government- sponsored enterprises, provided that:

    a. No more than 25% of the portfolio may be invested in any single Agency/GSE issuer.

    b. The maximum maturity does not exceed five (5) years.

3. Municipal securities provided that:

    a. They are an obligation of any of the 50 states in the United States, including bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the other 49 states, in addition to California; or,

b. They are an obligation of a local agency within the State of California;

c. The securities are rated in a rating category of "A" or its equivalent or better by at least one nationally recognized statistical rating organization ("NRSRO").

d. No more than 5% of the portfolio may be invested in any single issuer.

e. No more than 30% of the portfolio may be in Municipal Securities.

f. Their maturity does not exceed 5 years.

4. Bankers' acceptances provided that:

a. They are issued by institutions the short term obligations of which are rated a minimum of A-1 or its equivalent or better by at least one NRSRO; or, if the short term obligations are unrated, the long-term obligations of which are rated a minimum of the rating category of A or its equivalent or better by at least one NRSRO;

b. The maturity does not exceed 180 days; and

c. No more than 40% of the total portfolio may be invested in bankers' acceptances and no more than 5% per issuer.

5. Time deposits (Non-negotiable certificates of deposit) in a nationally or state-chartered bank or a state or federal association, or a state-licensed branch of a foreign bank to the extent that deposits are insured by the Federal Deposit Insurance Corporation (FDIC), provided that:

a. No more than 30% of the portfolio shall be invested in a combination of federally insured and collateralized time deposits; and,

b. The maturity of such deposits does not exceed 5 years.

6. Negotiable certificates of deposit (NCDs) issued by a nationally or state-chartered bank, a savings association or a federal association, a state or federal credit union, or by a federally licensed or state-licensed branch of a foreign bank, provided that:

a. The amount of the NCD insured up to the FDIC limit does not require any credit ratings.

b. Any amount above the FDIC insured limit must be issued by institutions which have long-term obligations which are rated in a rating category of "A" or its equivalent or higher by at least one NRSRO; and/or have short term debt obligations rated "A-l" or higher, or the equivalent, by at least one NRSRO;

c. The maturity does not exceed 5 years; and

d. No more than 30% of the total portfolio may be invested in NCDs and no more than 5% per issuer.

7. Commercial paper provided that:

a. The maturity does not exceed 270 days from the date of purchase;

b. The issuer is a corporation organized and operating in the United States with assets in excess of $500 million;

c. They are issued by institutions whose short term obligations are rated "A-l" or higher, or the equivalent, by at least one NRSRO; and whose long-term obligations are rated in the rating category of "A" or its equivalent or higher by at least one NRSRO; and,

d. No more than 25% of the portfolio is invested in commercial paper and no more than 5% per issuer.

8. State of California Local Agency Investment Fund (LAIF), provided that:

a. the Fund may invest up to the maximum permitted amount in LAIF; and,

b. LAIF's investments in instruments prohibited by or not specified in the Fund's policy do not exclude it from the Fund's list of allowable investments, provided that the fund's repo1ts allow the Fund's Finance Director to adequately judge the 1isk inherent in LAIF's portfolio.

9. Sonoma County Pooled Investment Fund, provided that the Fund does not exceed 10% of the portfolio in the County Pool.

10. Corporate medium-term notes, provided that:

a. such notes have a maximum maturity of five years;

b. are issued by corporations organized and operating within the United States or by depository institutions licensed by the United States or any state and operating within the United States;

c. shall be rated "A" category or better by at least one nationally recognized statistical rating organization; and,

d. holdings of medium-term notes may not exceed 30 percent of the portfolio and no more than 5% per issuer.

11. Money market mutual funds that are registered with the Securities and Exchange Commission under the Investment Company Act of 1940:

a. Provided that such funds meet either of the following criteria:

i. Attained the highest ranking or the highest letter and numerical rating provided by not less than two NRSROs; or,

ii. Have retained an investment adviser registered or exempt from registration with the Securities and Exchange Commission with not less than five years' experience investing in the securities and obligations authorized by California Government Code Section 53601 (a through k) and with assets under management in excess of $500 million.

b. purchases of securities authorized by this subdivision may not exceed 20% of the portfolio.

12. Asset-Backed, Mortgage-Backed, Mortgage Passthrough securities, and collateralized Mortgage Obligations From Issuers Not Defined in Sections 1 and 2 of the Permitted Investments Section of this Policy, provided that:

a. The securities are rated in a rating category of "AA" or its equivalent or better by a NRSRO.

b. No more than 10% of the total portfolio may be invested in these securities

c. No more than 5% of the portfolio may be invested in any single Asset-Backed or Commercial Mortgage security issuer

d. The maximum legal final maturity does not exceed five (5) years

13. Supranational, provided that:

a. Issues are US dollar denominated senior unsecured unsubordinated obligations issued or unconditionally guaranteed by the International Bank for Reconstruction and Development, International Finance Corporation, or Inter-American Development Bank.

b. No more than 15% of the total portfolio may be invested in these securities.

c. No more than 5% of the portfolio may be invested in any single issuer.

d. The maximum maturity does not exceed five (5) years.

B. Investment Pools

The Authority shall conduct a thorough investigation of any pool or mutual fund prior to making an investment, and on a continual basis thereafter. REMIF's Finance Director shall develop a questionnaire which will answer the following general questions:

1. A description of eligible investment securities, and a written statement of investment policy and objectives.

2. A description of interest calculations and how it is distributed, and how gains and losses are treated.

3. A description of how the securities are safeguarded (including the settlement processes), and how often the securities are priced, and the program audited.

4. A description of who may invest in the program, how often, what size deposit and withdrawal are allowed.

5. A schedule for receiving statements and portfolio listings.

6. Are reserves, retained earnings, etc. utilized by the pool/fund?

7. A fee schedule, and when and how is it assessed.

8. Is the pool/fund eligible for bond proceeds and/or will it accept such proceeds?

C. Collateralization

Certificates of Deposit (CDS). REMIF shall require any commercial bank or savings and loan association to deposit eligible securities with an agency of a depository approved by the State Banking Department to secure any uninsured portion of a Non-Negotiable Certificate of Deposit. The value of eligible securities as defined pursuant to California Government Code, Section 53651, pledged against a Certificate of Deposit shall be equal to 150% of the face value of the CD if the securities are classified as mortgages and 110% of the face value of the CD for all other classes of security.

Collateralization of Bank Deposits. This is the process by which a bank or financial institution pledges securities, or other deposits for the purpose of securing repayment of deposited funds. REMIF shall require any bank or financial institution to comply with the collateralization criteria defined in California Government Code, Section 53651.

D. Portfolio Risk Management

Prohibited investment vehicles and practices

1. State law notwithstanding, any investments not specifically described herein are prohibited, including, but not limited to futures and options. This does not apply to securities with embedded call options (see Section VIII C 2).

2. In accordance with Government Code Section 53601.6, investment in inverse floaters, range notes, or mortgage derived interest-only strips is prohibited.

3. Investment in any security that could result in a zero-interest accrual if held to maturity is prohibited.

4. Trading securities for the sole purpose of speculating on the future direction of interest rates is prohibited.

5. Purchasing or selling securities on margin is prohibited.

6. The use of reverse re-purchase agreements, securities lending or any other form of borrowing or leverage is prohibited.

7. The purchase of foreign currency denominated securities is prohibited.

E. Mitigating credit risk in the portfolio

Credit risk is the risk that a security or a portfolio will lose some or all of its value due to a real or perceived change in the ability of the issuer to repay its debt. REMIF shall mitigate credit risk by adopting the following strategies:

1. No more than 5% of the total portfolio may be invested in securities of any single issuer, other than the US Government, its agencies and instrumentalities;

2. REMIF may elect to sell a security prior to its maturity and record a capital gain or loss in order to improve the quality, liquidity or yield of the portfolio in response to market conditions or the Fund's risk preferences; and,

3. If securities owned by the Fund are downgraded to a level below the quality required by this Investment Policy, it shall be REMIF's policy to review the credit situation and make a determination as to whether to sell or retain such securities in the portfolio.

a. If a security is downgraded, the Finance Director will use discretion in determining whether to sell or hold the security based on its current maturity, the economic outlook for the issuer, and other relevant factors.

b. If a decision is made to retain a downgraded security in the portfolio, its presence in the portfolio will be monitored and reported to the REMIF Board.

F. Mitigating market risk in the portfolio

Market risk is the risk that the portfolio value will fluctuate due to changes in the general level of interest rates. REMIF recognizes that, over time, longer-term portfolios have the potential to achieve higher returns. On the other hand, longer- term portfolios have higher volatility of return. REMIF shall mitigate market risk by providing adequate liquidity for short-term cash needs, and by making longer- term investments only with funds that are not needed for current cash flow purposes. REMIF further recognizes that certain types of securities, including variable rate securities, securities with principal pay downs prior to maturity, and securities with embedded options, will affect the market risk profile of the portfolio differently in different interest rate environments. REMIF, therefore, adopts the following strategies to control and mitigate its exposure to market risk:

1. REMIF shall maintain a minimum of six months of budgeted operating expenditures in short term investments to provide sufficient liquidity for expected disbursements;

2. The maximum percent of callable securities (excluding make-whole calls) in the portfolio shall be 15%;

3. The maximum stated final maturity of individual securities in the portfolio shall be five years, except as otherwise stated in this policy; and,

4. The duration of the portfolio shall at all times be approximately equal to the duration of a Market Benchmark Index selected by REMIF based on the Fund's investment objectives, constraints and risk tolerances.

IV. Specific objectives and expectations

Specific objective: The investment portfolio shall be designed commensurate with the investment risk, constraints and cash flow needs of the Fund and with the overall investment

performance objective of earning a total rate of return throughout economic and market cycles which is approximately equal to the return on the Benchmark Index selected by REMIF.

V. Reporting, internal controls and Policy review

A. Monthly reports

Monthly investment reports shall be submitted by the portfolio manager to the Treasurer/Finance Officer. These reports shall disclose, at a minimum, the following information about the risk characteristics of the Fund's portfolio:

1. An asset listing showing par value, cost and accurate and complete market value of each security, type of investment, issuer, and interest rate;

2. A one-page summary report which shows:

a. Average maturity of the portfolio and modified duration of the portfolio;

b. Maturity distribution of the portfolio;

c. Average portfolio credit quality; and

d. Time-weighted total rate of return for the portfolio for the prior three months, twelve months, year to date, and since inception compared to the Benchmark Index returns for the same periods;

3. A statement of compliance with investment policy, including a schedule of any transactions or holdings which do not comply with this policy or with the California Government Code, including a justification for their presence in the portfolio and a timetable for resolution; and

4. A statement that the Fund has adequate funds to meet its cash flow requirements for the next six months.

B. Internal controls

A system of internal controls shall be established and maintained in written form designed to ensure that the assets of the Fund are protected from loss, theft or misuse. The internal control structure shall be designed to provide reasonable assurance that these objectives are met. The most important controls are: control of collusion, separation of duties, separation of transaction authority from accounting and bookkeeping, custodial safekeeping, delegation of authority, limitations regarding losses and remedial action, written confirmation of telephone transactions, minimization of the number of authorized investment officials, documentation of transactions and strategies, and annual review of controls by the Finance Director.

Board adopted: 06/29/16
Board adopted (revisions): 01/31/20

REMIF
REDWOOD
EMPIRE
MUNICIPAL
INSURANCE
FUND

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Member Cities: Arcata, Cloverdale, Cotati, Eureka,
Ft. Bragg, Fortuna, Healdsburg, Lakeport, Rohnert Park,
St. Helena, Sebastopol, Sonoma, Ukiah, Willits, Windsor

ITEM 9.0

AGENDA ITEM SUMMARY

TITLE: DRAFT ACTUARIAL REPORT, OTHER POST EMPLOYMENT BENEFITS
PRESENTED BY: AMY NORTHAM, GENERAL MANAGER

ISSUE
The Other Post-Employment Benefits ("OPEB") actuarial report requires ratification by the Board of Directors. The attached OPEB actuarial study was completed for purposes of booking the outstanding financial liability on the financial statement (as of June 30, 2020) and for GASB 75 requirements.

BACKGROUND
Other Post-Employment Benefits (or OPEB) are benefits (other than pensions) that public agencies and governments provide to their retired employees. These benefits primarily include medical benefits, but also may include dental coverage, vision coverage, life insurance, EAP and other services.

Unless there have been material changes in the plan benefits or members covered by the plan, typically a full actuarial valuation for OPEB is only required to be prepared every two years. However, updated GASB 75 exhibits and trust investment gains/losses must be reviewed annually.

An actuarial study to comply with GASB 75 was conducted. The primary purposes of this report were to:

1. Re-measure plan liabilities as of June 30, 2020 in accordance with GASB 75's biennial valuation requirement,
2. Develop Actuarially Determined Contributions levels for prefunding plan benefits,
3. Provide information required by GASB 75 ("Accounting and Financial Reporting for Postemployment Benefits Other Than Pension") to be reported in REMIF's financial statements for the fiscal year ending June 30, 2020.

This full actuarial valuation includes both the explicit subsidy liability (projecting retiree medical premiums projected to be paid by REMIF) plus the implicit subsidy liability (calculation of the difference between projected retiree medical and life insurance claims and the premiums expected to be charged for retiree coverage).

The reported liabilities of the OPEB fund are $2,168,030 and the fiduciary net position is $2,736,175, resulting in a net OPEB asset of $568,145.

FISCAL IMPACT
None

RECOMMENDED ACTION
Staff recommends the Board approve the OPEB valuation as of June 30, 2020.

ATTACHMENT
9.0 Draft GASB 75 Actuarial Report for the Fiscal Year ending June 30, 2020

MacLeod Watts

October 25, 2020

DRAFT

Amy Northam
General Manager
Redwood Empire Municipal Insurance Fund
414 W. Napa Street, 2nd Floor Suite C
Sonoma, CA 95476

Re: June 30, 2020 Actuarial Valuation and GASB 75 Report for Fiscal Year Ending June 30, 2020

Dear Ms. Northam:

We are pleased to enclose our actuarial report providing financial information about the other post-employment benefit (OPEB) liabilities of the Redwood Empire Municipal Insurance Fund. The report's text describes our analysis and assumptions in detail.

The primary purposes of this report are to:

1. Remeasure plan liabilities as of June 30, 2020 in accordance with GASB 75's biennial valuation requirement,
2. Develop Actuarially Determined Contributions levels for prefunding plan benefits,
3. Provide information required by GASB 75 ("Accounting and Financial Reporting for Postemployment Benefits Other Than Pension") to be reported in REMIF's financial statements for the fiscal year ending June 30, 2020.

The results presented are based on the employee data, details on plan benefits, OPEB trust information and retiree benefit payments reported to us by REMIF for this valuation. As with any analysis, the soundness of the report is dependent on the inputs. Please review our summary of this information to be comfortable that it matches your records.

We appreciate the opportunity to work on this analysis and acknowledge the efforts of REMIF employees who provided valuable time and information to enable us to prepare this report. Please let us know if we can be of further assistance.

Sincerely,

Catherine L. MacLeod, FSA, FCA, EA, MAAA
Principal & Consulting Actuary

Enclosure

Table of Contents

A. Executive Summary

This report presents the results of the June 30, 2020 actuarial valuation and accounting information for the other post-employment benefit (OPEB) program of the Redwood Empire Municipal Insurance Fund (REMIF). The purposes of this valuation are to: 1) summarize the results of the valuation; 2) develop Actuarially Determined Contribution (ADC) levels for prefunding plan benefits; and 3) assess the OPEB liabilities and provide disclosure information as required by Statement No. 75 of the Governmental Accounting Standards Board (GASB 75) for the fiscal year ending June 30, 2020.

Important background information regarding the valuation process can be found in Addendum 1. We recommend users of the report read this information to familiarize themselves with the process and context of actuarial valuations, including the requirements of GASB 75. The pages following this executive summary present various exhibits and other relevant information appropriate for disclosures under GASB 75.

Absent material changes to this program, the results of the June 30, 2020 valuation may also be applied to prepare REMIF's GASB 75 report for the fiscal year ending June 30, 2021. If there are any significant changes in the employee population, plan benefits or eligibility, or to REMIF's funding policy, an earlier valuation might be required or appropriate.[1]

OPEB Obligations of REMIF

REMIF provides continuation of medical, dental, vision and/or life insurance coverage to eligible retiring employees. Access to this coverage may create one or more of the following types of OPEB liabilities:

- **Explicit subsidy liabilities**: An "explicit subsidy" exists when the employer contributes directly toward the cost of retiree healthcare.[2] In this program, REMIF pays a portion of medical, dental, and vision premiums for qualifying retirees. REMIF also contributes a portion of retiree life insurance premiums for a closed group of current retirees and one active employee. Details are provided in Supporting Information Section 2A.
- **Implicit subsidy liabilities**: An "implicit subsidy" exists when the premiums charged for retiree coverage are lower than the expected retiree claims for that coverage. We determine the implicit rate subsidy for retirees as the projected difference between (a) retiree medical claim costs by age and (b) premiums charged for retiree coverage. For more information on this process see Section 3 and Addendum 2: MacLeod Watts Age Rating Methodology.

  The claims experience of active and retired members is co-mingled in setting premium rates for the life insurance plans in which REMIF employees and retirees participate. We believe an implicit subsidy of retiree premiums exists with respect to the life insurance plans because we expect retiree claims to exceed the premiums charged for retiree coverage.

  We assumed no implicit subsidy exists for retiree dental or vision coverage.

[1] We understand that REMIF is expected to merge with the Public Agency Risk Sharing Authority of California (PARSAC) effective July 1, 2021 to form the California Intergovernmental Risk Authority (CIRA). The OPEB provisions and eligibility requirements for existing REMIF employees and retirees may change substantially at that time. Any resulting changes to the liability will be reflected in the first full valuation following the merger.

[2] A liability for potential future excise tax liability for "high cost" retiree coverage was included in the prior valuation. However, this provision of the Affordable Care Act was repealed in December 2019, so this liability was eliminated.

Executive Summary
(Continued)

OPEB Funding Policy

REMIF's OPEB funding policy affects the calculation of liabilities by impacting the discount rate that is used to develop the plan liability and expense. "Prefunding" is the term used when an agency consistently contributes an amount based on an actuarially determined contribution (ADC) each year. GASB 75 allows prefunded plans to use a discount rate that reflects the expected earnings on trust assets. Pay-as-you-go, or "PAYGO", is the term used when an agency only contributes the required retiree benefits when due. When an agency finances retiree benefits on a pay-as-you-go basis, GASB 75 requires the use of a discount rate equal to a 20-year high grade municipal bond rate.

As of the measurement date, REMIF's OPEB trust assets exceed the Total OPEB Liability by a significant margin. Trust assets are also greater than the Actuarial Present Value of all Projected Future Benefits. If all assumptions used in this valuation are met, no future OPEB trust contributions should be required. Therefore, with REMIF's approval, the discount rate used in this valuation is 5.0%, the long term expected return on trust assets, including some margin for adverse performance.

Actuarial Assumptions

Some of the actuarial "demographic" assumptions (i.e. rates of retirement and mortality) used in this report were chosen to be the same as the actuarial demographic assumptions used for the most recent valuation of the retirement plan(s) covering REMIF employees. With only one current active member potentially eligible for benefits, we assumed 100% probability of remaining with REMIF and qualifying for benefits under the plan. Other assumptions, such as age-related healthcare claims, healthcare trend, retiree participation rates and spouse coverage, were selected based on demonstrated plan experience and/or our best estimate of expected future experience. All these assumptions, and more, impact expected future benefits. Please note that this valuation has been prepared on a closed group basis. This means that only employees and retirees present as of the valuation date are considered. We do not consider replacement employees for those we project to leave the current population of plan participants until the valuation date following their employment.

We emphasize that this actuarial valuation provides a projection of future results based on many assumptions. Actual results are likely to vary to some extent and we will continue to monitor these assumptions in future valuations. See Section 3 for a description of assumptions used in this valuation.

Important Dates for GASB 75 in this Report

GASB 75 allows reporting liabilities as of any fiscal year end based on: (1) a *valuation date* no more than 30 months plus 1 day prior to the close of the fiscal year end; and (2) a *measurement date* up to one year prior to the close of the fiscal year. The following dates were used for this report:

Fiscal Year End	June 30, 2020
Measurement Date	June 30, 2020
Measurement Period	June 30, 2019 to June 30, 2020
Valuation Date	June 30, 2020

Executive Summary
(Concluded)

Significant Results and Differences from the Prior Valuation

No benefit changes were reported to MacLeod Watts relative to those in place at the time the June 2018 valuation was prepared. We reviewed and updated certain assumptions used to project the OPEB liability. Differences between actual and expected results based on updated census and premium data since June 2018 were also reflected (referred to as "plan experience"). See *Recognition Period for Deferred Resources* on page 10 for details on how these changes are recognized.

Overall, the Total OPEB Liability on the current measurement date is lower than that reported one year ago. Section C. June 30, 2020 Valuation Results provides additional information on the impact of the new assumptions and plan experience. Assumption changes are described at the end of Section 3.

Impact on Statement of Net Position and OPEB Expense for Fiscal 2020

The plan's impact to Net Position will be the sum of difference between assets and liabilities as of the measurement date plus the unrecognized net outflows and inflows of resources. Different recognition periods apply to deferred resources depending on their origin. The plan's impact on Net Position on the measurement date can be summarized as follows:

Items	For Reporting At Fiscal Year Ending June 30, 2020
Total OPEB Liability	$ 2,168,030
Fiduciary Net Position	2,736,175
Net OPEB Liability (Asset)	(568,145)
Deferred (Outflows) of Resources	(109,994)
Deferred Inflows of Resources	-
Impact on Statement of Net Position	$ (678,139)
OPEB Expense, FYE 6/30/2020	$ (143,611)

Important Notices

This report is intended to be used only to present the actuarial information relating to other postemployment benefits for REMIF's financial statements. The results of this report may not be appropriate for other purposes, where other assumptions, methodology and/or actuarial standards of practice may be required or more suitable. We note that various issues in this report may involve legal analysis of applicable law or regulations. REMIF should consult counsel on these matters; MacLeod Watts does not practice law and does not intend anything in this report to constitute legal advice. In addition, we recommend REMIF consult with their internal accounting staff or external auditor or accounting firm about the accounting treatment of OPEB liabilities.

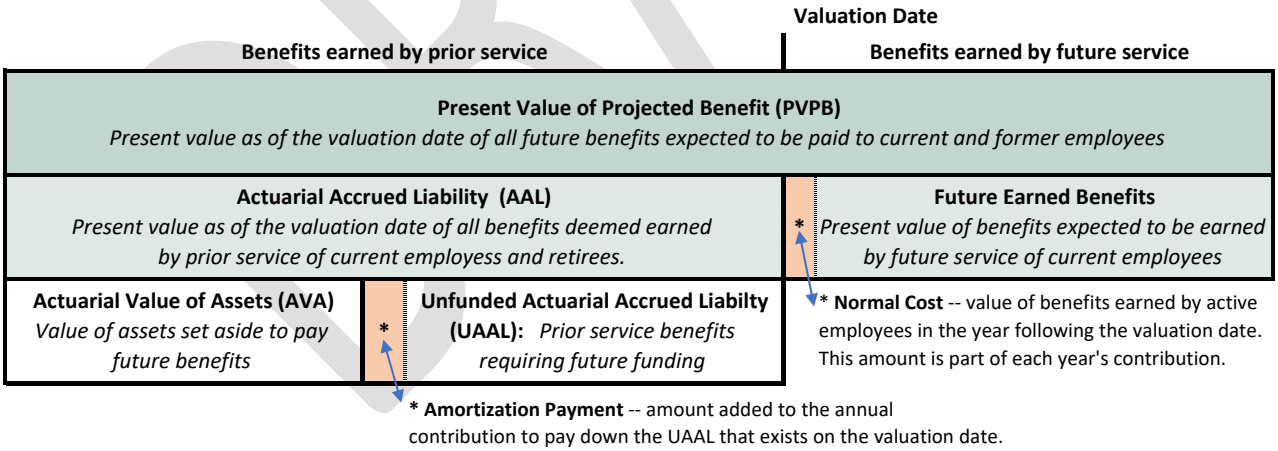
B. Valuation Process

The June 30, 2020 valuation has been based on employee census data and benefits initially submitted to us by REMIF and clarified in various related communications. A summary of the employee data is provided in Section 1 and a summary of the benefits provided under the Plan is provided in Section 2. While individual employee records have been reviewed to verify that they are reasonable in various respects, the data has not been audited and we have otherwise relied on REMIF as to its accuracy. The valuation described below has been performed in accordance with the actuarial methods and assumptions described in Section 3 and is consistent with our understanding of Actuarial Standards of Practice.

Projecting Plan Benefits and Liabilities

In projecting benefit values and liabilities, we first determine an expected premium or benefit stream over each current retiree's or active employee's future or remaining retirement years. Benefits may include both direct employer payments (explicit subsidies) and any implicit subsidies arising when retiree premiums are expected to be partially subsidized by premiums paid for active employees. The projected benefit streams reflect assumed trends in the cost of those benefits and assumptions as to the expected dates when benefits will end. We also apply important assumptions regarding the probability that each employee will remain in service to receive benefits, if so, when they will begin, and the likelihood the employee will elect coverage for themselves and their dependents.

We then calculate a present value of these future benefit streams by discounting the value of each future expected employer payment, multiplied by the probability of payment, back to the valuation date using the discount rate. This present value is called the **Present Value of Projected Benefits (PVPB)** and represents the current value of all expected future plan payments to current retirees and current active employees. Note that this long-term projection does not anticipate entry of future employees.



The next step in the valuation process splits the Present Value of Projected Benefits into 1) the value of benefits already earned by *prior service* of current employees and retirees and 2) the value of benefits expected to be earned by *future service* of current employees. Actuaries employ an "attribution method" to divide the PVPB into prior service liabilities and future service liabilities. For this valuation we used the **Entry Age Normal** attribution method. This is the most common method used by public agencies for plan funding and is the only attribution method allowed for financial reporting under GASB 75.

Valuation Process
(Concluded)

Certain actuarial terms and GASB 75 terms may be used interchangeably. Some are compared below.

Actuarial Funding Terminology	GASB 75 Terminology
Present Value of Projected Benefits (PVPB)	N/A; typically not reported for accounting purposes
Actuarially Accrued Liability (AAL)	Total OPEB Liability (TOL)
Market Value of Assets	Fiduciary Net Position
Unfunded Actuarially Accrued Liability (UAAL)	Net OPEB Liability
Normal Cost	Service Cost

Using funding terminology, we call the value of benefits deemed earned by prior service the **Actuarial Accrued (AAL)**. Benefits deemed earned by service of active employees in a single year is called the **Normal Cost** of benefits. The present value of all future normal costs (PVFNC) plus the Actuarial Accrued Liability will equal the Present Value of Projected Benefits (i.e. PVPB = AAL + PVFNC).

Incorporating Plan Assets

Funds set aside for future benefits may be considered contributions to an OPEB plan only if the account established for holding the accumulated assets are separate from and independent of the control of the employer and legally protected from its creditors. Furthermore, the sole purpose of the account should be to provide benefits and/or pay expenses of the plan. These conditions generally require the establishment of a legal trust, such as REMIF's trust account.

REMIF makes regular contributions to the trust to prefund plan benefits. Trust assets and earnings accumulate so that the trust can make benefit payments to retirees or reimburse REMIF for making those payments directly, to the extent that benefit payments exceed the Actuarially Determined Contributions. The difference between the value of trust assets (i.e. the Market Value of Assets), or a smoothed asset value (i.e. the Actuarial Value of Assets), and the Actuarial Accrued Liability is referred to as the **Unfunded Actuarial Accrued Liability (UAAL)**. The UAAL represents the past service portion of the present value of benefits which remains unfunded as of the valuation date. A plan is generally considered "fully funded" when the UAAL is zero, i.e., when the accumulated prior service costs and plan assets are in equilibrium.

Future contributions by REMIF will fund 1) the remaining part of OPEB benefits earned by past service (the Unfunded Actuarial Accrued Liability) and 2) the value of benefits earned each year by service of active employees (i.e. annual Normal Costs). Various strategies might be employed to pay down the UAAL such as longer or shorter amortization payments, and flat or escalating payments depending on the plan sponsors goals and funding philosophy.

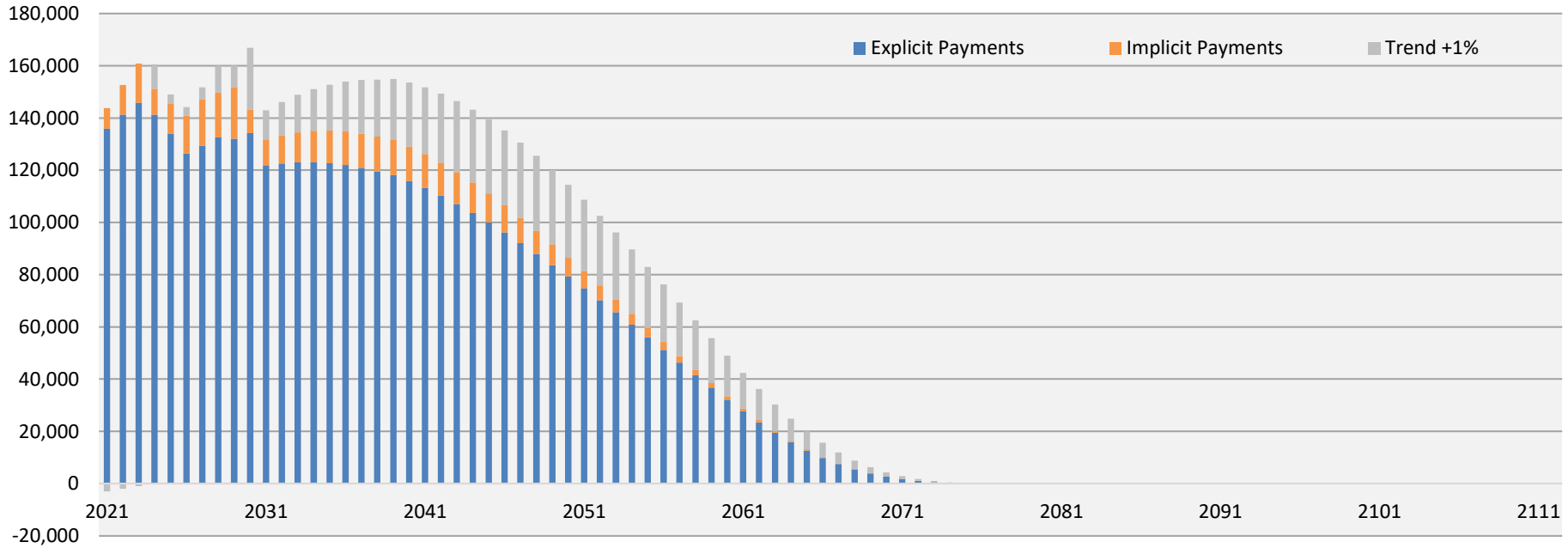
Variation in Future Results

Please note that projections of future benefits over such long periods (frequently 60 or more years) which are dependent on numerous assumptions regarding future economic and demographic variables are subject to revision as future events unfold. While we believe that the assumptions and methods used in this valuation are reasonable for the purposes of this report, the costs to REMIF reflected in this report may change in the future, perhaps materially. Demonstrating the range of potential future plan costs was beyond the scope of our assignment.

C. June 30, 2020 Valuation Results

This section presents the basic results of our recalculation of the OPEB liability using the updated employee data, plan provisions and asset information provided to us for the June 30, 2020 valuation. We described the general process for projecting all future benefits to be paid to retirees and current employees in Section B. Projected annual benefit payments are illustrated in the graph below. The projections (in gray) reflect increases in benefit levels if actual healthcare trend is 1% higher than assumed.

OPEB Payments
Projected to be Paid During Retirement to Current Employees and Retirees



Projected annual benefit payments for the next 15 years are provided in tabular form in the Accounting Section of the report.

C. June 30, 2020 Valuation Results

This chart compares the results measured as of June 30, 2019, based on the June 30, 2018 valuation, with the results measured as of June 30, 2020, based on the June 30, 2020 actuarial valuation.

Valuation Date	**6/30/2018**			**6/30/2020**		
Fiscal Year Ending	**6/30/2019**			**6/30/2020**		
Measurement Date	**6/30/2019**			**6/30/2020**		
Subsidy	Explicit	Implicit	Total	Explicit	Implicit	Total
Discount rate	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%
Number of Covered Employees						
Actives	2	2	2	1	1	1
Retirees	14	14	14	14	14	14
Total Participants	16	16	16	15	15	15
Actuarial Present Value of Projected Benefits						
Actives	$ 396,334	$ 8,770	$ 405,104	$ 195,042	$ 11,893	$ 206,935
Retirees	2,028,243	135,535	2,163,778	1,880,194	185,582	2,065,776
Total APVPB	2,424,577	144,305	2,568,882	2,075,236	197,475	2,272,711
Total OPEB Liability (TOL)						
Actives	156,205	3,464	159,669	96,377	5,877	102,254
Retirees	2,028,243	135,535	2,163,778	1,880,194	185,582	2,065,776
TOL	2,184,448	138,999	2,323,447	1,976,571	191,459	2,168,030
Fiduciary Net Position			2,876,053			2,736,175
Net OPEB Liability			(552,606)			(568,145)
Service Cost For the period following the measurement date	26,871	594	27,465	12,739	777	13,516

The ratio of the Fiduciary Net Position (plan assets) to the Total OPEB Liability measured for accounting purposes is 126.2% on June 30, 2020. This is up from 123.8% as of June 30, 2019. The change in these values compared to those one year ago are discussed on the following page.

June 30, 2020 Valuation Results
(Concluded)

Change in plan assets: Assets reported as of June 30, 2019 were expected to grow to $2,892,353 on June 30, 2020. The actual trust value on that date was $2,736,175 ($156,178 lower than expected) due to higher than expected trust investment earnings.

Change in TOL: The TOL decreased by $155,417 from the TOL on the prior measurement date. We expected an increase of $14,530 from normal plan operation and the passage of time. Unexpected decreases of $169,947 account for the remaining difference. Unexpected changes include:

- *Benefit changes:* No benefit changes were reported since the June 2018 valuation was prepared.
- *Plan experience* includes differences between what was previously assumed and what actually occurred since the prior valuation. The net decrease from plan experience was $53,795.
- *Changes in actuarial assumptions or methodology*: Changes made are shown below; collectively these assumption changes decreased the TOL by $116,152. The most significant component of this decrease relates to elimination of the prior liability for the now repealed excise tax on high cost coverage. For more on the assumption changes, see the last page of Supporting Information, Section 3.

This chart reconciles the TOL reported for fiscal year end June 30, 2019 to the TOL to be reported as of June 30, 2020.

Reported Total OPEB Liability at June 30, 2019 Measurement Date June 30, 2019	**$ 2,323,447**
Expected Changes:	
Service Cost	27,465
Benefit Payments	(127,298)
Interest Cost	114,363
Total Expected Change	14,530
Expected Total OPEB Liability at June 30, 2020 Measurement Date June 30, 2020	**$ 2,337,977**
Unexpected Changes:	
Plan experience different than assumed	(53,795)
Assumption changes	
Elimination of excise tax liability	(54,774)
Change in medical trend model	(28,687)
Change in dental and vision trend	(22,220)
Change in economic assumptions and mortality improvement scale	(10,471)
Total Unexpected Change	(169,947)
Actual Total OPEB Liability at June 30, 2020 Measurement Date June 30, 2020	**$ 2,168,030**

D. Accounting Information (GASB 75)

The following exhibits are designed to satisfy the reporting and disclosure requirements of GASB 75 for the fiscal year end June 30, 2020. REMIF is classified for GASB 75 purposes as a single employer.

Components of Net Position and Expense

The exhibit below shows the development of Net Position and Expense as of the Measurement Date.

Plan Summary Information for FYE June 30, 2020 *Measurement Date is June 30, 2020*	**REMIF**
Items Impacting Net Position:	
Total OPEB Liability	$ 2,168,030
Fiduciary Net Position	2,736,175
Net OPEB Liability (Asset)	(568,145)
Deferred (Outflows) Inflows of Resources Due to:	
Assumption Changes	-
Plan Experience	-
Investment Experience	(109,994)
Deferred Contributions	-
Net Deferred (Outflows) Inflows of Resources	(109,994)
Impact on Statement of Net Position, FYE 6/30/2020	**$ (678,139)**
Items Impacting OPEB Expense:	
Service Cost	$ 27,465
Cost of Plan Changes	-
Interest Cost	114,363
Expected Earnings on Assets	(140,693)
Actuarial Fees	1,800
Recognized Deferred Resource items:	
Assumption Changes	(116,152)
Plan Experience	(53,795)
Investment Experience	23,401
OPEB Expense, FYE 6/30/2020	**$ (143,611)**

Accounting Information
(Continued)

Change in Net Position During the Fiscal Year

The exhibit below shows the year-to-year changes in the components of Net Position.

For Reporting at Fiscal Year End *Measurement Date*	**6/30/2019** *6/30/2019*	**6/30/2020** *6/30/2020*	**Change During Period**
Total OPEB Liability	$ 2,323,447	$ 2,168,030	$ (155,417)
Fiduciary Net Position	2,876,053	2,736,175	(139,878)
Net OPEB Liability (Asset)	(552,606)	(568,145)	(15,539)
Deferred Resource (Outflows) Inflows Due to:			
Assumption Changes	-	-	-
Plan Experience	-	-	-
Investment Experience	22,783	(109,994)	(132,777)
Deferred Contributions	-	-	-
Net Deferred (Outflows) Inflows	22,783	(109,994)	(132,777)
Impact on Statement of Net Position	$ (529,823)	$ (678,139)	$ (148,316)

Change in Net Position During the Fiscal Year	
Impact on Statement of Net Position, FYE 6/30/2019	$ (529,823)
OPEB Expense (Income)	(143,611)
Employer Contributions During Fiscal Year	(4,705)
Impact on Statement of Net Position, FYE 6/30/2020	$ (678,139)

OPEB Expense	
Employer Contributions During Fiscal Year	$ 4,705
Deterioration (Improvement) in Net Position	(148,316)
OPEB Expense (Income), FYE 6/30/2020	$ (143,611)

Accounting Information
(Continued)

Change in Fiduciary Net Position During the Measurement Period

	Assets Reported	Implied Receivable (Payable)	Fiduciary Net Position
Fiduciary Net Position at Fiscal Year Ending 6/30/2019 Measurement Date 6/30/2019	**2,922,246**	**(46,193)**	**$ 2,876,053**
Changes During the Period:			
Investment Income	(15,485)	-	(15,485)
Actuarial Fees	(1,800)	-	(1,800)
Employer Contributions			
Implicit employer contributions for plan year	4,705	-	4,705
Benefit Payments			
Benefits paid during plan year	(62,833)	-	(62,833)
Implicit employer contributions for plan year	(4,705)		(4,705)
Reimbursement to REMIF for prior year retiree benefits paid	(46,193)	46,193	-
Accrued 6/30/20 benefit reimbursement due to REMIF	-	(59,760)	(59,760)
Net Changes During the Period	(126,311)	(13,567)	(139,878)
Fiduciary Net Position at Fiscal Year Ending 6/30/2020 Measurement Date 6/30/2020	**$ 2,795,935**	**$ (59,760)**	**$ 2,736,175**

Expected Long-term Return on Trust Assets

REMIF established and maintains a single employer irrevocable OPEB trust. The specific trust investment holdings and the long term expected return on trust assets are determined based on guidance provided by its investment advisors. REMIF is less optimistic about the future expected returns and approved a 1.77% margin for adverse investment returns. Accordingly, the assumed long term trust return applied in this valuation is5.0%, the same assumption used in the prior valuation.

Expected Long-Term Rate of Return	Average Target Allocation	Expected Long-Term Rate of Return (including inflation)
Asset Class Component		
Domestic Equities	48%	8.56%
International Equities	11%	8.39%
Fixed Income	31%	3.76%
REIT	8%	6.69%
Commodities	2%	5.00%
Cash and Other	0%	n/a
Weighted composite real rate of return (from above)		6.83%
Assumed Long-Term Investment Expenses		-0.06%
Margin for Adverse Deviation in asset returns		-1.77%
Expected Long-Term Net Rate of Return, rounded		**5.00%**

Accounting Information
(Continued)

Recognition Period for Deferred Resources

Liability changes due to plan experience which differs from what was assumed in the prior measurement period and/or from assumption changes during the period are recognized over the plan's Expected Average Remaining Service Life ("EARSL"). The EARSL of 1 year is the period used to recognize such changes in the OPEB Liability arising during the current measurement period.

When applicable, changes in the Fiduciary Net Position due to investment performance different from the assumed earnings rate are always recognized over 5 years.

Liability changes attributable to benefit changes occurring during the period, if any, are recognized immediately.

Deferred Resources as of Fiscal Year End and Expected Future Recognition

The exhibit below shows deferred resources as of the fiscal year end June 30, 2020.

Redwood Empire Municipal Insurance Fund	Deferred Outflows of Resources	Deferred Inflows of Resources
Changes of Assumptions	$ -	$ -
Differences Between Expected and Actual Experience	-	-
Net Difference Between Projected and Actual Earnings on Investments	109,994	-
Deferred Contributions	-	-
Total	$ 109,994	$ -

Future recognition of these deferred resources is shown below.

For the Fiscal Year Ending June 30	Recognized Net Deferred Outflows (Inflows) of Resources
2021	$ 23,401
2022	23,400
2023	31,959
2024	31,234
2025	-
Thereafter	-

Accounting Information
(Continued)

Sensitivity of Liabilities to Changes in the Discount Rate and Healthcare Cost Trend Rate

The discount rate used for accounting purposes for the fiscal year end 2020 is 5.0%. Healthcare Cost Trend Rate was assumed to start at 5.4% (increase effective 2021) and grade down to 4% for years 2076 and later. The impact of a 1% increase or decrease in these assumptions is shown in the chart below.

Sensitivity to:			
Change in Discount Rate	**Current - 1% 4.00%**	**Current 5.00%**	**Current + 1% 6.00%**
Total OPEB Liability	2,427,091	2,168,030	1,953,304
Increase (Decrease)	259,061		(214,726)
% Increase (Decrease)	11.9%		-9.9%
Net OPEB Liability (Asset)	(309,084)	(568,145)	(782,871)
Increase (Decrease)	259,061		(214,726)
% Increase (Decrease)	45.6%		-37.8%
Change in Heathcare Cost Trend Rate	**Current Trend - 1%**	**Current Trend**	**Current Trend + 1%**
Total OPEB Liability	1,967,179	2,168,030	2,406,712
Increase (Decrease)	(200,851)		238,682
% Increase (Decrease)	-9.3%		11.0%
Net OPEB Liability (Asset)	(768,996)	(568,145)	(329,463)
Increase (Decrease)	(200,851)		238,682
% Increase (Decrease)	-35.4%		42.0%

Accounting Information
(Continued)

Schedule of Changes in REMIF's Net OPEB Liability and Related Ratios

GASB 75 requires presentation of the 10-year history of changes in the Net OPEB Liability. Only results for years since GASB 75 was implemented (fiscal years 2018, 2019 and 2020) are shown in the table.

Fiscal Year End *Measurement Date*	**FYE 2020** ***6/30/2020***	**FYE 2019** ***6/30/2019***	**FYE 2018** ***6/30/2018***
Total OPEB liability			
Service Cost	$ 27,465	$ 26,600	$ 100,153
Interest	114,363	114,390	190,208
Changes of benefit terms	-	-	-
Differences between expected and actual experience	(53,795)	-	(1,166,627)
Changes of assumptions	(116,152)	-	448,000
Benefit payments	(127,298)	(157,471)	(115,806)
Net change in total OPEB liability	(155,417)	(16,481)	(544,072)
Total OPEB liability - beginning	2,323,447	2,339,928	2,884,000
Total OPEB liability - ending (a)	$ 2,168,030	$ 2,323,447	$ 2,339,928
Plan fiduciary net position			
Contributions - employer	$ 4,705	$ 16,442	$ 115,806
Net investment income	(15,485)	139,284	221,995
Benefit payments	(127,298)	(157,471)	(115,806)
Actuarial Fees	(1,800)	-	-
Reimbursement to REMIF for prior year retiree benefits paid	-	(101,232)	-
Net change in plan fiduciary net position	(139,878)	(102,977)	221,995
Plan fiduciary net position - beginning	2,876,053	2,979,030	2,757,035
Plan fiduciary net position - ending (b)	$ 2,736,175	$ 2,876,053	$ 2,979,030
Net OPEB liability - ending (a) - (b)	$ (568,145)	$ (552,606)	$ (639,102)
Covered-employee payroll	$ 72,240	$ 122,480	$ 467,743
Net OPEB liability as a % of covered-employee payroll	-786.47%	-451.18%	-136.64%

Accounting Information
(Continued)

Schedule of Contributions

REMIF has contributed 100% or more of the Actuarially Determined Contribution (ADC) or maintained a funded ratio of at least 100% every year since establishing the OPEB trust. This chart shows the contributions for the fiscal years since GASB 75 was implemented.

	FYE 2020	FYE 2019	FYE 2018
Actuarially Determined Contribution	$ -	$ -	$ -
Contributions in relation to the actuarially determined contribution	4,705	16,442	115,806
Contribution deficiency (excess)	$ (4,705)	$ (16,442)	$ (115,806)
Covered employee payroll	$ 72,240	$ 122,480	$ 467,743
Contributions as a % of covered employee payroll	6.51%	13.42%	24.76%

Notes to Schedule

Valuation Date:	6/30/2020	6/30/2018	6/30/2018

Methods and assumptions used to determine contribution rates:

Actuarial cost method	Entry Age Normal, Closed Group, Level % of Pay	Entry Age Normal, Closed Group, Level % of Pay	Entry Age Normal, Closed Group, Level % of Pay
Asset valuation method	Market value of assets	Market value of assets	Market value of assets
Inflation	2.50%	2.75%	2.75%
Healthcare cost trend rates	5.4% in 2021 fluctuating down to 4% by 2076	7.5% in Jul 2019, step down .5% per year to 5.25% by 2024	7.5% in Jul 2019, step down .5% per year to 5.25% by 2024
Salary increases	3.00%	3.25%	3.25%
Investment rate of return	5.00%	5.00%	5.00%
Retirement age	From 50 to 75	From 50 to 75	From 50 to 75
Mortality	2017 CalPERS Experience Study; Improvement using MacLeod Watts Scale 2020	2017 CalPERS Experience Study; Improvement using MacLeod Watts Scale 2018	2017 CalPERS Experience Study; Improvement using MacLeod Watts Scale 2018

Accounting Information
(Continued)

Detail of Changes to Net Position

The chart below details changes to all components of Net Position.

Redwood Empire Municipal Insurance Fund	Total OPEB Liability (a)	Fiduciary Net Position (b)	Net OPEB Liability (c) = (a) - (b)	(d) Deferred Outflows (Inflows) Due to:				Impact on Statement of Net Position (e) = (c) - (d)
				Assumption Changes	Plan Experience	Investment Experience	Deferred Contributions	
Balance at Fiscal Year Ending 6/30/2019 *Measurement Date 6/30/2019*	$ 2,323,447	$ 2,876,053	$ (552,606)	$ -	$ -	$ (22,783)	$ -	$ (529,823)
Changes During the Period:								
Service Cost	27,465		27,465					27,465
Interest Cost	114,363		114,363					114,363
Expected Investment Income		140,693	(140,693)					(140,693)
Employer Contributions		4,705	(4,705)					(4,705)
Changes of Benefit Terms	-		-					-
Actuarial Fees		(1,800)	1,800					1,800
Benefit Payments	(127,298)	(127,298)	-					-
Assumption Changes	(116,152)		(116,152)	(116,152)				-
Plan Experience	(53,795)		(53,795)		(53,795)			-
Investment Experience		(156,178)	156,178			156,178		-
Recognized Deferred Resources				116,152	53,795	(23,401)		(146,546)
Employer Contributions in Fiscal Year								-
Net Changes in Fiscal Year 2019-2020	(155,417)	(139,878)	(15,539)	-	-	132,777	-	(148,316)
Balance at Fiscal Year Ending 6/30/2020 *Measurement Date 6/30/2020*	$ 2,168,030	$ 2,736,175	$ (568,145)	$ -	$ -	$ 109,994	$ -	$ (678,139)

Accounting Information
(Continued)

Schedule of Deferred Outflows and Inflows of Resources

A listing of all deferred resource bases used to develop the Net Position and OPEB Expense is shown below. Deferred Contributions are not shown.

Measurement Date: June 30, 2020

Deferred Resource						Recognition of Deferred Outflow or Deferred (Inflow) in Measurement Period:						
Date Created	Cause	Initial Amount	Period (Yrs)	Annual Recognition	Balance as of Jun 30, 2020	2019-20 (FYE 2020)	2020-21 (FYE 2021)	2021-22 (FYE 2022)	2022-23 (FYE 2023)	2023-24 (FYE 2024)	2024-25 (FYE 2025)	Thereafter
6/30/2018	Investment Earnings Greater than Expected	$ (42,786)	5.00	$ (8,557)	$ (17,115)	$ (8,557)	$ (8,557)	$ (8,558)	$ -	$ -	$ -	$ -
6/30/2019	Investment Earnings Less than Expected	3,611	5.00	722	2,167	722	722	722	723	-	-	-
6/30/2020	Gain Due To Plan Experience	(53,795)	1.00	(53,795)	-	(53,795)	-	-	-	-	-	-
6/30/2020	Gain Due To Assumption Changes	(116,152)	1.00	(116,152)	-	(116,152)	-	-	-	-	-	-
6/30/2020	Investment Earnings Less than Expected	156,178	5.00	31,236	124,942	31,236	31,236	31,236	31,236	31,234	-	-

Accounting Information
(Continued)

REMIF Contributions to the Plan

REMIF contributions to the Plan occur as benefits are paid to or on behalf of retirees. Benefit payments may occur in the form of direct payments for premiums ("explicit subsidies") and/or indirect payments to retirees in the form of higher premiums for active employees ("implicit subsidies"). Note: The implicit subsidy contribution does not represent cash payments to retirees, but a reclassification of a portion of the active healthcare expense to be recognized instead as a retiree healthcare expense. For details, see Addendum 1 – Important Background Information.

Benefits and other contributions paid by REMIF during the measurement period. Because the measurement period is the current fiscal year, there are no deferred contributions to be reported.

Benefit Payments During the Measurement Period, Jul 1, 2019 thru Jun 30, 2020	**REMIF**
Benefits Paid by Trust	$ 122,593
Benefits Paid by Employer (not reimbursed by trust)	-
Implicit benefit payments	4,705
Total Benefit Payments During the Measurement Period	$ 127,298

Employer Contributions During the Measurement Period, Jul 1, 2019 thru Jun 30, 2020	**REMIF**
Employer Contributions to the Trust	$ -
Employer Contributions in the Form of Direct Benefit Payments (not reimbursed by trust)	-
Implicit contributions	4,705
Total Employer Contributions During the Measurement Period	$ 4,705

Accounting Information
(Continued)

Projected Benefit Payments (15-year projection)

The following is an estimate of other post-employment benefits to be paid on behalf of current retirees and current employees expected to retire from REMIF. Expected annual benefits have been projected on the basis of the actuarial assumptions outlined in Section 3.

These projections do not include any benefits expected to be paid on behalf of current active employees *prior to* retirement, nor do they include any benefits for potential *future employees* (i.e., those who might be hired in future years).

Projected Annual Benefit Payments							
Fiscal Year Ending June 30	Explicit Subsidy			Implicit Subsidy			Total
	Current Retirees	Future Retirees	Total	Current Retirees	Future Retirees	Total	
2020	$ 122,593	$ -	$ 122,593	$ 4,705	$ -	$ 4,705	$ 127,298
2021	135,896	-	135,896	7,956	-	7,956	143,852
2022	141,325	-	141,325	11,219	65	11,284	152,609
2023	144,692	1,136	145,828	14,723	346	15,069	160,897
2024	138,661	2,631	141,292	8,979	911	9,890	151,182
2025	129,606	4,323	133,929	11,254	334	11,588	145,517
2026	121,668	4,711	126,379	13,616	892	14,508	140,887
2027	122,857	6,561	129,418	16,066	1,687	17,753	147,171
2028	123,844	8,726	132,570	18,560	(1,435)	17,125	149,695
2029	124,533	7,467	132,000	21,180	(1,378)	19,802	151,802
2030	125,093	9,123	134,216	10,150	(1,200)	8,950	143,166
2031	111,412	10,475	121,887	10,876	(938)	9,938	131,825
2032	110,938	11,654	122,592	11,395	(626)	10,769	133,361
2033	110,210	12,771	122,981	11,770	(280)	11,490	134,471
2034	109,233	13,772	123,005	11,989	87	12,076	135,081

The amounts shown in the Explicit Subsidy table reflect the expected payment by REMIF toward retiree medical, dental, vision and life insurance in each of the years shown. The amounts are shown separately, and in total, for those retired on the valuation date ("current retirees") and those expected to retire after the valuation date ("future retirees").

The amounts shown in the Implicit Subsidy table reflect the expected excess of retiree medical and life insurance claims over the premiums expected to be charged during the year for retirees' coverage. *Note that future retirees are ineligible for REMIF life insurance coverage.* These amounts are also shown separately and in total for those currently retired on the valuation date and for those expected to retire in the future.

Accounting Information
(Concluded)

Sample Journal Entries

Beginning Account Balances As of the fiscal year beginning 7/1/2019	**Debit**	**Credit**
Net OPEB Liability	552,606	
Deferred Resource -- Assumption Changes	-	
Deferred Resource -- Plan experience	-	
Deferred Resource -- Investment Experience		22,783
Deferred Resource -- Contributions	-	
Net Position		529,823

** The entries above assume nothing is on the books at the beginning of the year. So to the extent that values already exist in, for example, the Net OPEB Liability account, then only the difference should be adjusted. The entries above represent the values assumed to exist at the start of the fiscal year.*

Journal entries to record implicit subsidies during the fiscal year	**Debit**	**Credit**
OPEB Expense	4,705	
Premium Expense		4,705

** This entry assumes that premiums for active employees were recorded to an account called "Premium Expense". This entry reverses the portion of premium payments that represent implicit subsidies and assigns that value to OPEB Expense.*

Journal entries to record other account activity during the fiscal year	**Debit**	**Credit**
Net OPEB Liability	15,539	
Deferred Resource -- Assumption Changes	-	
Deferred Resource -- Plan experience	-	
Deferred Resource -- Investment Experience	132,777	
Deferred Resource -- Contributions	-	
OPEB Expense		148,316

E. Funding Information

The employer's OPEB funding policy and level of contributions to an irrevocable OPEB trust directly affects the discount rate used to calculate the OPEB liability to be reported in the employer's financial statements. Prefunding (setting aside funds to accumulate in an irrevocable OPEB trust) has certain advantages, one of which is the ability to (potentially) use a higher discount rate in the determination of liabilities for GASB 75 reporting purposes. Prefunding also improves the security of benefits for current and potential future recipients and contributes to intergenerational taxpayer equity by better matching the cost of the benefits to the service years in which they are "earned" and which correspond to years in which taxpayers benefit from those services.

REMIF has been prefunding its OPEB liability by contributing 100% or more of the Actuarially Determined Contribution (ADC) each year. The ADC typically consists of two basic components, adjusted with interest to each fiscal year end:

- The amounts attributed to service performed in the current fiscal year (normal cost) and
- Amortization of the unfunded actuarial accrued liability (UAAL).

In recent years, this program has realized some gains (reductions) in the Actuarial Present Value of Projected Future Benefits (APVPB). The APVPB includes the Total OPEB Liability as well as all projected future service costs. **As of the June 30, 2020 measurement date, trust assets exceed the APVPB and the Actuarially Determined Contribution is $0**. If all assumptions are met in the future, trust assets should be sufficient to pay all retiree benefits and no further employer contributions should be required. Trust sufficiency cannot be guaranteed to a certainty, however, due to the non-trivial risk that the assumptions used to project future benefit liabilities may not be realized.

The following provides some additional background about the APVPB and various components to aid in understanding the funding status of this plan:

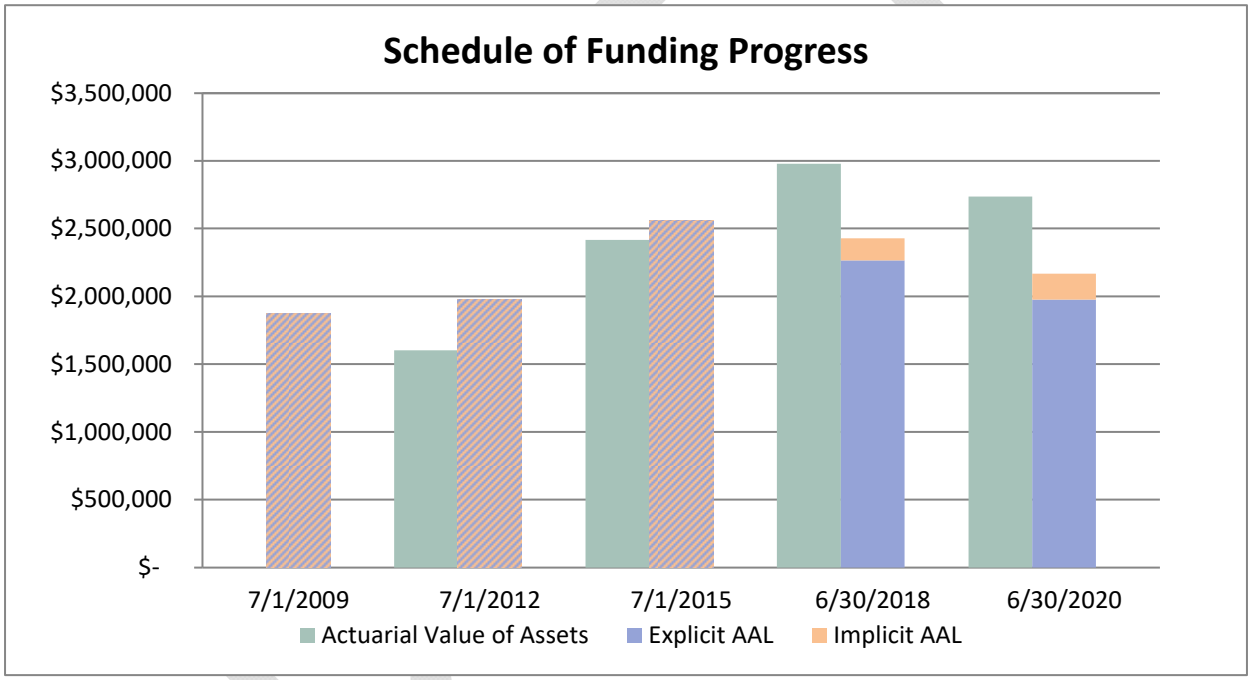
- **Actuarial Present Value of Projected Benefits (APVPB)**: APVPB refers to the discounted total value of all future benefits expected to be paid to current retirees or beneficiaries and to current active employees after they retire. AVPVB on 6/30/2020: $2,272,711
- **Actuarial Accrued Liability (AAL):** The AAL, referred to as the Total OPEB Liability (TOL) for accounting purposes, is a subset of the APVPB. It represents the portion of the APVPB which has been attributed to service worked prior to the valuation date. For active employees, the AAL is less than the APVPB because there is always some future service possible and a portion of costs will be assigned to those years. AAL on 6/30/2020: $2,168,030
- **Normal Cost (NC):** NC, also referred to as service cost for accounting purposes, is also a subset of the PVPB. It refers to the cost of future retiree benefits assigned to the current service year. Only active employees have a current service cost. NC on 6/30/2020: $13,516
- **Plan Assets:** The actuarial value of the balance set aside for the plan in an irrevocable trust, dedicated to providing benefits to retirees and their beneficiaries, and legally protected from creditors of the employer and/or plan administrator. Plan Assets on 6/30/2020: $2,736,175
- **Unfunded Actuarial Accrued Liability (UAAL):** The UAAL, referred to as Net OPEB Liability for accounting purposes, is the AAL minus Plan Assets. UAAL on 6/30/2020: $(568,145)

OPEB Funding Information
(Continued)

In this section, we provide a review of key components of valuation results from 2009 through 2020.

Schedule of Funding Progress

Actuarial Valuation Date	Actuarial Value of Assets (a)	Actuarial Accrued Liability (b)	Unfunded Actuarial Accrued Liability (b-a)	Funded Ratio (a/b)	Covered Payroll (c)	UAAL as a Percentage of Covered Payroll ((b-a)/c)	Discount Rate
7/1/2009	$ -	$ 1,875,000	$ 1,875,000	0.0%	*not available*	*not available*	6.5%
7/1/2012	$ 1,603,000	$ 1,977,000	$ 374,000	81.1%	*not available*	*not available*	6.5%
7/1/2015	$ 2,417,000	$ 2,563,000	$ 146,000	94.3%	*not available*	*not available*	6.5%
6/30/2018	$ 2,979,028	$ 2,429,132	$ (549,896)	122.6%	$ 467,743	-117.6%	5.0%
6/30/2020	$ 2,736,175	$ 2,168,030	$ (568,145)	126.2%	$ 72,240	-786.5%	5.0%



Note: The portions of REMIF's liability related to the explicit and implicit subsidy were not separately identified in the 2009, 2012 and 2015 valuations.

F. Certification

The purpose of this report is to provide actuarial information of the other postemployment benefits (OPEB) provided by the Redwood Empire Municipal Insurance Fund (REMIF) in compliance with Statement 75 of the Governmental Accounting Standards Board (GASB 75). We summarized the benefits in this report and our calculations were based on our understanding of the benefits as described herein.

In preparing this report we relied without audit on information provided by REMIF. This information includes, but is not limited to, plan provisions, census data, and financial information. We performed a limited review of this data and found the information to be reasonably consistent. The accuracy of this report is dependent on this information and if any of the information we relied on is incomplete or inaccurate, then the results reported herein will be different from any report relying on more accurate information.

We consider the actuarial assumptions and methods used in this report to be individually reasonable under the requirements imposed by GASB 75 and taking into consideration reasonable expectations of plan experience. The results provide an estimate of the plan's financial condition at one point in time. Future actuarial results may be significantly different due to a variety of reasons including, but not limited to, demographic and economic assumptions differing from future plan experience, changes in plan provisions, changes in applicable law, or changes in the value of plan benefits relative to other alternatives available to plan members.

Alternative assumptions may also be reasonable; however, demonstrating the range of potential plan results based on alternative assumptions was beyond the scope of our assignment except to the limited extent required by GASB 75 and in accordance with REMIF's stated OPEB funding policy. Results for accounting purposes may be materially different than results obtained for other purposes such as plan termination, liability settlement, or underlying economic value of the promises made by the plan.

This report is prepared solely for the use and benefit of REMIF and may not be provided to third parties without prior written consent of MacLeod Watts. Exceptions are: REMIF may provide copies of this report to their professional accounting and legal advisors who are subject to a duty of confidentiality, and REMIF may provide this work to any party if required by law or court order. No part of this report should be used as the basis for any representations or warranties in any contract or agreement without the written consent of MacLeod Watts.

The undersigned actuaries are unaware of any relationship that might impair the objectivity of this work. Nothing within this report is intended to be a substitute for qualified legal or accounting counsel. Both actuaries are members of the American Academy of Actuaries and meet the qualification standards for rendering this opinion.

Signed: October 25, 2020

Catherine L. MacLeod, FSA, FCA, EA, MAAA	Yunyi (Susan) Qu, ASA, ACA, MAAA

G. Supporting Information

Section 1 - Summary of Employee Data

Active employees: REMIF reported 1 active, OPEB-eligible members in the data provided to us for the June 2020 valuation. As of the valuation date, this employee's age was 56.5 and years of REMIF service was 7.5. If this employee remains with REMIF until retirement, she is expected to qualify for some benefit in about 3 years. *This plan is closed to other current and potential future employees.*

Retirees: There are also 14 retired employees receiving benefits under this program on the valuation date. The following chart summarizes the ages of current retirees included in this valuation.

Retirees by Age		
Current Age	**Number**	**Percent**
Below 50	0	0%
50 to 54	0	0%
55 to 59	2	14%
60 to 64	1	7%
65 to 69	2	14%
70 to 74	5	36%
75 to 79	1	7%
80 & up	3	21%
Total	**14**	**100%**
Average Age:		
On 6/30/2020	71.49	
At retirement	60.86	

Summary of Plan Member Counts: The number of members currently or potentially eligible to receive benefits under the OPEB plan are required to be reported in the notes to the financial statements.

Summary of Plan Member Counts	
Number of active plan members	1
Number of inactive plan members currently receiving benefits	14
Number of inactive plan members entitled to but not receiving benefits	0*

* We are not aware of any retirees who are eligible but not currently enrolled.

Changes since the prior valuation: The chart below reconciles the number of actives and retirees included in the June 30, 2018 valuation of the REMIF plan with those included in the June 30, 2020 valuation.

Reconciliation of REMIF Plan Members Between Valuation Dates			
Status	Actives	Retirees	Total
Number reported as of June 30, 2018	2	14	16
New retiree, waiving coverage	(1)	-	(1)
Number reported as of June 30, 2020	**1**	**14**	**15**

Supporting Information
(Continued)

Section 2A - Summary of Retiree Benefit Provisions

OPEB provided: REMIF provides retiree medical, dental, vision and life insurance plan coverage for a closed group of employees.

Access to coverage: REMIF manages a number of self-funded pooled healthcare plans for participating member agencies. Premiums and claims experience for plans covering retirees before and after eligibility for Medicare are maintained separately from plans available for active employees of participating member agencies.

REMIF coverage is available to its own employees hired before July 1, 2014 who retire from REMIF with at least 10 years of continuous REMIF service. Retirees may also cover a spouse or other eligible dependents. A surviving spouse and other eligible dependents may also continue coverage and receive the benefits described below.

Benefits provided: For retirees who elect coverage in one or more REMIF-sponsored plans, REMIF pays a percentage of medical, dental and vision premiums (including premiums for any enrolled dependents) based on hire date and years of REMIF service. In addition, REMIF pays the applicable percentage of the retiree life insurance premium for a closed group of retirees.

The chart below summarizes the percentage paid by REMIF:

Hire Date	Benefit	
Before July 1, 1993	100% of premiums paid by REMIF	
After June 30, 1993 and before July 1, 2014	Years of REMIF Service	% of Premiums Paid by REMIF
	10 but less than 15	50%
	15 but less than 25	65%
	25 or more	80%
After June 30, 2014	No coverage or subsidies provided	

REMIF health plan premium rates: The monthly premium rates in effect on July 1, 2020 are:

REMIF Premium Rates 7/1/2020 - 6/30/2021			
Plan	Single	Two Party	Family
Retiree REMIF EPO 250	$ 1,109.00	$ 2,324.00	$ 3,318.00
Active REMIF EPO 250	837.00	1,753.00	2,503.00
AmWINS Medicare Supplement	539.16	1,078.32	n/a
Delta Dental	97.91		
Vision	18.56		

Life Insurance Coverage: A closed group of retirees remain eligible for coverage in REMIF's life insurance plan. The initial face amount of life insurance for retirees is $60,000 for Management and $10,000 for Non-Management retirees. The face amount decreases to 65% of the initial amount at age 70 and to 50% of the initial face amount at age 75. The rate per $1,000 in coverage is $1.33 at all ages.

Supporting Information
(Continued)

Section 2B - Excise Taxes for High Cost Retiree Coverage (Repealed)

The Patient Protection and Affordable Care Act (ACA) included a 40% excise tax on high-cost employer-sponsored health coverage. The tax applied to the aggregate annual cost of an employee's applicable coverage that exceeds a dollar limit. Implementation of this tax had been delayed by subsequent legislation to 2022.

As noted earlier in this report, this excise tax on high cost retiree coverage was repealed by Senate Amendment to H.R. 1865, *Further Consolidated Appropriations Act, 2020*, and signed by the President on December 20, 2019. Accordingly, the valuation no longer includes any liability previously estimated for this prior tax.

Supporting Information
(Continued)

Section 3 - Actuarial Methods and Assumptions

The ultimate real cost of an employee benefit plan is the value of all benefits and other expenses of the plan over its lifetime. These payments depend only on the terms of the plan and the administrative arrangements adopted. The actuarial assumptions are used to estimate the cost of these benefits; the funding method spreads the expect costs on a level basis over the life of the plan.

Fiscal Year End	June 30, 2020
GASB 75 Measurement Date	June 30, 2020 (last day of the current fiscal year)
Valuation Date	June 30, 2020
Funding Method	Entry Age Normal Cost, level percent of pay
Asset Valuation Method	Market value of assets
Long Term Return on Assets	5.0% as of June 30, 2020 and as of June 30, 2019, net of plan investment expenses and trust administrative expenses
Discount Rate	5.0%
Participants Valued	Only current active employees and retired participants and covered dependents are valued. *This plan is closed to new members.*
Salary Increase	3.0% per year; since benefits do not depend on salary, this is used to allocate the cost of benefits between service years
General Inflation Rate	2.5% per year
Mortality rates	We assumed no deaths among active employees prior to retirement. For retirees, we used the mortality rates published by CalPERS, adjusted to back out 15 years of Scale MP 2016 to central year 2015, then projected improvements forward from 2015 using MacLeod Watts Scale 2020 applied generationally (see Addendum 3).

Supporting Information
(Continued)

Section 3 - Actuarial Methods and Assumptions

Mortality After Retirement
(before improvement applied)

Healthy Lives

CalPERS Public Agency Miscellaneous, Police & Fire Post Retirement Mortality		
Age	Male	Female
40	0.00070	0.00040
50	0.00431	0.00390
60	0.00758	0.00524
70	0.01490	0.01044
80	0.04577	0.03459
90	0.14801	0.11315
100	0.35053	0.30412
110	1.00000	1.00000

Disabled Miscellaneous

CalPERS Public Agency Disabled Miscellaneous Post-Retirement Mortality		
Age	Male	Female
20	0.00027	0.00008
30	0.00044	0.00018
40	0.00070	0.00040
50	0.01371	0.01221
60	0.02447	0.01545
70	0.03737	0.02462
80	0.07218	0.05338
90	0.16585	0.14826

Continuation to Retirement

We assumed 100% probability that active employees covered by this plan would continue in service to retirement with REMIF; probabilities of retirement are shown below and assumed to begin when first eligible for retiree health benefits. No deaths or termination of service with REMIF prior to retirement are expected to occur.

Service Retirement Rates

Miscellaneous Employees: 2.7% at 55 formula From CalPERS Experience Study Report Issued December 2017						
Current Age	Years of Service					
	5	10	15	20	25	30
50	0.0030	0.0100	0.0160	0.0340	0.0330	0.0450
55	0.0330	0.0550	0.0780	0.1130	0.1560	0.2340
60	0.0600	0.0860	0.1120	0.1500	0.1820	0.2380
65	0.1400	0.1740	0.2080	0.2540	0.3060	0.3890
70	0.1500	0.1810	0.2120	0.2430	0.2910	0.3500
75 & over	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000

Medicare Eligibility

Absent contrary data, all individuals are assumed to be eligible for Medicare Parts A and B at age 65.

Supporting Information
(Continued)

Section 3 - Actuarial Methods and Assumptions

Healthcare Trend

Medical plan premiums and claims costs by age are assumed to increase once each year. The increases over the prior year's levels are assumed to be effective on the dates shown below:

Effective*	Premium Increase	Effective*	Premium Increase
2021	5.40%	2067	4.70%
2022	5.30%	2068	4.60%
2023-26	5.20%	2069	4.50%
2027-46	5.30%	2070-71	4.40%
2047	5.20%	2072	4.30%
2048-49	5.10%	2073-74	4.20%
2050-53	5.00%	2075	4.10%
2054-59	4.90%	2076	4.00%
2060-66	4.80%	& later	4.00%

* REMIF EPO premiums change effective July 1 of each year; AmWINS premiums change effective January 1 of each year

The healthcare trend shown above was developed using the Getzen Model 2019_b published by the Society of Actuaries using the following settings: CPI 2.5%; Real GDP Growth 1.5%; Excess Medical Growth 1.2%; Expected Health Share of GDP in 2028 20.5%; Resistance Point 25%; Year after which medical growth is limited to growth in GDP 2075.

Dental costs are assumed to increase by 5.25% per year. Vision costs are assumed to increase by 3.25% per year.

Participation Rate

Active employees: 100% are assumed to continue their current plan election in retirement.

Retired participants: Existing medical plan elections are assumed to be continued until the retiree's death.

Spouse Coverage

Active employees: 100% are assumed to be married and elect coverage for their spouse in retirement. Husbands are assumed to be 3 years older than their wives.

Retired participants: Existing elections for spouse coverage are assumed to be maintained until the spouse's death. Actual spouse ages are used. Spouse gender is assumed to be the opposite of the employee.

Dependent Coverage

Active employees and retired participants covering dependent children are assumed to end such coverage when the youngest currently covered dependent reaches age 26.

Supporting Information
(Concluded)

Section 3 - Actuarial Methods and Assumptions

Development of Age-related Medical Premiums

Actual premium rates for retirees and their spouses were adjusted to an age-related basis by applying medical claim cost factors developed from the data presented in the report, "Health Care Costs – From Birth to Death", sponsored by the Society of Actuaries. A description of the use of claims cost curves can be found in MacLeod Watts's Age Rating Methodology provided in Addendum 2 to this report.

Plan	Retiree Age	Males	Females
REMIF EPO	55	$ 928	$ 1,017
	58	1,068	1,094
	61	1,216	1,198
	64	1,382	1,333
AmWINS Medicare Supplement	67	493	476
	70	526	509
	73	556	537
	76	578	557
	79	595	572
	82	601	580
	85	591	581
	88	573	574
	91	562	566
	94	560	561
	97	559	557
	100	559	554

Changes recognized during the current measurement period:

Mortality Improvement — The mortality improvement scale was updated from MacLeod Watts Scale 2018 to MacLeod Watts Scale 2020 (see Addendum 3), reflecting continued updates in available information.

Salary Scale — Decreased from 3.25% per year to 3.0% per year

General Inflation Rate — Decreased from 2.75% to 2.5% per year

Medical Trend — Updated to use the Getzen healthcare trend model sponsored by the Society of Actuaries

Excise Tax Repeal — As noted in Section 2B, we excluded the excise tax from the valuation results due to the December 2019 repeal.

Addendum 1: Important Background Information

General Types of Other Post-Employment Benefits (OPEB)

Post-employment benefits other than pensions (OPEB) comprise a part of compensation that employers offer for services received. The most common OPEB are medical, prescription drug, dental, vision, and/or life insurance coverage. Other OPEB may include outside group legal, long-term care, or disability benefits outside of a pension plan. OPEB does not generally include COBRA, vacation, sick leave (unless converted to defined benefit OPEB), or other direct retiree payments.

A direct employer payment toward the cost of OPEB benefits is referred to as an "explicit subsidy". In addition, if claims experience of employees and retirees are pooled when determining premiums, retiree premiums are based on a pool of members which, on average, are younger and healthier. For certain types of coverage such as medical insurance, this results in an "implicit subsidy" of retiree premiums by active employee premiums since the retiree premiums are lower than they would have been if retirees were insured separately. GASB 75 and Actuarial Standards of Practice generally require that an implicit subsidy of retiree premium rates be valued as an OPEB liability.

<table>
<tr><td colspan="3">Expected retiree claims</td></tr>
<tr><td colspan="2">Premium charged for retiree coverage</td><td>Covered by higher active premiums</td></tr>
<tr><td>Retiree portion of premium</td><td>Agency portion of premium
Explicit subsidy</td><td>Implicit subsidy</td></tr>
</table>

This chart shows the sources of funds needed to cover expected medical claims for pre-Medicare retirees. The portion of the premium paid by the Agency does not impact the amount of the implicit subsidy.

Valuation Process

The valuation was based on employee census data and benefits provided by REMIF. A summary of the employee data is provided in Section 1 and a summary of the benefits provided under the Plan is provided in Section 2. While individual employee records have been reviewed to verify that they are reasonable in various respects, the data has not been audited and we have otherwise relied on REMIF as to its accuracy. The valuation was also based on the actuarial methods and assumptions described in Section 3.

In developing the projected benefit values and liabilities, we first determine an expected premium or benefit stream over the employee's future retirement. Benefits may include both direct employer payments (explicit subsidies) and/or an implicit subsidy, arising when retiree premiums are expected to be subsidized by active employee premiums. The projected benefit streams reflect assumed trends in the cost of those benefits and assumptions as to the expected date(s) when benefits will end. We then apply assumptions regarding:

- The probability that each individual employee will or will not continue in service to receive benefits.
- The probability of when such retirement will occur for each retiree, based on current age, service and employee type; and
- The likelihood that future retirees will or will not elect retiree coverage (and benefits) for themselves and/or their dependents.

Important Background Information
(Continued)

We then calculate a present value of these benefits by discounting the value of each future expected benefit payment, multiplied by the assumed expectation that it will be paid, back to the valuation date using the discount rate. These benefit projections and liabilities have a very long time horizon. The final payments for currently active employees may not be made for many decades.

The resulting present value for each employee is allocated as a level percent of payroll each year over the employee's career using the entry age normal cost method and the amounts for each individual are then summed to get the results for the entire plan. This creates a cost expected to increase each year as payroll increases. Amounts attributed to prior fiscal years form the "Total OPEB Liability". The OPEB cost allocated for active employees in the current year is referred to as "Service Cost".

Where contributions have been made to an irrevocable OPEB trust, the accumulated value of trust assets ("Fiduciary Net Position") is applied to offset the "Total OPEB Liability", resulting in the "Net OPEB Liability". If a plan is not being funded, then the Net OPEB Liability is equal to the Total OPEB Liability.

It is important to remember that an actuarial valuation is, by its nature, a projection of one possible future outcome based on many assumptions. To the extent that actual experience is not what we assumed, future results will differ. Some possible sources of future differences may include:

- A significant change in the number of covered or eligible plan members
- A significant increase or decrease in the future premium rates
- A change in the subsidy provided by the Agency toward retiree premiums
- Longer life expectancies of retirees
- Significant changes in expected retiree healthcare claims by age, relative to healthcare claims for active employees and their dependents
- Higher or lower returns on plan assets or contribution levels other than were assumed, and/or
- Changes in the discount rate used to value the OPEB liability

Important Background Information
(Continued)

Requirements of GASB 75

The Governmental Accounting Standards Board (GASB) issued GASB Statement No. 75, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*. This Statement establishes standards for the measurement, recognition, and disclosure of OPEB expense and related liabilities (assets), note disclosures, and, required supplementary information (RSI) in the financial reports of state and local governmental employers.

Important Dates

GASB 75 requires that the information used for financial reporting falls within prescribed timeframes. Actuarial valuations of the total OPEB liability are generally required at least every two years. If a valuation is not performed as of the Measurement Date, then liabilities are required to be based on roll forward procedures from a prior valuation performed no more than 30 months and 1 day prior to the most recent year-end. In addition, the net OPEB liability is required to be measured as of a date no earlier than the end of the prior fiscal year (the "Measurement Date").

Recognition of Plan Changes and Gains and Losses

Under GASB 75, gains and losses related to changes in Total OPEB Liability and Fiduciary Net Position are recognized in OPEB expense systematically over time.

- *Timing of recognition*: Changes in the Total OPEB Liability relating to changes in plan benefits are recognized immediately (fully expensed) in the year in which the change occurs. Gains and Losses are amortized, with the applicable period based on the type of gain or loss. The first amortized amounts are recognized in OPEB expense for the year the gain or loss occurs. The remaining amounts are categorized as deferred outflows and deferred inflows of resources related to OPEB and are to be recognized in future OPEB expense.
- *Deferred recognition periods:* These periods differ depending on the source of the gain or loss.

Difference between projected and actual trust earnings:	5 year straight-line recognition
All other amounts:	Straight-line recognition over the expected average remaining service lifetime (EARSL) of all members that are provided with benefits, determined as of the beginning of the Measurement Period. In determining the EARSL, all active, retired and inactive (vested) members are counted, with the latter two groups having 0 remaining service years.

Important Background Information
(Continued)

Implicit Subsidy Plan Contributions

An implicit subsidy occurs when expected retiree claims exceed the premiums charged for retiree coverage. When this occurs, we expect part of the premiums paid for active employees to cover a portion of retiree claims. This transfer represents the current year's "implicit subsidy". Because GASB 75 treats payments to an irrevocable trust *or directly to the insurer* as employer contributions, each year's implicit subsidy is treated as a contribution toward the payment of retiree benefits.

The following hypothetical example illustrates this treatment:

Hypothetical Illustration of Implicit Subsidy Recognition	For Active Employees	For Retired Employees
Prior to Implicit Subsidy Adjustment		
Premiums Paid by Agency During Fiscal Year	$ 411,000	$ 48,000
Accounting Treatment	Compensation Cost for Active Employees	Contribution to Plan & Benefits Paid from Plan
After Implicit Subsidy Adjustment		
Premiums Paid by Agency During Fiscal Year	$ 411,000	$ 48,000
Implicit Subsidy Adjustment	(23,000)	23,000
Accounting Cost of Premiums Paid	$ 388,000	$ 71,000
Accounting Treatment Impact	Reduces Compensation Cost for Active Employees	Increases Contributions to Plan & Benefits Paid from Plan

The example above shows that total payments toward active and retired employee healthcare premiums is the same, but for accounting purposes part of the total is shifted from actives to retirees. This shifted amount is recognized as an OPEB contribution and reduces the current year's premium expense for active employees.

Important Background Information
(Continued)

Discount Rate

When the financing of OPEB liabilities is on a pay-as-you-go basis, GASB 75 requires that the discount rate used for valuing liabilities be based on the yield or index rate for 20-year, tax-exempt general obligation municipal bonds with an average rating of AA/Aa or higher (or equivalent quality on another rating scale). When a plan sponsor makes regular, sufficient contributions to a trust in order to prefund the OPEB liabilities, GASB 75 allows use of a rate up to the expected rate of return of the trust. Therefore, prefunding has an advantage of potentially being able to report overall lower liabilities due to future expected benefits being discounted at a higher rate.

Actuarial Funding Method and Assumptions

The "ultimate real cost" of an employee benefit plan is the value of all benefits and other expenses of the plan over its lifetime. These expenditures are dependent only on the terms of the plan and the administrative arrangements adopted, and as such are not affected by the actuarial funding method.

The actuarial funding method attempts to spread recognition of these expected costs on a level basis over the life of the plan, and as such sets the "incidence of cost". GASB 75 specifically requires that the actuarial present value of projected benefit payments be attributed to periods of employee service using the Entry Age Actuarial Cost Method, with each period's service cost determined as a level percentage of pay.

The results of this report may not be appropriate for other purposes, where other assumptions, methodology and/or actuarial standards of practice may be required or more suitable.

Addendum 2: MacLeod Watts Age Rating Methodology

Both accounting standards (e.g. GASB 75) and actuarial standards (e.g. ASOP 6) require that expected retiree claims, not just premiums paid, be reflected in most situations where an actuary is calculating retiree healthcare liabilities. Unfortunately, the actuary is often required to perform these calculations without any underlying claims information. In most situations, the information is not available, but even when available, the information may not be credible due to the size of the group being considered.

Actuaries have developed methodologies to approximate healthcare claims from the premiums being paid by the plan sponsor. Any methodology requires adopting certain assumptions and using general studies of healthcare costs as substitutes when there is a lack of credible claims information for the specific plan being reviewed.

Premiums paid by sponsors are often uniform for all employee and retiree ages and genders, with a drop in premiums for those participants who are Medicare-eligible. While the total premiums are expected to pay for the total claims for the insured group, on average, the premiums charged would not be sufficient to pay for the claims of older insureds and would be expected to exceed the expected claims of younger insureds. An age-rating methodology takes the typically uniform premiums paid by plan sponsors and spreads the total premium dollars to each age and gender intended to better approximate what the insurer might be expecting in actual claims costs at each age and gender.

The process of translating premiums into expected claims by age and gender generally follows the steps below.

1. *Obtain or Develop Relative Medical Claims Costs by Age, Gender, or other categories that are deemed significant*. For example, a claims cost curve might show that, if a 50 year old male has $1 in claims, then on average a 50 year old female has claims of $1.25, a 30 year male has claims of $0.40, and an 8 year old female has claims of $0.20. The claims cost curve provides such relative costs for each age, gender, or any other significant factor the curve might have been developed to reflect. Section 3 provides the source of information used to develop such a curve and shows sample relative claims costs developed for the plan under consideration.
2. *Obtain a census of participants, their chosen medical coverage, and the premium charged for their coverage.* An attempt is made to find the group of participants that the insurer considered in setting the premiums they charge for coverage. That group includes the participant and any covered spouses and children. When information about dependents is unavailable, assumptions must be made about spouse age and the number and age of children represented in the population. These assumptions are provided in Section 3.
3. *Spread the total premium paid by the group to each covered participant or dependent based on expected claims.* The medical claims cost curve is used to spread the total premium dollars paid by the group to each participant reflecting their age, gender, or other relevant category. After this step, the actuary has a schedule of expected claims costs for each age and gender for the current premium year. It is these claims costs that are projected into the future by medical cost inflation assumptions when valuing expected future retiree claims.

The methodology described above is dependent on the data and methodologies used in whatever study might be used to develop claims cost curves for any given plan sponsor. These methodologies and assumptions can be found in the referenced paper cited as a source in the valuation report.

Addendum 3: MacLeod Watts Mortality Projection Methodology

Actuarial standards of practice (e.g., ASOP 35, Selection of Demographic and Other Noneconomic Assumptions for Measuring Pension Obligations, and ASOP 6, Measuring Retiree Group Benefits Obligations) indicate that the actuary should reflect the effect of mortality improvement (i.e., longer life expectancies in the future), both before and after the measurement date. The development of credible mortality improvement rates requires the analysis of large quantities of data over long periods of time. Because it would be extremely difficult for an individual actuary or firm to acquire and process such extensive amounts of data, actuaries typically rely on large studies published periodically by organizations such as the Society of Actuaries or Social Security Administration.

As noted in a recent actuarial study on mortality improvement, key principles in developing a credible mortality improvement model would include the following:

(1) Short-term mortality improvement rates should be based on recent experience.
(2) Long-term mortality improvement rates should be based on expert opinion.
(3) Short-term mortality improvement rates should blend smoothly into the assumed long-term rates over an appropriate transition period.

The **MacLeod Watts Scale 2020** was developed from a blending of data and methodologies found in two published sources: (1) the Society of Actuaries Mortality Improvement Scale MP-2019 Report, published in October 2019 and (2) the demographic assumptions used in the 2019 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, published April 2019.

MacLeod Watts Scale 2020 is a two-dimensional mortality improvement scale reflecting both age and year of mortality improvement. The underlying base scale is Scale MP-2019 which has two segments – (1) historical improvement rates for the period 1951-2015 and (2) an estimate of future mortality improvement for years 2016-2018 using the Scale MP-2019 methodology but utilizing the assumptions obtained from Scale MP-2015. The MacLeod Watts scale then transitions from the 2018 improvement rate to the Social Security Administration (SSA) Intermediate Scale linearly over the 10-year period 2019-2028. After this transition period, the MacLeod Watts Scale uses the constant mortality improvement rate from the SSA Intermediate Scale from 2028-2042. The SSA's Intermediate Scale has a final step down in 2043 which is reflected in the MacLeod Watts scale for years 2043 and thereafter. Over the ages 95 to 115, the SSA improvement rate is graded to zero.

Scale MP-2019 can be found at the SOA website and the projection scales used in the 2019 Social Security Administrations Trustees Report at the Social Security Administration website.

Glossary

Actuarial Funding Method – A procedure which calculates the actuarial present value of plan benefits and expenses, and allocates these expenses to time periods, typically as a normal cost and an actuarial accrued liability

Actuarial Present Value of Projected Benefits (APVPB) – The amount presently required to fund all projected plan benefits in the future. This value is determined by discounting the future payments by an appropriate interest rate and the probability of nonpayment.

CalPERS – Many state governments maintain a public employee retirement system; CalPERS is the California program, covering all eligible state government employees as well as other employees of other governments within California who have elected to join the system

Defined Benefit (DB) – A pension or OPEB plan which defines the monthly income or other benefit which the plan member receives at or after separation from employment

Deferred Contributions – When an employer makes contributions after the measurement date and prior to the fiscal year end, recognition of these contributions is deferred to a subsequent accounting period by creating a deferred resource. We refer to these contributions as Deferred Contributions.

Defined Contribution (DC) – A pension or OPEB plan which establishes an individual account for each member and specifies how contributions to each active member's account are determined and the terms of distribution of the account after separation from employment

Discount Rate - Interest rate used to discount future potential benefit payments to the valuation date. Under GASB 75, if a plan is prefunded, then the discount rate is equal to the expected trust return. If a plan is not prefunded (pay-as-you-go), then the rate of return is based on a yield or index rate for 20-year, tax-exempt general obligation municipal bonds with an average rating of AA/Aa or higher.

Expected Average Remaining Service Lifetime (EARSL) – Average of the expected remaining service lives of all employees that are provided with benefits through the OPEB plan (active employees and inactive employees), beginning in the current period

Entry Age Actuarial Cost Method – An actuarial funding method where, for each individual, the actuarial present value of benefits is levelly spread over the individual's projected earnings or service from entry age to the last age at which benefits can be paid

Excise Tax – The Affordable Care Act created an excise tax on the value of employer sponsored coverage which exceeds certain thresholds ("Cadillac Plans"). This tax was repealed in December 2019.

Explicit Subsidy – The projected dollar value of future retiree healthcare costs expected to be paid directly by the Employer, e.g., the Employer's payment of all or a portion of the monthly retiree premium billed by the insurer for the retiree's coverage

Fiduciary Net Position –The value of trust assets used to offset the Total OPEB Liability to determine the Net OPEB Liability.

Government Accounting Standards Board (GASB) – A private, not-for-profit organization which develops generally accepted accounting principles (GAAP) for U.S. state and local governments; like FASB, it is part of the Financial Accounting Foundation (FAF), which funds each organization and selects the members of each board

Glossary
(Continued)

Health Care Trend – The assumed rate(s) of increase in future dollar values of premiums or healthcare claims, attributable to increases in the cost of healthcare; contributing factors include medical inflation, frequency or extent of utilization of services and technological developments.

Implicit Subsidy – The projected difference between future retiree claims and the premiums to be charged for retiree coverage; this difference results when the claims experience of active and retired employees are pooled together and a 'blended' group premium rate is charged for both actives and retirees; a portion of the active employee premiums subsidizes the retiree premiums.

Net OPEB Liability (NOL) – The liability to employees for benefits provided through a defined benefit OPEB. Only assets administered through a trust that meet certain criteria may be used to reduce the Total OPEB Liability.

Net Position – The Impact on Statement of Net Position is the Net OPEB Liability adjusted for deferred resource items

OPEB Expense – The OPEB expense reported in the Agency's financial statement. OPEB expense is the annual cost of the plan recognized in the financial statements.

Other Post-Employment Benefits (OPEB) – Post-employment benefits other than pension benefits, most commonly healthcare benefits but also including life insurance if provided separately from a pension plan

Pay-As-You-Go (PAYGO) – Contributions to the plan are made at about the same time and in about the same amount as benefit payments and expenses coming due

PEMHCA – The Public Employees' Medical and Hospital Care Act, established by the California legislature in 1961, provides community-rated medical benefits to participating public employers. Among its extensive regulations are the requirements that a contracting Agency contribute toward medical insurance premiums for retired annuitants and that a contracting Agency file a resolution, adopted by its governing body, with the CalPERS Board establishing any new contribution.

Plan Assets – The value of cash and investments considered as 'belonging' to the plan and permitted to be used to offset the AAL for valuation purposes. To be considered a plan asset, GASB 75 requires (a) contributions to the OPEB plan be irrevocable, (b) OPEB assets to dedicated to providing OPEB benefit to plan members in accordance with the benefit terms of the plan, and (c) plan assets be legally protected from creditors, the OPEB plan administrator and the plan members.

Public Agency Miscellaneous (PAM) – Non-safety public employees.

Select and Ultimate – Actuarial assumptions which contemplate rates which differ by year initially (the select period) and then stabilize at a constant long-term rate (the ultimate rate)

Service Cost – Total dollar value of benefits expected to be earned by plan members in the current year, as assigned by the actuarial funding method; also called normal cost

Total OPEB Liability (TOL) – Total dollars required to fund all plan benefits attributable to service rendered as of the valuation date for current plan members and vested prior plan members; a subset of "Actuarial Present Value"

Vesting – As defined by the plan, requirements which when met make a plan benefit nonforfeitable on separation of service before retirement eligibility

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ITEM 10.0

AGENDA ITEM SUMMARY

TITLE: PARSAC/REMIF STRATEGIC PARTNERSHIP: DISCUSSION AND DIRECTION TO STAFF AND POSSIBLE ACTION ON TRANSITION COMMITTEE RECOMMENDATIONS

PRESENTED BY: AMY NORTHAM, GENERAL MANAGER

ISSUE

Exploring a partnership with another JPA/Pool requires ratification by the Board of Directors. The REMIF Board of Directors directed staff and the REMIF Executive Committee to explore a strategic partnership with PARSAC.

BACKGROUND

As the Board of Directors is aware, the Redwood Empire Municipal Insurance Fund (REMIF), representing 15 small to medium sized cities/towns, is a self-insured joint powers authority. It was formed in 1976 with a mission to provide workers' compensation coverage and to handle the insurance claims, benefit programs, and risk management needs of the members. Coverage was expanded in the mid-1980s to include liability coverage and other lines.

The Public Agency Risk Sharing Authority of California (PARSAC), representing 35 small to medium sized cities/towns, is also a self-insured joint powers authority. It was formed in 1986 with a mission to provide liability coverage in response to the insurance crisis that eliminated commercial coverage for cities.

Like REMIF, PARSAC provides a self-funded liability program for general liability, public officials' errors and omissions, auto liability and employment practices liability coverage. They have additional coverage programs including self-funded workers' compensation, group purchase property, special events, fidelity bonds, cyber liability and ancillary benefits.

PARSAC focuses on managing and maintaining a financially stable risk sharing pool and has a conservative funding and investment philosophy, which has given them programs that are funded in excess of the 90% confidence level. The PARSAC Board's philosophy is to embrace diverse opinions, have discussions that are constructive and collaborative, encourage participation from the members, balance member interests with those of the pool and work together towards a greater good.

REMIF and PARSAC share a similar culture in that both pools are member owned, member governed, member driven and exist to serve the members. Both pools also serve small to medium sized cities/towns, and share similar footprints in that they have Clearlake, we have Lakeport; they have Calistoga and Yountville, we have St. Helena; they have Ferndale, Trinidad, and Blue Lake; we have Eureka, Arcata and Fortuna.

PARSAC's president, John Gillison, says of PARSAC: "PARSAC is unique in my experience because of the shared governance structure and our collective values which place good governance and sound fiscal policy first, above individual self-interests. We work well together because we share risk in a partnership, not merely a business relationship. As member agencies, we can exchange knowledge, learn from one another, work together in unique ways that span the distances between our agencies and tailor the services the pool provides to the greatest common good while preserving our unique individuality."

When I met with the REMIF member agencies, a few members expressed an interest to "grow" REMIF out of a need to add more stability to the programs, as well as to spread both the risk and the costs amongst more members. Of course, that growth would need to be strategic, with careful consideration and intentional actions.

At the REMIF Board of Directors meeting in April of 2019, the Board directed staff to explore a strategic partnership with PARSAC. Per the Board's direction, REMIF initially entered into an exploratory partnership agreement with PARSAC with the concept of exploring the feasibility and practicability of a strategic partnership, as well as to explore the benefits in sharing resources, sharing expenses and drawing on strengths. While exploring this partnership, consideration was given to everything from succession planning, more robust, stable programs, to long term program sustainability to redundancies. It was ultimately decided that REMIF and PARSAC would merge together, but the REMIF health plan would remain a separate entity.

At the September of 2019 meeting, the Board directed the Executive Committee (and staff) to further explore the merger, including direction to explore options for an alternative experience modifier for the workers' compensation program. The merger will result in the creation of a new organization, called CIRA or the California Intergovernmental Risk Authority.

In response, both PARSAC and REMIF created a joint "Transition Committee," which contains REMIF's Executive Committee and representatives from PARSAC's Board of Directors, Executive Committee and other Committees. The Transition Committee meets monthly to discuss various aspects of the merger and provides recommendations to the Board of Directors.

I. TRANSITION COMMITTEE

A. October 19, 2020 Transition Committee meeting

At the October 19, 2020 Transition Committee meeting, the committee members reviewed:

1. Presentation by ERMA

ERMA reduces employment practices risk by proactive claims management, innovative training and education and subject matter expertise. They are the first and only state-wide public section employment practices liability risk sharing pool. They have over 200 public entity members and are CAJPA accredited. They are financially stable and well-funded.

Some of the advantages of joining ERMA are:
Share cost of risk among similar entities, pool determines scope of coverage, develop governing documents, develop risk control programs, target performance standards, proactive litigation management.

They offer:
Live Training Workshops (Individual and Regional), Online Training, ERMANet, Hot Topic Trainings, Jackson Lewis and Liebert Cassidy Whitmore, Employee Reporting Line (24/7 access via telephone or online), Attorney Hotline (one hour per month).

The Committee recommends the REMIF Board of Directors participate in ERMA under CIRA and direct staff to take all necessary steps for this to occur. This will require the REMIF members to adopt a resolution to participate in ERMA.

2. Options for Excess Liability Coverage
While cost is one consideration to the excess liability provider, it is not the only consideration. Governance, financial stability, coverage, membership are other considerations, just to name a few.

The committee has been examining three options for excess liability: CJPRMA (REMIF's current partner), PRISM (formerly known as CSAC EIA and PARSAC's current partner), and CARMA.

At this point, the committee has not selected an excess liability partner.

3. Options for the Property Program

The committee has been examining three options for the property program: the Alliant program (called APIP or PEPIP) through the CJPRMA program, the Alliant program (called APIP or PEPIP) as a stand alone offering or a program through PRISM (formerly known as CSAC EIA).

At this point, the committee has not selected a property program.

4. Options for the Excess Workers' Compensation Coverage

The committee has been examining three options for the excess workers' compensation: a fully insured program (through Safety National, REMIF's current partner), PRISM (formerly known as CSAC EIA), and LAWCX.

At the point, the committee has not selected an excess workers' compensation partner.

5. Retiree Health Benefits for New CIRA Employees

There was interest from the Committee to eliminate retiree health benefits for new CIRA employees hired after 07/01/21. All current employees will retain this coverage.

6. Draft Resolution Establishing Name Change from PARSAC to CIRA and Selection of CIRA logo

As previously presented, for purposes of CalPERS, PARSAC will change it's name from PARSAC to CIRA. The committee reviewed, and approved, a resolution for the name change.

In addition, options for the CIRA logo were approved, and the Committee recommended the following logo:

CIRA

CALIFORNIA INTERGOVERNMENTAL RISK AUTHORITY

7. CIRA Risk Control Plan

The CIRA Risk Control Plan builds upon the existing programs of both PARSAC and REMIF with a primary objective of providing direct services to members that reduce liability and improve safety for employees and the public. The Plan focuses on improving program resources and delivery in the following areas:
• Onsite Member Support
• Training and Education
• Technology and Operational Efficiency
In addition to the above targeted programs, the Finance Committee will also consider the development of a Safety Grant Fund program that will provide limited annual funding for members CIRA Transition Committee Meeting to support risk reduction efforts specific to their agencies. Based on PARSAC's current program, estimated budget would provide $2,500 per agency based on liability and workers' compensation program participation.

8. Timelines

The timelines set out by staff were reviewed.

B. November 4, 2020, Transition Finance Committee meeting

As a reminder, the members of the Transition Finance Committee are:

REMIF:

Aaron Felmlee, Finance Director, City of Fortuna
Nicholas Walker, Director of Finance, City of Lakeport
Daniel Buffalo, Finance Director, City of Ukiah

PARSAC:

Chuck Dantuono, Director of Administrative Services/City Treasurer, City of Highland
Amber Johnson, Administrative Services Manager, City of Belvedere
Dave Warren, Assistant City Manager/Director of Finance, City of Placerville
Noah Daniels, Finance Manager, City of Rancho Cucamonga

At the November 4, 2020, Transition Finance Committee meeting, the committee members reviewed:

1. Preliminary Operating Budget (first draft)

The Transition Finance Committee reviewed and discussed the first DRAFT of the CIRA budget prepared by staff. The Transition Committee provided input and feedback into various pieces of the budget.

2. Funding Recommendations

Funding options were discussed for the workers' compensation program. The funding options discussed are similar to REMIF's current funding methodology (funding at 75% confidence level).

3. Cost allocation Formulas

There are two primary cost allocation formulas that are used in determining member contributions. The first allocation is for allocating the budget to the programs (workers' comp, liability, etc) and the second allocation is for allocating the contributions to the members.

The intent of this item was to discuss the second allocation (allocating contributions to the members). PARSAC and REMIF use similar allocations for workers' compensation, but there are some differences in the allocation for general liability. The differences were discussed in detail, as was a blending of the programs.

4. Member Deductible Discussions

The options for the members' deductibles were discussed. Staff recommended that we proceed to CIRA with member deductibles in place.

5. Retrospective Rating Formulas

The formula used by both REMIF and PARSAC are similar in calculating the Retrospective Rating Formula. It is recommended that CIRA follow a similar formula.

C. November 23, 2020, Transition Committee meeting

At the November 23, 2020 Transition Committee meeting, the committee members reviewed:

1. Liability Memorandum of Coverage

REMIF's General Counsel, Doug Alliston, drafted a Memorandum of Coverage for the Liability Program. The MOC was reviewed in detail by the Committee members, and the Committee provided input and feedback. Staff and Mr. Alliston would report back to the Committee with recommended changes.

2. Workers' Compensation Master Program Documents

Staff drafted a document to outline the policies and procedures for the workers' compensation program. This document has been named the "Master Program Documents." It addresses funding, contributions, self-insured retentions/deductibles, experience modification, excess coverage, administration, claims administration, settlement authority, the defense panel and participation.

The Transition Committee recommends the REMIF Board of Directors adopt the Workers' Compensation Master Program Documents.

3. Meeting locations and timeframes for Executive Committee and Board of Directors

The Transition Committee reviewed and discussed options for meeting locations and timeframes during the year in which to meet, and **the Committee is recommending the REMIF Board of Directors adopt the following schedule:**

Board of Directors meetings dates/locations:

January/Sacramento
May/Sacramento

Executive Committee meetings dates/locations:

August/Member location
January/Sacramento
March/Member location
May/Sacramento

4. Retiree Health Benefits for CIRA employees

As discussed above, there was interest from the Committee to eliminate retiree health benefits for new CIRA employees hired after 07/01/21. All current employees will retain this coverage.

5. Update on the Finance Transition Committee Meeting

The Committee was updated on discussions held at the Finance Transition Committee Meeting.

6. Update on Excess Liability and Workers' Compensation Excess Coverage

As discussed above, the Committee heard updates on options for the excess liability and workers' compensation coverage.

7. Timelines

The timelines set out by staff were reviewed.

D. December 14, 2020, Transition Committee meeting

At the December 14, 2020, Transition Committee meeting, the committee members reviewed:

1. Liability Memorandum of Coverage
As discussed above, REMIF's General Counsel, Doug Alliston, drafted a Memorandum of Coverage for the Liability Program. The MOC was reviewed in detail by the Committee members, and the Committee provided input and feedback. Staff and Mr. Alliston reported back to the Committee with recommended changes. After a general liability excess partner is selected, staff will work with Mr. Alliston on additional changes that may need to be incorporated in the MOC.

2. Update on the Property Program

As discussed above, the Committee heard updates on options for the property coverage.

3. General Liability Master Program Documents
Staff drafted a document to outline the policies and procedures for the liability program. This document has been named the "Master Program Documents." It addresses funding, contributions, self-insured retentions/deductibles, experience modification, excess coverage, administration, claims administration, settlement authority, the defense panel and participation.
The master program document was discussed in detail and staff will bring back this document for further review by the Committee.

4. Program Cost Allocation Formula

There are two primary cost allocation formulas that are used in determining member contributions. The first allocation is for allocating the budget to the programs (workers' comp, liability, etc) and the second allocation is for allocating the contributions to the members.

The intent of this item was to discuss the first allocation (allocating the budget to the programs).
As part of the budgeting process, individual program budgets are prepared to facilitate preparation of contributions by program. As part of this process indirect costs are allocated to each program based on a prescribed allocation. Both PARSAC and REMIF currently allocate costs to each program but use different methodologies. Staff has reviewed the methods used by PARSAC and REMIF and have formulated a combined method for CIRA. The method proposed by staff is to allocate the indirect costs as follows:
Liability Program: 49%
Workers' Compensation Program: 44%
Property Program: 7%

The costs were allocated based on expected staff time for the property program with remaining expenses allocated between the liability program and workers' compensation program based on the 2020/21 budgeted contributions.

In addition to the allocation between programs, CIRA will bill by contract a portion of administrative and overhead costs to the REMIF health plan. It is anticipated that those indirect costs will total about 16% of indirect costs or approximately $255,000. The net indirect costs after billing the REMIF health plan will be allocated by the above percentages.

The Committee recommends the REMIF Board of Directors adopt the Program Cost Allocation Formula as outline above.

5. Update on Health Insurance Plan for CIRA employees
Options for health insurance for the CIRA employees were discussed.

6. Update on Excess Liability and Workers' Compensation

As discussed above, the Committee heard updates on options for the excess liability and workers' compensation coverage.

7. Update on Member Adoption of CIRA JPA and Bylaws

The Committee heard an update as to the adoption of the CIRA JPA and bylaws by the REMIF and PARSAC members.

8. Timelines

The timelines set out by staff were reviewed.

E. January 11, 2020, Transition Committee meeting

At the January 11, 2020, Transition Committee meeting, the committee members reviewed:

1. Employment Practices Liability (EPL) Program Experience Modification Options
The Committee heard a presentation by actuary Mike Harrington on various options for incorporating an experience modification to the self-insured layer of the EPL program.

The Committee recommends the REMIF Board of Directors adopt an Experience Modification for the EPL program, specifically a Frequency Adjustment Option using a normalized frequency figure (i.e., number of claims per every $100 of payroll) as follows:

- **0.00 claims per $100K of payrolls: -5.6% discount**
- **Over 0.00 to 0.75 claims per $100K of payrolls: +4.3% surcharge**
- **Over 0.75 claims per $100K of payrolls: +9.3% surcharge**

2. Experience Modification Factor Formula for the Property Program
The Committee heard a presentation by Tracey Smith-Reed on using an experience modification for the property program. She proposed an experience modification for the property program as follows:

Member loss ratio is calculated using 5 years of member premiums compared to 5 years of member losses capped at $100,000. Members with a loss ratio over 75% will have adjustments made to the contributions, in an amount not to exceed 120% of base premium based on insured values.

The adjustments applied to the base premium will be as follows:
a. 75% - 100% loss ratio = 5% adjustment
b. 100% - 150% loss ratio = 5% adjustment
c. 150% - 200% loss ratio = 5% adjustment
d. 200% - 250% loss ratio = 5% adjustment

The Committee recommends the REMIF Board of Directors adopt an Experience Modification for the property program as outlined above.

3. Health Benefits for CIRA Employees
Staff was directed to explore options outside of CalPERS for employee health benefits. Staff explored obtaining employee health benefits through SDRMA. As part of the process to withdraw PARSAC employees from the CalPERS Health Program, a resolution will need to be submitted to CalPERS to terminate coverage effective the new plan year beginning January 1, 2022. Health coverage for CIRA employees for the period July 1, 2021 – December 31, 2021, will need to continue through their current provider.

Health benefits coverage would begin through SDRMA for all employees of CIRA effective January 1, 2022. SDRMA's resolution and memorandum of understanding will need to be approved for membership in their program.

The Committee recommends the REMIF Board of Directors approve a resolution for PARSAC to withdraw from the CalPERS health program and to direct staff to take steps necessary to secure coverage through SDRMA.

4. Contract for Administration of REMIF Health
Staff drafted a contract for CIRA to administer the REMIF Health program, under REMIF. The contract allows for full administration of the program by CIRA staff, at a cost to be determined by the CIRA budget (but not to exceed $300,000).

The Committee recommends the REMIF Board of Directors approve the draft contract for CIRA to administer the REMIF Health program.

II. CIRA EXECUTIVE COMMITTEE

As the Board may recall, the initial election of the CIRA Executive Committee will permit each respective pool forming CIRA to nominate candidates. REMIF will nominate at least five candidates and PARSAC will nominate eight candidates to serve on the CIRA Executive Committee. The CIRA Executive Committee will be comprised of 13 members:

1 President
1 Vice President
1 Treasurer
1 Auditor/Controller
3 Representatives of members by location (north/central/south)
3 Representatives of members by size (small/medium/large)
3 Representatives of members at large

To help ensure continuity during the first few election cycles of the CIRA Executive Committee, it was recommended that we stagger terms.

REMIF will need to elect the five candidates it would like to nominate for the CIRA Executive Committee.

III. DEPARTMENT OF INDUSTRIAL RELATIONS

Because of the merger, REMIF will need to re-apply to permissibly self-insure under the Department of Industrial Relations. To do so, the REMIF members will need to adopt a resolution with the application.

Staff recommends the Board of Directors direct staff to work with the members in the application and adoption of the resolution.

FISCAL IMPACT

Unknown

RECOMMENDED ACTION

The Transition Committee, which includes the REMIF Executive Committee, recommends the REMIF Board of Directors adopt the actions as outlined below.

The Committee recommends the REMIF Board of Directors:

1. Participate in ERMA under CIRA and direct staff to take all necessary steps for this to occur. This will require the REMIF members to adopt a resolution to participate in ERMA.

2. Adopt the CIRA logo as shown above.

3. Adopt the Workers' Compensation Master Program Documents.

4. Adopt the following meeting schedule:

CIRA Board of Directors meetings dates/locations:

January/Sacramento
May/Sacramento

CIRA Executive Committee meetings dates/locations:

August/Member location
January/Sacramento
March/Member location
May/Sacramento

5. Adopt the Program Cost Allocation Formula as outline above.

6. Elect the five candidates it would like to nominate for the CIRA Executive Committee.

7. Direct staff to work with the members in the application and adoption of a resolution to obtain permission to self-insure under the Department of Industrial Relations.

8. Adopt an Experience Modification for the EPL program, specifically a Frequency Adjustment Option using a normalized frequency figure (i.e., number of claims per every $100 of payroll) as follows:

- **0.00 claims per $100K of payrolls: -5.6% discount**
- **Over 0.00 to 0.75 claims per $100K of payrolls: +4.3% surcharge**
- **Over 0.75 claims per $100K of payrolls: +9.3% surcharge**

9. The Committee recommends the REMIF Board of Directors adopt an Experience Modification for the property program as outlined above.

10. The Committee recommends the REMIF Board of Directors approve the draft contract for CIRA to administer the REMIF Health program.

ATTACHMENTS

10.1 Transition Committee Agenda Packet (10/19/20)
10.2 Transition Finance Committee presentation (11/04/20)
10.3 Transition Committee Agenda Packet (11/23/20)
10.4 Transition Committee Agenda Packet (12/14/20)
10.5 Transition Committee Agenda Packet (01/11/20)
10.6 ERMA Resolution
10.7 DIR Resolution

REMIF
REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

PUBLIC AGENCY RISK SHARING AUTHORITY OF CALIFORNIA
PARSAC

AGENDA
PARSAC/REMIF TRANSITION COMMITTEE MEETING
October 19, 2020 – 9:00 a.m. – 2:00 p.m.
Zoom Meeting

Link: https://zoom.us/j/98281872401?pwd=c01DT1AzS05GR0YwVis2VVoxNWlqQT09
Dial in: +1 669 900 9128
Passcode: 636105

CALL TO ORDER
ROLL CALL

Page No.	**ACTION AND INFORMATION CALENDAR** **denotes attachments enclosed for this item*	**RECOMMENDATION**
2	1. Presentation by ERMA – Jennifer Jobe & Kathy Maylin	*Provide direction to staff*
15	2. Options for Excess Liability Coverage – Mike Simmons	*Provide direction to staff regarding which excess liability pool to consider.*
22	3. Update on Exploration of Options for Property Program – Mike Simmons	*Provide direction to staff on next steps for the property program*
24	4. Options for Excess Workers' Compensation Coverage – Erike Young	*Receive and file*
28	5. Retiree Health Benefits for New CIRA Employees	*Receive and file*
36	6. Review Draft Resolution Establishing Name Change from PARSAC to CIRA a) CIRA Logo	*Approve and recommend PARSAC Board ratification*
37	7. CIRA Risk Control Plan	*Provide direction to staff*
	8. Timelines – Kin Ong & Amy Northam	*Discuss*
	9. Schedule Next Meetings: a. Transition Committee – November 23, 2020, and December 14, 2020 b. Transition Finance Committee – November 4, 2020 c. CIRA Board - May 26, 2021	

ADJOURNMENT OF MEETING

ERMA
Employment
Risk Management Authority

CIRA

California Intergovernmental Risk Authority
Transition Committee

October 19, 2020

What is ERMA?

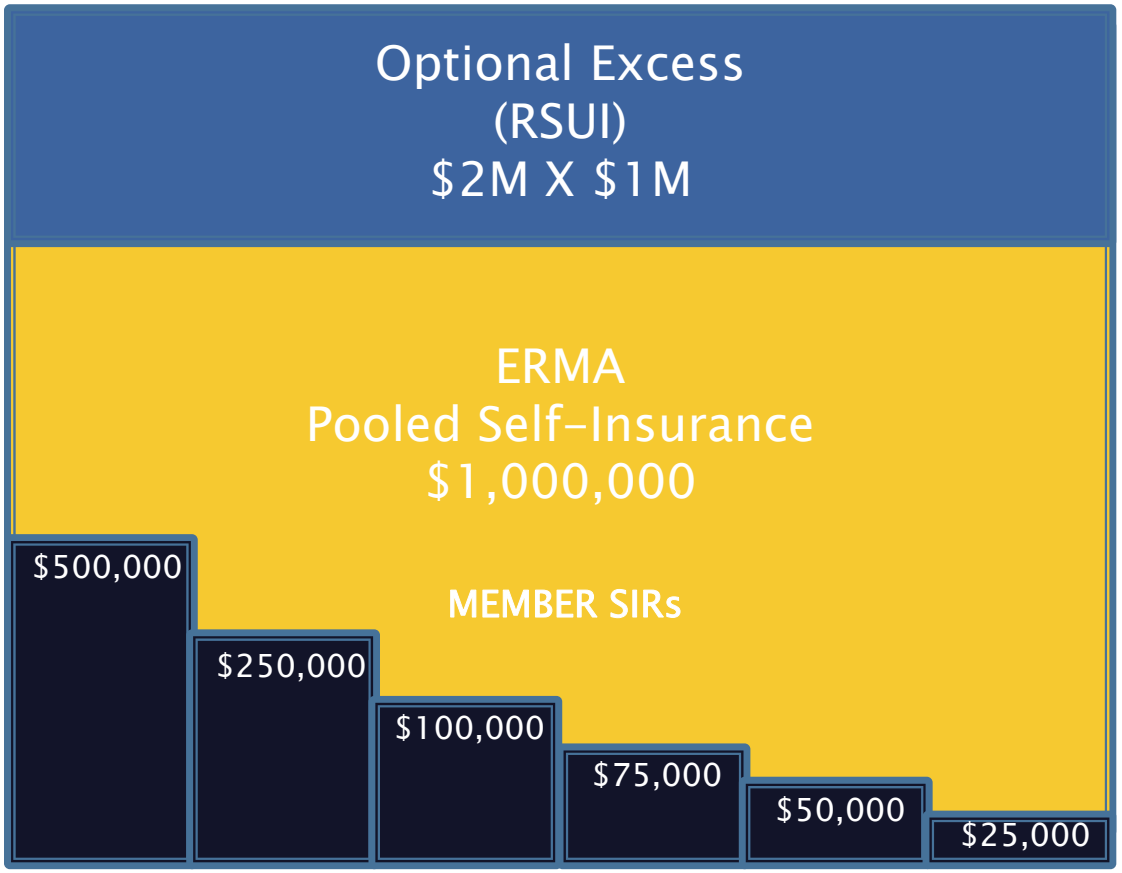
- Reduce employment practices risk via:
  - ✓ Proactive claims management
  - ✓ Innovative training & education
  - ✓ Subject matter expertise
- First and only State-wide public sector EPL risk sharing pool
- 200+ public entities
- CAJPA Accreditation with Excellence

ERMA
Employment
Risk Management Authority

Membership

MBASIA

Coverage Structure

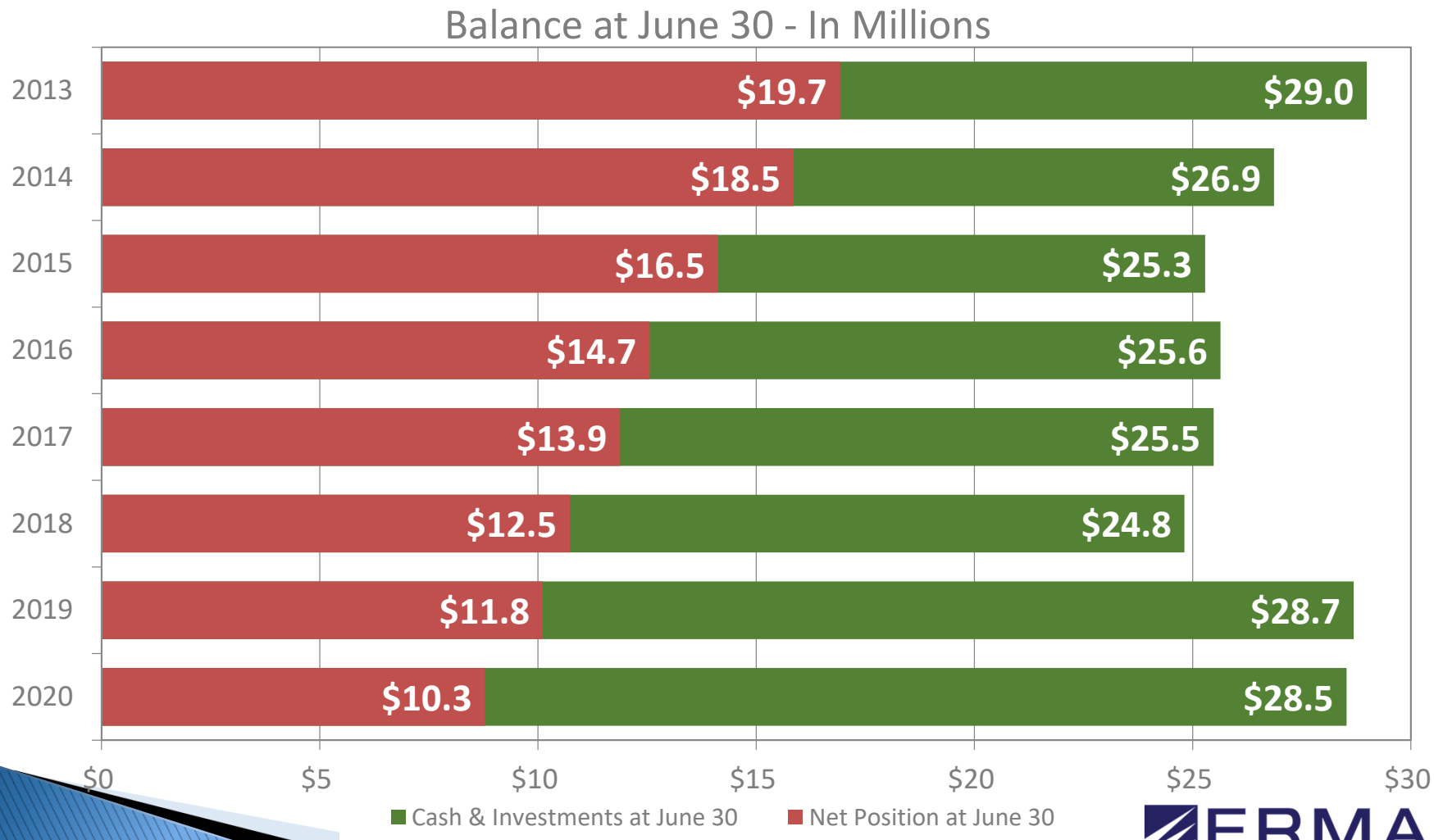


Recommended SIRs	Payroll Range
$25K	<$10M
$50K	<$25M
$75K	<$30M
$100k, $250k or $500K	<$50M

ERMA
Employment Risk Management Authority

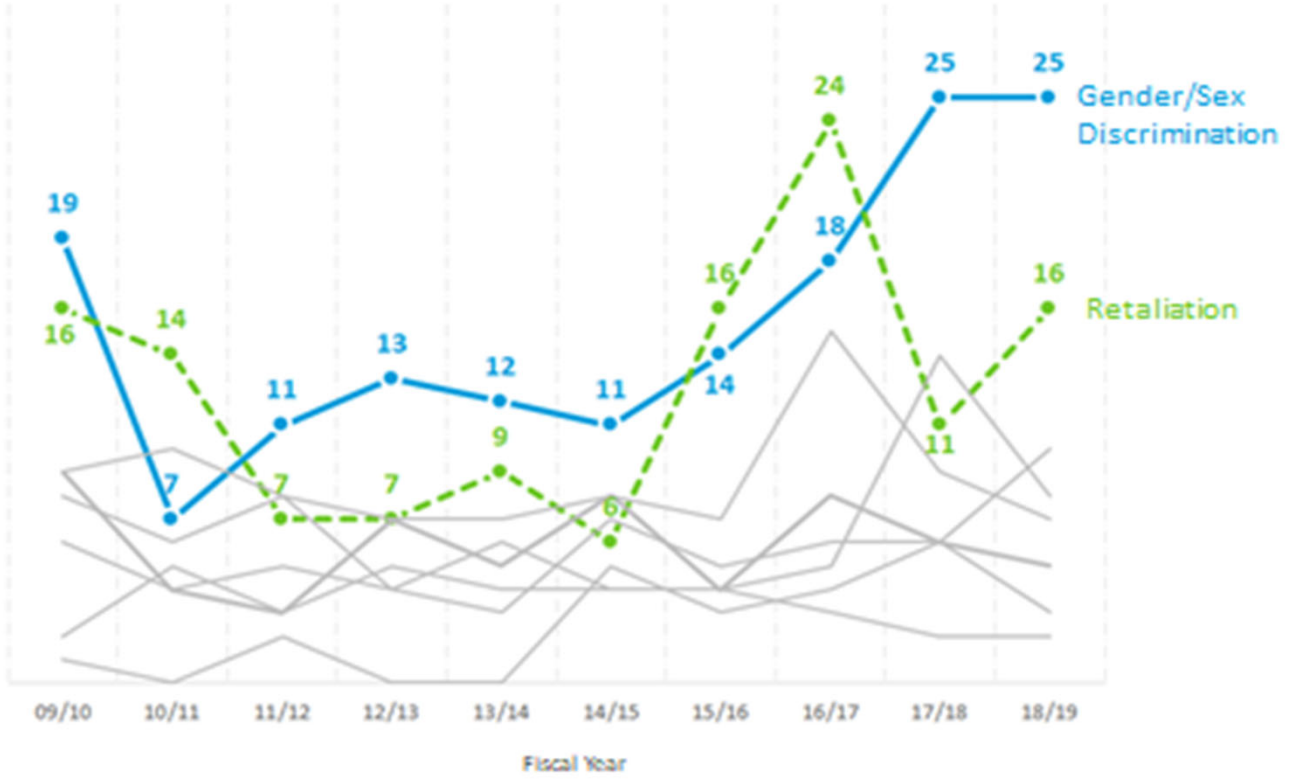
Finances

Net Position and Cash & Investment Balances



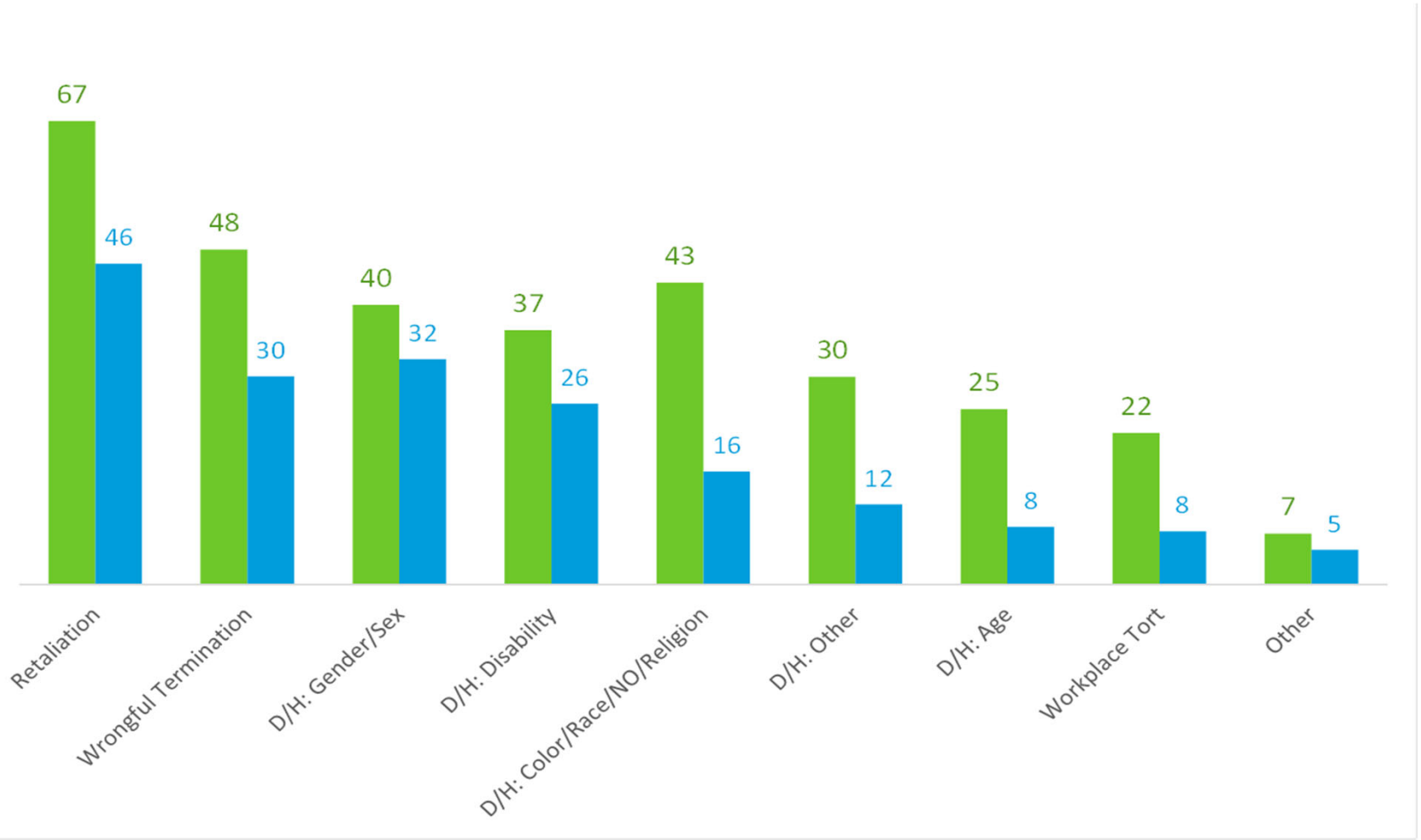
ERMA
Employment Risk Management Authority

Number of Claims by Type: Last 10 years



ERMA Employment Risk Management Authority

By Type – Expense/Indemnity per Claim: Incurred on Closed Claims, in Thousands



ERMA Employment Risk Management Authority

Program Advantages

- Share cost of risk among similar entities
- Determine scope of coverage
- Develop governing documents
- Develop risk control programs
- Target performance standards
- Proactive litigation management

ERMA
Employment
Risk Management Authority

Program Services

- Live Training Workshops
  - Individual and Regional
- Online Training
  - *ERMANet*
- Hot Topic Trainings
  - Jackson Lewis and Liebert Cassidy Whitmore regional workshops
- Employee Reporting Line
  - 24/7 access via telephone or online
- Attorney Hotline
  - one hour per month

ERMA
Employment
Risk Management Authority

Financial Advantages

- Conservatively funded – 80% confidence level
- Rates based upon JPA and individual member experience
- Capped individual member experience modifier
- Rates are not profit-driven
- Flexibility of SIRs
- Dividend plans and incentives – $23.6M over the last seven program years

ERMA
Employment Risk Management Authority

Litigation Management: Investigation and Defense of Claims

- Litigation Management
  - Litigation Manager provides guidance, oversight and management of all employment practices matters
- Investigations
  - Investigator Panel
- Defense of the Claim
  - Defense Panel

ERMA Employment Risk Management Authority

Defense Panel

- Jackson Lewis P.C.
- Liebert Cassidy Whitmore
- Allen, Glaessner, Hazelwood & Werth
- Bertrand Fox, Elliott, Osman & Wenzel
- Best, Best & Krieger LLP
- Carpenter, Rothans & Dumont
- Casey Law Group
- Lozano Smith
- Porter Scott
- Richards, Watson & Gershon
- Skane Wilcox LLP

ERMA
Employment
Risk Management Authority

ERMA
Employment
Risk Management Authority

OPTIONS FOR EXCESS LIABLITY COVERAGE

SUMMARY: At the August 24th Transition Committee meeting, staff presented three options for options for excess general liability coverage. These options included both pools current providers, California Joint Powers Risk Management Authority (CJPRMA) and PRISM (formally CSAC-EIA), the California Affiliated Risk Management Authority (CARMA) as a third option. In addition to meeting with the management team of each of the pools being considered, staff has worked closely with our Mike Simmons, our broker with Alliant. As the liability insurance market continues to be challenged, Mr. Simmons has provided options for the committee to consider in the event the insurers for the excess pools under consideration limit their underwriting for new members. Mr. Simmons letter is attached and discusses options for the Committee's Consideration

Additionally, as requested by the Committee, Staff has conducted additional analysis of the three excess pools under consideration utilizing financial benchmarks published by the Association of Government Risk Pools (AGRIP), which provide an indication of liquidity and the ability of a JPA to pay losses even under adverse conditions. Of the three pools, only CARMA has met the target equity ratios for all years evaluated. Both PRISM and CJPRMA have trended negative in recent years, however, both are taking steps to address their financial condition. PRISM is doing this through a Loss Portfolio Transfer (LPT) and CJPRMA is evaluating several actions that will be on their December board agenda.

RECOMMENDATION: Provide direction to staff regarding which excess liability pool to consider.

DISCUSSION: The hardening of the liability excess insurance market presents additional challenges for CIRA that go beyond pricing and coverage considerations. While all of the excess pools under consideration have indicated their interest in having CIRA join their pool, they must also get approval from their underwriters for the coverage layers above their SIR. Mike Simmons, our broker with Alliant has prepared options for the Committee's consideration and will discuss them in more detail at the meeting.

In addition to the placement options discussed above, staff has conducted additional financial analysis of the three excess pools under consideration. The pools were evaluated in terms of financial strength using utilizing financial benchmarks published by the Association of Government Risk Pools (AGRIP), which provide an indication of liquidity and the ability of a JPA to pay losses even under adverse conditions. These benchmarks also try to balance the need to be liquid and hold adequate reserves against the members' need to keep as much of their cash as possible for their own operations.

Four target equity benchmarks were used to compare each pool's performance and include:

Member Contributions to Equity
Compares current equity for all program years to current year net contributions and measures whether a pool as sufficient assets to support contribution of its members. Target is less than 3:1 ratio. Ratio over 3:1 indicates a pool is accepting risk by collecting premiums at higher rate than obligations can be supported by surplus.

Unpaid Claims to Equity
Compares equity for all program years to total claims liability and measures a pools ability to withstand adverse loss development in a given year. Target is less than 4:1 ratio. Ratios exceeding 4:1 indicate a pool may not have enough surplus to meet claim liabilities and may be prone to member assessments.

Equity to Self-Insured Retention
Compares equity for all program years to current SIR and measures the degree to which a pool can withstand multiple large losses at or above its SIR. Target is more than 5:1 ratio. The higher the equity, the more "full hits" the pool can absorb.

Operating Ratio
Compares revenue to expenses during a given year and measures inflows versus outflows in each program year. Target is less than 100%. The higher the revenue and/or lower the expenses, the lower the percentage.

In addition to the scorecard below, staff will present charts for each of the target equity ratios being evaluated. Each pool shows that all target equity ratios were not achieved in prior years, however, they have trended in a positive direction and have met targets for the most current year evaluated.

CJPRMA Scorecard	FY'16	FY'17	FY'18	FY'19
Member Contributions to Net Assets				
Unpaid Claims to Net Position				
Net Position to SIR				
Operating Ratio				

PRISM Scorecard	FY'16	FY'17	FY'18	FY'19
Member Contributions to Net Assets				
Unpaid Claims to Net Position				
Net Position to SIR				
Operating Ratio				

CARMA	FY'16	FY'17	FY'18	FY'19
Member Contributions to Net Assets				
Unpaid Claims to Net Position				
Net Position to SIR				
Operating Ratio				

FISCAL IMPLICATIONS: Potential cost savings through economies of scale and loss control services.

ATTACHMENT: Letter from Mike Simmons regarding GL Excess Options
Target Equity Ratios and Scorecard Presentation

DATE: October 14, 2020

TO: Kin Ong and Amy Northam

FROM: Mike Simmons, Vice Chair – Public Entities - Alliant

CIRA Analysis – Excess Liability Pool Considerations for FY 21/22

The continued deterioration of the Liability insurance marketplace will make the ability to combine the excess insurance Pools into CIRA difficult effective July 2021. The merger is occurring during an extreme hardening of the property and liability insurance market, possibly even worst than 1986. It is important to recognize that the July 2020 liability renewals were a good sign of what could occur in July 2021; excess insurance carriers may not be providing final insurance quotations until late May or even early June. Even without COVID-19 and the looting/rioting events in June, **the insurance market is going to be hesitant to attract additional high-risk exposures like California municipalities**.

Although the Excess Pools that CIRA will consider may be eager to have you participate in their self-funded layers, all of them are going to have to get their current member programs **defined, and priced, first before carriers will consider "new members"** participating**.** Most of these Pools won't have their own actuarial studies done to develop rates until February, and their December 31st loss runs are what carriers rely on to price July 1st renewals. In the past three months alone, reported police claims (frequency) have skyrocketed, and settlements are increasing daily. The City of Walnut Creek just settled a new claim for $4 million two weeks ago; an occurrence just one year old. This is just one of many example of the impact expected from these claims.

REMIF has been with CJPRMA since 1986 excess coverage, and PARSAC has been with either CARMA or PRISM for at least 30 years. There are 3 excess Pool partners that are being evaluated:

1. **CARMA** is a strong pool of similar size/type cities; all members of 5 JPAs. It has a $1 million attachment and a $34 million limit of liability. It offers a sub-limit for Subsidence to $5 million and it offers an Inverse Condemnation sub-limit of $2 million. Pretty much all the other coverages are similar to what you have right now. CARMA will not know whether they can admit CIRA until around April 1st, and then CARMA will not know whether their excess carrier will insure CIRA until very close to your July 1st renewal. *CARMA has a 3-year commitment and a 6 months Intent of Notice to Withdrawal.*

2. **CJPRMA** is a great pool mostly made up of Northern California municipalities of similar size. REMIF has been involved with this group for some time, and instrumental in its formation. It also provides at least $5 million in Subsidence sub-limit and Inverse Condemnation coverage. With those two exceptions, it is very comparable to the other Pools you are evaluating. This Pool's Net Position will likely be just in excess of $4 million as of June 30, 2020. It is currently discussing an increase in annual funding to raise it from Expected to the 70% (or higher) Confidence Level. In addition, an Equity infusion is being discussed to return Net Position back above $20 million over the next few years - a "re-building" policy in process. CJPRMA may not know whether they can admit PARSAC until late February/March, and then CJPRMA will not know whether their excess carrier will insure

CIRA until very close to your July 1st renewal. *CJPRMA has a 3-year commitment and a 6 months Intent of Notice to Withdrawal.*

3. **PRISM** is an extremely large Pool that covers more than just Northern California municipalities. That broader base adds premium volume, but also takes into consideration those members slightly different claims. Unfortunately, it does not offer not offer Subsidence coverage, and this coverage can not be purchased standalone through the commercial marketplace. It offers Inverse Condemnation coverage to its full $50 million limit, but that inverse condemnation coverage may be more limited than the other JPA forms, and this should be reviewed.

   PRISM's Net Position is negative as of June 30, 2020. Many Pools develop negative Net Position during their lifecycle; **what is important is how they recognize this and take all the necessary steps to establish policies and processes to correct the negative position**. I understand that your staff has been discussing that with PRISM and has gained a strong understanding of process.

   Although excess liability program rates from carriers will not be final until late May/early June it is not as critical. PRISM has an Underwriting Committee that next meets on December 9th. Since PARSAC is already a member, that committee could underwrite REMIF cities joining PARSAC effective July 1, 2021. REMIF's loss data could be immediately included in the renewal submission once approved by the committee, and presented along with the other GL1 Members, in the renewal process that begins that month. Because REMIF's historic claims are less than PARSAC's, we believe they would easily roll together. *PRISM does not have a 3-year minimum commitment; it has a unique process to discourage members from leaving - - you can withdraw from this program at the end of any program year, but if you do you may not re-join for 3 years.*

It may very well be that 2021 is not the year for two pools of your size to merge your excess insurance programs. But, that does not mean you cannot continue to move forward with the merger.

The Boards of REMIF and PARSAC need to anticipate the possible need to implement a **Plan "B"**, **recognizing the possibility that the new CIRA pool will have two separate liability excess partners** above CIRA's combined $1,000,000 pool limit. Many other large JPAs have multiple liability programs. This plan means that you combine your membership into one self-insured pool that has its own MOC, but that two groups are now CIRA#1 and CIRA#2, each with separate excess program partners.

Plan "B" is the back-up plan that allows CIRA to continue your momentum forward without looking at April 1st as a drop-dead date. It is a important date only for REMIF, who may need to give final notice to CJPRMA if they plan to leave their excess partner. We quickly need to determine if this date is negotiable because, in part, CJPRMA will not be able to provide PARSAC with solid excess carrier sign-off all the way through the excess limits.

The downside of implementing Plan "B" involves more complexity in managing the program(s) on an ongoing basis. But it is really just a short-term solution to continue with the formation until the excess liability insurance market softens and allows you to combine the two excess programs back into one program. This may be more than just one year.

The key coverage difference between the programs you are looking at is the $5 million Subsidence sub-limit that CJPRMA offers. You could actuarial determine the cost of Subsidence and endorse the coverage onto just the REMIF members group for at least $1 million if the PARSAC members did not want the coverage, but honestly, there will be trade-offs that both REMIF and PARSAC need to consider when combining and these coverage enhancement can't become a deal-breakers.

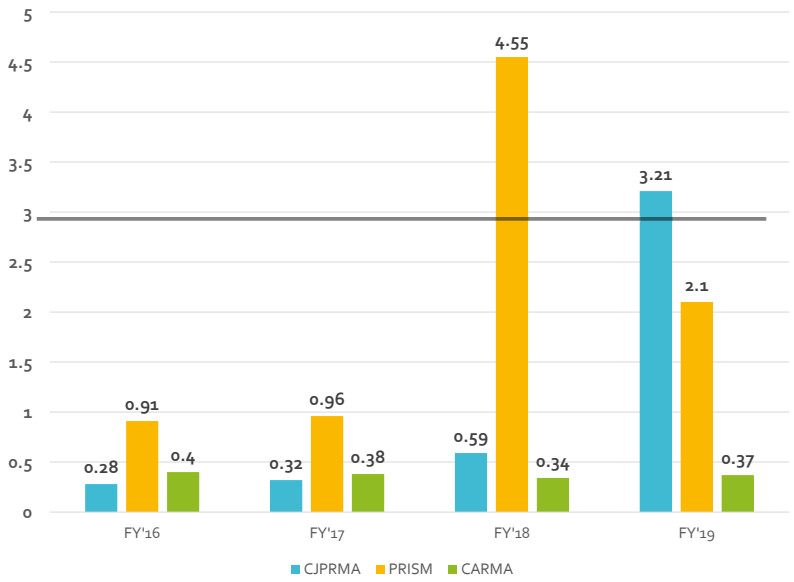
Plan "B" has a secondary beneficial feature; if REMIF stayed in CJPRMA for excess liability insurance then they could continue to stay in that program for property if we cannot separately solve that situation.

Member Contributions to Equity

Compares:
Current equity for all program years to current year net contributions

Measure of:
Whether pool has sufficient assets to support contributions of its members.

Target:
Less than 3:1
Ratio over 3:1 indicate pool is accepting risk by collecting premiums at higher rate than obligations can be supported by surplus.



9

Unpaid Claims to Equity

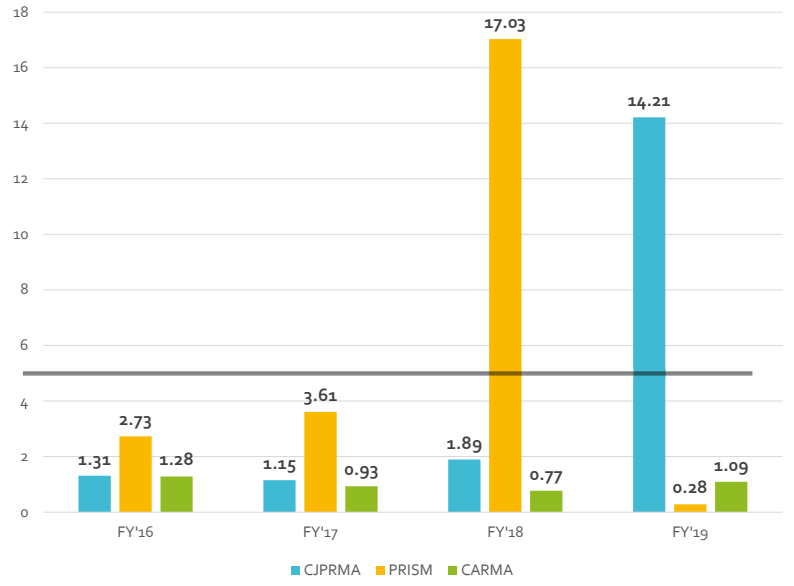
Compares:

Current equity for all program years current SIR

Measure of:

The maximum amount that equity could decline due to a single loss

Target:
More than 5:1
The higher the equity, the more "full hits" the pool can absorb. *HIGH ratio is desirable*



10

Equity to Self Insured Retention

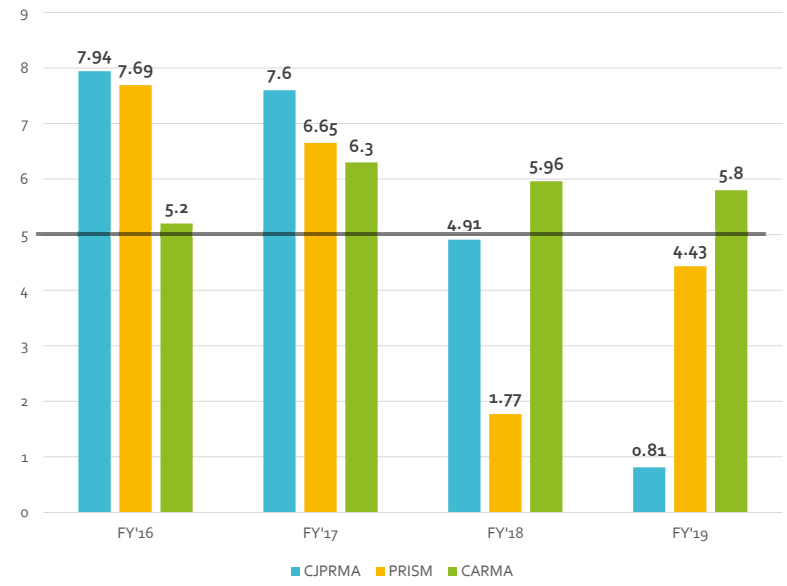
Compares:

Current equity for all program years current SIR

Measure of:

The maximum amount that equity could decline due to a single loss

Target:
More than 5:1
The higher the equity, the more "full hits" the pool can absorb. *HIGH ratio is desirable*



11

Operating Ratio

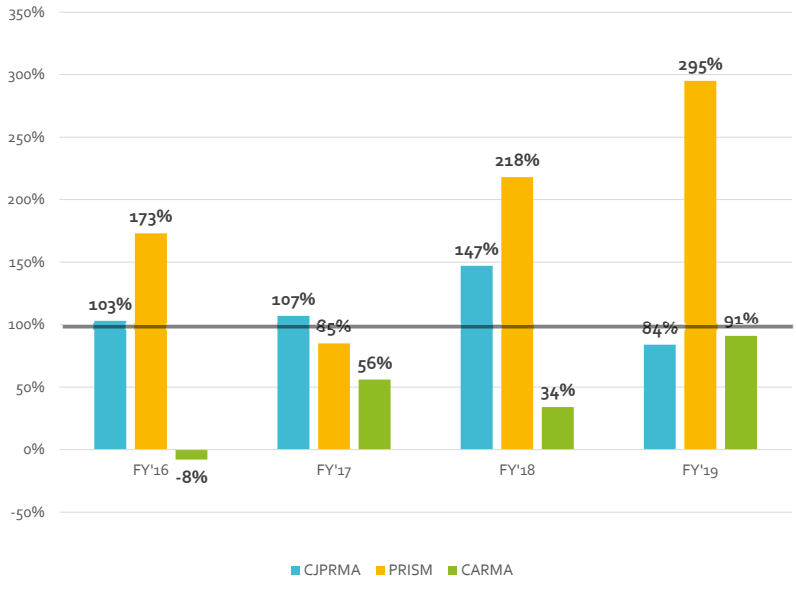
Compares:

Revenues to Expenses during a given year

Measure of:

The inflows versus the outflows in each program year

Target:
Less than 100%
The higher the revenues and/or the lower the expenses, the lower the ratio.



12

DATE: October 14, 2020

TO: Kin Ong and Amy Northam

FROM: Mike Simmons, Vice Chair – Public Entities - Alliant

CIRA Analysis – Property Program Considerations for FY 21/22

Over the past several months we have had numerous discussions regarding the two Alliant property programs: APIP and PRISM. PARSAC is currently in APIP and REMIF is a member of a *hybrid* APIP program through its current self-insurance pool, CJPRMA. Coverages in this hybrid program are the same as the APIP form, but deductibles are significantly different then what PARSAC currently purchases through APIP. PARSAC has a low, $10,000 deductible for "All Risk" coverage.

Alliant acts in the role of Broker, and separately, the AUS Division acts in the Underwriting role for the APIP and PRISM programs. The two programs are managed by the same team of professional property insurance underwriters. This is important because every property risk, and every property carrier, has specific needs and loss profiles.

- The programs are designed to meet the tailored needs of membership, and coverages are constantly improved in both programs, based on the goals to provide the broadest coverage for membership exposures available in the ever-changing and dynamic property insurance marketplace. **The programs are similar with only a few unique coverage characteristics; many of which we will discuss below**.

- In general, the two programs would price the same members similarly. But, that conclusion has conditions; most importantly are the types of losses the member may have and, **most importantly, the self-insured retention/deductible** they select.

- **Unfortunately, the two programs never compete against each other**; it's just not possible. That creates a problem for us when combining REMIF and PARSAC into CIRA. We will need for you to determine which program you commonly want to participate in effective July 1, 2021 so that we can meet your needs and successfully combine your *very different programs* into one larger program that will have Total Insurable Values (TIV) of approximately $3.5 billion, and losses over the past nine years approaching $15 million.

- We will not know the price the program would offer until officially proposed by the insurance carriers closer to renewal date. The APIP program renews July 1st. and in a hard market environment, final pricing is not known before June 1st each year. The PRISM program renews March 31st. and final pricing comes together the beginning of that month.

- The major coverage differences you should focus on are the following:

Wildfire

This fire exposure is significantly responsible for the California municipal property insurance market deterioration. Many programs have high wildfires deductibles. Currently, the REMIF program has a

wildfire deductible of $500,000 for all members *(with a buy-down through CJPRMA to $100,000)*. PARSAC has two members that have had their wildfire deductible increased from the program deductible of $10,000 to $100,000 for FY20/21 (and we could see more cities facing this higher deductible in future years). **PRISM does not have a wildfire deductible higher than the "all risk" deductible for members,** and has no plans to institute one. They have the ability to control this since the deductible is within their self-insured layer, and it is unlikely they will consider this change in their program anytime in the near future.

Tax Interruption Coverage

This *unique* coverage is included on the APIP form, currently to a $1 million limit, for ALL members, (and up to a $3 million limit for members who report specific values). At least 2 PARSAC member cities have received prior claims payments under this coverage and benefited from the coverage advantage. Tax Interruption Coverage is a *contingent business interruption* exposure. **It is not offered on the PRISM form**. If PARSAC were to move to PRISM, members would lose this coverage advantage and there would be no way for us to find a separate market that would provide it at any cost.

Flood

PRISM covers Flood at the "All Risk" deductible for all members including the more hazardous zones, A and V. The pricing for this very important coverage benefit is reasonable. Currently, REMIF purchases flood coverage for all of its members through their current program. Currently, PARSAC only has flood coverage for 3 members. Purchasing flood coverage would be a valuable improvement to PARSAC's program.

Combining REMIF and PARSAC's property programs is complex, to say the least. Both Pools will be giving up something to meet in the middle. There will be give-and-take by both sides if we proceed in this direction. We are comfortable that we will be able to achieve a $25,000 deductible in PRISM at rates similar to those currently paid by PARSAC for their current $10,000 deductible, but including flood coverage for all PARSAC members. If we are successful in securing a $10,000 deductible option, it will be a higher cost than those current rates, in part because the marketplace is deteriorating, and member losses are high.

Note: are there other options to consider? We do not believe so in the current market environment and the historical loss experience of both these two pools.

OPTIONS FOR EXCESS WORKERS' COMPENSATION COVERAGE

SUMMARY: At the August 24th Transition Committee meeting, staff presented three options for excess workers' compensation coverage. These options included both pools' current providers, Safety National and the Local Agency Workers' Compensation Excess Joint Powers Authority (LAWCX), and PRISM (formally CSAC-EIA) as a third option. As requested by the Transition Committee, Staff has conducted additional analysis of the two pools under consideration utilizing financial benchmarks published by the Association of Government Risk Pools (AGRIP), which provide an indication of liquidity and the ability of a JPA to pay losses even under adverse conditions. Safety National was not included in the financial analysis, as commercial carriers receive credit ratings to measure financial health. Safety National is currently rated as A++. Both pools are currently meeting the target equity benchmarks; however, based on coverage, governance and pricing, staff is recommending that PRISM be eliminated from consideration.

As noted at the last meeting, Safety National provides coverage for non-safety at a $750,000 SIR and safety at $1 million SIR. This is above the actuaries recommended SIR of $500,000, which the committee approved. Safety National also included an additional self-insured retention of $2 million for public safety presumption claims. Staff met with another broker who is proposing a drop down (buffer) layer that would provide coverage from $500,000 to $1 million with another commercial carrier and Safety National, providing coverage above $1 million. There is a potential for considerable savings with this approach; however, without a multi-year rate guarantee savings may be temporary. Staff is recommending that a reduction to $500,000 SIR, elimination of the $2 million claim presumption SIR, and three-year rate guarantee be included as part of the coverage requirements. Safety National has indicated a decision to reduce the SIR, remove the presumptive claim SIR, and provide a rate guarantee will not be made until January 2021, which is after PARSAC's requirement to notify LAWCX of its intent to withdraw. In order to allow more time to consider excess options, PARSAC staff will be recommending to its board that PARSAC provide a notice to withdraw from LAWCX. The deadline to rescind this notice is May 1, 2021.

RECOMMENDATION: Receive and file

DISCUSSION: The two excess pools under consideration, LAWCX and PRISM, were evaluated in terms of financial strength, utilizing financial benchmarks published by the Association of Government Risk Pools (AGRIP), which provide an indication of liquidity and the ability of a JPA to pay losses even under adverse conditions. These benchmarks also try to balance the need to be liquid and hold adequate reserves against the members' need to keep as much of their cash as possible for their own operations.

Four target equity benchmarks were used to compare each pool's performance and include:

Member Contributions to Equity
Compares current equity for all program years to current year net contributions and measures whether a pool as sufficient assets to support contribution of its members. Target is less than 3:1 ratio. Ratio over 3:1 indicates a pool is accepting risk by collecting premiums at higher rate than obligations can be supported by surplus.

Unpaid Claims to Equity
Compares equity for all program years to total claims liability and measures a pools ability to withstand adverse loss development in a given year. Target is less than 4:1 ratio. Ratios exceeding 4:1 indicate a pool may not have enough surplus to meet claim liabilities and may be prone to member assessments.

Equity to Self-Insured Retention
Compares equity for all program years to current SIR and measures the degree to which a pool can withstand multiple large losses at or above its SIR. Target is more than 5:1 ratio. The higher the equity, the more "full hits" the pool can absorb.

Operating Ratio
Compares revenue to expenses during a given year and measures inflows versus outflows in each program year. Target is less than 100%. The higher the revenue and/or lower the expenses, the lower the percentage.

In addition to the scorecard below, staff will present charts for each of the target equity ratios being evaluated. Each pool shows that all target equity ratios were not achieved in prior years, however, they have trended in a positive direction and have met targets for the most current year evaluated.

LAWCX Scorecard	FY'16	FY'17	FY'18	FY'19
Member Contributions to Net Assets				
Unpaid Claims to Net Position				
Net Position to SIR				
Operating Ratio				

PRISM Scorecard	FY'16	FY'17	FY'18	FY'19
Member Contributions to Net Assets				
Unpaid Claims to Net Position				
Net Position to SIR				
Operating Ratio				

While both pools show similar financial performance, based on 4850 coverage, governance, and pricing, staff is recommending that PRISM be eliminated from consideration.

Safety National is still under consideration; however, the Committee indicated that if a SIR could not be reduced to $500,000 and the $2 million self-insured retention for presumptive claims removed, it would no longer be considered. Staff met with another broker who is proposing a drop down (buffer) layer that would provide coverage from $500,000 to $1 million with another commercial carrier and Safety National, providing coverage above $1 million. There is a potential for considerable savings with this approach; however, without a multi-year rate guarantee savings may be temporary. Staff is also recommending that due to volatility in the excess market due to COVID-19, that a three-year price guarantee also be included as a condition.

FISCAL IMPLICATIONS: Potential cost savings through economies of scale and loss control services.

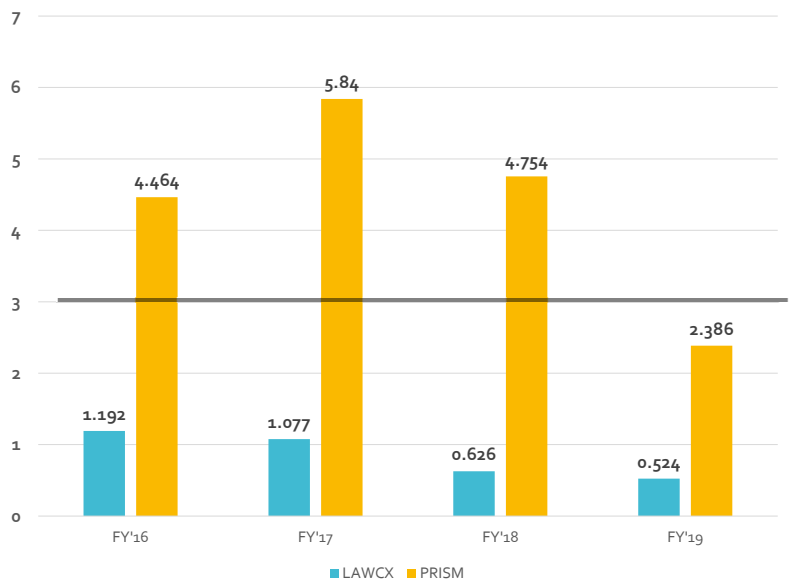
ATTACHMENT: Target Equity Ratios and Scorecard Presentation

Member Contributions to Equity

Compares:
Current equity for all program years to current year net contributions

Measure of:
Whether pool has sufficient assets to support contributions of its members.

Target:
Less than 3:1
Ratio over 3:1 indicate pool is accepting risk by collecting premiums at higher rate than obligations can be supported by surplus.



3

Unpaid Claims to Equity

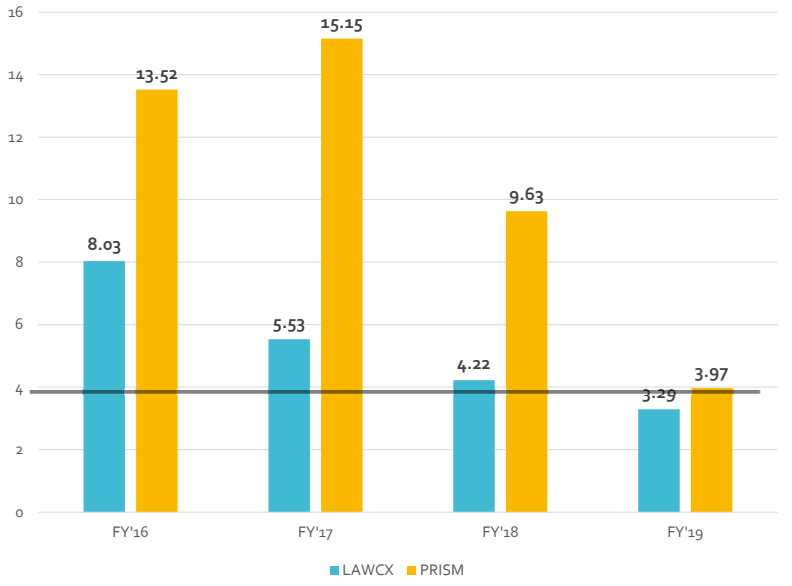
Compares:

Current equity for all program years to total claims liability

Measure of:

Pools ability to withstand adverse loss development in a given year.

Target:
Less than 4:1
Ratios exceeding 4:1 indicate pool may not have enough surplus to meet claim liabilities and may be prone to member assessments



4

Equity to Self Insured Retention

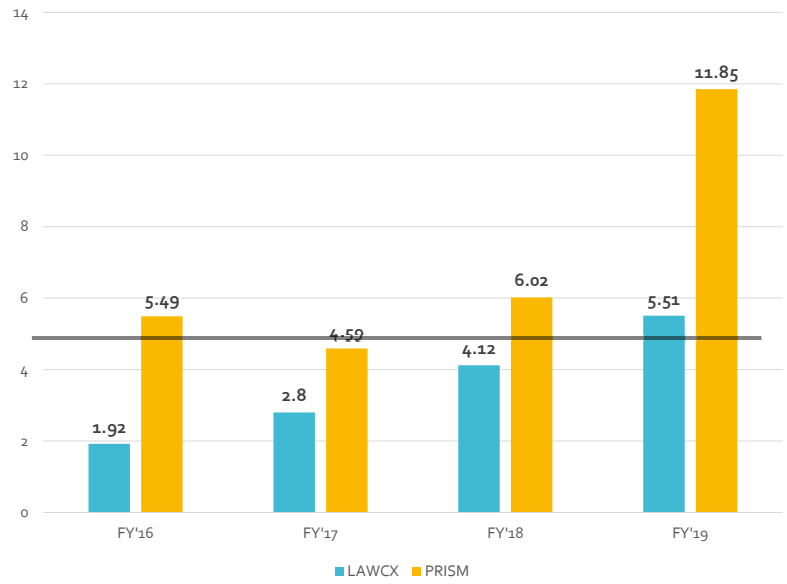
Compares:

Current equity for all program years current SIR

Measure of:

The degree to which a pool can withstand multiple large losses at or above it's self insured retention

Target:
More than 5:1
The higher the equity, the more "full hits" the pool can absorb. *HIGH ratio is desirable*



5

Operating Ratio

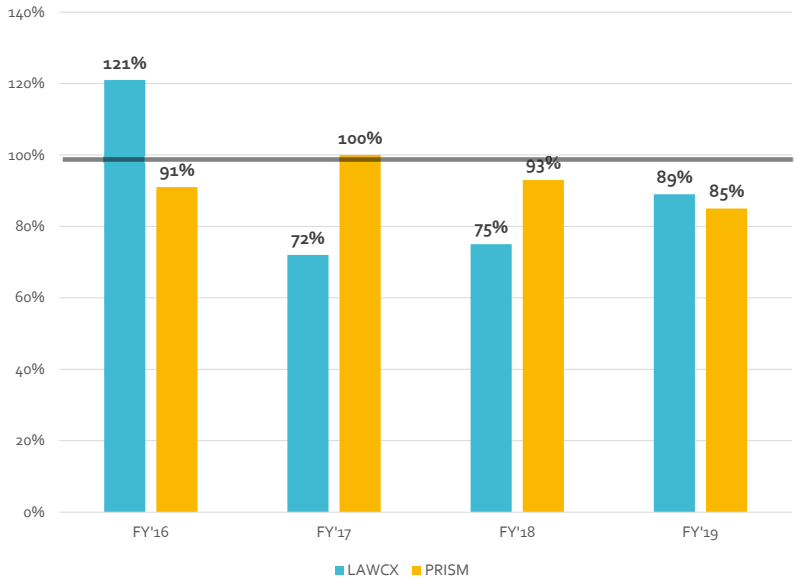
Compares:

Revenues to Expenses during a given year

Measure of:

The inflows versus the outflows in each program year

Target:
Less than 100%
The higher the revenues and/or the lower the expenses, the lower the ratio.



6

RETIREE HEALTH BENEFITS FOR NEW CIRA EMPLOYEES

SUMMARY: As PARSAC and REMIF move toward the merger into CIRA, one of the items that has been discussed is the elimination of retiree health benefits for new employees beginning July1, 2021. As PARSAC contracts for health benefits with CalPERS, retiree health benefits are subject to the Public Employees Medical and Hospital Care Act (PEMCHA) and California Government Code 22893 which does not allow for the elimination of retiree health but does allow for the adoption of a vesting schedule.

RECOMMENDATION: Receive and file.

DISCUSSION: During the last CIRA Transition Committee meeting, the Committee proposed eliminating the retiree health care benefit effective July 1, 2021. After discussing the elimination of retiree health benefits with CalPERS for new employees beginning July 1, 2021, it was determined that CIRA will need to follow the Public Employees Medical and Hospital Care Act (PEMCHA) and adhere to California Government Code 22893 which will prohibit the total elimination of retiree health benefits.

Government Code 22893 while not allowing for the complete elimination of retiree health benefits, allows for a vesting schedule to be adopted. The vesting schedule is defined in the government code and allows employees to begin earning half benefits after ten years of service credit, five of which would need to be earned working for CIRA. The vesting schedule increases five percent annually as detailed in the Code Section 22893 attachment.

As CIRA will not be able to eliminate retiree health benefits, it is proposed that CIRA adopt the attached sample resolution adopting the vesting schedule as defined in the attached 22893 code section while grandfathering in PARSAC's current staff retiree health benefits for both PARSAC and REMIF's active employees. Both PARSAC and REMIF have fully funded their OPEB liability for active employees and retirees. By adding the current REMIF employees to PARSAC's current retiree health benefits, there will be an additional accrued liability of $122,833. It is proposed that as REMIF is fully funded with a surplus of $568,000, the additional accrued liability amount be transferred from the REMIF OPEB trust account and deposited into a Section 115 OPEB trust account for CIRA.

FISCAL IMPLICATIONS: Transfer of OPEB asset of $122,833 from REMIF OPEB trust account to cover actuarial accrued liability for current REMIF member. CIRA will fund OPEB liability for active employees beginning July 1, 2021.

ATTACHMENT: Sample Health Resolution
California Government Code Section 22893

Health Resolution Template Packet

Contract vs. Resolution

The CalPERS Health Program is governed by the Public Employees Medical and Hospital Care Act (PEMHCA), and the California Code of Regulations (CCR), of the California Public Employees Retirement Law (PERL). PEMHCA contains all the rules and regulations that a contracting agency must adhere to. We define PEMHCA as the actual *health contract,* and the *resolution* as the method by which an agency elects to become subject to PEMHCA.

Resolution Type (Enclosed)

PA Vesting 22893 Resolution	**Purpose**
Format: ❖ All, New ☐ All, Change ☐ All, Rescind ☐ By Group, New ☐ By Group, Change ☐ By Group, Rescind	A public agency employer must file a *vesting resolution* to establish that employees hired on or after the effective date of the vesting resolution are subject to health vesting requirements and schedule outlined in PEMHCA Government Code 22893, and to designate the monthly employer health contribution an annuitant who is subject to vesting would receive based on years of credited service.

Instructions

- The enclosed resolution should be completed by filling in the editable fields with the information requested in the field tab. Contracting agencies may not add, edit, or remove language in the enclosed resolution, other than the editable fields. CalPERS may reject resolutions that are submitted with additional changes.
- The certification shown following the resolution is to be completed by those individuals authorized to sign for the contracting agency in legal actions and is to include the name of the governing body (i.e. Board of Directors, Board of Trustees, etc.), and the location and the date of signing.
- **This resolution serves as a legally binding document, and we require the original resolution, certified copy with original signatures, or a copy of the resolution with the agency's raised seal.** Please complete and include the enclosed cover sheet when mailing the resolution.

Questions or Additional Information

The Health Resolutions & Compliance Unit is responsible for authoring and maintaining this document. The unit can be contacted directly at HealthContracts@calpers.ca.gov.

CalPERS

Please staple on top of your health resolution(s) or cover letter.
This will ensure that the CalPERS mailroom expedites delivery to our office.
Mail packet to either:

Overnight Mail Service
California Public Employees' Retirement System
Health Resolutions & Compliance Services, HAMD
400 Q Street
Sacramento, CA 95811

Regular Mail
California Public Employees' Retirement System
Health Resolutions & Compliance Services, HAMD
PO BOX 942714
Sacramento, CA 94229-2714

HEALTH RESOLUTION

CalPERS ID #	**10-digit CalPERS ID Number**
Agency Name	**Full Name of Contracting Agency**
Desired Effective Date	**Month Day, Year**

RESOLUTION NO. Number
ELECTING TO ADOPT PUBLIC AGENCY VESTING UNDER SECTION 22893 OF THE PUBLIC EMPLOYEES' MEDICAL AND HOSPITAL CARE ACT

WHEREAS, (1) Full Name of Contracting Agency is a contracting agency under Government Code Section 22920 and subject to the Public Employees' Medical and Hospital Care Act (the "Act"); and

WHEREAS, (2) Government Code Section 22893 provides that a contracting agency subject to the Act the may file a resolution with the Board of the California Public Employees' Retirement System to provide a postretirement health benefits vesting requirement to employees who retire for service in accordance with Government Code Section 22893; and

WHEREAS, (3) Full Name of Contracting Agency certifies, some or all employees are represented by a bargaining unit and there is an applicable memorandum of understanding; and

OR (delete unnecessary paragraph)

WHEREAS, (3) Full Name of Contracting Agency certifies, some or all employees are not represented by a bargaining unit and there is no applicable memorandum of understanding; and

WHEREAS, (4) The credited service of an employee for purposes of determining the percentage of employer contribution applicable under Government Code Section 22893 shall mean service as defined in Government Code Section 20069, except that not less than five years of that service shall be performed entirely with the Full Name of Contracting Agency; and

WHEREAS, (5) The employer contribution for active employees cannot be less then what is defined in Government Code Section 22892(b); now, therefore be it

RESOLVED, (a) That employees first hired on or after the effective date of this resolution shall be subject to the requirements defined in Government Section 22893, except that the employer may, once each year without discrimination, allow all employees who were first employed before Government Code Section 22893 became applicable to the employer to individually elect to be subject to the provisions of Government Code Section 22893, and the employer shall notify the Board which employees have made that election; and be it further

RESOLVED, (b) That the employer contribution for each annuitant subject to vesting shall be the amount necessary to pay the full cost of his/her enrollment, including the enrollment of family members in a health benefits plan up to a maximum of Contribution Amount per month with respect to employee enrolled for self alone, Contribution Amount per month for employee enrolled for self and one family member, and Contribution Amount per month for employee enrolled for

self and two or more family members, but not less than the amounts prescribed by Section 22893(a)(1), plus administrative fees and Contingency Reserve Fund assessments; and be it further

OR (delete unnecessary paragraph)

RESOLVED, (b) That the employer contribution for each annuitant subject to vesting shall be the amount necessary to pay the full cost of his/her enrollment, including the enrollment of family members, in a health benefits plan up to a maximum of Contribution Amount per month, but not less than the amounts prescribed by Section 22893(a)(1), plus administrative fees and Contingency Reserve Fund assessments; and be it further

OR (delete unnecessary paragraph)

RESOLVED, (b) That the employer contribution for each annuitant subject to vesting shall be the amount necessary to pay the full cost of his/her enrollment, including the enrollment of family members, in a health benefits plan up to a maximum of the amounts prescribed by Government Code Section 22893(a)(1), plus administrative fees and Contingency Reserve assessments; and be it further

RESOLVED, (c) That the percentage of employer contribution payable for post-retirement health benefits for each annuitant shall be based on the employee's completed years of credited service based upon the table in Government Code Section 22893; and be it further

RESOLVED, (d) Full Name of Contracting Agency has fully complied with any and all applicable provisions of Government Code Section 7507 in electing the benefits set forth above; and be it further

RESOLVED, (e) That the participation of the employees and annuitants of Full Name of Contracting Agency shall be subject to determination of its status as an "agency or instrumentality of the state or political subdivision of a State" that is eligible to participate in a governmental plan within the meaning of Section 414(d) of the Internal Revenue Code, upon publication of final Regulations pursuant to such Section. If it is determined that Full Name of Contracting Agency would not qualify as an agency or instrumentality of the state or political subdivision of a State under such final Regulations, the California Public Employees' Retirement System may be obligated, and reserves the right to terminate the health coverage of all participants of the employer; and be it further

RESOLVED, (f) That the executive body appoint and direct, and it does hereby appoint and direct, Position Title or Name of Person to file with the Board a verified copy of this resolution, and to perform on behalf of Full Name of Contracting Agency all functions required of it under the Act; and be it further

RESOLVED, (g) That coverage under the Act be effective on Month Day, Year.

Adopted at a regular or special meeting of the Governing Body at Location, this Day day of Month, Year.

Signed: _____
(President, Chairman, etc.)

Attest: _____
(Secretary or appropriate officer)

22893. (a) Notwithstanding Section 22892, the percentage of employer contribution payable for postretirement health benefits for an employee of a contracting agency subject to this section shall, except as provided in subdivision (b), be based on the member's completed years of credited state service at retirement as shown in the following table:

Credited Years of Service	Percentage of Employer Contribution
10 _____	50 _____
11 _____	55 _____
12 _____	60 _____
13 _____	65 _____
14 _____	70 _____
15 _____	75 _____
16 _____	80 _____
17 _____	85 _____
18 _____	90 _____
19 _____	95 _____
20 or more _____	100 _____

This subdivision shall apply only to employees who retire for service and are first employed after this section becomes applicable to their employer, except as otherwise provided in paragraph (6). The application of this subdivision shall be subject to the following provisions:

(1) The employer contribution with respect to each annuitant shall be adjusted by the employer each year. Those adjustments shall be based upon the principle that the employer contribution for each annuitant may not be less than the amount equal to 100 percent of the weighted average of the health benefit plan premiums for an employee or annuitant enrolled for self-alone, during the benefit year to which the formula is applied, for the four health benefit plans that had the largest state enrollment, excluding family members, during the previous benefit year. For each annuitant with enrolled family members, the employer shall contribute an additional 90 percent of the weighted average of the additional premiums required for enrollment of those family members, during the benefit year to which the formula is applied, in the four health benefit plans that had the largest state enrollment, excluding family members, during the previous benefit year. Only the enrollment of, and premiums paid by, state employees and annuitants enrolled in basic health benefit plans shall be counted for purposes of calculating the employer contribution under this section.

(2) The employer shall have, in the case of employees represented by a bargaining unit, reached an agreement with that bargaining unit to be subject to this section.

(3) The employer shall certify to the board, in the case of employees not represented by a bargaining unit, that there is not an applicable memorandum of understanding.

(4) The credited service of an employee for the purpose of determining the percentage of employer contributions applicable under this section shall mean state service as defined in Section 20069, except that at least five years of service shall have been performed entirely with that employer.

(5) The employer shall provide the board any information requested that the board determines is necessary to implement this section.

(6) The employer may, once each year without discrimination, allow all employees who were first employed before this section became applicable to the employer to individually elect to be subject to the provisions of this section, and the employer shall notify the board which employees have made that election.

(b) Notwithstanding subdivision (a), the contribution payable by an employer subject to this section shall be equal to 100 percent of the amount established pursuant to paragraph (1) of subdivision (a) on behalf of any annuitant

who either:

(1) Retired for disability.

(2) Retired for service with 20 or more years of service credit entirely with that employer, regardless of the number of days after separation from employment. The contribution payable by an employer under this paragraph shall be paid only if it is greater than, and made in lieu of, a contribution payable to the annuitant by another employer under this part. The board shall establish application procedures and eligibility criteria to implement this paragraph.

(c) This section does not apply to any contracting agency, its employees, or annuitants unless and until the agency files with the board a resolution of its governing body electing to be so subject. The resolution shall be adopted by a majority vote of the governing body and shall be effective at the time provided in board regulations.

(Added by Stats. 2004, Ch. 69, Sec. 22. Effective June 24, 2004.)

RESOLUTION NO. 2020-05

RESOLUTION OF THE BOARD OF DIRECTORS OF THE PUBLIC AGENCY RISK SHARING AUTHORITY OF CALIFORNIA (PARSAC) CHANGING THE PARSAC NAME TO CALIFORNIA INTERGOVERNMENTAL RISK AGENCY

WHEREAS, PARSAC was originally created as the California Municipal Insurance Authority, effective May 21, 1986, pursuant to Government Code Section 6500 et seq.;

WHEREAS, the original name was changed to Public Agency Risk Sharing Authority of California (PARSAC), effective November 19, 1993;

WHEREAS, PARSAC wishes to change its name to the California Intergovernmental Risk Agency;

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of PARSAC that as of July 1, 2021, PARSAC shall be known as the California Intergovernmental Risk Authority (CIRA). PARSAC members wishing to continue funding programs of insurance for workers' compensation, liability, property, and other coverages, must become parties to the CIRA Joint Powers Agreement.

Effective Date. This Resolution shall become effective July 1, 2021, upon approval by two-thirds of the Board of Directors present and voting.

ADOPTED this 26th, of May 2021.

_____
John Gillison, PARSAC President

ATTEST:

_____
Kin Ong, Board Secretary

CIRA RISK CONTROL PLAN

SUMMARY: The CIRA Risk Control Plan builds upon the existing programs of both PARSAC and REMIF with a primary objective of providing direct services to members that reduce liability and improve safety for employees and the public. The Plan focuses on improving program resources and delivery in the following areas:

- Onsite Member Support
- Training and Education
- Technology and Operational Efficiency

RECOMMENDATION: Receive and File

DISCUSSION: The primary objective of the CIRA risk control plan is to protect the assets of our members and the pool. This is accomplished by partnering with our member agencies in the development and implementation of risk management best practices and prioritizing pool resources to those exposures with the highest potential for loss.

Additionally, the risk control plan has adopted an objective-based approach, which focuses both on insurable and non-insurable risks of our members. Under an objective-based program, risk is defined as "the effect of uncertainty on objectives," and focuses on reducing the uncertainty associated with the non-insurable risks of our members. These risks include hazard, financial, compliance, reputational, operational, and strategic risks. By assisting our members in addressing risks that can impact achieving their mission and objectives, it will in turn help CIRA achieve its mission.

Risk Control Plan Elements

The Risk Control Plan builds upon the existing programs of both pools, while taking into account those programs and services that may not directly support reducing member and pool liability. The Plan focuses on providing resources and assistance in the following areas:

- Onsite Member Support
- Training and Education
- Technology and Operational Efficiency

Onsite Member Support

Both pools have provided limited onsite support for their member agencies in the past and mostly took the form of performing risk assessments or providing safety training. Under the new CIRA Risk Control Plan, Staff is proposing a Rent A Risk Manager program that will provide a minimum of four days of dedicated onsite service to each member. Larger members would receive up to eight days of onsite service. Under the Rent a Risk Manager model, an annual loss analysis and risk assessment will be performed for each member as part of the first day of service. Risk assessments would not include a formal written report; however, an executive summary indicating

key findings and recommendations would be documented. The second day would be dedicated to addressing the findings from the risk assessment and assisting the member in implementing the suggested recommendations. For subsequent visits, staff would continue to assist the member in completing any outstanding risk assessment findings, as well as providing other services in consultation with the member such as:

- Employee safety training
- Ergonomic assessments
- Safety inspections
- Safety and Risk Control Program development
- Implementation of online training
- Implementation of online safety inspection platform
- Contract reviews

Based on the combined membership of CIRA, a total of 284 onsite service days would be provided annually.

Member Size	**Number of Members**	**Onsite Days Provided**	**Total Onsite Days**
Small	17	4	68
Medium	24	6	144
Large	9	8	72
Total	**50**		**284**

As the Rent a Risk Manager program will require significant travel and staff resources, a dedicated part-time consultant is being proposed to augment staffing with a proposed budget of $125,000. Travel costs for the program have been estimated at $50,000 per year.

Education and Training

Both REMIF and PARSAC provide a number of education and training opportunities for its members throughout the year. With the merging our respective pools, we will have greater economies of scale and the ability to expand those education and training opportunities.

In addition to the onsite training that members may receive through the Rent a Risk Manager program, regional trainings will be provided twice per year in each of CIRA's three regions, as well as webinars at least once per quarter. For the regional trainings, outside consultants would be utilized. A training calendar will be developed with training material (posters, infographics, etc.) to be provided to each member for distribution to employees. CIRA will continue to support the Police Chiefs and Public Works Forums that were hosted by REMIF in the past, as well as an annual full-day Academy that was hosted with PARSAC.

Based on each respective pool's prior budgets to support education and training programs, it is estimated that the annual cost to support these programs will be $50,000.

Technology and Operational Efficiency

The use of technology and mobile devices for safety and risk management have grown tremendously in the last several years and provide an opportunity to reduce losses and improve efficiency. Additionally, as every member is required to comply with Cal/OSHA requirements, the use of technology can assist with those efforts and provide management a tool to help ensure program compliance. The following table provides current and proposed tools that will be provided to CIRA members, as well as their estimated cost.

Program	Cost`	Notes
Lexipol	$280,000	Police/Fire policy/procedure development and Daily Training Bulletins
TargetSolutions	$0 (no cost if excess provided by LAWCX or PRISM) $260,000 If purchased separately	Online training platform with safety, risk and HR courses.
TargetSolutions CEU Courses	$15,000	Optional CEU courses priced at $80/student for water treatment and EMT Paramedic personnel.
A-Check America Electronic DMV Employer Pull Notice Program	$0 (no cost if excess provided by LAWCX or PRISM) $5/driver If purchased separately	Online interface to enroll and manage drivers using the DMV EPN program
WaiverSign	$1500 annual fee	Electronic waiver program to allow customization assumption of risk and hold harmless agreements for members
Simple But Needed (SBN)	$10,000	Mobile safety management platform to conduct: • Inspections • Ergonomic assessments • Asset/inventory management • Permits (lockout/tagout, confined space, hot work)
PowToons	$700	Online training authoring tool
Safety BLR	$1300	Safety library resource with templates and model policies

In addition to the above targeted programs, the Finance Committee will also consider the development of a Safety Grant Fund program that will provide limited annual funding for members

to support risk reduction efforts specific to their agencies. Based on PARSAC's current program, estimated budget would provide $2,500 per agency based on liability and workers' compensation program participation.

FISCAL IMPLICATIONS: Staff will be proposing one additional loss control consultant be included in the FY 2021-2022 budget at an annual cost of $125,000, as well as estimated annual travel costs of $50,000. Increased staffing costs are expected to be offset by elimination and/or reduction of underutilized programs of both pools. There are also expected to be potential savings to both the General Liability and Workers' Compensation programs due to improvements in members risk control programs.

ATTACHMENT: None

PARSAC/REMIF
FINANCE TRANSITION COMMITTEE MEETING
November 4, 2020

CIRA
PRELIMINARY OPERATING BUDGET

CIRA

2021/22 Preliminary Budget

	2020/21 PARSAC and REMIF Budget adjusted for costs associated with PARSAC and REMIF legacy claims, REMIF Health Program, and retiree benefits.			CIRA Budget	
	PARSAC	REMIF	Total Budget 2020/21	Proposed Budget	Budget Difference
	2020/21			2021/22	% Change
INCOME					
Member Contributions					
Liability Contributions	$ 9,429,296	$ 5,592,039	$ 15,021,335	$ 15,021,335	0%
Workers' Compensation Contributions	6,170,861	7,362,265	13,533,126	13,533,126	0%
Property Contributions	2,766,736	3,307,316	6,074,052	6,074,052	0%
Bond Income	78,000	-	78,000	78,000	0%
Auto Physical Damage	-	372,364	372,364	372,364	0%
Total Member Contributions	18,444,893	16,633,984	35,078,877	35,078,877	0%
Misc Fees	-	104,400	104,400	104,400	0%
TOTAL INCOME	18,444,893	16,738,384	35,183,277	35,183,277	0%
EXPENSE					
Excess Insurance					
Liability Insurance Premium	3,149,467	1,170,000	4,319,467	4,319,467	0%
ERMA	1,346,595	-	1,346,595	1,346,595	0%
Pollution	12,000	-	12,000	12,000	0%
Auto Physical Damage	-	248,000	248,000	248,000	0%
Workers Comp Premium - LAWCX	1,311,345	402,500	1,713,845	1,713,845	0%
Property Insurance - PEPIP	2,713,070	2,823,997	5,537,067	5,537,067	0%
Bond Insurance	78,000	-	78,000	78,000	0%
Total Excess Insurance	8,610,477	4,644,497	13,254,974	13,254,974	0%
Claims Expense					
Liability Claims Expense					
Liability Claims Expense	3,657,736	2,998,451	6,656,187	6,656,187	0%
Liab Adm Fees	427,000	127,000	554,000	410,000	-26%
Sewer Consultant	15,000	-	15,000	15,000	0%
Total Liability Claims Expense	4,099,736	3,125,451	7,225,187	7,081,187	-2%
Workers Compensation Claims Expense					

CIRA

2021/22 Preliminary Budget

	2020/21 PARSAC and REMIF Budget adjusted for costs associated with PARSAC and REMIF legacy claims, REMIF Health Program, and retiree benefits.			CIRA Budget	
	PARSAC	REMIF	Total Budget 2020/21	Proposed Budget	Budget Difference
	2020/21			2021/22	% Change
WC Claims Expense at expected	3,605,157	5,134,690	8,739,847	8,739,847	0%
WC Adm Fees	448,880	570,000	1,018,880	1,018,880	0%
Total Workers Compensation Claims Exp	4,054,037	5,704,690	9,758,727	9,758,727	0%
Total Claims Expense	8,153,773	8,830,141	16,983,914	16,839,914	-1%
WC Self Insurance Fees	150,000	253,867	403,867	-	-100%
WC self insurance fees alloacted to legacy claims	(150,000)	(253,867)	(403,867)	-	-100%
Total WC Self Insurance Fees	-	-	-	-	0%
Payroll and Benefits					
Employee Salary	532,389	372,243	904,632	743,688	-18%
Potential Merit/Contract Increase	-	-	-	37,185	0%
Accrued Vacation Expense	8,000	-	8,000	5,375	-33%
COLA Increase	-	-	-	-	0%
Performance Pay	3,500	-	3,500	-	-100%
Payroll Taxes PARSAC	8,505	23,000	31,505	10,634	-66%
Medical	130,000	92,703	222,703	110,423	-50%
Ancillary Benefits	16,500	5,035	21,535	10,513	-51%
PERS Retirement Cost	53,509	59,000	112,509	81,451	-28%
Unfunded Liability	26,072	230,000	256,072	-	
Salary & Benefits Allocated to REMIF Health Program '20/21	-	(187,427)	(187,427)	-	
Unfunded Liability Allocated to REMIF Health Program '20/21	(26,072)	(230,000)	(256,072)	-	
Total Payroll and Benefits	752,403	364,554	1,116,957	999,270	-11%
Consultants					
Actuarial Liability Fee	18,700	10,609	29,309	14,500	-51%
Actuarial WC Fee	20,125	10,609	30,734	14,500	-53%
Actuarial - OPEB	7,000	10,000	17,000	7,500	-56%
Computer Consultant	12,000	5,305	17,305	5,000	-71%

CIRA

2021/22 Preliminary Budget

	2020/21 PARSAC and REMIF Budget adjusted for costs associated with PARSAC and REMIF legacy claims, REMIF Health Program, and retiree benefits.			CIRA Budget	
	PARSAC	REMIF	Total Budget 2020/21	Proposed Budget	Budget Difference
	2020/21			2021/22	% Change
Web Development	2,500	5,000	7,500	6,000	-20%
Legal- General	50,000	35,000	85,000	45,000	-47%
Financial Audit/Accounting	26,500	28,000	54,500	20,000	-63%
Finance Manager	-	99,225	99,225	-	-100%
Consultants Liab Other	7,500	-	7,500	-	-100%
Consultants WC Other	7,500	-	7,500	-	-100%
Consultants Allocated to REMIF Health Program '20/21	-	(58,665)	(58,665)	-	
Total Consultants	151,825	145,083	296,908	112,500	-62%
Safety & Loss Control					
New Member Audit	2,500	-	2,500	-	-100%
On-line Training	12,000	-	12,000	20,000	67%
OccuMed	-	9,000	9,000	-	-100%
DOT (Pass-Through)	-	11,430	11,430	-	-100%
Safety/MSDS (Pass-Through)	-	63,860	63,860	-	-100%
Group Legal (Pass-Through)	-	10,040	10,040	-	-100%
DKF Solutions	-	68,600	68,600	-	-100%
Acceptable Risk	-	24,000	24,000	-	-100%
Marines	-	10,000	10,000	-	-100%
Lexipol	80,000	53,500	133,500	215,000	61%
EPL Consortium	-	47,616	47,616	125,000	163%
WaiverSign	1,000	-	1,000	2,000	100%
Safety/BLR/Powtoons (Tableau PY Only)	3,922	-	3,922	2,000	-49%
Simple But Needed	7,500	-	7,500	10,000	33%
Misc Loss Control	7,578	5,733	13,311	5,000	-62%
Annual Academy	15,000	-	15,000	15,000	0%
RM 101	5,000	-	5,000	-	-100%
Conference Reimbursements	-	81,000	81,000	-	-100%
Workshops	-	36,500	36,500	36,500	0%
Grant Program	152,500	-	152,500	175,000	15%

CIRA

2021/22 Preliminary Budget

	2020/21 PARSAC and REMIF Budget adjusted for costs associated with PARSAC and REMIF legacy claims, REMIF Health Program, and retiree benefits.			CIRA Budget	
	PARSAC	REMIF	Total Budget 2020/21	Proposed Budget	Budget Difference
	2020/21			2021/22	% Change
Rent a Risk Manager	-	-	-	140,000	New
Total Safety & Loss Control	287,000	421,279	708,279	745,500	5%
General and Administrative					
Advertising & Promotion	6,000	-	6,000	6,000	0%
Bank Service Fee	5,000	7,000	12,000	2,200	-82%
Capital Expenditures - Expensed	10,000	-	10,000	-	-100%
Computer Cost (Software)	4,000	43,150	47,150	11,900	-75%
Contingency/Misc. Expense	15,000	6,500	21,500	10,000	-53%
Copier Maintenance	7,500	5,000	12,500	10,000	-20%
Dues	5,000	2,000	7,000	5,000	-29%
Employee WC Insurance	23,000	-	23,000	20,200	-12%
Insurance Liability Office	12,000	-	12,000	12,000	0%
Office Expense	8,000	13,000	21,000	10,000	-52%
Payroll Service	2,000	19,096	21,096	1,000	-95%
Postage & Express Mail	3,000	1,200	4,200	2,500	-40%
Printing	4,000	-	4,000	4,000	0%
Rent/Equipment Lease	-	5,000	5,000	-	-100%
Telecommunications	8,500	13,000	21,500	14,875	-31%
'20/21. Includes Travel, Board Exp, and some Building Costs	-	(94,645)	(94,645)	-	
Total General and Administrative	113,000	20,301	133,301	109,675	-18%
Staff Travel and Training					
Staff-Educ & Training	5,000	-	5,000	5,000	0%
Staff-Travel Cost	15,000	15,000	30,000	30,000	0%
Staff - Car Allowance	6,000	-	6,000	6,000	0%
Total Staff Travel and Training	26,000	15,000	41,000	41,000	0%
Board Expenses					
Board Directors- Travel & Meetings	60,000	30,000	90,000	60,000	-33%
Total Board Expenses	60,000	30,000	90,000	60,000	-33%

CIRA

2021/22 Preliminary Budget

	2020/21 PARSAC and REMIF Budget adjusted for costs associated with PARSAC and REMIF legacy claims, REMIF Health Program, and retiree benefits.			CIRA Budget	
	PARSAC	REMIF	Total Budget 2020/21	Proposed Budget	Budget Difference
	2020/21			2021/22	% Change
Building Maintenance					
Utilities	16,350	11,025	27,375	23,755	-13%
Building Repairs	15,000	41,500	56,500	42,880	-24%
Janitorial Service	9,500		9,500	9,500	0%
Landscaping Service	6,000		6,000	6,000	0%
Pest Control	700		700	700	0%
Security/Alarm	600		600	600	0%
Property Taxes	11,500	9,000	20,500	17,545	-14%
Insurance - Property (Office)	10,000	5,000	15,000	13,360	-11%
Total Building Expenses	69,650	66,525	136,175	114,340	-16%
TOTAL EXPENSE	18,224,128	14,537,380	32,761,508	32,277,173	-1%
Total Operating Income	220,765	2,201,004	2,421,769	2,906,104	
Other Expenses					
Rental Income	-	71,300	71,300	36,275	-49%
Investment Income	830,066	100,000	930,066	-	-100%
Investments Allocated to REMIF Health Program '20/21 and Legacy Claims	(775,550)	(75,000)	(850,550)	-	
Investment Consultants	(54,516)	(25,000)	(79,516)	-	-100%
Total Investment Income	-	71,300	71,300	36,275	-49%
Total Other Income/(Expense)	-	71,300	71,300	36,275	-49%
NET INCOME	**220,765**	**2,272,304**	**2,493,069**	**2,942,379**	
Rate Stabilization/Special Events Credits	(652,223)	-	(652,223)		
Capital Replacement Fund	(20,000)	-	(20,000)		
Depreciation	(30,000)	-	(30,000)		

CIRA

2021/22 Preliminary Budget

	2020/21 PARSAC and REMIF Budget adjusted for costs associated with PARSAC and REMIF legacy claims, REMIF Health Program, and retiree benefits.			CIRA Budget	
	PARSAC	REMIF	Total Budget 2020/21	Proposed Budget	Budget Difference
	2020/21			2021/22	% Change
Excess Dividend Received	149,723	-	149,723		
Health Program Contributions (Direct Costs)	-	15,679,588	15,679,588		
Health Program Expenses (Direct Costs)	-	(15,667,238)	(15,667,238)		
Total Adjusted for Health Program and Legacy Claims	(176,815)	(815,604)	(992,419)		
Adjust for Investment Income Allocated to Health Program and Legacy Claims.	775,550	75,000	850,550		
Retiree Benefits	-	(182,500)	(182,500)		
EAP	-	(57,090)	(57,090)		
Net Income Per 20/21 Budgets	267,000	1,304,460	1,571,460		

CIRA
FUNDING RECOMMENDATIONS

Workers' Compensation Program

ARTICLE III: PROGRAM ELEMENTS

A. FUNDING

1. Funding each year shall be at the 75% confidence level at the discretion of the Board of Directors. A discount factor shall be applied as approved by the Board.
2. The Target Equity goal is set at five times the **Program's SIR**.
3. Funding in excess of the 90% confidence level excluding the target equity will be available for distribution at the discretion of the Board of Directors.
4. A Rate Stabilization Fund in an amount not to exceed $1,000,000 may be established to off-set pool and excess rate increases as determined by the Board of Directors. The Fund will be replenished prospectively at the Board of Director's discretion when the fund falls below 50% capacity.
5. If the overall confidence level falls below 70% according to actuarial projections, the Board of Directors may declare an assessment to be shared by all **Program Participants.**
6. Upon completing seven years, a program year shall be eligible for a dividend or assessment.

   Dividends or assessments will be made in the following percentages:

7. 50% of equity in year 8 — 70% of equity in year 10
   60% of equity in year 9 — 90% of equity in year 11-15
8. Program years may be considered for closure 15 years after the year-end, and it has been at least one year since closure of the last claim in the proposed year(s). Once declared closed, 100% of remaining equity may be distributed to members through the RPA.
9. If a claim is reported or reopened after a year has been closed and equity returned, surplus in excess of the 90% confidence level in positive years may be used to offset the deficit in negative years or members may be assessed per the discretion of the board.

10. The following benchmarks will be reviewed before a dividend or assessment is declared:

- **Net Contributions to Equity**

Calculation: *(Contribution – Excess Insurance) / Equity*
Measures the impact of pricing inaccuracies on equity (a low ratio is desirable). A low ratio indicates that more equity is available to cover under-charged years. The target is less than 200%

- **Claim Reserves and IBNR to Equity**
  Calculation: *(Claim Reserves + IBNR + ULAE) / Equity*
  Measures the impact of reserves inaccuracies on equity (a low ratio is desirable). A low ratio indicates more equity available to cover years with large losses. The target is less than 300%

- **Prior Year Loss Development**
  Calculation: *(Year 1 Loss Reserves / Year 2 Loss Reserves) / (Yr 2 / Yr3) – 1*
  Measures the change in loss reserves from one year to the prior year. A lower ratio indicates not much change in reserves between years. Target of less than 20% is desirable.

- **Change in Equity**
  Calculation: *(Year 2 Equity / Year 1 Equity) – 1*
  Measures the change in equity. Any increase is desirable. The target is less than 10%.

CIRA
COST ALLOCATION FORMULA

Cost Allocation Comparison

PARSAC

GL and WC programs based on payroll, loss experience and SIR.

General Adm. Expenses allocated by payroll, loss experience and SIR.

Pooled GL claims adm. allocated by payroll and loss experience and SIR.

Primary GL claims adm. minimum $1,000 per agency, allocated by payroll and loss experience.

GL and WC excess coverage allocated by payroll.

REMIF

GL program based on vehicle valuations, member budgeted expenditures, loss experience and member deductible.

WC program based on actual payroll, loss experience and member deductible.

GL General Admin, Claims Admin, & Excess Coverage Expenses allocated by vehicle valuations, member budgeted expenditures, loss experience and member deductible.

WC General Admin, Claims Admin, & Excess Coverage Expenses allocated by payroll, loss experience and member deductible.

CIRA
MEMBER SIR DISCUSSION

2020/21 PARSAC & REMIF Member SIRs

Member Agency	*Liabilities*	*EPL*	*WC*
Arcata	$5,000	$5,000	$5,000
Amador City	$10,000	$10,000	
Avalon	$25,000	$25,000	$10,000
Belvedere	$25,000	$25,000	$100,000
Blue Lake	$5,000	$5,000	$5,000
California City	$100,000	$100,000	
Calimesa	$10,000	$10,000	$25,000
Calistoga	$10,000	$10,000	$25,000
Citrus Heights	$100,000	$100,000	$100,000
Clearlake	$50,000	$25,000	$50,000
Cloverdale	$5,000	$5,000	$5,000
Coalinga	$25,000	$25,000	$25,000
Cotati	$5,000	$5,000	$5,000
Eureka	$25,000	$25,000	$10,000
Ferndale	$5,000	$5,000	$5,000
Fort Bragg	$5,000	$5,000	$5,000
Fortuna	$5,000	$5,000	$5,000
Grass Valley	$25,000	$25,000	$25,000
Healdsburg	$5,000	$5,000	$5,000
Highland	$100,000	$25,000	$5,000
Lakeport	$10,000	$10,000	$5,000
Menifee	$150,000	$25,000	$50,000
Nevada City	$25,000	$25,000	
Placentia	$100,000	$100,000	
Placerville	$50,000	$50,000	
Plymouth	$5,000	$5,000	$5,000
Point Arena	$5,000	$5,000	$5,000
Rancho Cucamonga	$500,000	$250,000	$250,000
Rancho Cucamonga FPD	$250,000	$75,000	$250,000
Rancho Santa Margarita	$10,000	$10,000	$10,000
Rohnert Park	$25,000	$25,000	$5,000
San Juan Bautista	$5,000	$5,000	
Sebastopol	$5,000	$5,000	$5,000
Sierra Madre (7/1/21)	$25,000	$25,000	$25,000
Sonoma	$5,000	$5,000	$5,000
South Lake Tahoe	$250,000	$100,000	
St. Helena	$10,000	$10,000	$5,000
Tehama	$5,000	$5,000	$5,000
Trinidad	$5,000	$5,000	$5,000
Truckee (town)	$50,000	$25,000	$25,000
Twentynine Palms	$10,000	$10,000	$5,000
Ukiah	$25,000	$25,000	$10,000
Watsonville	$500,000	$250,000	$150,000
Wheatland	$5,000	$5,000	$5,000
Wildomar	$5,000	$5,000	$5,000
Willits	$5,000	$5,000	$5,000
Windsor (town)	$10,000	$10,000	$10,000
Yountville (town)	$10,000	$10,000	$5,000
Yucaipa	$50,000	$50,000	$5,000
Yucca Valley (town)	$100,000	$100,000	$5,000

RETROSPECTIVE RATING FORMULA

RPA Calculation

Contributions
+ Investment Earnings
- Administrative Expenses
- Claim Payments
- Claim Reserves (Reported & IBNR)
= Equity (If positive available dividend, if negative member assessment)

RPA Calculation Guidelines

Program	Equity Requirements	First Year Eligible	Maximum Assessment **
Liability	90% CL * + $5,000,000 (5 x SIR)	5th Year at 50% of Available Equity up to 90% at Year 9. All equity may be returned after 10 years if no open claims	25% of Premium
Workers' Compensation	90% CL* + $2,500,000 (5 x SIR)	8th Year at 50% of Available Equity up to 90% at Year 9. All equity may be returned after 10 years if no open claims	25% of Premium

* CL – Confidence level determined by actuary

** Maximum may be exceeded for large deficit

Financial Benchmarks

1)Net Contributions to Net Assets

2)Claims Liabilities to Net Assets

3) Change in Loss Development

4)Change in Net Assets

.

REMIF
REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

PUBLIC AGENCY RISK SHARING AUTHORITY OF CALIFORNIA
PARSAC

AGENDA
PARSAC/REMIF TRANSITION COMMITTEE MEETING
November 23, 2020 – 9:00 a.m. – 2:00 p.m.
Zoom Meeting

Link: https://zoom.us/j/93933527732
Dial: +1 (669) 900-9128
Meeting ID: 939 3352 7732
Passcode: 084731

CALL TO ORDER
ROLL CALL

Page No.	**ACTION AND INFORMATION CALENDAR** **denotes attachments enclosed for this item*	**RECOMMENDATION**
3	1. Liability Memorandum of Coverage – Doug Alliston	*Review and discuss*
21	2. Workers' Compensation Master Program Document – Amy Northam a. Confidence Level Funding b. RPA Formula and Target Equity Goals	*Review and approve*
	3. Meeting Location and Meeting Timeframes for Executive Committee and Board of Directors – Amy Northam	*Review and approve*
36	4. Retiree Health Benefits for New CIRA Employees – Tracey Smith-Reed	*Review and discuss*
39 *41*	5. Update on the Finance Transition Committee Meeting – Tracey Smith-Reed a. CIRA Budget and Services b. Cost Allocation Funding c. Cost Allocation to the REMIF Health Plan d. Cost Allocation to Programs e. Actuary & Valuation Date	*Review, discuss and approve*
	6. Update on Excess Liability and Workers' Compensation – Erike Young	*Review and discuss*

7. Timelines – Kin Ong & Amy Northam

8. Schedule Next Meetings:
   a. Transition Committee – December 14, 2020
   b. Transition Finance Committee – December 9, 2020
   c. CIRA Board - May 26, 2021

ADJOURNMENT OF MEETING

LIABILITY
MEMORANDUM OF COVERAGE
FOR
CALIFORNIA INTERGOVERNMENTAL RISK AUTHORITY

CIRA

Effective July 1, 2021 to June 30, 2022

MEMORANDUM OF COVERAGE
FOR THE
CALIFORNIA INTERGOVERNMENTAL RISK AUTHORITY
(CIRA)

This Memorandum of Coverage does not provide insurance, but instead provides for pooled risk sharing. This **Memorandum** is a negotiated agreement among the **Members** of the **Authority** and none of the parties to the **Memorandum** is entitled to rely on any contract interpretation principles which require interpretation of ambiguous language against the drafter of such **Memorandum**. This **Memorandum** shall be applied according to the principles of contract law, giving full effect to the intent of the **Members** of the **Authority**, acting through the Board of Directors in adopting this Memorandum of Coverage.

Throughout this **Memorandum**, words and phrases that appear in boldface have special meanings as provided in Section VII – Definitions.

In consideration of the payment of the contribution deposit, the **Authority** agrees with the **Members** as follows:

SECTION I – LIABILITY COVERAGE AGREEMENT

The **Authority** will pay **Ultimate Net Loss** in excess of the **Retained Limit** that the **Covered Party** shall become obligated to pay by reason of **Tort Liability** imposed by law or assumed in a **Covered Contract** because of **Bodily Injury**, **Property Damage**, **Personal Injury**, **Employment Practices**, or **Public Officials Errors or Omissions**, if caused by an **Occurrence** to which this **Memorandum** applies.

SECTION II—DEFENSE AND SETTLEMENT

A. Duty to Defend. The **Authority** shall have the right to participate in the defense of any **Claim** or **Suit** against a **Covered Party** if the final judgment or settlement is likely to result in an **Ultimate Net Loss** in excess of the **Retained Limit**. The **Authority** shall have no obligation to defend or contribute to the defense of uncovered **Claims**, including uncovered **Claims** contained in a suit that contains covered **Claims**.

B. Selection and Assignment of Defense Counsel.

1. With respect to any potentially covered **Claim** or **Suit**, the **Authority** shall select and assign counsel to defend the **Covered Party(s)**. The **Authority** will consider the wishes of a **Covered Party** with respect to the assignment of counsel, but the **Authority** retains the sole right to make the assignment of counsel. If the **Covered Party** refuses to be defended by the counsel assigned by the **Authority**, then this **Memorandum** shall not provide any defense or indemnity to such **Covered Party** for such **Claim**, and the **Authority** shall not be required to contribute to any **Defense Costs**, settlement or judgment arising from such **Claim**.

2. A **Covered Party** may select as its defense counsel the in-house City or Town Attorney directly employed as such by the **Member**. For purposes of this provision,

in-house City or Town Attorney shall not include any outside counsel contracted to act as a City or Town Attorney by the **Member** or any outside counsel contracted by the **Covered Party** to act as counsel for any **Claim**. In the event that a **Covered Party** selects the in-house City or Town Attorney to defend any **Claim**, the **Authority** shall not be required to contribute to any **Defense Costs** arising from such **Claim** or **Suit**, and any **Defense Costs** arising from such **Claim** or **Suit** or sums incurred by the **Member** for salaries, fees, benefits or costs of any nature of the in-house counsel shall not apply toward satisfaction of the **Retained Limit**. Notwithstanding the foregoing, and subject to the **Authority's** review and approval, with respect to any covered **Claim** or **Suit** where the **Retained Limit** is $350,000 or higher, the **Covered Party** may select as its defense counsel outside counsel contracted by the **Member** to act as the City or Town Attorney, but only if the outside counsel has demonstrated experience with the subject matter of the **Claim**. If as the result of the **Authority's** review of the defense counsel's performance on the **Claim** or **Suit**, the **Authority** withdraws its approval of such counsel, then counsel shall be determined and assigned as provided in paragraph 1, regardless of the **Member's Retained Limit**.

3. With respect to the defense of any covered **Claim** or **Suit** against a **Member** for **Tort Liability** assumed in a **Covered Contract**, the **Authority** shall select and assign counsel to defend such parties identified in the **Covered Contract**. The **Authority** shall select counsel from a list of Panel Counsel established by the **Authority**. The **Authority** will consider the wishes of a **Covered Party** with respect to the assignment of counsel, but the **Authority** retains the sole right to make the assignment of counsel. In the event of a *disagreement regarding the assignment of counsel, the **Covered Party** retains the right to appeal to the Board of Directors, whose decision shall be final*. If either the **Covered Party** or the party identified in the **Covered Contract** refuses to have such party(s) be defended by the counsel assigned by the **Authority**, then the obligation of the **Authority** to contribute to **Defense Costs** arising from such **Claim** or **Suit** shall be limited to such amounts as would be incurred if counsel selected from the Panel Counsel list were assigned the defense of such **Claim** or **Suit**.

C. *Termination of Authority's Obligation.* The **Authority**'s obligation to defend and/or cover any **Claim** shall cease after the **Coverage Limit** stated in Section V has been exhausted by payment of settlement(s), judgment(s) and/or **Defense Costs**.

D. *Settlement.* No **Claim** shall be settled for an amount in excess of the **Retained Limit** without the prior written consent of the **Authority** and the **Authority** shall not be required to contribute to any settlement to which it has not consented.

If the **Member**'s **Retained Limit** has already been expended the **Authority** shall have the sole discretion to control the defense and settlement of the **Claim**. Any such decision to settle shall be final.

If the **Member**'s **Retained Limit** has not been expended (i.e., the **Member** will have to contribute funds to effectuate the settlement), then the consent of the **Member** to any settlement shall be required. If however, the **Member** refuses to consent to any settlement or compromise recommended by the Authority or its Claim Administrator and elects instead to continue to contest the **Claim**, then the **Authority**'s liability shall not exceed the amount for which the **Authority** would have been able to settle the **Claim** plus **Defense Costs** at the time the **Claim** could have been settled or compromised.

SECTION III—COVERAGE LIMIT

A. The Limit of Coverage shown in **Cover Page** and the rules below determine the most the **Authority** will pay, inclusive of **Defense Costs**, regardless of the number of:

1. **Covered Parties;**
2. **Occurrences;**
3. **Claims** made or **Suits** brought; or
4. Persons or organizations that sustain injuries or **Damages.**

B. The **Authority** shall pay only for **Ultimate Net Loss** in excess of the **Retained Limit**.

C. The Limit of Coverage stated in the **Cover Page** is the most the **Authority** will pay for **Ultimate Net Loss** as respects the sum of **Damages** and **Defense Costs** arising out of any one **Occurrence.**

D. In determining the Limit of Coverage, all injury or damage arising out of exposure to substantially the same general condition(s) shall be considered as arising out of one **Occurrence**.

E. Any loss of use of tangible property not physically injured or destroyed shall be deemed to occur at the time of the **Occurrence** that caused such loss of use. Any other injury or damage occurring or alleged to have occurred over more than one coverage period shall be deemed to have occurred during the coverage period when the **Occurrence** begins, and only the **Limit of Coverage** for that coverage period shall apply.

SECTION IV—COVERAGE PERIOD AND TERRITORY

This **Memorandum** applies to **Bodily Injury, Property Damage, Personal Injury**, **Employment Practices**, or **Public Officials Errors or Omissions** that occur anywhere in the world during the **Coverage Period**.

SECTION V—EXCLUSIONS

This **Memorandum**, including any obligation to defend or to pay **Defense Costs**, is subject to the following exclusions:

A. *Additional Covered Party*. This **Memorandum** does not apply to **Claims** arising out of the active or sole negligence of an **Additional Covered Party**. Also, no **Additional Covered Party** is covered for **Claims** by another **Covered Party**.

B. *Aircraft or Airport Operations*. This **Memorandum** does not apply to **Claims** arising out of the ownership, operation, use or maintenance of any **Aircraft** or **Airport** owned by a **Covered Party.** However, this exclusion does not apply to claims arising out of the ownership, operation, use or maintenance of any **Unmanned Aerial Vehicle (UAV)** that is owned or operated by or on behalf of any **Member**.

C. *Antitrust or Restraint of Trade*. This **Memorandum** does not apply to **Claims** arising out of violation of state or federal antitrust or restraint-of-trade laws.

D. *Bounce House.* This **Memorandum** does not apply to **Claims** arising out of the ownership, maintenance, or use of any inflatable rebound device or equipment.

E. *Breach of Contract*. This **Memorandum** does not apply to **Claims** arising out of failure to perform, or breach of, a contractual obligation.

F. *Contractual Liability*. This **Memorandum** does not apply to **Claims** arising out of the **Covered Party's** assumption of **Tort Liability** in a written agreement or contract, but this exclusion does not apply to liability assumed in a **Covered Contract** if the **Damages** occur subsequent to the execution of the **Covered Contract**.

G. *Dam Failure*. This **Memorandum** does not apply to **Claims** arising out of the partial or complete structural failure of any **Dam**.

H. *Disability Accommodation Expenses.* This Memorandum does not apply to the cost of providing reasonable accommodation pursuant to the Americans with Disabilities Act, Fair Employment and Housing Act, or any similar law.

I. *Employee Benefits Plans*. This **Memorandum** does not apply to **Claims** arising out of any act or omission regarding benefits payable under any employee benefits plan established by the **Covered Party**.

J. *Employee Injury***.** This **Memorandum** does not apply to **Bodily Injury** or **Personal Injury** to:

1. any past or current employee of the **Covered Party** arising out of and in the course of employment by the **Covered Party**; or

2. The spouse, child, parent, brother, sister, or other relative of such employee as a consequence of 1. above.

K. *Employer Obligation Limitation*. The defense and indemnity coverage afforded by this **Memorandum** to a past or present official, employee or volunteer of a **Member** is not broader than the **Member's** duty to defend and indemnify its official, employee or volunteer, pursuant to California Government Code Section 815, 815.3, 825 to 825.6, 995 to 996.6, inclusive, and any amendments thereof. If the **Member** which employs the official, employee or volunteer is not obligated under the California Government Code to provide a defense or to provide indemnity for a **Claim**, or if said **Member** refuses to provide such defense and/or indemnity to said official, employee or volunteer, then this **Memorandum** shall not provide any such defense or indemnity coverage to said official, employee or volunteer. All immunities, defenses, rights, and privileges afforded to a **Member** under California Government Code Section 815, 815.3, 825 to 825.6, 995 to 996.6, inclusive, and any amendments thereof, shall be afforded to the **Authority** to bar any defense or indemnity coverage under this Memorandum to that **Member's** official, employee or volunteer.

L. *Estimates, Plans and Contract Awards*. This **Memorandum** does not apply to **Public Officials Errors or Omissions** arising out of:

1. estimates of probable costs or cost estimates being exceeded

2. faulty preparation of bid specifications, or architectural or engineering drawings, plans or specifications

3. failure to award contracts in accordance with ordinances, regulations or statutes governing such contracts that must be submitted for bids

M. *Failure to Supply Utilities*. This **Memorandum** does not apply to any **Claim** arising out of the failure to supply or provide an adequate supply of gas, water, sewage capacity or electricity. However, this exclusion does not apply if the failure to supply results from direct and immediate accidental injury to tangible property owned or used by a **Covered Party** to procure, produce, process or transmit gas, water, sewage capacity or electricity.

N. *Fiduciary Liability*. This **Memorandum** does not apply to **Claims** arising out of any breach of responsibility, obligation or duty imposed upon or imputed to a **Covered Party**:

1. under the Employee Retirement Income Security Act of 1974 and any law amendatory thereof

2. under Article XVI, Section 17 of the California Constitution and any law amendatory thereto

3. under any other law imposing or imputing fiduciary responsibilities, obligations or duties upon a **Covered Party**.

O. *Fines, Penalties and Punitive Damages*. This **Memorandum** does not apply to **Claims** for fines, penalties, restitution, disgorgement, punitive damages, or exemplary damages.

P. *Impairment or Loss of Property.* This **Memorandum** does not apply to **Public Officials Errors or Omissions** arising out of or resulting in injury or damage to, destruction of, disappearance of, loss of, loss of use of, or diminution of value of any tangible property, money or securities; or failure to pay debt obligations.

Q. *Knowingly False Statements*. This **Memorandum** does not apply to **Personal Injury** arising out of a publication or utterance concerning any organization or business enterprise, or its products or services, made by or at the direction of any **Covered Party** with knowledge of the falsity thereof.

R. *Labor Disputes and Class Actions.* This **Memorandum** does not apply to any potential or actual liability arising out of a lockout, strike, picket line, replacement or other similar action in connection with labor disputes or labor negotiations; or to any potential or actual liability arising from **Claims** filed or certified as class actions in which employees or other persons represent a class of employees who are alleging similar or related **Claims**.

S. *Land-Use and Other Regulation*. This **Memorandum** does not apply to:

1. any **claim** arising out of or in connection with land-use regulation, land-use planning, the adoption or administrative application of any ordinance, building code, resolution, or regulation; or the approval or disapproval of any land-use entitlement including but not limited to general plan amendments, zoning amendments, conditional-use permits,

tract maps, development agreements, owner-participation agreements, or any other land-use related agreements. This exclusion shall not apply to the physical enforcement of an ordinance, resolution or regulation, such as **Tort Liability** arising from the act of delivering a fine, citation, warning, notice or inspection.

2. the principles of eminent domain or inverse condemnation, by whatever name called, or condemnation proceedings, regardless of whether such claims are made directly against the **Covered Party** or by virtue of any agreement entered into by or on behalf of the **Covered Party**. However, this exclusion shall not apply to claims arising from physical damage to tangible property; provided however, this exception shall not apply to any nonphysical consequential **damages** including but not limited to claims for loss of use, loss of income, loss of profits, and loss of business goodwill.

3. the approval or disapproval of any rent control ordinance, outdoor advertising ordinance, or adult bookstore ordinance, taxi ordinance.

4. the approval or disapproval of the operation of a cannabis dispensary whether medical, recreational, or otherwise; the enactment of any ordinances governing cannabis dispensaries, and any enforcement of ordinances governing cannabis dispensaries.

T. *Medical and Healthcare Operations*. This **Memorandum** does not apply to **Claims** arising out of ownership, use, operation or maintenance of any hospital, health care or medical clinic facility, and any professional medical services performed by or on behalf of the **Covered Party**, including, but not limited to, dental, veterinary and chiropractic, but this exclusion does not apply to such services performed by emergency medical technicians or paramedics functioning under the direction and control of the **Covered Individuals**.

U. *Medicare Compliance*. This **Memorandum** does not apply to **Claims** arising from or relating to any sums sought by Medicare with respect to a **Claim** or **Suit** settled by a **Member** within its **Retained Limit**.

V. *Motorized Racing Contest*. This **Memorandum** does not apply to **Claims** arising out of automobile or motorcycle drag racing, speed racing, or similar speed contests sponsored, controlled or participated in by a **Covered Party**.

W. *Non-Monetary Relief.* This **Memorandum** does not apply to **Claims** alleging, based upon or arising out of claims, demands or actions seeking relief or redress in any form other than money damages, or for claimant/plaintiff attorney fees, costs or expenses relating to claims, demands or actions seeking relief or redress in any form other than money damages.

X. *Nuclear*. This **Memorandum** does not apply to **Bodily Injury or Property Damage** arising out of the hazardous properties of **Nuclear Material**.

Y. *Pollution*. This **Memorandum** does not apply to **Claims** arising out of the actual, alleged or threatened discharge, dispersal, escape, migration, release, or seepage of **Pollutants**. However, this exclusion does not apply to **Bodily Injury or Property Damage** arising out of or caused by any actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of **Pollutants** if:

1. It was directly caused by **Hostile Fire,** explosion, lightning, windstorm, vandalism malicious mischief, or by the collision, overturning or upset of a motor vehicle; or

2. It was accidental and neither expected nor intended by the **Covered Party**; and

3. It was instantaneous and was demonstrable as having commenced at a specific time and date during the **Covered Period**; and

4. Its commencement became known to the **Covered Party** within seven days; and

5. Its commencement was reported in writing to the Authority within twenty days of becoming known to the **Covered Party**; and

6. The **Covered Party** takes reasonable steps to correct or terminate the discharge, dispersal, seepage, migration, release or escape of **Pollutants**.

Nothing contained in this Exclusion S shall operate to provide any coverage or any obligation to defend or pay **Defense Costs** with respect to:

a. Any site or location used by others on the **Covered Party's** behalf for the handling, storage, disposal, dumping, processing, or treatment of waste material. This exclusion applies whether the action by others was known to the **Covered Party**;

b. Any clean-up costs mandated by the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA) and any similar laws or statutes;

c. Clean up, removal, containment, treatment, detoxification, or neutralization of **Pollutants** situated on the premises the **Covered Party** currently owns, rents, or occupies.

d. Any **Claim**, liability, loss, cost, or expense based upon or arising out of **Personal Injury** or **Public Officials Errors or Omissions**.

Z. *Property in the Covered Party's Control*. This **Memorandum** does not apply to **Property Damage** to:

1. property owned by the **Covered Party**;

2. property rented to, leased to the **Covered Party** where the **Covered Party** has assumed liability for damage to or destruction of such property, unless the **Covered Party** would have been liable in the absence of such assumption of liability; or

3. **Aircraft** or **Watercraft** in the **Covered Party's** care, custody or control.

AA. *Refunds*. This **Memorandum** does not apply to **Claims** arising out of the refund of taxes, fees, or assessments.

BB. *Transit Operations*. This **Memorandum** does not apply to **Bodily Injury or Property Damage** arising out of any transit authority, transit system or public transportation system owned or operated by the **Covered Party**, but this exclusion does not apply to any transit

system operating over non-fixed routes, including dial-a-ride, senior citizen transportation, or handicapped transportation.

Commented [DA1]: Make sure consistent with excess

CC. *Unlawful Financial Gain*. This **Memorandum** does not apply to **Claims** arising in whole or in part out of any **Covered Individual's** obtaining remuneration or financial gain to which the **Covered Individual** was not legally entitled.

DD. *Watercraft*. This Memorandum does not apply to **Claims** arising out of the ownership, operation, use or maintenance of any **Watercraft** owned by a **Covered Party**.

EE. *Willful Violation of Any Law*. This **Memorandum** does not apply to **Personal Injury** arising out of the willful violation of any law committed by or with the knowledge or consent of the **Covered Party. Public Officials Errors or Omissions** arising out of the willful violation of any law.

FF. *Wage and Hour.* This **Memorandum** does not apply to any **Claim** brought under the Fair Labor Standards Act (29 U.S.C. 201 et seq.), the California Labor Code, or any other state or local law governing minimum wages, overtime compensation, reimbursement of employee expenses, timely payment of employee compensation, or errors in wage statements or other employment records;

GG. *Workers' Compensation*. This **Memorandum** does not apply to **Claims** for which the **Member** or its insurance company may be held liable under any workers' compensation, unemployment compensation or disability benefits law, or under any similar law.

HH. *Use of a Firearm.* This **Memorandum** does not apply to **Claims** arising from the use of a firearm in connection with **Code Enforcement** by non-**Peace Officers** in connection with the enforcement of the criminal laws of the State of California by non-**Peace Officers**.

Commented [DA2]: Review after excess coverage decision.

SECTION VI—CONDITIONS

A. *Amendment or Cancellation*. This **Memorandum** may be amended or cancelled at any time in accordance with the provisions of the Joint Powers Agreement creating CIRA and its Bylaws. The terms of this **Memorandum** may not be changed except by written amendment issued by the **Authority** to form a part of this **Memorandum.**

B. *Appeal of Disputes with Authority*. Any disputes concerning coverage or procedures of the **Authority** may be appealed only to the **Authority's** Board of Directors in the manner and form that it may from time to time determine. Decisions by the **Authority** to assume control of the negotiation, appeal, or settlement of a **Claim**, or whether or not coverage exists for a particular **Claim** or part of a **Claim** or any other dispute that arises under and in connection with the Memorandum shall be made by the Board of Directors of the **Authority** or the Executive Committee as set forth herein. An appeal of a coverage determination of the General Manager or Coverage Counsel of the **Authority** or of any other dispute that arises under and in connection with the Memorandum shall be made in writing to the **Authority** within 60 days of the decision or dispute and shall be heard and determined by the Board at the next regularly scheduled meeting of the Board. If at the request of the **Covered Party**, or in the event that in the judgment of the **Authority** that exceptional circumstances warrant, an appeal of a coverage determination or any other

dispute that arises under and in connection with the Memorandum shall be heard by the Executive Committee within 21 days of receipt of the appeal. Any determination by the Executive Committee may be appealed by the **Covered Party** and shall be determined at the next regularly scheduled meeting of the Board.

C. *Appeal of Judgments*. In the event the **Covered Party** elects not to appeal a judgment, the **Authority** may elect to do so at its own expense, but in no event shall the **Authority's** liability for **Ultimate Net Loss** plus all **Defense Costs** necessary and incident to such appeal exceed the limit of coverage stated in Section V.

D. *Bankruptcy*. Bankruptcy or insolvency of the **Covered Party** shall not relieve the **Authority** of any of its obligations under this **Memorandum**.

E. *Duties in the Event of an Occurrence or Claim*.

1. The **Covered Party** shall cooperate with the **Authority** and upon the **Authority's** request assist in making settlements, in the conduct of suits and in enforcing any right of contribution or indemnity against any person or organization who may be liable to the **Covered Party** because of **Bodily Injury, Property Damage, Personal Injury**, **Employment Practices**, or **Public Officials Errors or Omissions** with respect to which coverage is afforded under this **Memorandum**; and the **Covered Party** shall attend hearings and trials and assist in securing and giving evidence and obtaining the attendance of witnesses.

2. The **Covered Party** shall provide a copy to the **Authority** within 15 calendar days of all Government Code Section 910 claims likely to exceed 50% of the **Member's Retained Limit** and within 7 calendar days of all suits covered by this **Memorandum**, except property damage claims under five thousand dollars ($5,000.00).

3. The **Covered Party** shall notify the **Authority** not later than 7 calendar days of any **Occurrence** reasonably considered a serious incident that is likely to be covered by this **Memorandum**, including but not limited to:

   (i) One or more fatalities;
   (ii) Loss of a limb;
   (iii) Loss of use of any sensory organ;
   (iv) Paralysis, Quadriplegia or paraplegia;
   (v) Third degree burns involving more than ten percent of the body;
   (vi) Serious facial disfigurement;
   (vii) Long term hospitalization;
   (viii) Closed head injury; or
   (ix) Serious loss of use of any bodily function.

4. The **Covered Party** shall forward to the **Authority** every demand, notice summons or other process received.

5. The **Covered Party** shall not, except at its own cost and expense, voluntarily make any payment, assume any obligation or incur any expense without the written consent of the **Authority**.

F. *Duties with Respect to **Covered Contracts**.*

1. With respect to any contract for which a **Covered Party** seeks coverage as a **Covered Contract,** the **Covered Party** shall submit the proposed contract to the **Authority** for its review and approval, at least 14 days prior to the date of execution of the contract, or its effective date, whichever is earlier.

2. The factors that shall be considered by the **Authority** in determining approval of a contract shall include:

   a. the party contracting with the **Covered Party** has requested indemnification for services the contracting party is providing to the **Covered Party**;

   b. the subject matter of the proposed contract does not pertain to an essential service of the **Covered Party** and there are available options to contract with other providers;

   c. whether all efforts to negotiate terms acceptable to the **Authority** have been exhausted;

   d. whether there is alternative coverage through the commercial market for the proposed subject matter of the contract, for example, special events coverage; and,

   e. whether the **Member** executes the contract against the **Authority's** recommendation.

G. *Other Coverage or Insurance*. If collectible insurance with any insurer, coverage with any other joint powers authority or other self-funding mechanism is available to the **Covered Party** covering a loss to which this **Memorandum** applies (whether on a primary, excess or contingent basis), the coverage of this **Memorandum** shall be in excess of, and shall not contribute with, such other insurance or coverage; provided that this clause does not apply with respect to excess insurance or coverage purchased specifically to be in excess of this **Memorandum**. The bankruptcy of, insolvency of, or placement into rehabilitation or receivership by any regulatory agency of any joint powers authority or insurance company providing joint powers authority coverage or insurance coverage to the **Covered Party** shall not amend the application of this condition.

H. *Satisfaction of Retained Limit.* In order for defense or indemnity to be available hereunder, the **Covered Party** must first pay the full amount of its **Retained Limit**. Payment of the **Retained Limit** by the **Covered Party** is required in addition to, and regardless of, any payment from any other source for or on behalf of the **Covered Party**, such as, for example, insurance procured by a third party pursuant to which the **Covered Party** is an additional named insured or otherwise covered. The foregoing does not apply to any insurance purchased by the **Member** or any **Covered Party** to cover all or any part of the **Retained Limit**.

I. *Relationship to Joint Powers Agreement*. The provisions of this **Memorandum** are subject to and subordinate to the terms and provisions of the Joint Powers Agreement creating CIRA, and in the event of any conflict between the terms and provisions of said Agreement and this **Memorandum**, the terms and provisions of the Agreement shall control.

J. *Severability of Interests*. The coverage applies separately to each **Covered Party** against whom **Claim** is made, as if a separate **Memorandum** were issued to it, except with respect to the **Authority's** Limit of Coverage.

K. *Subrogation*. To the extent of any payment under this **Memorandum**, the **Authority** shall be subrogated to all the **Covered Party's** rights of recovery thereof. The **Covered Party** shall do everything necessary to secure such rights and shall do nothing after the **Occurrence** to prejudice such rights. Any amount so recovered shall be apportioned as follows:

1. The **Authority** shall be reimbursed to the extent of all payment under this **Memorandum**. Any remaining balance shall be applied to reimburse the **Covered Party**.

2. The expenses of such recovery proceedings shall be apportioned in the ratio of respective recoveries. If there is no recovery in proceedings conducted solely by the **Authority**, the **Authority** shall bear the expenses thereof.

L. *Actions.* No action shall lie against the **Authority** with respect to the coverages and related provisions defined in the **Memorandum** unless, as a condition precedent thereto, there shall have been full compliance with all of the terms of this **Memorandum**, nor until the amount of the **Covered Party's** obligations to pay shall have been finally determined either by judgment against the **Covered Party** after actual trial or by written agreement of the **Covered Party**, the claimant and the **Authority**. Any person or organization or the representative thereof who has secured such judgment or written agreement shall thereafter be entitled to recovery under this **Memorandum** to the extent of the coverage afforded by this **Memorandum**. No person or entity shall have the right under this **Memorandum** to join the **Authority** as a party to any action against the **Covered Party** to determine the **Authority's** liability, nor shall the **Authority** be impleaded by the **Covered Party** or its legal representative.

M. *Venue.* In the event of any dispute between a **Member** and the **Authority** concerning the coverage provided by the **Memorandum,** the place of venue for any **Suit** concerning such coverage dispute shall be the County of Sacramento, and any action concerning such dispute shall be filed in the Superior Court for the County of Sacramento, California.

N. *Medicare Compliance.* Where a **Member** settles a claim within its **Retained Limit**, in which a claimant is either presently Medicare eligible or will be Medicare eligible within 30 months of the settlement, the **Member** shall comply with all pertinent laws and regulations applicable to the settlement, and shall ensure that Medicare's interests are fully addressed, protected and documented in the settlement.

The failure by a **Member** to comply with all pertinent laws and regulations applicable to the settlement or to properly protect and document Medicare's interests in the settlement, shall preclude coverage under the Memorandum for **Claims** arising from or relating to any sums

sought by Medicare with respect to a **Claim** or **Suit** settled by a **Member** within its **Retained Limit**.

SECTION VII—DEFINITIONS

Additional Covered Party means any person, organization or entity that is specifically named by the **Authority** in a written attachment to this **Memorandum**.

Aircraft means any vehicle controlled directly by a person from within or on the vehicle, designed to transport people or property through the air.

Airport means any locality either on land or water which is adopted for the landing and taking off of **Aircraft**, including all land, water, buildings, structures, equipment or other improvements necessary or convenient in the establishment and operation of an **Airport**.

Authority means the California Intergovernmental Risk Authority (CIRA).

Automobile means a land motor vehicle, trailer, or semi-trailer.

Bodily Injury means bodily injury, sickness or disease sustained by any person, including death resulting from any of these at any time.

Claim means a notice, demand, or **Suit** against a **Covered Party** to recover **Damages**.

Code Enforcement means enforcement of zoning laws, regulations, and ordinances; land use laws, regulations, and ordinances; and nuisance, abatement, dumping or similar municipal ordinances.

Covered Contract means that part of any written agreement or contract pertaining to the **Member's** operations or business under which the **Member** assumes the **Tort Liability** of another party to pay for **Bodily Injury or Property Damage** to a third person or organization. A **Covered Contract** does not include any part of any contract or agreement:

1. That indemnifies any person or organization for **Bodily Injury or Property Damage** caused by the sole negligence of such person or organization.

2. That indemnifies any person or organization for **Bodily Injury or Property Damage** arising out of the ownership, operation, maintenance or use of any **Aircraft, Unmanned Aerial Vehicle, Airport or Watercraft.**

3. That indemnifies an architect, engineer or surveyor for **Bodily Injury or Property Damage** arising out of:

    a. Preparing, approving, or failing to prepare or approve maps, drawings, opinions, reports, surveys, change orders, designs, or specifications

    b. Giving directions or instructions, or failing to give directions or instructions, if that is the primary cause of the **Bodily Injury or Property Damage**.

4. Under which the **Covered Party,** if an architect, engineer, or surveyor, assumes liability for **Bodily Injury or Property Damage** arising out of the **Covered Party's** rendering or failing to render professional services, including those listed in 3. above, and supervisory, inspection or engineering services.

5. That has not been approved by the **Authority** at least 14 days in advance of its execution by the Member or its effective date, whichever is earlier**.**

Covered Individuals means persons who are, or were, elected or appointed officials, employees, or volunteers of the **Member**, whether or not compensated, while acting for or on behalf of the **Member.** However, no coverage or defense will be provided to a volunteer while using his or her personal **Automobile,** unless such use is for the business of the **Member** and at the express direction of the **Member,** nor to any person who is an independent contractor and not an employee of the **Member,** but who either provides services to or acts as an official of the **Member** in exchange for compensation pursuant to an oral or written contract with the **Member. Covered Individual** shall not include any person, whether or not compensated, who is not acting in the course and scope of his or her employment or whose conduct, as a matter of law, is not within the course and scope of his or her employment by the **Member** at the time of the act or acts alleged in a **Claim.**

Covered Party means:

1. The **Member**;

2. **Covered Individuals**;

3. Any **Additional Covered Party**;

4. With respect to any **Automobile** owned or leased by the **Member**, or loaned to or hired for use by or on behalf of the **Member**, any person while using such **Automobile** and any person or organization legally responsible for the use thereof, provided the actual use is with the express permission of the **Member**, but this coverage does not apply to:

   a. any person or organization, or any agent or employee thereof, operating an **Automobile** sales agency, repair shop, service station, storage garage or public parking place, with respect to an **Occurrence** arising out of the operation thereof; or

   b. the owner or any lessee, other than the **Member**, of any **Automobile** hired by or loaned to the **Member** or to any agent or employee of such owner or lessee.

Cover Page means the document that is issued with this **Memorandum,** identifying the **Member,** the **Coverage Period,** the **Limit of Coverage,** and the **Retained Limit**.

Coverage Limit means the limit of coverage shown in the **Cover Page** as more fully defined under Section IV of this **Memorandum**.

Coverage Period means the time period shown on the **Cover Page** of this **Memorandum**. The phrase "coverage period" without boldface or capitalization refers to any annual period, including but not limited to the time period shown in the **Cover Page**.

Dam means any artificial barrier, together with appurtenant works, which does or may impound or divert water, and which either (a) is 25 feet or more in height from the natural bed of the stream or watercourse at the downstream toe of the barrier, or from the lowest elevation of the outside limit of the barrier, if it is not across a stream channel or watercourse, to the maximum possible water storage elevation; or (b) has an impounding capacity of 50 acre-feet or more.

Any such barrier which is not more than six (6) feet in height, regardless of storage capacity, or which has a storage capacity not more than 15 acre-feet, regardless of height, shall not be considered a **Dam**.

No obstruction in a canal used to raise or lower water therein or divert water therefrom, no levee, including but not limited to a levee on the bed of a natural lake the primary purpose of which levee is to control flood-waters, no railroad fill or structure, tank constructed of steel or concrete or of a combination thereof, no tank elevated above the ground, and no barrier which is not across a stream channel, watercourse, or natural drainage area and which has the principal purpose of impounding water for agricultural use shall be considered a **Dam**. In addition, no obstruction in the channel of a stream or watercourse which is 15 feet or less in height from the lowest elevation of the obstruction and which has the single purpose of spreading water within the bed of the stream or watercourse upstream from the construction for percolation underground shall be considered a **Dam**. Nor shall any impoundment constructed and utilized to hold treated water from a sewage treatment plant be considered a **Dam**. Nor shall any wastewater treatment or storage pond exempted from State regulations and supervision by Water Code Section 6025.5 be considered a **Dam.**

Regardless of the language of the above definition, however, no structure specifically exempted from jurisdiction by the State of California Department of Water Resources, Division of Safety of Dams shall be considered a **Dam**, unless such structure is under the jurisdiction of any agency of the Federal government.

Damages means money that the **Covered Party** is legally obligated to pay, or agrees to pay with the **Authority's** agreement, as the result of a **Claim**, including claimant's attorney fees, interest on judgments, and costs. **Damages** does not include amounts incurred by the **Covered Party** to comply with non-monetary remedies such as injunctions.

Defense Costs means all fees and expenses incurred in connection with the adjustment, investigation, defense and appeal of a **Claim** covered hereunder, including defense attorney fees, court costs, premiums for appeal bonds, and interest on judgments accruing after the entry of judgment, and also shall include the costs of any claims administrator or defense counsel specifically assigned by the **Authority** to respond to any **Claim** on behalf of the **Authority**. **Defense Costs** shall not include attorneys' fees or costs arising in connection with **Claims** that are not covered by this Memorandum. **Defense Costs** shall not include the office expenses of the **Authority** or the **Covered Party**, nor the salaries of employees or officials of the **Authority** or the **Covered Party**, nor expenses of any claim administrator engaged by the **Covered Party**. **Defense Costs** shall not include any fee or expense relating to coverage issues or disputes between the **Authority** and any **Covered Party. Defense Costs** does not include attorney fees awarded to the prevailing plaintiff.

Employment Practices means unlawful discrimination, sexual harassment, retaliation, or wrongful termination of employment alleged by a **Covered Party's** employee, former employee, or applicant for employment.

Hostile Fire means a fire that becomes uncontrollable and breaks out from where it is intended to be.

Limit of Coverage means the amount of coverage shown in the **Cover Page**, or sublimits as started therein, for each **Covered Party** per **Occurrence** subject to any lower sublimit stated in this **Memorandum**. For each **Occurrence**, there shall be only one **Limit of Coverage** regardless of the number of claimants or **Covered Parties** against whom a claim is made. In the event of a structured settlement, whether purchased from or through a third-party, or paid directly by the **Covered Party** in installments, as utilized in the resolution of a claim or suit, the **Authority** will pay only up to the amount stated in the **Cover Page** in present value of the claim, as determined on the date of settlement, regardless of whether the full value of the settlement exceeds the amount sated in the **Cover Page**.

Member means the entity which a party to the Joint Powers Agreement creating CIRA and whose name appears on the **Cover Page**. **Member** includes any other agency, commission, district, or board coming under the **Member's** direction or control or for which the **Member**'s board members act as the governing board.

Memorandum means the CIRA Memorandum of Coverage, including the **Cover Page** and any attachments and endorsements forming a part thereof.

Nuclear Material means source material, special nuclear material, or by-product material. "Source Material", "Special Nuclear Material", and "By-Product Material" have the meanings given them in the Atomic Energy Act of 1954 or any law amendatory thereof.

Occurrence means:

1. With respect to **Bodily Injury** or **Property Damage**, an accident or event, including continuous or repeated exposure to substantially the same generally harmful conditions, which results during the **Coverage Period** in **Bodily Injury** or **Property Damage** neither expected nor intended from the standpoint of the **Covered Party**, except that assault and battery committed by, at the direction of, or with the consent of the **Covered Party** for the purpose of protecting persons or property from injury or death shall be considered an **Occurrence**;

2. With respect to **Personal Injury**, the commission of an offense described in the definition of **Personal Injury** during the **Coverage Period**;

3. With respect to **Public Officials Errors or Omissions** and **Employment Practices**, conduct described in the definitions of those phrases during the **Coverage Period.**

Peace Officer means a person designated under Penal Code Sections 830 to 832.6 as a peace officer, or a public officer authorized under Penal Code Sections 830 to 832.6 to carry a firearm, and who is authorized by the **Member** to carry a firearm in the course and scope of employment.

Personal Injury means injury resulting from one or more of the following offenses:

1. False arrest, detention, or imprisonment

2. Malicious prosecution or abuse of process

3. Wrongful entry by any employee of a **Member** into a room, dwelling or other similar premises that a person occupies

4. Wrongful eviction by any employee of a **Member** of a person from a room, dwelling or other similar premises that such person occupies

5. The publication or utterance of a libel or slander, including disparaging statements concerning the condition, value, quality or use of real or personal property, or a publication or utterance in violation of rights of privacy

6. Discrimination or violation of civil rights

7. Infliction of emotional distress

Pollutants means any solid, liquid, gaseous or thermal irritant or contaminant, including but not limited to acids, alkalis, asbestos, chemicals, fumes, hazardous waste, polychlorinated biphenyls, radioactive material, smoke, soot, toxic substances, vapor, mold, fungal pathogens, electromagnetic fluids and airborne particles or fibers, waste and any related material. Waste includes material to be recycled, reconditioned, or reclaimed. The term **Pollutants** as used herein shall not include potable water or agricultural water or water furnished to commercial users or water used for fire suppression.

Property Damage means:

1. Physical injury to or destruction of tangible property, including all resulting loss of use of that property. All such loss of use shall be deemed to occur at the time of the physical injury that caused it.

2. Loss of use of tangible property that is not physically injured. All such loss of use shall be deemed to occur at the time of the **Occurrence** that caused it.

Public Officials Errors or Omissions means any act, error, omission, misstatement, misleading statement, neglect, or breach of duty by any **Covered Party** (individually or collectively) arising in the course and scope of their duties with the **Covered Party** or claimed against them solely by reason of their being or having been public officials or employees, and which results in **Damages** neither expected nor intended from the standpoint of the **Covered Party**.

Retained Limit means the amount of **Ultimate Net Loss,** specified in the **Cover Page**, which the **Covered Party** must incur or become liable to pay before the **Authority** is obligated to make payment. Payments by others on the **Covered Party's** behalf count toward satisfaction of the **Covered Party's Retained Limit**. For each **Occurrence**, there shall be only one **Retained** Limit applicable regardless of the number of claimants or **Covered Parties** against whom a **Claim** is made. If the **Covered Parties** have different **Retained Limits**, the lowest **Retained Limit** of any party found liable will apply. Payment of the **Retained Limit** shall be apportioned among multiple **Covered Parties** in accordance with their proportionate shares of

liability. If the apportionment requires arbitration the **Covered Parties** will pay all costs of the **Authority** in seeking such determination, including the **Authority's** attorney fees, according to their proportionate shares of liability.

Suit means a civil proceeding in which a **Covered Party** is named as a party defendant or cross-defendant, or an arbitration proceeding or alternative-dispute resolution proceeding to which a **Covered Party** submits with the **Authority's** written consent.

Tort Liability means civil liability imposed by law in the absence of any agreement or contract.

Unmanned Aerial Vehicle (UAV) or drone means an aircraft (with its aerial system or control device) that is not controlled directly by a person from within or on the aircraft, and which is piloted or operated in conformance with 14 C.F.R. 107 et seq. Any pilot or operator must have a remote pilot certificate issued in compliance with Subpart C of Section 107 or possess a valid Certificate of Waiver or Authorization issued by the FAA and satisfy the requirements of Section 107.65.

Ultimate Net Loss means **Damages** and **Defense Costs** the **Covered Party** is legally obligated to pay by reason of a judgment or a settlement made with the written consent of the claimant(s), the **Covered Party**, and the **Authority**.

Watercraft means a vessel more than 26 feet in length designed to transport persons or property in, on or through water.

CALIFORNIA INTERGOVERNMENTAL
RISK AUTHORITY

MASTER PROGRAM DOCUMENT FOR
THE
POOLED WORKERS' COMPENSATION PROGRAM

DRAFT NOVEMBER 10, 2020

CALIFORNIA INTERGOVERNMENTAL RISK AUTHORITY (CIRA)

MASTER PROGRAM DOCUMENT (MPD)
FOR THE
POOLED WORKERS' COMPENSATION PROGRAM (PWCP)

ARTICLE I: DEFINITIONS

The following definitions apply to this MPD:

1. **General Manager** shall mean the person responsible for the daily administration, management, and operation of the **Authority's** programs as defined in the Bylaws.

2. **Authority** shall mean the California Intergovernmental Risk Authority (CIRA).

3. **Board** shall mean the Board of Directors for the California Intergovernmental Risk Authority (CIRA) Joint Powers Authority.

4. **Deposit Contribution** shall mean that amount to be paid by each **Participant** for each **program year** as determined by the **Board** in accordance with Article III, Section B of this MPD.

5. **Joint Powers Agreement** shall mean the agreement made by and among the public entities listed in Appendix A (**Member Entities**) of the **Joint Powers Agreement,** hereafter referred to as **Agreement**.

6. **Limit of Coverage** shall mean the amount of coverage stated in the Declarations or certificate of coverage, or sublimits as stated therein for each **Participant** or **covered party** per **occurrence**, subject to any lower sublimit stated in the MOC.

7. **Loss Experience** shall mean only such amounts as incurred (paid and reserves) as are actually paid by the **Participant** or the **Authority** in payment of benefits under the Workers' Compensation Act, in settlement of claims, or in satisfaction of awards or judgments for liabilities imposed by the Workers' Compensation Act for **bodily injury** or **occupational disease** to an **employee** as defined in the Workers' Compensation Act and **Program** Memorandum of Coverage (MOC).

8. **Member Entity** shall mean a signatory to the **Agreement** establishing the California Intergovernmental Risk Authority (CIRA) Joint Powers Authority.

9. **Memorandum of Coverage** shall mean a document issued by the Authority specifying the coverages and limits provided to the Members participating in the Program.

10. **Participant** shall mean a **Member Entity** who has elected to participate in the Program

11. **Program** shall mean the self-funded Workers' Compensation Program of the Authority.

12. **Program Year** shall mean that period of time commencing at 12:01 a.m. on July 1 and ending at 12:00 am on the following July 1.

13. **Retained Limits** shall mean the amount stated on the applicable Declarations or certificate of coverage, which will be paid by the **Participant** or **covered party** before the **Authority** is obligated to make any payment from the pooled funds.

14. **Self-Insured Retention (SIR)** shall mean the **Authority's limit of coverage** above **Participant's Retained Limits** and up to the attachment point for excess coverage.

15. **Third Party Administrator (TPA)** shall mean the Program claims administrator for the **Authority**
.

ARTICLE II: GENERAL

A. AUTHORITY

1. The Program Master Program Document (MPD) is one of the **Authority's** governing documents. However, any conflict between the Program MPD, the **Authority's Joint Powers Agreement**, the Bylaws, or the Memorandum of Coverage (MOC) shall be determined in favor of the **Agreement**, the Bylaws, or the MOC, in that order.

2. The **Program** MPD is intended to be the primary source of information, contain the rules and regulations, and serve as the operational guide for the conduct of the **Program**.

3. The **Program** has been organized under authority granted by, and shall be conducted in accordance with, the laws of the State of California; regulations prescribed by the Department of Industrial Relations (DIR) and the State of California Audit Unit; and the accreditation standards set forth by the California Association of Joint Powers Authorities (CAJPA).

B. PURPOSE

The **Authority**, as a part of its overall objectives, has designed the **Program** to provide for the needs of the **Program Participants** in the area of workers' compensation liability.

C. PARTICIPATION

All **Member Entities** may become **Participants** in the **Program** and are encouraged to do so. However, the terms and conditions which may be imposed on **Member Entities** which desire to join the **Program** may be different, depending upon payroll, number of employees, the size of the **Member Entity**, its loss record, and other pertinent information.

D. GOVERNANCE

Each **Participant's** appointed Director and alternate Director shall be the representative for the **Program**. The **Participant** will be entitled to one vote on all issues or decisions that involve the **Program**.

E. GOALS AND OBJECTIVES -

1. The **Authority** offers **Member Entities** this **Program** designed to provide coverage for the liabilities imposed by the workers' compensation laws of California as well as those imposed by common law upon employers.

2. The **Program** shall provide workers' compensation coverage for the **Participants** utilizing an optimum mix of risk retention and risk transfer. The **Program** may provide various levels of retentions for the **Participants**, provide a risk sharing pool for losses above individual retention levels up to the **Authority's Self-Insured Retention** (**SIR**), and obtain excess coverage for the amount of the loss which exceeds the **Authority's SIR**. Additionally, the **Program** shall provide for the sharing of operating costs and payment of the excess coverage by charging all **Participants** their share of such costs.

3. Although the **Program** is provided to the **Participants** under those terms and conditions which prevail at the time of the **Participant's** joining the **Program**, the **Board** shall have the right to alter, from time to time, the terms and conditions of the excess coverage and the pooled underlying coverage in response to the needs and abilities of the **Program** and the **Participants**, as well as in response to availability of coverage from outside sources.

4. The **Authority** offers participation in a risk sharing pool, covering losses of **Participants** in accordance with the MOC adopted by the **Member Entities**. The assets of the pooled **Program** shall be maintained at all times as the assets of the **Participants** collectively. The assets may be disbursed only pursuant to the provisions of this MPD, and no **Participant** shall have an individual right to exercise control over said assets.

5. The **Program** will provide coverage for injuries and illnesses to the **Participants'** employees under the terms and conditions set forth in the MOC. In addition to the coverage provided by the MOC, the **Authority** may purchase excess insurance or reinsurance. The amount of coverage to be pooled and/or purchased is at the discretion of the **Board**.

ARTICLE III: PROGRAM ELEMENTS

A. FUNDING

1. Funding each year shall be at the 75% confidence level at the discretion of the Board of Directors.

2. The Target Equity goal is set at five times the **Program's SIR.**

3. A Rate Stabilization Fund in an amount not to exceed $1,000,000 may be established to off-set pool and excess rate increases as determined by the Board of Directors. The Fund may be replenished at the Board of Director's discretion when the fund falls below 50% capacity.

4. Funding in excess of the 90% confidence level, excluding the target equity goal, may be available for distribution at the discretion of the Board of Directors.

5. If the overall confidence level falls below 70% according to actuarial projections, the Board of Directors may declare an assessment to be shared by all **Program Participants.**

6. Upon completing seven years, a program year shall be available for Retrospective Premium Adjustment (RPA)

7. Distributions under the RPA formula will be made in the following percentages:

50% of equity in year 8	70% of equity in year 10
60% of equity in year 9	90% of equity in year 11-15

8. Program years may be considered for closure 15 years after the year-end, and it has been at least on year since closure of the last claim in the proposed year(s). Once declared closed, 100% of remaining equity may be distributed to members through the RPA formula.

9. If a claim is reported or reopened after a year, and the year has been closed and equity returned, surplus in positive years may be used to offset the deficit in negative years. If there is no offset available, members may be assessed at the discretion of the board.

10. The following four benchmarks will be reviewed before an RPA is issued:

- **Net Contribution to Equity**
  Calculation: *(Contribution – Excess Insurance) / Equity*

  Measures the impact of pricing inaccuracies on equity (a low ratio is desirable). A low ratio indicates that more equity is available to cover under-charged years. The target is less than 200%

- **Claim Reserves and IBNR to Equity**
  Calculation: *(Claim Reserves + IBNR + ULAE) / Equity*

  Measures the impact of reserves inaccuracies on equity (a low ratio is desirable). A low ratio indicates more equity available to cover years with large losses. The target is less than 300%

- **Prior Year Loss Development**
  Calculation: *(Year 1 Loss Reserves / Year 2 Loss Reserves) / (Yr 2 / Yr3) – 1*

  Measures the change in loss reserves from one year to the prior year. A lower ratio indicates not much change in reserves between years. Target of less than 20% is desirable.

- **Change in Equity**
  Calculation: *(Year 2 Equity / Year 1 Equity) – 1*

  Measures the change in equity. Any increase is desirable. The target is less than 10%.

B. DEPOSIT CONTRIBUTIONS

1. Annually, each **Participant** shall pay a **deposit contribution** to the **Authority** for each **program year**. Such **deposit contribution** shall consist of the amount needed to cover excess insurance or reinsurance premiums (if any), administrative expenses and actuarially-determined losses, plus a margin for added confidence as determined by the **Board**.

2. The following criteria is used to calculate the **deposit contribution** for each **Participant**:

   Participant's payroll
   Participant's loss experience
   Participant's self-insured retention

3. The **deposit contribution** is calculated by taking the **Participant's** estimated payroll and multiplying it by the actuarially determined rate per $100 of payroll. Administrative and excess insurance or reinsurance are also included in the calculations. The estimated payroll is annualized for the remainder of the year with an inflation factor of three percent, unless the **Participant** provides the **Authority** with a different estimated payroll projection for its Entity.

4. The excess insurance or reinsurance premiums (if any), shall be allocated among the **Participant's** using deposit contribution calculation.

5. The administrative expenses (including claims administration) shall be allocated among the **Participants** based on payroll, loss experience and self-insured retention with the experience modification.

6. Each year the **Authority** shall bill **Participants** for a workers' compensation **deposit contribution** for the next **program year** to be paid on an annual or quarterly basis. The invoices shall be billed to **Participants** at least 30 days prior to the inception of a new **program year**, when practicable, and due within 45 days of the billing date.

   A 2% fee of the balance due shall be assessed on late premium payments, every 30 days; this assessment will apply 60 days after the billing date.

   Former **Participants** in the **Program** shall be required to pay all applicable billings for the **program years** in which they participated in accordance with the Bylaws, and shall continue to pay for administrative costs as determined by the Board of Directors.

C. SELF INSURED RETENTION

1. **Participants** may select an **SIR** of $5,000, $10,000, $25,000, $50,000, $100,000, $150,000, $250,000, or $350,000 and must notify the **Program** of their SIR selection by April 1 of the preceding **Program Year**.

2. A **Participant's SIR** evaluation shall be completed every three years in conjunction with the annual actuarial study. As a result, **Participants** may be subject to an **SIR** adjustment based on the following:

   a. Number of losses above its **SIR**, or a disproportionate number of losses within its **SIR** level compared to the pool average; and or

   b. Payroll that is disproportionate in size to the payroll of the other **Participants** within the **SIR** level.

3. A statistical model developed by the **Program**'s actuary shall be the standard by which the Board determines which **Participants** are candidates for **SIR** adjustments. **Participants** identified as candidates for adjustment will be notified of such determinations. Should the **Participant** deem the adjustment is not warranted, they may request exception to the adjustment by submitting a request for exception to the Board of Directors at the next regular meeting in order to provide new or updated information for consideration prior to ratification of the **SIR** adjustment. Final decisions will be in the sole discretion of the Board of Directors.

4. Approved **SIR** adjustments shall, at minimum, increase the **Participant's SIR** to the next available **SIR** level and will become effective for the next **program year.** The **Participant** shall remain at the adjusted **SIR** level for a minimum of three program

years, unless otherwise approved by the Board of Directors, at which time the **SIR** may be re-evaluated based on the statistical model.

The **Program** shall pay all claims expenses within the **Participant's SIR**, which shall be reconciled and invoiced to the **Participant** quarterly. The **Participant** shall have 30 days from the date of invoice to submit its **SIR** payment.
A 2% fee of the balance due shall be assessed on late premium payments, every 30 days; this assessment will apply 60 days after the billing date.

C. EXPERIENCE MODIFICATION

1. Each **Participant** shall be evaluated each year for an experience modification adjustment that shall be applied to the **deposit contribution**.

2. The calculation of the adjustment shall include the actual **loss experience** of the individual **Participant** as it relates to the average **loss experience** of the group as a whole. The experience modification formula shall:

   a. Not consider loss years that are more than five years old.
   b. Limit losses to $250,000 per claim.
   c. Apply a credibility factor based on the **Participant's** weight, between 10%-75%
   d. Cap the experience modification factor at a minimum of 0.50 and maximum of 2.00
   e. Not increase or decrease more than 25% from the prior year for any **Participant**.

D. EXCESS COVERAGE

1. The **Board** shall ensure that, each **program year, Participants** are provided with excess workers' compensation coverage for the **Participants**. It is the intent and purpose of the **Authority** to continue to provide such coverage to the **Participants**, provided that such coverage can be obtained, and the coverage is not unreasonably priced. This coverage may be obtained from an insurance company, by participating in another pool established under the Government Code as a joint powers authority, or offered through another **Program** pooling procedure. If the coverage is purchased from an insurance company, such insurance company shall have an A.M. Best Rating Classification of A- or better and an A.M. Best Financial Rating of VII or better or their equivalents.

2. Premiums for such coverages shall be paid by the **Program** from the proceeds received as **deposit contributions** from the **Participants**.

3. The **Board** may, from time to time, alter excess coverage based on insurance market conditions, available alternatives, costs, and other factors. The **Board** shall place excess coverage with the two competing objectives of security and minimizing costs to the **Program** as a whole.

ARTICLE IV: ADMINISTRATION

A. BOARD

1. The **Board** shall have the responsibility and authority to carry out and perform all functions, and make all decisions**,** affecting the **Program**, consistent with the powers of the **Authority** and not in conflict with the **Agreement**, the Bylaws, or the MOC.

B. GENERAL MANAGER

The **General Manager** shall be responsible for:

1. General oversight of the **Program**, which includes:

   a. Monitoring the status of the **Program** and its operations, the development of losses, the program's administrative and operational costs, service companies' performance, and brokers' performance;

   b. Developing, for **Board** approval, performance standards for **Third Party Administrator (TPA).**

   c. Work with the **Third Party Administrators,** including but not limited to the following:

      i. Periodically review third party **Third Party Administrators'** claims files. The review should include the new indemnity claims reported, claims currently open and reported twelve months prior, and those claims for which a **Participant** has requested a specific review;

      ii. Provide guidance to the **Third Party Administrator** on the management of problem or complex claims;

      iii. Advise, where needed, on the selection of legal representation in anticipation of litigation;

      iv. Monitor and evaluate the effectiveness of the defense firms and the management of the litigation;

      v. Monitor and evaluate the effectiveness of medical treatment as respects claims costs, especially those involving complex medical issues;

      vi. Evaluate, where needed, recommendations for settlement of claims;

vii. Mediate differences, if any, between the **Third Party Administrator** and a **Participant**; and

viii. Review the performance of the **Third Party Administrators'** personnel assigned to the **Authority's** account with special emphasis in the handling of "open claims."

d. Recommend to the **Board** the setting of reserves for those cases that are likely to penetrate to pooled funds;

e. Upon the reporting of each claim that has an expectation of exceeding the minimum incurred loss threshold set by the **Board**, review said claim for the **Authority** and report said claims to the **Board** at the next scheduled meeting;

f. Review the progress of all reported claims for the **Authority** and, if directed by the **Board**, propose reserve changes, and/or take control and assume settlement authority for the claim;

ARTICLE V: CLAIMS ADMINISTRATION

A. CLAIMS PROCEDURES MANUAL

1. A Workers' Compensation Claims Procedures Manual (Manual) including reporting procedures, forms, and other vital information is included in Appendix A and will be updated from time to time as needed.

2. All **Participants** shall be held accountable for understanding and abiding by the procedures stated in the Manual, as well as any changes thereto.

B. CLAIM SETTLEMENT AUTHORITY

1. Authority for the settlement of Workers' Compensation claims shall be in the following increments:

Authorizing Entity	Authority
Third Party Administrator	$0
Deputy General Manager	$1- $50,000
General Manager	$1 - $100,000
General Manager, Workers' Compensation Subcommittee Chairperson and Executive Officer (must participate in program)	$100,000+

2. The **Third Party Administrator** will ensure the **Participant** is kept informed regarding these claims and will take into consideration the **Participant**'s desires in any settlement process. Authorization on all settlement or stipulations shall be obtained.

3. Should the settlement value enter into the excess layer of funding, authority from the excess coverage provider would be required.

4. The **Third Party Administrator** shall consult with and obtain authorization prior to settlement of any claim, including but not limited to Stipulations, Compromise & Releases and lien settlements. All requests for settlement authority shall include a written claim summary, estimate of permanent disability, and any comments and recommendations.

C. DISPUTES BETWEEN PARTICIPANTS AND GENERAL MANAGER, OR Board

Any matter in dispute between a **Participant** and the **Program** shall be heard by the Executive Committee whose decision may be appealed to the **Board** within thirty (30) days of the Committee's decision. The decision of the Executive Committee or, if appealed, the decision of the **Board** shall be final.

ARTICLE VI: DEFENSE PANEL

A. CRITERIA FOR DEFENSE PANEL

1. The defense panel shall include all attorneys listed in the attached Appendix B, which may be amended at the discretion of the General Manager.

2. Attorneys must meet and agree to the following provisions before consideration of inclusion on the panel:

   a. The firm must have demonstrated success representing public entities and specific expertise in the workers' compensation arena.

   b. Firms must have no less than 5 years litigation practice which includes substantial and significant experience in public entity defense to be eligible for case assignment.

   c. The firm shall provide a resume setting forth the experience of the individual attorneys that would be assigned to cases and their areas of expertise.

   d. The firm must agree to the maximum hourly rates outlined in the fee schedule outlined below, in section B, unless specialized legal representation is necessary, which requires prior approval. The maximum hourly rate will be reviewed on a bi-annual basis.

   e. The firm must agree to abide by the policies and procedures established by CIRA for handling of litigation.

   f. The firm must evidence general liability, automobile liability, workers' compensation, and professional liability insurance. The policy limits must

not be less than $1,000,000 per occurrence. CIRA, its officials, officers, employees, and agents must be named additional insured for general liability and auto liability and follow all insurance requirements of the **Authority.**

3. The General Manager and Officers may appoint a particular attorney or law firm other than panel counsel when specialized, unforeseen defense is required. The law firm or attorney shall comply with conditions a-f above.

4. CIRA will assign defense counsel in collaboration with the **Participant.**

Participants may assign cases to firms listed on the Panel. Nothing in this MPD shall be construed to limit the right of the **Participant** to retain its own defense counsel to represent the **Participant** in any litigation. Except where prior approval has been given, the **Participant** is responsible for amounts in excess of the maximum hourly rates, which shall not reduce the **Participant's** self-insured retention obligation.

B. MAXIMUM FEE SCHEDULE

Legal Staff	***Maximum Rate***
Partners	$175
Associates	$145
Paralegals	$75

ARTICLE VII: PARTICIPATION

A. ELIGIBILITY AND APPLICATION

1. ELIGIBILITY

a. New applicants must commit to at least five full **program years** of participation in this **Program**.

b. Any **Member Entity** may apply to participate in the **Program** by providing an adopted resolution of its governing body and such other information/materials as may be required. The applicant's resolution shall commit the applicant to five full years of participation in the **Program**, if accepted, and consent to be governed for workers' compensation matters in accordance with the MPD, the MOC and other documents and policies adopted by the **Board**. The resolution may also state the **retained limit** desired by the applicant.

c. The application for participation shall be submitted at least thirty (30) days prior to the date of the last **Board** meeting of the **program year** to ensure that the State Certificate of Consent to Self-Insure is received prior to the inception date, and that the **Board** has adequate time to review and evaluate

the acceptability of the applicant. It is recommended that an applicant enter the **Program** only at the commencement of a new **program year**. If an applicant chooses to enter the **Program** at any other time, the **deposit contribution** for the remainder of the **program year** will be pro-rated. The new **Participant** will begin coverage on the date that is mutually acceptable to the **Participant** and the **Board**; however, the new **Participant** will be required to share losses with the other members of the **Program** for the entire **program year**.

2. APPROVAL OF APPLICATION

The **Board** shall, after reviewing the resolution and other underwriting criteria, determine the acceptability of the exposures presented by the applicant and shall advise the applicant in writing of its decision to accept or reject the request within 10 days after the decision has been made.

B. PARTICIPANTS' DUTIES

1. The **Participants** shall provide payroll, using data as included on the State DE-9 form, and all other requested information in conformance with the policies adopted by the **Board**.

2. The **Participants** shall disclose activities not usual and customary in their operation.

3. The **Participants** shall at all times cooperate with the **Authority's General Manager** and **Third Party Administrator** in regards to claims handling and underwriting activities of the **Authority**.

ARTICLE VII: TERMINATION AND DISSOLUTION OF THE PROGRAM

The **Program** may be terminated and dissolved at any time by a vote of two-thirds of the **Participants**. However, the **Program** may continue to exist for the purpose of disposing of all claims, distributing assets, and all other functions necessary to conclude the affairs of the **Program,** at the Board's discretion.

Upon termination of the **Program**, all assets of the **Program** shall be distributed only among the current **Participants**. The **Board** shall determine such distribution within six months after the last pending claim or loss covered by the **Program** has been finally resolved and there is a reasonable expectation that no new claims will be filed.

ARTICLE VIII: AMENDMENTS

This MPD may be amended by a two-thirds (2/3rds) vote of the **Participants** at the meeting, provided prior written notice, as provided within the Bylaws, has been given to the **Board**.

Appendix A

Workers' Compensation Claims Manual

Appendix B

Workers' Compensation Defense Panel Approved Firm List

Law Offices of C. Robert Bakke

Barbara L. Kiely, Attorney at Law

Joe Montgomery, Hannah Brophy

Joseph T. Todoroff, II, Hannah Brophy

Lenahan Lee Slater & Pearse

Boone T. White, MacIntyre & White

Richard, Thorson, Graves & Royer

Wall McCormick Baroldi Green & Dugan

Robert A. Sanders, Witzig Hannah Sanders

Mullin & Filippi (Santa Rosa, Redding)

Michael Ash (Novato)

Nathan Geronimo, Esq - Hanna and Brophy (Santa Rosa)

Laughlin, Falbo, Levy & Moresi

RETIREE HEALTH BENEFITS FOR NEW CIRA EMPLOYEES

SUMMARY: As PARSAC and REMIF move toward the merger into CIRA, one of the items that has been discussed is the elimination of retiree health benefits for new employees beginning July 1, 2021. As PARSAC contracts for health benefits with CalPERS, retiree health benefits are subject to the Public Employees Medical and Hospital Care Act (PEMCHA) and California Government Code 22893 which does not allow for the elimination of retiree health but does allow for the adoption of a vesting schedule as well as equal and unequal contributions.

RECOMMENDATION: Receive and file.

DISCUSSION: During the last CIRA Transition Committee meeting, the committee directed staff to explore healthcare options allowing for the reduction or elimination of healthcare benefits for retirees. In consulting with legal counsel, the following options were presented as allowable under PEMCHA:

- The most common option is pursuant to equal contribution rule of Gov. Code Section 22892 ("Equal Rule"). The Equal Rule requires that an employer's contribution "shall be an equal amount" for both current employees and annuitants within an employee group. Public agencies that provide benefits under the Equal Rule are required to make the exact same contribution available to all employees and annuitants within the group. This is current method adopted by PARSAC.

- Some agencies adopt the unequal contribution method of Gov. Code Section 22892(c) ("Unequal Rule"). The Unequal Rule permits an employer to establish a lesser monthly employer contribution for annuitants than for employees, provided that the monthly contribution for annuitants is increased annually to equal an amount not less than the number of years that the employer has been subject to Section 22892(c) multiplied by 5 percent of the current monthly contribution for employees, subject to an annual $100 limit to the increase, until the time that the employer's contribution for annuitants equals the employer's contribution for employees. Under CalPERS rules, the Unequal Rule has to be adopted the first year that an agency extends PEMHCA coverage to an employee group.

- The third way is the vesting schedule set forth at Gov. Code Section 22893 ("Vesting Schedule"). The Vesting Schedule is the only CalPERS recognized mechanism through which a contracting agency may impose a minimum years of service condition on the receipt of *retiree* health benefits. It generally provides that the contribution paid on behalf of annuitants first employed on or after the effective date of the Vesting Schedule is determined, in part, by the individual's years of service and, in part, by a contribution level based on a weighted average

of premiums. Once the Vesting Schedule is adopted, all employees hired on or after the effective date are subject to the Vesting Schedule for p purposes of their retirement benefit irrespective of any future amendments to an agency's PEMHCA resolution unless the Vesting Schedule is rescinded. However, under the Vesting Schedule of Section 22893, only 5 years must be worked for PARSAC/CIRA and the rest can come from any other CalPERS employer. In addition, the contribution amount required of the employer is set by the State unless the agency wants to provide a more generous contribution.

Limitations: The preceding rules limit CIRA's ability to create multiple tiers of benefits for annuitants within the same group based on years of service with CIRA. The Equal Rule requires that all annuitants from the same group receive the same employer contribution irrespective of hire date, retirement date or years of service (other than the 5 year minimum for retirement eligibility). The Unequal Rule allows for different contributions for employees compared to annuitants for a period of time but does not allow for variances amongst members of each category (i.e., all employees must be eligible for same contribution as other employees; and all annuitants must be eligible for the same contribution as other annuitants). While the vesting schedule allows years of service to be used as a factor, it only requires 5 years of service with CIRA with the rest coming from any CalPERS employer.

Alternative: Although the use of multiple tiers cannot be accomplished through PEMHCA, CIRA can adopt a contribution design, in conjunction with a cafeteria plan and/or a health reimbursement arrangement ("HRA"), that would permit it to create multiple tiers on the basis of any nondiscriminatory factor, such as years of service, without violating PEMHCA. To do so, CIRA would need to replace its current PEMHCA resolutions with a resolution that adopts the minimum employer contribution required by Gov. Code Section 22892(b) (the "MEC"). For 2021, the MEC will be $143 (it's currently $139) and is adjusted annually. This would obligate CIRA to contribute no less and no more than the MEC on behalf of current and future employees and annuitants (so long as CIRA remains in PEMHCA, it cannot provide a contribution directly to CalPERS on behalf of employees and annuitants in the same group that is less than the MEC). In addition, CIRA would need to adopt a cafeteria plan (if doesn't already have one) for employees and an HRA for retirees that designates a portion or all of the allowance that CIRA provides for health benefits as the MEC, thereby complying with PEMHCA. Once having a cafeteria plan and/or an HRA in place, CIRA could then subsidize the difference between the amount CIRA has agreed to pay on behalf of current employees and annuitants (taking into account factors such as years of service with CIRA (can only include REMIF), date of hire, retirement date, etc.) and the MEC through additional contributions to the cafeteria plan for employees and the HRA for retirees.

This alternative does require greater administration by CIRA (or a third party if contracted out) in the form of reimbursements to retirees for the difference between the amount they are entitled to and the MEC. A reimbursement is necessary because CalPERS will deduct the difference between the premium of the plan they have enrolled in and the MEC from their monthly pension check. However, this process has gone smoothly for employers that have adopted it starting with clear communication to existing retirees that will be affected (if any) and including direct deposit to time reimbursements to coincide with pension payments.

In addition to the above options, staff continues to explore additional options including coverage through the REMIF health plan, PRISM, and SDRMA. As additional information is obtained, the item will be brought back for additional discussion.

FISCAL IMPLICATIONS: The elimination of retiree healthcare or adoption of either the unequal payments or vesting schedule will reduce the long-term OPEB liability of CIRA.

ATTACHMENT: None

UPDATE ON FINANCE TRANSITION COMMITTEE MEETING

SUMMARY: On November 4, 2020, the CIRA Transition Finance Committee met to discuss the preliminary CIRA budget including the risk management proposed program, various cost allocations, and actuarial services.

RECOMMENDATION: Receive and file.

DISCUSSION: On November 4, 2020, the CIRA Transition Finance Committee held their first meeting. The Committee is comprised of the finance committee members from both PARSAC and REMIF. During the meeting, the Committee was presented a preliminary budget, various cost allocations, and discussed actuarial services. Below is a brief overview some of those items:

CIRA Preliminary Budget and Services: The attached preliminary budget was presented for review and discussion. Contributions, excess insurance, and claims expenses were brought forward as placeholders pending additional information. All other costs were based on a detailed review of the PARSAC and REMIF 2020/21 budget to determine those costs necessary to CIRA, costs that could be reduced, eliminated, or allocated back to PARSAC and REMIF. Those costs that are to be allocated back to PARSAC for legacy claims and employee benefits, and REMIF pension and Health Care Program costs were adjusted in the comparison budget to reflect only those costs related to CIRA operations. A detailed discuss was had regarding risk management services including the funding of Lexipol, Target Solutions, safety and loss control grants, and the new Rent-A-Risk Manager Program.

Currently, the budget has been updated to reflect a cost savings of $145,000 for liability claims administration services. George Hills claims administrator for both PARSAC and REMIF has agreed to reduce costs for the combined pool.

Payroll and benefits have been reduced $117,000 to reflect current staffing. Both PARSAC and REMIF have open administrative positions. The open positions are not expected to be filled in the upcoming year with current staff taking over the administrative duties. During the first year, staffing will be reviewed to determine what positions CIRA may need if any going forward. In addition to payroll and benefits, general administrative and overhead costs are expected to decrease an additional $75,000 through reductions and elimination of costs.

Consulting costs will be reduced $209,000. Redundant costs associated with actuarial studies, financial audits, and legal counsel will be eliminated. Current staff will be responsible for the financial needs of CIRA eliminating the need for an outside finance manager.

While most general administrative and overhead costs have been reduced, the risk management program costs are expected to have a minimal increase of $38,000. When risk management services were evaluated those programs that were the most beneficial and utilized were included in the CIRA budget. The budget also includes a Rent a Risk Manager program to provide more direct, value-added services to members. Under the program, each member will be provided a minimum of four days of onsite service with larger members receiving up to eight days. The onsite services will include an annual risk assessment, loss analysis, and customized program development. Savings from duplicate program offerings were reallocated towards the Rent a Risk Manager program to pay for increased travel and contracted services to support the program.

Overall, the preliminary budget projects cost savings of $508,000. As additional information is received, the budget will be updated for further review and discussion.

Cost Allocation to the REMIF Health Plan: The budget presented reflects adjustments made to allocate indirect costs to the REMIF Health Plan. These costs include payroll and benefits, general administrative and overhead costs, etc. The allocation made was based on the percentages allocated to the Health Plan based on the 2020/21 REMIF budget.

Cost Allocation to Programs: A brief discussion was had regarding the allocation of expenses not direct program cost. The current costs allocations are below. The allocations will be discussed further at an upcoming meeting.

Program	PARSAC	REMIF
Liability Program	50%	21.35%
Workers' Compensation Program	45%	25.25%
Property Program	5%	12.74%
Auto Program		7.84
Health Plan (Medical/Dental/Vision)		32.82%

Actuary and Valuation Date: The committee recommends Mike Harrington from Bickmore Actuarial Consulting be retained as the Actuary for CIRA with an initial actuarial study valuation date of September 30, 2020.

FISCAL IMPLICATIONS: None

ATTACHMENT: CIRA 2021/22 Preliminary Budget

CIRA

2021/22 Preliminary Budget

	2020/21 PARSAC and REMIF Budget adjusted for costs associated with PARSAC and REMIF legacy claims, REMIF Health Program, and retiree benefits.			CIRA Budget	
	PARSAC	REMIF	Total Budget 2020/21	Proposed Budget	Budget Difference
	2020/21			2021/22	% Change
INCOME					
Member Contributions					
Liability Contributions	$ 9,429,296	$ 5,592,039	$ 15,021,335	$ 15,021,335	0%
Workers' Compensation Contributions	6,170,861	7,362,265	13,533,126	13,533,126	0%
Property Contributions	2,766,736	3,307,316	6,074,052	6,074,052	0%
Bond Income	78,000	-	78,000	78,000	0%
Auto Physical Damage	-	372,364	372,364	372,364	0%
Total Member Contributions	18,444,893	16,633,984	35,078,877	35,078,877	0%
Misc Fees	-	104,400	104,400	104,400	0%
TOTAL INCOME	18,444,893	16,738,384	35,183,277	35,183,277	0%
EXPENSE					
Excess Insurance					
Liability Insurance Premium	3,149,467	1,170,000	4,319,467	4,319,467	0%
ERMA	1,346,595	-	1,346,595	1,346,595	0%
Pollution	12,000	-	12,000	12,000	0%
Auto Physical Damage	-	248,000	248,000	248,000	0%
Workers Comp Premium - LAWCX	1,311,345	402,500	1,713,845	1,713,845	0%
Property Insurance - PEPIP	2,713,070	2,823,997	5,537,067	5,537,067	0%
Bond Insurance	78,000	-	78,000	78,000	0%
Total Excess Insurance	8,610,477	4,644,497	13,254,974	13,254,974	0%
Claims Expense					
Liability Claims Expense					
Liability Claims Expense	3,657,736	2,998,451	6,656,187	6,656,187	0%
Liab Adm Fees	427,000	127,000	554,000	410,000	-26%
Sewer Consultant	15,000	-	15,000	15,000	0%
Total Liability Claims Expense	4,099,736	3,125,451	7,225,187	7,081,187	-2%
Workers Compensation Claims Expense					
WC Claims Expense at expected	3,605,157	5,134,690	8,739,847	8,739,847	0%
WC Adm Fees	448,880	570,000	1,018,880	1,018,880	0%
Total Workers Compensation Claims Exp	4,054,037	5,704,690	9,758,727	9,758,727	0%
Total Claims Expense	8,153,773	8,830,141	16,983,914	16,839,914	-1%
WC Self Insurance Fees	150,000	253,867	403,867	-	-100%
WC self insurance fees alloacted to legacy claims	(150,000)	(253,867)	(403,867)	-	-100%
Total WC Self Insurance Fees	-	-	-	-	0%
Payroll and Benefits					
Employee Salary	532,389	372,243	904,632	743,688	-18%
Potential Merit/Contract Increase	-	-	-	37,185	0%
Accrued Vacation Expense	8,000	-	8,000	5,375	-33%
COLA Increase	-	-	-	-	0%

CIRA

2021/22 Preliminary Budget

	2020/21 PARSAC and REMIF Budget adjusted for costs associated with PARSAC and REMIF legacy claims, REMIF Health Program, and retiree benefits.			CIRA Budget	
	PARSAC	REMIF	Total Budget 2020/21	Proposed Budget	Budget Difference
	2020/21			2021/22	% Change
Performance Pay	3,500	-	3,500	-	-100%
Payroll Taxes PARSAC	8,505	23,000	31,505	10,634	-66%
Medical	130,000	92,703	222,703	110,423	-50%
Ancillary Benefits	16,500	5,035	21,535	10,513	-51%
PERS Retirement Cost	53,509	59,000	112,509	81,451	-28%
Unfunded Liability	26,072	230,000	256,072	-	
Salary & Benefits Allocated to REMIF Health Program '20/21	-	(187,427)	(187,427)	-	
Unfunded Liability Allocated to REMIF Health Program '20/21	(26,072)	(230,000)	(256,072)	-	
Total Payroll and Benefits	752,403	364,554	1,116,957	999,270	-11%
Consultants					
Actuarial Liability Fee	18,700	10,609	29,309	14,500	-51%
Actuarial WC Fee	20,125	10,609	30,734	14,500	-53%
Actuarial - OPEB	7,000	10,000	17,000	7,500	-56%
Claims Audit	-	25,000	25,000	-	-100%
Computer Consultant	12,000	5,305	17,305	5,000	-71%
Web Development	2,500	5,000	7,500	6,000	-20%
Legal- General	50,000	35,000	85,000	45,000	-47%
Financial Audit/Accounting	26,500	28,000	54,500	20,000	-63%
Finance Manager	-	99,225	99,225	-	-100%
Consultants Liab Other	7,500	-	7,500	-	-100%
Consultants WC Other	7,500	-	7,500	-	-100%
Consultants Allocated to REMIF Health Program '20/21	-	(58,665)	(58,665)	-	
Total Consultants	151,825	170,083	321,908	112,500	-65%
Safety & Loss Control					
New Member Audit	2,500	-	2,500	-	-100%
On-line Training	12,000	-	12,000	20,000	67%
OccuMed	-	9,000	9,000	-	-100%
DOT (Pass-Through)	-	11,430	11,430	-	-100%
Safety/MSDS (Pass-Through)	-	63,860	63,860	-	-100%
Group Legal (Pass-Through)	-	10,040	10,040	-	-100%
DKF Solutions	-	68,600	68,600	-	-100%
Acceptable Risk	-	24,000	24,000	-	-100%
Marines	-	10,000	10,000	-	-100%
Lexipol	80,000	53,500	133,500	215,000	61%
EPL Consortium	-	47,616	47,616	125,000	163%
E-Certs	-	-	-	1,500	New
WaiverSign	1,000	-	1,000	2,000	100%
Safety/BLR/Powtoons (Tableau PY Only)	3,922	-	3,922	2,000	-49%
Simple But Needed	7,500	-	7,500	10,000	33%
Misc Loss Control	7,578	5,733	13,311	5,000	-62%
Annual Academy	15,000	-	15,000	15,000	0%

CIRA

2021/22 Preliminary Budget

	2020/21 PARSAC and REMIF Budget adjusted for costs associated with PARSAC and REMIF legacy claims, REMIF Health Program, and retiree benefits.			CIRA Budget	
	PARSAC	REMIF	Total Budget 2020/21	Proposed Budget	Budget Difference
	2020/21			2021/22	% Change
RM 101	5,000	-	5,000	-	-100%
Conference Reimbursements	-	81,000	81,000	-	-100%
Workshops	-	36,500	36,500	36,500	0%
Grant Program	152,500	-	152,500	175,000	15%
Rent a Risk Manager	-	-	-	140,000	New
Total Safety & Loss Control	287,000	421,279	708,279	747,000	5%
General and Administrative					
Advertising & Promotion	6,000	-	6,000	6,000	0%
Bank Service Fee	5,000	7,000	12,000	2,200	-82%
Capital Expenditures - Expensed	10,000	-	10,000	-	-100%
Computer Cost (Software)	4,000	43,150	47,150	11,900	-75%
Contingency/Misc. Expense	15,000	6,500	21,500	10,000	-53%
Copier Maintenance	7,500	5,000	12,500	10,000	-20%
Dues	5,000	2,000	7,000	5,000	-29%
Employee WC Insurance	23,000	-	23,000	20,200	-12%
Insurance Liability Office	12,000	-	12,000	12,000	0%
Office Expense	8,000	13,000	21,000	10,000	-52%
Payroll Service	2,000	19,096	21,096	1,000	-95%
Postage & Express Mail	3,000	1,200	4,200	2,500	-40%
Printing	4,000	-	4,000	4,000	0%
Rent/Equipment Lease	-	5,000	5,000	-	-100%
Telecommunications	8,500	13,000	21,500	14,875	-31%
'20/21. Includes Travel, Board Exp, and some Building Costs	-	(94,645)	(94,645)	-	
Total General and Administrative	113,000	20,301	133,301	109,675	-18%
Staff Travel and Training					
Staff-Educ & Training	5,000	-	5,000	5,000	0%
Staff-Travel Cost	15,000	15,000	30,000	30,000	0%
Staff - Car Allowance	6,000	-	6,000	6,000	0%
Total Staff Travel and Training	26,000	15,000	41,000	41,000	0%
Board Expenses					
Board Directors- Travel & Meetings	60,000	30,000	90,000	60,000	-33%
Total Board Expenses	60,000	30,000	90,000	60,000	-33%
Building Maintenance					
Utilities	16,350	11,025	27,375	23,755	-13%
Building Repairs	15,000	41,500	56,500	42,880	-24%
Janitorial Service	9,500		9,500	9,500	0%
Landscaping Service	6,000		6,000	6,000	0%
Pest Control	700		700	700	0%
Security/Alarm	600		600	600	0%
Property Taxes	11,500	9,000	20,500	17,545	-14%
Insurance - Property (Office)	10,000	5,000	15,000	13,360	-11%

CIRA

2021/22 Preliminary Budget

	2020/21 PARSAC and REMIF Budget adjusted for costs associated with PARSAC and REMIF legacy claims, REMIF Health Program, and retiree benefits.			CIRA Budget	
	PARSAC	REMIF	Total Budget 2020/21	Proposed Budget	Budget Difference
	2020/21			2021/22	% Change
Total Building Expenses	69,650	66,525	136,175	114,340	-16%
TOTAL EXPENSE	18,224,128	14,562,380	32,786,508	32,278,673	-2%
Total Operating Income	220,765	2,176,004	2,396,769	2,904,604	
Other Expenses					
Rental Income	-	71,300	71,300	36,275	-49%
Investment Income	830,066	100,000	930,066	-	-100%
Investments Allocated to REMIF Health Program '20/21 and Legacy Claims	(775,550)	(75,000)	(850,550)	-	
Investment Consultants	(54,516)	(25,000)	(79,516)	-	-100%
Total Investment Income	-	71,300	71,300	36,275	-49%
Total Other Income/(Expense)	-	71,300	71,300	36,275	-49%
NET INCOME	**220,765**	**2,247,304**	**2,468,069**	**2,940,879**	
Rate Stabilization/Special Events Credits	(652,223)	-	(652,223)		
Capital Replacement Fund	(20,000)	-	(20,000)		
Depreciation	(30,000)	-	(30,000)		
Excess Dividend Received	149,723	-	149,723		
Health Program Contributions (Direct Costs)	-	15,679,588	15,679,588		
Health Program Expenses (Direct Costs)	-	(15,667,238)	(15,667,238)		
Total Adjusted for Health Program and Legacy Claims	(176,815)	(815,604)	(992,419)		
Adjust for Investment Income Allocated to Health Program and Legacy Claims.	775,550	75,000	850,550		
Retiree Benefits	-	(182,500)	(182,500)		
EAP	-	(57,090)	(57,090)		
Net Income Per 20/21 Budgets	267,000	1,279,460	1,546,460		

REMIF
REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

PUBLIC AGENCY RISK SHARING AUTHORITY OF CALIFORNIA
PARSAC

AGENDA
PARSAC/REMIF TRANSITION COMMITTEE MEETING
December 14, 2020 – 9:00 a.m. – 2:00 p.m.
Zoom Meeting
Link: https://zoom.us/j/91862513737
Dial: +1 (669) 900-9128
Meeting ID: 918 6251 3737
Passcode: 771477

CALL TO ORDER
ROLL CALL

Page No.	**ACTION AND INFORMATION CALENDAR** **denotes attachments enclosed for this item*	**RECOMMENDATION**
2	1. Liability Memorandum of Coverage – Doug Alliston	*Receive and file*
	2. Update on the Property Program – Mike Simmons	*Receive and file*
20 *37*	3. General Liability and Workers' Compensation Master Program Documents – Amy Northam	*Approve*
54	4. Program Cost Allocation Formula – Tracey Smith-Reed	*Approve*
55	5. Update on Health Insurance Plan for CIRA Employees – Amy Northam & Tracey Smith-Reed	*Review and discuss*
	6. Update on Excess Liability and Workers' Compensation – Erike Young	*Receive and file*
	7. Update on Member Adoption of CIRA JPA and Bylaws – Yahaira Martinez	*Information only*
	8. Timelines – Kin Ong & Amy Northam	
	9. Schedule Next Meetings: a. Transition Committee – January 11, 2021 b. Transition Finance Committee – February 24, 2021 c. CIRA Board - May 26, 2021	

ADJOURNMENT OF MEETING

LIABILITY
MEMORANDUM OF COVERAGE
FOR
CALIFORNIA INTERGOVERNMENTAL RISK AUTHORITY

CIRA

Effective July 1, 2021 to June 30, 2022

MEMORANDUM OF COVERAGE
FOR THE
CALIFORNIA INTERGOVERNMENTAL RISK AUTHORITY
(CIRA)

This Memorandum of Coverage does not provide insurance, but instead provides for pooled risk sharing. This **Memorandum** is a negotiated agreement among the **Members** of the **Authority** and none of the parties to the **Memorandum** is entitled to rely on any contract interpretation principles which require interpretation of ambiguous language against the drafter of such **Memorandum**. This **Memorandum** shall be applied according to the principles of contract law, giving full effect to the intent of the **Members** of the **Authority**, acting through the Board of Directors in adopting this Memorandum of Coverage.

Throughout this **Memorandum**, words and phrases that appear in boldface have special meanings as provided in Section VII – Definitions.

In consideration of the payment of the contribution deposit, the **Authority** agrees with the **Members** as follows:

SECTION I – LIABILITY COVERAGE AGREEMENT

The **Authority** will pay **Ultimate Net Loss** in excess of the **Retained Limit** that the **Covered Party** shall become obligated to pay by reason of **Tort Liability** imposed by law or assumed in a **Covered Contract** because of **Bodily Injury**, **Property Damage**, **Personal Injury**, **Employment Practices**, or **Public Officials Errors or Omissions**, if caused by an **Occurrence** to which this **Memorandum** applies.

SECTION II—DEFENSE AND SETTLEMENT

A. Duty to Defend. The **Authority** shall have the right to participate in the defense of any **Claim** or **Suit** against a **Covered Party** if the final judgment or settlement is likely to result in an **Ultimate Net Loss** in excess of the **Retained Limit**. The **Authority** shall have no obligation to defend or contribute to the defense of uncovered **Claims**, including uncovered **Claims** contained in a suit that contains covered **Claims**.

B. Selection and Assignment of Defense Counsel.

1. With respect to any potentially covered **Claim** or **Suit**, the **Authority** shall select and assign counsel to defend the **Covered Party(s)**. The **Authority** will consider the wishes of a **Covered Party** with respect to the assignment of counsel, but the **Authority** retains the sole right to make the assignment of counsel. If the **Covered Party** refuses to be defended by the counsel assigned by the **Authority**, then this **Memorandum** shall not provide any defense or indemnity to such **Covered Party** for such **Claim**, and the **Authority** shall not be required to contribute to any **Defense Costs**, settlement or judgment arising from such **Claim**.

2. A **Covered Party** may select as its defense counsel the in-house City or Town Attorney directly employed as such by the **Member**. For purposes of this provision,

in-house City or Town Attorney shall not include any outside counsel contracted to act as a City or Town Attorney by the **Member** or any outside counsel contracted by the **Covered Party** to act as counsel for any **Claim**. In the event that a **Covered Party** selects the in-house City or Town Attorney to defend any **Claim**, the **Authority** shall not be required to contribute to any **Defense Costs** arising from such **Claim** or **Suit**, and any **Defense Costs** arising from such **Claim** or **Suit** or sums incurred by the **Member** for salaries, fees, benefits or costs of any nature of the in-house counsel shall not apply toward satisfaction of the **Retained Limit**. Notwithstanding the foregoing, and subject to the **Authority's** review and approval, with respect to any covered **Claim** or **Suit** where the **Retained Limit** is $350,000 or higher, the **Covered Party** may select as its defense counsel outside counsel contracted by the **Member** to act as the City or Town Attorney, but only if the outside counsel has demonstrated experience with the subject matter of the **Claim**. If as the result of the **Authority's** review of the defense counsel's performance on the **Claim** or **Suit**, the **Authority** withdraws its approval of such counsel, then counsel shall be determined and assigned as provided in paragraph 1, regardless of the **Member's Retained Limit**.

3. With respect to the defense of any covered **Claim** or **Suit** against a **Member** for **Tort Liability** assumed in a **Covered Contract**, the **Authority** shall select and assign counsel to defend such parties identified in the **Covered Contract**. The **Authority** shall select counsel from a list of Panel Counsel established by the **Authority**. The **Authority** will consider the wishes of a **Covered Party** with respect to the assignment of counsel, but the **Authority** retains the sole right to make the assignment of counsel. In the event of a *disagreement regarding the assignment of counsel, the **Covered Party** retains the right to appeal to the Board of Directors, whose decision shall be final*. If either the **Covered Party** or the party identified in the **Covered Contract** refuses to have such party(s) be defended by the counsel assigned by the **Authority**, then the obligation of the **Authority** to contribute to **Defense Costs** arising from such **Claim** or **Suit** shall be limited to such amounts as would be incurred if counsel selected from the Panel Counsel list were assigned the defense of such **Claim** or **Suit**.

C. *Termination of Authority's Obligation.* The **Authority**'s obligation to defend and/or cover any **Claim** shall cease after the **Coverage Limit** stated in Section V has been exhausted by payment of settlement(s), judgment(s) and/or **Defense Costs**.

D. *Settlement.* No **Claim** shall be settled for an amount in excess of the **Retained Limit** without the prior written consent of the **Authority** and the **Authority** shall not be required to contribute to any settlement to which it has not consented.

If the **Member**'s **Retained Limit** has already been expended the **Authority** shall have the sole discretion to control the defense and settlement of the **Claim**. Any such decision to settle shall be final.

If the **Member**'s **Retained Limit** has not been expended (i.e., the **Member** will have to contribute funds to effectuate the settlement), then the consent of the **Member** to any settlement shall be required. If however, the **Member** refuses to consent to any settlement or compromise recommended by the Authority or its Claim Administrator and elects instead to continue to contest the **Claim**, then the **Authority**'s liability shall not exceed the amount for which the **Authority** would have been able to settle the **Claim** plus **Defense Costs** at the time the **Claim** could have been settled or compromised.

SECTION III—COVERAGE LIMIT

A. The Limit of Coverage shown in **Cover Page** and the rules below determine the most the **Authority** will pay, inclusive of **Defense Costs**, regardless of the number of:

1. **Covered Parties;**
2. **Occurrences;**
3. **Claims** made or **Suits** brought; or
4. Persons or organizations that sustain injuries or **Damages.**

B. The **Authority** shall pay only for **Ultimate Net Loss** in excess of the **Retained Limit**.

C. The Limit of Coverage stated in the **Cover Page** is the most the **Authority** will pay for **Ultimate Net Loss** as respects the sum of **Damages** and **Defense Costs** arising out of any one **Occurrence.**

D. In determining the Limit of Coverage, all injury or damage arising out of exposure to substantially the same general condition(s) shall be considered as arising out of one **Occurrence**.

E. Any loss of use of tangible property not physically injured or destroyed shall be deemed to occur at the time of the **Occurrence** that caused such loss of use. Any other injury or damage occurring or alleged to have occurred over more than one coverage period shall be deemed to have occurred during the coverage period when the **Occurrence** begins, and only the **Limit of Coverage** for that coverage period shall apply.

SECTION IV—COVERAGE PERIOD AND TERRITORY

This **Memorandum** applies to **Bodily Injury, Property Damage, Personal Injury**, **Employment Practices**, or **Public Officials Errors or Omissions** that occur anywhere in the world during the **Coverage Period**.

SECTION V—EXCLUSIONS

This **Memorandum**, including any obligation to defend or to pay **Defense Costs**, is subject to the following exclusions:

A. *Additional Covered Party*. This **Memorandum** does not apply to **Claims** arising out of the active or sole negligence of an **Additional Covered Party**. Also, no **Additional Covered Party** is covered for **Claims** by another **Covered Party**.

B. *Aircraft or Airport Operations*. This **Memorandum** does not apply to **Claims** arising out of the ownership, operation, use or maintenance of any **Aircraft** or **Airport** owned by a **Covered Party.** However, this exclusion does not apply to claims arising out of the ownership, operation, use or maintenance of any **Unmanned Aerial Vehicle (UAV)** that is owned or operated by or on behalf of any **Member**.

C. *Antitrust or Restraint of Trade*. This **Memorandum** does not apply to **Claims** arising out of violation of state or federal antitrust or restraint-of-trade laws.

D. *Bounce House.* This **Memorandum** does not apply to **Claims** arising out of the ownership, maintenance, or use of any inflatable rebound device or equipment.

E. *Breach of Contract*. This **Memorandum** does not apply to **Claims** arising out of failure to perform, or breach of, a contractual obligation.

F. *Contractual Liability*. This **Memorandum** does not apply to **Claims** arising out of the **Covered Party's** assumption of **Tort Liability** in a written agreement or contract, but this exclusion does not apply to liability assumed in a **Covered Contract** if the **Damages** occur subsequent to the execution of the **Covered Contract**.

G. *Dam Failure*. This **Memorandum** does not apply to **Claims** arising out of the partial or complete structural failure of any **Dam**.

H. *Disability Accommodation Expenses.* This Memorandum does not apply to the cost of providing reasonable accommodation pursuant to the Americans with Disabilities Act, Fair Employment and Housing Act, or any similar law.

I. *Employee Benefits Plans*. This **Memorandum** does not apply to **Claims** arising out of any act or omission regarding benefits payable under any employee benefits plan established by the **Covered Party**.

J. *Employee Injury***.** This **Memorandum** does not apply to **Bodily Injury** or **Personal Injury** to:

1. any past or current employee of the **Covered Party** arising out of and in the course of employment by the **Covered Party**; or

2. The spouse, child, parent, brother, sister, or other relative of such employee as a consequence of 1. above.

K. *Employer Obligation Limitation*. The defense and indemnity coverage afforded by this **Memorandum** to a past or present official, employee or volunteer of a **Member** is not broader than the **Member's** duty to defend and indemnify its official, employee or volunteer, pursuant to California Government Code Section 815, 815.3, 825 to 825.6, 995 to 996.6, inclusive, and any amendments thereof. If the **Member** which employs the official, employee or volunteer is not obligated under the California Government Code to provide a defense or to provide indemnity for a **Claim**, or if said **Member** refuses to provide such defense and/or indemnity to said official, employee or volunteer, then this **Memorandum** shall not provide any such defense or indemnity coverage to said official, employee or volunteer. All immunities, defenses, rights, and privileges afforded to a **Member** under California Government Code Section 815, 815.3, 825 to 825.6, 995 to 996.6, inclusive, and any amendments thereof, shall be afforded to the **Authority** to bar any defense or indemnity coverage under this Memorandum to that **Member's** official, employee or volunteer.

L. *Estimates, Plans and Contract Awards*. This **Memorandum** does not apply to **Public Officials Errors or Omissions** arising out of:

1. estimates of probable costs or cost estimates being exceeded

2. faulty preparation of bid specifications, or architectural or engineering drawings, plans or specifications

3. failure to award contracts in accordance with ordinances, regulations or statutes governing such contracts that must be submitted for bids

M. *Failure to Supply Utilities*. This **Memorandum** does not apply to any **Claim** arising out of the failure to supply or provide an adequate supply of gas, water, sewage capacity or electricity. However, this exclusion does not apply if the failure to supply results from direct and immediate accidental injury to tangible property owned or used by a **Covered Party** to procure, produce, process or transmit gas, water, sewage capacity or electricity.

N. *Fiduciary Liability*. This **Memorandum** does not apply to **Claims** arising out of any breach of responsibility, obligation or duty imposed upon or imputed to a **Covered Party**:

1. under the Employee Retirement Income Security Act of 1974 and any law amendatory thereof

2. under Article XVI, Section 17 of the California Constitution and any law amendatory thereto

3. under any other law imposing or imputing fiduciary responsibilities, obligations or duties upon a **Covered Party**.

O. *Fines, Penalties and Punitive Damages*. This **Memorandum** does not apply to **Claims** for fines, penalties, restitution, disgorgement, punitive damages, or exemplary damages.

P. *Impairment or Loss of Property.* This **Memorandum** does not apply to **Public Officials Errors or Omissions** arising out of or resulting in injury or damage to, destruction of, disappearance of, loss of, loss of use of, or diminution of value of any tangible property, money or securities; or failure to pay debt obligations.

Q. *Knowingly False Statements*. This **Memorandum** does not apply to **Personal Injury** arising out of a publication or utterance concerning any organization or business enterprise, or its products or services, made by or at the direction of any **Covered Party** with knowledge of the falsity thereof.

R. *Labor Disputes and Class Actions.* This **Memorandum** does not apply to any potential or actual liability arising out of a lockout, strike, picket line, replacement or other similar action in connection with labor disputes or labor negotiations; or to any potential or actual liability arising from **Claims** filed or certified as class actions in which employees or other persons represent a class of employees who are alleging similar or related **Claims**.

S. *Land-Use and Other Regulation*. This **Memorandum** does not apply to:

1. any **claim** arising out of or in connection with land-use regulation, land-use planning, the adoption or administrative application of any ordinance, building code, resolution, or regulation; or the approval or disapproval of any land-use entitlement including but not limited to general plan amendments, zoning amendments, conditional-use permits,

tract maps, development agreements, owner-participation agreements, or any other land-use related agreements. This exclusion shall not apply to the physical enforcement of an ordinance, resolution or regulation, such as **Tort Liability** arising from the act of delivering a fine, citation, warning, notice or inspection.

2. the principles of eminent domain or inverse condemnation, by whatever name called, or condemnation proceedings, regardless of whether such claims are made directly against the **Covered Party** or by virtue of any agreement entered into by or on behalf of the **Covered Party**. However, this exclusion shall not apply to claims arising from physical damage to tangible property; provided however, this exception shall not apply to any nonphysical consequential **damages** including but not limited to claims for loss of use, loss of income, loss of profits, and loss of business goodwill.

3. the approval or disapproval of any rent control ordinance, outdoor advertising ordinance, or adult bookstore ordinance, taxi ordinance.

4. the approval or disapproval of the operation of a cannabis dispensary whether medical, recreational, or otherwise; the enactment of any ordinances governing cannabis dispensaries, and any enforcement of ordinances governing cannabis dispensaries.

T. *Medical and Healthcare Operations*. This **Memorandum** does not apply to **Claims** arising out of ownership, use, operation or maintenance of any hospital, health care or medical clinic facility, and any professional medical services performed by or on behalf of the **Covered Party**, including, but not limited to, dental, veterinary and chiropractic, but this exclusion does not apply to such services performed by emergency medical technicians or paramedics functioning under the direction and control of the **Covered Individuals**.

U. *Medicare Compliance*. This **Memorandum** does not apply to **Claims** arising from or relating to any sums sought by Medicare with respect to a **Claim** or **Suit** settled by a **Member** within its **Retained Limit**.

V. *Motorized Racing Contest*. This **Memorandum** does not apply to **Claims** arising out of automobile or motorcycle drag racing, speed racing, or similar speed contests sponsored, controlled or participated in by a **Covered Party**.

W. *Non-Monetary Relief.* This **Memorandum** does not apply to **Claims** alleging, based upon or arising out of claims, demands or actions seeking relief or redress in any form other than money damages, or for claimant/plaintiff attorney fees, costs or expenses relating to claims, demands or actions seeking relief or redress in any form other than money damages.

X. *Nuclear*. This **Memorandum** does not apply to **Bodily Injury or Property Damage** arising out of the hazardous properties of **Nuclear Material**.

Y. *Pollution*. This **Memorandum** does not apply to **Claims** arising out of the actual, alleged or threatened discharge, dispersal, escape, migration, release, or seepage of **Pollutants**. However, this exclusion does not apply to **Bodily Injury or Property Damage** arising out of or caused by any actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of **Pollutants** if:

1. It was directly caused by **Hostile Fire,** explosion, lightning, windstorm, vandalism malicious mischief, or by the collision, overturning or upset of a motor vehicle; or

2. It was accidental and neither expected nor intended by the **Covered Party**; and

3. It was instantaneous and was demonstrable as having commenced at a specific time and date during the **Covered Period**; and

4. Its commencement became known to the **Covered Party** within seven days; and

5. Its commencement was reported in writing to the Authority within twenty days of becoming known to the **Covered Party**; and

6. The **Covered Party** takes reasonable steps to correct or terminate the discharge, dispersal, seepage, migration, release or escape of **Pollutants**.

Nothing contained in this Exclusion S shall operate to provide any coverage or any obligation to defend or pay **Defense Costs** with respect to:

a. Any site or location used by others on the **Covered Party's** behalf for the handling, storage, disposal, dumping, processing, or treatment of waste material. This exclusion applies whether the action by others was known to the **Covered Party**;

b. Any clean-up costs mandated by the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA) and any similar laws or statutes;

c. Clean up, removal, containment, treatment, detoxification, or neutralization of **Pollutants** situated on the premises the **Covered Party** currently owns, rents, or occupies.

d. Any **Claim**, liability, loss, cost, or expense based upon or arising out of **Personal Injury** or **Public Officials Errors or Omissions**.

Z. *Property in the Covered Party's Control*. This **Memorandum** does not apply to **Property Damage** to:

1. property owned by the **Covered Party**;

2. property rented to, leased to the **Covered Party** where the **Covered Party** has assumed liability for damage to or destruction of such property, unless the **Covered Party** would have been liable in the absence of such assumption of liability; or

3. **Aircraft** or **Watercraft** in the **Covered Party's** care, custody or control.

AA. *Refunds*. This **Memorandum** does not apply to **Claims** arising out of the refund of taxes, fees, or assessments.

BB. *Transit Operations*. This **Memorandum** does not apply to **Bodily Injury or Property Damage** arising out of any transit authority, transit system or public transportation system owned or operated by the **Covered Party**, but this exclusion does not apply to any transit

system operating over non-fixed routes, including dial-a-ride, senior citizen transportation, or handicapped transportation.

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CC. *Unlawful Financial Gain*. This **Memorandum** does not apply to **Claims** arising in whole or in part out of any **Covered Individual's** obtaining remuneration or financial gain to which the **Covered Individual** was not legally entitled.

DD. *Watercraft*. This Memorandum does not apply to **Claims** arising out of the ownership, operation, use or maintenance of any **Watercraft** owned by a **Covered Party**.

EE. *Willful Violation of Any Law*. This **Memorandum** does not apply to **Personal Injury** arising out of the willful violation of any law committed by or with the knowledge or consent of the **Covered Party. Public Officials Errors or Omissions** arising out of the willful violation of any law.

FF. *Wage and Hour*. This **Memorandum** does not apply to any **Claim** brought under the Fair Labor Standards Act (29 U.S.C. 201 et seq.), the California Labor Code, or any other state or local law governing minimum wages, overtime compensation, reimbursement of employee expenses, timely payment of employee compensation, or errors in wage statements or other employment records;

GG. *Workers' Compensation*. This **Memorandum** does not apply to **Claims** for which the **Member** or its insurance company may be held liable under any workers' compensation, unemployment compensation or disability benefits law, or under any similar law.

HH. *Use of a Firearm.* This **Memorandum** does not apply to **Claims** arising from the use of a firearm in connection with **Code Enforcement** by non-**Peace Officers** in connection with the enforcement of the criminal laws of the State of California by non-**Peace Officers**.

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SECTION VI—CONDITIONS

A. *Amendment or Cancellation*. This **Memorandum** may be amended or cancelled at any time in accordance with the provisions of the Joint Powers Agreement creating CIRA and its Bylaws. The terms of this **Memorandum** may not be changed except by written amendment issued by the **Authority** to form a part of this **Memorandum.**

B. *Appeal of Disputes with Authority*. Any disputes concerning coverage or procedures of the **Authority** may be appealed only to the **Authority's** Board of Directors in the manner and form that it may from time to time determine. Decisions by the **Authority** to assume control of the negotiation, appeal, or settlement of a **Claim**, or whether or not coverage exists for a particular **Claim** or part of a **Claim** or any other dispute that arises under and in connection with the Memorandum shall be made by the Board of Directors of the **Authority** or the Executive Committee as set forth herein. An appeal of a coverage determination of the General Manager or Coverage Counsel of the **Authority** or of any other dispute that arises under and in connection with the Memorandum shall be made in writing to the **Authority** within 60 days of the decision or dispute and shall be heard and determined by the Board at the next regularly scheduled meeting of the Board. If at the request of the **Covered Party**, or in the event that in the judgment of the **Authority** that exceptional circumstances warrant, an appeal of a coverage determination or any other

dispute that arises under and in connection with the Memorandum shall be heard by the Executive Committee within 21 days of receipt of the appeal. Any determination by the Executive Committee may be appealed by the **Covered Party** and shall be determined at the next regularly scheduled meeting of the Board.

C. *Appeal of Judgments*. In the event the **Covered Party** elects not to appeal a judgment, the **Authority** may elect to do so at its own expense, but in no event shall the **Authority's** liability for **Ultimate Net Loss** plus all **Defense Costs** necessary and incident to such appeal exceed the limit of coverage stated in Section V.

D. *Bankruptcy*. Bankruptcy or insolvency of the **Covered Party** shall not relieve the **Authority** of any of its obligations under this **Memorandum**.

E. *Duties in the Event of an Occurrence or Claim*.

1. The **Covered Party** shall cooperate with the **Authority** and upon the **Authority's** request assist in making settlements, in the conduct of suits and in enforcing any right of contribution or indemnity against any person or organization who may be liable to the **Covered Party** because of **Bodily Injury, Property Damage, Personal Injury**, **Employment Practices**, or **Public Officials Errors or Omissions** with respect to which coverage is afforded under this **Memorandum**; and the **Covered Party** shall attend hearings and trials and assist in securing and giving evidence and obtaining the attendance of witnesses.

2. The **Covered Party** shall provide a copy to the **Authority** within 15 calendar days of all Government Code Section 910 claims likely to exceed 50% of the **Member's Retained Limit** and within 7 calendar days of all suits covered by this **Memorandum**, except property damage claims under five thousand dollars ($5,000.00).

3. The **Covered Party** shall notify the **Authority** not later than 7 calendar days of any **Occurrence** reasonably considered a serious incident that is likely to be covered by this **Memorandum**, including but not limited to:

   (i) One or more fatalities;
   (ii) Loss of a limb;
   (iii) Loss of use of any sensory organ;
   (iv) Paralysis, Quadriplegia or paraplegia;
   (v) Third degree burns involving more than ten percent of the body;
   (vi) Serious facial disfigurement;
   (vii) Long term hospitalization;
   (viii) Closed head injury; or
   (ix) Serious loss of use of any bodily function.

4. The **Covered Party** shall forward to the **Authority** every demand, notice summons or other process received.

5. The **Covered Party** shall not, except at its own cost and expense, voluntarily make any payment, assume any obligation or incur any expense without the written consent of the **Authority**.

F. *Duties with Respect to **Covered Contracts**.*

1. With respect to any contract for which a **Covered Party** seeks coverage as a **Covered Contract,** the **Covered Party** shall submit the proposed contract to the **Authority** for its review and approval, at least 14 days prior to the date of execution of the contract, or its effective date, whichever is earlier.

2. The factors that shall be considered by the **Authority** in determining approval of a contract shall include:

   a. the party contracting with the **Covered Party** has requested indemnification for services the contracting party is providing to the **Covered Party**;

   b. the subject matter of the proposed contract does not pertain to an essential service of the **Covered Party** and there are available options to contract with other providers;

   c. whether all efforts to negotiate terms acceptable to the **Authority** have been exhausted;

   d. whether there is alternative coverage through the commercial market for the proposed subject matter of the contract, for example, special events coverage; and,

   e. whether the **Member** executes the contract against the **Authority's** recommendation.

G. *Other Coverage or Insurance*. If collectible insurance with any insurer, coverage with any other joint powers authority or other self-funding mechanism is available to the **Covered Party** covering a loss to which this **Memorandum** applies (whether on a primary, excess or contingent basis), the coverage of this **Memorandum** shall be in excess of, and shall not contribute with, such other insurance or coverage; provided that this clause does not apply with respect to excess insurance or coverage purchased specifically to be in excess of this **Memorandum**. The bankruptcy of, insolvency of, or placement into rehabilitation or receivership by any regulatory agency of any joint powers authority or insurance company providing joint powers authority coverage or insurance coverage to the **Covered Party** shall not amend the application of this condition.

H. *Satisfaction of Retained Limit.* In order for defense or indemnity to be available hereunder, the **Covered Party** must first pay the full amount of its **Retained Limit**. Payment of the **Retained Limit** by the **Covered Party** is required in addition to, and regardless of, any payment from any other source for or on behalf of the **Covered Party**, such as, for example, insurance procured by a third party pursuant to which the **Covered Party** is an additional named insured or otherwise covered. The foregoing does not apply to any insurance purchased by the **Member** or any **Covered Party** to cover all or any part of the **Retained Limit**.

I. *Relationship to Joint Powers Agreement*. The provisions of this **Memorandum** are subject to and subordinate to the terms and provisions of the Joint Powers Agreement creating CIRA, and in the event of any conflict between the terms and provisions of said Agreement and this **Memorandum**, the terms and provisions of the Agreement shall control.

J. *Severability of Interests*. The coverage applies separately to each **Covered Party** against whom **Claim** is made, as if a separate **Memorandum** were issued to it, except with respect to the **Authority's** Limit of Coverage.

K. *Subrogation*. To the extent of any payment under this **Memorandum**, the **Authority** shall be subrogated to all the **Covered Party's** rights of recovery thereof. The **Covered Party** shall do everything necessary to secure such rights and shall do nothing after the **Occurrence** to prejudice such rights. Any amount so recovered shall be apportioned as follows:

1. The **Authority** shall be reimbursed to the extent of all payment under this **Memorandum**. Any remaining balance shall be applied to reimburse the **Covered Party**.

2. The expenses of such recovery proceedings shall be apportioned in the ratio of respective recoveries. If there is no recovery in proceedings conducted solely by the **Authority**, the **Authority** shall bear the expenses thereof.

L. *Actions.* No action shall lie against the **Authority** with respect to the coverages and related provisions defined in the **Memorandum** unless, as a condition precedent thereto, there shall have been full compliance with all of the terms of this **Memorandum**, nor until the amount of the **Covered Party's** obligations to pay shall have been finally determined either by judgment against the **Covered Party** after actual trial or by written agreement of the **Covered Party**, the claimant and the **Authority**. Any person or organization or the representative thereof who has secured such judgment or written agreement shall thereafter be entitled to recovery under this **Memorandum** to the extent of the coverage afforded by this **Memorandum**. No person or entity shall have the right under this **Memorandum** to join the **Authority** as a party to any action against the **Covered Party** to determine the **Authority's** liability, nor shall the **Authority** be impleaded by the **Covered Party** or its legal representative.

M. *Venue.* In the event of any dispute between a **Member** and the **Authority** concerning the coverage provided by the **Memorandum,** the place of venue for any **Suit** concerning such coverage dispute shall be the County of Sacramento, and any action concerning such dispute shall be filed in the Superior Court for the County of Sacramento, California.

N. *Medicare Compliance.* Where a **Member** settles a claim within its **Retained Limit**, in which a claimant is either presently Medicare eligible or will be Medicare eligible within 30 months of the settlement, the **Member** shall comply with all pertinent laws and regulations applicable to the settlement, and shall ensure that Medicare's interests are fully addressed, protected and documented in the settlement.

The failure by a **Member** to comply with all pertinent laws and regulations applicable to the settlement or to properly protect and document Medicare's interests in the settlement, shall preclude coverage under the Memorandum for **Claims** arising from or relating to any sums

sought by Medicare with respect to a **Claim** or **Suit** settled by a **Member** within its **Retained Limit**.

SECTION VII—DEFINITIONS

Additional Covered Party means any person, organization or entity that is specifically named by the **Authority** in a written attachment to this **Memorandum**.

Aircraft means any vehicle controlled directly by a person from within or on the vehicle, designed to transport people or property through the air.

Airport means any locality either on land or water which is adopted for the landing and taking off of **Aircraft**, including all land, water, buildings, structures, equipment or other improvements necessary or convenient in the establishment and operation of an **Airport**.

Authority means the California Intergovernmental Risk Authority (CIRA).

Automobile means a land motor vehicle, trailer, or semi-trailer.

Bodily Injury means bodily injury, sickness or disease sustained by any person, including death resulting from any of these at any time.

Claim means a notice, demand, or **Suit** against a **Covered Party** to recover **Damages**.

Code Enforcement means enforcement of zoning laws, regulations, and ordinances; land use laws, regulations, and ordinances; and nuisance, abatement, dumping or similar municipal ordinances.

Covered Contract means that part of any written agreement or contract pertaining to the **Member's** operations or business under which the **Member** assumes the **Tort Liability** of another party to pay for **Bodily Injury or Property Damage** to a third person or organization. A **Covered Contract** does not include any part of any contract or agreement:

1. That indemnifies any person or organization for **Bodily Injury or Property Damage** caused by the sole negligence of such person or organization.

2. That indemnifies any person or organization for **Bodily Injury or Property Damage** arising out of the ownership, operation, maintenance or use of any **Aircraft, Unmanned Aerial Vehicle, Airport or Watercraft.**

3. That indemnifies an architect, engineer or surveyor for **Bodily Injury or Property Damage** arising out of:

    a. Preparing, approving, or failing to prepare or approve maps, drawings, opinions, reports, surveys, change orders, designs, or specifications

    b. Giving directions or instructions, or failing to give directions or instructions, if that is the primary cause of the **Bodily Injury or Property Damage**.

4. Under which the **Covered Party,** if an architect, engineer, or surveyor, assumes liability for **Bodily Injury or Property Damage** arising out of the **Covered Party's** rendering or failing to render professional services, including those listed in 3. above, and supervisory, inspection or engineering services.

5. That has not been approved by the **Authority** at least 14 days in advance of its execution by the Member or its effective date, whichever is earlier**.**

Covered Individuals means persons who are, or were, elected or appointed officials, employees, or volunteers of the **Member**, whether or not compensated, while acting for or on behalf of the **Member.** However, no coverage or defense will be provided to a volunteer while using his or her personal **Automobile,** unless such use is for the business of the **Member** and at the express direction of the **Member,** nor to any person who is an independent contractor and not an employee of the **Member,** but who either provides services to or acts as an official of the **Member** in exchange for compensation pursuant to an oral or written contract with the **Member. Covered Individual** shall not include any person, whether or not compensated, who is not acting in the course and scope of his or her employment or whose conduct, as a matter of law, is not within the course and scope of his or her employment by the **Member** at the time of the act or acts alleged in a **Claim.**

Covered Party means:

1. The **Member**;

2. **Covered Individuals**;

3. Any **Additional Covered Party**;

4. With respect to any **Automobile** owned or leased by the **Member**, or loaned to or hired for use by or on behalf of the **Member**, any person while using such **Automobile** and any person or organization legally responsible for the use thereof, provided the actual use is with the express permission of the **Member**, but this coverage does not apply to:

   a. any person or organization, or any agent or employee thereof, operating an **Automobile** sales agency, repair shop, service station, storage garage or public parking place, with respect to an **Occurrence** arising out of the operation thereof; or

   b. the owner or any lessee, other than the **Member**, of any **Automobile** hired by or loaned to the **Member** or to any agent or employee of such owner or lessee.

Cover Page means the document that is issued with this **Memorandum,** identifying the **Member,** the **Coverage Period,** the **Limit of Coverage,** and the **Retained Limit**.

Coverage Limit means the limit of coverage shown in the **Cover Page** as more fully defined under Section IV of this **Memorandum**.

Coverage Period means the time period shown on the **Cover Page** of this **Memorandum**. The phrase "coverage period" without boldface or capitalization refers to any annual period, including but not limited to the time period shown in the **Cover Page**.

Dam means any artificial barrier, together with appurtenant works, which does or may impound or divert water, and which either (a) is 25 feet or more in height from the natural bed of the stream or watercourse at the downstream toe of the barrier, or from the lowest elevation of the outside limit of the barrier, if it is not across a stream channel or watercourse, to the maximum possible water storage elevation; or (b) has an impounding capacity of 50 acre-feet or more.

Any such barrier which is not more than six (6) feet in height, regardless of storage capacity, or which has a storage capacity not more than 15 acre-feet, regardless of height, shall not be considered a **Dam**.

No obstruction in a canal used to raise or lower water therein or divert water therefrom, no levee, including but not limited to a levee on the bed of a natural lake the primary purpose of which levee is to control flood-waters, no railroad fill or structure, tank constructed of steel or concrete or of a combination thereof, no tank elevated above the ground, and no barrier which is not across a stream channel, watercourse, or natural drainage area and which has the principal purpose of impounding water for agricultural use shall be considered a **Dam**. In addition, no obstruction in the channel of a stream or watercourse which is 15 feet or less in height from the lowest elevation of the obstruction and which has the single purpose of spreading water within the bed of the stream or watercourse upstream from the construction for percolation underground shall be considered a **Dam**. Nor shall any impoundment constructed and utilized to hold treated water from a sewage treatment plant be considered a **Dam**. Nor shall any wastewater treatment or storage pond exempted from State regulations and supervision by Water Code Section 6025.5 be considered a **Dam.**

Regardless of the language of the above definition, however, no structure specifically exempted from jurisdiction by the State of California Department of Water Resources, Division of Safety of Dams shall be considered a **Dam**, unless such structure is under the jurisdiction of any agency of the Federal government.

Damages means money that the **Covered Party** is legally obligated to pay, or agrees to pay with the **Authority's** agreement, as the result of a **Claim**, including claimant's attorney fees, interest on judgments, and costs. **Damages** does not include amounts incurred by the **Covered Party** to comply with non-monetary remedies such as injunctions.

Defense Costs means all fees and expenses incurred in connection with the adjustment, investigation, defense and appeal of a **Claim** covered hereunder, including defense attorney fees, court costs, premiums for appeal bonds, and interest on judgments accruing after the entry of judgment, and also shall include the costs of any claims administrator or defense counsel specifically assigned by the **Authority** to respond to any **Claim** on behalf of the **Authority**. **Defense Costs** shall not include attorneys' fees or costs arising in connection with **Claims** that are not covered by this Memorandum. **Defense Costs** shall not include the office expenses of the **Authority** or the **Covered Party**, nor the salaries of employees or officials of the **Authority** or the **Covered Party**, nor expenses of any claim administrator engaged by the **Covered Party**. **Defense Costs** shall not include any fee or expense relating to coverage issues or disputes between the **Authority** and any **Covered Party. Defense Costs** does not include attorney fees awarded to the prevailing plaintiff.

Employment Practices means unlawful discrimination, sexual harassment, retaliation, or wrongful termination of employment alleged by a **Covered Party's** employee, former employee, or applicant for employment.

Hostile Fire means a fire that becomes uncontrollable and breaks out from where it is intended to be.

Limit of Coverage means the amount of coverage shown in the **Cover Page**, or sublimits as started therein, for each **Covered Party** per **Occurrence** subject to any lower sublimit stated in this **Memorandum**. For each **Occurrence**, there shall be only one **Limit of Coverage** regardless of the number of claimants or **Covered Parties** against whom a claim is made. In the event of a structured settlement, whether purchased from or through a third-party, or paid directly by the **Covered Party** in installments, as utilized in the resolution of a claim or suit, the **Authority** will pay only up to the amount stated in the **Cover Page** in present value of the claim, as determined on the date of settlement, regardless of whether the full value of the settlement exceeds the amount sated in the **Cover Page**.

Member means the entity which a party to the Joint Powers Agreement creating CIRA and whose name appears on the **Cover Page**. **Member** includes any other agency, commission, district, or board coming under the **Member's** direction or control or for which the **Member**'s board members act as the governing board.

Memorandum means the CIRA Memorandum of Coverage, including the **Cover Page** and any attachments and endorsements forming a part thereof.

Nuclear Material means source material, special nuclear material, or by-product material. "Source Material", "Special Nuclear Material", and "By-Product Material" have the meanings given them in the Atomic Energy Act of 1954 or any law amendatory thereof.

Occurrence means:

1. With respect to **Bodily Injury** or **Property Damage**, an accident or event, including continuous or repeated exposure to substantially the same generally harmful conditions, which results during the **Coverage Period** in **Bodily Injury** or **Property Damage** neither expected nor intended from the standpoint of the **Covered Party**, except that assault and battery committed by, at the direction of, or with the consent of the **Covered Party** for the purpose of protecting persons or property from injury or death shall be considered an **Occurrence**;

2. With respect to **Personal Injury**, the commission of an offense described in the definition of **Personal Injury** during the **Coverage Period**;

3. With respect to **Public Officials Errors or Omissions** and **Employment Practices**, conduct described in the definitions of those phrases during the **Coverage Period.**

Peace Officer means a person designated under Penal Code Sections 830 to 832.6 as a peace officer, or a public officer authorized under Penal Code Sections 830 to 832.6 to carry a firearm, and who is authorized by the **Member** to carry a firearm in the course and scope of employment.

Personal Injury means injury resulting from one or more of the following offenses:

1. False arrest, detention, or imprisonment

2. Malicious prosecution or abuse of process

3. Wrongful entry by any employee of a **Member** into a room, dwelling or other similar premises that a person occupies

4. Wrongful eviction by any employee of a **Member** of a person from a room, dwelling or other similar premises that such person occupies

5. The publication or utterance of a libel or slander, including disparaging statements concerning the condition, value, quality or use of real or personal property, or a publication or utterance in violation of rights of privacy

6. Discrimination or violation of civil rights

7. Infliction of emotional distress

Pollutants means any solid, liquid, gaseous or thermal irritant or contaminant, including but not limited to acids, alkalis, asbestos, chemicals, fumes, hazardous waste, polychlorinated biphenyls, radioactive material, smoke, soot, toxic substances, vapor, mold, fungal pathogens, electromagnetic fluids and airborne particles or fibers, waste and any related material. Waste includes material to be recycled, reconditioned, or reclaimed. The term **Pollutants** as used herein shall not include potable water or agricultural water or water furnished to commercial users or water used for fire suppression.

Property Damage means:

1. Physical injury to or destruction of tangible property, including all resulting loss of use of that property. All such loss of use shall be deemed to occur at the time of the physical injury that caused it.

2. Loss of use of tangible property that is not physically injured. All such loss of use shall be deemed to occur at the time of the **Occurrence** that caused it.

Public Officials Errors or Omissions means any act, error, omission, misstatement, misleading statement, neglect, or breach of duty by any **Covered Party** (individually or collectively) arising in the course and scope of their duties with the **Covered Party** or claimed against them solely by reason of their being or having been public officials or employees, and which results in **Damages** neither expected nor intended from the standpoint of the **Covered Party**.

Retained Limit means the amount of **Ultimate Net Loss,** specified in the **Cover Page**, which the **Covered Party** must incur or become liable to pay before the **Authority** is obligated to make payment. Payments by others on the **Covered Party's** behalf count toward satisfaction of the **Covered Party's Retained Limit**. For each **Occurrence**, there shall be only one **Retained** Limit applicable regardless of the number of claimants or **Covered Parties** against whom a **Claim** is made. If the **Covered Parties** have different **Retained Limits**, the lowest **Retained Limit** of any party found liable will apply. Payment of the **Retained Limit** shall be apportioned among multiple **Covered Parties** in accordance with their proportionate shares of

liability. If the apportionment requires arbitration the **Covered Parties** will pay all costs of the **Authority** in seeking such determination, including the **Authority's** attorney fees, according to their proportionate shares of liability.

Suit means a civil proceeding in which a **Covered Party** is named as a party defendant or cross-defendant, or an arbitration proceeding or alternative-dispute resolution proceeding to which a **Covered Party** submits with the **Authority's** written consent.

Tort Liability means civil liability imposed by law in the absence of any agreement or contract.

Unmanned Aerial Vehicle (UAV) or drone means an aircraft (with its aerial system or control device) that is not controlled directly by a person from within or on the aircraft, and which is piloted or operated in conformance with 14 C.F.R. 107 et seq. Any pilot or operator must have a remote pilot certificate issued in compliance with Subpart C of Section 107 or possess a valid Certificate of Waiver or Authorization issued by the FAA and satisfy the requirements of Section 107.65.

Ultimate Net Loss means **Damages** and **Defense Costs** the **Covered Party** is legally obligated to pay by reason of a judgment or a settlement made with the written consent of the claimant(s), the **Covered Party**, and the **Authority**.

Watercraft means a vessel more than 26 feet in length designed to transport persons or property in, on or through water.

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CALIFORNIA INTERGOVERNMENTAL
RISK AUTHORITY

MASTER PROGRAM DOCUMENT FOR
THE
POOLED GENERAL LIABILITY ~~WORKERS' COMPENSATION~~ PROGRAM

DRAFT DECEMBER 04, 2020~~MAY 28, 2020~~

CALIFORNIA INTERGOVERNMENTAL RISK AUTHORITY (CIRA)

MASTER PROGRAM DOCUMENT (MPD)
FOR THE
POOLED GENERAL LIABILITY ~~WORKERS'~~

~~COMPENSATION~~ PROGRAM (PGL~~WCPP~~) ARTICLE I:

DEFINITIONS

The following definitions apply to this MPD:

1. **General Manager** shall mean the person responsible for the daily administration, management, and operation of the **Authority's** programs as defined in the Bylaws.

2. **Authority** shall mean the California Intergovernmental Risk Authority (CIRA).

3. **Board** shall mean the Board of Directors for~~of~~ the California Intergovernmental Risk Authority (CIRA) Joint Powers Authority.

4. **Deposit Contribution** shall mean that amount to be paid by each **Participant** for each **program year** as determined by the **Board** in accordance with Article III, Section B of this MPD.

5. **Joint Powers Agreement** shall mean the agreement made by and among the public entities listed in Appendix A (**Member Entities**) of the **Joint Powers Agreement,** hereafter referred to as **Agreement**.

6. **Limit of Coverage** shall mean the amount of coverage stated in the Declarations or certificate of coverage, or sublimits as stated therein for each **Participant** or **covered party** per **occurrence**, subject to any lower sublimit stated in the MOC.

7. **Loss Experience** shall mean only such amounts as incurred (paid and reserves) as are actually paid by the **Participant** or the **Authority**, including payments to investigators and defense attorneys, ~~in payment of benefits under the Workers' Compensation Act, in settlement of claims, or in satisfaction of awards or judgments for liabilities imposed by the Workers' Compensation Act for **bodily injury** or **occupational disease** to an **employee** as defined in the Workers' Compensation Act and~~ as outlined in the **Program** Memorandum of Coverage (MOC).

8. **Member Entity** shall mean a signatory to the **Agreement** establishing the California Intergovernmental Risk Authority (CIRA) Joint Powers Authority.

9. **Memorandum of Coverage** shall mean a document issued by the Authority specifying the coverages and limits provided to the Members participating in the Program.

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10. **Participant** shall mean a **Member Entity** who has elected to participate in the Program

11. **Program** shall mean the ~~self funded~~self-funded General Liability ~~Workers' Compensation~~ Program of the Authority.

12. **Program Year** shall mean that period of time commencing at 12:01 a.m. on July 1 and ending at 12:00 am on the following July 1.

13. **Retained Limits** shall mean the amount stated on the applicable Declarations or certificate of coverage, which will be paid by the **Participant** or **covered party** before the **Authority** is obligated to make any payment from the pooled funds.

14. **Self-Insured Retention (SIR)** shall mean the **Authority's limit of coverage** above **Participant's Retained Limits** and up to the attachment point for excess coverage.

15. **Third Party Administrator (TPA)** shall mean the Program claims administrator for the **Authority**
.

ARTICLE II: GENERAL

A. AUTHORITY

1. The Program Master Program Document (MPD) is one of the **Authority's** governing documents. However, any conflict between the Program MPD, the **Authority's Joint Powers Agreement**, the Bylaws, or the Memorandum of Coverage (MOC) shall be determined in favor of the **Agreement**, the Bylaws, or the MOC, in that order.

2. The **Program** MPD is intended to be the primary source of information, contain the rules and regulations, and serve as the operational guide for the conduct of the **Program**.

3. The **Program** has been organized under authority granted by, and shall be conducted in accordance with, the laws of the State of California; regulations prescribed by the Department of Industrial Relations (DIR) and the State of California Audit Unit; and the accreditation standards set forth by the California Association of Joint Powers Authorities (CAJPA).

B. PURPOSE

The **Authority**, as a part of its overall objectives, has designed the **Program** to provide for the needs of the **Program Participants** in the area of general liability ~~workers' compensation liability~~.

C. PARTICIPATION

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All **Member Entities** may become **Participants** in the **Program**, and are encouraged to do so. However, the terms and conditions which may be imposed on **Member Entities** which desire to join the **Program** may be different, depending upon payroll, number of employees, the size of the **Member Entity**, its loss record, and other pertinent information.

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D. GOVERNANCE

Each **Participant's** appointed Director and ~~one~~ alternate Director shall be the representative for the **Program**. The **Participant** will be entitled to one vote on all issues or decisions that involve the **Program**.

Either the appointed Director or appointed alternate Director must attend at least one Board of Directors meeting for each Program Year, either in person or virtually. Violation of this requirement will result in a $1,000 penalty. Payments for the penalty shall be included and paid in the next billing cycle.

E. GOALS AND OBJECTIVES

~~1.~~ The **Authority** offers **Member Entities** this **Program** designed to provide coverage for the liabilities outlined in the Memorandum of Coverage. ~~imposed by the workers' compensation laws of California as well as those imposed by common law upon employers.~~

1.

2. The **Program** shall provide general liability ~~workers' compensation~~ coverage for the **Participants** utilizing an optimum mix of risk retention and risk transfer. The **Program** may provide various levels of retentions for the **Participants**, provide a risk sharing pool for losses above individual retention levels up to the **Authority's Self-Insured Retention** (**SIR**), and obtain excess coverage for the amount of the loss which exceeds the **Authority's SIR**. Additionally, the **Program** shall provide for the sharing of operating costs and payment of the excess coverage by charging all **Participants** their share of such costs.

3. Although the **Program** is provided to the **Participants** under those terms and conditions which prevail at the time of the **Participant's** joining the **Program**, the **Board** shall have the right to alter, from time to time, the terms and conditions of the excess coverage and the pooled underlying coverage in response to the needs and abilities of the **Program** and the **Participants**, as well as in response to availability of coverage from outside sources.

4. The **Authority** offers participation in a risk sharing pool, covering losses of **Participants** in accordance with the MOC adopted by the **Member Entities**. The assets of the pooled **Program** shall be maintained at all times as the assets of the **Participants** collectively. The assets may be disbursed only pursuant to the provisions of this MPD, and no **Participant** shall have an individual right to exercise control over said assets.

5. The **Program** will provide coverage ~~for injuries and illnesses to the **Participants'** employees~~ under the terms and conditions set forth in the MOC. In addition to the coverage provided by the MOC, the **Authority** may purchase excess insurance or reinsurance. The amount of coverage to be pooled and/or purchased is at the discretion of the **Board**.

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ARTICLE III: PROGRAM ELEMENTS

A. FUNDING

1. Funding each year shall be at the 8075% confidence level at the discretion of the Board of Directors.

2. The Target Equity goal is set at five times the **Program's SIR.**

3. A Rate Stabilization Fund in an amount not to exceed $21,000,000 may be shall be established maintained to off-set pool and excess rate increases as determined by the Board of Directors. The Fund may will be replenished prospectively at the Board of Director's discretion when the fund falls below 50% capacity.

4. Funding in excess of the 90% confidence level, excluding the target equity goal, maywill be available for distribution at the discretion of the Board of Directors.

5. If the overall confidence level falls below 70% according to actuarial projections, the Board of Directors may declare an assessment to be shared by all **Program Participants.**

6. Upon completing seven years, a program year shall be available for Retrospective Premium Adjustment (RPA)

7. RPA dDistributions under the RPA formula will be made in the following percentages:

50% of equity in year 68	70% of equity in year 810
60% of equity in year 79	90% of equity in year 911-15

8. Program years may be considered for closure 105 years after the year-end, and it has been at least on year since closure of the last claim in the proposed year(s). Once declared closed, 100% of remaining equity may be distributed to members through the RPA formula.

9. If a claim is reported or reopened after a year, and the year has been closed and equity returned, surplus in positive years may be used to offset the deficit in negative years. Any surplus in a positive year must exceed a funding level equal to a 90% confidence level to be used to offset a deficit. If there is no offset available, or members may be assessed atper the discretion of the board.

10. The following four benchmarks will be reviewed before an RPA is issued:

- **Net Contribution to Equity**
  Calculation: *(Contribution – Excess Insurance) / Equity*

  Measures the impact of pricing inaccuracies on equity (a low ratio is desirable).

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A low ratio indicates that more equity is available to cover under-charged years. The target is less than 200%

- **Claim Reserves and IBNR to Equity**
  Calculation: *(Claim Reserves + IBNR + ULAE) / Equity*

  Measures the impact of reserves inaccuracies on equity (a low ratio is desirable). A low ratio indicates more equity available to cover years with large losses. The target is less than 300%

- **Prior Year Loss Development**
  Calculation: *(Year 1 Loss Reserves / Year 2 Loss Reserves) / (Yr 2 / Yr3) – 1*

  Measures the change in loss reserves from one year to the prior year. A lower ratio indicates not much change in reserves between years. Target of less than 20% is desirable.

- **Change in Equity**
  Calculation: *(Year 2 Equity / Year 1 Equity) – 1*

  Measures the change in equity. Any increase is desirable. The target is less than 10%.

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B. DEPOSIT CONTRIBUTIONS

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1. Annually, each **Participant** shall pay a **deposit contribution** to the **Authority** for each **program year**. Such **deposit contribution** shall consist of the amount needed to cover excess insurance or reinsurance premiums (if any), administrative expenses and actuarially-determined losses, plus a margin for added confidence as determined by the **Board**.

2. The following criteria is used to calculate the **deposit contribution** for each **Participant**:

   Participant's payroll
   Participant's loss experience
   Participant's self-insured retention

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3. The **deposit contribution** is calculated by taking the **Participant's** estimated ~~payroll, and~~payroll and multiply~~ing it ied~~ by the actuarially determined rate per $100 of payroll. Administrative and excess insurance or reinsurance are also included in the calculations. The estimated payroll is annualized for the remainder of the year with an inflation factor of three percent, unless the **Participant** provides the **Authority** with a different estimated payroll projection for its Entity.

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4. The excess insurance or reinsurance premiums (if any), shall be allocated among the

Participant's using deposit contribution calculation. ~~with the experience modification~~.

5. The administrative expenses (including claims administration) shall be allocated among the **Participants** based on payroll, loss experience and self-insured retention with the experience modification.

6. Each year the **Authority** shall bill **Participants** for the general liability ~~a workers' compensation~~ **deposit contribution** for the next **program year** to be paid on an annual ~~or quarterly basis~~. The invoices ~~billings~~ shall be billed to **Participants** at least 30 days prior to the inception of a new **program year**, when practicable, and due within 45 days of the billing date.

A 2~~1~~% fee of the balance due shall be assessed on late premium payments, every 30 days; this assessment will apply 60 days after the billing date.

~~7.~~ Former **Participants** in the **Program** shall be required to pay all applicable billings for the **program years** in which they participated in accordance with the Bylaws, and shall continue to pay for administrative costs as outlined in the Bylaws. ~~Article XV of the Bylaws. [include formula that requires withdrawn members to continue paying admin expenses for three years after withdrawal]~~

~~A Rate Stabilization Fund in an amount not to exceed $500,000 shall be maintained to off-set pool and excess rate increases as determined by the Board of Directors. The Fund will be replenished prospectively at the Board of Director's discretion when the fund falls below 50% capacity.~~

~~C.~~ SELF INSURED RETENTION

1. **Participants** may select an **SIR** of $5,000, $10,000, $25,000, $50,000, $100,000, $150,000, $250,000, ~~and~~ $350,000, and $500,000 and must notify the **Program** of their SIR selection by April 1 of the preceding **Program Year**.

2. A **Participant's SIR** evaluation shall be completed every three years in conjunction with the annual actuarial study. As a result, **Participants** may be subject to an **SIR** adjustment based on the following:

   a. Number of losses above its **SIR**, or a disproportionate number of losses within its **SIR** level compared to the pool average; and or

   b. Payroll that is disproportionate in size to the payroll of the other **Participants** within the **SIR** level.

3. A statistical model developed by the **Program**'s ~~CIRA's~~ actuary shall be the standard by which the Board determines which **Participants** are candidates for **SIR** adjustments. **Participants** identified as candidates for adjustment will be notified of such determinations. Should the **Participant** deem the adjustment is not warranted,

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they may request exception to the adjustment by submitting a request for exception ~~make a presentation~~ to the Board of Directors at the next regular meeting in order to provide new or updated information for consideration prior to ratification of the **SIR** adjustment. Final decisions will be in the sole discretion of the Board of Directors.

4. Approved **SIR** adjustments shall, at minimum, increase the **Participant's SIR** to the next available **SIR** level and will become effective for the next **program year.** The **Participant** shall remain at the adjusted **SIR** level for a minimum of three program years, unless otherwise approved by the Board of Directors, at which time the **SIR** may be re-evaluated based on the statistical model.

For those members with a SIR below $100,000, the **Program**~~CIRA~~ shall pay all claims expenses within the **Participant's SIR**, which shall be reconciled and invoiced to the **Participant** quarterly. The **Participant** shall have 30 days from the date of invoice to submit its **SIR** payment.

For those members with a SIR above $100,000, the **Program** may pay all claims expenses within the **Participant's SIR**, which shall be reconciled and invoiced to the **Participant** quarterly. The **Member** has the option of paying for claims expenses directly. The **Participant** shall have 30 days from the date of invoice to submit its **SIR** payment.

A 2% fee of the balance due shall be assessed on late premium payments, every 30 days; this assessment will apply 60 days after the billing date.
~~A penalty shall be applied that is equivalent LAIF rate but not to exceed 2% to the balance if payment is not received by the due date.~~

~~5.~~

C. EXPERIENCE MODIFICATION

1. Each **Participant** shall be evaluated each year for an experience modification adjustment that shall be applied to the **deposit contribution**.

2. The calculation of the adjustment shall include the actual **loss experience** of the individual **Participant** as it relates to the average **loss experience** of the group as a whole. The experience modification formula shall:

   a. Not consider loss years that are more than five years old.
   b. Limit losses to $250,000 per claim.
   c. Apply a credibility factor based on the **Participant's** weight, between 10%-75%
   d. Cap the experience modification factor at a minimum of 0.50 and maximum of 2.00
   e. Not increase or decrease more than 25% from the prior year for any **Participant**.

D. EXCESS COVERAGE

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Hybrid
SIR $100k or below, we pay everything
Over $100k SIR, then they have option of paying

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1. The **Board** shall ensure that, each **program year, Participants** are~~is~~ provided with excess general liability ~~workers' compensation~~ coverage for the **Participants**. It is the intent and purpose of the **Authority** to continue to provide such coverage to the **Participants**, provided that such coverage can be obtained, and the coverage is not unreasonably priced. This coverage may be obtained from an insurance company, by participating in another pool established under the Government Code as a joint powers authority, or offered through another **Program** pooling procedure. If the coverage is purchased from an insurance company, such insurance company shall have an A.M. Best Rating Classification of A- or better and an A.M. Best Financial Rating of VII or better or their equivalents.

2. Premiums for such coverages shall be paid by the **Program** from the proceeds received as **deposit contributions** from the **Participants**.

3. The **Board** may, from time to time, alter excess coverage based on insurance market conditions, available alternatives, costs, and other factors. The **Board** shall place excess coverage with the two competing objectives of security and minimizing costs to the **Program** as a whole.

ARTICLE IV: ADMINISTRATION

A. BOARD

1. The **Board** shall have the responsibility and authority to carry out and perform all functions, and make all decisions**,** affecting the **Program**, consistent with the powers of the **Authority** and not in conflict with the **Agreement**, the Bylaws, or the MOC.

B. GENERAL MANAGER

The **General Manager** shall be responsible for:

1. General oversight of the **Program**, which includes:

   a. Monitoring the status of the **Program** and its operations, the development of losses, the program's administrative and operational costs, service companies' performance, and brokers' performance;

   b. Developing, for **Board** approval, performance standards for **Third Party Administrator (TPA).**

   c. Work with the **Third Party Administrators,** including but not limited to the following:

      i. Periodically review third party **Third Party Administrators'** claims files. The review should include all open claims, whether litigated or

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not, ~~the new indemnity claims reported, claims currently open and~~ all claims reported twelve months prior, and those claims for which a **Participant** has requested a specific review;

ii. Provide guidance to the **Third Party Administrator** on the management of problem or complex claims;

iii. Advise, where needed, on the selection of legal representation in anticipation of litigation;

iv. Monitor and evaluate the effectiveness of the defense firms and the management of the litigation;

~~v. Monitor and evaluate the effectiveness of medical treatment as respects claims costs, especially those involving complex medical issues;~~

~~vi.~~v. Evaluate, where needed, recommendations for settlement of claims;

~~vii.~~vi. Mediate differences, if any, between the **Third Party Administrator** and a **Participant**; and

~~viii.~~vii. Review the performance of the **Third Party Administrators'** personnel assigned to the **Authority's** account with special emphasis in the handling of "open claims."

d. Recommend to the **Board** the setting of reserves for those cases that are likely to penetrate to pooled funds;

e. Upon the reporting of each claim that has an expectation of exceeding the minimum incurred loss threshold set by the **Board**, review said claim for the **Authority** and report said claims to the **Board** at the next scheduled meeting;

f. Review the progress of all reported claims for the **Authority** and, if directed by the **Board**, propose reserve changes, and/or take control and assume settlement authority for the claim;

ARTICLE V: CLAIMS ADMINISTRATION

A. CLAIMS PROCEDURES MANUAL

1. A General Liability ~~Workers' Compensation~~ Claims Procedures Manual (Manual) including reporting procedures, forms, and other vital information is included in Appendix A and will be updated from time to time as needed.

2. All **Participants** shall be held accountable for understanding and abiding by the

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procedures stated in the Manual, as well as any changes thereto.

B. CLAIM SETTLEMENT AUTHORITY

1. Authority for the settlement of General Liability ~~Workers' Compensation~~ claims shall be in the following increments:

Authorizing Entity	Authority
Third Party Administrator	$0
Deputy General Manager	$1- $50,000
General Manager	$1 - $100,000
~~General Manager, Workers' Compensation Subcommittee~~Executive Committee	$100,000-~~+~~500,000
Board of Directors ~~Chairperson and Executive Officer (must participate in program)~~	$500,000+

2. The **Third Party Administrator** will ensure the **Participant** is kept informed regarding these claims~~,~~ and will take into consideration the **Participant**'s desires in any settlement process. A~~. The written a~~uthorization on all settlement or stipulations shall be obtained.

3. Should the settlement value enter into the excess layer of funding, authority from the excess coverage provider would be required.

4. The **Third Party Administrator** shall consult with and obtain authorization prior to settlement of any claim. ~~; this includes Stipulation, Compromise & Release and lien settlements.~~ All requests for settlement authority shall include a written claim summary, factual background, litigation summary ~~estimate of permanent disability~~, and any comments and recommendations.

C. DISPUTES BETWEEN PARTICIPANTS AND GENERAL MANAGER, OR Board

~~1.~~ Any matter in dispute between a **Participant** and the **Program** shall be heard by the Executive Committee whose decision may be appealed to the **Board** within thirty (30) days of the Committee's decision. The decision of the Executive Committee or, if appealed, the decision of the **Board** shall be final.

ARTICLE VI: DEFENSE PANEL

A. CRITERIA FOR DEFENSE PANEL

1. The defense panel shall include all attorneys listed in the attached Appendix B, which may be amended at the discretion of the General Manager.

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2. Attorneys must meet and agree to the following provisions before ~~CIRA will~~ consideration of ~~their~~ inclusion on the panel:

   a. The firm must have demonstrated success representing public entities and specific expertise in the public entity defense, specifically to municipalities. ~~workers' compensation arena.~~

   b. Firms must have no less than 5 years litigation practice which includes substantial and significant experience in public entity defense to be eligible for case assignment.

   c. The firm shall provide a resume setting forth the experience of the individual attorneys that would be assigned to cases and their areas of expertise.

   d. The firm must agree to the maximum hourly rates outlined in the fee schedule outlined below, in section B, unless specialized legal representation is necessary, which requires prior approval ~~from CIRA~~. The maximum hourly rate will be reviewed on a bi-annual basis.

   e. The firm must agree to abide by the policies and procedures established by CIRA for handling of litigation.

   f. The firm must evidence general liability, automobile liability, workers' compensation, and professional liability insurance. The policy limits must not be less than $1,000,000 per occurrence. ~~and~~ CIRA, its officials, officers, employees, and agents~~, with the exception of workers' compensation and professional liability,~~ must be named additional insured for general liability and auto liability and follow all insurance requirements of the **Authority**.

3. The General Manager and Officers may appoint a particular attorney or law firm other than panel counsel when specialized, unforeseen defense is required. The law firm or attorney shall comply with conditions a-f above.

4. CIRA will assign defense counsel in collaboration with the **Participant.**

   Participants may assign cases to firms listed on the Panel. Nothing in this MPD shall be construed to limit the right of the **Participant** to retain its own defense counsel to represent the **Participant** in any litigation. Except where prior approval has been given, the **Participant** is responsible for amounts in excess of the maximum hourly rates, which shall not reduce the **Participant's** self-insured retention obligation.

B. MAXIMUM FEE SCHEDULE

Legal Staff	***Maximum Rate***
Partners	$225~~175~~
Associates	$185~~45~~
Paralegals	$95~~75~~

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ARTICLE VII: PARTICIPATION

A. ELIGIBILITY AND APPLICATION

1. ELIGIBILITY

a. New~~The~~ applicants must commit to at least five full **program years** of participation in this **Program**.

b. Any **Member Entity** may apply to participate in the **Program** by providing an adopted resolution of its governing body and such other information/materials as may be required. The applicant's resolution shall commit the applicant to five full years of participation in the **Program**, if accepted, and consent to be governed for general liability ~~workers' compensation~~ matters in accordance with the MPD, the MOC and other documents and policies adopted by the **Board**. The resolution may also state the **retained limit** desired by the applicant.

c. The application for participation shall be submitted at least thirty (30) days prior to the date of the last **Board** meeting of the **program year** to ensure that the State Certificate of Consent to Self-Insure is received prior to the inception date, and that the **Board** has adequate time to review and evaluate the acceptability of the applicant. It is recommended that an applicant enter the **Program** only at the commencement of a new **program year**. If an applicant chooses to enter the **Program** at any other time, the **deposit contribution** for the remainder of the **program year** will be pro-rated. The new **Participant** will begin coverage on the date that is mutually acceptable to the **Participant** and the **Board**; however, the new **Participant** will be required to share losses with the other members of the **Program** for the entire **program year**.

2. APPROVAL OF APPLICATION

The **Board** shall, after reviewing the resolution and other underwriting criteria, determine the acceptability of the exposures presented by the applicant and shall advise the applicant in writing of its decision to accept or reject the request within 10 days after the decision has been made.

B. PARTICIPANTS' DUTIES

1. The **Participants** shall provide payroll, using data as included on the ~~the~~ State DE-9 form, and all other requested information in conformance with the policies adopted by the **Board**.

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2. The **Participants** shall disclose activities not usual and customary in their operation.

3. The **Participants** shall at all times cooperate with the **Authority's General Manager** and **Third Party Administrator** in regards to claims handling and underwriting activities of the **Authority**.

ARTICLE VII: TERMINATION AND DISSOLUTION OF THE PROGRAM

The **Program** may be terminated and dissolved at any time by a vote of two-thirds of the **Participants**. However, the **Program** may~~shall~~ continue to exist for the purpose of disposing of all claims, distributing assets, and all other functions necessary to conclude the affairs of the **Program**, at the Board's discretion.~~,~~

Upon termination of the **Program**, all assets of the **Program** shall be distributed only among the current **Participants**. The **Board** shall determine such distribution within six months after the last pending claim or loss covered by the **Program** has been finally resolved and there is a reasonable expectation that no new claims will be filed.

ARTICLE VIII: AMENDMENTS

This MPD may be amended by a two-thirds (2/3rds) vote of the **Participants** at the meeting, provided prior written notice, as provided within the Bylaws, has been given to the **Board**.

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Appendix A

General Liability ~~Workers' Compensation~~ Claims Manual

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Appendix B

General Liability ~~Workers' Compensation~~ Defense Panel Approved Firm List

~~Law Offices of C. Robert Bakke~~

~~Barbara L. Kiely, Attorney at Law~~

~~Joe Montgomery, Hannah Brophy~~

~~Joseph T. Todoroff, II, Hannah Brophy~~

~~Lenahan Lee Slater & Pearse~~

~~Boone T. White, MacIntyre & White~~

~~Richard, Thorson, Graves & Royer~~

~~Wall McCormick Baroldi Green & Dugan~~

~~Robert A. Sanders, Witzig Hannah Sanders~~

Ewing and Associates
Perry, Johnson, Anderson, Miller & Moskowitz
Geary, Shea, O'Donnell,Grattan & Mitchell
Mitchell, Brisso, Delaney & Vrieze
Shapiro, Galvin, Shapiro & Moran& Moran
Allen, Glaessner, Hazelwood & Werth LLP
Bertrand, Fox, Elliott, Osman & Wenzel
Nisso, Pincin & Hill
McNamara, Ney, Beatty, Slattery, Borges & Ambacher LLP
Porter, Scott, P.C.
James A. Wyatt
Jones & Dyer P.C.
Richards, Watson & Gerson
Gibbons & Conley
Angelo, Kilday & Kilduff

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CALIFORNIA INTERGOVERNMENTAL
RISK AUTHORITY

MASTER PROGRAM DOCUMENT FOR
THE
POOLED WORKERS' COMPENSATION PROGRAM

DRAFT DECEMBER 07, 2020~~MAY 28, 2020~~

CALIFORNIA INTERGOVERNMENTAL RISK AUTHORITY (CIRA)

MASTER PROGRAM DOCUMENT (MPD)
FOR THE
POOLED WORKERS' COMPENSATION PROGRAM (PWCP)

ARTICLE I: DEFINITIONS

The following definitions apply to this MPD:

1. **General Manager** shall mean the person responsible for the daily administration, management, and operation of the **Authority's** programs as defined in the Bylaws.

2. **Authority** shall mean the California Intergovernmental Risk Authority (CIRA).

3. **Board** shall mean the Board of Directors for~~of~~ the California Intergovernmental Risk Authority (CIRA) Joint Powers Authority.

4. **Deposit Contribution** shall mean that amount to be paid by each **Participant** for each **program year** as determined by the **Board** in accordance with Article III, Section B of this MPD.

5. **Joint Powers Agreement** shall mean the agreement made by and among the public entities listed in Appendix A (**Member Entities**) of the **Joint Powers Agreement,** hereafter referred to as **Agreement**.

6. **Limit of Coverage** shall mean the amount of coverage stated in the Declarations or certificate of coverage, or sublimits as stated therein for each **Participant** or **covered party** per **occurrence**, subject to any lower sublimit stated in the MOC.

7. **Loss Experience** shall mean only such amounts as incurred (paid and reserves) as are actually paid by the **Participant** or the **Authority** in payment of benefits under the Workers' Compensation Act, in settlement of claims, or in satisfaction of awards or judgments for liabilities imposed by the Workers' Compensation Act for **bodily injury** or **occupational disease** to an **employee** as defined in the Workers' Compensation Act and **Program** Memorandum of Coverage (MOC).

8. **Member Entity** shall mean a signatory to the **Agreement** establishing the California Intergovernmental Risk Authority (CIRA) Joint Powers Authority.

9. **Memorandum of Coverage** shall mean a document issued by the Authority specifying the coverages and limits provided to the Members participating in the Program.

10. **Participant** shall mean a **Member Entity** who has elected to participate in the Program

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11. **Program** shall mean the ~~self-funded~~self-funded Workers' Compensation Program of the Authority.

12. **Program Year** shall mean that period of time commencing at 12:01 a.m. on July 1 and ending at 12:00 am on the following July 1.

13. **Retained Limits** shall mean the amount stated on the applicable Declarations or certificate of coverage, which will be paid by the **Participant** or **covered party** before the **Authority** is obligated to make any payment from the pooled funds.

14. **Self-Insured Retention (SIR)** shall mean the **Authority's limit of coverage** above **Participant's Retained Limits** and up to the attachment point for excess coverage.

15. **Third Party Administrator (TPA)** shall mean the Program claims administrator for the **Authority**
.

ARTICLE II: GENERAL

A. AUTHORITY

1. The Program Master Program Document (MPD) is one of the **Authority's** governing documents. However, any conflict between the Program MPD, the **Authority's Joint Powers Agreement**, the Bylaws, or the Memorandum of Coverage (MOC) shall be determined in favor of the **Agreement**, the Bylaws, or the MOC, in that order.

2. The **Program** MPD is intended to be the primary source of information, contain the rules and regulations, and serve as the operational guide for the conduct of the **Program**.

3. The **Program** has been organized under authority granted by, and shall be conducted in accordance with, the laws of the State of California; regulations prescribed by the Department of Industrial Relations (DIR) and the State of California Audit Unit; and the accreditation standards set forth by the California Association of Joint Powers Authorities (CAJPA).

B. PURPOSE

The **Authority**, as a part of its overall objectives, has designed the **Program** to provide for the needs of the **Program Participants** in the area of workers' compensation liability.

C. PARTICIPATION

All **Member Entities** may become **Participants** in the **Program**~~,~~ and are encouraged to do so. However, the terms and conditions which may be imposed on **Member Entities** which desire to join the **Program** may be different, depending upon payroll, number of employees,

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the size of the **Member Entity**, its loss record, and other pertinent information.

D. GOVERNANCE

Each **Participant's** appointed Director and ~~one~~ alternate Director shall be the representative for the **Program**. The **Participant** will be entitled to one vote on all issues or decisions that involve the **Program**.

E. GOALS AND OBJECTIVES

1. The **Authority** offers **Member Entities** this **Program** designed to provide coverage for the liabilities imposed by the workers' compensation laws of California as well as those imposed by common law upon employers.

2. The **Program** shall provide workers' compensation coverage for the **Participants** utilizing an optimum mix of risk retention and risk transfer. The **Program** may provide various levels of retentions for the **Participants**, provide a risk sharing pool for losses above individual retention levels up to the **Authority's Self-Insured Retention** (**SIR**), and obtain excess coverage for the amount of the loss which exceeds the **Authority's SIR**. Additionally, the **Program** shall provide for the sharing of operating costs and payment of the excess coverage by charging all **Participants** their share of such costs.

3. Although the **Program** is provided to the **Participants** under those terms and conditions which prevail at the time of the **Participant's** joining the **Program**, the **Board** shall have the right to alter, from time to time, the terms and conditions of the excess coverage and the pooled underlying coverage in response to the needs and abilities of the **Program** and the **Participants**, as well as in response to availability of coverage from outside sources.

4. The **Authority** offers participation in a risk sharing pool, covering losses of **Participants** in accordance with the MOC adopted by the **Member Entities**. The assets of the pooled **Program** shall be maintained at all times as the assets of the **Participants** collectively. The assets may be disbursed only pursuant to the provisions of this MPD, and no **Participant** shall have an individual right to exercise control over said assets.

5. The **Program** will provide coverage for injuries and illnesses to the **Participants'** employees under the terms and conditions set forth in the MOC. In addition to the coverage provided by the MOC, the **Authority** may purchase excess insurance or reinsurance. The amount of coverage to be pooled and/or purchased is at the discretion of the **Board**.

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ARTICLE III: PROGRAM ELEMENTS

A. FUNDING

1. Funding each year shall be at the 75% confidence level at the discretion of the Board of Directors.

2. The Target Equity goal is set at five times the **Program's SIR.**

3. A Rate Stabilization Fund in an amount not to exceed $1,000,000 may be ~~shall be~~ established ~~maintained~~ to off-set pool and excess rate increases as determined by the Board of Directors. The Fund may ~~will~~ be replenished ~~prospectively~~ at the Board of Director's discretion when the fund falls below 50% capacity.

4. Funding in excess of the 90% confidence level, ~~-~~excluding the target equity goal, may~~will~~ be available for distribution at the discretion of the Board of Directors.

5. If the overall confidence level falls below 70% according to actuarial projections, the Board of Directors may declare an assessment to be shared by all **Program Participants.**

6. Upon completing seven years, a program year shall be available for Retrospective Premium Adjustment (RPA)

7. ~~RPA d~~Distributions under the RPA formula will be made in the following percentages:

50% of equity in year 8	70% of equity in year 10
60% of equity in year 9	90% of equity in year 11-15

8. Program years may be considered for closure 15 years after the year-end, and it has been at least on year since closure of the last claim in the proposed year(s). Once declared closed, 100% of remaining equity may be distributed to members through the RPA formula.

9. If a claim is reported or reopened after a year, and the year has been closed and equity returned, surplus in positive years may be used to offset the deficit in negative years. Any surplus in a positive year must exceed a funding level equal to a 90% confidence level to be used to offset a deficit. If there is no offset available, ~~or~~ members may be assessed at~~per~~ the discretion of the board.

10. The following four benchmarks will be reviewed before an RPA is issued:

- **Net Contribution to Equity**
  Calculation: *(Contribution – Excess Insurance) / Equity*

  Measures the impact of pricing inaccuracies on equity (a low ratio is desirable).

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A low ratio indicates that more equity is available to cover under-charged years. The target is less than 200%

- **Claim Reserves and IBNR to Equity**
  Calculation: *(Claim Reserves + IBNR + ULAE) / Equity*

  Measures the impact of reserves inaccuracies on equity (a low ratio is desirable). A low ratio indicates more equity available to cover years with large losses. The target is less than 300%

- **Prior Year Loss Development**
  Calculation: *(Year 1 Loss Reserves / Year 2 Loss Reserves) / (Yr 2 / Yr3) – 1*

  Measures the change in loss reserves from one year to the prior year. A lower ratio indicates not much change in reserves between years. Target of less than 20% is desirable.

- **Change in Equity**
  Calculation: *(Year 2 Equity / Year 1 Equity) – 1*

  Measures the change in equity. Any increase is desirable. The target is less than 10%.

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B. DEPOSIT CONTRIBUTIONS

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1. Annually, each **Participant** shall pay a **deposit contribution** to the **Authority** for each **program year**. Such **deposit contribution** shall consist of the amount needed to cover excess insurance or reinsurance premiums (if any), administrative expenses and actuarially-determined losses, plus a margin for added confidence as determined by the **Board**.

2. The following criteria is used to calculate the **deposit contribution** for each **Participant**:

   Participant's payroll
   Participant's loss experience
   Participant's self-insured retention

3. The **deposit contribution** is calculated by taking the **Participant's** estimated ~~payroll, and~~payroll and multiplying it ~~ied~~ by the actuarially determined rate per $100 of payroll. Administrative and excess insurance or reinsurance are also included in the calculations. The estimated payroll is annualized for the remainder of the year with an inflation factor of three percent, unless the **Participant** provides the **Authority** with a different estimated payroll projection for its Entity.

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4. The excess insurance or reinsurance premiums (if any), shall be allocated among the

Participant's using deposit contribution calculation ~~with the experience modification~~.

5. The administrative expenses (including claims administration) shall be allocated among the **Participants** based on payroll, loss experience and self-insured retention with the experience modification.

6. Each year the **Authority** shall bill **Participants** for a workers' compensation **deposit contribution** for the next **program year** to be paid on an annual or quarterly basis. The invoices ~~billings~~ shall be billed to **Participants** at least 30 days prior to the inception of a new **program year**, when practicable, and due within 45 days of the billing date.

A 2~~1~~% fee of the balance due shall be assessed on late premium payments, every 30 days; this assessment will apply 60 days after the billing date.

~~7.~~ Former **Participants** in the **Program** shall be required to pay all applicable billings for the **program years** in which they participated in accordance with the Bylaws, and shall continue to pay for administrative costs as outlined in the Bylaws. ~~Former **Participants** in the **Program** shall be required to pay all applicable billings for the **program years** in which they participated in accordance with Article XV of the Bylaws. [include formula that requires withdrawn members to continue paying admin expenses for three years after withdrawal]~~

~~A Rate Stabilization Fund in an amount not to exceed $500,000 shall be maintained to off-set pool and excess rate increases as determined by the Board of Directors. The Fund will be replenished prospectively at the Board of Director's discretion when the fund falls below 50% capacity.~~

C. SELF INSURED RETENTION

1. **Participants** may select an **SIR** of $5,000, $10,000, $25,000, $50,000, $100,000, $150,000, $250,000, or ~~and~~ $350,000 and must notify the **Program** of their SIR selection by April 1 of the preceding **Program Year**.

2. A **Participant's SIR** evaluation shall be completed every three years in conjunction with the annual actuarial study. As a result, **Participants** may be subject to an **SIR** adjustment based on the following:

   a. Number of losses above its **SIR**, or a disproportionate number of losses within its **SIR** level compared to the pool average; and or

   b. Payroll that is disproportionate in size to the payroll of the other **Participants** within the **SIR** level.

3. A statistical model developed by the **Program's** ~~CIRA's~~ actuary shall be the standard

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by which the Board determines which **Participants** are candidates for **SIR** adjustments. **Participants** identified as candidates for adjustment will be notified of such determinations. Should the **Participant** deem the adjustment is not warranted, they may request exception to the adjustment by submitting a request for exception ~~make a presentation~~ to the Board of Directors at the next regular meeting in order to provide new or updated information for consideration prior to ratification of the **SIR** adjustment. Final decisions will be in the sole discretion of the Board of Directors.

4. Approved **SIR** adjustments shall, at minimum, increase the **Participant's SIR** to the next available **SIR** level and will become effective for the next **program year.** The **Participant** shall remain at the adjusted **SIR** level for a minimum of three program years, unless otherwise approved by the Board of Directors, at which time the **SIR** may be re-evaluated based on the statistical model.

The **PROGRAM**~~CIRA~~ shall pay all claims expenses within the **Participant's SIR**, which shall be reconciled and invoiced to the **Participant** quarterly. The **Participant** shall have 30 days from the date of invoice to submit its **SIR** payment.
A 2% fee of the balance due shall be assessed on late premium payments, every 30 days; this assessment will apply 60 days after the billing date.
~~A penalty shall be applied that is equivalent LAIF rate but not to exceed 2% to the balance if payment is not received by the due date.~~
~~5.~~

C. EXPERIENCE MODIFICATION

1. Each **Participant** shall be evaluated each year for an experience modification adjustment that shall be applied to the **deposit contribution**.

2. The calculation of the adjustment shall include the actual **loss experience** of the individual **Participant** as it relates to the average **loss experience** of the group as a whole. The experience modification formula shall:

   a. Not consider loss years that are more than five years old.
   b. Limit losses to $250,000 per claim.
   c. Apply a credibility factor based on the **Participant's** weight, between 10%-75%
   d. Cap the experience modification factor at a minimum of 0.50 and maximum of 2.00
   e. Not increase or decrease more than 25% from the prior year for any **Participant**.

D. EXCESS COVERAGE

1. The **Board** shall ensure that, each **program year, Participants** are~~is~~ provided with excess workers' compensation coverage for the **Participants**. It is the intent and purpose of the **Authority** to continue to provide such coverage to the **Participants**, provided that such coverage can be obtained, and the coverage is not unreasonably priced. This coverage may be obtained from an insurance company, by participating

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in another pool established under the Government Code as a joint powers authority, or offered through another **Program** pooling procedure. If the coverage is purchased from an insurance company, such insurance company shall have an A.M. Best Rating Classification of A- or better and an A.M. Best Financial Rating of VII or better or their equivalents.

2. Premiums for such coverages shall be paid by the **Program** from the proceeds received as **deposit contributions** from the **Participants**.

3. The **Board** may, from time to time, alter excess coverage based on insurance market conditions, available alternatives, costs, and other factors. The **Board** shall place excess coverage with the two competing objectives of security and minimizing costs to the **Program** as a whole.

ARTICLE IV: ADMINISTRATION

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A. BOARD

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1. The **Board** shall have the responsibility and authority to carry out and perform all functions, and make all decisions**,** affecting the **Program**, consistent with the powers of the **Authority** and not in conflict with the **Agreement**, the Bylaws, or the MOC.

B. GENERAL MANAGER

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The **General Manager** shall be responsible for:

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1. General oversight of the **Program**, which includes:

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   a. Monitoring the status of the **Program** and its operations, the development of losses, the program's administrative and operational costs, service companies' performance, and brokers' performance;

   b. Developing, for **Board** approval, performance standards for **Third Party Administrator (TPA).**

   c. Work with the **Third Party Administrators,** including but not limited to the following:

      i. Periodically review third party **Third Party Administrators'** claims files. The review should include the new indemnity claims reported, claims currently open and reported twelve months prior, and those claims for which a **Participant** has requested a specific review;

      ii. Provide guidance to the **Third Party Administrator** on the management of problem or complex claims;

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iii. Advise, where needed, on the selection of legal representation in anticipation of litigation;

iv. Monitor and evaluate the effectiveness of the defense firms and the management of the litigation;

v. Monitor and evaluate the effectiveness of medical treatment as respects claims costs, especially those involving complex medical issues;

vi. Evaluate, where needed, recommendations for settlement of claims;

vii. Mediate differences, if any, between the **Third Party Administrator** and a **Participant**; and

viii. Review the performance of the **Third Party Administrators'** personnel assigned to the **Authority's** account with special emphasis in the handling of "open claims."

d. Recommend to the **Board** the setting of reserves for those cases that are likely to penetrate to pooled funds;

e. Upon the reporting of each claim that has an expectation of exceeding the minimum incurred loss threshold set by the **Board**, review said claim for the **Authority** and report said claims to the **Board** at the next scheduled meeting;

f. Review the progress of all reported claims for the **Authority** and, if directed by the **Board**, propose reserve changes, and/or take control and assume settlement authority for the claim;

ARTICLE V: CLAIMS ADMINISTRATION

A. CLAIMS PROCEDURES MANUAL

1. A Workers' Compensation Claims Procedures Manual (Manual) including reporting procedures, forms, and other vital information is included in Appendix A and will be updated from time to time as needed.

2. All **Participants** shall be held accountable for understanding and abiding by the procedures stated in the Manual, as well as any changes thereto.

B. CLAIM SETTLEMENT AUTHORITY

1. Authority for the settlement of Workers' Compensation claims shall be in the following increments:

Authorizing Entity	Authority
Third Party Administrator	$0
Deputy General Manager	$1- $50,000
General Manager	$1 - $100,000
~~General Manager, Workers' Compensation Subcommittee~~Executive Committee	$100,000- ~~+~~350,000
Board of Directors ~~Chairperson and Executive Officer (must participate in program)~~	$350,000+

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2. The **Third Party Administrator** will ensure the **Participant** is kept informed regarding these claims~~,~~ and will take into consideration the **Participant**'s desires in any settlement process. A. ~~The written a~~uthorization on all settlement or stipulations shall be obtained.

3. Should the settlement value enter into the excess layer of funding, authority from the excess coverage provider would be required.

4. The **Third Party Administrator** shall consult with and obtain authorization prior to settlement of any claim, including ~~; this includes~~ but not limited to Stipulations, Compromise & Releases and lien settlements. All requests for settlement authority shall include a written claim summary, estimate of permanent disability, and any comments and recommendations.

C. DISPUTES BETWEEN PARTICIPANTS AND GENERAL MANAGER, OR Board

~~1.~~ ~~-~~Any matter in dispute between a **Participant** and the **Program** shall be heard by the Executive Committee whose decision may be appealed to the **Board** within thirty (30) days of the Committee's decision. The decision of the Executive Committee or, if appealed, the decision of the **Board** shall be final.

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ARTICLE VI: DEFENSE PANEL

A. CRITERIA FOR DEFENSE PANEL

1. The defense panel shall include all attorneys listed in the attached Appendix B, which may be amended at the discretion of the General Manager.

2. Attorneys must meet and agree to the following provisions before ~~CIRA will~~ consideration of ~~their~~ inclusion on the panel:

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a. The firm must have demonstrated success representing public entities and specific expertise in the workers' compensation arena.

b. Firms must have no less than 5 years litigation practice which includes

substantial and significant experience in public entity defense to be eligible for case assignment.

c. The firm shall provide a resume setting forth the experience of the individual attorneys that would be assigned to cases and their areas of expertise.

d. The firm must agree to the maximum hourly rates outlined in the fee schedule outlined below, in section B, unless specialized legal representation is necessary, which requires prior approval ~~from CIRA~~. The maximum hourly rate will be reviewed on a bi-annual basis.

e. The firm must agree to abide by the policies and procedures established by CIRA for handling of litigation.

f. The firm must evidence general liability, automobile liability, workers' compensation, and professional liability insurance. The policy limits must not be less than $1,000,000 per occurrence. ~~and~~ CIRA, its officials, officers, employees, and agents~~, with the exception of workers' compensation and professional liability,~~ must be named additional insured for general liability and auto liability and follow all insurance requirements of the **Authority**.

3. The General Manager and Officers may appoint a particular attorney or law firm other than panel counsel when specialized, unforeseen defense is required. The law firm or attorney shall comply with conditions a-f above.

4. CIRA will assign defense counsel in collaboration with the **Participant.**

Participants may assign cases to firms listed on the Panel. Nothing in this MPD shall be construed to limit the right of the **Participant** to retain its own defense counsel to represent the **Participant** in any litigation. Except where prior approval has been given, the **Participant** is responsible for amounts in excess of the maximum hourly rates, which shall not reduce the **Participant's** self-insured retention obligation.

B. MAXIMUM FEE SCHEDULE

Legal Staff	***Maximum Rate***
Partners	$175
Associates	$145
Paralegals	$75

ARTICLE VII: PARTICIPATION

A. ELIGIBILITY AND APPLICATION

1. ELIGIBILITY

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a. New~~The~~ applicants must commit to at least five full **program years** of participation in this **Program**.

b. Any **Member Entity** may apply to participate in the **Program** by providing an adopted resolution of its governing body and such other information/materials as may be required. The applicant's resolution shall commit the applicant to five full years of participation in the **Program**, if accepted, and consent to be governed for workers' compensation matters in accordance with the MPD, the MOC and other documents and policies adopted by the **Board**. The resolution may also state the **retained limit** desired by the applicant.

c. The application for participation shall be submitted at least thirty (30) days prior to the date of the last **Board** meeting of the **program year** to ensure that the State Certificate of Consent to Self-Insure is received prior to the inception date, and that the **Board** has adequate time to review and evaluate the acceptability of the applicant. It is recommended that an applicant enter the **Program** only at the commencement of a new **program year**. If an applicant chooses to enter the **Program** at any other time, the **deposit contribution** for the remainder of the **program year** will be pro-rated. The new **Participant** will begin coverage on the date that is mutually acceptable to the **Participant** and the **Board**; however, the new **Participant** will be required to share losses with the other members of the **Program** for the entire **program year**.

2. APPROVAL OF APPLICATION

The **Board** shall, after reviewing the resolution and other underwriting criteria, determine the acceptability of the exposures presented by the applicant and shall advise the applicant in writing of its decision to accept or reject the request within 10 days after the decision has been made.

B. PARTICIPANTS' DUTIES

1. The **Participants** shall provide payroll, using data as included on the ~~the~~ State DE-9 form, and all other requested information in conformance with the policies adopted by the **Board**.

2. The **Participants** shall disclose activities not usual and customary in their operation.

3. The **Participants** shall at all times cooperate with the **Authority's General Manager** and **Third Party Administrator** in regards to claims handling and underwriting activities of the **Authority**.

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ARTICLE VII: TERMINATION AND DISSOLUTION OF THE PROGRAM

The **Program** may be terminated and dissolved at any time by a vote of two-thirds of the **Participants**. However, the **Program** may~~shall~~ continue to exist for the purpose of disposing of all claims, distributing assets, and all other functions necessary to conclude the affairs of the **Program**, at the Board's discretion.~~.~~

Upon termination of the **Program**, all assets of the **Program** shall be distributed only among the current **Participants**. The **Board** shall determine such distribution within six months after the last pending claim or loss covered by the **Program** has been finally resolved and there is a reasonable expectation that no new claims will be filed.

ARTICLE VIII: AMENDMENTS

This MPD may be amended by a two-thirds (2/3rds) vote of the **Participants** at the meeting, provided prior written notice, as provided within the Bylaws, has been given to the **Board**.

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Appendix A

Workers' Compensation Claims Manual

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Appendix B

Workers' Compensation Defense Panel Approved Firm List

Law Offices of C. Robert Bakke

Barbara L. Kiely, Attorney at Law

Joe Montgomery, Hannah Brophy

Joseph T. Todoroff, II, Hannah Brophy

Lenahan Lee Slater & Pearse

Boone T. White, MacIntyre & White

Richard, Thorson, Graves & Royer

Wall McCormick Baroldi Green & Dugan

Robert A. Sanders, Witzig Hannah Sanders

Mullin & Filippi (Santa Rosa, Redding)

Michael Ash (Novato)

Nathan Geronimo, Esq - Hanna and Brophy (Santa Rosa)

Laughlin, Falbo, Levy & Moresi

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PROGRAM COST ALLOCATION FORMULA

SUMMARY: As we move forward towards preparing a final 2021/22 budget for CIRA, a component of the budgeting process includes budgets prepared on a program basis. A program cost allocation method will need to be determined in order to allocate indirect expenses to individual programs. In addition to allocation of costs to CIRA programs, a portion of CIRA staff time and expenses will need to be allocated to manage the REMIF Health Program.

RECOMMENDATION: Approve Program Cost Allocation Formula.

DISCUSSION: As part of the budgeting process, individual program budgets are prepared to facilitate preparation of contributions by program. As part of this process indirect costs are allocated to each program based on a prescribed allocation. Both PARSAC and REMIF currently allocate costs to each program but use different methodologies. Staff has reviewed the methods used by PARSAC and REMIF and have formulated a combined method for CIRA. The method proposed by staff is to allocate the indirect costs as follows:

Liability Program	49%
Workers' Compensation Program	44%
Property Program	7%

The costs were allocated based on expected staff time for the property program with remaining expenses allocated between the liability program and workers' compensation program based on the 2020/21 budgeted contributions.

In addition to the allocation between programs, CIRA will bill by contract a portion of administrative and overhead costs to the REMIF health plan. It is anticipated that those indirect costs will total about 16% of indirect costs or approximately $255,000. The net indirect costs after billing the REMIF health plan will be allocated by the above percentages.

FISCAL IMPLICATIONS: Allocation of indirect costs to CIRA programs.

ATTACHMENT: None

HEALTH BENEFITS FOR CIRA EMPLOYEES

SUMMARY: The CIRA Transition Committee has indicated the desire to eliminate retiree health benefits for CIRA employees hired after July 1, 2021. As CalPERS requires retiree healthcare benefits other health coverage options are being explored.

RECOMMENDATION: Receive and file.

DISCUSSION: During the last CIRA Transition Committee meeting staff presented options for healthcare and retire healthcare benefits for the CIRA staff and existing PARSAC retirees. Since that time, staff has explored additional options including the REMIF health plan and PRISMS health plan.

REMIF offers a limited number and variety of health plans which would require the majority of CIRA staff and PARSAC retirees to switch coverage. There are some limitations to this coverage as it does not offer the full "suite" of plans (i.e. Kaiser, HMO) available through CalPERS and PRISM.

PRISM offers health coverage through SDRMA and GSRMA. They offer a variety of health plans that would provide all staff member the same or similar coverage as they currently receive. The PRISM health plan would allow CIRA to eliminate retiree health. However, due to limited membership when compared to the CalPERS health enrollment, PRISM is unable to negotiate as competitive of rates as CalPERS. If all employees were to switch to a comparable health plan through PRIMS, monthly rates would increase $2,200. There is an option for two current REMIF employees to stay within the REMIF plan and would reduce the cost increase to $1,021 per month. While costs would increase, this would be offset in part over the long term by a reduction in retiree healthcare costs.

Staff will continue to explore other options based on the Committee's input and direction.

FISCAL IMPLICATIONS: A switch from CalPERS health would increase monthly health premiums but would eliminate the retiree healthcare benefit to CIRA employees haired after July 1, 2021.

ATTACHMENT: Staff and Retiree Health Premium Summary

Current Plan		Current Plans Premiums		PRISM Plans Premiums		Comparable PRISM Plan
CIRA Staff	**Covered**	**CalPERS**	**REMIF**	**PRISM****	**Premium Increase with PRISM Plans**	
Blue Cross Select HMO - Region 1	Family	2,407		2,745	338	Blue Shield Access+ HMO 15
Kaiser - California Region 1	EE + 1	1,627		1,832	205	Kaiser HMO 15
Blue Cross PPO - PERS Choice Region 1	EE	936		982	46	Blue Shield Platinum PPO
Kaiser - California Region 1	EE +1	1,627		1,832	205	Kaiser HMO 15
Kaiser (Napa/Sonoma)***	EE +1	-	1,627	1,854	227	Kaiser HMO 15
Blue Cross EPO 250	EE +1	-	1,753	2,370	617	Blue Shield EPO
Blue Cross EPO 250	Family	-	2,503	3,081	578	Blue Shield EPO
CIRA Staff Premiums		6,597	5,883	14,696	**2,216**	
PARSAC Retirees	**Covered**					
PERS Choice Medicare Supplement - out of State	EE+1	700		966	266	Blue Shield Silver PPO
PERS Care Medicare Supplement - out of State	EE	381		483	102	Blue Shield Silver PPO
Western Health Advantage - Region 1	EE+1	1,514		2,110	596	Changed to Blue Cross HMO - Western Health not offered
Kaiser - California Region 1	EE	814		927	113	Kaiser HMO 15
PARSAC Retiree Premiums		3,409	-	4,486	**1,077**	

xPremiums based on rates for January 2021
***REMIF Kaiser coverage provided through the City of Rohnert Park.
**PRISM Plans offeered through SDRMA & GSRMA

REMIF
REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

PUBLIC AGENCY RISK SHARING AUTHORITY OF CALIFORNIA
PARSAC

AGENDA
PARSAC/REMIF TRANSITION COMMITTEE MEETING
January 11, 2020 – 9:00 a.m. – 2:00 p.m.
Zoom Meeting

Link: https://zoom.us/j/92810271337?pwd=NElESEhGUVZwVEN4Z3EyOC9JNkxPUT09

Dial: +1 (669) 900-9128
Meeting ID: 928 1027 1337
Passcode: 624274

CALL TO ORDER
ROLL CALL

Page No.	**ACTION AND INFORMATION CALENDAR** **denotes attachments enclosed for this item*	**RECOMMENDATION**
2	1. EPL Program Experience Modification Options - Mike Harrington	*Review, discuss and approve*
35	2. Experience Modification Factor Formula for Property Program – Tracey Smith-Reed	*Review, discuss and approve*
38	3. Health Benefits for CIRA Employees – Tracey Smith-Reed	*Review, discuss and approve*
45	4. Contract for Administration of REMIF Health Program – Amy Northam	*Review, discuss and approve*
	5. CIRA Meeting Dates - Amy Northam	
	6. Timelines – Kin Ong & Amy Northam	
	7. Schedule Next Meetings: a. Transition Committee – March 1, 2021 b. Transition Finance Committee – February 24, 2021 c. CIRA Board - May 26, 2021	

ADJOURNMENT OF MEETING

Bickmore Actuarial

Actuarial Review of the Self-Insured Employment Practices Liability Program

Premium Allocation Options

Forecast for Program Year 2021-22

Presented to

California Intergovernmental Risk Authority (CIRA)

January 7, 2021 - DRAFT

DRAFT

Thursday, January 7, 2021

Mr. Kin Ong
General Manager
Public Agency Risk Sharing Authority of California
1525 Response Road, Suite 1
Sacramento, CA 95815

Ms. Amy Northam
General Manager
Redwood Empire Municipal Insurance Fund
414 West Napa Street
Sonoma, California 95476

RE: CIRA EPL Premium Allocation Options

Dear Kin and Amy:

As requested, we have completed our estimates of Employment Practices Liability (EPL) claim costs, experience modification calculations, and various premium allocation options for the newly formed California Intergovernmental Risk Authority (CIRA).

In this analysis, we have considered the following six options for allocating EPL costs between members:

- Option 1: 100% Pooling Option (Current Method)
- Option 2 and 3: Experience Modification Options
  - Option 2: 5 years experience, $50K loss cap, and 33%/5% max/min credibility
  - Option 3: 5 years experience, $100K loss cap, and 33%/5% max/min credibility
- Option 4: Claim Frequency Option – Based upon the 100% Pooling Option with the following premium adjustments:
  - 0 claims: -6.6% discount
  - 1 claim: +3.2% surcharge
  - 2+ claims: +8.2% surcharge

All options make the following assumptions:

- Estimated 2021-22 EPL member deductibles provided by CIRA
- Estimated 2021-22 member payrolls provided by CIRA
    - Sierra Madre payrolls estimated using 2019-20 actual payrolls increased by 3% per year.
- Rates from the analysis of EPL losses at 9/30/20 and recent actuarial studies and analysis
- Discount rate assumed to be 1.5%
- Confidence levels of 80% and 85%
- Pool retention of $250,000

The estimates contained in this report take these considerations into account with regard to the appropriate premium for each member.

Background

California Intergovernmental Risk Authority (CIRA) is a municipal risk pool currently being formed as the combination of two existing risk pools, the Public Agency Risk Sharing Authority of California (PARSAC) and the Redwood Empire Municipal Insurance Fund (REMIF). Both underlying pools are members of excess risk pools to provide coverage above their self-insured retention (SIR).

PARSAC currently has a SIR of $25,000 for employment practices liability (EPL). REMIF currently has a SIR of $750,000 employment practices liability (EPL). The combined entity CIRA is considering both $250,000 and $350,000 as potential SIR options for the 2021-22 policy year.

Approach

Base rates are taken from the analysis of most recent EPL losses at 9/30/20 and limit factors taken from the most recent CIRA pool retention report dated August 21, 2020. As such, this should be considered an addendum, and the conditions and limitations contained in those reports apply to this report as well.

Industry information was also utilized to assess rates for various limits not contained in the prior reports.

Premiums assume a $250,000 pool limit; however, impacts relative to the base 100% Pooling Option would be very similar.

DRAFT

We appreciate the opportunity to be of service to PARSAC and REMIF in preparing this report for CIRA. Please feel free to call Mike Harrington at (916) 244-1162, Becky Richard at (916) 244-1183, or David Kim at (916) 244-1166 with any questions you may have concerning this report.

Sincerely,

Bickmore Actuarial

DRAFT

Mike Harrington, FCAS, MAAA
President and Principal, Bickmore Actuarial

DRAFT

Becky Richard, ACAS, MAAA
Senior Actuarial Manager, Bickmore Actuarial

DRAFT

David Kim, MA
Senior Actuarial Analyst, Bickmore Actuarial

Exhibit 1

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premium Options @ 85% Confidence Level

Parameters		Option 1	Option 2	Option 3	Option 4
SIR		$250,000	$250,000	$250,000	$250,000
X-Mod		N	Y	Y	N
Experience Period			5	5	
Loss Limit			50K	100K	
Maximum Credibility			33%	33%	
Frequency Adjustment		N	N	N	Y
	2021-22	Option 1	Option 2	Option 3	Option 4
Amador City	10,000	187	170	172	175
Arcata	5,000	58,115	48,606	49,216	54,283
Avalon	25,000	22,186	26,509	26,841	23,995
Belvedere	25,000	12,440	14,863	15,050	12,842
Blue Lake	5,000	2,927	2,658	2,691	2,734
California City	100,000	12,509	14,946	15,133	13,529
Calimesa	10,000	11,367	10,322	10,451	10,617
Calistoga	10,000	30,478	34,419	31,990	32,963
Citrus Heights	100,000	37,712	45,059	41,581	40,787
Clearlake	25,000	20,170	24,100	24,402	21,814
Cloverdale	5,000	25,049	22,554	22,837	23,397
Coalinga	25,000	29,266	34,968	35,406	31,652
Cotati	5,000	23,477	22,972	22,632	24,237
Eureka	25,000	68,254	81,552	82,575	73,820
Ferndale	5,000	4,028	4,813	4,873	4,159
Fort Bragg	5,000	23,758	21,460	21,729	22,191
Fortuna	5,000	31,765	28,298	28,653	29,670
Grass Valley	25,000	30,110	30,724	29,267	31,085
Healdsburg	5,000	104,198	82,966	84,007	97,327
Highland	25,000	13,581	12,332	12,487	12,685
Lakeport	10,000	19,495	21,924	20,596	20,127
Menifee	25,000	77,401	92,482	93,642	83,713
Nevada City	25,000	11,842	14,149	14,326	12,807
Placentia	100,000	29,828	35,639	36,086	30,794
Placerville	50,000	21,101	18,314	18,543	19,709
Plymouth	5,000	3,834	3,482	3,525	3,581
Point Arena	5,000	1,714	1,556	1,576	1,601

Exhibit 1

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premium Options @ 85% Confidence Level

Parameters		Option 1	Option 2	Option 3	Option 4
SIR		$250,000	$250,000	$250,000	$250,000
X-Mod		N	Y	Y	N
Experience Period			5	5	
Loss Limit			50K	100K	
Maximum Credibility			33%	33%	
Frequency Adjustment		N	N	N	Y
	2021-22	Option 1	Option 2	Option 3	Option 4
Rancho Cucamonga	250,000	-	-	-	-
Rancho Cucamonga FD	75,000	33,303	27,122	27,462	31,107
Rancho Santa Margarita	10,000	13,945	12,663	12,822	13,025
Rohnert Park	25,000	95,677	114,317	115,751	98,775
San Juan Bautista	5,000	4,818	4,375	4,430	4,500
Sebastopol	5,000	33,993	40,616	41,125	35,093
Sierra Madre	25,000	26,282	23,062	23,351	24,549
Sonoma	5,000	19,853	18,028	18,254	18,544
South Lake Tahoe	100,000	37,711	45,059	40,084	40,786
St. Helena	10,000	41,153	35,875	36,325	38,440
Tehama	5,000	378	343	347	353
Trinidad	5,000	2,074	1,883	1,907	1,937
Truckee	25,000	50,947	42,271	42,801	47,588
Twentynine Palms	10,000	13,212	15,786	15,984	14,289
Ukiah	25,000	86,548	66,680	67,453	89,351
Watsonville	250,000	-	-	-	-
Wheatland	5,000	10,015	11,966	12,116	10,339
Wildomar	5,000	8,327	7,561	7,656	7,778
Willits	5,000	20,783	18,872	19,109	19,412
Windsor	10,000	54,024	45,650	46,222	50,462
Yountville	10,000	20,769	18,859	19,096	19,399
Yucaipa	50,000	14,237	12,683	12,842	13,298
Yucca Valley	100,000	7,293	6,622	6,706	6,812
Total		1,322,131	1,322,131	1,322,131	1,322,131

Exhibit 2

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premium Options @ 85% Confidence Level
Dollar Change from Option 1 - 100% Pooling Option

Parameters		Option 1	Option 2	Option 3	Option 4
SIR		$250,000	$250,000	$250,000	$250,000
X-Mod		N	Y	Y	N
Experience Period			5	5	
Loss Limit			50K	100K	
Maximum Credibility			33%	33%	
Frequency Adjustment		N	N	N	Y
Member	2021-22 Deductible	Option 1 $ Change	Option 2 $ Change	Option 3 $ Change	Option 4 $ Change
Amador City	10,000	-	(17)	(15)	(12)
Arcata	5,000	-	(9,509)	(8,899)	(3,832)
Avalon	25,000	-	4,323	4,655	1,809
Belvedere	25,000	-	2,424	2,610	403
Blue Lake	5,000	-	(269)	(236)	(193)
California City	100,000	-	2,437	2,625	1,020
Calimesa	10,000	-	(1,045)	(915)	(750)
Calistoga	10,000	-	3,941	1,512	2,485
Citrus Heights	100,000	-	7,347	3,869	3,075
Clearlake	25,000	-	3,930	4,232	1,645
Cloverdale	5,000	-	(2,494)	(2,211)	(1,652)
Coalinga	25,000	-	5,702	6,140	2,386
Cotati	5,000	-	(505)	(845)	760
Eureka	25,000	-	13,298	14,321	5,565
Ferndale	5,000	-	785	845	130
Fort Bragg	5,000	-	(2,298)	(2,028)	(1,567)
Fortuna	5,000	-	(3,467)	(3,112)	(2,095)
Grass Valley	25,000	-	614	(843)	975
Healdsburg	5,000	-	(21,232)	(20,191)	(6,871)
Highland	25,000	-	(1,248)	(1,094)	(896)
Lakeport	10,000	-	2,429	1,100	631
Menifee	25,000	-	15,080	16,240	6,311
Nevada City	25,000	-	2,307	2,485	966
Placentia	100,000	-	5,811	6,258	966
Placerville	50,000	-	(2,787)	(2,557)	(1,391)
Plymouth	5,000	-	(352)	(309)	(253)
Point Arena	5,000	-	(158)	(138)	(113)

Exhibit 2

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premium Options @ 85% Confidence Level
Dollar Change from Option 1 - 100% Pooling Option

Parameters		Option 1	Option 2	Option 3	Option 4
SIR		$250,000	$250,000	$250,000	$250,000
X-Mod		N	Y	Y	N
Experience Period			5	5	
Loss Limit			50K	100K	
Maximum Credibility			33%	33%	
Frequency Adjustment		N	N	N	Y
Member	2021-22 Deductible	Option 1 $ Change	Option 2 $ Change	Option 3 $ Change	Option 4 $ Change
Rancho Cucamonga	250,000	-	-	-	-
Rancho Cucamonga FD	75,000	-	(6,181)	(5,841)	(2,196)
Rancho Santa Margarita	10,000	-	(1,282)	(1,123)	(920)
Rohnert Park	25,000	-	18,641	20,074	3,098
San Juan Bautista	5,000	-	(443)	(388)	(318)
Sebastopol	5,000	-	6,623	7,132	1,101
Sierra Madre	25,000	-	(3,220)	(2,931)	(1,733)
Sonoma	5,000	-	(1,825)	(1,599)	(1,309)
South Lake Tahoe	100,000	-	7,347	2,372	3,075
St. Helena	10,000	-	(5,278)	(4,828)	(2,714)
Tehama	5,000	-	(35)	(30)	(25)
Trinidad	5,000	-	(191)	(167)	(137)
Truckee	25,000	-	(8,677)	(8,147)	(3,360)
Twentynine Palms	10,000	-	2,574	2,772	1,077
Ukiah	25,000	-	(19,868)	(19,095)	2,802
Watsonville	250,000	-	-	-	-
Wheatland	5,000	-	1,951	2,101	324
Wildomar	5,000	-	(765)	(671)	(549)
Willits	5,000	-	(1,911)	(1,674)	(1,370)
Windsor	10,000	-	(8,375)	(7,802)	(3,562)
Yountville	10,000	-	(1,909)	(1,673)	(1,370)
Yucaipa	50,000	-	(1,554)	(1,395)	(939)
Yucca Valley	100,000	-	(670)	(587)	(481)
Total		-	0	0	0

Exhibit 3

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premium Options @ 85% Confidence Level
Percentage Change from Option 1 - 100% Pooling Option

Parameters		Option 1	Option 2	Option 3	Option 4
SIR		$250,000	$250,000	$250,000	$250,000
X-Mod		N	Y	Y	N
Experience Period			5	5	
Loss Limit			50K	100K	
Maximum Credibility			33%	33%	
Frequency Adjustment		N	N	N	Y
Member	2021-22 Deductible	Option 1 % Change	Option 2 % Change	Option 3 % Change	Option 4 % Change
Amador City	10,000	0.0%	-9.2%	-8.1%	-6.6%
Arcata	5,000	0.0%	-16.4%	-15.3%	-6.6%
Avalon	25,000	0.0%	19.5%	21.0%	8.2%
Belvedere	25,000	0.0%	19.5%	21.0%	3.2%
Blue Lake	5,000	0.0%	-9.2%	-8.1%	-6.6%
California City	100,000	0.0%	19.5%	21.0%	8.2%
Calimesa	10,000	0.0%	-9.2%	-8.1%	-6.6%
Calistoga	10,000	0.0%	12.9%	5.0%	8.2%
Citrus Heights	100,000	0.0%	19.5%	10.3%	8.2%
Clearlake	25,000	0.0%	19.5%	21.0%	8.2%
Cloverdale	5,000	0.0%	-10.0%	-8.8%	-6.6%
Coalinga	25,000	0.0%	19.5%	21.0%	8.2%
Cotati	5,000	0.0%	-2.2%	-3.6%	3.2%
Eureka	25,000	0.0%	19.5%	21.0%	8.2%
Ferndale	5,000	0.0%	19.5%	21.0%	3.2%
Fort Bragg	5,000	0.0%	-9.7%	-8.5%	-6.6%
Fortuna	5,000	0.0%	-10.9%	-9.8%	-6.6%
Grass Valley	25,000	0.0%	2.0%	-2.8%	3.2%
Healdsburg	5,000	0.0%	-20.4%	-19.4%	-6.6%
Highland	25,000	0.0%	-9.2%	-8.1%	-6.6%
Lakeport	10,000	0.0%	12.5%	5.6%	3.2%
Menifee	25,000	0.0%	19.5%	21.0%	8.2%
Nevada City	25,000	0.0%	19.5%	21.0%	8.2%
Placentia	100,000	0.0%	19.5%	21.0%	3.2%
Placerville	50,000	0.0%	-13.2%	-12.1%	-6.6%
Plymouth	5,000	0.0%	-9.2%	-8.1%	-6.6%
Point Arena	5,000	0.0%	-9.2%	-8.1%	-6.6%

Exhibit 3

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premium Options @ 85% Confidence Level
Percentage Change from Option 1 - 100% Pooling Option

Parameters		Option 1	Option 2	Option 3	Option 4
SIR		$250,000	$250,000	$250,000	$250,000
X-Mod		N	Y	Y	N
Experience Period			5	5	
Loss Limit			50K	100K	
Maximum Credibility			33%	33%	
Frequency Adjustment		N	N	N	Y
Member	2021-22 Deductible	Option 1 % Change	Option 2 % Change	Option 3 % Change	Option 4 % Change
Rancho Cucamonga	250,000	0.0%	0.0%	0.0%	0.0%
Rancho Cucamonga FD	75,000	0.0%	-18.6%	-17.5%	-6.6%
Rancho Santa Margarita	10,000	0.0%	-9.2%	-8.1%	-6.6%
Rohnert Park	25,000	0.0%	19.5%	21.0%	3.2%
San Juan Bautista	5,000	0.0%	-9.2%	-8.1%	-6.6%
Sebastopol	5,000	0.0%	19.5%	21.0%	3.2%
Sierra Madre	25,000	0.0%	-12.3%	-11.2%	-6.6%
Sonoma	5,000	0.0%	-9.2%	-8.1%	-6.6%
South Lake Tahoe	100,000	0.0%	19.5%	6.3%	8.2%
St. Helena	10,000	0.0%	-12.8%	-11.7%	-6.6%
Tehama	5,000	0.0%	-9.2%	-8.1%	-6.6%
Trinidad	5,000	0.0%	-9.2%	-8.1%	-6.6%
Truckee	25,000	0.0%	-17.0%	-16.0%	-6.6%
Twentynine Palms	10,000	0.0%	19.5%	21.0%	8.2%
Ukiah	25,000	0.0%	-23.0%	-22.1%	3.2%
Watsonville	250,000	0.0%	0.0%	0.0%	0.0%
Wheatland	5,000	0.0%	19.5%	21.0%	3.2%
Wildomar	5,000	0.0%	-9.2%	-8.1%	-6.6%
Willits	5,000	0.0%	-9.2%	-8.1%	-6.6%
Windsor	10,000	0.0%	-15.5%	-14.4%	-6.6%
Yountville	10,000	0.0%	-9.2%	-8.1%	-6.6%
Yucaipa	50,000	0.0%	-10.9%	-9.8%	-6.6%
Yucca Valley	100,000	0.0%	-9.2%	-8.1%	-6.6%
Total		0.0%	0.0%	0.0%	0.0%

Exhibit 1

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premium Options @ 80% Confidence Level

Parameters		Option 1	Option 2	Option 3	Option 4
SIR		$250,000	$250,000	$250,000	$250,000
X-Mod		N	Y	Y	N
Experience Period			5	5	
Loss Limit			50K	100K	
Maximum Credibility			33%	33%	
Frequency Adjustment		N	N	N	Y
	2021-22	Option 1	Option 2	Option 3	Option 4
Amador City	10,000	173	157	159	161
Arcata	5,000	53,645	44,867	45,430	50,107
Avalon	25,000	20,480	24,470	24,777	22,150
Belvedere	25,000	11,483	13,720	13,892	11,855
Blue Lake	5,000	2,702	2,454	2,484	2,524
California City	100,000	11,547	13,796	13,969	12,488
Calimesa	10,000	10,492	9,528	9,647	9,800
Calistoga	10,000	28,134	31,771	29,530	30,428
Citrus Heights	100,000	34,811	41,593	38,382	37,649
Clearlake	25,000	18,618	22,246	22,525	20,136
Cloverdale	5,000	23,122	20,820	21,081	21,597
Coalinga	25,000	27,015	32,278	32,683	29,218
Cotati	5,000	21,671	21,205	20,891	22,373
Eureka	25,000	63,004	75,279	76,223	68,141
Ferndale	5,000	3,718	4,443	4,498	3,839
Fort Bragg	5,000	21,930	19,809	20,058	20,484
Fortuna	5,000	29,321	26,121	26,449	27,388
Grass Valley	25,000	27,794	28,360	27,016	28,694
Healdsburg	5,000	96,183	76,584	77,545	89,840
Highland	25,000	12,536	11,383	11,526	11,709
Lakeport	10,000	17,996	20,238	19,011	18,579
Menifee	25,000	71,447	85,368	86,438	77,273
Nevada City	25,000	10,931	13,060	13,224	11,822
Placentia	100,000	27,533	32,898	33,310	28,425
Placerville	50,000	19,477	16,905	17,117	18,193
Plymouth	5,000	3,539	3,214	3,254	3,306
Point Arena	5,000	1,582	1,436	1,454	1,478

Exhibit 1

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premium Options @ 80% Confidence Level

Parameters		Option 1	Option 2	Option 3	Option 4
SIR		$250,000	$250,000	$250,000	$250,000
X-Mod		N	Y	Y	N
Experience Period			5	5	
Loss Limit			50K	100K	
Maximum Credibility			33%	33%	
Frequency Adjustment		N	N	N	Y
	2021-22	Option 1	Option 2	Option 3	Option 4
Rancho Cucamonga	250,000	-	-	-	-
Rancho Cucamonga FD	75,000	30,741	25,035	25,349	28,714
Rancho Santa Margarita	10,000	12,872	11,689	11,836	12,023
Rohnert Park	25,000	88,317	105,524	106,847	91,176
San Juan Bautista	5,000	4,447	4,038	4,089	4,154
Sebastopol	5,000	31,378	37,491	37,962	32,394
Sierra Madre	25,000	24,260	21,288	21,555	22,661
Sonoma	5,000	18,326	16,641	16,850	17,118
South Lake Tahoe	100,000	34,811	41,593	37,000	37,649
St. Helena	10,000	37,988	33,116	33,531	35,483
Tehama	5,000	349	317	320	326
Trinidad	5,000	1,914	1,738	1,760	1,788
Truckee	25,000	47,028	39,019	39,508	43,927
Twentynine Palms	10,000	12,195	14,571	14,754	13,190
Ukiah	25,000	79,891	61,551	62,264	82,478
Watsonville	250,000	-	-	-	-
Wheatland	5,000	9,244	11,046	11,184	9,544
Wildomar	5,000	7,686	6,980	7,067	7,179
Willits	5,000	19,184	17,420	17,639	17,919
Windsor	10,000	49,868	42,138	42,666	46,580
Yountville	10,000	19,171	17,409	17,627	17,907
Yucaipa	50,000	13,142	11,707	11,854	12,275
Yucca Valley	100,000	6,732	6,113	6,190	6,288
Total		1,220,429	1,220,429	1,220,429	1,220,429

Exhibit 2

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premium Options @ 80% Confidence Level
Dollar Change from Option 1 - 100% Pooling Option

Parameters		Option 1	Option 2	Option 3	Option 4
SIR		$250,000	$250,000	$250,000	$250,000
X-Mod		N	Y	Y	N
Experience Period			5	5	
Loss Limit			50K	100K	
Maximum Credibility			33%	33%	
Frequency Adjustment		N	N	N	Y
Member	2021-22 Deductible	Option 1 $ Change	Option 2 $ Change	Option 3 $ Change	Option 4 $ Change
Amador City	10,000	-	(16)	(14)	(11)
Arcata	5,000	-	(8,777)	(8,215)	(3,537)
Avalon	25,000	-	3,990	4,297	1,670
Belvedere	25,000	-	2,237	2,409	372
Blue Lake	5,000	-	(248)	(218)	(178)
California City	100,000	-	2,250	2,423	942
Calimesa	10,000	-	(965)	(845)	(692)
Calistoga	10,000	-	3,638	1,396	2,294
Citrus Heights	100,000	-	6,782	3,571	2,839
Clearlake	25,000	-	3,627	3,906	1,518
Cloverdale	5,000	-	(2,302)	(2,041)	(1,525)
Coalinga	25,000	-	5,263	5,668	2,203
Cotati	5,000	-	(466)	(780)	702
Eureka	25,000	-	12,275	13,219	5,137
Ferndale	5,000	-	724	780	120
Fort Bragg	5,000	-	(2,121)	(1,872)	(1,446)
Fortuna	5,000	-	(3,200)	(2,872)	(1,934)
Grass Valley	25,000	-	567	(778)	900
Healdsburg	5,000	-	(19,599)	(18,638)	(6,343)
Highland	25,000	-	(1,152)	(1,010)	(827)
Lakeport	10,000	-	2,242	1,016	583
Menifee	25,000	-	13,920	14,991	5,826
Nevada City	25,000	-	2,130	2,293	891
Placentia	100,000	-	5,364	5,777	892
Placerville	50,000	-	(2,572)	(2,360)	(1,284)
Plymouth	5,000	-	(325)	(285)	(233)
Point Arena	5,000	-	(145)	(127)	(104)

Exhibit 2

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premium Options @ 80% Confidence Level
Dollar Change from Option 1 - 100% Pooling Option

Parameters		Option 1	Option 2	Option 3	Option 4
SIR		$250,000	$250,000	$250,000	$250,000
X-Mod		N	Y	Y	N
Experience Period			5	5	
Loss Limit			50K	100K	
Maximum Credibility			33%	33%	
Frequency Adjustment		N	N	N	Y
Member	2021-22 Deductible	Option 1 $ Change	Option 2 $ Change	Option 3 $ Change	Option 4 $ Change
Rancho Cucamonga	250,000	-	-	-	-
Rancho Cucamonga FD	75,000	-	(5,706)	(5,392)	(2,027)
Rancho Santa Margarita	10,000	-	(1,183)	(1,037)	(849)
Rohnert Park	25,000	-	17,207	18,530	2,860
San Juan Bautista	5,000	-	(409)	(358)	(293)
Sebastopol	5,000	-	6,113	6,584	1,016
Sierra Madre	25,000	-	(2,972)	(2,705)	(1,600)
Sonoma	5,000	-	(1,685)	(1,476)	(1,208)
South Lake Tahoe	100,000	-	6,782	2,190	2,838
St. Helena	10,000	-	(4,872)	(4,457)	(2,505)
Tehama	5,000	-	(32)	(28)	(23)
Trinidad	5,000	-	(176)	(154)	(126)
Truckee	25,000	-	(8,009)	(7,520)	(3,101)
Twentynine Palms	10,000	-	2,376	2,559	994
Ukiah	25,000	-	(18,340)	(17,626)	2,587
Watsonville	250,000	-	-	-	-
Wheatland	5,000	-	1,801	1,940	299
Wildomar	5,000	-	(707)	(619)	(507)
Willits	5,000	-	(1,764)	(1,545)	(1,265)
Windsor	10,000	-	(7,730)	(7,202)	(3,288)
Yountville	10,000	-	(1,762)	(1,544)	(1,264)
Yucaipa	50,000	-	(1,434)	(1,287)	(867)
Yucca Valley	100,000	-	(619)	(542)	(444)
Total		-	0	0	0

Exhibit 3

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premium Options @ 80% Confidence Level
Percentage Change from Option 1 - 100% Pooling Option

Parameters		Option 1	Option 2	Option 3	Option 4
SIR		$250,000	$250,000	$250,000	$250,000
X-Mod		N	Y	Y	N
Experience Period			5	5	
Loss Limit			50K	100K	
Maximum Credibility			33%	33%	
Frequency Adjustment		N	N	N	Y
Member	2021-22 Deductible	Option 1 % Change	Option 2 % Change	Option 3 % Change	Option 4 % Change
Amador City	10,000	0.0%	-9.2%	-8.1%	-6.6%
Arcata	5,000	0.0%	-16.4%	-15.3%	-6.6%
Avalon	25,000	0.0%	19.5%	21.0%	8.2%
Belvedere	25,000	0.0%	19.5%	21.0%	3.2%
Blue Lake	5,000	0.0%	-9.2%	-8.1%	-6.6%
California City	100,000	0.0%	19.5%	21.0%	8.2%
Calimesa	10,000	0.0%	-9.2%	-8.1%	-6.6%
Calistoga	10,000	0.0%	12.9%	5.0%	8.2%
Citrus Heights	100,000	0.0%	19.5%	10.3%	8.2%
Clearlake	25,000	0.0%	19.5%	21.0%	8.2%
Cloverdale	5,000	0.0%	-10.0%	-8.8%	-6.6%
Coalinga	25,000	0.0%	19.5%	21.0%	8.2%
Cotati	5,000	0.0%	-2.2%	-3.6%	3.2%
Eureka	25,000	0.0%	19.5%	21.0%	8.2%
Ferndale	5,000	0.0%	19.5%	21.0%	3.2%
Fort Bragg	5,000	0.0%	-9.7%	-8.5%	-6.6%
Fortuna	5,000	0.0%	-10.9%	-9.8%	-6.6%
Grass Valley	25,000	0.0%	2.0%	-2.8%	3.2%
Healdsburg	5,000	0.0%	-20.4%	-19.4%	-6.6%
Highland	25,000	0.0%	-9.2%	-8.1%	-6.6%
Lakeport	10,000	0.0%	12.5%	5.6%	3.2%
Menifee	25,000	0.0%	19.5%	21.0%	8.2%
Nevada City	25,000	0.0%	19.5%	21.0%	8.2%
Placentia	100,000	0.0%	19.5%	21.0%	3.2%
Placerville	50,000	0.0%	-13.2%	-12.1%	-6.6%
Plymouth	5,000	0.0%	-9.2%	-8.1%	-6.6%
Point Arena	5,000	0.0%	-9.2%	-8.1%	-6.6%

Exhibit 3

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premium Options @ 80% Confidence Level
Percentage Change from Option 1 - 100% Pooling Option

Parameters		Option 1	Option 2	Option 3	Option 4
SIR		$250,000	$250,000	$250,000	$250,000
X-Mod		N	Y	Y	N
Experience Period			5	5	
Loss Limit			50K	100K	
Maximum Credibility			33%	33%	
Frequency Adjustment		N	N	N	Y
Member	2021-22 Deductible	Option 1 % Change	Option 2 % Change	Option 3 % Change	Option 4 % Change
Rancho Cucamonga	250,000	0.0%	0.0%	0.0%	0.0%
Rancho Cucamonga FD	75,000	0.0%	-18.6%	-17.5%	-6.6%
Rancho Santa Margarita	10,000	0.0%	-9.2%	-8.1%	-6.6%
Rohnert Park	25,000	0.0%	19.5%	21.0%	3.2%
San Juan Bautista	5,000	0.0%	-9.2%	-8.1%	-6.6%
Sebastopol	5,000	0.0%	19.5%	21.0%	3.2%
Sierra Madre	25,000	0.0%	-12.3%	-11.2%	-6.6%
Sonoma	5,000	0.0%	-9.2%	-8.1%	-6.6%
South Lake Tahoe	100,000	0.0%	19.5%	6.3%	8.2%
St. Helena	10,000	0.0%	-12.8%	-11.7%	-6.6%
Tehama	5,000	0.0%	-9.2%	-8.1%	-6.6%
Trinidad	5,000	0.0%	-9.2%	-8.1%	-6.6%
Truckee	25,000	0.0%	-17.0%	-16.0%	-6.6%
Twentynine Palms	10,000	0.0%	19.5%	21.0%	8.2%
Ukiah	25,000	0.0%	-23.0%	-22.1%	3.2%
Watsonville	250,000	0.0%	0.0%	0.0%	0.0%
Wheatland	5,000	0.0%	19.5%	21.0%	3.2%
Wildomar	5,000	0.0%	-9.2%	-8.1%	-6.6%
Willits	5,000	0.0%	-9.2%	-8.1%	-6.6%
Windsor	10,000	0.0%	-15.5%	-14.4%	-6.6%
Yountville	10,000	0.0%	-9.2%	-8.1%	-6.6%
Yucaipa	50,000	0.0%	-10.9%	-9.8%	-6.6%
Yucca Valley	100,000	0.0%	-9.2%	-8.1%	-6.6%
Total		0.0%	0.0%	0.0%	0.0%

Appendix A
Option 1

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 X-Mods

	Non-Zero Claims (A)	5-year 50K Losses (B)	Estimated 5-year Payrolls (C)	% 5-year Losses (D)	% 5-year Payrolls (E)	Ratio (F)	Min/Max 5%/33% Credibility (G)	X-mod (H)
Amador City	0	0	182,926	0%	0%	0.000	0.050	0.950
Arcata	0	0	43,229,053	0%	3%	0.000	0.125	0.875
Avalon	2	51,085	28,684,572	3%	2%	1.882	0.087	1.250
Belvedere	1	44,379	6,901,612	3%	0%	6.794	0.050	1.250
Blue Lake	0	0	2,209,569	0%	0%	0.000	0.050	0.950
California City	5	140,669	33,740,377	10%	2%	4.405	0.101	1.250
Calimesa	0	0	5,182,048	0%	0%	0.000	0.050	0.950
Calistoga	2	6,160	25,183,758	0%	2%	0.258	0.077	1.181
Citrus Heights	3	52,502	92,626,115	4%	6%	0.599	0.235	1.250
Clearlake	4	110,946	16,876,694	8%	1%	6.946	0.053	1.250
Cloverdale	0	0	18,474,372	0%	1%	0.000	0.058	0.942
Coalinga	3	72,412	26,999,542	5%	2%	2.834	0.082	1.250
Cotati	1	946	13,564,466	0%	1%	0.074	0.050	1.024
Eureka	4	200,000	71,358,084	14%	5%	2.961	0.191	1.250
Ferndale	1	7,221	3,211,527	0%	0%	2.376	0.050	1.250
Fort Bragg	0	0	17,467,785	0%	1%	0.000	0.055	0.945
Fortuna	0	0	22,037,349	0%	1%	0.000	0.068	0.932
Grass Valley	1	5,420	33,982,662	0%	2%	0.168	0.101	1.067
Healdsburg	0	0	60,298,267	0%	4%	0.000	0.167	0.833
Highland	0	0	13,377,986	0%	1%	0.000	0.050	0.950
Lakeport	1	3,031	14,137,853	0%	1%	0.226	0.050	1.176
Menifee	2	59,931	25,554,017	4%	2%	2.478	0.078	1.250
Nevada City	3	57,694	12,223,025	4%	1%	4.987	0.050	1.250
Placentia	1	50,000	57,159,373	3%	4%	0.924	0.159	1.250
Placerville	0	0	30,716,611	0%	2%	0.000	0.092	0.908
Plymouth	0	0	2,727,614	0%	0%	0.000	0.050	0.950
Point Arena	0	0	1,507,085	0%	0%	0.000	0.050	0.950

Appendix A
Option 1

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 X-Mods

	Non-Zero Claims (A)	5-year 50K Losses (B)	Estimated 5-year Payrolls (C)	% 5-year Losses (D)	% 5-year Payrolls (E)	Ratio (F)	Min/Max 5%/33% Credibility (G)	X-mod (H)
Rancho Cucamonga	14	179,225	150,916,126	12%	10%	1.255	0.333	1.250
Rancho Cucamonga FD	0	0	52,563,123	0%	3%	0.000	0.148	0.852
Rancho Santa Margarita	0	0	13,231,815	0%	1%	0.000	0.050	0.950
Rohnert Park	1	50,000	83,515,674	3%	5%	0.633	0.217	1.250
San Juan Bautista	0	0	2,602,561	0%	0%	0.000	0.050	0.950
Sebastopol	1	50,000	23,952,043	3%	2%	2.206	0.074	1.250
Sierra Madre	0	0	26,847,233	0%	2%	0.000	0.082	0.918
Sonoma	0	0	13,569,255	0%	1%	0.000	0.050	0.950
South Lake Tahoe	2	42,172	86,678,416	3%	6%	0.514	0.223	1.250
St. Helena	0	0	29,225,694	0%	2%	0.000	0.088	0.912
Tehama	0	0	177,847	0%	0%	0.000	0.050	0.950
Trinidad	0	0	1,644,629	0%	0%	0.000	0.050	0.950
Truckee	0	0	46,005,982	0%	3%	0.000	0.132	0.868
Twentynine Palms	2	61,363	11,476,669	4%	1%	5.649	0.050	1.250
Ukiah	1	140	73,518,350	0%	5%	0.002	0.196	0.806
Watsonville	7	223,523	144,533,697	15%	9%	1.634	0.324	1.250
Wheatland	1	3,654	7,312,885	0%	0%	0.528	0.050	1.250
Wildomar	0	0	5,489,347	0%	0%	0.000	0.050	0.950
Willits	0	0	14,185,189	0%	1%	0.000	0.050	0.950
Windsor	0	0	39,550,815	0%	3%	0.000	0.116	0.884
Yountville	0	0	13,772,903	0%	1%	0.000	0.050	0.950
Yucaipa	0	0	21,993,772	0%	1%	0.000	0.068	0.932
Yucca Valley	0	0	13,379,390	0%	1%	0.000	0.050	0.950
Total	63	$1,472,472	$1,555,757,757	100%				

Appendix B
Option 1

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premiums
$250,000 Pool Limit

	2021-22 Deductible (A)	Estimated 2021-22 Payroll (B)	X-mod (C)	Base Rate (D)	Off Balance (E)	Rate for Layer from Deductible to $250,000 Pool Limit					Frequency Adjustment Factor (G)	Premium for Layer from Deductible to $250,000 Pool Limit				
						Expected (F)	75% (F)	80% (F)	85% (F)	90% (F)		Expected (H)	75% (H)	80% (H)	85% (H)	90% (H)
Amador City	10,000	35,000	1.000	0.374	1.000	0.374	0.461	0.493	0.534	0.589	1.00	131	161	173	187	206
Arcata	5,000	10,004,194	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	40,640	50,109	53,645	58,115	64,048
Avalon	25,000	5,250,000	1.000	0.296	1.000	0.296	0.364	0.390	0.423	0.466	1.00	15,515	19,130	20,480	22,186	24,451
Belvedere	25,000	2,943,625	1.000	0.296	1.000	0.296	0.364	0.390	0.423	0.466	1.00	8,699	10,726	11,483	12,440	13,710
Blue Lake	5,000	503,874	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	2,047	2,524	2,702	2,927	3,226
California City	100,000	7,136,124	1.000	0.123	1.000	0.123	0.151	0.162	0.175	0.193	1.00	8,747	10,786	11,547	12,509	13,786
Calimesa	10,000	2,126,792	1.000	0.374	1.000	0.374	0.461	0.493	0.534	0.589	1.00	7,949	9,801	10,492	11,367	12,527
Calistoga	10,000	5,702,662	1.000	0.374	1.000	0.374	0.461	0.493	0.534	0.589	1.00	21,313	26,279	28,134	30,478	33,590
Citrus Heights	100,000	21,513,986	1.000	0.123	1.000	0.123	0.151	0.162	0.175	0.193	1.00	26,372	32,517	34,811	37,712	41,562
Clearlake	25,000	4,772,835	1.000	0.296	1.000	0.296	0.364	0.390	0.423	0.466	1.00	14,105	17,391	18,618	20,170	22,229
Cloverdale	5,000	4,312,001	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	17,517	21,598	23,122	25,049	27,606
Coalinga	25,000	6,925,291	1.000	0.296	1.000	0.296	0.364	0.390	0.423	0.466	1.00	20,466	25,234	27,015	29,266	32,254
Cotati	5,000	4,041,493	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	16,418	20,243	21,671	23,477	25,874
Eureka	25,000	16,151,203	1.000	0.296	1.000	0.296	0.364	0.390	0.423	0.466	1.00	47,730	58,851	63,004	68,254	75,223
Ferndale	5,000	693,416	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	2,817	3,473	3,718	4,028	4,439
Fort Bragg	5,000	4,089,753	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	16,614	20,485	21,930	23,758	26,183
Fortuna	5,000	5,468,152	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	22,213	27,389	29,321	31,765	35,008
Grass Valley	25,000	7,125,000	1.000	0.296	1.000	0.296	0.364	0.390	0.423	0.466	1.00	21,056	25,962	27,794	30,110	33,184
Healdsburg	5,000	17,937,173	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	72,866	89,844	96,183	104,198	114,837
Highland	25,000	3,213,600	1.000	0.296	1.000	0.296	0.364	0.390	0.423	0.466	1.00	9,497	11,710	12,536	13,581	14,967
Lakeport	10,000	3,647,730	1.000	0.374	1.000	0.374	0.461	0.493	0.534	0.589	1.00	13,633	16,810	17,996	19,495	21,486
Menifee	25,000	18,315,703	1.000	0.296	1.000	0.296	0.364	0.390	0.423	0.466	1.00	54,127	66,738	71,447	77,401	85,304
Nevada City	25,000	2,802,105	1.000	0.296	1.000	0.296	0.364	0.390	0.423	0.466	1.00	8,281	10,210	10,931	11,842	13,051
Placentia	100,000	17,016,217	1.000	0.123	1.000	0.123	0.151	0.162	0.175	0.193	1.00	20,859	25,719	27,533	29,828	32,873
Placerville	50,000	7,792,934	1.000	0.189	1.000	0.189	0.233	0.250	0.271	0.298	1.00	14,756	18,194	19,477	21,101	23,255
Plymouth	5,000	660,000	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	2,681	3,306	3,539	3,834	4,225
Point Arena	5,000	295,000	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	1,198	1,478	1,582	1,714	1,889

Appendix B
Option 1

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premiums
$250,000 Pool Limit

	2021-22 Deductible (A)	Estimated 2021-22 Payroll (B)	X-mod (C)	Base Rate (D)	Off Balance (E)	Rate for Layer from Deductible to $250,000 Pool Limit: Expected (F)	75% (F)	80% (F)	85% (F)	90% (F)	Frequency Adjustment Factor (G)	Premium for Layer from Deductible to $250,000 Pool Limit: Expected (H)	75% (H)	80% (H)	85% (H)	90% (H)
Rancho Cucamonga	250,000	31,308,573	1.000	0.000	1.000	0.000	0.000	0.000	0.000	0.000	1.00	0	0	0	0	0
Rancho Cucamonga FD	75,000	15,295,870	1.000	0.152	1.000	0.152	0.188	0.201	0.218	0.240	1.00	23,289	28,715	30,741	33,303	36,703
Rancho Santa Margarita	10,000	2,609,185	1.000	0.374	1.000	0.374	0.461	0.493	0.534	0.589	1.00	9,752	12,024	12,872	13,945	15,369
Rohnert Park	25,000	22,640,187	1.000	0.296	1.000	0.296	0.364	0.390	0.423	0.466	1.00	66,907	82,496	88,317	95,677	105,445
San Juan Bautista	5,000	829,382	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	3,369	4,154	4,447	4,818	5,310
Sebastopol	5,000	5,851,688	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	23,771	29,310	31,378	33,993	37,463
Sierra Madre	25,000	6,219,225	1.000	0.296	1.000	0.296	0.364	0.390	0.423	0.466	1.00	18,379	22,662	24,260	26,282	28,966
Sonoma	5,000	3,417,654	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	13,883	17,118	18,326	19,853	21,880
South Lake Tahoe	100,000	21,513,777	1.000	0.123	1.000	0.123	0.151	0.162	0.175	0.193	1.00	26,372	32,516	34,811	37,711	41,562
St. Helena	10,000	7,700,076	1.000	0.374	1.000	0.374	0.461	0.493	0.534	0.589	1.00	28,779	35,484	37,988	41,153	45,355
Tehama	5,000	65,000	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	264	326	349	378	416
Trinidad	5,000	357,000	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	1,450	1,788	1,914	2,074	2,286
Truckee	25,000	12,055,837	1.000	0.296	1.000	0.296	0.364	0.390	0.423	0.466	1.00	35,628	43,929	47,028	50,947	56,149
Twentynine Palms	10,000	2,472,000	1.000	0.374	1.000	0.374	0.461	0.493	0.534	0.589	1.00	9,239	11,392	12,195	13,212	14,561
Ukiah	25,000	20,480,152	1.000	0.296	1.000	0.296	0.364	0.390	0.423	0.466	1.00	60,523	74,625	79,891	86,548	95,385
Watsonville	250,000	40,571,986	1.000	0.000	1.000	0.000	0.000	0.000	0.000	0.000	1.00	0	0	0	0	0
Wheatland	5,000	1,724,000	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	7,003	8,635	9,244	10,015	11,037
Wildomar	5,000	1,433,403	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	5,823	7,180	7,686	8,327	9,177
Willits	5,000	3,577,634	1.000	0.406	1.000	0.406	0.501	0.536	0.581	0.640	1.00	14,533	17,920	19,184	20,783	22,905
Windsor	10,000	10,108,262	1.000	0.374	1.000	0.374	0.461	0.493	0.534	0.589	1.00	37,779	46,582	49,868	54,024	59,540
Yountville	10,000	3,885,925	1.000	0.374	1.000	0.374	0.461	0.493	0.534	0.589	1.00	14,523	17,907	19,171	20,769	22,889
Yucaipa	50,000	5,257,920	1.000	0.189	1.000	0.189	0.233	0.250	0.271	0.298	1.00	9,956	12,275	13,142	14,237	15,690
Yucca Valley	100,000	4,160,493	1.000	0.123	1.000	0.123	0.151	0.162	0.175	0.193	1.00	5,100	6,288	6,732	7,293	8,038
Total		$404,011,092										$924,567	$1,139,991	$1,220,429	$1,322,131	$1,457,118

Appendix A
Option 2

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 X-Mods

	Non-Zero Claims (A)	5-year 50K Losses (B)	Estimated 5-year Payrolls (C)	% 5-year Losses (D)	% 5-year Payrolls (E)	Ratio (F)	Min/Max 5%/33% Credibility (G)	X-mod (H)
Amador City	0	0	182,926	0%	0%	0.000	0.050	0.950
Arcata	0	0	43,229,053	0%	3%	0.000	0.125	0.875
Avalon	2	51,085	28,684,572	3%	2%	1.882	0.087	1.250
Belvedere	1	44,379	6,901,612	3%	0%	6.794	0.050	1.250
Blue Lake	0	0	2,209,569	0%	0%	0.000	0.050	0.950
California City	5	140,669	33,740,377	10%	2%	4.405	0.101	1.250
Calimesa	0	0	5,182,048	0%	0%	0.000	0.050	0.950
Calistoga	2	6,160	25,183,758	0%	2%	0.258	0.077	1.181
Citrus Heights	3	52,502	92,626,115	4%	6%	0.599	0.235	1.250
Clearlake	4	110,946	16,876,694	8%	1%	6.946	0.053	1.250
Cloverdale	0	0	18,474,372	0%	1%	0.000	0.058	0.942
Coalinga	3	72,412	26,999,542	5%	2%	2.834	0.082	1.250
Cotati	1	946	13,564,466	0%	1%	0.074	0.050	1.024
Eureka	4	200,000	71,358,084	14%	5%	2.961	0.191	1.250
Ferndale	1	7,221	3,211,527	0%	0%	2.376	0.050	1.250
Fort Bragg	0	0	17,467,785	0%	1%	0.000	0.055	0.945
Fortuna	0	0	22,037,349	0%	1%	0.000	0.068	0.932
Grass Valley	1	5,420	33,982,662	0%	2%	0.168	0.101	1.067
Healdsburg	0	0	60,298,267	0%	4%	0.000	0.167	0.833
Highland	0	0	13,377,986	0%	1%	0.000	0.050	0.950
Lakeport	1	3,031	14,137,853	0%	1%	0.226	0.050	1.176
Menifee	2	59,931	25,554,017	4%	2%	2.478	0.078	1.250
Nevada City	3	57,694	12,223,025	4%	1%	4.987	0.050	1.250
Placentia	1	50,000	57,159,373	3%	4%	0.924	0.159	1.250
Placerville	0	0	30,716,611	0%	2%	0.000	0.092	0.908
Plymouth	0	0	2,727,614	0%	0%	0.000	0.050	0.950
Point Arena	0	0	1,507,085	0%	0%	0.000	0.050	0.950

Appendix A
Option 2

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 X-Mods

	Non-Zero Claims (A)	5-year 50K Losses (B)	Estimated 5-year Payrolls (C)	% 5-year Losses (D)	% 5-year Payrolls (E)	Ratio (F)	Min/Max 5%/33% Credibility (G)	X-mod (H)
Rancho Cucamonga	14	179,225	150,916,126	12%	10%	1.255	0.333	1.250
Rancho Cucamonga FD	0	0	52,563,123	0%	3%	0.000	0.148	0.852
Rancho Santa Margarita	0	0	13,231,815	0%	1%	0.000	0.050	0.950
Rohnert Park	1	50,000	83,515,674	3%	5%	0.633	0.217	1.250
San Juan Bautista	0	0	2,602,561	0%	0%	0.000	0.050	0.950
Sebastopol	1	50,000	23,952,043	3%	2%	2.206	0.074	1.250
Sierra Madre	0	0	26,847,233	0%	2%	0.000	0.082	0.918
Sonoma	0	0	13,569,255	0%	1%	0.000	0.050	0.950
South Lake Tahoe	2	42,172	86,678,416	3%	6%	0.514	0.223	1.250
St. Helena	0	0	29,225,694	0%	2%	0.000	0.088	0.912
Tehama	0	0	177,847	0%	0%	0.000	0.050	0.950
Trinidad	0	0	1,644,629	0%	0%	0.000	0.050	0.950
Truckee	0	0	46,005,982	0%	3%	0.000	0.132	0.868
Twentynine Palms	2	61,363	11,476,669	4%	1%	5.649	0.050	1.250
Ukiah	1	140	73,518,350	0%	5%	0.002	0.196	0.806
Watsonville	7	223,523	144,533,697	15%	9%	1.634	0.324	1.250
Wheatland	1	3,654	7,312,885	0%	0%	0.528	0.050	1.250
Wildomar	0	0	5,489,347	0%	0%	0.000	0.050	0.950
Willits	0	0	14,185,189	0%	1%	0.000	0.050	0.950
Windsor	0	0	39,550,815	0%	3%	0.000	0.116	0.884
Yountville	0	0	13,772,903	0%	1%	0.000	0.050	0.950
Yucaipa	0	0	21,993,772	0%	1%	0.000	0.068	0.932
Yucca Valley	0	0	13,379,390	0%	1%	0.000	0.050	0.950
Total	63	$1,472,472	$1,555,757,757	100%				

Appendix B
Option 2

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premiums
$250,000 Pool Limit

	2021-22 Deductible (A)	Estimated 2021-22 Payroll (B)	X-mod (C)	Base Rate (D)	Off Balance (E)	Rate for Layer from Deductible to $250,000 Pool Limit					Frequency Adjustment Factor (G)	Premium for Layer from Deductible to $250,000 Pool Limit				
						Expected (F)	75% (F)	80% (F)	85% (F)	90% (F)		Expected (H)	75% (H)	80% (H)	85% (H)	90% (H)
Amador City	10,000	35,000	0.950	0.374	0.956	0.339	0.418	0.448	0.485	0.535	1.00	119	146	157	170	187
Arcata	5,000	10,004,194	0.875	0.406	0.956	0.340	0.419	0.448	0.486	0.535	1.00	33,990	41,910	44,867	48,606	53,569
Avalon	25,000	5,250,000	1.250	0.296	0.956	0.353	0.435	0.466	0.505	0.556	1.00	18,538	22,857	24,470	26,509	29,215
Belvedere	25,000	2,943,625	1.250	0.296	0.956	0.353	0.435	0.466	0.505	0.556	1.00	10,394	12,816	13,720	14,863	16,381
Blue Lake	5,000	503,874	0.950	0.406	0.956	0.369	0.455	0.487	0.528	0.581	1.00	1,859	2,292	2,454	2,658	2,929
California City	100,000	7,136,124	1.250	0.123	0.956	0.146	0.181	0.193	0.209	0.231	1.00	10,452	12,887	13,796	14,946	16,472
Calimesa	10,000	2,126,792	0.950	0.374	0.956	0.339	0.418	0.448	0.485	0.535	1.00	7,218	8,900	9,528	10,322	11,376
Calistoga	10,000	5,702,662	1.181	0.374	0.956	0.422	0.520	0.557	0.604	0.665	1.00	24,069	29,677	31,771	34,419	37,933
Citrus Heights	100,000	21,513,986	1.250	0.123	0.956	0.146	0.181	0.193	0.209	0.231	1.00	31,510	38,852	41,593	45,059	49,660
Clearlake	25,000	4,772,835	1.250	0.296	0.956	0.353	0.435	0.466	0.505	0.556	1.00	16,853	20,780	22,246	24,100	26,560
Cloverdale	5,000	4,312,001	0.942	0.406	0.956	0.366	0.451	0.483	0.523	0.576	1.00	15,772	19,447	20,820	22,554	24,857
Coalinga	25,000	6,925,291	1.250	0.296	0.956	0.353	0.435	0.466	0.505	0.556	1.00	24,453	30,151	32,278	34,968	38,538
Cotati	5,000	4,041,493	1.024	0.406	0.956	0.397	0.490	0.525	0.568	0.626	1.00	16,064	19,807	21,205	22,972	25,317
Eureka	25,000	16,151,203	1.250	0.296	0.956	0.353	0.435	0.466	0.505	0.556	1.00	57,030	70,318	75,279	81,552	89,879
Ferndale	5,000	693,416	1.250	0.406	0.956	0.485	0.598	0.641	0.694	0.765	1.00	3,366	4,150	4,443	4,813	5,304
Fort Bragg	5,000	4,089,753	0.945	0.406	0.956	0.367	0.452	0.484	0.525	0.578	1.00	15,007	18,504	19,809	21,460	23,651
Fortuna	5,000	5,468,152	0.932	0.406	0.956	0.362	0.446	0.478	0.518	0.570	1.00	19,789	24,400	26,121	28,298	31,187
Grass Valley	25,000	7,125,000	1.067	0.296	0.956	0.302	0.372	0.398	0.431	0.475	1.00	21,485	26,491	28,360	30,724	33,861
Healdsburg	5,000	17,937,173	0.833	0.406	0.956	0.323	0.399	0.427	0.463	0.510	1.00	58,018	71,537	76,584	82,966	91,437
Highland	25,000	3,213,600	0.950	0.296	0.956	0.268	0.331	0.354	0.384	0.423	1.00	8,624	10,633	11,383	12,332	13,591
Lakeport	10,000	3,647,730	1.176	0.374	0.956	0.420	0.518	0.555	0.601	0.662	1.00	15,331	18,904	20,238	21,924	24,162
Menifee	25,000	18,315,703	1.250	0.296	0.956	0.353	0.435	0.466	0.505	0.556	1.00	64,673	79,741	85,368	92,482	101,924
Nevada City	25,000	2,802,105	1.250	0.296	0.956	0.353	0.435	0.466	0.505	0.556	1.00	9,894	12,200	13,060	14,149	15,593
Placentia	100,000	17,016,217	1.250	0.123	0.956	0.146	0.181	0.193	0.209	0.231	1.00	24,922	30,729	32,898	35,639	39,278
Placerville	50,000	7,792,934	0.908	0.189	0.956	0.164	0.203	0.217	0.235	0.259	1.00	12,807	15,791	16,905	18,314	20,184
Plymouth	5,000	660,000	0.950	0.406	0.956	0.369	0.455	0.487	0.528	0.581	1.00	2,435	3,002	3,214	3,482	3,837
Point Arena	5,000	295,000	0.950	0.406	0.956	0.369	0.455	0.487	0.528	0.581	1.00	1,088	1,342	1,436	1,556	1,715

Appendix B
Option 2

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premiums
$250,000 Pool Limit

	2021-22 Deductible (A)	Estimated 2021-22 Payroll (B)	X-mod (C)	Base Rate (D)	Off Balance (E)	Rate for Layer from Deductible to $250,000 Pool Limit: Expected (F)	75% (F)	80% (F)	85% (F)	90% (F)	Frequency Adjustment Factor (G)	Premium for Layer from Deductible to $250,000 Pool Limit: Expected (H)	75% (H)	80% (H)	85% (H)	90% (H)
Rancho Cucamonga	250,000	31,308,573	1.250	0.000	0.956	0.000	0.000	0.000	0.000	0.000	1.00	0	0	0	0	0
Rancho Cucamonga FD	75,000	15,295,870	0.852	0.152	0.956	0.124	0.153	0.164	0.177	0.195	1.00	18,966	23,385	25,035	27,122	29,891
Rancho Santa Margarita	10,000	2,609,185	0.950	0.374	0.956	0.339	0.418	0.448	0.485	0.535	1.00	8,855	10,919	11,689	12,663	13,956
Rohnert Park	25,000	22,640,187	1.250	0.296	0.956	0.353	0.435	0.466	0.505	0.556	1.00	79,942	98,569	105,524	114,317	125,989
San Juan Bautista	5,000	829,382	0.950	0.406	0.956	0.369	0.455	0.487	0.528	0.581	1.00	3,059	3,772	4,038	4,375	4,822
Sebastopol	5,000	5,851,688	1.250	0.406	0.956	0.485	0.598	0.641	0.694	0.765	1.00	28,403	35,020	37,491	40,616	44,762
Sierra Madre	25,000	6,219,225	0.918	0.296	0.956	0.259	0.320	0.342	0.371	0.409	1.00	16,127	19,885	21,288	23,062	25,417
Sonoma	5,000	3,417,654	0.950	0.406	0.956	0.369	0.455	0.487	0.528	0.581	1.00	12,607	15,545	16,641	18,028	19,869
South Lake Tahoe	100,000	21,513,777	1.250	0.123	0.956	0.146	0.181	0.193	0.209	0.231	1.00	31,510	38,851	41,593	45,059	49,659
St. Helena	10,000	7,700,076	0.912	0.374	0.956	0.326	0.402	0.430	0.466	0.513	1.00	25,088	30,933	33,116	35,875	39,538
Tehama	5,000	65,000	0.950	0.406	0.956	0.369	0.455	0.487	0.528	0.581	1.00	240	296	317	343	378
Trinidad	5,000	357,000	0.950	0.406	0.956	0.369	0.455	0.487	0.528	0.581	1.00	1,317	1,624	1,738	1,883	2,075
Truckee	25,000	12,055,837	0.868	0.296	0.956	0.245	0.302	0.324	0.351	0.386	1.00	29,560	36,447	39,019	42,271	46,586
Twentynine Palms	10,000	2,472,000	1.250	0.374	0.956	0.447	0.551	0.589	0.639	0.704	1.00	11,039	13,611	14,571	15,786	17,397
Ukiah	25,000	20,480,152	0.806	0.296	0.956	0.228	0.281	0.301	0.326	0.359	1.00	46,630	57,494	61,551	66,680	73,488
Watsonville	250,000	40,571,986	1.250	0.000	0.956	0.000	0.000	0.000	0.000	0.000	1.00	0	0	0	0	0
Wheatland	5,000	1,724,000	1.250	0.406	0.956	0.485	0.598	0.641	0.694	0.765	1.00	8,368	10,318	11,046	11,966	13,188
Wildomar	5,000	1,433,403	0.950	0.406	0.956	0.369	0.455	0.487	0.528	0.581	1.00	5,288	6,520	6,980	7,561	8,333
Willits	5,000	3,577,634	0.950	0.406	0.956	0.369	0.455	0.487	0.528	0.581	1.00	13,197	16,272	17,420	18,872	20,799
Windsor	10,000	10,108,262	0.884	0.374	0.956	0.316	0.389	0.417	0.452	0.498	1.00	31,923	39,361	42,138	45,650	50,310
Yountville	10,000	3,885,925	0.950	0.374	0.956	0.339	0.418	0.448	0.485	0.535	1.00	13,188	16,261	17,409	18,859	20,785
Yucaipa	50,000	5,257,920	0.932	0.189	0.956	0.169	0.208	0.223	0.241	0.266	1.00	8,869	10,936	11,707	12,683	13,978
Yucca Valley	100,000	4,160,493	0.950	0.123	0.956	0.111	0.137	0.147	0.159	0.175	1.00	4,631	5,710	6,113	6,622	7,299
Total		$404,011,092										$924,567	$1,139,991	$1,220,429	$1,322,131	$1,457,118

Appendix A
Option 3

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 X-Mods

	Non-Zero Claims (A)	5-year 100K Losses (B)	Estimated 5-year Payrolls (C)	% 5-year Losses (D)	% 5-year Payrolls (E)	Ratio (F)	Min/Max 5%/33% Credibility (G)	X-mod (H)
Amador City	0	0	182,926	0%	0%	0.000	0.050	0.950
Arcata	0	0	43,229,053	0%	3%	0.000	0.125	0.875
Avalon	2	101,085	28,684,572	4%	2%	2.327	0.087	1.250
Belvedere	1	44,379	6,901,612	2%	0%	4.245	0.050	1.250
Blue Lake	0	0	2,209,569	0%	0%	0.000	0.050	0.950
California City	5	206,808	33,740,377	9%	2%	4.047	0.101	1.250
Calimesa	0	0	5,182,048	0%	0%	0.000	0.050	0.950
Calistoga	2	6,160	25,183,758	0%	2%	0.161	0.077	1.084
Citrus Heights	3	52,502	92,626,115	2%	6%	0.374	0.235	1.139
Clearlake	4	160,946	16,876,694	7%	1%	6.296	0.053	1.250
Cloverdale	0	0	18,474,372	0%	1%	0.000	0.058	0.942
Coalinga	3	122,412	26,999,542	5%	2%	2.993	0.082	1.250
Cotati	1	946	13,564,466	0%	1%	0.046	0.050	0.996
Eureka	4	377,920	71,358,084	16%	5%	3.496	0.191	1.250
Ferndale	1	7,221	3,211,527	0%	0%	1.484	0.050	1.250
Fort Bragg	0	0	17,467,785	0%	1%	0.000	0.055	0.945
Fortuna	0	0	22,037,349	0%	1%	0.000	0.068	0.932
Grass Valley	1	5,420	33,982,662	0%	2%	0.105	0.101	1.004
Healdsburg	0	0	60,298,267	0%	4%	0.000	0.167	0.833
Highland	0	0	13,377,986	0%	1%	0.000	0.050	0.950
Lakeport	1	3,031	14,137,853	0%	1%	0.142	0.050	1.092
Menifee	2	109,931	25,554,017	5%	2%	2.840	0.078	1.250
Nevada City	3	107,694	12,223,025	5%	1%	5.817	0.050	1.250
Placentia	1	70,000	57,159,373	3%	4%	0.808	0.159	1.250
Placerville	0	0	30,716,611	0%	2%	0.000	0.092	0.908
Plymouth	0	0	2,727,614	0%	0%	0.000	0.050	0.950
Point Arena	0	0	1,507,085	0%	0%	0.000	0.050	0.950

Appendix A
Option 3

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 X-Mods

	Non-Zero Claims (A)	5-year 100K Losses (B)	Estimated 5-year Payrolls (C)	% 5-year Losses (D)	% 5-year Payrolls (E)	Ratio (F)	Min/Max 5%/33% Credibility (G)	X-mod (H)
Rancho Cucamonga	14	249,225	150,916,126	11%	10%	1.090	0.333	1.250
Rancho Cucamonga FD	0	0	52,563,123	0%	3%	0.000	0.148	0.852
Rancho Santa Margarita	0	0	13,231,815	0%	1%	0.000	0.050	0.950
Rohnert Park	1	100,000	83,515,674	4%	5%	0.790	0.217	1.250
San Juan Bautista	0	0	2,602,561	0%	0%	0.000	0.050	0.950
Sebastopol	1	100,000	23,952,043	4%	2%	2.756	0.074	1.250
Sierra Madre	0	0	26,847,233	0%	2%	0.000	0.082	0.918
Sonoma	0	0	13,569,255	0%	1%	0.000	0.050	0.950
South Lake Tahoe	2	42,172	86,678,416	2%	6%	0.321	0.223	1.098
St. Helena	0	0	29,225,694	0%	2%	0.000	0.088	0.912
Tehama	0	0	177,847	0%	0%	0.000	0.050	0.950
Trinidad	0	0	1,644,629	0%	0%	0.000	0.050	0.950
Truckee	0	0	46,005,982	0%	3%	0.000	0.132	0.868
Twentynine Palms	2	111,363	11,476,669	5%	1%	6.406	0.050	1.250
Ukiah	1	140	73,518,350	0%	5%	0.001	0.196	0.805
Watsonville	7	373,523	144,533,697	16%	9%	1.706	0.324	1.250
Wheatland	1	3,654	7,312,885	0%	0%	0.330	0.050	1.250
Wildomar	0	0	5,489,347	0%	0%	0.000	0.050	0.950
Willits	0	0	14,185,189	0%	1%	0.000	0.050	0.950
Windsor	0	0	39,550,815	0%	3%	0.000	0.116	0.884
Yountville	0	0	13,772,903	0%	1%	0.000	0.050	0.950
Yucaipa	0	0	21,993,772	0%	1%	0.000	0.068	0.932
Yucca Valley	0	0	13,379,390	0%	1%	0.000	0.050	0.950
Total	63	$2,356,531	$1,555,757,757	100%				

Appendix B
Option 3

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premiums
$250,000 Pool Limit

	2021-22 Deductible (A)	Estimated 2021-22 Payroll (B)	X-mod (C)	Base Rate (D)	Off Balance (E)	Rate for Layer from Deductible to $250,000 Pool Limit					Frequency Adjustment Factor (G)	Premium for Layer from Deductible to $250,000 Pool Limit				
						Expected (F)	75% (F)	80% (F)	85% (F)	90% (F)		Expected (H)	75% (H)	80% (H)	85% (H)	90% (H)
Amador City	10,000	35,000	0.950	0.374	0.968	0.344	0.424	0.454	0.491	0.542	1.00	120	148	159	172	190
Arcata	5,000	10,004,194	0.875	0.406	0.968	0.344	0.424	0.454	0.492	0.542	1.00	34,417	42,436	45,430	49,216	54,241
Avalon	25,000	5,250,000	1.250	0.296	0.968	0.358	0.441	0.472	0.511	0.563	1.00	18,770	23,144	24,777	26,841	29,582
Belvedere	25,000	2,943,625	1.250	0.296	0.968	0.358	0.441	0.472	0.511	0.563	1.00	10,524	12,976	13,892	15,050	16,586
Blue Lake	5,000	503,874	0.950	0.406	0.968	0.374	0.461	0.493	0.534	0.589	1.00	1,882	2,321	2,484	2,691	2,966
California City	100,000	7,136,124	1.250	0.123	0.968	0.148	0.183	0.196	0.212	0.234	1.00	10,583	13,049	13,969	15,133	16,679
Calimesa	10,000	2,126,792	0.950	0.374	0.968	0.344	0.424	0.454	0.491	0.542	1.00	7,309	9,011	9,647	10,451	11,518
Calistoga	10,000	5,702,662	1.084	0.374	0.968	0.392	0.484	0.518	0.561	0.618	1.00	22,371	27,583	29,530	31,990	35,257
Citrus Heights	100,000	21,513,986	1.139	0.123	0.968	0.135	0.167	0.178	0.193	0.213	1.00	29,077	35,852	38,382	41,581	45,826
Clearlake	25,000	4,772,835	1.250	0.296	0.968	0.358	0.441	0.472	0.511	0.563	1.00	17,064	21,040	22,525	24,402	26,893
Cloverdale	5,000	4,312,001	0.942	0.406	0.968	0.370	0.457	0.489	0.530	0.584	1.00	15,970	19,691	21,081	22,837	25,169
Coalinga	25,000	6,925,291	1.250	0.296	0.968	0.358	0.441	0.472	0.511	0.563	1.00	24,760	30,529	32,683	35,406	39,021
Cotati	5,000	4,041,493	0.996	0.406	0.968	0.392	0.483	0.517	0.560	0.617	1.00	15,827	19,514	20,891	22,632	24,943
Eureka	25,000	16,151,203	1.250	0.296	0.968	0.358	0.441	0.472	0.511	0.563	1.00	57,745	71,199	76,223	82,575	91,006
Ferndale	5,000	693,416	1.250	0.406	0.968	0.491	0.606	0.649	0.703	0.775	1.00	3,408	4,202	4,498	4,873	5,371
Fort Bragg	5,000	4,089,753	0.945	0.406	0.968	0.372	0.458	0.490	0.531	0.586	1.00	15,195	18,736	20,058	21,729	23,948
Fortuna	5,000	5,468,152	0.932	0.406	0.968	0.366	0.452	0.484	0.524	0.577	1.00	20,037	24,706	26,449	28,653	31,579
Grass Valley	25,000	7,125,000	1.004	0.296	0.968	0.287	0.354	0.379	0.411	0.453	1.00	20,466	25,235	27,016	29,267	32,255
Healdsburg	5,000	17,937,173	0.833	0.406	0.968	0.328	0.404	0.432	0.468	0.516	1.00	58,746	72,434	77,545	84,007	92,584
Highland	25,000	3,213,600	0.950	0.296	0.968	0.272	0.335	0.359	0.389	0.428	1.00	8,732	10,767	11,526	12,487	13,762
Lakeport	10,000	3,647,730	1.092	0.374	0.968	0.395	0.487	0.521	0.565	0.622	1.00	14,403	17,758	19,011	20,596	22,698
Menifee	25,000	18,315,703	1.250	0.296	0.968	0.358	0.441	0.472	0.511	0.563	1.00	65,484	80,741	86,438	93,642	103,202
Nevada City	25,000	2,802,105	1.250	0.296	0.968	0.358	0.441	0.472	0.511	0.563	1.00	10,018	12,353	13,224	14,326	15,789
Placentia	100,000	17,016,217	1.250	0.123	0.968	0.148	0.183	0.196	0.212	0.234	1.00	25,235	31,115	33,310	36,086	39,770
Placerville	50,000	7,792,934	0.908	0.189	0.968	0.166	0.205	0.220	0.238	0.262	1.00	12,967	15,989	17,117	18,543	20,437
Plymouth	5,000	660,000	0.950	0.406	0.968	0.374	0.461	0.493	0.534	0.589	1.00	2,465	3,040	3,254	3,525	3,885
Point Arena	5,000	295,000	0.950	0.406	0.968	0.374	0.461	0.493	0.534	0.589	1.00	1,102	1,359	1,454	1,576	1,737

Appendix B
Option 3

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premiums
$250,000 Pool Limit

	2021-22 Deductible (A)	Estimated 2021-22 Payroll (B)	X-mod (C)	Base Rate (D)	Off Balance (E)	Rate for Layer from Deductible to $250,000 Pool Limit: Expected (F)	75% (F)	80% (F)	85% (F)	90% (F)	Frequency Adjustment Factor (G)	Premium for Layer from Deductible to $250,000 Pool Limit: Expected (H)	75% (H)	80% (H)	85% (H)	90% (H)
Rancho Cucamonga	250,000	31,308,573	1.250	0.000	0.968	0.000	0.000	0.000	0.000	0.000	1.00	0	0	0	0	0
Rancho Cucamonga FD	75,000	15,295,870	0.852	0.152	0.968	0.126	0.155	0.166	0.180	0.198	1.00	19,204	23,679	25,349	27,462	30,266
Rancho Santa Margarita	10,000	2,609,185	0.950	0.374	0.968	0.344	0.424	0.454	0.491	0.542	1.00	8,966	11,055	11,836	12,822	14,131
Rohnert Park	25,000	22,640,187	1.250	0.296	0.968	0.358	0.441	0.472	0.511	0.563	1.00	80,945	99,805	106,847	115,751	127,569
San Juan Bautista	5,000	829,382	0.950	0.406	0.968	0.374	0.461	0.493	0.534	0.589	1.00	3,098	3,820	4,089	4,430	4,882
Sebastopol	5,000	5,851,688	1.250	0.406	0.968	0.491	0.606	0.649	0.703	0.775	1.00	28,759	35,460	37,962	41,125	45,324
Sierra Madre	25,000	6,219,225	0.918	0.296	0.968	0.263	0.324	0.347	0.375	0.414	1.00	16,330	20,134	21,555	23,351	25,736
Sonoma	5,000	3,417,654	0.950	0.406	0.968	0.374	0.461	0.493	0.534	0.589	1.00	12,765	15,740	16,850	18,254	20,118
South Lake Tahoe	100,000	21,513,777	1.098	0.123	0.968	0.130	0.161	0.172	0.186	0.205	1.00	28,030	34,562	37,000	40,084	44,176
St. Helena	10,000	7,700,076	0.912	0.374	0.968	0.330	0.407	0.435	0.472	0.520	1.00	25,402	31,321	33,531	36,325	40,034
Tehama	5,000	65,000	0.950	0.406	0.968	0.374	0.461	0.493	0.534	0.589	1.00	243	299	320	347	383
Trinidad	5,000	357,000	0.950	0.406	0.968	0.374	0.461	0.493	0.534	0.589	1.00	1,333	1,644	1,760	1,907	2,101
Truckee	25,000	12,055,837	0.868	0.296	0.968	0.248	0.306	0.328	0.355	0.391	1.00	29,931	36,904	39,508	42,801	47,171
Twentynine Palms	10,000	2,472,000	1.250	0.374	0.968	0.452	0.558	0.597	0.647	0.713	1.00	11,177	13,782	14,754	15,984	17,616
Ukiah	25,000	20,480,152	0.805	0.296	0.968	0.230	0.284	0.304	0.329	0.363	1.00	47,170	58,161	62,264	67,453	74,340
Watsonville	250,000	40,571,986	1.250	0.000	0.968	0.000	0.000	0.000	0.000	0.000	1.00	0	0	0	0	0
Wheatland	5,000	1,724,000	1.250	0.406	0.968	0.491	0.606	0.649	0.703	0.775	1.00	8,473	10,447	11,184	12,116	13,353
Wildomar	5,000	1,433,403	0.950	0.406	0.968	0.374	0.461	0.493	0.534	0.589	1.00	5,354	6,601	7,067	7,656	8,438
Willits	5,000	3,577,634	0.950	0.406	0.968	0.374	0.461	0.493	0.534	0.589	1.00	13,363	16,476	17,639	19,109	21,060
Windsor	10,000	10,108,262	0.884	0.374	0.968	0.320	0.394	0.422	0.457	0.504	1.00	32,323	39,854	42,666	46,222	50,941
Yountville	10,000	3,885,925	0.950	0.374	0.968	0.344	0.424	0.454	0.491	0.542	1.00	13,354	16,465	17,627	19,096	21,045
Yucaipa	50,000	5,257,920	0.932	0.189	0.968	0.171	0.211	0.225	0.244	0.269	1.00	8,980	11,073	11,854	12,842	14,153
Yucca Valley	100,000	4,160,493	0.950	0.123	0.968	0.113	0.139	0.149	0.161	0.178	1.00	4,689	5,782	6,190	6,706	7,390
Total		$404,011,092										$924,567	$1,139,991	$1,220,429	$1,322,131	$1,457,118

Appendix A
Option 4

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 X-Mods

	Non-Zero Claims (A)	5-year 50K Losses (B)	Estimated 5-year Payrolls (C)	% 5-year Losses (D)	% 5-year Payrolls (E)	Ratio (F)	Min/Max 5%/33% Credibility (G)	X-mod (H)
Amador City	0	0	182,926	0%	0%	0.000	0.050	0.950
Arcata	0	0	43,229,053	0%	3%	0.000	0.125	0.875
Avalon	2	51,085	28,684,572	3%	2%	1.882	0.087	1.250
Belvedere	1	44,379	6,901,612	3%	0%	6.794	0.050	1.250
Blue Lake	0	0	2,209,569	0%	0%	0.000	0.050	0.950
California City	5	140,669	33,740,377	10%	2%	4.405	0.101	1.250
Calimesa	0	0	5,182,048	0%	0%	0.000	0.050	0.950
Calistoga	2	6,160	25,183,758	0%	2%	0.258	0.077	1.181
Citrus Heights	3	52,502	92,626,115	4%	6%	0.599	0.235	1.250
Clearlake	4	110,946	16,876,694	8%	1%	6.946	0.053	1.250
Cloverdale	0	0	18,474,372	0%	1%	0.000	0.058	0.942
Coalinga	3	72,412	26,999,542	5%	2%	2.834	0.082	1.250
Cotati	1	946	13,564,466	0%	1%	0.074	0.050	1.024
Eureka	4	200,000	71,358,084	14%	5%	2.961	0.191	1.250
Ferndale	1	7,221	3,211,527	0%	0%	2.376	0.050	1.250
Fort Bragg	0	0	17,467,785	0%	1%	0.000	0.055	0.945
Fortuna	0	0	22,037,349	0%	1%	0.000	0.068	0.932
Grass Valley	1	5,420	33,982,662	0%	2%	0.168	0.101	1.067
Healdsburg	0	0	60,298,267	0%	4%	0.000	0.167	0.833
Highland	0	0	13,377,986	0%	1%	0.000	0.050	0.950
Lakeport	1	3,031	14,137,853	0%	1%	0.226	0.050	1.176
Menifee	2	59,931	25,554,017	4%	2%	2.478	0.078	1.250
Nevada City	3	57,694	12,223,025	4%	1%	4.987	0.050	1.250
Placentia	1	50,000	57,159,373	3%	4%	0.924	0.159	1.250
Placerville	0	0	30,716,611	0%	2%	0.000	0.092	0.908
Plymouth	0	0	2,727,614	0%	0%	0.000	0.050	0.950
Point Arena	0	0	1,507,085	0%	0%	0.000	0.050	0.950

Appendix A
Option 4

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 X-Mods

	Non-Zero Claims (A)	5-year 50K Losses (B)	Estimated 5-year Payrolls (C)	% 5-year Losses (D)	% 5-year Payrolls (E)	Ratio (F)	Min/Max 5%/33% Credibility (G)	X-mod (H)
Rancho Cucamonga	14	179,225	150,916,126	12%	10%	1.255	0.333	1.250
Rancho Cucamonga FD	0	0	52,563,123	0%	3%	0.000	0.148	0.852
Rancho Santa Margarita	0	0	13,231,815	0%	1%	0.000	0.050	0.950
Rohnert Park	1	50,000	83,515,674	3%	5%	0.633	0.217	1.250
San Juan Bautista	0	0	2,602,561	0%	0%	0.000	0.050	0.950
Sebastopol	1	50,000	23,952,043	3%	2%	2.206	0.074	1.250
Sierra Madre	0	0	26,847,233	0%	2%	0.000	0.082	0.918
Sonoma	0	0	13,569,255	0%	1%	0.000	0.050	0.950
South Lake Tahoe	2	42,172	86,678,416	3%	6%	0.514	0.223	1.250
St. Helena	0	0	29,225,694	0%	2%	0.000	0.088	0.912
Tehama	0	0	177,847	0%	0%	0.000	0.050	0.950
Trinidad	0	0	1,644,629	0%	0%	0.000	0.050	0.950
Truckee	0	0	46,005,982	0%	3%	0.000	0.132	0.868
Twentynine Palms	2	61,363	11,476,669	4%	1%	5.649	0.050	1.250
Ukiah	1	140	73,518,350	0%	5%	0.002	0.196	0.806
Watsonville	7	223,523	144,533,697	15%	9%	1.634	0.324	1.250
Wheatland	1	3,654	7,312,885	0%	0%	0.528	0.050	1.250
Wildomar	0	0	5,489,347	0%	0%	0.000	0.050	0.950
Willits	0	0	14,185,189	0%	1%	0.000	0.050	0.950
Windsor	0	0	39,550,815	0%	3%	0.000	0.116	0.884
Yountville	0	0	13,772,903	0%	1%	0.000	0.050	0.950
Yucaipa	0	0	21,993,772	0%	1%	0.000	0.068	0.932
Yucca Valley	0	0	13,379,390	0%	1%	0.000	0.050	0.950
Total	63	$1,472,472	$1,555,757,757	100%				

demographic characteristics, loss experience of all public entities participating in the PROGRAM and differences in benefits provided (plan design), if any.

SDRMA will administrate a billing to ENTITY each month, with payments due by the date specified by SDRMA. Payments received after the specified date will accrue penalties up to and including termination from the PROGRAM. Premiums are based on a full month, and there are no partial months or prorated premiums. Enrollment for mid-year qualifying events and termination of coverage will be made in accordance with the SDRMA Program Administrative Guidelines.

5. BENEFITS. Benefits provided to ENTITY participants shall be as set forth in ENTITY's Plan Summary for the PROGRAM and as agreed upon between the ENTITY and its recognized employee organizations as applicable. Not all plan offerings will be available to ENTITY, and plans requested by ENTITY must be submitted to PROGRAM underwriter for approval.

6. COVERAGE DOCUMENTS. Except as otherwise provided herein, coverage documents from each carrier outlining the coverage provided, including terms and conditions of coverage, are controlling with respect to the coverage of the PROGRAM and will be provided by SDRMA to each ENTITY. SDRMA will provide each ENTITY with additional documentation, defined as the SDRMA Program Administrative Guidelines which provide further details on administration of the PROGRAM.

7. PROGRAM FUNDING. It is the intent of this MEMORANDUM to provide for a fully funded PROGRAM by any or all of the following: pooling risk; purchasing individual stop loss coverage to protect the pool from large claims; and purchasing aggregate stop loss coverage.

8. ASSESSMENTS. Should the PROGRAM not be adequately funded for any reason, pro-rata assessments to the ENTITY may be utilized to ensure the approved funding level for applicable policy periods. Any assessments which are deemed necessary to ensure approved funding levels shall be made upon the determination and approval of the COMMITTEE in accordance with the following:

   a. Assessments/dividends will be used sparingly. Generally, any over/under funding will be factored into renewal rates.

   b. If a dividend/assessment is declared, allocation will be based upon each ENTITY's proportional share of total premiums paid for the preceding 3 years. An ENTITY must be a current participant to receive a dividend, except upon termination of the PROGRAM and distribution of assets.

Appendix B
Option 4

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premiums
$250,000 Pool Limit

	2021-22 Deductible (A)	Estimated 2021-22 Payroll (B)	X-mod (C)	Base Rate (D)	Off Balance (E)	Rate for Layer from Deductible to $250,000 Pool Limit Expected (F)	75% (F)	80% (F)	85% (F)	90% (F)	Frequency Adjustment Factor (G)	Premium for Layer from Deductible to $250,000 Pool Limit Expected (H)	75% (H)	80% (H)	85% (H)	90% (H)
Amador City	10,000	35,000	1.000	0.374	0.983	0.367	0.453	0.485	0.525	0.579	0.95	122	151	161	175	193
Arcata	5,000	10,004,194	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	0.95	37,960	46,805	50,107	54,283	59,825
Avalon	25,000	5,250,000	1.000	0.296	0.983	0.291	0.358	0.384	0.416	0.458	1.10	16,780	20,690	22,150	23,995	26,445
Belvedere	25,000	2,943,625	1.000	0.296	0.983	0.291	0.358	0.384	0.416	0.458	1.05	8,981	11,073	11,855	12,842	14,154
Blue Lake	5,000	503,874	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	0.95	1,912	2,357	2,524	2,734	3,013
California City	100,000	7,136,124	1.000	0.123	0.983	0.121	0.149	0.159	0.172	0.190	1.10	9,461	11,665	12,488	13,529	14,910
Calimesa	10,000	2,126,792	1.000	0.374	0.983	0.367	0.453	0.485	0.525	0.579	0.95	7,425	9,155	9,800	10,617	11,701
Calistoga	10,000	5,702,662	1.000	0.374	0.983	0.367	0.453	0.485	0.525	0.579	1.10	23,051	28,422	30,428	32,963	36,329
Citrus Heights	100,000	21,513,986	1.000	0.123	0.983	0.121	0.149	0.159	0.172	0.190	1.10	28,522	35,168	37,649	40,787	44,951
Clearlake	25,000	4,772,835	1.000	0.296	0.983	0.291	0.358	0.384	0.416	0.458	1.10	15,255	18,809	20,136	21,814	24,042
Cloverdale	5,000	4,312,001	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	0.95	16,361	20,174	21,597	23,397	25,786
Coalinga	25,000	6,925,291	1.000	0.296	0.983	0.291	0.358	0.384	0.416	0.458	1.10	22,135	27,292	29,218	31,652	34,884
Cotati	5,000	4,041,493	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	1.05	16,949	20,898	22,373	24,237	26,712
Eureka	25,000	16,151,203	1.000	0.296	0.983	0.291	0.358	0.384	0.416	0.458	1.10	51,622	63,650	68,141	73,820	81,357
Ferndale	5,000	693,416	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	1.05	2,908	3,586	3,839	4,159	4,583
Fort Bragg	5,000	4,089,753	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	0.95	15,518	19,134	20,484	22,191	24,457
Fortuna	5,000	5,468,152	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	0.95	20,748	25,583	27,388	29,670	32,699
Grass Valley	25,000	7,125,000	1.000	0.296	0.983	0.291	0.358	0.384	0.416	0.458	1.05	21,738	26,803	28,694	31,085	34,259
Healdsburg	5,000	17,937,173	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	0.95	68,061	83,919	89,840	97,327	107,264
Highland	25,000	3,213,600	1.000	0.296	0.983	0.291	0.358	0.384	0.416	0.458	0.95	8,871	10,937	11,709	12,685	13,980
Lakeport	10,000	3,647,730	1.000	0.374	0.983	0.367	0.453	0.485	0.525	0.579	1.05	14,075	17,354	18,579	20,127	22,182
Menifee	25,000	18,315,703	1.000	0.296	0.983	0.291	0.358	0.384	0.416	0.458	1.10	58,540	72,180	77,273	83,713	92,260
Nevada City	25,000	2,802,105	1.000	0.296	0.983	0.291	0.358	0.384	0.416	0.458	1.10	8,956	11,043	11,822	12,807	14,115
Placentia	100,000	17,016,217	1.000	0.123	0.983	0.121	0.149	0.159	0.172	0.190	1.05	21,534	26,551	28,425	30,794	33,937
Placerville	50,000	7,792,934	1.000	0.189	0.983	0.186	0.230	0.246	0.266	0.293	0.95	13,783	16,994	18,193	19,709	21,721
Plymouth	5,000	660,000	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	0.95	2,504	3,088	3,306	3,581	3,947
Point Arena	5,000	295,000	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	0.95	1,119	1,380	1,478	1,601	1,764

Appendix B
Option 4

California Intergovernmental Risk Authority (CIRA) - Employee Practices Liability
2021-22 Estimated Premiums
$250,000 Pool Limit

	2021-22 Deductible (A)	Estimated 2021-22 Payroll (B)	X-mod (C)	Base Rate (D)	Off Balance (E)	Rate for Layer from Deductible to $250,000 Pool Limit: Expected (F)	75% (F)	80% (F)	85% (F)	90% (F)	Frequency Adjustment Factor (G)	Premium for Layer from Deductible to $250,000 Pool Limit: Expected (H)	75% (H)	80% (H)	85% (H)	90% (H)
Rancho Cucamonga	250,000	31,308,573	1.000	0.000	0.983	0.000	0.000	0.000	0.000	0.000	1.10	0	0	0	0	0
Rancho Cucamonga FD	75,000	15,295,870	1.000	0.152	0.983	0.150	0.185	0.198	0.214	0.236	0.95	21,753	26,821	28,714	31,107	34,283
Rancho Santa Margarita	10,000	2,609,185	1.000	0.374	0.983	0.367	0.453	0.485	0.525	0.579	0.95	9,109	11,231	12,023	13,025	14,355
Rohnert Park	25,000	22,640,187	1.000	0.296	0.983	0.291	0.358	0.384	0.416	0.458	1.05	69,073	85,167	91,176	98,775	108,859
San Juan Bautista	5,000	829,382	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	0.95	3,147	3,880	4,154	4,500	4,960
Sebastopol	5,000	5,851,688	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	1.05	24,541	30,259	32,394	35,093	38,676
Sierra Madre	25,000	6,219,225	1.000	0.296	0.983	0.291	0.358	0.384	0.416	0.458	0.95	17,167	21,167	22,661	24,549	27,056
Sonoma	5,000	3,417,654	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	0.95	12,968	15,989	17,118	18,544	20,438
South Lake Tahoe	100,000	21,513,777	1.000	0.123	0.983	0.121	0.149	0.159	0.172	0.190	1.10	28,522	35,168	37,649	40,786	44,951
St. Helena	10,000	7,700,076	1.000	0.374	0.983	0.367	0.453	0.485	0.525	0.579	0.95	26,881	33,144	35,483	38,440	42,364
Tehama	5,000	65,000	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	0.95	247	304	326	353	389
Trinidad	5,000	357,000	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	0.95	1,355	1,670	1,788	1,937	2,135
Truckee	25,000	12,055,837	1.000	0.296	0.983	0.291	0.358	0.384	0.416	0.458	0.95	33,278	41,032	43,927	47,588	52,447
Twentynine Palms	10,000	2,472,000	1.000	0.374	0.983	0.367	0.453	0.485	0.525	0.579	1.10	9,992	12,321	13,190	14,289	15,748
Ukiah	25,000	20,480,152	1.000	0.296	0.983	0.291	0.358	0.384	0.416	0.458	1.05	62,483	77,042	82,478	89,351	98,473
Watsonville	250,000	40,571,986	1.000	0.000	0.983	0.000	0.000	0.000	0.000	0.000	1.10	0	0	0	0	0
Wheatland	5,000	1,724,000	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	1.05	7,230	8,915	9,544	10,339	11,395
Wildomar	5,000	1,433,403	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	0.95	5,439	6,706	7,179	7,778	8,572
Willits	5,000	3,577,634	1.000	0.406	0.983	0.399	0.492	0.527	0.571	0.629	0.95	13,575	16,738	17,919	19,412	21,394
Windsor	10,000	10,108,262	1.000	0.374	0.983	0.367	0.453	0.485	0.525	0.579	0.95	35,288	43,510	46,580	50,462	55,614
Yountville	10,000	3,885,925	1.000	0.374	0.983	0.367	0.453	0.485	0.525	0.579	0.95	13,566	16,727	17,907	19,399	21,380
Yucaipa	50,000	5,257,920	1.000	0.189	0.983	0.186	0.230	0.246	0.266	0.293	0.95	9,299	11,466	12,275	13,298	14,656
Yucca Valley	100,000	4,160,493	1.000	0.123	0.983	0.121	0.149	0.159	0.172	0.190	0.95	4,764	5,874	6,288	6,812	7,507
Total		$404,011,092										$924,567	$1,139,991	$1,220,429	$1,322,131	$1,457,118

X-MOD FACTOR FORMULA FOR PROPERTY PROGRAM

SUMMARY: At the last transition committee meeting, Mike Simmons presented the PRISM property coverage option for CIRA. As we move forward with securing property coverage, staff has prepared an X-Mod formula for allocating property premiums among members.

RECOMMENDATION: Approve property X-Mod calculation.

DISCUSSION: As part of the calculation of members premiums, members prior losses and premiums are factored into creating an X-Mod. By applying an X-Mod to members property premiums not only will insured values be used to calculate members premiums but losses will as well. This will ensure that those with high losses, which drive rising excess costs, will offset some of those additional costs while still sharing risk among pool members.

The proposed X-Mod calculation is as follows:

1) 5 years of member premiums compared to 5 years of member losses capped at $100,000 calculates member loss ratio.

2) Members with a loss ratio over 75% will be charged a surcharge not to exceed 125% of base premium based on insured values.

3) Surcharges applied to base premium as follows:

    a. 75% - 100% loss ratio = 5% surcharge

    b. 100% - 150% loss ratio = 5% surcharge

    c. 150% - 200% loss ratio = 10% surcharge

    d. 200% - 250% loss ratio = 10% surcharge

    e. Above 250% - No additional surcharge

4) Reallocate base premium among members with surcharge applied to members with a loss ratio over 75%.

FISCAL IMPLICATIONS: Reallocation of premiums to apply a surcharge to members with loss rations over 75%.

ATTACHMENT: Sample Property Allocation Spreadsheet

CIRA

Property Premuim Allocation - 25% Cap with Loss Limit at $100,000, Loss Ratio Load at 75% (Example)

	A	B	C	D	E	F	G	H	I	J	K	L
						(A+B+C+D+E)	(F/ ttl. F)	As of 3/31/17				
Member	15/16 Prop. Prem.	16/17 Prop. Prem.	17/18 Prop. Prem.	18/19 Prop. Prem.	19/20 Prop. Prem.	Five Years Premium Totals	*% of Total*	Incurred Claims above deductible to $100,000	Five Year Loss Ratio	Property Premium FY 20/21 Excl. Flood & Earthquake	Claim Count	125% Max Premium
	66,281	57,469	61,847	65,301	91,266	342,164	***21.11%***	101,792	**30%**	116,708	**4**	145,885
	4,778	4,502	7,643	7,954	9,183	34,060	***2.10%***	0	**0%**	14,148	**0**	17,685
	45,307	40,144	56,302	59,829	96,414	297,996	***18.39%***	317,988	**107%**	121,317	**8**	151,646
	96,665	89,636	66,114	67,501	82,153	402,069	***24.81%***	0	**0%**	103,959	**1**	129,949
	80,059	77,648	106,573	121,473	141,767	527,520	***32.55%***	959,295	**182%**	182,558	**5**	228,198
	0	0	0	1,473	4,251	5,724	***0.35%***	75,225	**1314%**	5,471	**0**	6,839
	2,443	1,832	1,969	2,163	2,540	10,947	***0.68%***	0	**0%**	3,262	**0**	4,078
Total:	**295,533**	**271,231**	**300,448**	**325,694**	**427,574**	**1,620,480**	***100%***	**1,454,300**	**90%**	**547,423**	**18**	**684,279**

CIRA

Property Premuim Allocation - 25% Cap with Loss Limit at $100,000, Loss Ratio Load at 75% (Example)

M	N	O	P	Q	R	S	T	U	V	W	Z	AA	AB
						(M + N +O + P + Q + R)	(J + S)						
Loss Ratio above *75%* 5.00%	Loss Ratio above *100%* 5.00%	Loss Ratio above *150%* 10.00%	Loss Ratio above *200%* 10.00%	Loss Ratio above *250%* 0.00%	Loss Ratio above *300%* 0.00%	Premium PENALTY	New Premium before rebalance	New Premium AFTER rebalance	Capped Premium at 125%	Rebalanced Premium	Flood Premium	Earthquake Premium	Allocated Premium
$0	$0	$0	$0	$0	$0	0	116,708	106,889	106,889	106,889	-	-	106,889
$0	$0	$0	$0	$0	$0	0	14,148	12,958	12,958	12,958	-	-	12,958
$6,066	$6,066	$0	$0	$0	$0	12,132	133,449	122,222	122,222	122,222	53,036	-	175,258
$0	$0	$0	$0	$0	$0	0	103,959	95,213	95,213	95,213	-	-	95,213
$9,128	$9,128	$18,256	$0	$0	$0	36,512	219,070	200,639	200,639	200,639	-	18,000	218,639
$274	$274	$547	$547	$0	$0	1,641	7,112	6,514	6,514	6,514	-	-	6,514
$0	$0	$0	$0	$0	$0	0	3,262	2,988	2,988	2,988	9,143	-	12,131
						50,285	**597,708**	**547,423**	547,423	**547,423**	62,179	18,000	**627,602**

HEALTH BENEFITS FOR CIRA EMPLOYEES

SUMMARY: The CIRA Transition Committee has directed staff to move forward with acquiring health coverage for employees through SDRMA. As part of the process, a resolution is needed to withdraw PARSAC from the CalPERS Health Program effective January 1, 2022. An additional resolution is needed to enroll CIRA in the SDRMA Health Program and the Program's Memorandum of Understanding must be adopted with coverage beginning January 1, 2022.

RECOMMENDATION: 1) Approve Resolution to withdraw PARSAC from the CalPERS Health Program; 2) Approve Resolution to join SDRMA Health Program; 3) Adopt SDRMA Health Program Memorandum of Understanding.

DISCUSSION: At the last CIRA Transition Committee meeting, staff was directed to move forward with securing employee health benefits through SDRMA. As part of the process to withdraw PARSAC employees from the CalPERS Health Program, a resolution will need to be submitted to CalPERS to terminate coverage effective the new plan year beginning January 1, 2022. Health coverage for CIRA employees for the period July 1, 2021 – December 31, 2021, will continue through their current provider. Health benefits coverage will begin through SDRMA for all employees of CIRA effective January 1, 2022. SDRMA's resolution and memorandum of understanding will need to be approved for membership in their program.

FISCAL IMPLICATIONS: None

ATTACHMENT: Resolution to withdraw from CalPERS Health Program
Resolution to join SDRMA Health Program
SDRMA Health Plan Memorandum of Understanding

RESOLUTION NO. Number
ELECTING CEASE TO BE SUBJECT TO
THE PUBLIC EMPLOYEES' MEDICAL AND HOSPITAL CARE ACT

(000 All Employees PERS)

WHEREAS, (1) Government Code Section 22938 provides that a contracting agency which has elected to be subject to the Public Employees' Medical and Hospital Care Act (the "Act") may cease to be so subject by proper application by the contracting agency; and

WHEREAS, (2) Public Agency Risk Sharing Authority of California is a contracting agency under Government Code Section 22920 and subject to the Act; now, therefore be it

RESOLVED, (a) Public Agency Risk Sharing Authority of California elects to cease to be subject to the Act; and be it further

RESOLVED, (b) That coverage under the Act cease on December 31, 2021.

Adopted at a regular or special meeting of the Governing Body at Location, this Day day of Month, Year.

Signed: _____
(President, Chairman, etc.)

Attest: _____
(Secretary or appropriate officer)

RESOLUTION NO. _____

A RESOLUTION OF THE OF THE (GOVERNING BODY) OF California Intergovernmental Risk Authority APPROVING THE FORM OF AND AUTHORIZING THE EXECUTION OF A MEMORANDUM OF UNDERSTANDING AND AUTHORIZING PARTICIPATION IN THE SPECIAL DISTRICT RISK MANAGEMENT AUTHORITY'S HEALTH BENEFITS PROGRAM

WHEREAS, California Intergovernmental Risk Authority, a public agency duly organized and existing under and by virtue of the laws of the State of California (the "ENTITY"), has determined that it is in the best interest and to the advantage of the ENTITY to participate in the Health Benefits Program offered by Special District Risk Management Authority (the "Authority"); and

WHEREAS, the Authority was formed in 1986 in accordance with the provisions of California Government Code 6500 *et seq.,* for the purpose of providing risk financing, risk management programs and other coverage protection programs; and

WHEREAS, participation in Authority programs requires the ENTITY to execute and enter into a Memorandum of Understanding which states the purpose and participation requirements for the Health Benefits Program; and

WHEREAS, all acts, conditions and things required by the laws of the State of California to exist, to have happened and to have been performed precedent to and in connection with the consummation of the transactions authorized hereby do exist, have happened and have been performed in regular and due time, form and manner as required by law, and the ENTITY is now duly authorized and empowered, pursuant to each and every requirement of law, to consummate such transactions for the purpose, in the manner and upon the terms herein provided.

NOW, THEREFORE, BE IT RESOLVED BY THE GOVERNING BODY OF THE ENTITY AS FOLLOWS:

Section 1. Findings. The ENTITY's Governing Body hereby specifically finds and determines that the actions authorized hereby relate to the public affairs of the ENTITY.

Section 2. Memorandum of Understanding. The Memorandum of Understanding, to be executed and entered into by and between the ENTITY and the Authority, in the form presented at this meeting and on file with the ENTITY's Secretary, is hereby approved. The ENTITY's Governing Body and/or Authorized Officers ("The Authorized Officers") are hereby authorized and directed, for and in the name and on behalf of the ENTITY, to execute and deliver to the Authority the Memorandum of Understanding.

Section 3. Program Participation. The ENTITY's Governing Body approves participating in the Special District Risk Management Authority's Health Benefits Program.

Section 4. Other Actions. The Authorized Officers of the ENTITY are each hereby authorized and directed to execute and deliver any and all documents which are necessary in order to consummate the transactions authorized hereby and all such actions heretofore taken by such officers are hereby ratified, confirmed and approved.

Section 5. Effective Date. This resolution shall take effect immediately upon its passage.

PASSED AND ADOPTED this _____ day of _____, 20_____ by the following vote:

AYES: _____

NOES: _____

ABSENT: _____

_____
Name

_____
Title

_____
ENTITY Secretary

MEMORANDUM OF UNDERSTANDING

THIS MEMORANDUM OF UNDERSTANDING (HEREAFTER "MEMORANDUM") IS ENTERED INTO BY AND BETWEEN THE SPECIAL DISTRICT RISK MANAGEMENT AUTHORITY (HEREAFTER "SDRMA") AND THE PARTICIPATING PUBLIC ENTITY (HEREAFTER "ENTITY") WHO IS SIGNATORY TO THIS MEMORANDUM.

WHEREAS, on August 1, 2006, SDRMA was appointed administrator for the purpose of enrolling small public entities into the Public Risk Innovation, Solutions and Management (PRISM) Health and/or Employee Benefits Small Group Program (hereinafter "PROGRAM"); and

WHEREAS, the terms and conditions of the PROGRAM as well as benefit coverage, rates, assessments, and premiums are governed by the PRISM Health Committee and/or PRISM Employee Benefits Committee for the PROGRAM (the "COMMITTEE") and not SDRMA; and

WHEREAS, ENTITY desires to enroll and participate in the PROGRAM.

NOW THEREFORE, SDRMA and ENTITY agree as follows:

1. PURPOSE**.** ENTITY is signatory to this MEMORANDUM for the express purpose of enrolling in the PROGRAM.

2. ENTRY INTO PROGRAM**.** ENTITY shall enroll in the PROGRAM by making application through SDRMA which shall be subject to approval by the PROGRAM's Underwriter and governing documents and in accordance with applicable eligibility guidelines.

3. MAINTENANCE OF EFFORT**.** PROGRAM is designed to provide an alternative health benefit solution to all participants of the ENTITY including active employees, retired employees (optional), dependents (optional) and public officials (optional). ENTITY public officials may participate in the PROGRAM only if they are currently being covered and their own ENTITY's enabling act, plans and policies allow it. ENTITY must contribute at least the minimum percentage required by the eligibility requirements

4. PREMIUMS. ENTITY understands that premiums and rates for the PROGRAM are set by the COMMITTEE. ENTITY will remit monthly premiums based upon rates established for each category of participants and the census of covered employees, public officials, dependents and retirees.

   Rates for the ENTITY and each category of participant will be determined by the COMMITTEE designated for the PROGRAM based upon advice from its consultants and/or a consulting Benefits Actuary and insurance carriers. In addition, SDRMA adds an administrative fee to premiums and rates for costs associated with administering the PROGRAM. Rates may vary depending upon factors including, but not limited to,

c. ENTITY will be liable for assessments for 12 months following withdrawal from the PROGRAM.

d. Fund equity will be evaluated on a total PROGRAM-wide basis as opposed to each year standing on its own.

9. WITHDRAWAL. ENTITY may withdraw subject to the following condition: ENTITY shall notify SDRMA and the PROGRAM in writing of its intent to withdraw at least 90 days prior to their requested withdrawal date. ENTITY may rescind its notice of intent to withdraw. Once ENTITY withdraws from the PROGRAM, there is a 3-year waiting period to come back into the PROGRAM, and the ENTITY will be subject to underwriting approval again.

10. LIAISON WITH SDRMA. Each ENTITY shall maintain staff to act as liaison with SDRMA and between the ENTITY and SDRMA's designated PROGRAM representative.

11. GOVERNING LAW. This MEMORANDUM shall be governed in accordance with the laws of the State of California.

12. VENUE. Venue for any dispute or enforcement shall be in Sacramento, California.

13. ATTORNEY FEES. The prevailing party in any dispute shall be entitled to an award of reasonable attorney fees.

14. COMPLETE AGREEMENT. This MEMORANDUM together with the related PROGRAM documents constitutes the full and complete agreement of the ENTITY.

15. SEVERABILITY. Should any provision of this MEMORANDUM be judicially determined to be void or unenforceable, such determination shall not affect any remaining provision.

16. AMENDMENT OF MEMORANDUM. This MEMORANDUM may be amended by the SDRMA Board of Directors and such amendments are subject to approval of ENTITY's designated representative, or alternate, who shall have authority to execute this MEMORANDUM. Any ENTITY who fails or refuses to execute an amendment to this MEMORANDUM shall be deemed to have withdrawn from the PROGRAM on the next annual renewal date.

17. EFFECTIVE DATE. This MEMORANDUM shall become effective on the later of the first date of coverage for the ENTITY or the date of signing of this MEMORANDUM by the Chief Executive Officer or Board President of SDRMA.

18. EXECUTION IN COUNTERPARTS. This MEMORANDUM may be executed in several counterparts, each of which shall be an original, all of which shall constitute but one and the same instrument.

In Witness Whereof, the undersigned have executed the MEMORANDUM as of the date set forth below.

Dated: _____ By: _____

Special District Risk
Management Authority

Dated: _____ By: _____

California Intergovernmental Risk Authority

Tel 800.537.7790
Fax 916.231.4111
www.sdrma.org

AGREEMENT BETWEEN THE

CALIFORNIA INTERGOVERNMENTAL RISK AUTHORITY and REDWOOD EMPIRE MUNICIPAL INSURANCE FUND for ADMINISTRATION OF REDWOOD EMPIRE MUNICIPAL INSURANCE FUND'S HEALTH PLAN

This contract is dated for identification this 26th day of May, 2021, and is made by and between the California Intergovernmental Risk Authority (CIRA) and the Redwood Empire Municipal Insurance Fund (REMIF).

RECITALS

A. REMIF desires to retain the services of CIRA to provide administration of the REMIF self-insured health plan, which includes a medical, dental, and vision plan. And, to provide administration of the REMIF self-insured early retiree coverage and the fully insured retiree, life, disability and EAP coverage.

B. CIRA is a governmental risk pool formed under Government Code Section 6500 et seq. which authorizes two or more public entities to jointly exercise, under an agreement, any power which is common to each of them and qualified to provide the services outlined below.

NOW, THEREFORE, in consideration of the recitals and mutual promises contained herein, REMIF does hereby engage CIRA, and CIRA agrees, to perform the services set forth herein in accordance with the following terms and conditions:

1. Description of Services.

CIRA shall provide the following services:

1. General oversight of the REMIF Health Program (medical, dental, vision, retiree/early retiree, life, disability and EAP), which includes:

a. Monitoring the status of the Program and its operations, the development of losses, the program's administrative and operational costs, service companies' performance, and brokers' performance;

b. Work with the Third-Party Administrators, including but not limited to the following:

i. Periodically review Third-Party Administrators' claims files;

ii. Provide guidance to the Third-Party Administrator on the management of problem or complex claims;

iii. Compliance with program requirements, as well as local and federal laws; and

iv. Mediate differences, if any, between the Third Party Administrator and a Participant.

c. Work with Health Care Committee on establishing practice/policy;

d. Complete actuarial study annual and determine appropriate funding;

e. Ensure all plan documents are current, to include SPDs and policies and procedures.

f. Obtain REMIF Board of Director approval of funding for the Program and any changes to the Program.

2. Schedule and Term.

CIRA shall commence work under this contract on July 1, 2021 and shall continue until termination, pursuant to the terms of the agreement.

3. Compensation.

The annual compensation for services under this contract shall be determined by the Board of Directors and based on the budgetary expenses of that calendar year that area allocated to the REMIF Health Plan and shall not exceed $ 300,000.

4. Payment Schedule.

REMIF shall make periodic payments within thirty (30) days of receiving and approving a billing statement in proportion to the satisfactory completion of CIRA's services.

5. Termination.

Either party may terminate this Agreement at any time, for any and no reason, by providing 120 days advance written notice to the other party.

6. Independent Contractor.

It is agreed that CIRA is an independent contractor, and all persons working for or under the direction of CIRA are CIRA's agents, servants and employees, and said persons shall not be deemed agents, servants, or employees of REMIF.

7. Applicable Laws and Attorneys' Fees.

This Agreement shall be construed and enforced pursuant to the laws of the State of California. Should any legal action be brought by a party for breach of this Agreement or to enforce any provision herein, the prevailing party of such action shall be entitled to reasonable attorneys' fees, court costs, and such other costs as may be fixed by the court. Reasonable attorney fees shall be based upon comparable fees of private attorneys practicing in Sacramento County.

8. Indemnification.

Each party hereto (hereafter, "indemnifying Party") shall indemnify, defend and hold harmless the other party, its officers, agents, employees and volunteers against any loss, cost, damage, expense, claim, suit, demand, or liability of any kind or character, including but not limited to reasonable attorney fees, arising from or relating to any negligent or wrongful act or omission of the Indemnifying Party, its officers, agents or employees, which occurs in the performance of, or otherwise in connection with, this agreement, but only in proportion to and to the extent such loss, cost, damage, expense, claim, suit, demand, or liability of any kind or character, including reasonable attorney fees, is caused by or results from the negligent or wrongful act or omission of the Indemnifying Party, its officers, agents, or employees.

9. Reliance Upon Professional Skill.

It is mutually agreed by the parties that REMIF is relying upon the professional skill of CIRA, and CIRA represents to REMIF that its work shall conform to generally recognized professional standards in the industry. Acceptance of CIRA's work by REMIF does not operate as a release of CIRA's said representation.

11. Amendment.

This Agreement may be amended by written instrument signed by both parties.

12. Inconsistent Terms.

If the attachments or exhibits to this Agreement, if any, are inconsistent with this Agreement, this Agreement shall control.

13. Entire Agreement.

This Agreement contains the entire understanding between the parties with respect to the subject matter herein. There are no representations, agreements or understandings (whether oral or written) between or among the parties relating to the subject matter of this Agreement which are not fully expressed herein. If the attachments or exhibits to this Agreement, if any, are inconsistent with this Agreement, this Agreement shall control.

14. Notices.

Any notice required to be given to CIRA shall be deemed to be duly and properly given if mailed to CIRA, postage prepaid, addressed to:

CIRA
Attn: General Manager
1525 Response Rd #1,
Sacramento, CA 95815

or personally delivered to CIRA at such address or at such other addresses as CIRA may designate in writing to REMIF.

Any notice required to be given to REMIF shall be deemed to be duly and properly given if mailed to REMIF, postage prepaid, addressed to:

REMIF
Attn: Board President
414 W. Napa Street
Sonoma, CA 95476

or personally delivered to REMIF at such address or at such other addresses as REMIF may designate in writing to CIRA.

IN WITNESS WHEREOF, this Agreement is executed by CIRA and by REMIF.

APPROVED AS TO FORM AND CONTENT:

By: _____

CIRA President

REMIF:

By: _____

REMIF President

Sample Resolution

Authorizing Participation in ERMA

(*Agency Name*)

RESOLUTION OF THE (*AGENCY NAME*) AUTHORIZING PARTICIPATION IN THE EMPLOYMENT RISK MANAGEMENT AUTHORITY

WHEREAS, the (*Agency Name)* wishes to obtain Employment Practices Liability coverage for the period (*date*); and

WHEREAS, the Employment Risk Management Authority (ERMA) is a self-insured joint powers authority created for the sole purpose of Employment Practices Liability Coverage. ERMA is comprised of various public entities who risk share up to $1 million against potentially unlawful employment practices and discrimination claims; and

WHEREAS, ERMA formed primarily due to the fact that government entities have not historically been able to secure Employment Practices Liability (EPL) coverage at a competitive cost through the commercial insurance marketplace; and

WHEREAS, ERMA has met all of the high professional standards established by the California Association of Joint Powers Authorities (CAJPA) in the areas of governance, finance, claims control, safety and loss control and ERMA is fully accredited by CAJPA. CAJPA's accreditation process requires reviews by independent consultants in the areas of accounting, claims adjusting, and actuarial analysis; and

WHEREAS, ERMA provides services to both Joint Powers Insurance Authorities and individual public entities; and

WHEREAS, the (*Agency Name*) has determined that it is in the best interest to become a member of ERMA for the purpose of obtaining Employment Practices Liability coverage; and

WHEREAS, ERMA requires the (*Agency Name*) to pass a resolution expressing the desire and commitment of the (*Agency Name*)'s participation in ERMA, which requires a three year minimum participation period. (*Agency Name*) also understands our entity will be bound by the provisions in the ERMA Joint Powers

Agreement just as though it were fully set forth and incorporated herein whether our entity had signed it individually or through an underlying Joint Powers Insurance Authority.

NOW, THEREFORE, BE IT RESOLVED BY THE (*AGENCY NAME*):

THAT, the (*Agency Name*) approves participation in ERMA (*date*); and

THAT, the (*Executive Director/or City Manager*) on behalf of the (*Agency Name*) is hereby authorized to take any and all actions necessary to implement the foregoing resolution.

I hereby certify that the foregoing resolution is a full, true and correct copy of a resolution passed by (Agency Name) on (date).

_____
Secretary/Executive Director

ADOPTED: (date) RESOLUTION NO. (#)

State of California
Department of Industrial Relations
Office of Self-Insurance Plans
11050 Olson Drive, Suite 230
Rancho Cordova,Ca. 95670
Phone (916) 464-7000
Fax (916) 464-7007

Clear | Save | Print

State of California
Department of Industrial Relations
OFFICE OF SELF-INSURANCE PLANS

APPLICATION FOR CERTIFICATE OF CONSENT TO SELF-INSURE AS A PUBLIC AGENCY EMPLOYER SELF-INSURER

All questions must be answered. If not applicable, enter "N/A".

To the Director of the Department of Industrial Relations: The public agency employer identified below submits the following information to obtain a Certificate of Consent to Self-Insure the payment of workers' compensation under California Labor Code Section 3700.

LEGAL NAME OF APPLICANT (Show exactly as on Charter or other official documents):

_____

Address: _____

City: _____ State: _____ Zip + 4: _____ - _____

Federal Tax ID # of Group: _____

CONTACT - Who Should Correspondence Regarding This Applicant Be Addressed To:

Name: _____ Title: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip + 4: _____ - _____

Phone: _____ E-Mail: _____

TYPE OF PUBLIC ENTITY (Check one):

☐ City and/or County ☐ School District ☐ Police and/or Fire District ☐ Hospital District

☐ Joint Powers Authority ☐ Other (describe): _____

TYPE OF APPLICATION (Check one):

☐ New Application ☐ Reapplication (Merger/Unification) ☐ Reapplication (Name Change)

☐ Other (describe): _____

Date Self-Insurance Program will begin: _____

CURRENT WORKERS' COMPENSATION PROGRAM

☐ Currently Insured with State Fund Policy # _____ Expiration Date: _____

☐ Currently Self Insured, Certificate # _____

☐ Other (describe): _____

CLAIMS ADMINISTRATION

Who will be administering your agency's workers' compensation claims? (Check one)

☐ JPA will administer

☐ Third Party Administrator, TPA Certificate # _____

☐ Public entity will self-administer ☐ Insurance Carrier will administer

Name of Third Party Administrator:

Name: _____ Title: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip + 4: _____ - _____

Phone: _____ E-Mail: _____

# of claims reporting locations to be used to handle Agency's claims: _____

Does applicant currently have a California Certificate of Consent to Self-Insure? ☐ Yes ☐ No

If yes, what is the current Certificate Number: _____

Total Number of Affiliate's California employees to be covered by Group: _____

AGENCY EMPLOYER

Current # of Agency Employees: _____ # of Public Safety Employees (police//fire): _____

If school District, # of certificated employees: _____

Will all Agency employees be covered by this self-insurance plan? ☐ Yes ☐ No

If 'No', explain who is not covered and how workers' compensation coverage will be provided to the excluded employees:

_____

JOINT POWERS AUTHORITY

Will applicant be a member of a JPA for workers' compensation ?

☐ Yes ☐ No (If 'yes', complete the following)

Effective date of JPA Membership: _____ JPA Certificate # _____

Name of JPA: _____

AGENCY SAFETY PROGRAM

Does the Agency have a written Injury and Illness Prevention Program (IIPP)? ☐ Yes ☐ No

Individual responsible for Agency workplace safety and IIPP program:

Name: _____ Title: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip + 4: _____ - _____

Phone: _____ E-Mail: _____

SUPPLEMENTAL COVERAGE

1.) Will your program be supplemented by any insurance or pooled coverage under a **STANDARD** workers' compensation insurance policy? ☐ Yes ☐ No (If 'Yes', complete the following):

Name of Excess Pool/Carrier: _____

Policy #: _____ Effective Date of Coverage: _____

2.) Will your program be supplemented by any insurance or pooled coverage under a **SPECIFIC EXCESS** workers' compensation insurance policy? ☐ Yes ☐ No (If 'Yes', complete the following):

Name of Excess Pool/Carrier: _____

Policy #: _____ Effective Date of Coverage: _____

Retention Limits: _____

3.) Will your program be supplemented by any insurance or pooled coverage under an **AGGREGATE EXCESS** (stop loss) specific excess workers' compensation insurance policy? ☐ Yes ☐ No (If 'Yes', complete the following):

Name of Excess Pool/Carrier: _____

Policy #: _____ Effective Date of Coverage: _____

Retention Limits: _____

RESOLUTION FROM GOVERNING BOARD

Attach a properly executed Governing Board Resolution. See attached sample resolution on page 5.

CERTIFICATION

The undersigned on behalf of the applicant hereby applies for a Certificate of Consent to Self-Insure the payment of workers' compensation liabilities pursuant to Labor Code Section 3700. The above information is submitted for the purpose of procuring said Certificate from the Director of Industrial Relations, State of California. If the Certificate is issued, the applicant agrees to comply with applicable California statutes and regulations pertaining to the payment of compensation that may become due to the applicant's employees covered by the Certificate.

X_____ DATE: _____
SIGNED: Authorized Official / Representative

_____
Printed Name

_____
Title

_____
Agency Name

RESOLUTION NO.: _____ DATED: _____

**A RESOLUTION AUTHORIZING APPLICATION
TO THE DIRECTOR OF INDUSTRIAL RELATIONS, STATE OF CALIFORNIA
FOR A CERTIFICATE OF CONSENT TO SELF-INSURE
WORKERS' COMPENSATION LIABILITIES**

At a meeting of the _____
(Enter Name of the Board)

of the _____
(Enter Name of Public Agency, District, Etc.)

a _____ organized and existing under the
(Enter Type of Agency, i.e., County, City, School District, etc.)

laws of the State of California, held on the _____ day of _____, 20___,

the following resolution was adopted:

RESOLVED, that the above named public agency is authorized and empowered to make application to the Director of Industrial Relations, State of California, for a Certificate of Consent to Self-Insure workers' compensation liabilities and representatives of Agency are authorized to execute any and all documents required for such application.

IN WITNESS WHEREOF: I HAVE SIGNED AND AFFIXED THE AGENCY SEAL.

X_____ DATE: _____
SIGNED: Board Secretary or Chair

_____
Printed Name

_____
Title

Affix Seal Here

_____
Agency Name

REMIF
REDWOOD
EMPIRE
MUNICIPAL
INSURANCE
FUND

414 W. Napa Street | 2nd Floor, Suite C | Sonoma, CA 95476
Phone (707) 938-2388 | Fax (707) 938-0374 | www.remif.com

Member Cities: Arcata, Cloverdale, Cotati, Eureka,
Ft. Bragg, Fortuna, Healdsburg, Lakeport, Rohnert Park,
St. Helena, Sebastopol, Sonoma, Ukiah, Willits, Windsor

ITEM 11.0

AGENDA ITEM SUMMARY

TITLE: HEALTH PROGRAM
PRESENTED BY: AMY NORTHAM, GENERAL MANAGER

ISSUE

Changes to the REMIF self-insured health care plan (medical, dental, vision) require ratification by the Board of Directors. A Health Care Committee has been appointed to review and discuss issues surrounding the REMIF health care plan and provide recommendations to the Board of Directors for ratification.

BACKGROUND

REMIF has offered a self-insured health plan since 2015. The Board of Directors has contracted with RealCare/NFP as the broker for health care and other benefits. The plan uses the Anthem Blue Cross network and is administered through a third party, HealthComp.

A Health Care Committee has been appointed to review and discuss issues surrounding the REMIF health care plan and provides recommendations to the Board of Directors for consideration. The Committee recently addressed the following:

1. Emergency Protocols

Because of the numerous wildfires happening in California, Anthem has instituted emergency protocols for their fully insured groups. Most of the protocols that have adopted are already in place for the REMIF Self-Funded plan. However, Anthem added one additional protocol that should be considered:

Allow members to receive emergency **or urgent care** from any doctor or hospital, even if they are not in the plan's network. Claims are paid as if they are in the plan's network.

The REMIF plan already pays 100% of emergency care if rendered in an emergency room for in and out of network providers. If adopted, the REMIF plan could consider extending this for care received **in an urgent care setting**.

The Health Care Committee recommends the Board of Directors:
Because of the complexity of administering this (Health Comp would have to administer this benefit on an appeal basis only) the Committee decided to leave the benefit unchanged.

2. Request from City of Lakeport's Police Department to be added to REMIF health plan (medical, dental, vision)

From time-to-time agencies request that bargaining groups covered elsewhere be included on the REMIF benefit programs. Lakeport's Police Department is currently covered by the Operating Engineers 3 group health plan. They would like to join the REMIF benefit plans effective 7-1-21.

There are currently 10 active members and 2 early retirees.

Lakeport has filled out the New Agency Questionnaire and returned all the documentation needed for RealCare's Actuary to assess what an appropriate surcharge would be should this addition be approved. This information is currently being reviewed by the Actuary. Because the requested effective date is so far into the future, the surcharge will be a preliminary estimate and will be adjusted, if necessary, based upon current claims information submitted closer to the requested effective date.

The Health Care Committee recommends the Board of Directors:
Explore allowing the Lakeport Police Department to join the REMIF health plan.

3. Waiver of LiveHealth Online Co-pay

During the COVID 19 pandemic, the $10 copay was been waived for LiveHealth Online visits, until 12/31/20. The Committee recommends the Board of Directors extend the waiver of the co-pay for LiveHealth Online visits until April 30, 21.

The Health Care Committee recommend the Board of Directors:
Extend the waiver of the co-pay for LiveHealth Online visits until April 30, 2021.

4. Update of the SPDs

Each plan year, the Summary Plan Description (SPD) needs to be updated with any plan changes and/or amendments that happened during the previous plan year. Staff worked with Nick Welle of Foley and Lardner to review, suggest and make any necessary changes to this year's SPD.

Foley and Lardner produced a revised SPD and RealCare submitted it to HealthComp and the Stop Loss carrier for review and approval, and all have approved the document.

While this will be discussed at the next Health Care Committee meeting, at the writing of this staff report, the meeting had not yet been held.

Staff recommends the Board of Directors:
Adopt the current year SPD.

FISCAL IMPACT

None

RECOMMENDED ACTIONS

The Health Care Committee recommends the Board of Directors:
1. Maintain the current benefits for emergency care with no changes.
2. Explore allowing the Lakeport Police Department to join the REMIF health plan.
3. Extend the waiver of the co-pay for LiveHealth Online visits until April 30, 2021.
4. Adopt the current year SPD.

ATTACHMENTS

11.1 DRAFT SPD

PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR
REDWOOD EMPIRE MUNICIPAL INSURANCE FUND GROUP HEALTH PLAN

Effective July 1, 2020

TABLE OF CONTENTS

INTRODUCTION

This document is a description of Redwood Empire Municipal Insurance Fund Group Health Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to provide Covered Persons with coverage for certain qualified health expenses.

The purpose of the Plan is to provide coverage for qualified expenses that are not covered by a third party. If the Plan pays benefits for any claim you incur as the result of negligence, willful misconduct, or other actions of a third party, the Plan will be subrogated to all your rights of recovery. You must promptly give the Plan Administrator notice of any claim you have against anyone else, including an insurer, which involves benefits you have received under the Plan. You will be required to reimburse the Plan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, your own insurance company as the result of judgment, settlement, or otherwise. In addition, you will be required to assist the administrator of the Plan in enforcing these rights and may not negotiate any agreements with a third party that would undermine the subrogation rights of the Plan. This recovery may be up to the entire amount you recover from third parties, and will not be reduced for attorney's fees or expenses incurred by you in obtaining this recovery. You should review the Program Policies and Procedures, incorporated herein by reference, for the full details of the Plan subrogation rights and obligations.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

For Plan Years that begin on or after July 1, 2015, to the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of providers as a Network Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, Pre-authorization or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

It is the intent of this Plan and the Plan Administrator to comply with all applicable Federal and State laws and regulations. In the event of non-compliance with any such law or regulation, the Plan Document will be deemed amended to comply with said law or regulation as of its effective date, and the remainder of the Plan Document will remain in full force and effect. Similarly, in the event a law or regulation applicable to this Plan becomes effective after the initial effective date of this Plan Document, said law or regulation will

be deemed included in this Plan Document as of its effective date and without the necessity of an amendment to this Plan Document.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Summary of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim arising out of an accidental illness or injury, including but not limited to worker's compensation claims.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

Non-Assignment: The Plan does not recognize assignments of rights or benefits to any third parties, including medical providers. Although the Plan may make payments directly to providers in the interests of convenience to an Enrolled Member, such payments do not make a provider an assignee or otherwise confer on the provider any rights under the Plan, including any right to claim any breach of fiduciary duty. This provision does not prohibit an Enrolled Member from designating any individual to act on their behalf, but will not confer or transfer to that person any rights or benefits.

Notice re U.S. Code §1557 Compliance –
Discrimination is Against the Law

Redwood Empire Municipal Insurance Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Redwood Empire Municipal Insurance Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Redwood Empire Municipal Insurance Fund:

1. Provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters; written information in other formats (large print, audio, accessible electronic formats, other formats)

2. Provides free language services to people whose primary language is not English, such as: Qualified interpreters; Information written in other languages.

If you need these services, contact Redwood Empire Municipal Insurance Fund.

If you believe that Redwood Empire Municipal Insurance Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Redwood Empire Municipal Insurance Fund
414 W. Napa Street
Sonoma, California 95476
(707) 938-2388
Fax Number: 1-707-938-0374
Email address: anortham@remif.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Redwood Empire Municipal Insurance Fund is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the OCR Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-442-7247
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag 1-800-442-7247
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-442-7247
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-442-7247

SUMMARY OF BENEFITS

Verification of Eligibility (800) 442-7247

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Summary are percentages paid by the Plan and are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are based on the Recognized Charges, with the exception of inpatient care in a network Hospital, or emergency room care; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Plan Administrator with questions about specific supplies, treatments or procedures.

Note: The following is a partial list of services that must be pre-authorized or reimbursement from the Plan may be reduced or denied.

Autism Treatment
Applied Behavioral Analysis Therapy
Air Ambulance for Non-Emergent Transport
All Bariatric Procedures
Certain Prosthetics
Diagnostics, including:

- **AmniSure® ROM Test**
- **Computed Tomography Scans with or without Computer Assisted Detection (CAD) for Lung Cancer Screening**
- **Genetic testing for cancer susceptibility**
- **Genetic testing for Inherited Peripheral Neuropathies**
- **Genetic testing for PTEN Hamartoma Tumor Syndrome**
- **High technology radiology services such as MRI, MRA, MEG, PET, CAT, CTA, MRS, CT/PT, SPECT, ECHO cardiology, and some nuclear technology services**
- **Myocardial sympathetic innervations imaging with or without SPECT**
- **Thyroid Fine Needle Aspirate Molecular Markers**

Facility Based Substance Abuse/Mental Disorder treatments
Foot Orthotics
Home Health Care
Infusion Therapy
Inpatient Hospitalizations

- **Elective Admissions**
- **OB Related Medical Stay (OB complications, Excludes childbirth)**
- **Newborn Stays beyond Mother (NICU)**
- **Inpatient Skilled Nursing Facility**
- **Rehabilitation Facility Admissions**
- **Organ, Bone Marrow, and Stem Cell Transplants**

Outpatient surgical procedures and treatments
Rehabilitation services beyond stated Plan limits
Sex Change/Transgender Surgical Procedures

Please see the Cost Management section in this booklet for details.

The attending Physician does not have to obtain Pre-authorization from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Failure to obtain pre-authorization for a service requiring pre-authorization under the terms of the Plan may result in a reduction of coverage or total denial of coverage of the service by the Plan. The list of services provided above is a partial list. For further details on how to determine if a service requires pre-authorization, see the Cost Management section of this booklet.

PROVIDER NETWORK STATUS

This Plan has entered into an agreement with certain Hospitals, Physicians, Centers of Medical Excellence (CME), and Blue Distinction Centers for Specialty Care (BDCSC), and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher coinsurance percentage for services obtained from Network Providers.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. In most cases it is the Covered Person's choice as to which Provider to use. Terms of agreements that allow Plan Access to Network Providers and other discounts may differ from provisions of the Plan and will be honored by the Plan as required.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

- If a Covered Person has obtained an authorized out of network referral to a Non-Network provider.
- If a Covered Person has a Medical Emergency requiring immediate care.
- If a Covered Person requires emergency ambulance transportation.
- If a covered person has no choice of a Network Provider and receives services by a Non-Network Provider at a network facility.
- If a Covered Person is a new member who enrolled in this plan as a result of the group changing health plans, and the Covered Person is receiving services for an acute, serious, or chronic mental or nervous disorder from a Non-Network provider, the Covered Person may be able to continue the course of treatment with the Non-Network provider for a reasonable period of time prior to transferring to a Network Provider.

Your provider network publishes a directory of Network Providers. The directory lists all Network providers in your area, including health care facilities such as Hospitals and skilled nursing facilities, physicians, laboratories, and diagnostic x-ray and imaging providers. You may call us at the customer service number listed on your ID card or you may write to us and ask us to send you a directory. You may also search for a Network provider using the "Provider Finder" function on our website. The listings include the credentials of Network providers such as specialty designations and board certification.

MAXIMUM ALLOWABLE AMOUNT

Network Providers

Covered services provided by Network Providers are reimbursed based on the Maximum Allowable Amount defined in the provider network agreement. Members are not responsible for covered charges in excess of the Maximum Allowable Amount.

If you go to a Hospital which is a Network Provider you should not assume all providers in that Hospital are also Network Providers. To receive the greater benefits afforded when covered services are provided by a Network Provider, you should request that all your provider services (such as services by an anesthesiologist) be performed by Network Providers whenever you enter a Hospital.

If you are planning to have outpatient surgery, you should first find out if the facility where the surgery is to be performed is an ambulatory surgical center. An ambulatory surgical center is licensed as a separate facility even though it may be located on the same grounds as a Hospital (although this is not always the case). If the center is licensed separately, you should find out if the facility is a Network Provider before undergoing the surgery.

Non-Network Providers

Services from Non-Network Providers may or may not be covered depending on the terms listed in your benefit summary. In some plans, services provided by Non-Network Providers will only be covered for emergency services, urgent care, or with an Authorized Referral.

Covered Services from a Non-Network Provider are paid according to the plan's determination of an Maximum Allowable Amount based on one of the following: the Non-Network Provider rate or fee for your plan; an amount negotiated by us or a third party vendor which has been agreed to by the Non-Network Provider or other health care provider; an amount derived from the total charges billed by the Non-Network provider; or an amount based on the plan's determination of Recognized Charge. Members are always responsible for covered charges in excess of the Maximum Allowable Amount when using Non-Network Providers for non-emergency services.

Members who receive emergency services from Non-Network providers are not responsible for covered charges in excess of the Maximum Allowable Amount.

Members who receive non-emergency services from Non-Network providers as an inpatient at a Network hospital are not responsible for covered charges in excess of the Maximum Allowable Amount.

EPO Plans: Diagnostic laboratory and surgical pathology test services performed by a Non-Network provider as the result of a referral by a Network Provider will be considered Covered Services for members on an EPO plan. Covered Services are paid according to the plan's determination of an Maximum Allowable Amount based on one of the following: the Non-Network Provider rate or fee for your plan; an amount negotiated by us or a third party vendor which has been agreed to by the Non-Network Provider or other health care provider; an amount derived from the total charges billed by the Non-Network provider; or an amount based on the plan's determination of Recognized Charge. Members are always responsible for covered charges in excess of the Maximum Allowable Amount when using Non-Network Providers for non-emergency services.

The Claims Administrator has the sole and absolute discretion to determine the Maximum Allowable Amount for a particular service, supply, or procedure, utilizes its own internal coverage guidelines to do so, and expressly disavows use of usual, customary, and reasonable standards.

Authorized Referrals

In some circumstances we may authorize you to receive services provided by a Non-Network Provider. In such circumstance, you or your physician must contact us in advance of obtaining the covered service you receive from a Non-Network Provider. It is your responsibility to ensure that we have been contacted. Under certain circumstances we may retroactively authorize referrals due to medical necessity. Retroactive referrals will be restricted to services rendered within six (6) months prior to request for authorization. If we authorize you to receive services provided by a Non-Network Provider, you may still be liable for the difference between the Maximum Allowable Amount and the Non-Network Provider's charge. Please call the customer service telephone number on your ID card for Authorized Referral information or to request authorization.

Clinical Trials

The Maximum Allowable Amount for services and supplies provided in connection with Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a Network Provider.

Medicare Primary

If Medicare is the primary payor, the Maximum Allowable Amount does not include any charge:

(1) By a Hospital, in excess of the approved amount as deemed by Medicare; or

(2) By a physician who is a Network Provider who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or

(3) By a physician who is a Non-Network Provider or other health care provider who accepts Medicare assignment, in excess of lesser of the Maximum Allowable Amount stated above, or the approved amount as determined by Medicare; or

(4) By a physician or other health care provider who does not accept Medicare assignment, in excess of the lesser of the Maximum Allowable Amount stated above, or the limiting charge as determined by Medicare.

MEMBER COST SHARE

For certain covered services, and depending on your plan design, you may be required to pay all or a part of the Maximum Allowable Amount as your cost share amount (Deductibles, Copayments or Coinsurance). Please see your plan's Summary of Benefits for your cost share responsibilities and limitations, or call the customer service telephone number on your ID card to learn how this plan's benefits or cost share amounts may vary by the type of provider you use.

The Plan will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your provider for non-covered services, regardless of whether such services are performed by a Network Provider, Non-Network Provider or other health care provider. Non-covered services include services specifically excluded from coverage by the terms of your plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Medical Benefit Maximums or day/visit limits.

Deductibles/Copayments/Coinsurance payable by Covered Persons (See additional information under Medical Benefits section below)

Plan Year Deductibles

Deductibles are dollar amounts that the Covered Person must pay before the Plan pays. A deductible is an amount of money that is paid once per Plan Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each July 1st, a new deductible amount is required.

Copayment

A copayment is a fixed amount of money that is paid each time a particular service is used. There may be copayments on some services and not on other services Copayments are listed in the Summary of Benefits.

Coinsurance

Coinsurance is the Covered Person's share of the cost for Covered Services which is a percentage of the Allowable Amount. Coinsurance is paid after the deductible has been met. Coinsurance is listed in the Summary of Benefits.

OUT OF POCKET MAXIMUM LIMIT

The out of pocket maximum limit is the most you could pay during a Plan Year for your share of the cost of covered services. A Covered Person may have separate out of pocket maximum limits for medical services and for prescription benefits. Once a Covered Person meets the Out of Pocket Maximum Limit, covered charges will be payable at 100% (except for any charges excluded from the Out of Pocket Maximum Limit for the rest of the Plan year).

Meeting the Out of Pocket Maximum Limit

The Plan deductibles, copayments and coinsurance amounts are included in the out of pocket maximum limit. If, after you have met your deductible, you pay copayments and coinsurance equal to your out of pocket maximum limit during the Plan Year, you will no longer be required to make copayments or coinsurance payments for additional covered services or supplies during the remainder of that Plan Year, except as specifically stated under Charges Which Do Not Apply Toward the Out Of Pocket Maximum Limit below.

Internal Coverage Guidelines

The Claims Administrator may utilize internal coverage guidelines to determine Allowable Amounts, to determine whether a particular charge or service is Medically Necessary, or for other purposes in its capacity as Claims Administrator. These internal coverage guidelines are expressly incorporated into this document by this reference and are binding.

Charges Which Do Not Apply Toward the Out of Pocket Maximum Limit

The following charges will not be applied to the out of pocket maximum limit:

- Charges which are not covered under this plan;
- Charges which exceed the Maximum Allowable Amount.
- For the Exclusive Provider Organization ("EPO") plans: Charges incurred for services and supplies from a Non-Network provider without an Authorized Referral unless in connection with an emergency or urgent care.

SUMMARY OF BENEFITS EPO 250		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
MEDICAL DEDUCTIBLE, PER PLAN YEAR		
Per Covered Person	$250	
Per Family Unit	$750	
Each year, each Covered Person will be responsible for satisfying the Medical Deductible before the Plan begins to pay benefits. I f members of an enrolled family pay Deductible expenses in a year equal to the Family Unit Deductible, the Plan Year Deductible for all family members will be considered to have been met.		
MEDICAL MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR		
Per Covered Person	$3,400	
Two Party	$6,800	
Per Family Unit	$10,000	
The Plan will pay the designated percentage of Maximum Allowable Amounts until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the medical plan out-of-pocket maximum and are never paid at 100%: • Cost containment penalties • Amounts over the Maximum Allowable Amount • Outpatient Prescription Drug charges		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Percentage Payable – unless otherwise stated.	100% after deductible for covered services from contracted (in network) providers. Members are not responsible for covered charges in excess of Maximum Allowable Amounts.	Covered services from non- contracted (out of network) providers are not covered except in cases of emergency or authorized out of network referral. Members are always responsible for covered charges in excess of Maximum Allowable Amounts.
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Abortion – Elective	100% after deductible	Not covered
Acupuncture Services	100% after deductible; 12 visits Plan Year maximum	Not covered
Advanced Imaging (Including CAT Scans, MRI, PET Scans) - Pre-authorization is required.	100% after $50 copayment per date of service and deductible	Not covered
Ambulance Service - Pre-authorization is required for non-emergent transport.	100% after deductible	100% after deductible
Bariatric Surgical Procedures – Services for bariatric surgical procedures are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.		
Bariatric Surgical Procedures – Facility	100% after deductible	Not covered
Bariatric Surgical Procedures – Physician	100% after deductible	Not covered
Bariatric Surgical Procedures – Travel Charges– Coverage is available when the closest BDCSC and CME is 50 miles or more from the Covered Person's residence.	100%; deductible waived; $3,000 maximum per surgery	
Blood	100% after deductible	Not covered
Diabetes Education	100% after $25 copayment; deductible waived	Not covered

SUMMARY OF BENEFITS EPO 250		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Diabetes Supplies (such as insulin pumps and glucometers)	100% after deductible	Not covered
Dialysis	100% after deductible	Not covered
Durable Medical Equipment - Pre-authorization is required.	100% after deductible	Not covered
Emergency Room Visit – Including professional services	100% after $150 copayment and deductible; Copayment waived if admitted.	100% after $150 copayment and deductible; Copayment waived if admitted.
Foot Orthotics – Pre-authorization Required	100% after deductible	Not covered
Hearing Aids	100% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.	100% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.
Home Health Care - Pre- authorization is required.	100% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less	Not covered
Hospice Care	100%; deductible waived	Not covered
Bereavement Counseling	100%; deductible waived	Not covered
Hospital Services		
Inpatient - the semiprivate room rate. Pre-authorization is required.	100% after deductible	Not covered
Ambulatory/Outpatient Surgery Facilities. Pre-authorization is required for certain procedures.	100% after deductible	Not covered
Outpatient Services - Pre-authorization is required for certain services.	100% after deductible	Not covered
Infusion Therapy (Pre-authorization required)	100% after deductible	Not covered
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)	100% after deductible	Not covered
Lab & X-ray – includes pre-admission testing.	100% after $10 copayment per date of service and deductible	Not covered
LiveHealth Online telemedicine: Medical & Behavioral Health	100% after $10 copayment, deductible waived	N/A
Telemedicine Not Provided by LiveHealth Online: Medical & Behavioral Health	Covered the same as any other care based on type of service rendered	Not Covered
Mental Disorders		
Inpatient - the facility's semiprivate room rate - Pre-authorization is required; waived for emergencies.	100% after deductible	Not covered
Outpatient - Pre-authorization is required for certain services.	100% after deductible	Not covered
Office Setting	100% after $25 copayment; deductible waived	Not covered
Nutritional Evaluation and Counseling – coverage for eating disorders only	100% after deductible	Not covered

SUMMARY OF BENEFITS EPO 250		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Organ Transplants – for recipient and donor. Charges are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.	Covered the same as any other care based on type of service rendered	Not covered
Bone Marrow / Stem Cell Unrelated Donor Searches	100% after deductible; $30,000 maximum per transplant	Not covered
Accommodations and Travel Charges – benefits are available when the closest CME or BDCSC is 75 miles or more from the recipient's or donor's residence.	100%; deductible waived; $10,000 maximum per transplant	
Physician Services		
Inpatient visits	100% after deductible	Not covered
Office visits	100% after $25 copayment; deductible waived	Not covered
Specialist Office visit	100% after $35 copayment; deductible waived	Not covered
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	100% after deductible	Not covered
Second Surgical Opinion	100% after $25 copayment or $35 specialist copayment; deductible waived	Not covered
Surgery (Inpatient and Outpatient)	100% after deductible	Not covered
Assistant Surgeon and Anesthesiologists	100% after deductible	Not covered
Allergy injections, serum and testing	100% after deductible	Not covered
Contraceptive Methods	100%; deductible waived	Not covered
Pregnancy		
Prenatal visits	100%; deductible waived	Not covered
Postnatal visits	100% after $25 copayment; deductible waived	Not covered
Delivery and All Other Services	Covered the same as any other care based on type of service rendered	Not covered
Preventive Care – Services as defined by the Patient Protection Affordable Care Act for both Network and Non-Network Providers.		
Routine Well Care – All ages	100%; deductible waived	Not covered
Smoking/Tobacco Cessation – (See prescription drug benefits for coverage regarding medications)	100%; deductible waived	Not covered
Prosthetics Pre-authorization is required for certain prosthetics	100% after deductible	Not covered
Rehabilitation – includes Physical and Occupational Therapies. Additional visits allowed if Medically Necessary	100% after deductible; 24 visits Plan Year maximum combined with spinal manipulation / chiropractic	Not covered

SUMMARY OF BENEFITS EPO 250		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Sex Change / Transgender Surgical Procedures - Pre- authorization is required.	100% after deductible	Not covered
Sex Change / Transgender Surgery Travel Charges – Coverage is available when the closest surgical facility is 75 miles or more from the Covered Person's residence.	100%; deductible waived; $10,000 maximum per surgery or series of surgeries	
Skilled Nursing Facility – the facility's semiprivate room rate. Pre-authorization is required.	100% after deductible; 100 days Plan Year maximum	Not covered
Speech Therapy	100% after deductible	Not covered
Spinal Manipulation / Chiropractic	100% after deductible; 24 visits Plan Year maximum combined with Rehabilitation	Not covered
Substance Abuse		
Inpatient - the facility's semiprivate room rate - Pre-authorization is required; waived for emergencies.	100% after deductible	Not covered
Outpatient - Pre-authorization is required for certain services.	100% after deductible	Not covered
Office Setting	100% after $25 copayment; deductible waived	Not covered
Urgent Care – includes physician services	100% after $25 copayment; deductible waived	100% after $25 copayment; deductible waived
Voluntary Sterilization		
Female	100%; deductible waived	Not covered
Male	100% after deductible	Not covered
Wigs	Not covered	Not covered

PRESCRIPTION DRUG BENEFIT SUMMARY EPO 250

Please refer to the Employee ID card for the Prescription Drug Administrator's phone number. Please contact the Prescription Drug Administrator for additional information.

Dispense As Written (DAW) Penalty. If the Covered Person or the Covered Person's doctor requests a brand- name medicine when a generic alternative is available, the Covered Person will pay the brand copay plus the difference in cost between the brand-name and the generic medicine.

SUMMARY OF BENEFITS EPO 250		
COVERED CHARGES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
PRESCRIPTION DRUG MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of-Pocket amounts are not combined.		
Per Covered Person	$1,600	Unlimited
Per Family Unit	$3,200	Unlimited
Copayments apply toward the out-of-pocket maximum. Once the out-of-pocket maximums are reached, the Plan will pay 100% for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the prescription drug plan out-of-pocket maximum and are never paid at 100%: • Charges for Medical Services • Charges in excess of the prescription drug plan Maximum Allowable Amount		
Retail Pharmacy Option (30 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $10 copayment	100% of Maximum Allowable Amount after $10 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $25 copayment	100% of Maximum Allowable Amount after $25 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $50 copayment	100% of Maximum Allowable Amount after $50 copayment, the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Retail 90 Maintenance Drug Pharmacy Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $15 copayment	100% of Maximum Allowable Amount after $15 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $38 copayment	100% of Maximum Allowable Amount after $38 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	100% of Maximum Allowable Amount after $75 copayment, the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount

Mail Order Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $15 copayment	Not covered
Tier 2 - Preferred Brand Name Drugs	100% after $38 copayment	Not covered
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	Not covered
Tier 4 - Specialty Pharmacy – must be obtained through Specialty Mail Order Service. 30-day supply only.	100% after $150 copayment	Not covered

In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network-participating pharmacy, will be covered at 100% with no deductible or co-insurance required.

Refer to the Prescription Drug Section for details on the Prescription Drug benefit.

SUMMARY OF BENEFITS BLUECARD PPO 250

BLUECARD PPO 250		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
MEDICAL DEDUCTIBLE, PER PLAN YEAR - Network and Non-Network Deductibles are combined.		
Per Covered Person	$250	
Per Family Unit	$750	
Each year, each Covered Person will be responsible for satisfying the Medical Deductible before the Plan begins to pay benefits. If members of an enrolled family pay Deductible expenses in a year equal to the Family Unit Deductible, the Plan Year Deductible for all family members will be considered to have been met.		
MEDICAL MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of-Pocket amounts are not combined.		
Per Covered Person	$3,400	$4,400
Two Party	$6,800	$8,800
Per Family Unit	$10,000	$14,800
The Plan will pay the designated percentage of Maximum Allowable Amounts until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the medical plan out-of-pocket maximum and are never paid at 100%: • Cost containment penalties • Amounts over the Maximum Allowable Amount • Outpatient Prescription Drug charges		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Plan Year maximum is 60 days total which may be split between Network and Non-Network providers.		
Percentage Payable – unless otherwise stated.	100% after deductible for covered services from contracted (in network) providers. Members are not responsible for covered charges in excess of Maximum Allowable Amounts.	70% after deductible for covered services from non-contracted (out of network) providers. Members are always responsible for covered charges in excess of Maximum Allowable Amounts.
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Abortion – Elective	100% after deductible	70% after deductible
Acupuncture Services	100% after deductible; 12 visits Plan Year maximum	70% after deductible; 12 visits Plan Year maximum
Advanced Imaging (Including CAT Scans, MRI, PET Scans) – Pre-authorization is required.	100% after $50 copayment per date of service deductible	70% after deductible; $800, maximum per procedure
Ambulance Service – Pre-authorization is required for non-emergent transport.	100% after deductible	100% after deductible; Air transport that is not related to an emergency is limited to up to $50,000 per trip. This limit includes all services and supplies.
Bariatric Surgical Procedures – Services for bariatric surgical procedures are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.		
Bariatric Surgical Procedures - Facility	100% after deductible	Not covered
Bariatric Surgical Procedures - Physician	100% after deductible	Not covered

BLUECARD PPO 250		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Bariatric Surgical Procedures – Travel Charges - Coverage is available when the closest BDCSC or CME is 50 miles or more from the Covered Person's residence.	100%; deductible waived; $3,000 maximum per surgery	
Blood	80% after deductible	70% after deductible
Diabetes Education	100% after $25 copayment; deductible waived	70% after deductible
Diabetes Supplies (such as insulin pumps and glucometers)	100% after deductible	70% after deductible
Dialysis	100% after deductible	70% after deductible; $350 maximum per visit for all services and supplies
Durable Medical Equipment - Pre-authorization is required.	100% after deductible	70% after deductible
Emergency Room Visit – Including professional services	100% after $150 copayment and deductible; Copayment waived if admitted.	100% after $150 copayment and deductible; Copayment waived if admitted.
Foot Orthotics – Pre-authorization is required	100% after deductible	70% after deductible
Hearing Aids	100% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.	100% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.
Home Health Care – Pre-authorization is required.	100% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less	70% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less
Hospice Care	100%; deductible waived	70% after deductible
Bereavement Counseling	100%; deductible waived	70% after deductible
Hospital Services		
Inpatient - the semiprivate room rate. Pre-authorization is required.	100% after deductible	70% after deductible. Failure to obtain pre-authorization may result in a financial penalty or total denial of coverage for Non-Anthem Blue Cross PPO Hospitals or residential treatment centers.
Ambulatory/Outpatient Surgery Facilities. Pre-authorization is required for certain procedures.	100% after deductible	70% after deductible; Ambulatory Surgical Centers are limited to $350 per admit for all services
Outpatient Services – Pre-authorization is required for certain services.	100% after deductible	70% after deductible
Infusion Therapy Pre-authorization is required.	100% after deductible	70% after deductible; $600 per day maximum for all home infusion services and supplies
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)	100% after deductible	70% after deductible
Lab & X-ray – includes pre-admission testing.	100% after $10 copayment per date of service and deductible	70% after deductible

BLUECARD PPO 250		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
LiveHealth Online telemedicine: Medical & Behavioral Health	100% after $10 copayment, deductible waived	N/A
Telemedicine Not Provided by LiveHealth Online: Medical & Behavioral Health	Covered the same as any other care based on type of service rendered	Covered the same as any other care based on type of service rendered
Mental Disorders		
Inpatient - the facility's Semiprivate room rate - Pre- authorization is required; waived for emergencies.	100% after deductible	70% after deductible Failure to obtain pre-authorization may result in a financial penalty or total denial of coverage for Non-Anthem Blue Cross PPO Hospitals or residential treatment centers
Outpatient - Pre-authorization is required for certain services.	100% after deductible	70% after deductible
Office Setting	100% after $25 copayment; deductible waived	70% after deductible
Nutritional Evaluation and Counseling – coverage for eating disorders only	100% after deductible	70% after deductible
Organ Transplants – for recipient and donor. Charges are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.	Covered the same as any other care based on type of service rendered	Not covered
Bone Marrow / Stem Cell Unrelated Donor Searches	100% after deductible; $30,000 maximum per transplant	70% after deductible; $30,000 maximum per transplant
Accommodations and Travel Charges– benefits are available when the closest CME or BDCSC is 75 miles or more from the recipient's or donor's residence.	100%; deductible waived; $10,000 maximum per transplant	
Physician Services		
Inpatient visits	100% after deductible	70% after deductible
Office visits	100% after $25 copayment; deductible waived	70% after deductible
Specialist Office visits	100% after $35 copayment; deductible waived	70% after deductible
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	100% after deductible	70% after deductible
Second Surgical Opinion	100% after $25 copayment or $35 specialist copayment; deductible waived	70% after deductible
Surgery (Inpatient and Outpatient)	100% after deductible	70% after deductible
Assistant Surgeon and Anesthesiologists	100% after deductible	70% after deductible
Allergy injections, serum and testing	100% after deductible	70% after deductible
Contraceptive Methods	100%; deductible waived	70% after deductible
Pregnancy		
Prenatal visits	100%; deductible waived	70% after deductible
Postnatal visits	100% after $25 copayment; deductible waived	70% after deductible

BLUECARD PPO 250		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Delivery and All Other Services	Covered the same as any other care based on type of service rendered	Covered the same as any other care based on type of service rendered
Preventive Care – Services as defined by the Patient Protection Affordable Care Act for both Network and Non-Network Providers.		
Routine Well Care – All ages	100%; deductible waived	70% after deductible
Smoking/Tobacco Cessation – (See prescription drug benefits for coverage regarding medications)	100%; deductible waived	Not covered
Prosthetics - Pre-authorization is required for certain prosthetics	100% after deductible	70% after deductible
Rehabilitation – includes Physical, and Occupational Therapies. Additional visits are allowed if Medically Necessary.	100% after deductible; 24 visits Plan Year maximum combined with spinal manipulation / chiropractic	70% after deductible; 24 visits Plan Year maximum combined with spinal manipulation / chiropractic
Sex Change / Transgender Surgical Procedures - Pre-authorization is required.	100% after deductible	Not covered
Sex Change / Transgender Surgery Travel Charges – Coverage is available when the closest surgical facility is 75 miles or more from the Covered Person's residence.	100%; deductible waived; $10,000 maximum per surgery or series of surgeries	
Skilled Nursing Facility – the facility's semiprivate room rate - Pre-authorization is required.	100% after deductible; 100 days Plan Year maximum	70% after deductible; 100 days Plan Year maximum
Speech Therapy	100% after deductible	70% after deductible
Spinal Manipulation Chiropractic	100% after deductible; 24 visits Plan Year maximum combined with Rehabilitation	70% after deductible; 24 visits Plan Year maximum combined with Rehabilitation
Substance Abuse		
Inpatient - the facility's semiprivate room rate - Pre- authorization is required; waived for emergencies.	100% after deductible	70% after deductible. Failure to obtain pre-authorization may result in a financial penalty or total denial of coverage for Non-Anthem Blue Cross PPO Hospitals or residential treatment centers
Outpatient - Pre-authorization is required for certain services.	100% after deductible	70% after deductible
Office Setting	100% after $25 copayment; deductible waived	70% after deductible
Urgent Care - includes physician services	100% after $25 copayment; deductible waived	100% after $25 copayment; deductible waived
Voluntary Sterilization		
Female	100%; deductible waived	70% after deductible
Male	100% after deductible	70% after deductible
Wigs – after chemotherapy	Not covered	Not covered

PRESCRIPTION DRUG BENEFIT SUMMARY BLUECARD PPO 250

Please refer to the Employee ID card for the Prescription Drug Administrator's phone number.

Please contact the Prescription Drug Administrator for additional information.

Dispense As Written (DAW) Penalty. If the Covered Person or the Covered Person's doctor requests a brand- name medicine when a generic alternative is available, the Covered Person will pay the brand copay plus the difference in cost between the brand-name and the generic medicine.

BLUECARD PPO 250		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
PRESCRIPTION DRUG MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of-Pocket amounts are not combined.		
Per Covered Person	$1,600	Unlimited
Per Family Unit	$3,200	Unlimited
Copayments apply toward the out-of-pocket maximum. Once the out-of-pocket maximums are reached, the Plan will pay 100% for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the prescription drug plan out-of-pocket maximum and are never paid at 100%: • Charges for Medical Services • Charges in excess of the prescription drug plan Maximum Allowable Amount		
Retail Pharmacy Option (30 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $10 copayment	100% of Maximum Allowable Amount after $10 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $25 copayment	100% of Maximum Allowable Amount after $25 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $50 copayment	100% of Maximum Allowable Amount after $50 copayment, the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Retail 90 Maintenance Drug Pharmacy Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $15 copayment	100% of Maximum Allowable Amount after $15 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $38 copayment	100% of Maximum Allowable Amount after $38 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	100% of Maximum Allowable Amount after $75 copayment, the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount

Mail Order Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $15 copayment	Not covered
Tier 2 - Preferred Brand Name Drugs	100% after $38 copayment	Not covered
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	Not covered
Tier 4 - Specialty Pharmacy – must be obtained through Specialty Mail Order Service. 30-day supply only.	100% after $150 copayment	Not covered

In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network-participating pharmacy, will be covered at 100% with no deductible or co-insurance required.

Refer to the Prescription Drug Section for details on the Prescription Drug benefit.

SUMMARY OF BENEFITS EPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
MEDICAL DEDUCTIBLE, PER PLAN YEAR		
Per Covered Person	$500	
Per Family Unit	$1,500	
Each year, each Covered Person will be responsible for satisfying the Medical Deductible before the Plan begins to pay benefits. If members of an enrolled family pay Deductible expenses in a year equal to the Family Unit Deductible, the Plan Year Deductible for all family members will be considered to have been met.		
MEDICAL MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR		
Per Covered Person	$3,400	
Two Party	$6,800	
Per Family Unit	$10,000	
The Plan will pay the designated percentage of Maximum Allowable Amounts until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. • Cost containment penalties • Amounts over the Maximum Allowable Amount • Outpatient Prescription Drug charges		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Percentage Payable – unless otherwise stated.	90% after deductible for covered services from contracted (in network) providers. Members are not responsible for covered charges in excess of Maximum Allowable Amounts.	Covered services from non- contracted (out of network) providers are not covered except in cases of emergency or authorized out of network referral. Members are always responsible for covered charges in excess of Maximum Allowable Amounts.
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Abortion - Elective	90% after deductible	Not covered
Acupuncture Services	90% after deductible; 12 visits Plan Year maximum	Not covered
Advanced Imaging (Including CAT Scans, MRI, PET Scans) - Pre-authorization is required.	90% after deductible	Not covered
Ambulance Service - Pre-authorization is required for non-emergent transport.	90% after deductible	90% after deductible
Bariatric Surgical Procedures – Services for bariatric surgical procedures are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.		
Bariatric Surgical Procedures - Facility	90% after deductible	Not covered
Bariatric Surgical Procedures - Physician	90% after deductible	Not covered
Bariatric Surgical Procedures – Travel Charges - Coverage is available when the closest BDCSC is 50 miles or more from the Covered Person's residence.	100%; deductible waived; $3,000 maximum per surgery	
Blood	90% after deductible	Not covered
Diabetes Education	100% after $30 copayment; deductible waived	Not covered

SUMMARY OF BENEFITS EPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Diabetes Supplies (such as insulin pumps and glucometers)	90% after deductible	Not covered
Dialysis	90% after deductible	Not covered
Durable Medical Equipment - Pre-authorization is required.	90% after deductible	Not covered
Emergency Room Visit – Including professional services	90% after $150 copayment and deductible; copayment waived if admitted	90% after $150 copayment and deductible; copayment waived if admitted
Foot Orthotics– Pre-authorization Required	90% after deductible	Not covered
Hearing Aids	90% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.	90% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.
Home Health Care - Pre- authorization is required.	90% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less	Not covered
Hospice Care	100%; deductible waived	Not covered
Bereavement Counseling	100%; deductible waived	Not covered
Hospital Services		
Inpatient - the semiprivate room rate. Pre-authorization is required.	90% after deductible	Not covered
Ambulatory/Outpatient Surgery Facilities. Pre-authorization is required for certain procedures.	90% after deductible	Not covered
Outpatient Services - Pre-authorization is required for certain services.	90% after deductible	Not covered
Infusion Therapy (Pre-authorization required)	90% after deductible	Not covered
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)	90% after deductible	Not covered
Lab & X-ray – includes pre-admission testing.	90% after deductible	Not covered
LiveHealth Online telemedicine: Medical & Behavioral Health	100% after $10 copayment, deductible waived	N/A
Telemedicine Not Provided by LiveHealth Online: Medical & Behavioral Health	Covered the same as any other care based on type of service rendered	Not Covered
Mental Disorders		
Inpatient - the facility's semiprivate room rate. Pre- authorization is required; waived for emergencies.	90% after deductible	Not covered
Outpatient - Pre-authorization is required for certain services.	90% after deductible	Not covered
Office Setting	100% after $30 copayment; deductible waived	Not covered
Nutritional Evaluation and Counseling – coverage for eating disorders only	90% after deductible	Not covered

SUMMARY OF BENEFITS EPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Organ Transplants – for recipient and donor. Charges are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.	Covered the same as any other care based on type of service rendered	Not covered
Bone Marrow / Stem Cell Unrelated Donor Searches	90% after deductible; $30,000 maximum per transplant	Not Covered
Accommodations and Travel Charges – benefits are available when the closest CME or BDCSC is 75 miles or more from the recipient's or donor's residence.	100%; deductible waived; $10,000 maximum per transplant	
Physician Services		
Inpatient visits	90% after deductible	Not covered
Office visits	100% after $30 copayment; deductible waived	Not covered
Specialist Office visits	100% after $40 copayment; deductible waived	Not covered
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	90% after deductible	Not covered
Second Surgical Opinion	100% after $30 copayment or $40 specialist copayment; deductible waived	Not covered
Surgery (Inpatient and Outpatient)	90% after deductible	Not covered
Assistant Surgeon and Anesthesiologists	90% after deductible	Not covered
Allergy injections, serum and testing	90% after deductible	Not covered
Contraceptive Methods	100%; deductible waived	Not covered
Pregnancy		
Prenatal visits	100%; deductible waived	Not covered
Postnatal visits	100% after $30 copayment; deductible waived	Not covered
Delivery and All Other Services	Covered the same as any other care based on type of service rendered	Not covered
Preventive Care – Services as defined by the Patient Protection Affordable Care Act for both Network and Non-Network Providers.		
Routine Well Care – All ages	100%; deductible waived	Not covered
Smoking/Tobacco Cessation – (See prescription drug benefits for coverage regarding medications)	100%; deductible waived	Not covered
Prosthetics Pre-authorization is required for certain prosthetics	90% after deductible	Not covered
Rehabilitation – includes Physical and Occupational Therapies. Additional visits allowed if Medically Necessary	90% after deductible; 24 visits Plan Year maximum combined with spinal manipulation / chiropractic	Not covered

SUMMARY OF BENEFITS EPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Sex Change / Transgender Surgical Procedures - Pre- authorization is required.	90% after deductible	Not Covered
Sex Change / Transgender Surgery Travel Charges – Coverage is available when the closest surgical facility is 75 miles or more from the Covered Person's residence.	100%; deductible waived; $10,000 maximum per surgery or series of surgeries	
Skilled Nursing Facility – the facility's semiprivate room rate. Pre-authorization is required	90% after deductible; 100 days Plan Year maximum	Not covered
Speech Therapy	90% after deductible	Not covered
Spinal Manipulation / Chiropractic	90% after deductible; 24 visits Plan Year maximum combined with Rehabilitation	Not covered
Substance Abuse		
Inpatient - the facility's semiprivate room rate - Pre-authorization is required; waived for emergencies.	90% after deductible	Not covered
Outpatient - Pre-authorization is required for certain services.	90% after deductible	Not covered
Office Setting	100% after $30 copayment; deductible waived	Not covered
Urgent Care - includes physician services	100% after $30 copayment; deductible waived	100% after $30 copayment; deductible waived
Voluntary Sterilization		
Female	100%; deductible waived	Not covered
Male	90% after deductible	Not covered
Wigs	Not covered	Not covered

PRESCRIPTION DRUG BENEFIT SUMMARY EPO 500

Please refer to the Employee ID card for the Prescription Drug Administrator's phone number.

Please contact the Prescription Drug Administrator for additional information.

Dispense As Written (DAW) Penalty. If the Covered Person or the Covered Person's doctor requests a brand- name medicine when a generic alternative is available, the Covered Person will pay the brand copay plus the difference in cost between the brand-name and the generic medicine.

SUMMARY OF BENEFITS EPO 500		
COVERED CHARGES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
PRESCRIPTION DRUG MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of-Pocket amounts are not combined.		
Per Covered Person	$1,600	Unlimited
Per Family Unit	$3,200	Unlimited
Copayments apply toward the out-of-pocket maximum. Once the out-of-pocket maximums are reached, the Plan will pay 100% for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the prescription drug plan out-of-pocket maximum and are never paid at 100%: • Charges for Medical Services • Charges in excess of the prescription drug plan Maximum Allowable Amount		
Retail Pharmacy Option (30 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $15 copayment	100% of Maximum Allowable Amount after $15 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $35 copayment	100% of Maximum Allowable Amount after $35 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $50 copayment	100% of Maximum Allowable Amount after $50 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Retail 90 Maintenance Drug Pharmacy Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $23 copayment	100% of Maximum Allowable Amount after $23 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $53 copayment	100% of Maximum Allowable Amount after $53 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	100% of Maximum Allowable Amount after $75 copayment, the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount

Mail Order Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $23 copayment	Not covered
Tier 2 - Preferred Brand Name Drugs	100% after $53 copayment	Not covered
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	Not covered
Tier 4 - Specialty Pharmacy – must be obtained through Specialty Mail Order Service. 30-day supply only.	100% after $150 copayment	Not covered

In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network-participating pharmacy, will be covered at 100% with no deductible or co-insurance required.

Refer to the Prescription Drug Section for details on the Prescription Drug benefit.

SUMMARY OF BENEFITS PPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
MEDICAL DEDUCTIBLE, PER PLAN YEAR - Network and Non-Network Deductibles are not combined.		
Per Covered Person	$500	$1,000
Per Family Unit	$1,500	$3,000
Each year, each Covered Person will be responsible for satisfying the Medical Deductible before the Plan begins to pay benefits. If members of an enrolled family pay Deductible expenses in a year equal to the Family Unit Deductible, the Plan Year Deductible for all family members will be considered to have been met.		
MEDICAL MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of-Pocket amounts are not combined.		
Per Covered Person	$3,400	$8,400
Two Party	$6,800	$16,800
Per Family Unit	$10,000	$26,800
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the medical plan out-of-pocket maximum and are never paid at 100%: • Cost containment penalties • Amounts over the Maximum Allowable Amount • Outpatient Prescription Drug charges		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Plan Year maximum is 60 days total which may be split between Network and Non-Network providers.		
Percentage Payable – unless otherwise stated.	80% after deductible for covered services from contracted (in network) providers. Members are not responsible for covered charges in excess of Maximum Allowable Amounts.	70% after deductible for covered services from non-contracted (out of network) providers. Members are always responsible for covered charges in excess of Maximum Allowable Amounts.
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Abortion – Elective	80% after deductible	70% after deductible
Acupuncture Services	80% after deductible; 12 visits Plan Year maximum	70% after deductible; 12 visits Plan Year maximum
Advanced Imaging (Including CAT Scans, MRI, PET Scans) - Pre-authorization is required.	80% after deductible	70% after deductible; $800 maximum per procedure
Ambulance Service - Pre-authorization is required for non-emergent transport.	80% after deductible	80% after deductible; Air transport that is not related to an emergency is limited to up to $50,000 per trip. This limit includes all services and supplies.
Bariatric Surgical Procedures – Services for bariatric surgical procedures are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.		
Bariatric Surgical Procedures - Facility	80% after deductible	Not covered

SUMMARY OF BENEFITS PPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Bariatric Surgical Procedures - Physician	80% after deductible	Not covered
Bariatric Surgical Procedures – Travel Charges - Coverage is available when the closest BDCSC or CME is 50 miles or more from the Covered Person's residence.	100%; deductible waived; $3,000 maximum per surgery	
Blood	80% after deductible	70% after deductible
Diabetes Education	100% after $30 copayment; deductible waived	100% after $50 copayment; deductible waived
Diabetes Supplies (such as insulin pumps and glucometers)	80% after deductible	70% after deductible
Dialysis	80% after deductible	70% after deductible; $350 maximum per visit for all services and supplies
Durable Medical Equipment - Pre-authorization is required.	80% after deductible	70% after deductible
Emergency Room Visit – Including professional services	80% after $150 copayment and deductible; Copayment waived if admitted	80% after $150 copayment and deductible; Copayment waived if admitted
Foot Orthotics - Pre-authorization is required.	80% after deductible	70% after deductible
Hearing Aids	80% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.	80% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.
Home Health Care - Pre- authorization is required.	80% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less	70% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less
Hospice Care	100%; deductible waived	70% after deductible
Bereavement Counseling	100%; deductible waived	70% after deductible
Hospital Services		
Inpatient - the semiprivate room rate. Pre-authorization is required.	80% after deductible	70% after deductible Failure to obtain pre-authorization may result in a financial penalty or total denial of coverage for Non-Anthem Blue Cross PPO Hospitals or residential treatment centers
Ambulatory/Outpatient Surgery Facilities. Pre-authorization is required for certain procedures.	80% after deductible	70% after deductible; Ambulatory Surgical Centers are limited to $350 per admit for all services
Outpatient Services - Pre-authorization is required for certain services.	80% after deductible	70% after deductible
Infusion Therapy (Pre-authorization is required)	80% after deductible	70% after deductible; $600 per day maximum for all home infusion services and supplies

SUMMARY OF BENEFITS PPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)	80% after deductible	70% after deductible
Lab & X-ray – includes pre-admission testing.	80% after deductible	70% after deductible
LiveHealth Online telemedicine: Medical & Behavioral Health	100% after $10 copayment, deductible waived	N/A
Telemedicine Not Provided by LiveHealth Online: Medical & Behavioral Health	Covered the same as any other care based on type of service rendered	Covered the same as any other care based on type of service rendered
Mental Disorders		
Inpatient - the facility's semiprivate room rate - Pre-authorization is required; waived for emergencies.	80% after deductible	70% after deductible. Failure to obtain pre- authorization may result in a financial penalty or total denial of coverage for Non-Anthem Blue Cross PPO Hospitals or residential treatment centers
Outpatient - Pre-authorization is required for certain services.	80% after deductible	70% after deductible
Office Setting	100% after $30 copayment; deductible waived	100% after $50 copayment; deductible waived
Nutritional Evaluation and Counseling – coverage for eating disorders only	80% after deductible	70% after deductible
Organ Transplants – for recipient and donor. Charges are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.	Covered the same as any other care based on type of service rendered	Not covered
Bone Marrow / Stem Cell Unrelated Donor Searches	80% after deductible; $30,000 maximum per transplant	70% after deductible; $30,000 maximum per transplant
Accommodations and Travel Charges – benefits are available when the closest CME or BDCSC is 75 miles or more from the recipient's or donor's residence.	100%; deductible waived; $10,000 maximum per transplant	
Physician Services		
Inpatient visits	80% after deductible	70% after deductible
Office visits	100% after $30 copayment; deductible waived	100% after $50 copayment; deductible waived
Specialist Office Visits	100% after $40 copayment; deductible waived	100% after $60 copayment; deductible waived
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	80% after deductible	70% after deductible
Second Surgical Opinion	100% after $30 copayment or $40 specialist copayment; deductible waived	100% after $50 copayment or $60 specialist copayment; deductible waived
Surgery (Inpatient and Outpatient)	80% after deductible	70% after deductible
Assistant Surgeon and Anesthesiologists	80% after deductible	70% after deductible
Allergy injections, serum and testing	80% after deductible	70% after deductible

SUMMARY OF BENEFITS PPO 500		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Contraceptive Methods	100%; deductible waived	70% after deductible
Pregnancy		
Prenatal visits	100%; deductible waived	100% after $50 copayment; deductible waived
Postnatal visits	100% after $30 copayment; deductible waived	100% after $50 copayment; deductible waived
Delivery and All Other Services	Covered the same as any other care based on type of service rendered	Covered the same as any other care based on type of service rendered
Preventive Care – Services as defined by the Patient Protection Affordable Care Act for both Network and Non-Network Providers.		
Routine Well Care – All ages	100%; deductible waived	70% after deductible
Smoking/Tobacco Cessation – (See prescription drug benefits for coverage regarding medications)	100%; deductible waived	Not covered
Prosthetics Pre-authorization is required for certain prosthetics	80% after deductible	70% after deductible
Rehabilitation – includes Physical and Occupational Therapies. Additional visits allowed if Medically Necessary	80% after deductible; 24 visits Plan Year maximum with spinal manipulation / chiropractic	70% after deductible; 24 visits Plan Year maximum with spinal manipulation / chiropractic
Sex Change / Transgender Surgical Procedures - Pre-authorization is required	80% after deductible	Not covered
Sex Change / Transgender Surgery Travel Charges – Coverage is available when the closest surgical facility is 75 miles or more from the Covered Person's residence.	100%; deductible waived; $10,000 maximum per surgery or series of surgeries	
Skilled Nursing Facility – the facility's semiprivate room rate. Pre-authorization is required	80% after deductible; 100 days Plan Year maximum	70% after deductible; 100 days Plan Year maximum
Speech Therapy	80% after deductible	70% after deductible
Spinal Manipulation / Chiropractic	80% after deductible; 24 visits Plan Year maximum combined with Rehabilitation	70% after deductible; 24 visits Plan Year maximum combined with Rehabilitation
Substance Abuse		
Inpatient - the facility's semiprivate room rate - Pre- authorization is required; waived for emergencies.	80% after deductible	70% after deductible. Failure to obtain pre-authorization may result in a financial penalty or total denial of coverage for Non-Anthem Blue Cross PPO Hospitals or residential treatment centers
Outpatient - Pre-authorization is required for certain services.	80% after deductible	70% after deductible
Office Setting	100% after $30 copayment; deductible waived	100% after $50 copayment; deductible waived
Urgent Care – includes physician services	100% after $30 copayment; deductible waived	100% after $30 copayment; deductible waived
Voluntary Sterilization		
Female	100%; deductible waived	70% after deductible
Male	80% after deductible	70% after deductible
Wigs – after chemotherapy	Not covered	Not covered

PRESCRIPTION DRUG BENEFIT SUMMARY PPO 500

Please refer to the Employee ID card for the Prescription Drug Administrator's phone number.

Please contact the Prescription Drug Administrator for additional information.

Dispense As Written (DAW) Penalty. If the Covered Person or the Covered Person's doctor requests a brand- name medicine when a generic alternative is available, the Covered Person will pay the brand copay plus the difference in cost between the brand-name and the generic medicine.

SUMMARY OF BENEFITS PPO 500		
COVERED CHARGES	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
PRESCRIPTION DRUG MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of-Pocket amounts are not combined.		
Per Covered Person	$1,600	Unlimited
Per Family Unit	$3,200	Unlimited
Copayments apply toward the out-of-pocket maximum. Once the out-of-pocket maximums are reached, the Plan will pay 100% for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the prescription drug plan out-of-pocket maximum and are never paid at 100%: • Charges for Medical Services • Charges in excess of the prescription drug plan Maximum Allowable Amount		
Retail Pharmacy Option (30 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $15 copayment	100% of Maximum Allowable Amount after $15 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $35 copayment	100% of Maximum Allowable Amount after $35 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $50 copayment	100% of Maximum Allowable Amount after $50 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Retail 90 Maintenance Drug Pharmacy Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $23 copayment	100% of Maximum Allowable Amount after $23 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after $53 copayment	100% of Maximum Allowable Amount after $53 copayment; the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	100% of Maximum Allowable Amount after $75 copayment, the Covered Person is responsible for all charges in excess of the Maximum Allowable Amount

Mail Order Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after $23 copayment	Not covered
Tier 2 - Preferred Brand Name Drugs	100% after $53 copayment	Not covered
Tier 3 - Non-Preferred Brand Name Drugs	100% after $75 copayment	Not covered
Tier 4 - Specialty Pharmacy – must be obtained through Specialty Mail Order Service. 30-day supply only.	100% after $150 copayment	Not covered

In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network-participating pharmacy, will be covered at 100% with no deductible or co-insurance required.

Refer to the Prescription Drug Section for details on the Prescription Drug benefit.

SUMMARY OF BENEFITS HDHP 1400

A qualified High Deductible Health Plan (HDHP) with a Health Savings Account provides comprehensive coverage for high cost medical events and a tax-advantaged way to help build savings for future medical expenses. The Plan gives you greater control over how health care benefits are used. A HDHP satisfies certain statutory requirements with respect to minimum deductibles and out-of-pocket expenses for both single and family coverage. These minimum deductibles and limits for out-of-pocket expenses' limit are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

SUMMARY OF BENEFITS HDHP 1400		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
DEDUCTIBLE, PER PLAN YEAR - Network and Non-Network Deductibles are combined.		
Single	$1,400	
Family Unit	$2,800	
For single coverage, the Covered Person must meet the individual deductible before any money is paid by the Plan for any Covered Charge. For family coverage, the Aggregate Deductible must be met as a Family Unit before any money is paid by the Plan for any Covered Charge.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR - Network and Non-Network Out-of- Pocket amounts are combined.		
Single	$5,000	
Family Unit	$10,000	
For single coverage, the Plan will pay the designated percentage of Allowable Amounts until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise. The Family out-of-pocket includes an embedded out-of-pocket whereby once an individual reaches single covered out-of-pocket costs, the Plan will pay 100% of the remainder of Covered Charges for that individual for the rest of the Plan Year unless stated otherwise. Once the Family out-of-pocket is reached, the Plan will pay 100% of the remainder of Covered Charges for the entire family for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: • Cost containment penalties • Amounts over the Maximum Allowable Amount		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Plan Year maximum is 60 days total which may be split between Network and Non-Network providers.		
Percentage Payable – unless otherwise stated.	90% after deductible for covered services from contracted (in network) providers. Members are not responsible for covered charges in excess of Maximum Allowable Amounts.	70% after deductible for covered services from non-contracted (out of network) providers. Members are always responsible for covered charges in excess of Maximum Allowable Amounts.
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Abortion – Elective	90% after deductible	70% after deductible
Acupuncture Services	90% after deductible; 12 visits Plan Year maximum	70% after deductible; 12 visits Plan Year maximum
Advanced Imaging (Including CAT Scans, MRI, PET Scans) - Pre-authorization is required.	90% after deductible	70% after deductible; $800 maximum per procedure

SUMMARY OF BENEFITS HDHP 1400		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Ambulance Service - Pre-authorization is required for non-emergent transport.	90% after deductible	90% after deductible; Air transport that is not related to an emergency is limited to up to $50,000 per trip. This limit includes all services and supplies.
Bariatric Surgical Procedures – Services for bariatric surgical procedures are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.		
Bariatric Surgical Procedures - Facility	90% after deductible	Not covered
Bariatric Surgical Procedures - Physician	90% after deductible	Not covered
Bariatric Surgical Procedures – Travel Charges– Coverage is available when the closest CME is 50 miles or more from the Covered Person's residence.	100% after deductible; $3,000 maximum per surgery	
Blood	90% after deductible	70% after deductible
Diabetes Education	90% after deductible	70% after deductible
Diabetes Supplies (such as insulin pumps and glucometers)	90% after deductible	70% after deductible
Dialysis	90% after deductible	70% after deductible; $350 maximum per visit for all services and supplies
Durable Medical Equipment - Pre-authorization is required.	90% after deductible	70% after deductible
Emergency Room Visit – Including professional services	90% after deductible	90% after deductible
Foot Orthotics - Pre-authorization is required.	90% after deductible	70% after deductible
Hearing Aids	90% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.	90% after deductible $2,500 maximum per ear every 36 months This maximum will not apply to medically necessary hearing aids for children up to age 18.
Home Health Care - Pre- authorization is required.	90% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less	70% after deductible; 100 visits Plan Year maximum; one visit by a home health aide equals four hours or less
Hospice Care	90% after deductible	70% after deductible
Bereavement Counseling	90% after deductible	70% after deductible
Hospital Services		
Inpatient - the semiprivate room rate. Pre-authorization is required.	90% after deductible	70% after deductible
Ambulatory/Outpatient Surgery Facilities. Pre-authorization is required for certain procedures.	90% after deductible	70% after deductible; Ambulatory Surgical Centers are limited to $350 per admit for all services
Outpatient Services - Pre-authorization is required for certain services.	90% after deductible	70% after deductible
Infusion Therapy (Pre-authorization require)	90% after deductible	70% after deductible; $600 per day maximum for all home infusion services and supplies

SUMMARY OF BENEFITS HDHP 1400		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)	90% after deductible	70% after deductible
Lab & X-ray – includes pre-admission testing.	90% after deductible	70% after deductible
LiveHealth Online telemedicine: Medical & Behavioral Health	90% after deductible	N/A
Telemedicine Not Provided by LiveHealth Online: Medical & Behavioral Health	Covered the same as any other care based on type of service rendered	Covered the same as any other care based on type of service rendered
Mental Disorders		
Inpatient - the facility's semiprivate room rate. Pre-authorization is required.	90% after deductible	70% after deductible
Outpatient - Pre-authorization is required for certain services.	90% after deductible	70% after deductible
Office Setting	90% after deductible	70% after deductible
Nutritional Evaluation and Counseling – coverage for eating disorders only	90% after deductible	70% after deductible
Organ Transplants – for recipient and donor. Charges are not covered when performed at other than a designated BDCSC or CME. Pre-authorization is required.	Covered the same as any other care based on type of service rendered	Not covered
Bone Marrow / Stem Cell Unrelated Donor Searches	90% after deductible; $30,000 maximum per transplant	70% after deductible; $30,000 maximum per transplant
Accommodations and Travel Charges – benefits are available when the closest CME or BDCSC is 75 miles or more from the recipient's or donor's residence.	100% after deductible; $10,000 maximum per transplant	
Physician Services		
Inpatient visits	90% after deductible	70% after deductible
Office visits	90% after deductible	70% after deductible
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	90% after deductible	70% after deductible
Second Surgical Opinion	90% after deductible	70% after deductible
Surgery (Inpatient and Outpatient)	90% after deductible	70% after deductible
Assistant Surgeon and Anesthesiologists	90% after deductible	70% after deductible
Allergy injections, serum and testing	90% after deductible	70% after deductible
Contraceptive Methods	100%; deductible waived	70% after deductible
Pregnancy		
Prenatal visits	100%; deductible waived	70% after deductible
Postnatal visits	90% after deductible	70% after deductible
Delivery and All Other Services	Covered the same as any other care based on type of service rendered	Covered the same as any other care based on type of service rendered

SUMMARY OF BENEFITS HDHP 1400		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Prescription Drug Benefit In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network- participating pharmacy, will be covered at 100% with no deductible or co-insurance required. **Dispense As Written (DAW) Penalty.** If the Covered Person or the Covered Person's doctor requests a brand-name medicine when a generic alternative is available, the Covered Person will pay the brand copay plus the difference in cost between the brand-name and the generic medicine.		
Retail Pharmacy Option (30 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after deductible and $10 copayment	100% after deductible and $10 copayment; plus all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after deductible and $25 copayment	100% after deductible and $25 copayment; plus all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after deductible and $50 copayment	100% after deductible and $50 copayment; plus all charges in excess of the Maximum Allowable Amount
Retail 90 Maintenance Drug Pharmacy Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after deductible and $20 copayment	100% after deductible and $20 copayment; plus all charges in excess of the Maximum Allowable Amount
Tier 2 - Preferred Brand Name Drugs	100% after deductible and $50 copayment	100% after deductible and $50 copayment; plus all charges in excess of the Maximum Allowable Amount
Tier 3 - Non-Preferred Brand Name Drugs	100% after deductible and $100 copayment	100% after deductible and $100 copayment; plus all charges in excess of the Maximum Allowable Amount
Mail Order Option (90 Day Supply)		
Tier 1 – Typically Generic Drugs	100% after deductible and $20 copayment	Not covered
Tier 2 - Preferred Brand Name Drugs	100% after deductible and $50 copayment	Not covered
Tier 3 - Non-Preferred Brand Name Drugs	100% after deductible and $100 copayment	Not covered
Tier 4 - Specialty Pharmacy – must be obtained through Specialty Mail Order Service. 30- day supply only.	80% of the Maximum Allowable Amount after deductible	Not covered
Preventive Care – Services as defined by the Patient Protection Affordable Care Act for both Network and Non-Network Providers.		
Routine Well Care – All ages	100%; deductible waived	70% after deductible
Smoking/Tobacco Cessation – (See prescription drug benefits for coverage regarding medications)	100%; deductible waived	Not covered

SUMMARY OF BENEFITS HDHP 1400		
COVERED CHARGES	**WHAT THE PLAN PAYS NETWORK PROVIDERS**	**WHAT THE PLAN PAYS NON-NETWORK PROVIDERS**
Prosthetics Pre-authorization is required for certain prosthetics	90% after deductible	70% after deductible
Rehabilitation – includes Physical and Occupational Therapies. Additional visits allowed if Medically Necessary	90% after deductible; 24 visits Plan Year maximum combined with spinal manipulation / chiropractic	70% after deductible; 24 visits Plan Year maximum combined with spinal manipulation / chiropractic
Sex Change / Transgender Surgical Procedures - Pre-authorization is required.	90% after deductible	Not covered
Sex Change / Transgender Surgery Travel Charges – Coverage is available when the closest surgical facility is 75 miles or more from the Covered Person's residence.	100% after deductible; $10,000 maximum per surgery or series of surgeries	
Skilled Nursing Facility – the facility's semiprivate room rate. Pre-authorization is required.	90% after deductible; 100 days Plan Year maximum	70% after deductible; 100 days Plan Year maximum
Speech Therapy	90% after deductible	70% after deductible
Spinal Manipulation / Chiropractic	90% after deductible; 24 visits Plan Year maximum combined with Rehabilitation	70% after deductible; 24 visits Plan Year maximum combined with Rehabilitation
Substance Abuse		
Inpatient - the facility's semiprivate room rate. Pre- authorization is required.	90% after deductible	70% after deductible
Outpatient - Pre-authorization is required for certain services.	90% after deductible	70% after deductible
Office Setting	90% after deductible	70% after deductible
Urgent Care – includes physician services	90% after deductible	90% after deductible
Voluntary Sterilization		
Female	100%; deductible waived	70% after deductible
Male	90% after deductible	70% after deductible
Wigs – after chemotherapy	90% after deductible	70% after deductible

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant may contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees, as follows:

(1) For Employees: Employees are eligible to enroll if the Employee qualifies for medical coverage as defined in Participating Employer's policies and/or Memorandum of Understanding (MOU) with the Participating Employer. The usual residence of the Employee is within the State of California. The Plan does not allow dual coverage for Employees working for the same Employer. Any person covered on this Plan as an Employee cannot also be covered as a Dependent.

(2) For Retired Employees: Covered Employees who terminate employment due to retirement and who meet both the Participating Employer's definition of a retired Employee and the REMIF minimum 10 year service requirement may be entitled to retiree coverage under this Plan. Please check with the Human Resources Department of the applicable Employer to determine whether or not the Employer offers retiree health coverage and whether the Employee meets the eligibility guidelines for retiree health coverage. Retiree coverage under this Plan is not offered to Retirees who retire at the age of 65 or older, but such Retirees may be entitled to coverage under the REMIF Medicare Supplement Plan if the Participating Employer makes such coverage available to its Retirees and the Retirees otherwise satisfy the eligibility requirements set forth by the Participating Employer and REMIF in order to participate in that plan. The Employee may also be entitled to COBRA continuation of coverage. Eligibility for COBRA is based on Federal law and is discussed under the section entitled Continuation Coverage Rights Under COBRA in this booklet.

The Plan does not allow dual coverage for Retirees who retired from the same Employer. Any person covered on this Plan as a retiree cannot also be covered as a Dependent.

For Dependents of Eligible Retirees: A dependent who is under age 65 may remain eligible for this plan as long as the Retiree is under age 65, or, if age 65 or over, the Retiree enrolls in and remains covered by the REMIF Medicare Supplement Plan.

Covered Retirees who attain age 65 are no longer eligible for retiree coverage under this Plan. Please check with the Human Resources Department of the applicable Employer to determine whether or not the REMIF Medicare Supplement program is available to the Covered Retiree upon reaching age 65.

For Dependents of Retirees: Covered dependents who have not attained age 65 are eligible for coverage under this Plan. Covered dependents who attain age 65 are no longer eligible for retiree coverage under this Plan. Please check with the Human Resources Department of the applicable Employer to determine whether or not the REMIF Medicare Supplement program is available to a covered dependent when he/she turns 65.

If a covered Retiree returns to active services with a Participating Employer, the Retiree may be eligible to be covered as either an Active Employee or remain covered as a Retiree, but not both.

(3) For an Employee who retires due to a specific disability: An Employee who retires due to a service-connected disability need not meet the REMIF requirement of ten years of

service. An Employee who retires from services with a Participating Employer due to a PERS disability retirement (non-safety) or a PERS industrial disability retirement (safety) need not meet the REMIF requirement of ten years of service. However, he or she must have worked the minimum number of years as required by the Participating Employer's labor agreement.

(4) Special eligibility criteria to address COVID-19: Notwithstanding any other Plan provision providing for an earlier termination of coverage, all Employees who were enrolled in the Plan effective March 1, 2020 will remain eligible for continued enrollment in the Plan despite any actively-at-work or minimum-hour requirements during the time that:

(a) the Employee is placed on furlough or reduced-hours furlough by the Employer due to issues related to COVID-19, as determined in the Employer's sole discretion; or

(b) the Employee is absent in order to provide care for an immediate family member or themselves related to COVID-19, or to provide primary care for children where there is no other viable childcare available due to the closure of schools or childcare centers related to COVID-19 precautions, whichever is longer, if so approved by the Employer in its sole discretion.

This special continuation of coverage due to COVID-19 allows the Plan Participants described above to continue to participate in the Plan under the same terms and conditions as if the Plan Participants remained actively employed on a full-time status during such furlough; however, this special extension of coverage shall not exceed one hundred and fifty (150) days (or the end of the month following 150 days if the 150-day period does not end on the end of a month), unless such period of time is extended by the Employer or the Plan Administrator in its sole discretion. To remain enrolled, such Plan Participants must continue to timely make required contributions, as set forth in more detail elsewhere in the Plan. For purposes of this special extension of coverage, a "furlough" shall mean a temporary layoff or involuntary leave without pay, and a "reduced-hours furlough" shall mean a temporary and involuntary reduction in hours with a corresponding reduction in pay. The provisions of this paragraph do not apply to a termination of employment where the Employer has no intention for the Employee to return to work. Furlough and termination of employment determinations are made in the sole discretion of the Employer.

Employees become eligible for coverage in accordance with rules established by the Employer. For specific information about the Employer's eligibility rules for coverage, please contact the Human Resources or Benefits Department of the Employer.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse.

A Spouse is the Covered Employee's Spouse under a legally valid marriage. Spouse does not include any person who is in active service in the armed forces.

(2) For purposes of this Plan, the term Spouse shall also include the employee's Domestic Partner. Domestic Partner is the Covered Employee's Domestic Partner under a valid Declaration of Domestic Partnership filed with the California Secretary of State. Domestic Partners may be same or opposite sex. Domestic Partner does not include any person who is active service in the armed forces.

To obtain more detailed information or to apply for this benefit, the Employee must contact the Plan Administrator, Redwood Empire Municipal Insurance Fund, 414 W. Napa Street, Sonoma, California, 95476, (707) 938-2388.

In the event the domestic partnership is terminated, either partner is required to inform the Participating Employer or Redwood Empire Municipal Insurance Fund of the termination of the partnership.

The Plan Administrator may require documentation proving a legal marital and/or Domestic Partner relationship.

(3) The Spouse of a covered Retiree. The spouse of a Retired Employee remains eligible as long as the Retired Employee continues coverage under a REMIF sponsored plan.

(4) A covered Employee's or Retiree's Child(ren).

An Employee's "Child" includes his natural child, stepchild, child for whom the Employee is the legal guardian, adopted child, or a child placed with the Employee for adoption. An Employee's child will also include children of the Domestic Partner, a child for whom the Employee's Domestic Partner is the legal guardian, adopted children or children placed for adoption with the Employee's Domestic Partner. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age of 26, coverage will end on the last day of the child's birthday month.

A child for whom the Covered Employee, Spouse or Domestic Partner is a legal guardian is considered eligible on the date of the court decree (the "eligibility date"). REMIF must receive legal evidence of the decree.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

The child(ren) of a covered Retiree. The dependent child(ren) of a Retired Employee remains eligible as long as the Retired Employee continues coverage under a REMIF sponsored plan.

(5) An unmarried covered Dependent child who reaches the limiting age of 26 and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's or Retiree's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee or Retiree; any person who is on active duty in any military service of any country; any former Domestic Partner of the Employee; or any person who is covered under the Plan as an Employee or Retiree.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, eligible children can be covered as Dependents of the mother or father, or both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, Domestic Partner or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

Other Eligible Class. Any person deemed eligible based on a court order or legal settlement entered into by a Participating Employer if such coverage or equivalent coverage is available at the time of the court order or agreement.

FUNDING

Cost of the Plan. Participating Employers of Redwood Empire Municipal Insurance Fund may share the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Plan Administrator.

The level of any Employee contributions is set by the Participating Employer. The Participating Employer reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee and eligible dependents must enroll for coverage by properly filing a signed enrollment application along with the appropriate payroll deduction authorization. An application is considered properly filed if it is completed, signed, dated, and given to the employer within 31 days from the eligibility date. If any of these steps are not followed, coverage may be denied.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee is automatically enrolled in this Plan for 31 days for certain Covered Charges. Charges for covered nursery care and routine Physician care will be applied toward the Plan of the covered parent. For coverage other than nursery care and routine Physician care during the first 31 day period and/or to continue beyond this 31 day period, the Employee must properly submit a completed enrollment form to the Employer within the 31 day period following the child's date of birth. A birth certificate is not required to complete an application. The Plan may at any time require proof of birth to verify eligibility. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs. An application is considered properly filed if it is completed, signed, dated, and given to the employer within 31 days from the child's date of birth. A birth certificate is not required to complete an application. The Plan Administrator may require proof of birth at any time to verify eligibility.

If the child is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator before, on, or within 31 days after the person becomes eligible for the coverage, either initially or after a permitted Mid-Year Election Event, described in the "Mid-Year Election Events" section below.

If two Employees (husband and wife or Domestic Partners) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" as described in the "Timely Enrollment" provision above. Late Enrollees and their eligible Dependents who are not eligible to join the Plan because of a permitted Mid-Year Election Event may join only during open enrollment.

Unless otherwise required by law, if an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage will not begin for any Late Enrollee until the start of the subsequent Plan Year (effective the next July 1st for any Late Enrollee who enrolls during an Open Enrollment period).

MID-YEAR ELECTION EVENTS

You may change your election mid-year only if you experience one of the following Mid-Year Election Events:

- Marriage, divorce, legal separation or annulment, registration of a Domestic Partner or dissolution of a domestic partnership;
- The birth, adoption, placement for adoption or legal guardianship of a Child;
- The death of a Dependent;
- You or your Spouse or other eligible Dependent begin or terminate employment, go on strike or are locked out, change worksites, start an FMLA leave of absence, or have any other change in employment status (e.g. full-time to part-time) that affects your or your Spouse's or Dependent's eligibility for coverage under the Plan;
- Your Dependent Child no longer qualifies as an eligible Dependent;
- Changes in the cost of a benefit;
- Significant coverage curtailment;
- Addition of or significant improvement of a benefit option;
- You or your eligible Dependent(s) no longer live or work in a plan's network service area and no other benefit option is available to you or your eligible Dependent(s);

- Benefits are no longer offered by the applicable plan to a class of individuals that covers you or your eligible Dependent(s);

- Termination of your or your Dependent's coverage under Medicare, Medicaid or a State Child Health Insurance Program as a result of a loss of eligibility;

- You or your Dependent become eligible for enrollment in or for a premium assistance subsidy under Medicare, Medicaid or a State Child Health Insurance Program;

- A court order requires you or someone else to cover a Dependent;

- You experience a reduction in hours from more than 30 hours per week, on average, to less than 30 hours per week, on average, followed by enrollment in Health Insurance Marketplace coverage or other qualifying coverage no later than the start of the second full month following the reduction;

- You qualify for an annual or special enrollment in Health Insurance Marketplace coverage, with Marketplace coverage to begin no later than the day following the termination of coverage under this Plan; or

- A HIPAA Special Enrollment Right, as described in the sections immediately below (see sections entitled "Special Enrollment Rights" and "Special Enrollment Periods and Effective Dates").

Coverage election changes must be consistent with the triggering event. In other words, your election change must be because of and correspond with the triggering event. The Plan Administrator has sole discretion in determining whether an event permits a midyear election change under this Plan.

A request for an election change must be made within 31 days after the date of the Mid-Year Enrollment Event. Generally, coverage will become effective the first of the month following the date you file an election change. In the case of the birth, adoption or placement for adoption of a Child, coverage will be retroactively effective to the date of the birth or the date of the adoption or placement for adoption.

If a court has ordered coverage be provided for a Spouse, Domestic Partner or dependent child under your employee health plan, an application must be filed within 31 days from the date the court order is issued.

If a court has ordered that coverage be provided for a dependent child, coverage will become effective for that child on the earlier of (a) the first day of the month following the date you file the enrollment application or (b) within 31 days after REMIF receives a copy of the court order or of a request from the district attorney, either parent or the person having custody of the child, the employer, or the group administrator.

If a court has ordered that coverage be provided for a Spouse or Domestic Partner, coverage will become effective the first day of the first calendar month following the date the completed enrollment form is received.

For additional information on how to make a mid-year election change or on what election changes are allowed for a certain Mid-Year Enrollment Event, please contact the Human Resources coordinator at the applicable Participating Employer, or the Plan Administrator, Redwood Empire Municipal Insurance Fund, 414 W. Napa Street, Sonoma, California, 95476, (707) 938-2388.

SPECIAL ENROLLMENT RIGHTS

Federal law (HIPAA) provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents (including his or her Spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there

is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, registration for domestic partnership, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days of the birth, marriage, registration for domestic partnership, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Human Resources coordinator at the applicable Participating Employer, or the Plan Administrator, Redwood Empire Municipal Insurance Fund, 414 W. Napa Street, Sonoma, California, 95476, (707) 938-2388.

SPECIAL ENROLLMENT PERIODS AND EFFECTIVE DATES

The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

(1) Losing other coverage may create a Special Enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

(c) You certified in writing at the time you became eligible for coverage under this plan that you were declining coverage under this plan or disenrolling because you were covered under another health plan as stated above and you were given written notice that if you choose to enroll later, you may be required to wait until the group's next open enrollment period to do so.

For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(a) The Employee or Dependent has a loss of eligibility due to termination of employment or change in employment status, or reduction in the number of hours worked.

(b) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).

(c) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, termination of domestic partnership, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(d) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not

provide benefits to individuals who no longer reside, live or work in a Service Area, (whether or not within the choice of the individual).

(e) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a Service Area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

(f) The Employee or Dependent elects to terminate coverage under another employer sponsored group health plan during that plan's Open Enrollment period.

The Employee or Dependent must request enrollment in this Plan not later than 31 days after coverage described above ends. Coverage will begin the first of the month following the loss of coverage, but no later than the first day of the first calendar month following the date the completed enrollment form is received.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Acquiring a newly eligible Dependent may create a Special Enrollment right. If:

(a) The Employee is a Covered Person under this Plan (or has met the Waiting Period applicable to becoming a Covered Person under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and;

(b) A person becomes a Dependent of the Employee through marriage, registration of domestic partnership, birth, adoption or placement for adoption, then the Dependent may be enrolled under this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his or her eligible Dependents to enroll. In the case of the birth or adoption of a child, the Spouse or Domestic Partner of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse or Domestic Partner is otherwise eligible for coverage.

The Special Enrollment Period for newly eligible Dependents is a period of 31 days after the date of the marriage, domestic partnership registration, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

(c) The Special Enrollment Period resulting from the acquisition of a new dependent also allows the member to make a plan change.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, or in the case of domestic partnership registration, coverage will be effective on the first of the month following the date you file the enrollment application.

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(3) **Eligibility changes in Medicaid or State Child Health Insurance Programs may create a Special Enrollment right**. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not already enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Effective Date of Employee Coverage.

Your effective date of coverage is subject to the timely payment of subscription charges on your behalf. The date you become covered is determined as follows:

(1) **Timely Enrollment**. If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for Employees, on your eligibility date; and (b) for family members, on the later of (i) the date the Employee's coverage begins, or (ii) the first day of the month after the family member becomes eligible. If you become eligible before the agreement takes effect, coverage begins on the effective date of the agreement, provided the enrollment application is on time and in order.

(2) **Late Enrollment.** If you fail to enroll within 31 days after your eligibility date, you must wait until the group's next Open Enrollment Period to enroll.

(3) **Disenrollment.** If you voluntarily choose to disenroll from coverage under this plan, you will be eligible to reapply for coverage as set forth in the "Enrollment" provision above, during the group's next Open Enrollment period (see OPEN ENROLLMENT PERIOD).

For late enrollees and disenrollees: You may enroll earlier than the group's next Open Enrollment Period if you meet any of the conditions listed under MID-YEAR ELECTION EVENTS or SPECIAL ENROLLMENT PERIODS.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

TERMINATION OF COVERAGE

The Employer or Plan has the right to terminate any coverage of the Employee and/or Retiree and/or Dependents for making a fraudulent claim or an intentional misrepresentation in applying for or obtaining coverage or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage, so long as consistent with applicable law. If coverage is to be terminated or voided retroactively for fraud or intentional misrepresentation, the Plan will provide at least 30 days' advance written notice of such action and the impacted individual(s) will be given the opportunity to appeal as required by law. An advance notice and an opportunity to appeal is not required by law due to a Member's failure to timely pay a required contribution or the ineligibility of a Member (that was not an error of the Plan Administrator). The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

If a marriage or domestic partnership terminates, the Employee must give or send to the Participating Employer written notice of the termination within 60 days. Coverage for a former Spouses or Domestic Partners, and their dependent children, if any, ends according to the "Eligible Status" provisions outlined below. If the Plan suffers a loss because of the Employee failing to notify the Participating Employer of the termination of their marriage or domestic partnership, the Plan may seek recovery from the Employee for any actual loss resulting thereby. Failure to provide written notice to the Participating Employer will not delay or prevent termination of the marriage or domestic partnership. If the Employee notifies the Participating Employer in writing to cancel coverage for a former Spouse or Domestic Partner and the children of the Spouse or Domestic Partner, if any, immediately upon termination of the Employee's marriage or domestic partnership, such notice will be considered in compliance with the requirements of this provision.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The date the covered Employee's Eligible Class is eliminated. This includes elimination of an eligible class due to a Participating Employer's withdrawal from the REMIF plan.

(3) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes:

(a) death or termination of Active Employment of the covered Employee (or, if applicable, the covered Employee's reduction in hours). (See the section entitled Continuation Coverage Rights under COBRA.)

(b) Employee on disability leave of absence or other leave of absence, except for the continuation provisions set forth under the section entitled "Continuation During Periods of Employer Certified Disability or Leave of Absence" below.

(4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(5) If an Employee commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify

the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage, so long as consistent with applicable law.

(6) If you voluntarily cancel coverage as a result of a qualifying event under a Section 125 Cafeteria Plan, coverage ends on the required contribution due date coinciding with or following the date of voluntary cancellation, as provided by written notice to us.

Covered Employees who retire with a Participating Employer may be able to continue coverage under the Plan as a Retiree if they meet the eligibility requirements for retiree coverage as described in more detail in the Eligibility section above.

Continuation During Periods of Employer-Certified Disability or Leave of Absence. A person may remain eligible to continue to participate in the Plan for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For approved leave of absence only: six calendar months from the last day worked.

For Employer-Certified Disability: twelve calendar months from the last day worked.

These continuances only apply if the Employer approves of the leave, and if the subscription charges continue to be paid (by the Employer and Member, as applicable). These time periods may be extended if required by law.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

This continuation coverage is provided at the Employer's discretion. Any periods of coverage continuation required by COBRA will commence at the end of this discretionary continuation coverage. Your period for COBRA continuation coverage will begin after the six or twelve months of continuation coverage offered by your employer ends. The discretionary continuation coverage described in this section may be terminated or otherwise modified at any time for any reason in the Employer's sole discretion.

Continuation During Family and Medical Leave. This Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor, as well as any state employment regulations which require additional periods of leave and are applicable to the Plan Administrator.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage for the Employee under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired within six months of the date of termination will be eligible for coverage the first day of the calendar month following the date the Employee returns to work. A terminated Employee who is rehired after six months of the date of termination will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's covered Dependents under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service. The coverage of any dependents whose coverage was also terminated will also be reinstated. For dependents, this applies only to dependents who were covered under the plan and whose coverage terminated when the Employee's coverage terminated. Other dependents who were not covered will not be enrolled at this time unless they qualify for another reason described elsewhere in this Plan. For reservists and their dependents applying for reinstatement of coverage following reemployment with the Employer, coverage will be effective as of the date of discharge from active duty.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Redwood Empire Municipal Insurance Fund, 414 W. Napa Street, Sonoma, California, 95476, (707) 938-2388. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

Coverage of Surviving Family Members. Enrolled family members may or may not be eligible to continue coverage under this plan after the Employee's or Retiree's death. Please check with the applicable Human Resources Department to determine whether or not the applicable Participating Employer offers this continuation coverage as defined in the city/town policies and/or Memorandum of Understanding (MOU) and whether the required qualifications are met. Enrolled family members may also be entitled to COBRA continuation of coverage. Eligibility for COBRA is based on Federal law and is discussed under the section entitled Continuation Coverage Rights under COBRA in this booklet.

If offered, this continuation will end on the earliest of:

(1) The date the surviving Spouse or Domestic Partner remarries or enters into a new domestic partnership;

(2) The end of the period for which premiums are last paid to the Plan Administrator on the Covered Person's behalf;

(3) The date the Participating Employer cancels coverage for the class of Employees to which the Covered Person's deceased family member belonged;

(4) The date the policy terminates; or

(5) The premium due date coinciding with or following the date a child either (a) reaches age 26 or (b) no longer meets all of the conditions of coverage in the Eligibility, Funding, Effective Date and Termination Provisions.

Note: The cost of continuing coverage under this provision may be more than the cost of coverage the group provides to its Employees or their family members. The Covered Person may be responsible for all or part of the premium. A new dependent acquired during this continuation is not eligible to be enrolled as a family member.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

(3) Coverage will end the last day of the calendar month in which the covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) Coverage will end the last day of the calendar month in which the Child ceases to meet the applicable eligibility requirements except as specified for "Disabled Children" below: (See the section entitled Continuation Coverage Rights under COBRA.)

(a) **Disabled Children:** If a child reaches the age limit shown in the "Eligible Status" provision of this section, the child will continue to qualify as a family member if he or she is (i) covered under this plan, (ii) chiefly dependent on the Employee, Spouse or Domestic Partner for support and maintenance, and (iii) incapable of self-sustaining employment due to a physical or mental condition. A physician must certify in writing that the child has a physical or mental condition that makes the child incapable of obtaining self-sustaining employment. The Employee must send proof of the child's physical or mental condition within 60-days of the date the Employee receives their COBRA notice. If we do not complete our determination of the child's continuing eligibility by the date the child reaches the plan's upper age limit, the child will remain covered pending our determination. When a period of two years has passed, we may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the child is no longer chiefly dependent on the Employee, Spouse or Domestic Partner for support and maintenance or a physical or mental condition no longer exists. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

When Retiree Coverage Terminates. A covered Retiree's coverage will terminate as described in the Eligibility section above. Generally, a covered Retiree's coverage under this Plan will terminate upon attaining age 65. Upon reaching age 65, such Retirees may be entitled to coverage under the REMIF Medicare Supplement Plan if the Participating Employer makes such coverage available to its Retirees and the Retirees otherwise satisfy the eligibility requirements set forth by the Participating Employer and REMIF in order to participate in that plan.

As noted in the Eligibility section above, a Dependent who is under age 65 is generally eligible to continue coverage under this Plan as long as the covered Retiree is under age 65, or, if age 65 or over, the Retiree enrolls in and remains covered by the REMIF Medicare Supplement Plan.

If you were a covered Dependent of a Retired Employee who died, and the applicable Participating Employer has adopted eligibility for surviving family members, you might be entitled to non-COBRA continuation coverage as described in the "Coverage of Surviving Family Members" section above. If applicable, such coverage for family members will be effective on the date of death.

Unfair Termination of Coverage. If you believe that your coverage has been or will be improperly terminated, you may file an Appeal with the Plan Administrator by submitting a written request for appeal to REMIF at P.O. Box 885, Sonoma, CA 95475. You should file your Appeal as soon as possible after you receive notice that your coverage will end. If your coverage is still in effect when you submit an Appeal, we will continue to provide coverage until your stated termination date. If your appeal is granted, coverage will be reinstated back to the first of the month following the date of termination provided that all subscription charges are paid. This appeal process does not apply if your coverage is cancelled for non-payment of subscription charges. If your coverage is maintained in force pending outcome of the review, subscription charges must still be paid to us on your behalf.

OPEN ENROLLMENT

At a time designated by the Participating Employer the annual open enrollment period will be held. During the annual open enrollment period, Covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

During the annual open enrollment period, eligible Employees and their eligible Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective July 1 and remain in effect until the next July 1, unless there is a Mid-Year Election Event, as described in the "Mid-Year Election Events" section above.

Benefit choices for Late Enrollees made during the open enrollment period will become effective July 1.

Unless otherwise notified by a Participating Employer, a Covered Person who fails to make an election during open enrollment will automatically retain his or her present coverages.

Covered Persons will receive detailed information regarding open enrollment from their Participating Employer, including information on required employee contribution amounts.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury, Illness or Sickness and while the person is covered for these benefits under the Plan.

CONDITIONS OF COVERAGE

The following conditions of coverage must be met for expenses incurred for services or supplies to be covered under this Plan.

(1) You must incur this expense while you are covered under this Plan. An expense is incurred on the date a Covered Person receives the service or supply for which the charge is made.

(2) The expense must be for a medical service or supply furnished to a Covered Person as a result of Illness, Sickness or Injury or pregnancy, unless a specific exception is made.

(3) The expense must be for a medical service or supply included in the section "MEDICAL CARE"

(4) The expense must not be for a medical service or supply listed in "MEDICAL CARE THAT IS NOT COVERED". If the service or supply is partially excluded for coverage under this Plan, then only that portion which is not excluded from coverage will be covered under this Plan.

(5) The expense must not exceed any of the maximum benefits or limitations of this Plan.

(6) Any services received must be those which are regularly provided and billed by the provider. In addition, those services must be consistent with the Illness, Injury, Sickness or degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your Illness, Sickness or Injury.

(7) For EPO Plans: All services and supplies must be ordered by the Network Provider or Non Network Provider provided in connection with emergency services or with an Authorized Referral.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Plan Year a Covered Person must meet the Single or Per Covered Person deductible shown in the Summary of Benefits **for your plan.**

Family Unit Limit. When the family maximum amount shown in the Summary of Benefits has been incurred by any combination of members of a Family Unit toward their family Plan Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Plan Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under "What the Plan Pays" on the Summary of Benefits **for your plan**. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Plan Year until the out-of-pocket limit shown in the Summary of Benefits for your plan is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges excluded as shown in the Summary of Benefits for your plan for the rest of the Plan Year).

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for any charges excluded, as shown on the Summary of Benefits for your plan for the rest of the Plan Year).

COVERED CHARGES

Covered Charges or Covered Services are the Maximum Allowable Amounts that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care**. The medical services and supplies furnished by a Hospital or Ambulatory/Outpatient Surgical Center or a Birthing Center and Covered Charges for room and board will be payable as shown in the Summary of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Charges for a Private Room will be limited to the semi-private room rate. The private room rate will apply if the facility only has private rooms available.

Charges for an Intensive Care Unit stay are payable.

Benefit payments for Ambulatory/Outpatient Surgical Centers are limited as shown in the Summary of Benefits.

(2) **Coverage of Pregnancy.** The charges for the care and treatment of Pregnancy are covered the same as any Illness, including:

(a) All medical benefits for an enrolled member when provided for pregnancy or maternity care, including the following services:

(i) Prenatal and postnatal care.

(ii) Ambulatory care services (including ultrasounds, fetal non-stress tests, physician office visits, and other Medically Necessary maternity services performed outside of a Hospital.

(iii) Involuntary complications of pregnancy.

(b) Diagnosis of genetic disorders in case of high-risk pregnancy; and Inpatient Hospital care including labor and delivery Medical Hospital benefits for routine nursery care of a newborn child, if the child's natural mother is an enrolled member. Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.

Certain services are covered under the "Preventive Care" benefit. Please see that provision for further details.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility; and

(b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Summary of Benefits.

(4) **Physician Care.** The professional services of a Physician or anesthetist for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Maximum Allowable Amount that is allowed for the primary procedures; 50% of the Maximum Allowable Amount will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Maximum Allowable Amount for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Maximum Allowable Amount for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's allowance.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Outpatient private duty nursing care is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan. Covered services may include:

(a) Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a physician.

(b) Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.

(c) Services of a medical social service worker.

(d) Services of a health aide who is employed by (or who contracts with) a Home Health Agency. Services must be ordered and supervised by a registered nurse employed by the Home Health Agency as professional coordinator. These services are covered only if you are also receiving the services listed in (a) or (b) above.

(e) Medically necessary supplies provided by the home health agency.

In no event will benefits exceed 100 visits during a plan year. If the Plan applies covered charges toward the Plan Year Deductible and does not provide payment, those visits will be included in the 100 visits for that year.

Home health care services are subject to pre-authorization to determine medical necessity.

Home health care services are not covered if received while you are receiving benefits under the “Hospice Care” provision of this section.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person’s condition as being terminal, determined that the person is not expected to live more than one year and placed the person under a Hospice Care Plan. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Summary of Benefits and are available on a 24 hour basis for the management of a Covered Person’s condition. Services may include:

(a) Interdisciplinary team care with the development and maintenance of an appropriate plan of care.

(b) Short-term inpatient Hospital care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.

(c) Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.

(d) Social services and counseling services provided by a qualified social worker.

(e) Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.

(f) Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.

(g) Volunteer services provided by trained hospice volunteers under the direction of a hospice staff member.

(h) Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.

(i) Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the Covered Person's or the family member's death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means your Spouse, children, step-children, parents, and siblings.

(j) Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

(8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Surgical methods of terminating a pregnancy also called elective **abortion**.

(b) Prescription drug for Abortion. Mifepristone is covered when provided under the Food and Drug Administration (FDA) approved treatment regimen.

(c) The services of a Physician for **acupuncture treatment** to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electro acupuncture, cupping and moxibustion.

Benefit payments for acupuncture treatment is limited as shown in the Summary of Benefits.

(d) Local Medically Necessary professional land or air **ambulance** service. Ambulance services are covered when you are transported by a state licensed vehicle that is designed, equipped, and used to transport the sick and injured and is staffed by Emergency Medical Technicians (EMTs), paramedics, or other licensed or certified medical professionals. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

Benefit payments for ambulance services are limited as shown in the Summary of Benefits.

Important information about air ambulance coverage. Coverage is only provided for air ambulance services when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger the patient's health and the patient's medical condition requires a more rapid transport to a Hospital than the ground ambulance can provide, this plan will cover the air ambulance. Air ambulance will also be covered if the patient is in a location that a ground or water ambulance cannot reach.

Air ambulance will not be covered if the patient is taken to a Hospital that is not an acute care Hospital (such a skilled nursing facility), or if the patient is taken to a Physician's office or to the patient's home.

Hospital to Hospital transport: if the Covered Person is being transported from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger the Covered Person's health and if the Hospital that first treats the Covered Person cannot give the Covered Person the medical services the Covered Person needs. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. For services to be covered, the Covered Person must be taken to the closest Hospital that can treat the Covered Person. Coverage is not provided for air ambulance transfers because the Covered Person, the Covered Person's family, or Covered Person's Physician prefers a specific Hospital or Physician.

Ambulance services are subject to medical necessity reviews.

You must be taken to the nearest facility that can provide care for your condition. In certain cases, coverage may be approved for transportation to a facility that is not the nearest facility.

Coverage includes Medically Necessary treatment of an illness or injury by medical professionals from an ambulance service, even if you are not transported to a Hospital. If provided through the 911 emergency response system, ambulance services are covered if you reasonably believed that a medical emergency existed even if you are not transported to a Hospital.

(e) **Anesthetic**; **oxygen**; **blood and blood derivatives** intravenous injections and solutions. Administration of these items is included. Charges for the collection, processing and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure.

(f) **Advanced Imaging procedures**, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and nuclear cardiac imaging are subject to pre- authorization to determine medical necessity. See "Utilization Review Program" for details.

Benefit payments for advanced Imaging procedures are limited as shown in the Summary of Benefits.

(g) The following items and services when required for the Medically Necessary treatment of **pediatric asthma**:

(i) Nebulizers, including face masks and tubing. These items are covered under the plan's medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment").

(ii) Inhaler spacers and peak flow meters. These items are covered under the prescription drug benefits and are subject to the copayment for brand name drugs (see the Prescription Drug Benefits).

(iii) Education for pediatric asthma, including education to enable the child to properly use the items listed above. This education will be covered under the plan's benefits for office visits to a Physician.

(h) Services and supplies for **bariatric surgery** in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed at a designated CME or BDCSC facility.

The Covered Person must obtain pre-authorization for all bariatric surgical procedures. **Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than a CME or BDCSC will not be covered.**

Bariatric Travel Charges. Certain travel charges incurred in connection with an approved, specified bariatric surgery, performed at a designated BDCSC that is fifty (50) miles or more from the Covered Person's place of residence, are covered, provided the expenses are pre- authorized by the Utilization Review Administrator in advance. The fifty (50) mile radius around the BDCSC will be determined by the bariatric BDCSC coverage area. Our maximum payment will not exceed **$3,000** per surgery for the following travel expenses incurred by the Covered Person and/or one companion:

(i) Transportation for the Covered Person and/or one companion to and from the BDCSC.

(ii) Lodging, limited to one room, double occupancy.

(iii) Other reasonable expenses. Tobacco, alcohol, drug and meal expenses are excluded from coverage.

Customer service will confirm if the "Bariatric Travel Expense" benefit is available in connection with access to the selected bariatric BDCSC. Details regarding reimbursement can be obtained by calling the customer service number on the I.D. card.

A claim form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

(i) Services and supplies provided in connection with the screening for, diagnosis of, and treatment for **breast cancer** whether due to illness or injury, including:

(i) Diagnostic mammogram examinations in connection with the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially under the Preventive Care Services benefit.

(ii) Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation. When done as a preventive care service, BRCA testing will be covered under the Preventive Care Services benefit.

(iii) Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.

(iv) Reconstructive surgery of both breasts performed to restore and achieve symmetry following a Medically Necessary mastectomy.

(v) Breast prostheses following a mastectomy (see "Prosthetic Devices").

This coverage is provided according to the terms and conditions of this plan that apply to all other medical conditions.

(j) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; and (c) in a medical care facility.

(k) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(l) Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for **cleft palate** procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

(m) Routine patient care charges for **Clinical Trials.** The services must be those that are listed as covered by this plan for Covered Persons who are not enrolled in a clinical trial.

An "approved clinical trial" is a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or another life-threatening disease or condition, from which death is likely unless the disease or condition is treated. Coverage is limited to the following clinical trials:

(i) Federally funded trials approved or funded by one or more of the following:

- The National Institutes of Health,
- The Centers for Disease Control and Prevention,
- The Agency for Health Care Research and Quality,
- The Centers for Medicare and Medicaid Services,
- A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or

- Any of the following departments if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines (1) to be comparable to the system of peer review of investigations and studies used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

- The Department of Veterans Affairs,

- The Department of Defense, or

- The Department of Energy.

(ii) Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.

(iii) Studies or investigations done for drug trials that are exempt from the investigational new drug application.

When a service is part of an approved clinical trial, it is covered even though it may otherwise be an investigative service as defined by the plan (see the DEFINITIONS section).

Participation in the clinical trial must be recommended by your physician after determining participation has a meaningful potential to benefit you.

Routine patient costs do not include the costs associated with any of the following:

(i) The investigational item, device, or service itself.

(ii) Any item or service provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.

(iii) Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(iv) Any item, device, or service that is paid for, or should have been paid for, by the sponsor of the trial.

Note: You will be financially responsible for the costs associated with non-covered services. Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to Independent Medical Review as described in CLAIMS AND APPEALS PROCEDURES.

(n) Initial **contact lenses** or glasses required following cataract surgery.

(o) Contraceptives and products for contraceptive management including, but not limited to:

(i) Injectable drugs and implants for birth control, administered in a physician's office, if Medically Necessary.

(ii) Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a physician if Medically Necessary.

(iii) Professional services of a physician in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

If your physician determines that none of these contraceptive methods are appropriate for you based on your medical or personal history, coverage will be provided for another prescription contraceptive method that is approved by the Food and Drug Administration (FDA) and prescribed by your physician.

Certain contraceptives are covered under the "Preventive Care Services" benefit. Please see that provision for further details.

(p) Dental Care.

(i) Admissions for Dental Care. Listed inpatient Hospital services for up to three days during a Hospital stay, when such stay is required for dental treatment and has been ordered by a physician (M.D.) and a dentist (D.D.S. or D.M.D.). The Plan will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. Hospital stays for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in (ii), below.

(ii) General Anesthesia. General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a Hospital or ambulatory surgical center. This applies only if (a) the member is less than seven years old, (b) the member is developmentally disabled, or (c) the member's health is compromised and general anesthesia is Medically Necessary. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.

(iii) Dental Injury. Services of a physician (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an accidental injury to natural teeth. Coverage shall be limited to only such services that are Medically Necessary to repair the damage done by accidental injury and/or restore function lost as a direct result of the accidental injury. Damage to natural teeth due to chewing or biting is not accidental injury.

(iv) Cleft Palate. Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

(v) Orthognathic surgery. Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is Medically Necessary to attain functional capacity of the affected part.

Important: If you decide to receive dental services that are not covered under this Plan, a Network Provider who is a dentist will charge you his or her billed rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this plan, please call us at the customer service telephone number listed on your ID card.

(q) Services and supplies provided for a **diabetes education program** which:

(i) Is designed to teach an Covered Person who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;

(ii) Includes self-management training, education, and medical nutrition therapy to enable the Covered Person to properly use the equipment, supplies, and medications necessary to manage the disease; and

(iii) Is supervised by a Physician.

Diabetes education services are covered under plan benefits of office visits to physicians.

(r) Services and supplies provided for **diabetes equipment and supplies**, including:

(i) Some blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.

(ii) Insulin pumps.

(iii) Pen delivery systems for insulin administration (non-disposable).

(iv) Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

(v) Podiatric devices, such as therapeutic shoes and shoe inserts. To treat diabetes- related complications.

(vi) Screenings for gestational diabetes are covered under your Preventive Care Services benefit. Please review that provision for details.

Items (i) through (iv) above are covered under your plan's benefits for durable medical equipment (see "Durable Medical Equipment"). Item (v) above is covered under your plan's benefits for prosthetic devices (see "Prosthetic Devices").

The following items are covered under your prescription drug benefits:

- Insulin, glucagon, and other prescription drugs for the treatment of diabetes.
- Insulin syringes, disposable pen delivery systems for insulin administration.
- Testing strips, lancets, and alcohol swabs.
- Certain blood glucose monitors

These items must be obtained either from a retail pharmacy or through the home delivery program. See Your Prescription Drug Benefits for details.

(s) **Diagnostic Services.** Outpatient diagnostic imaging and laboratory services. This does not include services covered under the "Advanced Imaging Procedures" provision of this section.

(t) **Durable Medical Equipment** for rental or purchase, if deemed Medically Necessary. Rental or purchase of **dialysis equipment, dialysis supplies, and other medical equipment** if deemed Medically Necessary. Rental or purchase of other medical equipment and supplies which are:

(i) Of no further use when medical needs end;

(ii) For the exclusive use of the patient;

(iii) Not primarily for comfort or hygiene;

(iv) Not for environmental control or for exercise; and

(v) Manufactured specifically for medical use.

If purchased, the cost of the item shall not exceed the fair market value of the equipment at the time of purchase, and will only be covered if agreed to in advance by the Plan Administrator. Repair or replacement will be covered only when required due to growth or development of a dependent child, or deterioration from normal wear and tear if recommended by the attending Physician.

Specific durable medical equipment is subject to pre-authorization to determine medical necessity.

(u) Charges for orthopedic footwear used as an integral part of a brace; **foot orthotics** that are custom molded to the patient.

(v) **Genetic testing** for the purpose of determining the need for fetal therapy or to determine a Medically Necessary intervention for the mother.

(w) The following **hearing aid services** are covered when provided by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist.

(i) Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be covered under plan benefits for office visits to Physicians.

(ii) Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment.

(iii) Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

No benefits will be provided for the following:

(i) Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss.

(ii) Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). Medically Necessary surgically implanted hearing devices may be covered under this Plan's benefits for prosthetic devices.

(x) The following services and supplies when provided by a **home infusion therapy** provider in the home for the intravenous administration of the patient's total daily nutritional intake or fluid requirements, medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

(i) Medication, (specialty drugs must be obtained through the specialty drug program (See "Specialty Drugs" provision of this section), ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however medication which is delivered but not administered is not covered;

(ii) Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;

(iii) Hospital and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;

(iv) Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;

(v) Laboratory services to monitor the patient's response to therapy regimen.

Home infusion therapy services are subject to pre-authorization to determine medical necessity. Benefit payments for home infusion therapy shown in the Summary of Benefits.

(y) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ)**. The Plan will pay for splint therapy or surgical treatment for disorders or conditions of the joints linking the jawbones and the skull (the temporomandibular joints), including the complex of muscles, nerves and other tissues related to those joints.

(z) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

(aa) Treatment of **Mental Disorders and Substance Abuse**. Covered services shown below for the Medically Necessary treatment of mental or nervous disorders or substance abuse, or to prevent the deterioration of chronic conditions.

(i) Inpatient Hospital services and services from a residential treatment center as stated in the "Hospital" provision of this section, for inpatient services and supplies.

(ii) Partial hospitalization, including intensive outpatient programs and visits to a day treatment center. Partial hospitalization is covered as stated in the "Hospital" provision of this section, for outpatient services and supplies.

(iii) Physician visits during a covered inpatient stay.

(iv) Physician visits for outpatient psychotherapy or psychological testing for the treatment of mental or nervous disorders or substance abuse. This includes nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa.

(v) Behavioral health treatment for pervasive developmental disorder or autism. See the section MEDICAL BENEFITS for Pervasive Developmental Disorder or Autism for a description of the services that are covered. Note: You must obtain pre-authorization for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this plan. No benefits are payable for these services if pre-authorization is not obtained.

Treatment for substance abuse does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use.

(bb) Injury to or care of mouth, teeth and gums. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate. External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Reduction of dislocations and excision of temporomandibular joints (TMJs).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(cc) **Occupational therapy** by a licensed therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Occupational therapy programs are designed to maximize or improve a patient's extremity function, perceptual motor skills and ability to function in daily living activities. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

Occupational therapy is limited as shown in the Summary of Benefits.

For the purposes of this benefit, the term "visit" shall include any visit by a physician in that physician's office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

Up to 24 visits in a year for all covered physical therapy, physical medicine and occupational therapy services are payable, if Medically Necessary. If additional

visits are needed after receiving 24 visits in a year, pre-authorization must be obtained prior to receiving the services.

If we determine that an additional period of physical therapy, physical medicine or occupational therapy is Medically Necessary, we will authorize a specific number of additional visits. Such additional visits are not payable if pre-authorization is not obtained. (See UTILIZATION REVIEW PROGRAM.)

There is no limit on the number of covered visits for Medically Necessary physical therapy, physical medicine, and occupational therapy. But additional visits in excess of the number of visits stated above must be authorized in advance.

If we apply covered charges toward the Plan Year Deductible and do not provide payment, that visit will be included in the visit maximum (24 visits) for that year.

(dd) **Online Care Services/Telemedicine**. Covered Charges for medical consultations using the internet via webcam, camera phone, chat or voice. The Plan has contracted with a telemedicine vendor, LiveHealth Online, to provide telemedicine services to Covered Persons. In most cases, using LiveHealth Online for telemedicine services will result in the lowest cost-sharing responsibility for you, and LiveHealth Online may be the most convenient to access. However, the Plan generally covers telemedicine from other health care providers as well, if the consultation is deemed Medically Necessary and otherwise satisfies the terms and conditions for coverage under this Plan. Covered services include, but are not limited to, virtual "office" visits with physicians and consultations for members while admitted to the hospital or as patients in the Emergency Room. Non-covered services include, but are not limited to:

- Reporting normal lab or other test results, when done by administrative staff or a non-treating healthcare practitioner outside of a telehealth consultation.
- Office visit appointment requests or changes.
- Billing, insurance coverage, or payment questions.
- Patient telephone calls or emails to physicians or other healthcare practitioners or their administrative staff solely for the purpose of requesting a referral to another physician or healthcare practitioner.
- Benefit Pre-authorization.
- Consultations between physicians.

Note: You will be financially responsible for the costs associated with non-covered services. An itemized receipt for services will be required for claim reimbursement.

(ee) Services and supplies provided in connection with a non-investigative **organ or tissue transplant**, if the Covered Person is:

(i) The recipient; or

(ii) The donor.

Benefits for an organ donor are as follows:

(i) When both the person donating the organ and the person getting the organ are Covered Persons, each will get benefits under their plans.

(ii) When the person getting the organ is a Covered Person, but the person donating the organ is not, benefits under this plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.

(iii) If the Covered Person is donating the organ to someone who is **not** a Covered Person, benefits are not available under this plan.

The Maximum Allowable Amount for a donor, including donor testing and donor search, is limited to expense incurred for Medically Necessary medical services only. The Maximum Allowable Amount for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered. Payment for unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants is payable as shown in the Summary of Benefits.

Covered services are subject to any applicable deductibles, co-payments and medical benefit maximums set forth in the Summary of Benefits. The Maximum Allowable Amount does not include charges for services received without first obtaining pre-authorization or which are provided at a facility other than an approved transplant center approved by us. See Cost Management Services for details.

To maximize benefits, the patient should call the Utilization Review Administrator as soon as the patient thinks a transplant may be needed to talk about the benefit options. This must be done before an evaluation or work-up for a transplant. The transplant coordinator will help maximize the benefits by giving the patient coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, Centers of Medical Excellence (CME) or Blue Distinction Centers for Specialty Care (BDCSC) rules, or which exclusions (if any) apply. Call the Pre-authorization phone number on the back of the identification card to speak with the Utilization Review Administrator.

You or your physician must call the Utilization Review Administrator for Pre-authorization review prior to the transplant. Pre-authorization is required before benefits are provided for a transplant, whether it is performed in an inpatient or outpatient setting. The patient's Physician must certify, and the Utilization Review Administrator must agree, that the transplant is Medically Necessary. Physician should send a written request for Pre- authorization to the Utilization Review Administrator as soon as possible to start this process. Not getting Pre-authorization may result in a denial of benefits.

Please note that the Physician may ask for approval for HLA (human leukocyte antigen) testing, donor searches, or harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The harvest and storage request will be reviewed for medical necessity and may

be approved. However, such an approval for HLA testing, donor search, or harvest and storage is NOT an approval for the later transplant. A separate medical necessity decision will be needed for the transplant itself.

Specified Transplants

Pre-authorization must obtained for all services including, but not limited to, preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Specified transplants must be performed at Centers of Medical Excellence (CME) or Blue Distinction Centers for Specialty Care (BDCSC). **Charges for services provided for or in connection with a specified**

transplant performed at a facility other than a CME or BCDSC will not be considered covered. Call the toll-free telephone number for Pre-authorization on the identification card if the Physician recommends a specified transplant for the patient's medical care. A case manager will assist in facilitating access to a CME or BDCSC. See Cost Management Services for details.

Transplant Travel Charges

Certain travel expenses incurred in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated CME or BDCSC that is 75 miles or more from the recipient's or donor's place of residence are covered. The maximum payment will not exceed **the amount shown in the Summary of Benefits** per transplant for the following travel expenses incurred by the recipient and one companion* or the donor:

(i) Ground transportation to and from the CME or BDCSC when the designated CME or BDCSC is 75 miles or more from the recipient's or donor's place of residence.

(ii) Coach airfare to and from the CME or BDCSC when the designated CME or BDCSC is 300 miles or more from the recipient's or donor's residence.

(iii) Lodging, limited to one room, double occupancy.

(iv) Other reasonable expenses. Tobacco, alcohol, drug expenses, and meals are excluded.

*Note: When the Covered Person recipient is under 18 years of age, this benefit will apply to the recipient and two companions or caregivers.

For certain plans the Plan Year Deductible will not apply and no Copayments will be required for transplant travel charges pre-authorized in advance by the Utilization Review Administrator. Benefits will be provided for lodging and ground transportation, up to the current limits set forth in the Internal Revenue Code. See your Summary of Benefits for details.

Charges incurred for the following are not covered: travel expenses for interim visits to a medical care facility while waiting for the actual transplant procedure; travel expenses for a companion and/or caregiver for a transplant donor; return

visits for a transplant donor for treatment of a condition found during the evaluation; rental cars, buses, taxis or shuttle services; and mileage within the city in which the medical transplant facility is located.

Details regarding reimbursement can be obtained by calling the customer service number on the identification card. A claim form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

(ff) **Orthognathic surgery** for a physical abnormality that prevents normal function of the upper or lower jaw and is Medically Necessary to attain functional capacity of the affected part.

(gg) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(hh) This Plan provides coverage for behavioral health treatment for **Pervasive Developmental Disorder or autism**. This coverage is provided according to the terms and conditions of this Plan that apply to all other medical conditions, except as specifically stated in this section.

Behavioral health treatment services covered under this Plan are subject to the same deductibles, coinsurance, and copayments that apply to services provided for other covered medical conditions. Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals will be covered under Plan benefits for office visits to Physicians, whether services are provided in the provider's office or in the patient's home. Services provided in a facility, such as the outpatient department of a Hospital, will be covered under Plan benefits that apply to such facilities.

You must obtain pre-authorization for all behavioral health treatment services for the treatment of Pervasive Developmental Disorder or autism in order for these services to be covered by this Plan (see UTILIZATION REVIEW PROGRAM for details). No benefits are payable for these services if pre-authorization is not obtained.

The behavioral health treatment services covered by this Plan for the treatment of Pervasive Developmental Disorder or autism are limited to those professional services and treatment programs, including Applied Behavioral Analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or autism and that meet all of the following requirements:

(i) The treatment must be prescribed by a licensed Physician and surgeon (an M.D. or D.O.) or developed by a licensed clinical psychologist,

(ii) The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service provider, and

(iii) The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of Applied Behavioral Analysis services and Intensive Behavioral Intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:

- Describes the patient's behavioral health impairments to be treated,
- Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,
- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or autism,
- Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate, and
- The treatment plan is not used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. No coverage will be provided for any of these services or costs. The treatment plan must be made available upon request.

(ii) **Physical therapy and Physical medicine** must be administered in strict accordance with the referring Physician's orders regarding type of therapy, frequency and duration. The condition treated must also be established as one which receives substantial benefit from short-term therapy. Care must be provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths.)

Physical therapy is limited as shown in the Summary of Benefits.

For the purposes of this benefit, the term "visit" shall include any visit by a physician in that physician's office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

Up to 24 visits in a year for all covered physical therapy, physical medicine and occupational therapy services are payable, if Medically Necessary. If additional visits are needed after receiving 24 visits in a year, pre-authorization must be obtained prior to receiving the services.

If we determine that an additional period of physical therapy, physical medicine or occupational therapy is Medically Necessary, we will authorize a specific number of additional visits. Such additional visits are not payable if pre-authorization is not obtained. (See UTILIZATION REVIEW PROGRAM.)

There is no limit on the number of covered visits for Medically Necessary physical therapy, physical medicine, and occupational therapy. But additional visits in excess of the number of visits stated above must be authorized in advance.

If we apply covered charges toward the Plan Year Deductible and do not provide payment, that visit will be included in the visit maximum (24 visits) for that year.

(jj) Special food products and formulas that are part of a diet prescribed by a Physician for the treatment of **phenylketonuria (PKU)**.

(kk) **Prescription Drugs Obtained From or Administered By a Medical Provider.** Your plan includes benefits for prescription drugs when they are administered to you as part of a physician visit, services from a home health agency, or at an outpatient Hospital. This includes drugs for infusion therapy, chemotherapy, specialty pharmacy drugs, and blood products. This section describes your benefits when your physician orders the medication and administers it to you. Benefits are also available for prescription drugs that you receive under your prescription drug benefits, if included.

Non-duplication of benefits applies to pharmacy drugs under this plan. When benefits are provided for pharmacy drugs under the plan's medical benefits, they will not be provided under your prescription drug benefits, if included. Conversely, if benefits are provided for pharmacy drugs under your prescription drug benefits, if included, they will not be provided under the plan's medical benefits.

Pre-Authorization. Certain specialty pharmacy drugs require written pre-authorization of benefits in order for you to receive them. Pre-authorization criteria will be based on medical policy and the pharmacy and therapeutics process. You may need to try a drug other than the one originally prescribed if we determine that it should be clinically effective for you. However, if we determine through pre-authorization that the drug originally prescribed is Medically Necessary and is cost effective, you will be provided the drug originally requested. If, when you first become a member, you are already being treated for a medical condition by a drug that has been appropriately prescribed and is considered safe and effective for your medical condition, we will not require you to try a drug other than the one you are currently taking.

In order for you to get a specialty pharmacy drug that requires pre-authorization, your physician must make a request to us for you to get it. The request may be made by either telephone or facsimile to us. At the time the request is initiated, specific clinical information will be requested from your physician based on medical policy and/or clinical guidelines, based specifically on your diagnosis and/or the physician's statement in the request or clinical rationale for the specialty pharmacy drug.

If the request is not for urgently needed drugs, after we get the request from your physician:

- Based on your medical condition, as Medically Necessary, we will review it and decide if we will approve benefits within 5-business days. We will

tell you and your physician what we have decided in writing - by fax to your doctor, and by mail, to you.

- If more information is needed to make a decision, we will tell your physician in writing within 5-business days after we get the request what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your physician what information is missing within 5-business days, we will tell your physician that there is a problem as soon as we know that we cannot respond within 5-business days. In any event, we will tell you and your physician that there is a problem by telephone, and in writing by facsimile, to your physician, and in writing to you by mail.

- As soon as we can, based on your medical condition, as Medically Necessary, within 5-business days after we have all the information we need to decide if we will approve benefits, we will tell you and your physician what we have decided in writing - by fax to your physician and by mail to you.

If you have any questions regarding whether a specialty pharmacy drug requires pre- authorization, please call the number listed on your ID Card.

If we deny a request for pre-authorization of a specialty pharmacy drug, you or your prescribing physician may appeal our decision by calling the number listed on your ID card. If you are not satisfied with the resolution based on your inquiry, you may file an Appeal with us by following the procedures described in the section entitled HOW TO SUBMIT A CLAIM.

(II) Routine **Preventive Care Services.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Summary of Benefits. Standard Preventive Care shall be provided as required by applicable law if provided by a Network Provider. The plan year deductible will not apply to these services or supplies. No copayment will apply to these services or supplies. Standard Preventive Care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Screenings as ordered by an examining physician for: breast cancer (including BRCA testing if appropriate in conjunction with genetic counseling and evaluation), cervical cancer, human papillomavirus (HPV), human immunodeficiency virus (HIV), prostate cancer, colorectal cancer, other medically accepted cancer screening tests, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, blood lead levels, iron deficiency anemia in pregnant women, and obesity.

- Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

    - All FDA-approved contraceptive methods for women, including over the counter items, if prescribed by a physician. In order to be covered as preventive care, contraceptive prescription drugs

must be either generic or single source brand name drug. Also covered are sterilization procedures and counseling.

- Breastfeeding support, supplies, and counseling. One breast pump will be covered per pregnancy under this benefit.

- Gestational diabetes screening.

- Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, and tobacco use-related diseases.

- Preventive services for certain high-risk populations as determined by a physician, based on clinical expertise.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and

- www.cdc.gov/vaccines/recs/acip/

In accordance with Section 4203 of the CARES Act, the Plan will cover vaccines and other qualifying preventive services for COVID-19 on an expedited basis

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury, Illness or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury, Illness or Sickness. Standard Preventive Care shall be provided as required by applicable law if provided by a Network Provider. Standard Preventive Care for children includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:

  - Diphtheria,

  - Pertussis,

  - Tetanus,

  - Polio,

  - Measles,

  - Mumps,

  - Rubella,

- Hemophilus influenza b (Hib),
- Hepatitis B,
- Varicella.

- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

(mm) Coverage of **prosthetic devices**:

(i) Breast prostheses following a mastectomy.

(ii) Prosthetic devices to restore a method of speaking when required as a result of a covered Medically Necessary laryngectomy.

(iii) The Plan will pay for other Medically Necessary prosthetic devices, including:

- Surgical implants;
- Artificial limbs or eyes;
- The first pair of contact lenses or eye glasses when required as a result of a covered Medically Necessary eye surgery;
- Therapeutic shoes and inserts for the prevention and treatment of diabetes- related foot complications; and
- Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.

(nn) **Reconstructive surgery** performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance. This includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

This does not apply to orthognathic surgery. Please see the "Dental Care" provision below for a description of this service.

(oo) Charges associated with **Retail Health Clinics** provided by medical professionals who provide basic medical services in a retail health clinics including, but not limited to:

(i) Exams for minor illnesses and injuries

(ii) Preventive services and vaccinations

(iii) Health condition monitoring and testing

(pp) Care and treatment for **sleep disorders** when deemed Medically Necessary.

(qq) **Speech therapy** by a licensed therapist.

(rr) **Spinal Manipulation services** by a health care provider acting within the scope of his or her license. Spinal Manipulation services are limited as shown in the Summary of Benefits.

(ss) **Sterilization** procedures.

(tt) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(uu) Services and supplies provided in connection with **transgender services** when the patient has been diagnosed with gender identity disorder or gender dysphoria by a Physician. This coverage is provided according to the terms and conditions of the Plan that apply to all other covered medical conditions, including medical necessity requirements, utilization management, and exclusions for cosmetic services. Coverage includes, but is not limited to, Medically Necessary services related to gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training.

Coverage is provided for specific services according to Plan benefits that apply to that type of service generally, if the Plan includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, Medically Necessary surgery; hormone therapy would be covered under the Plan's prescription drug benefits (if such benefits are included).

Services that are excluded on the basis that they are cosmetic include, but are not limited to, liposuction, facial bone reconstruction, voice modification surgery, breast implants, and hair removal. Transgender services are subject to pre-authorization in order for coverage to be provided.

Transgender Travel Expense. Certain travel charges incurred in connection with an approved transgender surgery, when the Hospital at which the surgery is performed is 75 miles or more from the Covered Person's place of residence, provided the charges are pre- authorized in advance by the Utilization Review Administrator. The maximum payment will not exceed $10,000 per transgender surgery, or series of surgeries (if multiple surgical procedures are performed), for the following travel charges incurred by the patient and one companion:

(i) Ground transportation to and from the Hospital when it is 75 miles or more from the patient's place of residence.

(ii) Coach airfare to and from the Hospital when it is 300 miles or more from the patient's residence.

(iii) Lodging, limited to one room, double occupancy.

(iv) Other reasonable charges. Tobacco, alcohol, drug, and meal charges are excluded.

For certain plans, the Plan Year Deductible will not apply and no copayments will be required for transgender travel charges pre-authorized in advance by the Utilization Review Administrator. Benefits will be provided for lodging, transportation, and other reasonable charges up to the current limits set forth in the Internal Revenue Code, not to exceed the maximum amount specified above. This travel expense benefit is not available for non- surgical transgender services. Please see the Summary of Benefits for details.

Details regarding reimbursement can be obtained by calling the customer service number on the identification card. A claim form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

(vv) Services and supplies received from an **urgent care** center to prevent serious deterioration of the patient's health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, medical condition, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Services for urgent care are typically provided by an urgent care center or other facility such as a Physician's office.

(ww) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Mid-Year Election Events or Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to charges for nursery care for the newborn child while Hospital confined as a result of the child's birth, if the child's natural mother is a Covered Person.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to the charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth, if the child's natural mother is a Covered Person.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent.

If the baby is ill, suffers an injury, premature birth, congenital abnormality or requires care other than routine care, benefits will be provided on the same basis as for any other eligible expense provided the child is added to the Plan and coverage is in effect.

(xx) Charges associated with the initial purchase of a **wig after chemotherapy** are payable as shown in the Summary of Benefits.

(yy) Diagnostic **x-rays**.

Special Note Regarding COVID-19: As required by applicable law, the Plan will cover certain items and services related to medically necessary diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19 without imposing any cost-sharing or pre-authorization requirements during the public health emergency.

COST MANAGEMENT SERVICES

Cost Management Services include:

- Utilization Review
- Second and Third Opinion Program
- Pre-Admission Testing Services
- Case Management

Cost Management Services Phone Number

Please call the numbers listed on your ID Card or call HealthComp for additional information on Cost Management Services.

The provider, patient or family member must call the number for Pre-Authorization Review to receive certification of certain Cost Management Services. This call must be made at least 5 days in advance of services being rendered or within 72 hours after a Medical Emergency.

Failure to follow cost management procedures may result in the reduction of the Plan's reimbursement level, and any costs incurred because of reduced reimbursement due to failure to follow cost management procedures will not accrue toward the deductible or the maximum out-of-pocket payment.

UTILIZATION REVIEW

Benefits are provided only for Medically Necessary and appropriate services. Utilization Review is designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out of pocket expense.

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms and requirements of this plan.

Important: The Utilization Review Program requirements described in this section do not apply when coverage under this plan is secondary to another plan providing benefits for you or your family members.

The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your physician are advised if we have determined that services can be safely provided in an outpatient setting, or if an inpatient stay is recommended. Services that are Medically Necessary and appropriate are certified by us and monitored so that you know when it is no longer Medically Necessary and appropriate to continue those services.

Certain services require pre-authorization of benefits in order for benefits to be provided. Network Providers will initiate the review on your behalf. A Non-Network Provider may or may not initiate the review for you. In both cases, it is your responsibility to initiate the process and ask your physician to request pre-authorization. You may also call us directly. Pre-authorization criteria are based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. We may determine that a service that was initially prescribed or requested is not Medically Necessary if you have not previously tried alternative treatments that are more cost effective.

It is your responsibility to determine whether a particular service requires pre-authorization. Please read the following information to assist you in this determination and please feel free to call the toll-free number for pre-authorization printed on your identification card if you have any questions about making this determination.

It is also your responsibility to see that your physician starts the utilization review process before scheduling you for any service subject to the utilization review program. If you receive any such service, and do not follow the procedures set forth in this section, your benefits may be reduced.

Pre-authorization does not confirm or verify eligibility for coverage, nor is it a guarantee of payment.

The program consists of:

(1) Pre-authorization of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Autism Treatment
Applied Behavioral Analysis Therapy
Air Ambulance for Non-Emergent Transport All Bariatric Procedures
Certain Prosthetics Diagnostics, including:

- **AmniSure® ROM Test**
- **Computed Tomography Scans with or without Computer Assisted Detection (CAD) for Lung Cancer Screening**
- **Genetic testing for cancer susceptibility**
- **Genetic testing for Inherited Peripheral Neuropathies**
- **Genetic testing for PTEN Hamartoma Tumor Syndrome**
- **High technology radiology services such as MRI, MRA, MEG, PET, CAT, CTA, MRS, CT/PT, SPECT, ECHO cardiology, nuclear technology services**
- **Myocardial sympathetic innervations imaging with or without SPECT**
- **Thyroid Fine Needle Aspirate Molecular Markers Durable Medical Equipment**

Facility Based Substance Abuse/Mental Disorder treatments
Foot Orthotics

Home Health Care
Infusion Therapy
Inpatient Hospitalizations, including:

- **Elective Admissions**
- **OB Related Medical Stay (OB complications, Excludes childbirth)**
- **Newborn Stays beyond Mother (NICU)**
- **Inpatient Skilled Nursing Facility**
- **Rehabilitation Facility Admissions**

Organ, Bone Marrow, and Stem Cell Transplants
Outpatient surgical procedures and treatments
Rehabilitation services beyond stated Plan limits
Sex Change/Transgender Surgical Procedures

If you proceed with any services that have been determined to be not Medically Necessary and appropriate at any stage of the Pre-authorization process, benefits will not be provided for those services.

(2) Retrospective review for Medical Necessity is performed to review services that have already been provided. This applies in cases when pre-authorization or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not Medically Necessary and appropriate, benefits will not be provided for those services. Remaining benefits may be subject to previously noted reductions and limitations that apply when the required reviews are not obtained.

(3) Concurrent review determines whether services are Medically Necessary and appropriate when we are notified while services is ongoing, for example an emergency admission to the Hospital.

(4) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be Medically Necessary. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain Pre-authorization from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

HOW TO OBTAIN UTILIZATION REVIEW

Remember, it is always your responsibility to confirm that the pre-authorization has been performed. If the pre- authorization is not performed your benefits may be reduced as shown in the Summary of Benefits.

Pre-authorization

Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, authorize the care. Pre-authorization does not confirm or verify eligibility for coverage, nor is it a guarantee of payment. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Physicians who are Network Providers will initiate the review on your behalf. A Non Network provider may initiate the review, or you must call the Pre-Authorization Review telephone number on the Covered Person's ID card **at least 5 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services

If you do not receive the reviewed service within 60 days of the Pre-authorization, or if the nature of the service changes, a new Pre-Authorization review must be obtained.

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 72 hours** of the first business day after the admission.

The utilization review administrator will pre-authorize the number of days of Medical Care Facility confinement as determined by medical necessity. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive Pre-authorization as explained in this section, the benefit payment may be reduced or denied.

Concurrent Review and Discharge Planning

Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If we determine that the service is not Medically Necessary and appropriate, your physician will be notified by telephone no later than 24 hours following our decision. We will send written notice to you and your physician within two business days following our decision. However, care will not be discontinued until your physician has been notified and a plan of care that is appropriate for your needs has been agreed upon. If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-authorized, the attending Physician must request the additional services or days.

If Pre-authorization was not obtained, you, your physician or the provider of the service must contact us for Concurrent Review. For an emergency admission or procedure, we must be notified within one working day of the admission or procedure, unless extraordinary circumstances prevent such notification within that time period.

In determining "extraordinary circumstances", we may take into account whether or not your condition was severe enough to prevent you from notifying us, or whether or not a member of your family was available to notify us for you. You may have to prove that such "extraordinary circumstances" were present at the time of the emergency.

Retrospective Reviews

- If a pre-authorization or a concurrent review was not performed, a retrospective review will be done to review services that have already been provided to determine if they are Medically Necessary.

- Retrospective review is performed when we are not notified of the service you received, and are therefore unable to perform the appropriate review. It is also performed when pre-authorization or concurrent review has been done, but services continue longer than originally certified.

- It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-authorization or concurrent review was performed.

- Such services which have been retroactively determined to not be Medically Necessary and appropriate will be retrospectively denied authorization.

THE MEDICAL NECESSITY REVIEW PROCESS

We work with you and your health care providers to cover Medically Necessary and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, we are committed to ensuring that reviews are performed in a timely and professional manner. The following information explains our review process.

(1) A decision on the medical necessity of a pre-authorization request will be made no later than five business days from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition.

When your medical condition is such that you face an imminent and serious threat to your health, including the potential loss of life, limb, or other major bodily function and the normal five day timeframe described above would be detrimental to your life or health or could jeopardize your ability to regain maximum function, a decision on the medical necessity of a pre-authorization request will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision (or within any shorter period of time required by applicable federal law, rule, or regulation).

(2) A decision on the medical necessity of a concurrent review request will be made no later than one business day from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition. However, care will not be discontinued until your physician has been notified and a plan of care that is appropriate for your needs has been agreed upon.

(3) A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision to you and your physician.

(4) If we do not have the information we need, we will make every attempt to obtain that information from you or your physician. If we are unsuccessful, and a delay is anticipated, we will notify you and your physician of the delay and what we need to make a decision. We will also inform you of when a decision can be expected following receipt of the needed information.

(5) All pre-authorization, concurrent review, and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and our medical policy. These criteria and policies are developed and approved by practicing providers not employed by us, and are evaluated at least annually and updated as standards of practice or technology change. Such criteria and policies are incorporated into the Plan by reference herein and constitute binding Plan terms and conditions. Requests satisfying these criteria are certified as Medically Necessary. Review Coordinators are able to approve most requests.

(6) For pre-authorization and concurrent review requests, written confirmation including the specific service determined to be Medically Necessary will be sent to you and your provider no later than two business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-authorization and concurrent reviews.

(7) If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to authorize the service, the requesting physician is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to authorize the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.

(8) Only the Peer Clinical Reviewer may determine that the proposed services are not Medically Necessary and appropriate. Your physician will be notified by telephone within 24 hours of a decision not to authorize and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:

- an explanation of the reason for the decision,
- reference of the criteria used in the decision to modify or not authorize the request,
- the name and phone number of the Peer Clinical Reviewer making the decision to modify or not authorize the request,
- how to request reconsideration if you or your provider disagree with the decision.

(9) Reviewers may be plan employees or an independent third party we choose at our sole and absolute discretion.

(10) You or your physician may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. We disclose our medical

necessity review procedures to health care providers through provider manuals and newsletters.

A determination of medical necessity does not guarantee payment or coverage. The determination that services are Medically Necessary is based on the clinical information provided. Payment is based on the terms of your coverage at the time of service. These terms include certain exclusions, limitations, and other conditions. Payment of benefits could be limited for a number of reasons, including:

- The information submitted with the claim differs from that given by phone;
- The service is excluded from coverage; or
- You are not eligible for coverage when the service is actually provided.

(11) Reviewers may be plan employees or an independent third party we choose at our sole and absolute discretion.

(12) You or your physician may request copies of specific criteria and/or medical policies by writing to the address shown on your plan identification card. We disclose our medical necessity review procedures to health care providers through provider manuals and newsletters.

Revoking or modifying an authorization. An authorization for services or care may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

- Your coverage under this plan ends;
- The agreement with the group terminates;
- You reach a benefit maximum that applies to the services in question;
- Your benefits under the plan change so that the services in question are no longer covered or are covered in a different way.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) performed on an outpatient basis before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

OUTPATIENT SURGERY

Certain surgical procedures can be performed safely and efficiently outside of a Hospital. Outpatient surgical facilities are equipped for many uncomplicated surgical operations, such as some biopsies, cataract surgeries, tonsillectomies and adenoidectomies, dilation and curettages, and similar procedures.

CASE MANAGEMENT

The case management program helps coordinate services for Covered Persons with health care needs due to serious, complex, and/or chronic health conditions. If a Covered Person qualifies for and agrees to participate in a case management program, a case manager will work closely with the Covered Person, the Covered Person's family, the attending Physician, and other health care providers to ensure that the Covered Person receives appropriate care in the most effective setting possible, whether at home, as an outpatient, or inpatient in a Hospital or specialized facility. In addition, the case manager may assist in coordinating care with existing community-based programs and services the Covered Person may need. This may include giving information about external agencies and community-based programs and services.

The case manager assists in determining appropriate treatment options which will best meet the Covered Person's needs and keep costs manageable. The case manager will help coordinate the treatment program and arrange for necessary resources. Case managers are also available to answer questions and provide ongoing support. Case managers are credentialed health care professionals, trained in the appropriate clinical specialty area that applies to the Covered Person's condition.

The case management program is confidential and voluntary and is made available to you at no extra cost to you, if you qualify for the program. The case management program is separate from any covered services you may receive under the Plan. Eligible participants for the case management program will be identified through the utilization review procedures. In addition, you may request a case manager for a particular condition you may have, but the Plan is not obligated to provide a case manager to you. The Plan Administrator has the right in its sole and absolute discretion to determine who may participate in the case management program. A case manager is not assigned to every Covered Person. The case management program is only appropriate for Covered Persons with certain conditions that serious, complex, and/or chronic.

In certain cases, the case management program may authorize alternative benefits as described in the "Alternative Benefits" section below.

ALTERNATIVE BENEFITS

The Plan may elect, in its sole discretion, to provide alternative benefits that may otherwise be excluded under the Plan. Alternative benefits shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

Through the case management program, the Plan has the right to recommend and authorize an alternative treatment plan in order for the Covered Person to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolong periods of intensive medical care. It is the Plan's right to utilize the case management program to determine if an offer of alternative benefits will be made. The Plan Administrator may exercise this right in its sole and absolute discretion.

Covered Persons eligible for potential alternative benefits will be identified through the Plan's utilization review procedures. A Covered Person may also make a request for alternative benefits to the Plan Administrator; however, the Plan has no obligation to accept such a request.

To determine if alternative benefits will be covered by the Plan, a case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

If approved by the attending Physician and the patient, the case manager will coordinate and implement the alternative benefits program. Once a plan of care is developed, the Plan Administrator will direct the Plan to cover Medically Necessary charges as stated in the treatment plan, even if these charges normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for charges incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Any decision regarding treatment belongs to you and your physician. The plan will, in no way, compromise your freedom to make such decisions. The terms of this document control Plan coverage, not treatment decisions. However, note that if you choose a treatment that is not covered by the Plan, the Plan will not pay for any costs associated with such treatment.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer.

Ambulatory Surgical Center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

An **Appeal** is a formal written request for review following an adverse benefit decision.

Applied Behavioral Analysis (ABA) means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

Authorized Referral occurs when you, because of your medical needs, are referred to a non-participating provider, but only when:

- There is no participating provider who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 30-mile radius of your residence or within the county in which your residence is located, whichever is less; and
- You are referred in writing to the non-participating provider by the physician who is a participating provider; and
- Exception For Chiropractic Care only: There is no participating provider who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 20-mile radius of your residence or within the county in which your residence is located, whichever is less; and
- We have authorized the referral before services are rendered.

You or your physician must call the HealthComp toll-free telephone number printed on your identification card prior to scheduling an admission to, or receiving the services of, a non-participating provider.

Such Authorized Referrals are not available to bariatric surgical services. These services are only covered when performed at a bariatric CME.

If authorized services are received from a Non-Network provider you may be billed by the provider for the difference between the billed charges and the plan's Maximum Allowable Amount. In many situations, this difference could be significant.

BDCSC means Blue Distinction Centers for Specialty Care.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name Drug means a drug marketed under a proprietary, trademark-protected name.

Calendar Year means January 1st through December 31st of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance is the Covered Person's share of the cost for Covered Services which is a percentage of the Allowable Amount. Coinsurance is paid after the deductible has been met. Coinsurance is listed in the Summary of Benefits.

Copayment means a fixed amount of money that is paid each time a particular service is used. There may be copayments on some services and not on other services Copayments are listed in the Summary of Benefits.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee, Retiree or Dependent who is covered under this Plan.

Custodial Care is care provided primarily to meet personal needs. This includes help in walking, bathing or dressing. It also includes: Preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

If Medically Necessary, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

Domestic Partner means an individual who meets the Plan's eligibility requirements for Domestic Partners outlined in the eligibility section.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Eligibility Date for a new hire or a newly eligible employee is the effective date assigned based on the date of hire and the Participating Employer's waiting period guidelines. The Eligibility Date for those enrolling because of a permitted Mid-Year Enrollment Event may vary based on the specific event.

Embedded Out-of-Pocket means once an individual reaches the single coverage out-of-pocket, the Plan will pay 100% of the remainder of Covered Charges for that individual for the rest of the Plan Year unless stated otherwise. Once the Family out-of-pocket is reached, the Plan will pay 100% of the remainder of Covered Charges for the entire family for the rest of the Plan Year unless stated otherwise.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, a psychiatric emergency medical condition, or convulsions or other such acute medical conditions.

Final determination as to whether services were rendered in connection with an emergency will rest solely with the Plan.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship; or a person defined as eligible under the City/Town policies and/or Memorandum of Understanding (MOU).

Employer or Participating **Employer** is a city, town, or other local government entity that has chosen to participate in the Redwood Empire Municipal Insurance Fund. A list of Participating Employers can be found in Appendix A of this Plan.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental procedures (Experimental) are those that are mainly limited to laboratory and/or animal research, but which are not generally accepted as proven and effective procedures within the organized medical community. The Utilization Manager has discretion to make this determination. However, if a Member has a seriously debilitating condition and the Utilization Manager determines that requested treatment is not a Covered Service because it is Experimental, the Member may request an Independent Medical Review.

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan. The formulary drug list and prescription drug coverage, restrictions, and limitations are determined by the Pharmacy Benefits Manager and can change during the Plan Year.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about the genetic tests of an individual or his/her family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes as defined by the Genetic Information Nondiscrimination Act of 2008 (GINA).

Home Health Care Agency is a home health care provider which is licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in the home, and is recognized as a home health provider under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care offered under the plan is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Home Infusion Therapy provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice Agency is an agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A hospice must be: currently licensed as a hospice pursuant to Health and Safety Code section 1747 or a licensed home health agency with federal Medicare certification pursuant to Health and Safety Code section 1726 and 1747.1.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is a facility which provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of physicians. It must be licensed as a general acute care Hospital according to state and local laws. It must also be registered as a general Hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations.

For limited purpose of inpatient care, the definition of Hospital also includes: (1) psychiatric health facilities (only for the acute phase of a mental or nervous disorder or substance abuse), and (2) residential treatment centers.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning and provided in multiple settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Intensive Care Unit is defined as a separate, clearly designated Service Area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Investigational procedures (Investigational) are those:

(1) That have progressed to limited use on humans, but which are not generally accepted as proven and effective procedures within the organized medical community; or

(2) That do not have final approval from the appropriate governmental regulatory body; or

(3) That are not supported by scientific evidence which permits conclusions concerning the effect of the service, drug or device on health outcomes; or

(4) That do not improve the health outcome of the patient treated; or

(5) That are not beneficial as any established alternative; or

(6) Whose results outside the Investigational setting cannot be demonstrated or duplicated; or

(7) That are not generally approved or used by Physicians in the medical community.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or the time period permitted for a Mid-Year Election Event (if applicable).

Maximum Allowable Amount is a charge which is either the network Provider's reduced fee or the Recognized Charge for a service or supply. The Maximum Allowable Amount is the total reimbursement payable under the plan for covered services received from Network providers, Non-Network Providers, or other health care providers. If services are received from a Non-Network provider, you may be billed by the provider for the difference between the billed charges and the plan's Maximum Allowable Amount. In many situations, this difference could be significant.

If a service or supply is more expensive than an equivalent service or supply that is medically appropriate and is likely to produce the equivalent therapeutic or diagnostic result for the Covered Person, the Maximum Allowable Amount will be based on the less expensive service or supply, even if the Covered Person chooses the more expensive service or supply, unless otherwise required under a contract with a Network Provider or the Plan Administrator determines an exception is warranted in its sole and absolute discretion.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medically Necessary procedures, supplies, equipment or services are those we determined to be:

(1) Appropriate and necessary for the diagnosis or treatment of the medical condition;

(2) Provided for the diagnosis or direct care and treatment of the medical condition;

(3) Within standards of good medical practice within the organized medical community;

(4) Not primarily for our convenience, or for the convenience of the physician or another provider; and

(5) Not more costly than an equivalent service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient's illness, injury, or condition; and

(6) The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

(a) there must be valid scientific evidence demonstrating that the expected health benefit from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than other possible alternatives; and

(b) generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

(c) for Hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the patient's condition, and safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary, and whether an exception to the Medical Necessity requirement is available.

If a service or supply is more expensive than an equivalent service or supply that is medically appropriate and is likely to produce the equivalent therapeutic or diagnostic result for the patient, the more expensive service or supply shall not be Medically Necessary, unless the Plan Administrator deems an exception is warranted in its sole and absolute discretion.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Member is the covered employee or retiree, or the covered family member.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Network Provider is one of the following providers or other licensed health care professionals who have a Network Provider Agreement in effect with the Plan's contracted network at the time services are rendered:

- A Hospital
- A Physician
- An ambulatory surgical center
- A home health agency
- A facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A skilled nursing facility
- A clinical laboratory
- A home infusion therapy provider
- An urgent care center
- A retail health clinic
- A hospice agency or unit
- A licensed ambulance company
- A licensed qualified autism service provider

Network Providers agree to accept the Maximum Allowable Amount as payment for covered services. A directory of Network providers is available upon request.

Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Non-Network Provider is one of the following providers or other licensed health care professionals who DOES NOT have a Network Provider Agreement in effect with the Plan's contracted network at the time services are rendered:

- A Hospital
- A Physician
- An ambulatory surgical center
- A home health agency
- A facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A skilled nursing facility
- A clinical laboratory
- A home infusion therapy provider
- An urgent care center
- A retail health clinic
- A hospice agency or unit
- A licensed ambulance company
- A licensed qualified autism service provider

Non-Network Providers are not required to accept the Maximum Allowable Amount as payment for covered services. A directory of Network providers is available upon request.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Participating Pharmacy is a pharmacy which does not have a contract in effect with the pharmacy benefits manager at the time services are rendered.

Other health care provider is one of the following providers:

- A certified registered nurse anesthetist
- A blood bank

The provider must be licensed according to state and local laws to provide covered medical services.

Outpatient Care and/or Services is treatment including services, supplies and medicine s provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Outpatient Surgical Center, or the patient's home.

Outpatient Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Participating Pharmacy is a pharmacy which has a Participating Pharmacy Agreement in effect with the pharmacy benefit manager at the time services are rendered.

Pervasive Developmental Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, includes Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Pharmacy Benefits Manager (PBM) is the entity with which the Plan has contracted to administer its prescription drug benefits. The PBM is an independent contractor and not affiliated with the Plan.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Redwood Empire Municipal Insurance Fund Group Health Plan, which is a benefits plan for certain Employees of Redwood Empire Municipal Insurance Fund and is described in this document.

Plan Participant is any Employee, Retiree or Dependent who is covered under this Plan. **Plan Year** is the 12-month period beginning on July 1 and ending on the following June 30. **Pregnancy** is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin and; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Preventive Care Services- See page 61.

Qualified Autism Service Paraprofessional is an unlicensed and uncertified individual who meets all of the following requirements:

- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Meets the criteria set forth in any applicable state regulations adopted pursuant to state law concerning the use of paraprofessionals in group practice provider behavioral intervention services, and

- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

Qualified Autism Service Professional is a provider who meets all of the following requirements:

- Provides behavioral health treatment,
- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in state regulation, and
- Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to applicable state law.

Qualified Autism Service Provider is either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified; or
- A person licensed as a physician and surgeon (M.D. or D.O.), physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to state law, who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the licensee.

The network of *participating providers* is limited to licensed Qualified Autism Service Providers who contract with us and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

Recognized Charge is the lower of:

(1) The provider's usual charge to provide a service or supply, or

(2) The charge the Claims Administrator determines to be the recognized charge percentage for the service or supply, or

(3) The charge the Claims Administrator determines to be appropriate, based on factors such as:

(a) The cost of supplying the same or similar service or supply, and

(b) The manner in which the charges for the service or supply are made.

(c) The complexity of the service or supply,

(d) The degree of skill needed to provide it,

(e) The provider's specialty, and

(f) The Recognized Charge in other areas.

We may have internal data or policies that we use to determine a Recognized Charge. Such data and policies are incorporated into this Plan by reference herein and constitute binding Plan terms and conditions.

Retail Health Clinic is a facility that provides limited basic medical care services to *members* on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores.

Retired Employee or Retiree is any former Active Employee of the Employer who retired while employed by the Employer.

Service Area is the State of California.

Sickness is a Covered Person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare.

Specialty Medications are typically high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. Certain specified specialty drugs may require special handling, such as temperature controlled packaging and overnight delivery, and therefore, certain specified specialty drugs will be required to be obtained through the specialty pharmacy program, unless you qualify for an exception.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse means an individual who meets the plan's eligibility requirements for Spouses as outlined under ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATIONS.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means: In the case of a Dependent or Retired Employee, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health. In the case of an employee, Totally Disability means a person who, because of illness or injury, is unable to work for income in any job for which they are qualified or for which they become qualified by training or experience, and who is in fact unemployed.

Urgent Care Services means care and treatment for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

Waiting Period is the period of time that must pass before a new hire or newly eligible employee is eligible to participate in the Plan. Each Participating Employer has its own Waiting Period guidelines, but in no circumstances will a Participating Employer's Waiting Period exceed the maximum period of 90 days allowed under federal law.

We (us, our) refers to the Plan.

You (your) refers to a Covered Person enrolled for benefits under this Plan.

PLAN EXCLUSIONS

N**ote: Exclusions related to Prescription Drugs are shown in the Prescription Drug Plan. Contact the Prescription Drug Administrator for additional information.**

For all Medical Benefits shown in the Summary of Benefits, a charge for the following is not covered:

(1) **Acupuncture.** Acupuncture treatment except as specifically stated in the "Acupuncture" provision of MEDICAL BENEFITS. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

(2) **Air Conditioners.** Air purifiers, air conditioners, or humidifiers.

(3) **Clinical Trials.** Services and supplies in connection with clinical trials, except as specifically stated in the "Clinical Trials" provision under the section MEDICAL BENEFITS.

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

(5) **Contraceptive Devices.** Contraceptive devices prescribed for birth control except as specifically stated in the "Contraceptives" provision in MEDICAL BENEFITS.

(6) **Cosmetic Procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic Procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by injury, disease, trauma, congenital/developmental Anomalies, or previous covered therapeutic processes.

(7) **Custodial care.** Inpatient room and board charges in connection with a Hospital stay primarily for environmental change or physical therapy. Custodial care or rest cures, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL BENEFITS. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility, except as specifically stated in the "Skilled Nursing Facility" provision of MEDICAL BENEFITS.

(8) **Dental Services or Supplies.** For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated

expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:

- Extraction, restoration, and replacement of teeth;
- Services to improve dental clinical outcomes.

This exclusion does not apply to the following:

- Services which we are required by law to cover;
- Services specified as covered in this booklet;
- Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.

(9) Diabetic Supplies. Prescription and non-prescription diabetic supplies, except as specifically stated in "PRESCRIPTION DRUG BENEFITS" section of this booklet.

(10) Educational or vocational testing. Services for educational or vocational testing or training.

(11) Excess charges. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Recognized Charge. This exclusion does not apply to inpatient care in a network Hospital or to emergency room care.

(12) Exercise programs. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

(13) Experimental or not Medically Necessary. Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall not apply to the extent that the charge is for routine patient care of costs a Qualified Individual who is a participant in an approved clinical trial. Charges will be covered only to the extent specifically set forth in the "Covered Charges" section.

(14) Eye care. Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. Optometric services, eye exercises including orthoptics. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

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

(16) Foot care. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(17) Foreign travel and care outside the U.S. Care, treatment or supplies out of the U.S. if travel is for the purpose of obtaining medical services unless such services or supplies are furnished in connection with urgent care or an emergency.

(18) **Government coverage.** Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free. You are not required to seek any such services prior to receiving Medically Necessary health care services that are covered by this plan.

(19) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy as shown in the Summary of Benefits.

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

(21) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(22) **Illegal Acts or Nuclear Energy.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of the Covered Person's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence, Plan also excludes conditions that result from any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

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

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

(25) **Lifestyle Programs.** Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition.

(26) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.

(27) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(28) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(29) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(30) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

(31) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(32) **Non-Licensed Providers.** Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed physician, except as specifically provided or arranged by us. This exclusion does not apply to the Medically Necessary treatment of pervasive developmental disorder or autism, to the extent stated in the section MEDICAL BENEFITS for Pervasive Developmental Disorder or Autism.

(33) **Non-Medical Counseling and/or Ancillary Services**. All non-medical counseling and/or ancillary services, unless specifically included elsewhere in this Plan Document, including but not limited to alternative treatments such as homeopathy, naturopathic treatments, custodial services (see also Custodial Care above), educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis or hypnotherapy, massage therapy at a salon, aroma therapy, sleep therapy, return to work services, work hardening programs and driver safety courses.

(34) **Non-Network Providers.** For certain plans: services or supplies that are provided by a Non-Network Provider without an Authorized Referral, except emergency services or urgent care. See the Summary of Benefits for your plan for details.

(35) **Not Medically Necessary.** Services or supplies that are not Medically Necessary, as defined.

(36) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(37) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness is excluded. Medically Necessary non-surgical and surgical treatment of morbid obesity is covered.

(38) **Occupational.** Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.

If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to our right of recovery and reimbursement under California Labor Code Section 4903.

(39) **Orthodontia.** Braces and other orthodontic appliances or services, except as specifically stated in the "Reconstructive Surgery" or "Dental Care" provisions of MEDICAL BENEFITS.

(40) **Orthopedic Supplies.** Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the "Orthotic Appliances" provision of MEDICAL BENEFITS.

(41) **Outpatient Occupational Therapy.** Outpatient occupational therapy, except as stated under MEDICAL BENEFITS. This exclusion also does not apply to the Medically Necessary treatment of severe mental disorders, or to the Medically Necessary treatment

of pervasive developmental disorder or autism, to the extent stated in the section MEDICAL BENEFITS for Pervasive Developmental Disorder or Autism.

(42) **Outpatient Prescription Drugs and Medications.** Outpatient prescription drugs or medications and insulin, except as specifically stated in the "Infusion Therapy" or "Home Infusion Therapy," "Specialty Drugs," and "Prescription Drug for Abortion" provisions of MEDICAL BENEFITS or under YOUR PRESCRIPTION DRUG BENEFITS section of this booklet. Non-prescription, over-the- counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

(43) **Outpatient Speech Therapy.** Outpatient speech therapy except as stated in the "Outpatient Speech Therapy" provision of MEDICAL BENEFITS. This exclusion also does not apply to the Medically Necessary treatment of severe mental disorders, or to the Medically Necessary treatment of pervasive developmental disorder or autism, to the extent stated in the section MEDICAL BENEFITS for Pervasive Developmental Disorder or Autism.

(44) **Physical Therapy or Physical Medicine.** Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy" or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions of MEDICAL BENEFITS. This exclusion also does not apply to the Medically Necessary treatment of severe mental disorders, or to the Medically Necessary treatment of pervasive developmental disorder or autism, to the extent stated in the section MEDICAL BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

(45) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, over-the-counter humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(46) **Plan design exclusions.** Charges excluded by the Plan design as mentioned in this document.

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

(48) **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse.

(49) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(50) **Routine Exams or Tests.** Routine physical exams or tests required by employment or government authority.

(51) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(52) **Specialty Drugs.** Specialty drugs that must be obtained from the specialty drug program, but, which are obtained from a retail pharmacy are not covered by this plan. **You will have to pay the full cost of the specialty drugs you get from a retail pharmacy that you should have obtained from the specialty drug program**.

(53) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(54) **Surrogacy and surrogate mother.** All charges associated with surrogacy, a method of reproduction whereby a woman agrees to become pregnant and deliver a child for a contracted party.

(55) **Telephone, Facsimile Machine, and Electronic Mail Consultations.** Consultations provided using telephone, facsimile machine, or electronic mail, except as noted elsewhere in this Plan Document (see Online Care Services/Telemedicine in "Covered Charges" section).

(56) **Tobacco cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under Standard Preventive Care, including smoking deterrent products. Tobacco cessation care and treatment is otherwise excluded unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.

(57) **Transgender Services.** Services and supplies in connection with transgender services, except as specifically stated in the "Transgender Services" provision under the section MEDICAL BENEFITS.

(58) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance, transgender and organ transplant charges as defined as a Covered Charge.

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

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

(a) It must be internationally known as being devoted mainly to medical research;

(b) At least **10%** of its yearly budget must be spent on research not directly related to patient care;

(c) At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;

(d) It must accept patients who are unable to pay; and

(e) Two-thirds of its patients must have conditions directly related to the Hospital's research.

(f) **War.** Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

The Plan has contracted with a Pharmacy Benefit Manager (PBM) to charge Covered Persons reduced fees for covered Prescription Drugs. The Maximum Allowable Amount is the prescription drug maximum charge for each covered drug that will be accepted by the Plan for each different type of pharmacy.

You may avoid higher out of pocket expenses by choosing a Participating Pharmacy, or by utilizing the Mail Order option whenever possible. In addition, you may reduce your costs by asking your physician and your pharmacist for the more cost-effective generic form of prescription drug.

The Maximum Allowable Amount will always be the lesser of the billed charge or the prescription drug maximum charge.

When you choose a Participating Pharmacy, the Pharmacy Benefits Manager will subtract any expense which is not covered under your prescription drug benefits. The remainder is the amount of the Maximum Allowable Amount for that claim. You will not be responsible for any amount in excess of the Maximum Allowable Amount for covered services of a participating pharmacy.

When the Pharmacy Benefits Manager receives a claim for drugs supplied by a Non-Participating Pharmacy, they first subtract any expense which is not covered under your prescription drug benefits, and then any expense exceeding the prescription Maximum Allowable Amount. The remainder is the amount of prescription drug covered expense for that claim.

The formulary drug list and prescription drug coverage, restrictions, and limitations are determined by the Pharmacy Benefits Manager and can change during the Plan Year.

You will always be responsible for expense incurred which is not covered under this plan.

Copayments and Coinsurance

After the Pharmacy Benefits Manager determines the Maximum Allowable Amount, they will apply the applicable copayment or coinsurance. The copayment or coinsurance is applied to each covered pharmacy drug or mail order drug charge and is shown in the Summary of Benefits. The copayment or coinsurance amount is not a Covered Charge under the medical Plan. Copayments and coinsurance are applied to the Covered Person’s prescription drug out of pocket maximum.

Any one non-maintenance prescription is limited to a 30-day supply. Any one maintenance prescription is limited to a 90-day retail or mail order supply, unless indicated otherwise in the Summary of Benefits.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Covered Persons significant savings on their prescriptions.

Retail 90 Benefit Option

The Retail 90 drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.).

Specialty Medication Program

Certain specified Specialty Medications must be obtained through the Specialty Medication Program unless you are given an exception from the Plan's Pharmacy Benefit Manager. Specialty Medications are limited to a 30 day supply and must be delivered through the mail order Specialty Pharmacy. Specialty Medications are listed in the Pharmacy Benefit Manager's formulary list, which is updated periodically.

Pharmacy Cost Containment

The Plan has adopted the Pharmacy Benefit Manager Cost Containment provisions, including: Pre-Authorizations, Quantity Limits and Step Therapy. You or your physician can initiate requests for authorizations under these programs. Each program is administered by the Pharmacy Benefits Manager, who will have the authority to approve or deny requests for authorization.

- **Prior Authorizations:** Certain specified drugs require authorization by the Pharmacy Benefit Manager prior to dispensing. You or your physician will be able to request authorization for your medication based on medical necessity.

- **Quantity Limits:** Some medications are only available at specific quantities unless authorized for higher quantities. If a prescription is written for a drug quantity exceeds the Quantity Limit, the prescription will be rejected. You or your physician will be able to request a review for authorization of the prescribed quantity.

- **Step Therapy:** Specific categories and classes of drugs require a step therapy treatment where the primary treatment option is a lower cost, effective drug. Drugs that require Step Therapy will require a Covered Person to first try the use of a primary treatment option before a secondary treatment can be authorized. You or your physician will be able to request authorization to bypass Step Therapy requirements based on medical necessity.

The Pharmacy Benefit Manager will review all requests for authorizations under the Prior Authorizations, Quantity Limits and Step Therapy programs. The Pharmacy Benefit Manager may request documentation of medical necessity from your physician.

For details on the Plan's pharmacy cost containment provisions, Covered Persons should contact the Customer Service phone number for the Pharmacy Benefit Manager listed on the back of their ID Card.

Dispense As Written (DAW) Penalty

If the Covered Person or the Covered Person's doctor requests a brand-name medicine when a generic alternative is available, the Covered Person will pay the brand copay plus the difference in cost between the brand-name and the generic medicine.

Covered Prescription Drugs

(1) Drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives unless otherwise specifically excluded, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician.

(4) Injectable drugs or any prescription directing administration by injection.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(6) **FDA.** Any drug not approved by the Food and Drug Administration.

(7) **Immunization.** Immunization agents or biological sera.

(8) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(9) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(10) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(11) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(12) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or to over the counter drugs that are prescribed by a Physician as required for Standard Preventive Care.

(13) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

HOW TO USE YOUR PRESCRIPTION DRUG BENEFIT

When You Go to a Participating Retail Pharmacy. To identify yourself as a Covered Person, you will be issued an identification card. You must present this card to the pharmacy when you have a prescription filled. Provided you have properly identified yourself as a Covered Person, a Participating Pharmacy will only charge your Copayment or applicable coinsurance.

Generic drugs will be dispensed by the pharmacy when the prescription indicates a generic drug. When a brand name drug is specified, but a generic drug equivalent exists, the generic drug will be substituted. In certain plans, Brand name drugs will be dispensed by pharmacies when the prescription specifies a brand name and states "dispense as written" or no generic drug equivalent exists. (See the Summary of Benefits for your plan for more information.

For information on how to locate a Participating Pharmacy in your area, call the Customer Service phone number on the back of your ID card.

Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If you present a prescription to a pharmacy, and the pharmacy indicates your prescription cannot be filled, or requires an additional Copayment, this is not considered an adverse claim decision. If you want the prescription filled, you will have to pay either the full cost, or the additional Copayment, for the prescription drug. If you believe you are entitled to some plan benefits in connection with the prescription drug, submit a claim for reimbursement to the pharmacy benefits manager at the address shown below:

Envision/Rx Options, Inc.
2181 East Aurora Road
Suite 201
Twinsburg, Ohio 44087

Participating pharmacies usually have claims forms, but, if the participating pharmacy does not have claim forms, claim forms and customer service are available by calling the Customer Service number on the back of your ID card. Mail your claim, with the appropriate portion completed by the pharmacist, to the pharmacy benefits manager within 90 days of the date of purchase.

When You Go to a Non-Participating Pharmacy. If you purchase a prescription drug from a non-participating pharmacy, you will have to pay the full cost of the drug and submit a claim to us, at the address below:

Envision/Rx Options, Inc.
2181 East Aurora Road
Suite 201
Twinsburg, Ohio 44087

Non-participating pharmacies do not have the Plan's prescription drug claim forms. You must take a claim form with you to a non-participating pharmacy. The pharmacist must complete the pharmacy's portion of the form and sign it.

Claim forms and customer service are available by calling the Customer Service number on the back of your ID card. Mail your claim with the appropriate portion completed by the pharmacist to us within 90 days of the date of purchase.

When You are Out of State. If you need to purchase a prescription drug out of the state of California, you may locate a participating pharmacy by calling the Customer Service number on the back of your ID card. If you cannot locate a participating pharmacy, you must pay for the drug and submit a claim to us. (See "When You Go to a Non-Participating Pharmacy" above.)

When You Order Your Prescription Through the Mail Order Program. You can order your prescription through the mail order prescription drug program. Not all medications are available through the mail order pharmacy. The prescription must state the drug name, dosage, directions for use, quantity, the physician's name and phone number, the patient's name and address, and be signed by a physician. You must submit it with the appropriate payment for the amount of the purchase, and a properly completed order form. You need only pay the cost of your Copayment.

When You Order Your Prescription Through the Specialty Pharmacy Program. You must order your Specialty medication through the Pharmacy Benefit Manager's Specialty Pharmacy program. The prescription must state the drug name, dosage, directions for use, quantity, the physician's name and phone number, the patient's name and address, and be signed by a physician. Your payment arrangements will be set up by the Specialty Pharmacy once your prescriptions are submitted.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

You or your provider must send properly and fully completed claim forms to the addresses listed on the back of your ID card or the Plan Administrator directly within 90 days of the date you receive the service or supply for which a claim is made. Most Network Providers will submit claims on behalf of Covered Persons electronically.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the applicable Employer's Personnel Office or Human Resources Office, or the Plan Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(4) Send the above to the Claims Administrator at this address:

Medical:
Inside California Anthem
P.O. Box 60007
Los Angeles, CA 90060-0007

Outside California
Submit to the local BCBS office

Prescription Drug:
Envision/Rx Options, Inc.
2181 East Aurora Road, Suite 201
Twinsburg, Ohio 44087

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS & APPEALS PROCEDURES

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures, both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Administrator has not complied with the procedures described in this Section. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. Please contact the Plan Administrator with questions regarding these procedures.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. The Urgent Care Claim rules do not apply to claims involving urgent care where Plan benefits are not conditioned on prior approval. These claims are subject to the rules on Post-Service Claims described below.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. The Claims Administrator will defer to the attending provider's determination that the Claim involves Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

Notification to claimant of Claim determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Claims involving Urgent Care	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for	30 days Rescission Claims

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification or pre-authorization. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	30 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not an Urgent Care Claim or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	60 days

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external Appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures.

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. A claimant may submit written comments, documents, records, and other information relating to the Claim.

The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures.

(6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(7) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(9) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. The External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a treatment is experimental or investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within 4 months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the Plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.

COORDINATION OF BENEFITS

Coordination of Benefits Plans

The Coordination of benefits provision sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received. Coordination provisions apply separately to each Covered Person per Plan Year, and are largely determined by California law.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Maximum Allowable Amounts.

Definitions

The meanings of key terms used in this section are shown below.

Maximum Allowable Amount. For a charge to be allowable it must be a Negotiated or Recognized Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Maximum Allowable Amount any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Maximum Allowable Amount.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. The Plan shall always be considered the secondary carrier regardless of the individual's election to file a claim under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan. This provision will coordinate the medical and prescription benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Primary Plan. The plan that will have its benefits determined first will be the Primary Plan.

This Plan. Where the term "This Plan" is used, it will mean that portion of this Plan which provides benefits subject to this provision.

EFFECT ON BENEFITS

This provision will apply in determining a person's benefits under This Plan for any plan year if the benefits under This Plan and any other Benefit Plans, exceed the Allowable Expenses for that plan year.

(1) If This Plan is the Primary Plan, then its benefits will be determined first without taking into account the benefits or services of any other Benefit Plan.

(2) If This Plan is not the Primary Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.

(3) The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

Benefit plan payment order. When two or more plans provide benefits for the same Maximum Allowable Amount, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Maximum Allowable Amount:

(a) The Benefit Plan which covers the person directly (that is, as an employee, or Retired Employee) ("Plan A") will pay before those of the plan which covers the person as a dependent ("Plan B"). However, if you are retired and eligible for Medicare, Medicare pays before a Benefit Plan that covers you directly (as an employee or Retired Employee.)

(b) The Benefit Plan which covers a person as an Employee who is neither laid off nor retired will pay before those of a Benefit Plan which covers that person as a laid-off or Retired Employee. The Benefit Plan which covers a person as a Dependent of an Employee who is neither laid off nor retired will pay before those of a Benefit Plan which covers a person as a Dependent of a laid off or Retired Employee. If

the other Benefit Plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply and the Benefit Plan which has covered you the longest will be the Primary Plan. In this case, Allowable Expense is split equally between the two plans.

(c) The Benefit Plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired will pay before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The Benefit Plan of the parent whose birthday falls earlier in a year will pay before those of the Benefit Plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the Benefit Plan which has covered the parent for the longer time will pay before those of the Benefit Plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The Benefit Plan of the parent with custody will pay before the Benefit Plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The Benefit Plan of the parent with custody will be considered first. The Benefit Plan of the stepparent that covers the child as a Dependent will be considered next. The Benefit Plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the Benefit Plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the Benefit Plan which has covered the patient for the longer time will be considered first. This includes situations in which a person who is covered as a dependent child under one Benefit Plan is also covered as a dependent Spouse under another Benefit Plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Maximum Allowable Amounts when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. If a Plan Participant is Medicare entitled this Plan will base its payment upon benefits that would

have been paid by Medicare under Parts A, B and D, regardless of whether or not the person was enrolled under any of these parts.

Benefits for Medicare Eligible Members

For Active Employees and Family Members Enrolled Through Participating Agencies With Fewer Than 20 Employees. If you incur covered charges under this plan, we will determine our payment according to the provisions in the previous section entitled COORDINATION OF BENEFITS and the provision "Coordinating Benefits With Medicare", below.

However if any one participating employer in the group has 100 or more employees (according to federal OBRA legislation) and you are entitled to Medicare benefits as a disabled person and you have current employment status as determined by Medicare rules, you will receive the full benefits of this plan.

For Active Employees and Family Members Enrolled Through Participating Agencies With At Least 20 Employees. If you are entitled to Medicare, you will receive the full benefits of this plan, except as listed below:

(a) You are receiving treatment for end-stage renal disease following the first 30 months you are entitled to end-stage renal disease benefits under Medicare; or

(b) You are entitled to Medicare benefits as a disabled person, unless you have current employment status as determined by Medicare rules, and one or more of the Participating Agencies in the group has 100 or more employees (according to federal OBRA legislation).

In cases where exceptions (a) or (b) apply, our payment will be determined according to the provisions in the section entitled COORDINATION OF BENEFITS and the provision "Coordinating Benefits With Medicare", below.

For Retired Employees or Their Spouses under age 65. If you are a retired employee or the spouse of a retired employee and you are under age 65 and eligible for Medicare, your benefits under this plan will be subject to the section entitled COORDINATION OF BENEFITS and the provision "Coordinating Benefits With Medicare", below.

For Retired Employees or Their Spouses age 65 and older. If you are a retired employee or the Spouse of a retired employee and you are age 65 or older you are NOT eligible for benefits under this plan. Please consult your Human Resources Department for information on other coverage that may be available to you.

Coordinating Benefits With Medicare. Consistent with the "Benefits for Medicare Eligible Members" provision above, we will not provide benefits under this plan that duplicate any benefits to which you would be entitled under Medicare. This exclusion applies to all parts of Medicare in which you can enroll without paying additional premium. If you are required to pay additional premium for any part of Medicare, this exclusion will apply to that part of Medicare only if you are enrolled in that part.

If you are entitled to Medicare, your Medicare coverage will not affect the services covered under this plan except as follows (subject to the terms of the "Benefits for Medicare Eligible Members" provision above):

(a) Medicare must provide benefits first to any services covered both by Medicare and under this plan.

(b) For services you receive that are covered both by Medicare and under this plan, coverage under this plan will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.

(c) For any given claim, the combination of benefits provided by Medicare and the benefits provided under this plan will not exceed the Maximum Allowable Amount for the covered services.

We will apply any charges paid by Medicare for services covered under this plan toward your plan deductible, if any.

(4) If a Plan Participant is under a disability extension from a previous Benefit Plan, that Benefit Plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Plan Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Maximum Allowable Amounts.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another Benefit Plan. In this case this Plan may recover the amount paid from the other Benefit Plan or the Covered Person. That repayment will count as a valid payment under the other Benefit Plan.

Further, this Plan may pay benefits that are later found to be greater than the Maximum Allowable Amount. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party. In such circumstances, the Covered Person may have a claim for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or any other insurer or source, including but not limited to, “first party” underinsured or uninsured motorist coverage, worker’s compensation, crime victim restitution funds, medical or disability payments, homeowner’s plan, renter’s plan, medical malpractice plan, or any other liability plan or any other source of coverage.

This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Plan Administrator retains sole, full and final discretionary authority to construe, apply, and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator also retains the right to delegate this discretionary authority to the Claims Administrator without notice.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and Refund. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party or insurer to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses, even if the Covered Person's Recovery is less than the amount claimed, and, as a result, the Covered Person is not made whole. The Covered Person further specifically agrees and acknowledges that the "made whole doctrine" and "common fund" doctrine are completely abrogated under this Plan, and will not affect the Plan's right to 100% Subrogation or Refund for any and all benefits paid. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interfere with or compromise in any way the Plan's equitable subrogation lien. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party or insurer. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims and/or the Covered Person's claims under any other policy of insurance or other coverage.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person.

If you hired an attorney to gain your recovery from the third party, our lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.

If you did not hire an attorney, our lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.

If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien will be reduced by the same comparative fault percentage by which your recovery was reduced.

Our lien is subject to a pro rata reduction equal to your reasonable attorney's fees and costs in line with the common fund doctrine.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Failure by the Covered Person(s) and/or his attorney to comply with any of these requirements may, at the Plan's discretion, result in forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person(s) satisfies his or her obligation.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person or his designee by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 and related sections of the Public Health Service Act (hereinafter referred to as COBRA), certain Employees and their families covered under Redwood Empire Municipal Insurance Fund Group Health Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Covered Persons and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Redwood Empire Municipal Insurance Fund, 414 W. Napa Street, Sonoma, California, 95476, (707) 938-2388. COBRA continuation coverage for the Plan is administered by HealthComp Administrator, P.O. Box 45018, Fresno, California 93718-5018, (800) 442-7247. Complete

instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Covered Persons who become Qualified Beneficiaries under COBRA.

There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan, or enroll in coverage through the Health Insurance Marketplace. By enrolling through either of these options, you may qualify for lower costs on your monthly premiums and lower out-of- pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Covered Persons and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A Domestic Partner and his or her children are treated as Qualified Beneficiaries if they are covered under the Plan on the day before a Qualifying Event. This gives the Domestic Partner and children the contractual rights outlined in this Section but does not extend statutory provisions to the Domestic Partner or child.

Federal law does not recognize a Domestic Partner or his or her children as Qualified Beneficiaries. However, the Plan will treat a Domestic Partner and his or her Children or Qualified Dependents as Qualified Beneficiaries if they are covered under the Plan on the day before a Qualifying Event. For purposes of interpreting this Section, the Domestic Partner will be treated as the Spouse of the Employee, and a divorce will be deemed to have occurred on the first date that one or more of the eligibility requirements for a Domestic Partner ceases to be met. This gives the Domestic Partner, Children and Qualified Dependents the contractual rights outlined in this Section but does not extend statutory remedies to them.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provides at the time of the event that the Covered Person will lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) The end of a Domestic Partner's partnership with a covered Employee

(5) A covered Employee's enrollment in any part of the Medicare program.

(6) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

(7) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to

COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This Plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a Spouse's plan or through the individual market or California Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a Spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the individual market or California Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the individual market or the California Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

Once election has been made, payment of the initial premium must be delivered to the Plan Administrator within 45 days.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce, termination of domestic partnership or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Mail to:
HealthComp Administrators
P.O. Box 45018
Fresno, CA 93718

Fax to:
559-499-2464

Hand-deliver to:
HealthComp Administrators
621 Santa Fe
Fresno, CA 93721

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any

pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

(4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum

coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

GENERAL PROVISIONS

Providing of Care. The Plan is not responsible for providing any type of Hospital, medical or similar care, nor is it responsible for the quality of any such care received.

Independent Contractors. The Plan's relationship with providers is that of an independent contractor. Physicians, and other health care professionals, Hospitals, skilled nursing facilities and other community agencies are not agents of the Plan. Similarly, the Plan's employees, an employee or agent of any Hospital, medical group or medical care provider of any type are not agents of the Plan.

Non-Regulation of Providers. The benefits provided under this plan do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated by the Plan's contract with Network Providers.

Out of Area Services. The Plan has contracted with Anthem to provide access to providers outside of the Plan's Service Area. Whenever a Covered Person obtains healthcare services outside of our Service Area, the claims for these services may be processed through Anthem under their contract provisions.

Non-Participating Health Care Providers Outside Plan Service Area

- **Member Liability Calculation.** When covered health care services are provided outside of California by Non-Network health care providers, the amount you pay for such services will generally be based on either Anthem's local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the Non-Network health care provider bills and the payment the Plan will make for the covered services as set forth in this paragraph.

- **Exceptions.** In certain situations, Anthem may use other payment bases, such as billed covered charges, the payment the **Plan** would make if the health care services had been obtained within California, or a special negotiated payment, as permitted under the Plan policies, to determine the amount the Plan will pay for services rendered by Non-Network health care providers. In these situations, you may be liable for the difference between the amount that the Non-Network health care provider bills and the payment the Plan will make for the covered services as set forth in this paragraph.

Free Choice of Provider. The Plan in no way interferes with your right as a Covered Person entitled to Hospital benefits to select a Hospital. You may choose any physician who holds a valid physician and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the Hospital where services are received. You may also choose any other health care professional or

facility which provides care covered under this plan, and is properly licensed according to appropriate state and local laws. However, your choice may affect the benefits payable according to the Plan.

Provider Reimbursement. Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. Anthem pays all providers according to their contractual terms.

Medical Necessity. The benefits of the Plan are provided only for services which we determine to be Medically Necessary. The services must be ordered by the attending physician for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under the Plan is available to you upon request.

Expense in Excess of Benefits. The Plan is not liable for any expense you incur in excess of the benefits of the Plan.

Benefits Not Transferable. Only a Covered Person is entitled to receive benefits under the Plan. The right to benefits cannot be transferred.

Workers' Compensation Insurance. The terms of the Plan do not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

Prepayment Fees. Your Employer is responsible for paying subscription charges to the Plan for all coverage provided to you and your family members. Your Employer may require that you contribute all or part of the costs of these subscription charges. Please consult your employer for details.

Liability of Covered Person to Pay Providers. In accordance with California law, Covered Persons will not be required to pay any Network Provider or other health care provider any amounts the Plan owes to that provider (not including co-payments or deductibles), even in the unlikely event that the Plan fails to pay that provider. Covered Persons may be liable, however, to pay Non-Network providers any amounts not paid to them by the Plan.

Conformity with Laws. Any provision of the Plan which, on its effective date, is in conflict with the laws of the governing jurisdiction, is hereby amended to conform to the minimum requirements of such laws.

Transition Assistance for New Members: Transition Assistance is a process that allows for completion of covered services for new members receiving services from a Non-Network Provider. If you are a new member, you may request Transition Assistance if any one of the following conditions applies:

(1) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an Illness, Injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

(2) A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the Non-Network Provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Anthem.

(3) A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

(4) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

(5) The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the child enrolls with Anthem.

(6) Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll with Anthem.

Please contact customer service at the telephone number listed on your ID card to request Transition Assistance or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Transition Assistance does not provide coverage for services not otherwise covered under the Plan.

The Plan or its representatives will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the Plan. Financial arrangements with Non-Network Providers are negotiated on a case-by-case basis. We will request that the Non-Network Provider agree to accept reimbursement and contractual requirements that apply to Network Providers, including payment terms. If the Non-Network Provider does not agree to accept said reimbursement and contractual requirements, the Plan is not required to continue that provider's services. If you do not meet the criteria for Transition Assistance, you are afforded due process including having a physician review the request.

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, Anthem will provide benefits at the Network Provider level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a provider at the time the provider's contract with Anthem terminates (unless the provider's contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity).

You must be under the care of the Network Provider at the time the provider's contract terminates. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions of his or her agreement with Anthem prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with Anthem prior to termination. If the provider does not agree with these contractual terms and conditions, we are not required to continue the provider's services beyond the contract termination date.

Anthem will provide such benefits for the completion of covered services by a terminated provider only for the following conditions:

(1) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

(2) A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires

ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

(3) A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

(4) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

(5) The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

(6) Performance of a surgery or other procedure that the Plan has authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

Such benefits will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.

Please contact customer service at the telephone number listed on your ID card to request continuity of care or to obtain a copy of the written policy. Eligibility is based on the member's clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the Plan.

The Plan or its representatives will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the Plan. Financial arrangements with terminated providers are negotiated on a case-by-case basis. The Plan will request that the terminated provider agree to accept reimbursement and contractual requirements that apply to Network Providers, including payment terms. If the terminated provider does not agree to accept the same reimbursement and contractual requirements, the Plan is not required to continue that provider's services. If you disagree with our determination regarding continuity of care, you may file an Appeal with us by following the procedures described in the section entitled CLAIMS AND APPEALS PROCEDURES.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Redwood Empire Municipal Insurance Fund Group Health Plan is the benefit plan of Redwood Empire Municipal Insurance Fund, the Plan Administrator, also called the Plan Sponsor. An individual or committee may be appointed by Redwood Empire Municipal Insurance Fund to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Redwood Empire Municipal Insurance Fund shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and

those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Covered Person's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FORCE MAJEURE. Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally

shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Redwood Empire Municipal Insurance Fund's workforce are designated as authorized to receive Protected Health Information from Redwood Empire Municipal Insurance Fund Group Health Plan ("the Plan") in order to perform their duties with respect to the Plan: the Privacy Officer, and other individuals trained and authorized by the Privacy Officer to receive Protected Health Information.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to recover the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Person, the amount of overpayment may be deducted from future benefits payable.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured. This plan is **not** subject to the Employee Retirement Income Security Act of 1974 (ERISA).

PLAN NAME

Redwood Empire Municipal Insurance Fund Group Health Plan

PLAN NUMBER: 501

TAX ID NUMBER: 94-2378661

PLAN EFFECTIVE DATE: July 1, 2015

PLAN YEAR ENDS: June 30

EMPLOYER INFORMATION

Redwood Empire Municipal Insurance Fund
414 W. Napa Street
Sonoma, California 95476
(707) 938-2388

See Appendix A for a full list of Participating Employers under the Plan.

PLAN ADMINISTRATOR

Redwood Empire Municipal Insurance Fund
414 W. Napa Street
Sonoma, California 95476
(707) 938-2388

CLAIMS ADMINISTRATOR

HealthComp Administrators
P. O. Box 45018
Fresno, California 93718-5018
(800) 442-72447

Appendix A: List of Participating Employers

Redwood Empire Municipal Insurance Fund
414 W Napa Street
Sonoma, California 95476

City of Arcata
736 F Street
Arcata, CA 95521

City of Cloverdale
124 N. Cloverdale Boulevard
Cloverdale, CA 94525

City of Cotati
201 W. Sierra Avenue
Cotati, CA 94931

City of Eureka
531 K Street
Eureka, CA 95501

City of Fort Bragg
416 N. Franklin Street
Fort Bragg, CA 95437

City of Fortuna
621 11th Street
Fortuna, CA 95540

City of Healdsburg
401 Grove Street
Healdsburg, CA 95448

City of Lakeport
255 Park Street
Lakeport, CA 95453

City of Rohnert Park
130 Avram Avenue
Rohnert Park, CA 94928

City of Sebastopol
7120 Bodega Avenue
Sebastopol, CA 95473

City of Sonoma
No. 1 The Plaza
Sonoma, CA 95476

City of St. Helena
1480 Main Street
St. Helena, CA 94574

City of Ukiah
300 Seminary Drive
Ukiah, CA 95482

City of Willits
111 E. Commercial
Willits, CA 95490

Town of Windsor
9291 Old Redwood Highway
Windsor, CA 95492

REMIF
REDWOOD
EMPIRE
MUNICIPAL
INSURANCE
FUND

414 W. Napa Street | 2nd Floor, Suite C | Sonoma, CA 95476
Phone (707) 938-2388 | Fax (707) 938-0374 | www.remif.com

Member Cities: Arcata, Cloverdale, Cotati, Eureka, Ft. Bragg, Fortuna, Healdsburg, Lakeport, Rohnert Park, St. Helena, Sebastopol, Sonoma, Ukiah, Willits, Windsor

ITEM 12.0

AGENDA ITEM SUMMARY

TITLE: ADDITIONAL COVERED PARTIES LIST
PRESENTED BY: AMY NORTHAM, GENERAL MANAGER

ISSUE
Changes to the additional covered parties list requires ratification by the Board of Directors.

BACKGROUND
The REMIF Memorandum of Coverage for Liability identifies additional covered parties. These parties may have been added many years ago. It is important to continue to routinely evaluate whether that extension of coverage is still appropriate. While this does require research, it is extremely important that the research be conducted because the entity that is currently added for coverage may no longer exist, have a very different operation now (potentially one your agency does not want to continue to cover), or the relationship with your entity may no longer be the same.

Adding additional covered parties is not, and should not be, automatic. Considerations need to be given, such as:

Does the City (Member) intend on taking responsibility for covering this entity (Covered Party) in its entirety, as well as taking responsibility for the entity's self-insured retention/deductible?

Can you legally assume the liability for this entity? Does the entity exist for the benefit of the Member?

Does this entity have other exposures that need to be addressed? If coverage is not automatically provided, you should evaluate whether or not the entity should be added as a Covered Party under various coverage lines where exposure exists, or if coverage has been placed elsewhere.

If the entity you are looking to add as a Covered Party is a separate legal entity, is there a Memorandum of Understanding (MOU) or agreement in place stating that your entity is responsible to provide insurance for them? And if so, is this for all exposure or only specific lines?

Some public entities provide operational aspects for other public entities that were created to be in control and the gatekeeper of funds. In these situations liability in connection with the actual operations would be with the public entity that is doing the work, and they should add the other entity as an additional covered party for their work for them.

The liability memorandum of coverage is broad as compared to other forms. When adding an entity as a Covered Party, is it your intent to provide that entity coverage for Employment Practices Liability, Public Officials E&O and Auto Liability in the MOC? Be sure to

thoroughly compare what the contract requirement or agreement is compared to what coverage you have in place.

In a routine audit, it was discovered that the additional covered parties on the REMIF liability MOC needs to be updated. I reached out to the members, and the following is what I received:

Member	COVERED PARTY	Changes/adds/deletes
Arcata	CITY OF ARCATA COMMUNITY DEVELOPMENT AGENCY	CHANGE: SUCCESSOR AGENCY TO THE ARCATA COMMUNITY DEVELOPMENT AGENCY
Cloverdale	CITY OF CLOVERDALE COMMUNITY DEVELOPMENT AGENCY	CHANGE: CITY OF CLOVERDALE COMMUNITY DEVELOPMENT SUCCESSOR AGENCY
	CITY OF CLOVERDALE REDEVELOPMENT AGENCY	CHANGE: CITY OF CLOVERDALE REDEVELOPMENT SUCCESSOR AGENCY
Cotati	CITY OF COTATI REDEVELOPMENT AGENCY	CHANGE TO: SUCCESSOR AGENCY TO THE FORMER COTATI COMMUNITY REDEVELOPMENT AGENCY
	COTATI FACILITIES FINANCING AUTHORITY	
	CITY OF COTATI INDUSTRIAL DEVELOPMENT AUTHORITY	
Eureka	CITY OF EUREKA REDEVELOPMENT AGENCY	
Ft. Bragg	CITY OF FORT BRAGG JOINT POWERS FINANCING AUTHORITY	
	CITY OF FORT BRAGG REDEVELOPMENT AGENCY	CHANGE: FORT BRAGG REDEVELOPMENT SUCCESSOR AGENCY
	FORT BRAGG MUNICIPAL IMPROVEMENT DISTRICT	CHANGE: FORT BRAGG MUNICIPAL IMPROVEMENT DISTRICT NO. 1
	FORT BRAGG CAPITAL IMPROVEMENT AUTHORITY	REMOVE: REPORTED TO THE STATE CONTROLLER'S OFFICE AS INACTIVE IN JUNE OF 2017

Fortuna	FORTUNA PUBLIC IMPROVEMENT CORPORATION	REMOVE: WAS DISSOLVED
	FORTUNA REDEVELOPMENT AGENCY	CHANGE TO: SUCCESSOR AGENCY TO THE FORMER FORTUNA REDEVELOPMENT AGENCY
	FORTUNA PUBLIC FINANCING AUTHORITY added 1/94	
Healdsburg	HEALDSBURG COMMUNITY REDEVELOPMENT AGENCY	CHANGE TO: CITY OF HEALDSBURG REDEVELOPMENT SUCCESSOR AGENCY
	CITY OF HEALDSBURG INDUSTRIAL DEVELOPMENT AUTHORITY	
	HEALDSBURG PUBLIC IMPROVEMENT CORPORATION	REMOVE
	HEALDSBURG DOWNTOWN PARKING AND BUSINESS IMPROVEMENT DIST. 6/94	
		ADD: CITY OF HEALDSBURG HOUSING SUCCESSOR AGENCY HEALDSBURG PUBLIC FINANCING AUTHORITY HEALDSBURG TOURIST IMPROVEMENT DISTRICT (ASSESSMENTS LEVIED ON LODGING ESTABLISHMENTS WITHIN THE CITY FOR MARKETING PURPOSES)
Lakeport	CITY OF LAKEPORT MUNICIPAL SEWER DISTRICT #1	
	CITY OF LAKEPORT REDEVELOPMENT AGENCY	CHANGE: CITY OF LAKEPORT REDEVELOPMENT SUCCESSOR AGENCY
		ADD: CITY OF LAKEPORT INDUSTRIAL DEVELOPMENT AUTHORITY MUNICIPAL FINANCING AGENCY OF LAKEPORT

Rohnert Park	ROHNERT PARK CIVIC COMMISSION	
	ROHNERT PARK COMMUNITY SERVICES DISTRICT	ADD: AKA ROHNERT PARK DISTRICT
	CITY OF ROHNERT PARK GOLF COURSE CORPORATION	REMOVE: ENTITY DISSOLVED
	CITY OF ROHNERT PARK RECREATION CORPORATION	REMOVE: ENTITY DISSOLVED
	COMMUNITY DEVELOPMENT COMMISSION OF CITY OF ROHNERT PARK	
	ROHNERT PARK ASSOCIATION FOR THE ARTS	
		ADD: ROHNERT PARK FINANCIING AUTHORITY (CREATED BY JOINT EXERCISE OF POWERS AUTHORITY BETWEEN CITY OF ROHNERT PARK AND COMMUNITY DEVELOPMENT COMMISSION OF CITY OF ROHNERT PARK, CITY COUNCIL IS GOVERNING MEMBERS) CITY OF ROHNERT PARK FOUNDATION (ARTICLES OF INCORPORATION 2008)
Sebastopol	SEBASTOPOL INDUSTRIAL DEVELOPMENT AUTHORITY	REMOVE
	SEBASTOPOL COMMUNITY DEVELOPMENT AGENCY	
Sonoma	CITY OF SONOMA – SONOMA CREEK SENIOR HOUSING	
	SONOMA COMMUNITY DEVELOPMENT AGENCY added 7/1/94	
Ukiah	CITY OF UKIAH REDEVELOPMENT AGENCY	UKIAH REDEVELOPMENT SUCCESSOR AGENCY
		ADD: UKIAH INDUSTRIAL DEVELOPMENT AUTHORITY UKIAH PUBLIC FINANCING AUTHORITY
Willits	CITY OF WILLITS PUBLIC FACILITIES CORPORATION	
	CITY OF WILLITS COMMUNITY DEVELOPMENT COMMISSION	
	CITY OF WILLITS INDUSTRIAL DEVELOPMENT AUTHORITY	

Windsor	TOWN OF WINDSOR/WINDSOR WATER DISTRICT	
	TOWN OF WINDSOR REDEVELOPMENT AGENCY	CHANGE TO: WINDSOR REDEVELOPMENT SUCCESSOR AGENCY

Of those members that requested REMIF add additional covered parties to the list, none reported there were any known claims for those entities. In addition, for those that wanted to add additional covered parties, the member reported the City Council was also the governing board for the entity.

Staff recommends that these entities be added to the liability memorandum of coverage, effective 06/01/20.

FISCAL IMPACT
None anticipated.

RECOMMENDED ACTION
Approve changes/adds/deletes to the additional covered party list as outlined in the chart above.

ATTACHMENTS
None.