



**Philadelphia Parking Authority**

***Request for Proposal***

**Professional Actuarial Services**

**RFP No. 15-24**

**Issue Date: Wednesday, December 9, 2015**

**The Philadelphia Parking Authority is soliciting written proposals for Professional Actuarial Services for their self-funded health insurance plan.**

**The Philadelphia Parking Authority requests that responses be submitted by:**

**2:00 PM EST on Tuesday, January 5, 2016**

**Delivery Instructions:**

<b>Proposals may be Mailed or Hand Delivered</b>
All copies of the RFP must be submitted to: Mary Wheeler Manager of Contract Administration 701 Market Street, Suite 5400 Philadelphia, PA 19106
<b>Fax or email responses will NOT be accepted</b>

**REQUEST FOR PROPOSALS**  
**PROFESSIONAL ACTUARIAL SERVICES**  
**RFP No. 15-24**

The Philadelphia Parking Authority (the "Authority") is seeking responses to this Request For Proposals (RFP) in order to select one firm to serve as its actuary under a five (5) year contract.

**Scope of Services: Self-Funded Health Insurance Plan**

Services required consist of the drawing of a report, on an annual basis for each of the next five (5) years, indicating the values of the various obligations for self-funded healthcare benefits, both incurred and likely to be incurred, and the current values thereof, in order to accrue said liabilities in the Authority's books and records and report and disclose same in its financial statements in accordance with Generally Accepted Accounting Proposals, according to the following timetable:

Data Cut-Off Date	December 31 <sup>st</sup>
Data Availability Date	January 31 <sup>st</sup>
Report Delivery Date	April 15 <sup>th</sup>

In addition to using this report for general management purposes, the Authority specifically intends to use these reports, and the values therein, to prepare its annual financial statements and financial statement disclosures as of and for the years ending 31<sup>st</sup> March 2016, 2017, 2018, 2019 and 2020. These financial statements will be audited by a public accounting firm.

Please see the appendix to this document for data specific to the Authority.

**Response Requirements**

Responses should be printed on "8 ½ x 11" paper, single-sided.

The Philadelphia Parking Authority anticipates the following schedule for review of the responses:

<b>Activity</b>	<b>Date</b>
Opportunity posted	December 9, 2015
Last opportunity for questions	December 23, 2015
Response submission deadline	January 5, 2016
Estimated award date	January 18, 2016

One original, six (6) copies and an electronic PDF file of the response are to be delivered by no later than 2:00 PM on January 5, 2016 to the address below. All packages shall be marked, "RFP No. 15-24 Professional Actuarial Services" and include the name of your firm.

The Philadelphia Parking Authority  
701 Market Street Suite 5400  
Philadelphia, PA 19106  
Attn: Mary Wheeler, Manager of Contract Administration

## Questions Regarding this RFP

All vendors participating in this Request for Proposal process must register with the Authority by sending contact information (contact name, firm name, address, telephone number, email) to the attention of Mary Wheeler, Manager of Contract Administration at [mwheeler@philapark.org](mailto:mwheeler@philapark.org). Only registered vendors will receive addenda and be able to participate in this solicitation.

Questions regarding this RFP are to be submitted by email only to Mary Wheeler ([mwheeler@philapark.org](mailto:mwheeler@philapark.org)) by no later than 2:00 PM on December 23, 2015. All questions received before such time will be answered via Addendum. The subject title of such emails should read, **RFP No. 15-24 PROFESSIONAL ACTUARIAL SERVICES**. Questions emailed by respondents, and any additional information that the Authority provides in response to such questions, will be posted on the Authority's website, and will be forwarded via email directly to those respondents who had previously registered with the Authority.

**ATTENTION: No questions are to be directed to the Mayor's Office, the Philadelphia City Director of Finance, or any other City official or employee, or any other official or employee of the Philadelphia Parking Authority.**

## Selection Criteria and Process

The Authority anticipates selecting one firm to serve as its actuary for the stated purposes based on the information provided in the response contents as explained below.

## Response Contents

Responses are to follow the following format:

### ***TAB A. Cover Letter***

Please include a cover letter of no more than one page indicating the name, title, location, telephone number, and email address of the party responsible for negotiating on behalf of your firm. If the day-to-day contact person for your firm is different than the person negotiating on behalf of your firm, please include the day to day contact person's name, title, location, telephone number and email address.

***TAB B. Qualifications of the Firm***

Provide a brief overview of the firm, and why your firm is well suited to provide actuary services. Please include names, office addresses, and phone numbers of three governmental references.

Please submit evidence of the firm's membership in the American Academy of Enrolled Actuaries.

Each respondent shall also provide a list of the firm's relevant experience since 1<sup>st</sup> September 2006 with performing actuarial studies of the nature described. On this list, highlight or otherwise indicate any reports prepared for the Authority, the City of Philadelphia, and any subdivision or public agency of the City of Philadelphia.

**Note:** Do not include additional appendices; the only information that is to be included in the appendices is described above.

***TAB C. Experience with the City and City-related agencies***

Discuss your firm's relevant experience over the past ten years with the Authority or the City of Philadelphia, or any subdivision or public agency of the City of Philadelphia.

***TAB D. Assigned Professionals***

Provide the name, work address, and relevant qualifications and experience for individual(s) whom your firm anticipates will be assigned to work on this report(s). Describe the roles and responsibilities for each individual, and identify the individual charged with the day-to-day responsibility for the engagement. All individuals so assigned shall be enrolled actuaries – please include copies of their enrollment cards or certificates.

***TAB E. Legal and Firm Issues***

Does your firm have an equal employment opportunity policy and program? If so, will your firm provide information to the Authority regarding its policy and program upon request?

Please disclose and explain any significant negative events in your firm's recent history including criminal charges, civil litigation, or administrative actions involving allegations of securities law violations by your firm or its employees during the past five years.

Are there any other lines of business conducted by your firm that could complement or conflict with your role as actuary? Please disclose any arrangements that might present an actual or apparent conflict of interest with the role of actuary.

***TAB F. Fee Structure***

Please provide and explain your fee structure, and state your fee proposal for this engagement, for each of the five (5) years.

***TAB G. Additional Information***

Provide any additional information that you deem appropriate.

#### ***TAB H. Certificate of Insurance***

Each respondent shall submit in **Tab H** of their proposal a sample certificate of insurance from another recent project that meets the Authority's insurance requirements or a letter from its insurance company indicating that they will provide the required insurances as outlined in the Sample Contract provided for this RFP.

### **Philadelphia Parking Authority Policies and Reservation of Rights**

- Joint responses will not be accepted.
- The Authority will not be responsible for any costs incurred by respondents in responding to this RFP.
- Oral communications from the Authority personnel or other persons shall not be binding and shall in no way materially modify the provisions of the RFP.

The Authority encourages submissions by minority, women, and disabled owned firms ("MWDBP"). The Authority requires that any firm selected to participate as actuary for Authority financing agree not to discriminate nor permit discrimination against any person because of race, color, religion, national origin, or sexual orientation. In the event of such discrimination, the Authority reserves the right to terminate the firm's appointment to the issue.

## **APPENDIX**

The following information is being provided to assist in the preparation of responses to this RFP. As of 31<sup>st</sup> March 2015, the Authority had:

**General Information:** Independence Blue Cross (IBC) is the Third Party Administrator. IBC will receive an administrative fee of \$50 per member per month for plan year 4/1/2015 through 3/31/2016. IBC will receive an administrative fee of \$55 per member per month for plan year 4/1/2016 through 3/31/2017. IBC will receive an administrative fee of \$65 per member per month for plan year 4/1/2017 through 3/31/2018. Scrip World, a division of Meritain, is the pharmacy benefit manager utilizing the CVS/Caremark network.

**Overview of Stop Loss Program:** Highmark Insurance is the stop loss insurer for the Philadelphia Parking Authority. The agency has specific stop loss insurance with an attachment point of \$200,000 for health care claims only. The agency does not have aggregate stop loss insurance. Prescription drug claims are not part of the \$200,000 self-insured retention.

**Overview on any changes in the past few years:** The Philadelphia Parking Authority changed from a fully insured to a self-funded plan effective 4/1/2015 for the plan year 4/1/2015 to 3/31/2016. The agency changed pharmacy benefit managers effective 5/1/2015 from Future Scripts a division of Catamaran to Scrip World a division of Meritain. Last plan changes effective 4/1/2015. Copayment for primary care visit increased from \$10 to \$15. Copayment from specialist visit increased from \$15 to \$30. Copayment for emergency room visit increased from \$50 (not waived) to \$150 (waived if admitted to hospital). Preferred brand name prescriptions increased for \$10 to \$25. Non-Preferred brand name prescriptions increased from \$25 to \$40. Future Scripts, a division of Catamaran, replaced Express Scripts as the Pharmacy Benefit Manager.

# Keystone Health Plan East

HMO C1-F1



## Phila Parking Authority

Keystone Health Plan East is a Health Maintenance Organization (HMO). This is a managed care program. Coverage is available when your care is provided or referred by a Keystone primary care physician (PCP). Your Keystone PCP may also refer you to other Keystone providers for care, if needed.

**To get the most out of your benefits program, below are some key terms that you will need to understand.**

- **Referral** - Documentation from your PCP authorizing care at a participating specialist for covered services.
- **Preapproval/Precertification** - Approval from Independence Blue Cross (IBC) for non-emergency or elective hospital admissions and procedures prior to the admission or procedure. Your participating provider will contact IBC for authorization. For more information on the services requiring precertification, please refer to the back page of this summary.
- **Designated site** - PCPs are required to choose one radiology, physical therapy, occupational therapy, and laboratory provider where they will send all their Keystone members. You can view the sites selected by your PCP at [www.ibx.com](http://www.ibx.com).

Your Member Handbook will provide additional details about your benefits program. It will include information about exclusions and benefit limitations. It is important to note that this program may not cover all your health care services. Services may not be covered because they are not included under your benefits contract, not medically necessary, or limited by a benefit maximum (e.g., visit limit). After reviewing this information, please contact our Customer Service department if you have additional questions.

Benefit	Coverage
<b>Benefit Period</b>	Calendar year*
<b>Doctor's Office Visits</b>	
Primary Care Services	\$15 Copayment
Specialist Services	\$30 Copayment
<b>Preventive Care for Adults and Children</b>	100%
<b>Pediatric Immunizations</b>	100% (office visit copayment does not apply)
<b>Routine Eye Exam</b>	\$30 Copayment (once every two calendar years)
<b>Routine Gynecological Exam/PAP</b> 1 per calendar year for women of any age (No referral required)	100%
<b>Mammogram</b> (No referral required)	100%
<b>Nutrition Counseling For Weight Management</b> 6 visits per calendar year	100%

\* A calendar year benefit period begins on January 1 and ends on December 31. The deductible and out-of-pocket maximum amount resets to \$0 at the start of the calendar year on January 1.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.



Benefits are administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross-  
independent licensees of the Blue Cross and Blue Shield Association.  
[www.ibx.com](http://www.ibx.com)

Benefit	Coverage
<b>Outpatient Laboratory/Pathology</b>	100%
<b>Maternity</b>	
First OB Visit	\$15 Copayment
Hospital	100%
<b>Inpatient Hospital Services</b>	
Facility	100%
Physician/Surgeon	100%
<b>Inpatient Hospital Days</b>	Unlimited
<b>Outpatient Surgery</b>	
Facility	100%
Physician/Surgeon	100%
<b>Emergency Room</b>	\$150 Copayment (waived if admitted)
<b>Urgent Care Center</b>	\$50 Copayment
<b>Ambulance</b>	
Emergency	100%
Non-Emergency	100%
<b>Outpatient X-Ray/Radiology*</b>	
Routine Radiology/Diagnostic	\$30 Copayment
MRI/MRA, CT/CTA Scan, PET Scan	\$30 Copayment
<b>Therapy Services</b>	
Physical and Occupational 30 total visits combined per calendar year	\$30 Copayment
Cardiac Rehabilitation 36 visits per calendar year	\$30 Copayment
Pulmonary Rehabilitation 36 visits per calendar year	\$30 Copayment
Speech 20 visits per calendar year	\$30 Copayment
Orthoptic/Pleoptic 8 sessions lifetime maximum	\$30 Copayment
<b>Spinal Manipulations</b> 20 visits per calendar year	\$30 Copayment
<b>Allergy Injections</b> (Copayment waived if no office visit is charged)	100%
<b>Injectable Medications</b>	
Standard Injectables	100%**
Biotech/Specialty Injectables	100%
<b>Chemo/Radiation/Dialysis</b>	100%
<b>Outpatient Private Duty Nursing</b> 360 hours per calendar year	100%
<b>Skilled Nursing Facility</b> 120 days per calendar year	100%
<b>Hospice and Home Health Care</b>	100%

\*\* Office visits subject to copayment.

+ Copayment not applicable when service is performed in Emergency Room or office setting.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

Benefit	Coverage
<b>Durable Medical Equipment and Prosthetics</b>	100%
<b>Mental Health Care</b>	
Outpatient	\$30 Copayment
Inpatient	100%
<b>Serious Mental Illness Care</b>	
Outpatient	\$30 Copayment
Inpatient	100%
<b>Substance Abuse Treatment</b>	
Outpatient/Partial Facility Visits	\$30 Copayment
Rehabilitation	100%
Detoxification	100%
<b>Annual Copayment Maximum</b> (includes copayments only)	
Individual	\$1,000
Family	\$2,000

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

## What Is Not Covered?

- Services not medically necessary
- Service or supplies which are experimental or investigative except, when approved by Keystone Health Plan East, Routine Costs associated with Qualifying Clinical Trials
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Assisted fertilization techniques such as in-vitro fertilization, GIFT and ZIFT
- Reversal of voluntary sterilization
- Expenses related to organ donation for non-member recipients
- Dental care, including dental implants, and non-surgical treatment of temporomandibular joint syndrome (TMJ)
- Music therapy, equestrian therapy and hippotherapy
- Treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury
- Routine foot care, unless medically necessary or associated with the treatment of diabetes
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes
- Cranial prostheses including wigs intended to replace hair
- Routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premarital examinations
- Immunizations for travel or employment
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Cosmetic services/supplies
- Outpatient services that are not performed by your Primary Care Physician's Designated Provider
- Alternative Therapies/complementary medicine
- Self-injectable drugs

This summary represents only a partial listing of benefits and exclusions of the Keystone Health Plan East program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. This managed care plan may not cover all of your health care expenses. Read your contract/member handbook carefully to determine which health care services are covered. If you need more information, please call 215-241-2240 (if calling within Philadelphia) or 1-800-227-3115 (outside Philadelphia).

## Services That Require Precertification

### INPATIENT SERVICES

Surgical and Nonsurgical Inpatient Admissions  
 Acute Rehabilitation  
 Skilled Nursing Facility  
 Inpatient Hospice

### OUTPATIENT FACILITY/OFFICE SERVICES (other than inpatient)

MRI/MRA  
 CT/CTA Scan  
 PET Scan  
 Nuclear Cardiac Studies  
 Hyperbaric Oxygen  
 Hysterectomy  
 Cataract Surgery  
 Cochlear implant surgery  
 Nasal Surgery for Submucous Resection and Septoplasty  
 Transplants (except cornea)  
 Pain management procedures (including epidural injections, transforaminal epidural injections, paravertebral facet joint injections)  
 Obesity Surgery  
 Day Rehabilitation Programs  
 Dental Services as a Result of Accidental Injury  
 Uvulopalatopharyngoplasty  
 (including laser-assisted)

### ALL HOME CARE SERVICES (including infusion therapy in the home)

### INFUSION THERAPY DRUGS in an OUTPATIENT FACILITY or in a PROFESSIONAL PROFESSIONAL PROVIDER'S OFFICE (See list included in your Open Enrollment packet)

### MATERNITY ADMISSION AND BIRTHING CENTER (prenotification requested only)

### ELECTIVE (non-emergency) AMBULANCE TRANSPORT

### OUTPATIENT PRIVATE DUTY NURSING

### PROSTHETICS AND ORTHOTICS

Purchase items over \$500, including repairs and replacements (except ostomy supplies)

### DURABLE MEDICAL EQUIPMENT

Purchase items over \$500 including, repairs and replacements, and ALL rentals (except oxygen, diabetic supplies and unit dose medication for nebulizer)

### RECONSTRUCTIVE PROCEDURES & POTENTIALLY COSMETIC PROCEDURES

Blepharoplasty/ptosis repair  
 Breast: reconstruction, reduction, augmentation, mammoplasty, mastopexy, insertion and removal of breast implants  
 Canthopexy/canthoplasty  
 Cervicoplasty  
 Chemical Peels  
 Dermabrasion  
 Excision of excessive skin and/or subcutaneous tissue  
 Genetically and bio-engineered skin substitutes for wound care  
 Hair transplant  
 Injectable dermal fillers  
 Keloid Removal  
 Labiaplasty  
 Lipectomy, Liposuction, or any other excess fat removal procedure  
 Orthognathic surgery procedures, including but not limited to, bone graft, genioplasty, osteoplasty, mentoplasty, osteotomies  
 Otoplasty  
 Rhinoplasty  
 Rhytidectomy  
 Scar Revision  
 Skin closures, including skin grafts, skin flaps, tissue grafts  
 Sex reassignment surgery  
 Surgical treatment of gynecomastia  
 Surgery for varicose veins, including perforators and sclerotherapy

### MENTAL HEALTH/SERIOUS MENTAL ILLNESS/SUBSTANCE ABUSE

Mental health and serious mental illness treatment  
 (Inpatient/partial hospitalization programs/intensive outpatient programs)

Substance Abuse Treatment  
 (Inpatient/Outpatient/Partial Hospitalization)

### BIOTECHNOLOGY/SPECIALTY INJECTABLE DRUGS (See list included in your open enrollment packet)

### SERVICES BY A NON-PARTICIPATING PHYSICIAN/PROVIDER FOR NON-EMERGENCY SERVICES

Preapproval is not a determination of eligibility or a guarantee of payment. Coverage and payment are contingent upon, among other things, the patient being eligible, i.e., actively enrolled in the health benefits plan when the preapproval is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request. Preapproval list subject to change annually.

In addition to the preapproval requirements listed above, you should contact Independence Blue Cross and provide prenotification for certain categories of treatment so you will know prior to receiving treatment whether it is a covered service. The categories of treatment (in any setting) include:

- Any surgical procedure that may be considered potentially cosmetic; and
- Any procedure, treatment, drug, or device that represents new or emerging technology and
- Services that might be considered experimental/investigative.

Your PCP should be able to assist you in determining whether a proposed treatment falls into one of these three categories and should generally provide this prenotification for you.

### PENALTIES:

It is the network provider's responsibility to obtain preapproval for the services listed. Members are held harmless from financial penalties if the network provider does not obtain preapproval.

# Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

## Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

## Appeal

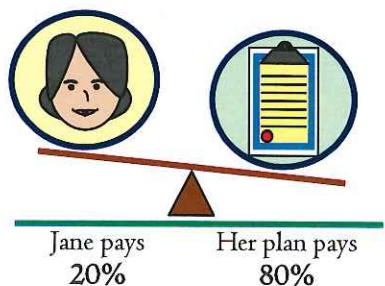
A request for your health insurer or **plan** to review a decision or a **grievance** again.

## Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may **not** balance bill you for covered services.

## Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance **plus** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.



(See page 4 for a detailed example.)

## Complications of Pregnancy

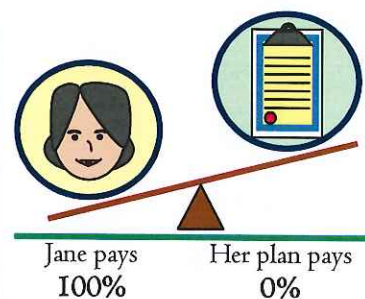
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

## Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

## Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

## Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

## Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

## Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

## Emergency Room Care

**Emergency services** you get in an emergency room.

## Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

## Excluded Services

Health care services that your **health insurance** or **plan** doesn't pay for or cover.

## Grievance

A complaint that you communicate to your health insurer or **plan**.

## Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

## Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

## Home Health Care

Health care services a person receives at home.

## Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

## Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

## Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

## In-network Co-insurance

The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

## In-network Co-payment

A fixed amount (for example, \$15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

## Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

## Network

The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

## Non-Preferred Provider

A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

## Out-of-network Co-insurance

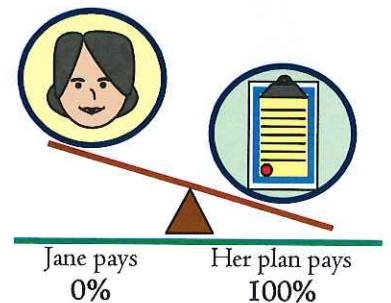
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

## Out-of-network Co-payment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

## Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.



(See page 4 for a detailed example.)

## Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

## Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

## Preauthorization

A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

## Preferred Provider

A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

## Premium

The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

## Prescription Drug Coverage

**Health insurance** or **plan** that helps pay for **prescription drugs** and medications.

## Prescription Drugs

Drugs and medications that by law require a prescription.

## Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

## Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

## Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

## Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

## Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

## Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

## Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

## UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

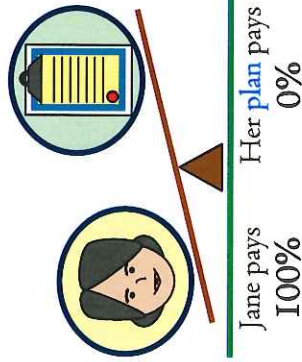
## Urgent Care

Care 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 care**.

# How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500      Co-insurance: 20%      Out-of-Pocket Limit: \$5,000

January 1<sup>st</sup>  
Beginning of Coverage  
Period



## Jane hasn't reached her \$1,500 deductible yet

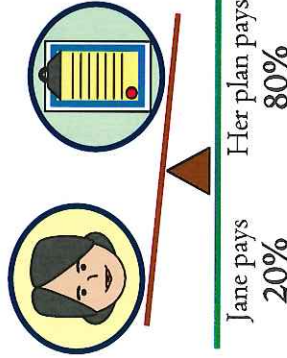
Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0

↑  
more costs



## Jane reaches her \$1,500 deductible, co-insurance begins

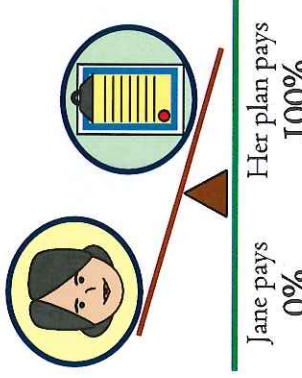
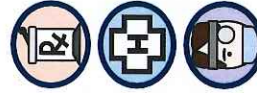
Jane has seen a doctor several times and paid \$1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: \$75

Jane pays: 20% of \$75 = \$15

Her plan pays: 80% of \$75 = \$60

↑  
more costs



## Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: \$200

Jane pays: \$0

Her plan pays: \$200

December 31<sup>st</sup>  
End of Coverage Period

## Selection Criteria



---

<b>User-Defined File Name:</b>	Demographic Analysis
<b>Selected Customer(s):</b>	0000357484-Philadelphia Parking Authority
<b>Selected Product(s):</b>	HMO/POS/PPO
<b>Current Period Incurred Date Range:</b>	All
<b>Current Period Paid Date Range:</b>	October 2014 - September 2015
<b>Prior Period Incurred Date Range:</b>	All
<b>Prior Period Paid Date Range:</b>	October 2013 - September 2014
<b>Selected Group(s):</b>	All
<b>Selected Account(s):</b>	All
<b>Request ID:</b>	364349
<b>Selected State(s):</b>	All
<b>Selected Payroll Location(s):</b>	All
<b>Selected Gender(s):</b>	All
<b>Selected Relationship(s) to Insured:</b>	All
<b>Selected Age Band(s):</b>	All

**Date Report Run:** Wednesday, November 18, 2015

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# Demographic Analysis

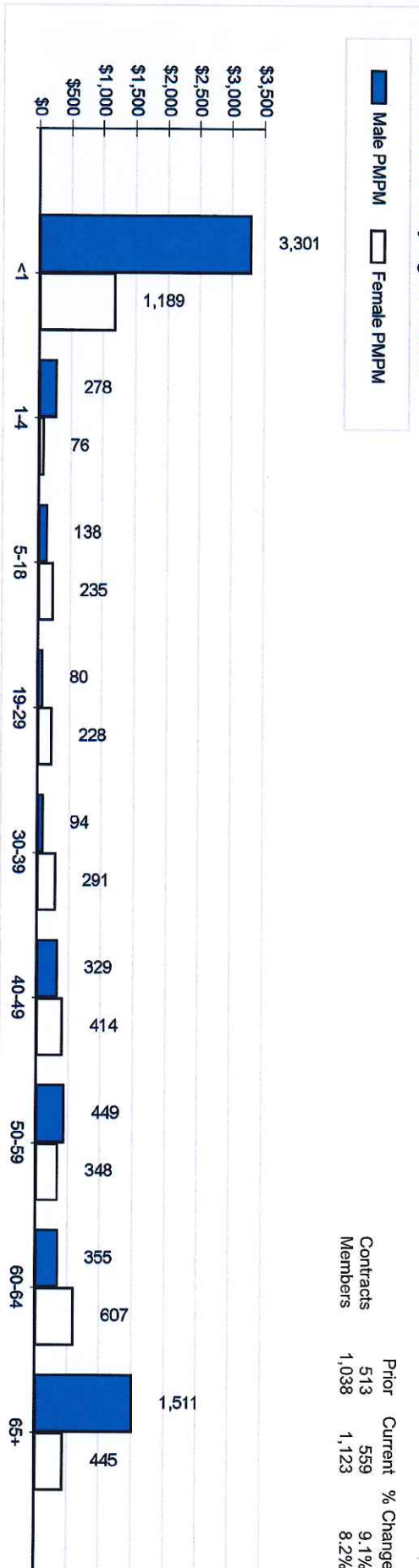


Age Bands	Member Counts - Male			Member Counts - Female			Member Counts - Total		
	Prior	Current	% Change	Prior	Current	% Change	Prior	Current	% Change
<1	2	5	120.7%	4	7	87.0%	6	13	100.0%
1-4	17	15	-13.6%	18	18	-2.3%	35	33	-7.8%
5-18	92	100	8.2%	89	94	5.7%	181	194	7.0%
19-29	101	115	13.5%	94	107	14.6%	195	222	14.0%
30-39	63	71	12.2%	49	56	15.0%	112	127	13.4%
40-49	76	74	-3.1%	82	86	4.4%	158	159	0.8%
50-59	100	114	14.6%	110	111	0.9%	210	225	7.4%
60-64	32	37	14.4%	50	53	6.2%	82	90	9.4%
65+	35	35	-1.0%	23	26	8.9%	58	60	3.0%
Total	519	565	8.9%	519	558	7.5%	1,038	1,123	8.2%

Average Member Age		
Male	Female	Total
Prior 36.5	Prior 37.5	Prior 37.0
Current 36.3	Current 36.8	Current 36.6
Norm --	Norm --	Norm --

Total Medical PMPM by Age / Gender



Contracts	Prior	Current	% Change
Members	513	559	9.1%
	1,038	1,123	8.2%

Numbers and percentages may vary slightly due to averaging and rounding.

This information is proprietary and confidential. Results are not guaranteed to match billing and/or rating statements.

Prior Period: Paid October 2013 - September 2014  
Current Period: Paid October 2014 - September 2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: HUSBAND/WIFE | PlanType: HMO



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.ibx.com](http://www.ibx.com) or by calling 1-800-ASK-BLUE.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your other costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	\$1,000 person / \$2,000 family	The <b><u>out-of-pocket limit</u></b> is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Coinsurance, deductibles, premiums, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See <a href="http://www.ibx.com">www.ibx.com</a> /find a provider or call 1-800-ASK-BLUE for a list of participating providers.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a specialist?	Yes. Electronic referral required.	This plan will pay some or all of the costs to see a <b>specialist</b> for covered services but only if you have the plan's permission before you see the <b>specialist</b>
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about <b>excluded services</b> .

**Questions:** Call 1-800-ASK-BLUE or visit us at [www.ibx.com](http://www.ibx.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.ibx.com](http://www.ibx.com) or call 1-800-ASK-BLUE to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		a Referred Provider	an Out Of Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 Copayment	Not Covered	-----none-----
	Specialist visit	\$30 Copayment	Not Covered	PCP referral required.
	Other practitioner office visit	\$30 Copayment	Not Covered	Spinal manipulations limited to 20 visits per benefit period. PCP referral required.
	Preventive care / screening / immunization	No Charge	Not Covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	\$30 Copayment(X-Ray) / No Charge(Blood Work)	Not Covered	PCP referral required for x-rays. Requisition form required for lab work.
	Imaging (CT/PET scans, MRIs)	\$30 Copayment	Not Covered	Precertification required. Imaging copay not applicable if performed in ER or office setting.
If you need drugs to treat your illness or condition	Generic drugs	\$5 Copayment (Retail) / \$5 Copayment (1-30 days supply) (Mail Order); \$5 Copayment (31-90 days supply) (Mail Order)	70%	Prior authorization required on some drugs; age, gender and quantity limits for some drugs; days supply limits on retail & mail order.
More information about <b>prescription drug coverage</b> is available at <a href="http://www.ibx.com/precapproval">http://www.ibx.com/precapproval</a>				

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		a Referred Provider	an Out Of Network Provider	
	Preferred brand drugs	\$25 Copayment (Retail)/ \$25 Copayment (1-30 days supply)(Mail Order); \$25 Copayment (31-90 days supply)(Mail Order)	70%	Prior authorization required on some drugs; age, gender and quantity limits for some drugs; days supply limits on retail & mail order.
	Non-preferred brand drugs	\$40 Copayment (Retail)/ \$40 Copayment (1-30 days supply)(Mail Order); \$40 Copayment (31-90 days supply)(Mail Order)	70%	Prior authorization required on some drugs; age, gender and quantity limits for some drugs; days supply limits on retail & mail order.
	Specialty drugs	No Charge	Not Covered	Prior-authorization required. A complete list of drugs requiring prior-authorization is available at <a href="http://www.ibx.com/preapproval">www.ibx.com/preapproval</a>
	Facility fee (e.g, ambulatory surgery center)	No Charge	Not Covered	Some outpatient surgeries require precertification. A complete list of surgeries requiring precertification is available at <a href="http://www.ibx.com/preapproval">www.ibx.com/preapproval</a>
If you have outpatient surgery	Physician/surgeon fees	No Charge	Not Covered	Some outpatient surgeries require precertification. A complete list of surgeries requiring precertification is available at <a href="http://www.ibx.com/preapproval">www.ibx.com/preapproval</a>
	Emergency room services	\$150 Copayment	\$150 Copayment	Your costs for Emergency Room services are waived if you are admitted to the hospital.
If you need immediate medical attention	Emergency medical transportation	No Charge	No Charge	-----none-----
	Urgent care	\$50 Copayment	Not Covered	Your costs for urgent care are based on care received at a designated urgent care center or facility, not your physician's office. Costs may vary depending on where you receive care.
If you have a hospital stay	Facility fee (e.g, hospital room)	No Charge	Not Covered	Precertification required.
	Physician/surgeon fee	No Charge	Not Covered	Precertification required.
If you have mental health, behavioral health, or substance	Mental/Behavioral health outpatient services	\$30 Copayment	Not Covered	-----none-----

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		a Referred Provider	an Out Of Network Provider	
abuse needs	Mental/Behavioral health inpatient services	No Charge	Not Covered	Precertification required.
	Substance abuse disorder outpatient services	\$30 Copayment	Not Covered	Precertification required.
	Substance abuse disorder inpatient services	No Charge	Not Covered	Precertification required.
	Prenatal and postnatal care	\$15 Copayment	Not Covered	Your cost is for first OB visit only.
If you are pregnant	Delivery and all inpatient services	No Charge	Not Covered	Pre-notification requested
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Precertification required.
	Rehabilitation services	\$30 Copayment	Not Covered	Speech Therapy: 20 visits per benefit period; Physical/Occupational Therapies: 30 visits combined per benefit period. PCP referral required.
	Habilitation services	\$30 Copayment	Not Covered	Speech Therapy: 20 visits per benefit period; Physical/Occupational Therapies: 30 visits combined per benefit period. PCP referral required.
	Skilled nursing care	No Charge	Not Covered	120 day limit per benefit period. Precertification required.
	Durable medical equipment	No Charge	Not Covered	Precertification required for purchases (including repairs and replacements) over \$500 and all rentals
If your child needs dental or eye care	Hospice service	No Charge	Not Covered	-----none-----
	Eye exam	\$30 Copayment	Not Covered	Once every two calendar years.
	Glasses	Not Covered	Not Covered	-----none-----
	Dental check-up	Not Covered	Not Covered	-----none-----

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- |   |                         |                        |
|---|-------------------------|------------------------|
| • Acupuncture   | • Cosmetic surgery      | • Dental care (Adult)  |
| • Hearing aids  | • Infertility treatment | • Long-term care       |
| • Non-emergency care when traveling outside the U.S. (For details, see <a href="http://www.ibx.com">www.ibx.com</a> ) | • Routine foot care     | • Weight loss programs |

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- |                            |                     |                        |
|----------------------------|---------------------|------------------------|
| • Bariatric surgery        | • Chiropractic care | • Private-duty nursing |
| • Routine eye care (Adult) |                     |                        |

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-671-5276. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cchp.cms.gov](http://www.cchp.cms.gov).

## Your Grievance and Appeals Rights:

Your health plan is subject to Employee Retirement Income Security Act (ERISA) requirements. If you are dissatisfied with a denial of coverage for claims under your plan, you may contact IBC at 1-800-ASK-BLUE. You may also contact the U.S. Dept. of Labor Employee Benefits Security Administration at 1-866-444-3272. As an alternative, the Pennsylvania Department of Insurance can also provide assistance. Please contact them at 1-877-881-6388.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does**

provide minimum essential coverage.

\_\_\_\_\_ *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* \_\_\_\_\_

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

■ Amount owed to providers: \$7,540

■ Plan Pays \$7,300

■ Patient Pays \$240

#### Sample Care Costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient Pays

Deductibles	\$0
Copays	\$90
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$240</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

■ Amount owed to providers: \$5,400

■ Plan Pays \$4,190

■ Patient Pays \$1,210

#### Sample Care Costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient Pays

Deductibles	\$0
Copays	\$1,130
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,210</b>

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

**X No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

**X No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

**✓ Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

**✓ Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call 1-800-ASK-BLUE or visit us at [www.ibx.com](http://www.ibx.com).

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## Selection Criteria

<b>User-Defined File Name:</b>	Claims and Enrollment
<b>Selected Customer(s):</b>	0000357484-Philadelphia Parking Authority
<b>Selected Product(s):</b>	HMO/POS/PPPO
<b>Current Period Incurred Date Range:</b>	All
<b>Current Period Paid Date Range:</b>	April 2015 - October 2015
<b>Prior Period Incurred Date Range:</b>	All
<b>Prior Period Paid Date Range:</b>	All
<b>Selected Group(s):</b>	All
<b>Selected Account(s):</b>	All
<b>Request ID:</b>	363901
<b>Selected State(s):</b>	All
<b>Selected Payroll Location(s):</b>	All
<b>Selected Gender(s):</b>	All
<b>Selected Relationship(s) to Insured:</b>	All
<b>Selected Age Band(s):</b>	All

**Date Report Run:**

Thursday, November 12, 2015

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# Claims and Enrollment

Group	Product	Month	Contracts	Members	Claims Expenses
10043012	HMO/POS/PRO	201504	19	50	\$13,853
10043012	HMO/POS/PRO	201505	20	52	\$11,086
10043012	HMO/POS/PRO	201506	40	102	\$46,375
10043012	HMO/POS/PRO	201507	20	51	\$15,764
10043012	HMO/POS/PRO	201508	20	52	\$22,814
10043012	HMO/POS/PRO	201509	42	108	\$47,299
10043012	HMO/POS/PRO	201510	21	55	\$62,833
Total for	10043012 - HMO/POS/PRO		182	470	\$220,025
10043013	HMO/POS/PRO	201504	1,044	2,086	\$622,508
10043013	HMO/POS/PRO	201505	1,040	2,076	\$614,698
10043013	HMO/POS/PRO	201506	1,048	2,086	\$726,073
10043013	HMO/POS/PRO	201507	1,066	2,088	\$721,601
10043013	HMO/POS/PRO	201508	1,114	2,172	\$538,040
10043013	HMO/POS/PRO	201509	1,112	2,162	\$751,721
10043013	HMO/POS/PRO	201510	1,104	2,144	\$987,944
Total for	10043013 - HMO/POS/PRO		7,530	14,784	\$4,962,585
10043014	HMO/POS/PRO	201504	34	78	\$84,854
10043014	HMO/POS/PRO	201505	32	72	\$64,937
10043014	HMO/POS/PRO	201506	32	72	\$32,204
10043014	HMO/POS/PRO	201507	32	72	\$20,220
10043014	HMO/POS/PRO	201508	32	72	\$35,863
10043014	HMO/POS/PRO	201509	32	72	\$1,055
10043014	HMO/POS/PRO	201510	32	70	\$22,572
Total for	10043014 - HMO/POS/PRO		226	508	\$269,085
443857	HMO/POS/PRO	201504	0	0	\$579
443857	HMO/POS/PRO	201505	0	0	\$148
443857	HMO/POS/PRO	201506	0	0	\$14,787
443857	HMO/POS/PRO	201507	0	0	\$47
443857	HMO/POS/PRO	201508	0	0	\$811
443857	HMO/POS/PRO	201509	0	0	-\$1,476
443857	HMO/POS/PRO	201510	0	0	-\$2,217
Total for	443857 - HMO/POS/PRO		0	0	\$12,681

Medical Claims Expenses includes Medical Claim Payments, Capitation, QIPs, and Integrated/IDHP Drug Claim Payments. It does not include Wellness, Disease Management, Administrative Fees/Retention, Commissions, or applicable Taxes.  
 This information is proprietary and confidential. Results are not guaranteed to match billing and/or rating statements.  
 Paid April 2015 - October 2015

# Claims and Enrollment

Group	Product	Month	Contracts	Members	Claims Expenses
ALL	HMO/POS/PPO	201504	1,097	2,214	\$731,795
ALL	HMO/POS/PPO	201505	1,092	2,200	\$690,869
ALL	HMO/POS/PPO	201506	1,120	2,240	\$819,438
ALL	HMO/POS/PPO	201507	1,120	2,211	\$757,633
ALL	HMO/POS/PPO	201508	1,166	2,296	\$597,019
ALL	HMO/POS/PPO	201509	1,186	2,342	\$796,490
ALL	HMO/POS/PPO	201510	1,157	2,269	\$1,071,133
Total for ALL HMO/POS/PPO			7,938	15,772	\$5,464,377

Medical Claims Expenses includes Medical Claim Payments, Capitation, QIPs, and Integrated/HDHP Drug Claim Payments. It does not include Wellness, Disease Management, Administrative Fees/Retention, Commissions, or applicable Taxes.

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Paid April 2015 - October 2015

# Claims and Enrollment

<u>Group</u>	<u>Product</u>	<u>Month</u>	<u>Contracts</u>	<u>Members</u>	<u>Claims Expenses</u>
ALL	ALL	201504	1,097	2,214	\$731,795
ALL	ALL	201505	1,092	2,200	\$690,869
ALL	ALL	201506	1,120	2,240	\$819,438
ALL	ALL	201507	1,120	2,211	\$757,633
ALL	ALL	201508	1,166	2,296	\$597,019
ALL	ALL	201509	1,186	2,342	\$796,480
ALL	ALL	201510	1,157	2,269	\$1,071,133
<b>Total for ALL Medical</b>			<b>7,938</b>	<b>15,772</b>	<b>\$5,464,377</b>

Medical Claims Expenses includes Medical Claim Payments, Capitation, QIPs, and Integrated/H-DHP Drug Claim Payments. It does not include Wellness, Disease Management, Administrative Fees/Retention, Commissions, or applicable Taxes.  
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 Paid April 2015 - October 2015

# Claims and Enrollment

<u>Group</u>	<u>Product</u>	<u>Month</u>	<u>Contracts</u>	<u>Members</u>	<u>Claims Expenses</u>
10043015	COMMERCIAL FREE STANDING	201504	595	1,177	\$223,444
10043015	COMMERCIAL FREE STANDING	201505	587	1,165	\$149,330
10043015	COMMERCIAL FREE STANDING	201506	598	1,174	\$186,469
10043015	COMMERCIAL FREE STANDING	201507	588	1,151	\$141,414
10043015	COMMERCIAL FREE STANDING	201508	610	1,192	\$119,563
10043015	COMMERCIAL FREE STANDING	201509	614	1,194	\$76,626
10043015	COMMERCIAL FREE STANDING	201510	609	1,184	\$87,118
<b>Total for</b>	<b>10043015 - COMMERCIAL FREE STANDING</b>		<b>4,201</b>	<b>8,227</b>	<b>\$983,964</b>
532780	COMMERCIAL FREE STANDING	201508	0	0	\$1,632
<b>Total for</b>	<b>532780 - COMMERCIAL FREE STANDING</b>		<b>0</b>	<b>0</b>	<b>\$1,632</b>

Medical Claims Expenses includes Medical Claim Payments, Capitation, QIPs, and Integrated/HDHP Drug Claim Payments. It does not include Wellness, Disease Management, Administrative Fees/Retention, Commissions, or applicable Taxes.  
 This information is proprietary and confidential. Results are not guaranteed to match billing and/or rating statements.  
 Paid April 2015 - October 2015

# Claims and Enrollment

Group	Product	Month	Contracts	Members	Claims Expenses
ALL	COMMERCIAL FREE STANDING	201504	585	1,177	\$223,444
ALL	COMMERCIAL FREE STANDING	201505	587	1,155	\$149,330
ALL	COMMERCIAL FREE STANDING	201506	598	1,174	\$186,469
ALL	COMMERCIAL FREE STANDING	201507	588	1,151	\$141,414
ALL	COMMERCIAL FREE STANDING	201508	610	1,192	\$121,196
ALL	COMMERCIAL FREE STANDING	201509	614	1,194	\$76,626
ALL	COMMERCIAL FREE STANDING	201510	609	1,184	\$87,118
Total for ALL COMMERCIAL FREE STANDING			4,201	8,227	\$985,597

Medical Claims Expenses includes Medical Claim Payments, Capitation, QIPs, and Integrated/HDHP Drug Claim Payments. It does not include Wellness, Disease Management, Administrative Fees/Retention, Commissions, or applicable Taxes.  
 This information is proprietary and confidential. Results are not guaranteed to match billing and/or rating statements.  
 Paid April 2015 - October 2015

# Claims and Enrollment

<u>Group</u>	<u>Product</u>	<u>Month</u>	<u>Contracts</u>	<u>Members</u>	<u>Claims Expenses</u>
ALL	ALL	201504	595	1,177	\$223,444
ALL	ALL	201505	587	1,155	\$149,330
ALL	ALL	201506	598	1,174	\$186,469
ALL	ALL	201507	588	1,151	\$141,414
ALL	ALL	201508	610	1,192	\$121,196
ALL	ALL	201509	614	1,194	\$76,626
ALL	ALL	201510	609	1,184	\$87,118
<b>Total for ALL Pharmacy</b>			<b>4,201</b>	<b>8,227</b>	<b>\$985,597</b>

Medical Claims Expenses includes Medical Claim Payments, Capitation, QIPs, and Integrated/HDP Drug Claim Payments. It does not include Wellness, Disease Management,

Administrative Fees/Retention, Commissions, or applicable Taxes.

This information is proprietary and confidential. Results are not guaranteed to match billing and/or rating statements.

Paid April 2015 - October 2015

Paid April 2015 - October 2015

# **Exhibit A**

**AGREEMENT FOR PROFESSIONAL ACTUARIAL  
SERVICES BY AND BETWEEN  
THE PHILADELPHIA PARKING AUTHORITY  
AND**

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PPA Contract No. K-16-00\_\_

**THIS AGREEMENT** effective as of the \_\_\_\_ day of \_\_\_\_\_, 2016 by and between **The Philadelphia Parking Authority**, an agency of the Commonwealth of Pennsylvania and a body corporate and politic, with its principal address at 701 Market Street, Suite 5400, Philadelphia, PA 19106 (the "Authority") and \_\_\_\_\_ a \_\_\_\_\_, with its principal place of business at \_\_\_\_\_ ("Company").

**WITNESSETH:**

**WHEREAS**, the Authority is a public body corporate and politic organized and existing under the Act of 2001, June 19, P.L. 287, No. 22, as amended;

**WHEREAS**, the Authority, in the public interest, desires to obtain high quality actuarial services to evaluate present and potential liabilities and obligations for self-funded health healthcare, subject to the terms and conditions set forth herein;

**WHEREAS**, the Authority initiated a request for proposal process under Request for Proposals Professional Actuarial Services RFP No. 15-24 (hereinafter the "RFP") for actuarial services in order foster competition and obtain best value;

**WHEREAS**, Company submitted a conforming Proposal to the RFP (the "Proposal") on \_\_\_\_\_, and is in the business of providing high quality actuarial services of the type desired by the Authority;

**WHEREAS**, upon review of the responses to the RFP, the Authority's Board voted at a public meeting to award this contract to Company.

**WHEREAS**, Company hereby agrees to furnish the Authority with professional actuarial services as hereinafter described.

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

**1. SCOPE OF SERVICES.**

The Authority hereby engages and Company hereby agrees to perform the following actuarial services ("Services") in consideration of the fee paid pursuant to Section 3 of this Agreement:

A. The Company shall provide an annual report to the Authority in accordance with the specifications set forth in the RFP.

B. Comply fully with all requirements and terms of the RFP, a true and correct copy of which is attached hereto and incorporated herein throughout as Exhibit "A" and Company's Proposal responding to the RFP, a true and correct copy of which is attached hereto and incorporated throughout as Exhibit "B"; provided however, that to the extent that any provisions of either Exhibits "A" or "B" are inconsistent or conflict with the provisions of this Agreement, then the terms contained in this Agreement shall control and govern the agreement of the parties.

C. To perform high quality actuarial services in the most cost effective manner utilizing personnel at the level of competence required relative to the nature of the work, and to follow all applicable federal, state, or local laws; and

D. It is understood that the Authority shall have the absolute discretion to accept, reject or modify any proposal or offer which Company may bring to the Authority's attention during the term of this Agreement.

E. To provide all services to the Authority as directed by its Executive Director or his designee.

**2. TERM.**

This Agreement shall be for a term of five (5) years.

**3. CONSIDERATION AND PAYMENT.**

A. Company agrees to accept as its sole fee for Services provided pursuant to this Agreement an annual service fee as detailed in its Proposal and outlined below:

**4. NO SOLICITATION/CONFLICTS OF INTEREST.**

A. Company does hereby warrant and represent that the laws of the Commonwealth of Pennsylvania have not been violated as they relate to the procurement or performance of this Agreement by any conduct, including payment or giving of any fee, commission, compensation, gift, gratuity or consideration of any kind, directly or indirectly to any Authority employee, officer or Company, including the Public Official and Employees Ethics Act, 65 Pa.C.S. §1101 *et seq.*

B. To the best of Company's knowledge, no Authority member or officer, and no employee of the Authority has any interest (whether contractual, non-contractual, financial or otherwise) in this transaction or in the business of Company. If such transaction comes to the

knowledge of the Company at any time, a full and complete disclosure of such information shall be made to the Authority.

C. Company hereby acknowledges receipt and acceptance of the Authority's Conflict of Interest Policy.

**5. INSURANCE & OTHER REQUIREMENTS.**

A. Company shall provide and maintain, at its own cost, Professional Liability Insurance Coverage for errors and omissions and negligent acts in a combined amount of not less than Ten Million and no/100 (\$10,000,000) Dollars per claim and aggregate. Such insurance shall extend to Company and to its legal representatives in the event of death, dissolution or bankruptcy, and shall cover the errors, omissions or negligent acts of Company's agents and employees. Such insurance shall extend to any covered act, error or omission in the performance of services under this Agreement committed by Company or alleged to have been committed by Company or any person for whom Company is responsible. Company shall also carry insurance in compliance with the applicable laws of the Commonwealth of Pennsylvania or such other workers' compensation requirements as may pertain.

B. Company shall also carry and maintain a Comprehensive General Liability Insurance Policy for bodily injury and property damage in the combined single limit of Five Million and no/100 (\$5,000,000) Dollars, and Automobile Liability Insurance coverage for bodily injury and property damage in the combined single limit of Two Million and no/100 (\$2,000,000) Dollars. The Commercial General Liability Insurance is to include Contractual Liability Insurance covering the Company's indemnification as set forth below. Company shall also maintain Valuable Papers and Records Coverage in the event of loss or destruction of the Authority's Valuable Papers and Records which are in the custody of the Company.

**6. INABILITY OF COMPANY TO PERFORM.**

The inability of Company to perform or provide the Services under this Agreement, for any reason, shall automatically terminate this Agreement, whereupon all liabilities or obligations for payment hereunder shall terminate as of the date of such termination.

**7. TERMINATION FOR CONVENIENCE OF AUTHORITY.**

The Authority and Company agree that this Agreement may be terminated by the Authority with or without cause upon thirty days notice in writing by the Authority to Company. If the Agreement is terminated by the Authority, as provided herein, Company will be entitled to any compensation for the Services satisfactorily performed pursuant to Section 3 herein for the period prior to the date of termination, and Company shall refund any part of the annual service fee that would have been earned after the date of termination. In such event, all memoranda, records, data, information and other documents prepared by Company shall become the property of the Authority and shall be forthwith delivered to the Authority. The payments to be made to the Company hereunder are the Company's sole remedy and right with respect to termination under this paragraph.

8. **GENERAL TERMS AND CONDITIONS.**

A. Confidential Matters.

Company agrees that it will treat as confidential any information or document from the files of the Authority which may come into their possession in pursuit of its duties under this Agreement.

B. Maintenance of Records.

Company understands that certain records related to this Agreement may be public records pursuant to Pennsylvania's Right-to-Know Law and Company must duly comply with demands made through the Authority for such records. 65 P.S. §67.101.*et seq.* Regardless of the impact of the Right-to-Know Law, Company shall maintain all data, records, memoranda, statements of services rendered, correspondence and copies thereof, in adequate form, detail and arrangement, for the Authority's benefit for a minimum of seven (7) years following the termination or expiration of this Agreement. Thereafter, Company shall contact the Authority before disposing any such materials and the Authority may direct that some or all of such materials be delivered to the Authority.

C. Assignment.

This Agreement may not be transferred or assigned by Company without the prior written consent of the Authority which consent may be withheld in the sole discretion of the Authority. Any assignment made without the consent of the Authority shall be void.

D. Non-Discrimination.

Company agrees to abide by all legal provisions regarding non-discrimination in hiring and contracting made applicable by federal, state and local laws.

E. Notices.

Any notice or demand given by one party to the other under this Agreement shall be in writing and served by nationally recognized overnight courier service or sent by United States certified or registered mail return receipt requested, postage prepaid, or by overnight express delivery service or by courier service, against written receipt or signed proof of delivery addressed to the other party at the address set forth below, unless a party shall have provided written notice to the other identifying a new address for notice:

**The Authority:**

The Philadelphia Parking Authority  
701 Market Street, Suite 5400  
Philadelphia, PA 19106  
Attn: Dennis G. Weldon, Jr.  
General Counsel

**The Company:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Attn: \_\_\_\_\_  
Title

All notices shall be deemed given on the day after the notice was given to the courier or postal service.

F. Captions.

The captions in this Agreement are for convenience only and are not a part of this Agreement and do not in any way define, limit, describe or amplify the terms and provisions of this Agreement or the scope or intent thereof.

G. General Indemnity.

Company, for itself, its successors, assigns, agents, and sub-contractors hereby agrees to indemnify, hold harmless and defend The Philadelphia Parking Authority, The City of Philadelphia and The Commonwealth of Pennsylvania and their agents, employees, representatives, officers and directors (the "Indemnified Parties") from and against any and all liability for loss (including those related to business interruption), damage (including special, consequential and incidental) liabilities, claims, demands, causes of action or expense (including attorney's fees and expenses) for which the Indemnified Parties may be held liable by reason of injury (including death or workers compensation) to any person (including Company's employees) or damage to any property of whatsoever kind or nature arising out of or in any manner connected with the work to be performed for the Indemnified Parties (including, but not limited to, work performed under this contract, work performed under Change Order, or any such other work performed for or on behalf of the Indemnified Parties), whether or not due in whole or in part to any act, omission, or negligence of the Indemnified Parties or any of their agents, employees, representatives, officers, directors, stockholders, subcontractors, third parties or parent, subsidiary and affiliated companies, whether known or unknown to the Indemnified Parties or Company. It is expressly understood and agreed that the indemnity contained in this paragraph covers claims by Company's employees. It is further expressly agreed that Company assumes the fullest extent of all obligations to indemnify and defend all parties whom the Indemnified Parties are obligated to indemnify and defend in the Indemnified Parties contract with others (whether or not such obligations may extend to items beyond those addressed in this Agreement). This obligation to indemnify, defend and hold harmless shall survive termination of this Agreement.

H. Entire Agreement.

This Agreement contains the entire agreement of the parties with respect to the matter covered by this Agreement. No other agreement, statement, representation, understanding or promise made by any party or by any employee, officer or agent of any party, that is not contained in this Agreement, shall be binding or valid. Any revisions, additions, and/or modifications of this Agreement must be set forth in writing and signed by all parties.

I. Specific Proposals.

It is understood that the Authority shall have the absolute discretion to accept, reject or modify any proposal or offer which Company may bring to the Authority's attention during the term of this Agreement.

J. Applicable Law and Venue.

All disputes arising in connection with this Agreement shall be interpreted and governed by the laws of the Commonwealth of Pennsylvania. The parties hereto irrevocably consent to the exclusive jurisdiction of the First Judicial District of Pennsylvania, being the Philadelphia Court of Common Pleas.

K. Taxes.

(1) Company hereby certifies that neither it, nor any of its parent or subsidiary entities, is delinquent or overdue in the payment of any tax or fee to the City or County of Philadelphia or the Commonwealth of Pennsylvania. Company also certifies that its Federal Employment Identification Number is \_\_\_\_\_ and its Philadelphia Business Privilege Tax ID. No. is: \_\_\_\_\_, and has attached a true, current, and correct copy of its Philadelphia Business Privilege License hereto as Exhibit "C".

(2) As an agency of the Commonwealth of Pennsylvania, and a local government agency, the Authority is exempt from the payment of state and local sales and use and other taxes on material, equipment or other personal property. Company agrees that the fees, price or rates stated in the Agreement (1) do not include any state or local taxes, surcharges or fees on the Authority in connection with this transaction, and (2) do include all other applicable taxes for which Company is liable. In the event Company's performance under this Agreement creates a tax liability, such taxes, including but not limited to, real estate taxes, school taxes, Use & Occupancy taxes, and sales taxes shall be the sole obligation of Company and Company shall maintain current accounts as to the payment of such taxes and be liable over to the Authority for any taxes assessed against the Authority as a result of Company's performance under this Agreement.

L. Conflict of Interest.

No officer or employee of the Authority shall participate in any decision relating to this Agreement which affects his/her personal interest or the interest of any corporation, partnership, or association in which (s)he is directly or indirectly interested, as set forth in the Authority's Conflict of Interest Policy, in the Agreement or the proceeds therefrom.

M. Waiver.

The Authority's exercise, or lack thereof, of any provision or right contained in this Agreement shall not be considered a waiver of any of its rights set forth in this Agreement, such waiver shall only occur through written amendment to this Agreement.

**IN WITNESS WHEREOF**, and intending to be legally bound pursuant to the Uniform Written Obligations Act, 33 P.S. § 6, the parties have set their hands and seals on the date first above written.

**The Philadelphia Parking Authority**

Attest: \_\_\_\_\_

Print Name: \_\_\_\_\_

Print Title: \_\_\_\_\_

By: \_\_\_\_\_

Vincent J. Fenerty, Jr.  
Executive Director

Approved as to Form:

\_\_\_\_\_  
Office of General Counsel

**Company**

Attest: \_\_\_\_\_

Print Name: \_\_\_\_\_

Print Title: \_\_\_\_\_

By: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_