David Ash – Chip Schutte – David Weiss - Sharon Keeler – Chuck Bishop

AGENDA
Joint Administrative Services Board
Monday January 22, 2018 1:00 p.m.
Joint Government Center

1. **Call to Order.**

   Determination of Quorum
   Selection of Chairperson
   Selection of Vice-Chairperson

   Establishment of meeting calendar. Please consider the following:

Date	Time	Location	Topic(s)
02/26/18	1:00:00 PM	JGC	Technology
03/26/18	1:00:00 PM	JGC	Technology
04/23/18	1:00:00 PM	JGC	Technology
05/21/18	1:00:00 PM	JGC	Audit, Technology
06/25/18	1:00:00 PM	JGC	*If needed*
07/23/18	1:00:00 PM	JGC	*If needed*
08/27/18	1:00:00 PM	JGC	*If needed*
09/24/18	1:00:00 PM	JGC	Technology
10/22/18	1:00:00 PM	JGC	Director Evaluation
11/26/18	1:00:00 PM	JGC	*If needed*
12/17/18	1:00:00 PM	JGC	*If needed*
01/28/19	1:00:00 PM	JGC	Organization, Budget, Technology

2. **Approval of Minutes. (November 27 Minutes Attached).**

3. **ERP Update.**

4. **JAS 2019 Budget.** Proposal to be developed by Monday.

5. **Next Meeting February 27.**

Joint Administrative Services Board
November 27, 2017 Regular Meeting 1:00 pm

At a regular meeting of the Joint Administrative Services Board held on Monday, November 27, 2017, at 1:00 pm in the Meeting Room AB, Berryville Clarke County Government Center, 101 Chalmers Court, 2nd Floor, Berryville, Virginia.

Members Present: David Ash, Chuck Bishop, Sharon Keeler, David Weiss

Members Absent: Chip Schutte

Staff Present: Tom Judge, Gordon Russell, Brianna Taylor

Others Present: None

1. Call to Order - Determination of Quorum

   At 1:01 pm, David Weiss called the meeting to order having determined that a quorum was present.

2. Approval of Agenda

   Chuck Bishop, seconded by David Ash, moved to approve the November 27, 2017 agenda as presented. The motion carried by the following vote:

David Ash	-	Aye
Chuck Bishop	-	Aye
Sharon Keeler	-	Aye
David Weiss	-	Aye

3. Approval of Minutes

   Chuck Bishop, seconded by David Ash, moved to approve the October 23, 2017 minutes as presented. The motion carried by the following vote:

David Ash	-	Aye
Chuck Bishop	-	Aye
Sharon Keeler	-	Aye
David Weiss	-	Aye

4. ERP Update: Taxation

Tom Judge reviewed the following:

a) Tyler has credited three credit days for training:

b) Tyler has added an addition Project Manager (Hope McLean). Working on conversion issues, Tax Relief for the Elderly and Disabled, and following up on issues with Gordon.

c) Staff request for hard copy documentation specific to Clarke.

Options: Pay fee to get the hard copy tailored for our needs from Tyler; or use a copy that we have of the document..

It was discussed and decided to use the copy of the document that we have. So that we could tailor and customize the document per departmental needs.

d) Suspending the decision on Go Live.

Not going live in December: looking at March- waiting on suggestions from Tyler.

e) Tyler Forms says custom programming is required to emulate our current bill.

It was discussed and decided that it was necessary to get the custom programming to emulate our current bills and supplemental bills.

Sharon Keeler, seconded by David Ash, moved to purchase the custom programming to emulate our current bills and supplemental bills. The motion carried by the following vote:

David Ash	-	Aye
Chuck Bishop	-	Aye
Sharon Keeler	-	Aye
David Weiss	-	Aye

5. Taxation Refund

Tom Judge stated that legal services are attempting to obtain our refund from the IRS.

6. Health Plan Option

Tom Judge stated that FY19 Rates for the State's health plan for localities have been distributed and are roughly 18% higher than our current rates. However, the terms of the plan have not been distributed, so its value is unclear. This matter will get discussed further in the next meeting.

7. Position Advertised

Tom Judge stated that the job advertisement has been posted for a replacement, for the outgoing Administrative Assistant at Purchasing for CCSA.

8. Next Meeting

The next regularly scheduled meeting is set for January 22, 2018.

9. Adjournment

At 1:45 pm, David Ash, seconded by Chuck Bishop, moved to adjourn the meeting.

Minutes Recorded and Transcribed by Brianna Taylor

The Local Choice Health Benefits Program

To: TLC Group Administrators

From: Walter E. Norman
Program Manager

Date: January 2018

Re: The Local Choice Health Benefits Renewal

Thank you for your continuing support of The Local Choice program. We are pleased to enclose The Local Choice (TLC) renewal for fiscal year 2019. TLC will again offer five statewide plans to all local employer groups along with a regional plan in certain geographic areas.

For all Statewide plans, medical, behavioral health, outpatient prescription drugs and routine vision is administered by Anthem BCBS. Delta Dental will administer the dental benefits through a separate agreement with Anthem. The regional plan will continue to be administered by Kaiser Permanente. Employer plan choices are:

Statewide plans

- Key Advantage With Expanded Benefits
- Key Advantage 250
- Key Advantage 500
- Key Advantage 1000
- TLC High Deductible Health Plan (HDHP) – HSA compatible

Regional plan

- Kaiser Permanente – available in certain service areas

Retiree Plans

- Key Advantage or Regional Plan coverage (only available to retirees not eligible for Medicare)
- Advantage 65
- Advantage 65 with Dental/Vision
- Medicare Complementary (Grandfathered for current participant groups, only)

All active employee TLC plans include the CommonHealth wellness program at no additional cost to your employees. CommonHealth features our *Future Moms* prenatal risk management program, our highly acclaimed *Quit For Life* tobacco cessation program, confidential, at work medical screenings plus other health and wellness programs including nutrition, stress management and fitness programs.

Your 2018-2019 renewal notebook includes a Comparison of Benefits brochure outlining the proposed benefits to assist you in determining which plan or plans you want to offer your employees.

Virginia Department of Human Resource Management • 101 North 14th Street • 13th Floor • Richmond, Virginia 23219
(804) 786-6460 • e-mail: tlc@dhrm.state.va.us

There are a few benefit changes to the **Key Advantage Expanded and Key Advantage 250 plans** this year.

	Key Advantage Expanded	Key Advantage 250
• Diagnostic tests and x-rays (OP, IP and ER)	20% no deductible	20% after deductible
• ER facility copayment	$250	$350
• Hospital, Maternity and Behavioral Health copayment per stay	$300	$400
• Shots (allergy and therapeutic injections)	20% no deductible	20% after deductible
• Therapy services	20% after deductible	20% after deductible

There are no benefit changes in the Key Advantage 500, 1000 and HDHP plans.

Rates for all available plan options are listed in Section 2 (Renewal Rate Sheets and Information). Together, the statewide Key Advantage plans, High Deductible Health Plan and the Kaiser Permanente HMO fully-insured regional plan (available in certain service areas) offer you a variety of choices with competitive administrative costs and quality coverage.

We encourage you to attend a TLC Regional Meeting in March of 2018. I, along with representatives from our program's vendors, will present plan highlights, improvements and changes in more detail. The RoadShow meeting schedule for 2018 will be distributed in January 2018.

Our goals are twofold – first, to help you offer a high quality, affordable health benefits package; and second, to assist you in attracting and retaining the highest quality employees. We value your participation, and we look forward to continuing our partnership in to the future.

Thank you for selecting The Local Choice program.

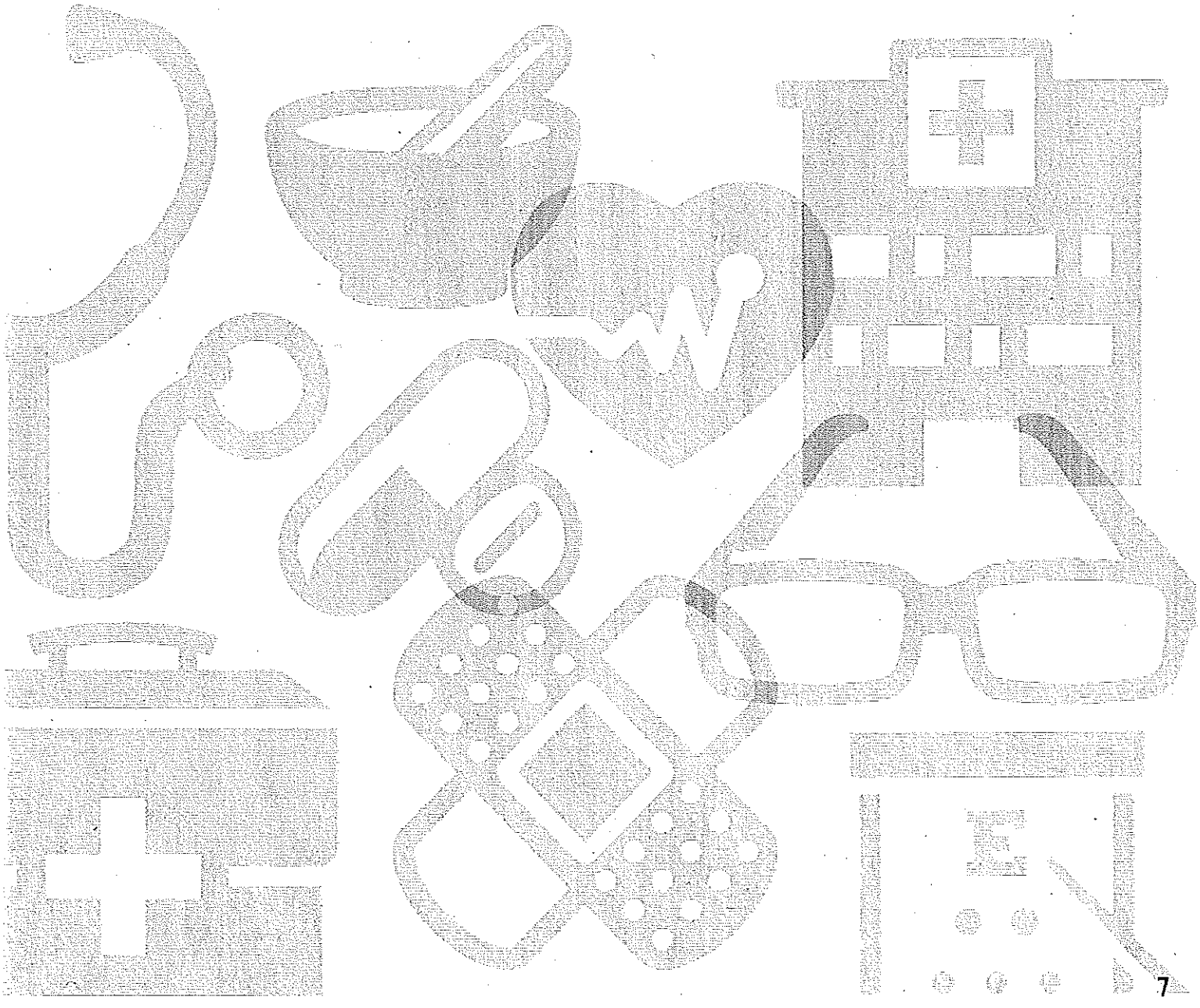
Sincerely,

Walter E. Norman
Program Manager

2018 COMPARISON OF STATEWIDE PLANS

Effective July 1, 2018 or October 1, 2018

The LOCAL CHOICE



The Local Choice 2018 Comparison of Statewide Plans

	Key Advantage Expanded			Key Advantage 250		
Plan Year Deductible (Key Advantage: Applies to Certain Medical Services as Indicated on Chart) (HDHP: Applies to Medical, Behavioral Health, and Prescription Drug Services)	In-Network: One Person $100 Out-of-Network: $200	Two People *See Family* *See Family*	Family $200 $400	In-Network: One Person $250 Out-of-Network: $500	Two People *See Family* *See Family*	Family $500 $1,000
Plan Year Out-of-pocket Expense Limit	In-Network: One Person $2,000 Out-of-Network: $3,000	Two People *See Family* *See Family*	Family $4,000 $6,000	In-Network: One Person $3,000 Out-of-Network: $5,000	Two People *See Family* *See Family*	Family $6,000 $10,000
Out-of-Network Benefits	Yes. Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services. Copayments and coinsurance for routine vision, outpatient prescription drugs and dental services will still apply.			Yes. Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services. Copayments and coinsurance for routine vision, outpatient prescription drugs and dental services will still apply.		
Medical Care When Traveling (BlueCard)	Included			Included		
Lifetime Maximum	Unlimited			Unlimited		
Covered Services	**In-Network You Pay**			**In-Network You Pay**		
Ambulance Travel	20% coinsurance after deductible			20% coinsurance after deductible		
Autism Spectrum Disorder 2 years through 10 years	Copayment/coinsurance determined by service received			Copayment/coinsurance determined by service received		
Behavioral Health and EAP *Inpatient treatment* • Facility Services • Professional Provider Services *Outpatient Professional Provider Visits*	 $300 copayment per stay $0 $15 copayment			 $400 copayment per stay $0 $20 copayment		
Employee Assistance Program (EAP) 4 visits per issue (per plan year)	$0			$0		
Dental Care **Preventive Dental Option** *(diagnostic and preventive services only for lower premium)*	$0			$0		
Comprehensive Dental Option *(for higher premium)*	*One Person*	*Two People*	*Family*	*One Person*	*Two People*	*Family*
Dental Plan Year Deductible	$25	$50	$75	$25	$50	$75
Plan Year Maximum (Except Orthodontics)	$1,500			$1,500		
• Preventive Dental Care	$0			$0		
• Primary Dental Care	20% coinsurance after dental deductible			20% coinsurance after dental deductible		
• Major Dental Care	50% coinsurance after dental deductible			50% coinsurance after dental deductible		
• Orthodontic Services (Includes Adult Ortho)	50% coinsurance, no dental deductible, with $1,500 lifetime maximum			50% coinsurance, no dental deductible, with $1,500 lifetime maximum		

Note: Yellow highlights denote benefit change for 2018.

Key Advantage 500			Key Advantage 1000			High Deductible Health Plan		
In-Network:			**In-Network:**					
One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
$500	*See Family*	$1,000	$1,000	*See Family*	$2,000	$2,800	See Family	$5,600
Out-of-Network:			**Out-of-Network:**			Deductible is combined for In-Network and Out-of-Network services.		
$1,000	*See Family*	$2,000	$2,000	*See Family*	$4,000			
In-Network:			**In-Network:**			**In-Network:**		
One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
$4,000	*See Family*	$8,000	$5,000	*See Family*	$10,000	$5,000	See Family	$10,000
Out-of-Network:			**Out-of-Network:**			**Out-of-Network:**		
$7,000	*See Family*	$14,000	$9,000	*See Family*	$18,000	$10,000	See Family	$20,000
Yes. Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services. Copayments and coinsurance for routine vision, outpatient prescription drugs and dental services will still apply.			Yes. Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services. Copayments and coinsurance for routine vision, outpatient prescription drugs and dental services will still apply.			Yes. Once you meet the combined deductible you pay 40% coinsurance for medical, behavioral health and prescription drug services from Out-of-Network providers.		
Included			Included			Included		
Unlimited			Unlimited			Unlimited		
In-Network You Pay			**In-Network You Pay**			**In-Network You Pay**		
20% coinsurance after deductible			20% coinsurance after deductible			20% coinsurance after deductible		
Copayment/coinsurance determined by service received			Copayment/coinsurance determined by service received			20% coinsurance after deductible		
20% coinsurance after deductible			20% coinsurance after deductible			20% coinsurance after deductible		
$0			$0			20% coinsurance after deductible		
$25 copayment			$25 copayment			20% coinsurance after deductible		
$0			$0			$0		
$0			$0			$0		
One Person	*Two People*	*Family*	*One Person*	*Two People*	*Family*	*One Person*	*Two People*	*Family*
$25	$50	$75	$25	$50	$75	$25	$50	$75
$1,500			$1,500			$1,500		
$0			$0			$0		
20% coinsurance after dental deductible			20% coinsurance after dental deductible			20% coinsurance after dental deductible		
50% coinsurance after dental deductible			50% coinsurance after dental deductible			50% coinsurance after dental deductible		
50% coinsurance, no dental deductible, with $1,500 lifetime maximum			50% coinsurance, no dental deductible, with $1,500 lifetime maximum			50% coinsurance, no dental deductible, with $1,500 lifetime maximum		

The Local Choice 2018 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Diabetic Education	$0	$0
Diabetic Equipment	20% coinsurance after deductible	20% coinsurance after deductible
Diabetic Supplies - See Outpatient Prescription Drugs		
Diagnostic Tests and X-rays (for specific conditions or diseases at a doctor's office, emergency room or outpatient hospital department)	20% coinsurance, no deductible	20% coinsurance after deductible
Doctor Visits - on an Outpatient Basis		
Primary Care Physicians	$15 copayment	$20 copayment
Specialty Care Providers	$25 copayment	$35 copayment
Early Intervention Services	Copayment/coinsurance determined by service received	Copayment/coinsurance determined by service received
Emergency Room Visits		
Facility Services	$250 copayment per visit (waived if admitted to hospital)	$350 copayment per visit (waived if admitted to hospital)
Professional Provider Services		
- Primary Care Physicians	$15 copayment	$20 copayment
- Specialty Care Providers	$25 copayment	$35 copayment
Diagnostic Tests and X-rays	20% coinsurance, no deductible	20% coinsurance after deductible
Home Health Services (90 visit plan year limit per member)	$0	$0
Home Private Duty Nurse's Services	20% coinsurance after deductible	20% coinsurance after deductible
Hospice Care Services	$0	$0
Hospital Services		
Inpatient Treatment		
• Facility Services	$300 copayment per stay	$400 copayment per stay
• Professional Provider Services		
- Primary Care Physicians	$0	$0
- Specialty Care Providers	$0	$0
Outpatient Treatment		
• Facility Services	$100 copayment	$150 copayment
• Professional Provider Services		
- Primary Care Physicians	$15 copayment	$20 copayment
- Specialty Care Providers	$25 copayment	$35 copayment
Diagnostic Tests and X-Rays	20% coinsurance, no deductible	20% coinsurance after deductible

Note: Yellow highlights denote benefit change for 2018.

Key Advantage 500 In-Network You Pay	Key Advantage 1000 In-Network You Pay	High Deductible Health Plan In-Network You Pay
$0	$0	20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
$25 copayment $40 copayment	$25 copayment $40 copayment	20% coinsurance after deductible 20% coinsurance after deductible
Copayment/coinsurance determined by service received	Copayment/coinsurance determined by service received	20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
$25 copayment $40 copayment 20% coinsurance after deductible	$25 copayment $40 copayment 20% coinsurance after deductible	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
$0	$0	20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
$0	$0	20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
$0 $0	$0 $0	20% coinsurance after deductible 20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
$25 copayment $40 copayment 20% coinsurance after deductible	$25 copayment $40 copayment 20% coinsurance after deductible	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible

The Local Choice 2018 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Maternity		
Professional Provider Services (Prenatal & Postnatal Care)		
- Primary Care Physicians	$15 copayment	$20 copayment
- Specialty Care Providers	$25 copayment	$35 copayment
	If your doctor submits one bill for delivery, prenatal and postnatal care services, there is no copayment required for physician care. If your doctor bills for these services separately, your payment responsibility will be determined by the services received.	
Delivery		
- Primary Care Physicians	$0	$0
- Specialty Care Providers	$0	$0
Hospital Services for Delivery (Delivery Room, Anesthesia, Routine Nursing Care for Newborn)	$300 copayment per stay*	$400 copayment per stay*
Outpatient Diagnostic Tests	20% coinsurance, no deductible	20% coinsurance after deductible
Medical Equipment, Appliances, Formulas, Prosthetics and Supplies	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Prescription Drugs - Mandatory Generic		
*Retail up to 34-day supply**	Tier 1 - $10 copayment	Tier 1 - $10 copayment
*You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments, or the coinsurance after the deductible	Tier 2 - $30 copayment Tier 3 - $45 copayment Tier 4 - $55 copayment	Tier 2 - $30 copayment Tier 3 - $45 copayment Tier 4 - $55 copayment
Home Delivery Services (Mail Order) Covered Drugs for up to a 90-Day Supply	Tier 1 - $20 copayment Tier 2 - $60 copayment Tier 3 - $90 copayment Tier 4 - $110 copayment	Tier 1 - $20 copayment Tier 2 - $60 copayment Tier 3 - $90 copayment Tier 4 - $110 copayment
Diabetic Supplies	20% coinsurance, no deductible	20% coinsurance, no deductible
Routine vision - Blue View Vision Network (Once Every Plan Year)		
Routine Eye Exam	$25 copayment	$35 copayment
Eyeglass Lenses	$20 copayment	$20 copayment
Eyeglass Frames	Up to $100 retail allowance**	Up to $100 retail allowance**
Contact Lenses (In Lieu of Eyeglass Lenses)		
• Elective	Up to $100 retail allowance	Up to $100 retail allowance
• Non-Elective	Up to $250 retail allowance	Up to $250 retail allowance
Upgrade Eyeglass Lenses (Available for Additional Cost)		
• UV Coating, Tints, Standard Scratch-Resistant	$15	$15
• Standard Polycarbonate	$40	$40
• Standard Progressive	$65	$65
• Standard Anti-Reflective	$45	$45
• Other Add-Ons	20% off retail	20% off retail
Shots – Allergy & Therapeutic Injections (At Doctor's Office, Emergency Room or Outpatient Hospital Department)	20% coinsurance, no deductible	20% coinsurance after deductible
Skilled Nursing Facility Stays (180-Day Per Stay Limit Per Member)		
Facility Services	$0	$0
Professional Provider Services	$0	$0

*This plan will waive the hospital copayment if the member enrolls in the maternity management pre-natal program within the first trimester of pregnancy, has a dental cleaning during pregnancy and satisfactorily completes the program.

**You may select a frame greater than the covered allowance and receive a 20% discount for any additional cost over the allowance.

Note: Yellow highlights denote benefit change for 2018.

Key Advantage 500 In-Network You Pay	Key Advantage 1000 In-Network You Pay	High Deductible Health Plan In-Network You Pay
$25 copayment $40 copayment If your doctor submits one bill for delivery, prenatal and postnatal care services, there is no copayment required for physician care. If your doctor bills for these services separately, your payment responsibility will be determined by the services received.	$25 copayment $40 copayment	20% coinsurance after deductible 20% coinsurance after deductible
$0 $0	$0 $0	20% coinsurance after deductible 20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Tier 1 - $10 copayment Tier 2 - $30 copayment Tier 3 - $45 copayment Tier 4 - $55 copayment	Tier 1 - $10 copayment Tier 2 - $30 copayment Tier 3 - $45 copayment Tier 4 - $55 copayment	20% coinsurance after deductible
Tier 1 - $20 copayment Tier 2 - $60 copayment Tier 3 - $90 copayment Tier 4 - $110 copayment	Tier 1 - $20 copayment Tier 2 - $60 copayment Tier 3 - $90 copayment Tier 4 - $110 copayment	20% coinsurance after deductible
20% coinsurance, no deductible	20% coinsurance, no deductible	20% coinsurance after deductible
$40 copayment $20 copayment Up to $100 retail allowance**	$40 copayment $20 copayment Up to $100 retail allowance**	$15 copayment $20 copayment Up to $100 retail allowance**
Up to $100 retail allowance Up to $250 retail allowance	Up to $100 retail allowance Up to $250 retail allowance	Up to $100 retail allowance Up to $250 retail allowance
$15 $40 $65 $45 20% off retail	$15 $40 $65 $45 20% off retail	$15 $40 $65 $45 20% off retail
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
$0 $0	$0 $0	20% coinsurance after deductible 20% coinsurance after deductible

The Local Choice 2018 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Spinal Manipulations and Other Manual Medical Interventions (30 Visits Per Plan Year Limit Per Member)		
Primary Care Physicians	$15 copayment	$20 copayment
Specialty Care Providers	$25 copayment	$35 copayment
Surgery – See Hospital Services		
Therapy Services *Infusion Services, Cardiac Rehabilitation Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy, Occupational Therapy, Physical Therapy, and Speech Therapy*		
Facility Services	20% coinsurance after deductible	20% coinsurance after deductible
Professional Provider Services		
- Primary Care Physicians	20% coinsurance after deductible	20% coinsurance after deductible
- Specialty Care Providers	20% coinsurance after deductible	20% coinsurance after deductible
Wellness services		
Well Child (Office Visits at Specified Intervals Through Age 6)		
- Primary Care Physicians; - Specialty Care Providers; - Immunizations and Screening Tests	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
Routine Wellness - Age 7 & Older		
• Annual Check-Up Visit (One Per Plan Year) - Primary Care Physicians - Specialty Care Providers - Immunizations, Lab and X-Ray Services	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
• Routine Screenings, Immunizations, Lab and X-Ray Services (Outside of Annual Check-Up Visit)	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
Preventive Care (One of Each Per Plan Year) • Gynecological Exam • Pap Test • Mammography Screening • Prostate Exam (Digital Rectal Exam) • Prostate Specific Antigen Test • Colorectal Cancer Screenings	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible

Note: Yellow highlights denote benefit change for 2018.

Key Advantage 500 In-Network You Pay	Key Advantage 1000 In-Network You Pay	High Deductible Health Plan In-Network You Pay
$25 copayment $40 copayment	$25 copayment $40 copayment	20% coinsurance after deductible 20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
20% coinsurance after deductible 20% coinsurance after deductible	20% coinsurance after deductible 20% coinsurance after deductible	20% coinsurance after deductible 20% coinsurance after deductible
No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible

THE LOCAL CHOICE HEALTH CARE PROGRAM

Anthem Blue Cross and Blue Shield

Renewal Analysis:

(Excludes Advantage 65 premiums and claims)

For

Clarke County And Schools

Group #47284

for July 1, 2018 through June 30, 2019

I.	Income at Current Rates (1)	$3,407,520
II.	Projected Medical Claims Related Charges (2)	
A.	Claims Cost (12/01/2016 through 11/30/2017)	$4,628,348
B.	100% Facility Network Savings	($1,036,762)
C.	100% Professional Network Savings	($1,293,379)
D.	Claims in excess of the $125,000 pooling limit	($127,582)
E.	Subtotal	$2,170,626
F.	Change in Incurred But Not Reported Claims	$21,706
G.	Benefit Adjustment	$0
H.	Enrollment Adjustment	($21,923)
I.	Trend	$247,733
J.	Total Medical Projected Incurred claims	$2,418,142
III.	Projected Reinsurance Charges	$335,396
IV.	Projected Medical Administrative Charges, Network Access Fees, and Affordable Care Act(3)	$150,005
V.	Projected Dental Capitation	$157,957
VI.	Projected Drug Capitation	$882,382
VII.	TLC Contingency Reserve or Risk Fee(4)	($60,154)
VIII.	Total Income Requirements (II.J. + III. + IV. + V. + VI. + VII.)	$3,883,728
	Percentage Adjustment	14.0%

[1] Illustrative income is based on current enrollment as follows:

	KA 250	KA 500	HDHP	TOTAL
Single	61	124	14	199
Dual	17	21	2	40
Family	19	40	8	67
TOTAL:	97	185	24	306

[2] There are 3 claims in excess of the $125,000 pooling limit.
Facility and Professional network savings represent 50.3% of medical claims cost.
Medical trends used in the renewal development were 7% annual.
For a 19 month projection, this equates to 11.3%

[3] Administrative charge as a percent of income requirements is 3.9%

[4] Includes DHRM Program Administration and CommonHealth

Assumes all have Comprehensive Dental.

FY 19 Monthly Health Benefit Rates

Effective 5/16/2018

Source: Joint Administrative Services

A. Plan Rates	Cost	Employer	Employee	Employer FY 19 Share*	Employer FY 18 Share*	FY 19 Employer Annual
				Rounding difference shifts year to year in KA250		
KA 250 Plan Option						
Regular Full Time						
Single	769.00	648.68	120.32	84%	85%	7,784
Dual	1,423.00	707.75	715.25	50%	50%	8,493
Family	2,076.00	1,033.02	1,042.98	50%	50%	12,396
Transportation, Food Service & Other						
Single	769.00	547.34	221.66	71%	71%	6,568
Dual	1,423.00	597.18	825.82	42%	42%	7,166
Family	2,076.00	871.64	1,204.36	42%	42%	10,460
KA 500 Plan Option						
Regular Full Time						
Single	706.00	648.68	57.32	92%	92%	7,784
Dual	1,306.00	707.75	598.25	54%	54%	8,493
Family	1,906.00	1,033.02	872.98	54%	54%	12,396
Transportation, Food Service & Other						
Single	706.00	547.34	158.66	78%	78%	6,568
Dual	1,306.00	597.18	708.82	46%	46%	7,166
Family	1,906.00	871.64	1,034.36	46%	46%	10,460
TLC High Deductible						
Regular Full Time						
Single	557.00	557.00	.00	100%	100%	6,684
Dual	1,030.00	633.04	396.96	61%	61%	7,596
Family	1,504.00	923.05	580.95	61%	61%	11,077
Transportation, Food Service & Other						
Single	557.00	469.99	87.01	84%	84%	5,640
Dual	1,030.00	534.14	495.86	52%	52%	6,410
Family	1,504.00	778.85	725.15	52%	52%	9,346
B. Account Contributions						
Regular Full Time						
TLC Health Savings Account Contribution (single)		91.68				1,100
TLC Health Savings Account Contribution (dual)		74.71				897
TLC Health Savings Account Contribution (family)		109.97				1,320
Transportation, Food Service & Other						
TLC Health Savings Account Contribution (single)		77.35				928
TLC Health Savings Account Contribution (dual)		63.04				756
TLC Health Savings Account Contribution (family)		92.79				1,114
C. Total Employer Cost Per Group Health Member						
Regular Full Time						
Single Health		648.68				
Dual Health		707.75				
Family Health		1,033.02				
TLC High Deductible Single Health & "HSA"		648.68				
TLC High Deductible Dual Health & "HSA"		707.75				
TLC High Deductible Family Health & "HSA"		1,033.02				
Transportation & Food Service						
Single Health		547.34				
Dual Health		597.18				
Family Health		871.64				
TLC Single Health & "HSA"		547.34				
TLC Dual Health & "HSA"		597.18			Overall Change	
TLC Family Health & "HSA"		871.64			14.00%	

Note: Where two employees are married, and they together opt for either a dual or family option, the employer will pay two times the single employer contribution for the plan option selected.

METHOD:
Force TLC High Deductible employee single contribution to zero.
Force 500 rates to percentage contributions from prior year.
Force 250 employer contribution to same as 500 contribution.
Force "HSA" contribution so total employer equal across plans.