GENESEO COMMUNITY SCHOOL DISTRICT #228
EXECUTIVE SUMMARY

SEPTEMBER 2013

FINANCIAL ANALYSIS

At the beginning of 2013 we split the retirees into their own group (8504). The expected annual cost per active employee for plan year ending 12.31.2013 is tracking to $5,852 PEPY after employee contribution for the active only. The Retiree cost after contribution is a negative (See report).

- Claim expenses are 78.6% of the overall cost of the health plan while 22.4% is the fixed costs incurred to run the program. SISCO is dedicated to reducing your claims cost. The Medical claim handling schematic in the financial reports shows how superior claims service and protection afforded to your plan by SISCO has protected the plan.

- As of 8/31/2013 three participants exceeded 50% of the stop loss deductible, with one participant having exceeded the stop loss deductible. Last year 3 participants exceeded 50% no one exceeded deductible.

- Healthcorp & QCCH, your managed care partner's, together with SISCO work to ensure your plan is not paying for claims that can be avoided. For the current plan year, nurses have managed 33 inpatient days along with 47 outpatient services and one case management participant.

- The pharmacy program through NPS has resulted in savings of $95,399 through 7 months, or 48% savings from the requested fees. The fee from NPS has not changed for SISCO clients in 12 years; it is still $.50 per claim with a minimal Network Access Fee on certain claims. Prescription Drug costs appears to be trending down from the last reporting.

PPO NETWORKS

PPO savings are key in the campaign against rising costs for health plans. Network strategy and partnerships have strongly re-emerged as a key performance measure.

You have a contract with QCCH PPO network for your groups. PPO contracts provide valuable savings and protection for your health plan. This year the plan has 76% of claims in network. The PPO Savings are $443,655 or an average of 35% for the group.

RENEWAL SUMMARY

C&B is conducting an extensive market search for stop loss coverage on behalf of the plan. Preliminary quotes are expected back from the market soon. Effective 11/1 carriers will allow us to lock in stop loss for the 2014 plan year with disclosure.

SERVICE FEES

The TPA fee adjustment from SISCO & Healthcorp & QCCH is 4% or $2,652 annually. This includes processing for your PPO Medical & RX claims, COBRA services along with all QCCH & Healthcorp services.

PLAN DESIGN CHANGES

We are happy to assist you with plan modeling or changes you may wish to consider.

GENESEO COMMUNITY SCHOOL DISTRICT #228
EXECUTIVE SUMMARY

SEPTEMBER 2013

HEALTHCARE REFORM.

Grandfathered plans are specifically prohibited from making the following changes:

- Significantly Cutting or Reducing Benefits. For example, if a plan decides to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS.
- Raising Co-Insurance Charges. Typically, co-insurance requires a patient to pay a fixed percentage of a charge (for example, 20 percent of a hospital bill). Grandfathered plans cannot increase this percentage.
- Significantly Raising Co-Payment Charges. Compared with the copayments in effect on March 23, 2010, grandfathered plans will be able to increase those co-pays by no more than the greater of $5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points.
- Significantly Raising Deductibles. Many plans require patients to pay the first bills they receive each year (for example, the first $500, $1,000 or $1,500 a year). Compared with the deductible required as of March 23, 2010, grandfathered plans can only increase these deductibles by a percentage equal to medical inflation plus 15 percentage points.
- Significantly Reducing Employer Contributions. Many employers pay a portion of their employees' premium for insurance and this is usually deducted from their paychecks. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points (for example, decrease their own share and increase the workers' share of premium from 15 percent to 25 percent).
- Adding or Tightening an Annual Limit. If they want to retain their status as grandfathered plans, plans cannot tighten any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit (which is more protective of high-cost enrollees).

HEALTHCARE REFORM REQUIRED CHANGES FOR 2014

- Cover dependent children regardless of employment to age 26
- Bariatric Surgery $ max
- Remove Pre-Existing all ages
- 90 Day Limit on waiting period
- Temporary Reinsurance Fees in budget

PCORI $1
63.50 2014
48.00 2015
25 2016
H/HS
November
Jan 2015

HEALTHCARE REFORM CHANGES THAT DO NOT APPLY TO GRANDFATHERED PLANS

- Approved Clinical Trial Coverage
- Provider Non Discrimination
- Out of Pocket cost sharing limits
- Preventative 100%

OTHER SERVICES AVAILABLE.

Health Risk Assessments When offered to employees, a health risk assessment helps identify participants with unknown conditions to encourage maintenance healthcare. If conditions are left unmanaged they have the potential to become catastrophic claimants, which may have been prevented if controlled in early stages. We have included information from HealthCheck 360 (a Cottingham & Butler company).

Implement the use of employee education materials to promote a Wellness Campaign. Through MyWave services currently offered as part of your benefit program, we can provide you with payroll stuffers, ready-to-use employee newsletters, and educational brochures on health & wellness designed to help you drive consumerism in your workplace. Sample communication topics include generic prescription drug cost savings, making wise healthcare choices, healthy lifestyle, healthy eating, etc. We would be able to design a communication calendar for the year for implementation.

Voluntary Benefit Offerings for Employees. We can provide market quotes for various lines of coverage paid for 100% by employees to include voluntary life, vision, travel accident, and flexible spending administration.

Health Reimbursement Accounts (H.R.A.) – You can offer your employees a health reimbursement arrangement to help them offset medical care expenses up to a maximum amount. Expenses that can be reimbursed through an HRA include insurance premiums and deductibles. SOLELY THE EMPLOYER FUNDS THE HRA. Employees can carry over unused amounts in an HRA from year to year to increase the maximum amount available to them; amounts carried over are not included in the employee's gross income. SISCO & Cottingham and Butler continue to offer several valuable services as your partner.

COMPLIANCE GUIDE & ASSISTANCE

Provided to support easy access to steps to being compliant with state and federal rules. With updates and email notices to keep you advised of changes.

HIPAA

HIPAA requires C&B along with SISCO & Healthcorp to have processes in place to protect health information of your health plan participants. These processes are documented and available for your review.

MEDICARE D CREDITABLE COVERAGE TEST & NOTICE

This service provides your group with the necessary notice and documentation needed for being compliant with this rule.

CMS REPORTING

This service provides your group with the necessary reporting and documentation needed for being compliant with this reporting requirement. SISCO acts as your RRE or responsible reporting entity.

Cottingham & Butler, Inc. is constantly searching for ways to improve our services while providing cost effective, user-friendly management and administration of your employee benefit plans. We appreciate any suggestions you may have of ways to service your account better. Cottingham & Butler, Inc. is compensated through fees and/or commissions for services provided to clients related to managing, reducing, and transferring risk. In addition, Cottingham & Butler, Inc. may enter into agreements with some insurance carriers through which it is compensated for services provided on behalf of the carriers. This compensation is based on several factors such as overall volume, growth, and in some cases profitability of the aggregate premium placed with such carriers. Cottingham & Butler subsidiaries may also receive compensation for services such as utilization review, case management and claims handling performed directly for the carriers.

GENESEO (:28 (8503 to 8503)

01/0 /2013 -- 08/31/2013

MEDICAL AND RX CLAIMS MONTHLY SUMMARY

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
FIXED COSTS													
Administrative Fees	4,491	4,491	3,229	3,229	3,229	3,245	3,245	3,245	0	0	0	0	28,402
Coordinated Care Fees	1,183	1,183	994	994	994	999	999	999	0	0	0	0	8,347
PPO Access Fees	2,717	2,717	2,532	2,532	2,532	2,544	2,537	2,552	0	0	0	0	20,662
Misc. Fees (ID cards, SPD, etc.)	2,688	2,683	2,657	2,657	2,655	2,658	2,658	2,661	0	0	0	0	21,317
Transplant Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0
Stop Loss Aggregate	1,001	1,057	973	973	973	978	978	978	0	0	0	0	7,910
Stop Loss Specific	13,310	14,113	12,973	12,973	12,973	13,228	13,370	13,228	0	0	0	0	106,167
Total Fixed Costs	25,390	26,244	23,357	23,357	23,355	23,652	23,786	23,663	0	0	0	0	192,804
ELIGIBLE CHARGES													
Discounted Rx Charges	20,609	18,061	18,767	12,326	14,402	10,569	10,428	16,981	0	0	0	0	122,143
Medical Charges	76,552	165,154	156,174	356,829	186,990	59,112	102,531	190,333	0	0	0	0	1,293,674
Medical Discounts	19,988	64,432	54,645	102,733	55,382	19,574	36,719	90,182	0	0	0	0	443,655
Medical Discount Percentage	26%	39%	35%	29%	30%	33%	36%	47%	N/A	N/A	N/A	N/A	34%
Total Eligible Charges after discount	**77,172**	**118,782**	**120,296**	**266,422**	**146,010**	**50,108**	**76,240**	**117,132**	**0**	**0**	**0**	**0**	**972,162**
EMPLOYEE LIABILITY													
Med/Rx Deductible	6,023	11,033	6,120	5,110	3,352	2,381	1,935	693	0	0	0	0	36,647
Medical Co-Pays	500	300	0	400	500	300	200	400	0	0	0	0	2,600
Rx Co-Pays	3,295	3,253	3,322	2,347	2,211	2,024	1,982	2,387	0	0	0	0	20,821
Med/Rx Co-insurance	3,750	16,299	8,725	7,025	16,258	8,364	11,569	9,987	0	0	0	0	81,976
Med/Rx Coordination of Benefits	18,911	33,023	10,187	1,264	7,490	3,014	3,696	1,048	0	0	0	0	78,632
Total Employee Share	**32,478**	**63,908**	**28,354**	**16,146**	**29,810**	**16,084**	**19,382**	**14,515**	**0**	**0**	**0**	**0**	**220,676**
Employee Share % of discounted charges	42.09%	53.80%	23.57%	6.06%	20.42%	32.10%	25.42%	12.39%	N/A	N/A	N/A	N/A	22.70%
Total Paid	**44,694**	**54,874**	**91,942**	**250,276**	**116,200**	**34,024**	**56,858**	**102,617**	**0**	**0**	**0**	**0**	**751,486**
EXPECTED STOP LOSS REIMBURSEMENTS													
Specific	0	0	0	0	3,445	372	1,301	23,945	0	0	0	0	29,063
Total Expected Stop Loss Reimb.	**0**	**0**	**0**	**0**	**3,445**	**372**	**1,301**	**23,945**	**0**	**0**	**0**	**0**	**29,063**
TOTAL PLAN EXPENSES AFTER STOP LOSS	70,084	81,118	115,299	273,633	136,110	57,304	79,344	102,335	-	-	-	-	915,228
PLAN FUNDING													
Employer Contributions	0	0	0	0	0	0	0	0	0	0	0	0	0
Employee Contributions	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Contributions	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
VARIANCE OF ACTUAL TO FUNDING	(70,084)	(81,118)	(115,299)	(273,633)	(136,110)	(57,304)	(79,344)	(102,335)	**0**	**0**	**0**	**0**	(915,228)
ENROLLMENT													
Total Covered Employees	206	206	206	206	206	207	207	207	208	208	208	208	207
Total Covered Members	406	406	406	408	408	409	411	412	406	404	404	404	407
COST METRICS													
Average Plan Expenses/Employee	340.21	393.78	559.71	1,328.32	660.73	276.83	383.30	494.37	-	-	-	-	4,423.17
Avg. Employer Cost/Employee	340.21	393.78	559.71	1,328.32	660.73	276.83	383.30	494.37	-	-	-	-	4,423.17
Average Plan Expenses/Member	172.62	199.80	283.99	670.67	333.60	140.11	193.05	248.39	-	-	-	-	2,248.72
Avg. Employer Cost/Member	172.62	199.80	283.99	670.67	333.60	140.11	193.05	248.39	-	-	-	-	2,248.72
ENROLLMENT													
# of Singles	123	123	123	122	121	122	121	121	125	125	125	125	1,476
# of Singles + Spouse	0	0	0	0	0	0	0	0	0	0	0	0	0
# of Singles + Child	0	0	0	0	0	0	0	0	0	0	0	0	0
# of Singles + Children	0	0	0	0	0	0	0	0	0	0	0	0	0
# of Families	83	83	83	84	85	85	86	86	83	83	83	83	1,007
Total Covered Employees	**206**	**206**	**206**	**206**	**206**	**207**	**207**	**207**	**208**	**208**	**208**	**208**	**2,483**

GENESEO CSD #228 (8504 to 8504)
01/01/2013 – 1/2013
MEDICAL AND RX CLAIMS MONTHLY SUMMARY

Retiree over under 65

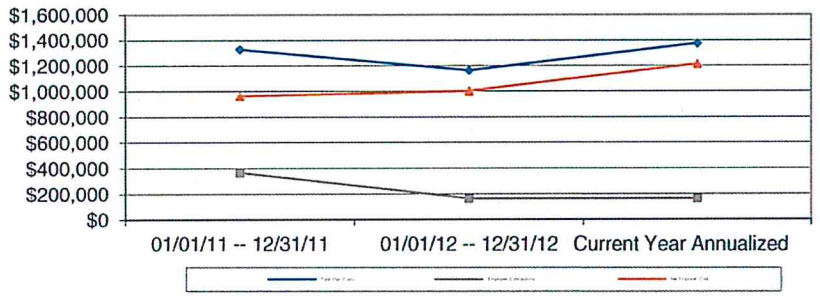
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
FIXED COSTS													
Administrative Fees	0	0	614	599	599	599	583	614	0	0	0	0	3,607
Coordinated Care Fees	0	0	189	184	184	184	179	189	0	0	0	0	1,111
PPO Access Fees	0	0	173	173	173	173	161	185	0	0	0	0	1,037
Misc. Fees (ID cards, SPD, etc.)	0	0	29	29	95	32	28	29	0	0	0	0	241
Transplant Insurance	0	0	0	0	0	0	0	0	0	0	0	0	0
Stop Loss Aggregate	0	0	73	73	89	78	73	84	0	0	0	0	470
Stop Loss Specific	0	0	627	627	755	669	627	712	0	0	0	0	4,017
Total Fixed Costs	0	0	1,705	1,684	1,895	1,735	1,650	1,814	0	0	0	0	10,482
ELIGIBLE CHARGES													
Discounted Rx Charges	0	0	0	9,666	10,410	9,751	8,300	12,527	0	0	0	0	50,654
Medical Charges	0	0	0	51,761	32,842	4,787	60,968	67,415	0	0	0	0	217,774
Medical Discounts	0	0	0	17,049	3,381	223	495	3,971	0	0	0	0	25,119
Medical Discount Percentage	N/A	N/A	N/A	33%	10%	5%	1%	6%	N/A	N/A	N/A	N/A	12%
Total Eligible Charges after discount	**0**	**0**	**0**	**44,378**	**39,872**	**14,315**	**68,773**	**75,971**	**0**	**0**	**0**	**0**	**243,309**
EMPLOYEE LIABILITY													
Med/Rx Deductible	0	0	0	1,830	469	344	419	56	0	0	0	0	3,118
Medical Co-Pays	0	0	0	200	400	0	200	0	0	0	0	0	800
Rx Co-Pays	0	0	0	1,709	1,526	1,284	1,146	1,638	0	0	0	0	7,303
Med/Rx Co-insurance	0	0	0	2,288	1,673	449	777	651	0	0	0	0	5,838
Med/Rx Coordination of Benefits	0	0	0	11,610	19,285	2,456	52,319	56,456	0	0	0	0	142,126
Total Employee Share	**0**	**0**	**0**	**17,638**	**23,353**	**4,533**	**54,861**	**58,801**	**0**	**0**	**0**	**0**	**159,185**
Employee Share % of discounted charges	N/A	N/A	N/A	39.74%	58.57%	31.66%	79.77%	77.40%	N/A	N/A	N/A	N/A	65.42%
Total Paid	**0**	**0**	**0**	**26,741**	**16,519**	**9,782**	**13,912**	**17,170**	**0**	**0**	**0**	**0**	**84,124**
EXPECTED STOP LOSS REIMBURSEMENTS													
Specific	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Expected Stop Loss Reimb.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL PLAN EXPENSES AFTER STOP LOSS	-	-	1,705	28,424	18,414	11,518	15,562	18,984	-	-	-	-	94,607
PLAN FUNDING													
Employer Contributions	0	0	0	0	0	0	0	0	0	0	0	0	0
Employee Contributions	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Contributions	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
VARIANCE OF ACTUAL TO FUNDING	**0**	**0**	**(1,705)**	**(28,424)**	**(18,414)**	**(11,518)**	**(15,562)**	**(18,984)**	**0**	**0**	**0**	**0**	**(94,607)**
ENROLLMENT													
Total Covered Employees	40	40	40	39	39	39	39	39	41	41	41	41	40
Total Covered Members	51	51	51	50	50	50	50	50	51	51	51	51	51
COST METRICS													
Average Plan Expenses/Employee	-	-	42.62	728.83	472.16	295.32	399.02	486.78	-	-	-	-	2,370.11
Avg. Employer Cost/Employee	-	-	42.62	728.83	472.16	295.32	399.02	486.78	-	-	-	-	2,370.11
Average Plan Expenses/Member	-	-	33.43	568.48	368.28	230.35	311.23	379.69	-	-	-	-	1,870.31
Avg. Employer Cost/Member	-	-	33.43	568.48	368.28	230.35	311.23	379.69	-	-	-	-	1,870.31
ENROLLMENT													
# of Singles	30	30	30	29	29	29	29	29	32	32	32	32	363
# of Singles + Spouse	0	0	0	0	0	0	0	0	0	0	0	0	0
# of Singles + Child	0	0	0	0	0	0	0	0	0	0	0	0	0
# of Singles + Children	0	0	0	0	0	0	0	0	0	0	0	0	0
# of Families	10	10	10	10	10	10	10	10	9	9	9	9	116
Total Covered Employees	**40**	**40**	**40**	**39**	**39**	**39**	**39**	**39**	**41**	**41**	**41**	**41**	**479**

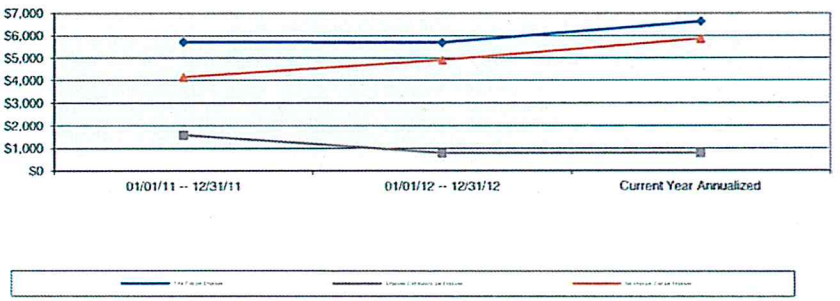
Geneseo Csd #228

Claims by Line of Coverage for Active Group 8503

Includes Retirees

	01/01/11 -- 12/31/11	01/01/12 -- 12/31/12	01/01/13 -- 08/31/13	Current Year Annualized	% Change (CYA/PY1)
Medical Claims	$1,043,098	$744,637	$650,164	$975,246	31.0%
Prescription Drug Claims	$297,111	$112,935	$101,323	$151,984	34.6%
Subtotal Claims	**$1,340,209**	**$857,572**	**$751,486**	**$1,127,230**	31.4%
Stop Loss Reimbursements	$15,943	$0	$29,063	$43,594	0.0%
Net Claims	**$1,324,266**	**$857,572**	**$722,424**	**$1,083,636**	26.4%
SISCO Fees	$0	$38,556	$28,402	$42,603	10.5%
HealthCorp Fees	$0	$11,790	$8,347	$12,520	6.2%
PPO Fees	$0	$29,356	$20,662	$30,992	5.6%
Stop Loss Premium	$0	$199,578	$114,077	$171,115	-14.3%
Misc. Fees	$1,616	$23,580	$21,317	$31,976	35.6%
Subtotal Administrative Fees	**$1,616**	**$302,860**	**$192,804**	**$289,206**	-4.5%
Total Plan Costs	**$1,325,882**	**$1,160,432**	**$915,228**	**$1,372,842**	**18.3%**
Employee Contributions	$365,455	$161,304	$107,943	$161,914	**0.4%**
Net Employer Cost	**$960,427**	**$999,128**	**$807,286**	**$1,210,928**	**21.2%**
Average Single Enrollment	133	121	123	123	1.7%
Average Family Enrollment	99	83	84	84	1.1%
Total Average Enrollment	**232**	**204**	**207**	**207**	**1.4%**
Total Average Members	231	405	407	407	0.5%
Dependent Ratio	**1.0**	**2.0**	**2.0**	**2.0**	**-0.9%**
Total Cost per Employee	**$5,715**	**$5,688**	**$4,423**	**$6,635**	**16.6%**
Employee Contributions per Employee	**$1,575**	**$791**	**$522**	**$783**	**-1.0%**
Net Employer Cost per Employee	**$4,140**	**$4,898**	**$3,902**	**$5,852**	**19.5%**





Ge..seo Csd #228

Benchmark Wizard

		01/01/13 – 08/31/13 (annualized)
Total Plan Cost per employee		$6,635
Less Dental/Vision costs per employee		$0
Avg Med/Rx Annual Cost per employee		$6,635
# of employees		207

Average number of employees with medical from 01/01/13 to 08/31/13

actual costs

expected costs using benchmark data

Benchmark Data [1]	Adjustment factor	AVG
Small Employer Avg Health costs per **active** employee (PPO Plan)		$9,526
Adjusted for trend	6.0%	$10,098
Predictive Modeling Age/Gender Adjustment	0.998	$10,078
Adjusted for number of covered dependents	($448.70)	$9,629
Adjusted for region	1.1%	$9,735
Adjusted for plan design	13.0%	$11,001

8.00% Annual since August Survey to mid-point of 08/01/12 to current = 8.00%/12 months*9.0 months.

Actuarial adjustment for Geneseo Csd #228 with average age of 31 and 45% males. Average group has adjustment factor of 1.00

Geneseo Csd #228 has 2.0 members per employee compared to the average of 2.1 members per employee.

Cost increase for Midwest region per Mercer Study.

Per underwriting table

[1] Source: Mercer National Survey of Employer-Sponsored Health Plans 2012.

Geneseo Csa #228

Health Plan Comparison

MEDICAL & RX BENEFITS	Geneseo Csd #228	Small Employer Average	National Employer Average	Midwest Employer Average
Median Deductible				
In-Network (Single/Family)	$150/$300	$1,000/$2,500	$1,000/$2,500	$500/$1,000
Out-of-Network (Single/Family)	$300/$600	$2,000/$4,000	$1,750/$4,000	$800/$2,000
Median Out of Pocket Maximums				
In-Network (Single/Family)	$550/$1,100	$2,500/$6,000	$2,500/$6,000	$2,000/$4,000
Out-of-Network (Single/Family)	$1,250/$2,500	$5,000/$10,000	$5,000/$10,000	$4,000/$8,000
Office Visit Copay				
In-Network	20% after deductible	$25 / $50	$25 / $50	$20 / $35
Out-of-Network	50% after deductible	40%	40%	40%
ER Copay	$100 then deductible/coins	$100	$100	$100
Coinsurance				
In-Network (Plan Pays/Employee Pays)	80% / 20%	80% / 20%	80% / 20%	80% / 20%
Out-of-Network (Plan Pays/Employee Pays)	50% / 50%	60% / 40%	60% / 40%	60% / 40%
Rx Copays				
Generic/Formulary Brand/Non-Formulary Brand	$10 / $25 / $40	$10 / $30 / $50	$10 / $30 / $50	$10 / $30 / $50
Monthly Employee Contributions				
Single	$0	$149	$148	$106
Family	$168	$550	$544	$363
Medical & RX Cost Per Employee	$6,635	$9,526	$10,007	$10,460

**Out of Pocket maximum includes deductible for this plan.*

Plan design information based on the 2012 Mercer National Survey of Employee-Sponsored Health Plans (PPO Plan Design).

Small Employer averages based upon employers with less than 500 employees

Geneseo Csd #228

PPO Network Results

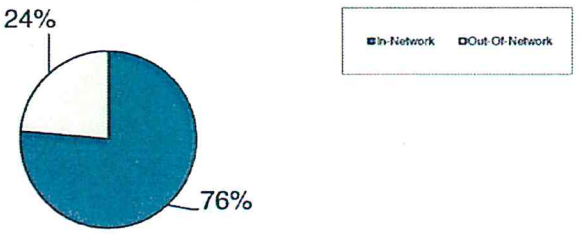
01/01/13 -- 08/31/13

PPO Discounts by Network				
Category	**PPO**	**Eligible $**	**Discount $**	**Discount %**
PPO	QCCH	988,520	407,338	41.2%
Totals		**988,520**	**407,338**	**41.2%**

Top 25 In-Network Providers By Paid Amount				
Provider Name	**PPO**	**Eligible $**	**Discount $**	**Discount %**
HAMMOND HENRY HOSPITAL	QCCH	230,682	137,011	59.4%
GENESIS HEALTH SYSTEM	QCCH	115,159	28,247	24.5%
GENESIS HEALTH SYSTEM	QCCH	109,746	21,559	19.6%
TRINITY MEDICAL CENTER	QCCH	108,760	47,849	44.0%
IOWA PHYS CLINIC MED FOUND	QCCH	69,248	19,173	27.7%
UNITYPOINT AT HOME	QCCH	44,976	11,244	25.0%
ORA ORTHOPEDICS PC	QCCH	40,175	17,982	44.8%
EMERGENCY MEDICAL SERVICES	QCCH	19,353	13,135	67.9%
METROPOLITAN MEDICAL LABORATOR	QCCH	17,522	12,714	72.6%
MEDICAL ARTS ASSOCIATES	QCCH	16,690	2,388	14.3%
PEDIATRIC GROUP ASSOCIATES SC	QCCH	14,311	5,473	38.2%
ROCK VALLEY OBSTETRICS & GYNEC	QCCH	13,329	6,376	47.8%
ADVANCED RADIOLOGY SC	QCCH	12,990	5,737	44.2%
QUAD CITY AMBULATORY SURG CTR	QCCH	11,313	4,349	38.4%
GASTROENTEROLOGY CONSULT SC	QCCH	10,009	7,707	77.0%
QUAD CITIES PATHOLOGISTS LLC	QCCH	8,896	5,900	66.3%
BIRKS CHIROPRACTIC AND WELLNES	QCCH	8,822	242	2.7%
MISSISSIPPI VALLEY SURGERY CTR	QCCH	8,701	5,001	57.5%
LUNDGREN CHIROPRACTIC LTD	QCCH	8,446	3,094	36.6%
RSC ILLINOIS LLC	QCCH	7,846	4,990	63.6%
CARDIOVASCULAR MEDICINE PC	QCCH	6,739	3,009	44.6%
EYE SURGEONS ASSOCIATES PC	QCCH	4,356	2,035	46.7%
VINCENT SOUTHPARK PSYCHOLOGY	QCCH	3,540	1,178	33.3%
STEP AHEAD FOOT CARE SC	QCCH	3,386	856	25.3%
ASIF J AHMED MD	QCCH	2,125	757	35.6%
Subtotal		897,121	368,006	41.0%
All Other In-Network Providers		91,400	39,332	43.0%

Top 10 Out-Of-Network Providers By Paid Amount				
Provider Name	**PPO**	**Eligible $**	**Discount $**	**Discount %**
UNIV OF IA HOSPITAL & CLINICS	CHUI	128,439	25,626	20.0%
SAINT FRANCIS MEDICAL CENTER		26,102	0	0.0%
HAMMOND HENRY HOSPITAL		18,402	0	0.0%
LAKELAND HOSPITALS AT NILES AN	PHCSHD	17,656	177	1.0%
PEORIA SURGICAL GROUP	PHCSHD	5,972	4,044	67.7%
MID AMERICAN ANESTHESIA AND PA		5,185	0	0.0%
NORTHWEST NEUROLOGY LTD	PHCSHD	4,314	1,508	35.0%
NORTHWEST COMMUNITY HOSP	PHCSHD	3,161	537	17.0%
ASSOCIATED ANESTHESIOLOGISTS		2,808	0	0.0%
SOUTHWEST MICHIGAN CENTER FOR		1,870	0	0.0%
Subtotal		213,909	31,892	14.9%
All Other Out-Of-Network Providers		91,244	4,425	4.8%

In-Network / Out-Of-Network Utilization



Observations: Including the University of Iowa claims, in-network utilization is 86.3%. St Francis Medical Center are two families that had services at this out of network provider. There were no discounts available through the wrap network at this provider. Hammon Henry Hospital out of network services are all coordination of benefits claims in which a primary network discount is not eligible.

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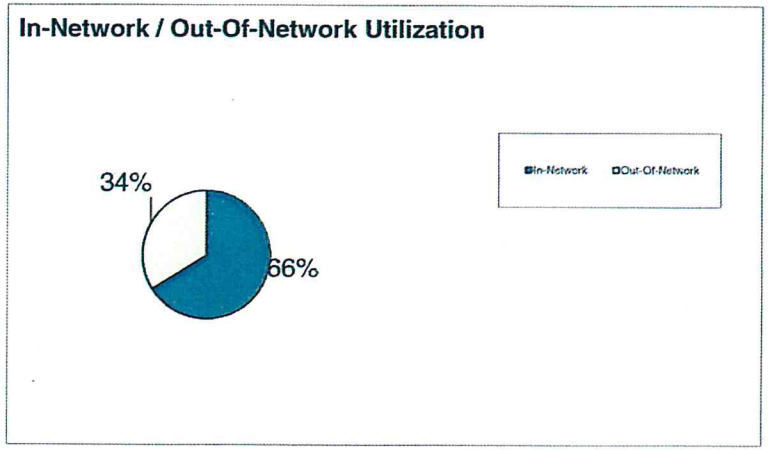
PPO Network Results
01/01/12 -- 12/31/12

PPO Discounts by Network				
Category	**PPO**	**Eligible $**	**Discount $**	**Discount %**
PPO	QCCH	1,266,344	556,629	44.0%
PPO	TPHO	178,889	36,906	20.6%
Totals		**1,445,233**	**593,535**	**41.1%**

Top 25 In-Network Providers By Paid Amount				
Provider Name	**PPO**	**Eligible $**	**Discount $**	**Discount %**
HAMMOND HENRY HOSPITAL	QCCH	392,625	204,168	52.0%
TRINITY MEDICAL CENTER	QCCH	256,013	113,176	44.2%
GENESIS HEALTH SYSTEM	QCCH	88,636	20,139	22.7%
TRINITY MEDICAL CENTER	TPHO	75,055	18,149	24.2%
IOWA PHYS CLINIC MED FOUND	QCCH	73,769	18,723	25.4%
HAMMOND HENRY HOSPITAL	TPHO	70,212	3,635	5.2%
OPTION CARE OF THE QUAD CITIES	QCCH	64,542	25,221	39.1%
ORA ORTHOPEDICS PC	QCCH	47,145	26,186	55.5%
MEDICAL ARTS ASSOCIATES	QCCH	38,635	3,713	9.6%
CARDIOVASCULAR MEDICINE PC	QCCH	23,253	11,600	49.9%
METROPOLITAN MEDICAL LABORATOR	QCCH	21,538	14,876	69.1%
EDGEPARK SURGICAL INC	QCCH	20,744	11,375	54.8%
ADVANCED RADIOLOGY SC	QCCH	17,461	8,293	47.5%
PEDIATRIC GROUP ASSOCIATES SC	QCCH	16,873	6,106	36.2%
ROCK VALLEY OBSTETRICS & GYNEC	QCCH	15,837	8,560	54.1%
EMERGENCY MEDICAL SERVICES	QCCH	13,224	8,855	67.0%
MISSISSIPPI VALLEY SURGERY CTR	QCCH	12,603	6,545	51.9%
EYE SURGEONS ASSOCIATES PC	QCCH	11,161	6,191	55.5%
ORTHOPAEDIC SPECIALISTS PC	TPHO	11,151	7,779	69.8%
QUAD CITIES PATHOLOGISTS LLC	QCCH	9,611	5,202	54.1%
ORA ORTHOPEDICS PC	TPHO	7,929	4,175	52.6%
LUNDGREN CHIROPRACTIC LTD	QCCH	6,278	2,425	38.6%
SPRING PARK SURGERY CENTER LLC	QCCH	5,968	2,089	35.0%
BIRKS CHIROPRACTIC AND WELLNES	QCCH	4,982	203	4.1%
QUAD CITY ENDOSCOPY LLC	TPHO	4,460	669	15.0%
Subtotal		1,309,706	538,050	41.1%
All Other In-Network Providers		135,527	55,485	40.9%

Top 10 Out-Of-Network Providers By Paid Amount				
Provider Name	**PPO**	**Eligible $**	**Discount $**	**Discount %**
HAMMOND HENRY HOSPITAL		184,133	0	0.0%
THE MILTON S HERSHEY MEDICAL C		67,176	0	0.0%
TRINITY MEDICAL CENTER		40,391	0	0.0%
ILLINOIS VALLEY COMMUNITY HOSP		37,651	0	0.0%
FRIENDSHIP MANOR		27,543	0	0.0%
UNIV OF IA HOSPITAL & CLINICS	CHUI	20,158	4,032	20.0%
IOWA PHYS CLINIC MED FOUND		9,752	0	0.0%
BIRKS CHIROPRACTIC AND WELLNES		7,721	0	0.0%
QUAD CITIES WELLNESS & REHAB		3,351	0	0.0%
MYRIAD GENETIC LABORATORIES IN	PHCSHD	3,340	167	5.0%
Subtotal		401,213	4,199	1.0%
All Other Out-Of-Network Providers		337,691	16,506	4.9%



Geneseo Csd #228

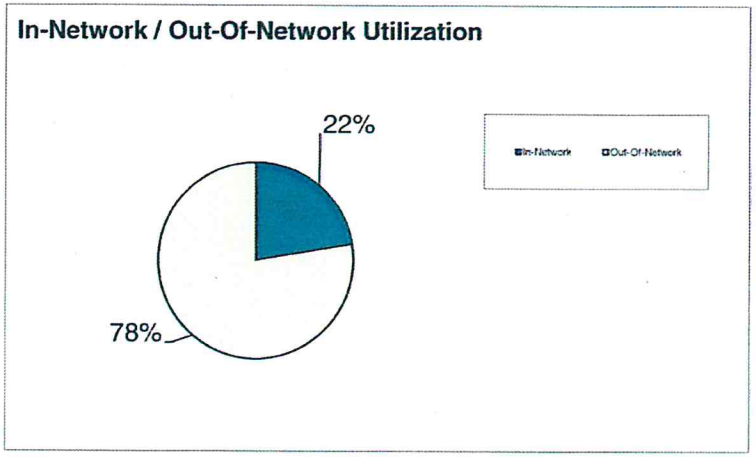
PPO Network Results

01/01/13 -- 08/31/13

PPO Discounts by Network				
Category	**PPO**	**Eligible $**	**Discount $**	**Discount %**
PPO	QCCH	48,650	24,858	51.1%
Totals		**48,650**	**24,858**	**51.1%**

Top 25 In-Network Providers By Paid Amount				
Provider Name	**PPO**	**Eligible $**	**Discount $**	**Discount %**
HAMMOND HENRY HOSPITAL	QCCH	17,620	9,550	54.2%
ORA ORTHOPEDICS PC	QCCH	7,858	4,911	62.5%
TRINITY MEDICAL CENTER	QCCH	4,266	905	21.2%
MISSISSIPPI VALLEY SURGERY CTR	QCCH	3,500	2,398	68.5%
EMERGENCY MEDICAL SERVICES	QCCH	3,211	2,160	67.3%
CARDIOVASCULAR MEDICINE PC	QCCH	1,990	973	48.9%
IOWA PHYS CLINIC MED FOUND	QCCH	1,407	300	21.3%
GENESIS HEALTH SYSTEM	QCCH	1,269	308	24.3%
EYE SURGEONS ASSOCIATES PC	QCCH	1,089	496	45.6%
ENDOCRINE ASSOCIATES	QCCH	850	422	49.6%
UROLOGICAL GROUP LTD	QCCH	788	585	74.2%
METROPOLITAN MEDICAL LABORATOR	QCCH	688	518	75.4%
STEP AHEAD FOOT CARE SC	QCCH	671	168	25.0%
ANESTHESIA AND PAIN CONSULTANT	QCCH	585	203	34.6%
GONCHIGARI NARAYANA MD	QCCH	519	46	8.8%
ADVANCED RADIOLOGY SC	QCCH	439	206	46.9%
LIFETIME EYECARE FAMILY VIS CT	QCCH	415	50	12.2%
MEDICAL ARTS ASSOCIATES	QCCH	339	18	5.2%
MAXHN H MCCAW DO	QCCH	326	214	65.6%
GREAT RIVER MEDICAL GROUP	QCCH	276	140	50.6%
QUAD CITIES PATHOLOGISTS LLC	QCCH	175	115	65.9%
QUAD CITY RHEUMATOLOGY SC	QCCH	112	39	34.9%
LABORATORY CORP OF AMERICA	QCCH	98	77	78.8%
UROLOGICAL ASSOCIATES	QCCH	97	22	22.4%
LABORATORY CORPORATION OF AMER	QCCH	62	36	58.1%
Subtotal		48,650	24,858	51.1%
All Other In-Network Providers		0	0	0.0%

Top 10 Out-Of-Network Providers By Paid Amount				
Provider Name	**PPO**	**Eligible $**	**Discount $**	**Discount %**
HAMMOND HENRY HOSPITAL		91,050	0	0.0%
TRINITY MEDICAL CENTER		19,352	0	0.0%
GENESIS HEALTH SYSTEM		10,043	0	0.0%
ORA ORTHOPEDICS PC		9,866	0	0.0%
GENESIS HEALTH SYSTEM		8,372	0	0.0%
IOWA PHYS CLINIC MED FOUND		4,211	0	0.0%
V ANN SCHWIEDER DC		1,436	0	0.0%
NORTH COCHISE COMM HOSPITAL		1,071	0	0.0%
EYE SURGEONS ASSOCIATES PC		755	0	0.0%
NEW SMYRNA BEACH URGENT		646	0	0.0%
Subtotal		146,802	0	0.0%
All Other Out-Of-Network Providers		22,322	261	1.2%



Health Care Reform: General Q&A for Employees

Common questions answered

I've heard a lot about the health care reform law. When do the reforms become effective? The health care reform bill was signed into law in March 2010. The changes made by the health care reform law go into effect over a period of years. Some of the law's changes are already in effect, such as the prohibition on pre-existing condition exclusions for individuals under age 19. Other key changes go into effect in 2014, such as the requirement for individuals to buy health coverage or pay a penalty.

Does health care reform allow people to keep their current health coverage? Yes. Nothing in the law requires individuals to terminate coverage that they had on the date the law was passed. However, due to new coverage requirements, the coverage provided under an individual's plan may change. Also, employers are not required to offer the same coverage in future years.

If an employer's health plan existed on March 23, 2010, and the employer has not made certain changes to the plan, the plan may have grandfathered status. Grandfathered plans are subject to many, but not all, of the health care reform law's requirements.

In 2014, most U.S. citizens must obtain health insurance coverage or they will be subject to penalties, with exceptions for low-income individuals and those unable to obtain affordable coverage.

Are individuals required to have health coverage? Starting in 2014, most individuals will be required to obtain acceptable health insurance coverage for themselves and their family members or pay a penalty. This provision of the health care reform law is often called the "individual mandate" because it has the effect of requiring individuals to have health coverage.

If you are covered under a health plan offered by your employer, or if you are currently covered by a government program such as Medicare, you can continue to be covered under those programs.

Who is exempt from the individual mandate? Certain individuals are exempt from the individual mandate. For example, you may be exempt from the penalty for not maintaining acceptable health coverage if you:

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Health Care Reform: General Q&A for Employees

Cannot afford coverage (that is, the required contribution for coverage would cost more than 8 percent of your household income)

Have income below the federal income tax filing threshold

Are not a citizen, national or lawfully present in the United States

What are the penalties for individuals who don't have health coverage? The penalty for not obtaining acceptable health coverage will be phased in over a three-year period. The amount of the penalty is the greater of two amounts—the "flat dollar amount" and "percentage of income amount."

2014: The penalty will start at $95 per person or up to 1 percent of income.

2015: The penalty increases to $325 per person or up to 2 percent of income.

2016 and after: The penalty increases to $695 per person or up to 2.5 percent of income.

The penalty for a child is half of that for an adult. The penalty is calculated on a monthly basis, and will be assessed for each month in which an individual goes without coverage. There is no penalty for a single lapse in coverage lasting less than three months in a year.

Does the law affect health flexible spending accounts (FSAs), health reimbursement arrangements (HRAs) and health savings accounts (HSAs)? As of Jan. 1, 2011, the costs of over-the-counter medications can be reimbursed under a health FSA, HRA or HSA only if the medications are purchased with a doctor's prescription. This restriction does not apply to the purchase of insulin.

Effective for 2013, there is an annual cap of $2,500 on employee pre-tax contributions to health FSAs. (The health care reform law does not change the limit on dependent care accounts, which remains capped at $5,000.) Also, if you are under age 65 and you withdraw money from your HSA for a purpose other than a qualified medical expense, you will be subject to an additional excise tax of 20 percent (up from 10 percent).

How long can my adult child remain covered under my health plan? Health plans are required to permit children to stay on family coverage until they turn 26. This rule applies to all plans in the individual market and to non-grandfathered employer plans. It also applies to grandfathered employer plans; however, the

Health Care Reform: General Q&A for Employees

sponsor of a grandfathered plan may decide to exclude from coverage adult children with another offer of employer-based coverage (such as through the child's job). Beginning in 2014, grandfathered plans must cover children up to age 26, even if they have another offer of coverage through an employer. Note that state law requirements may require offering coverage beyond age 26.

Is the coverage for my adult dependent taxable? No, the value of the coverage is not subject to federal tax for the employee or dependent. The health care reform law revised the Internal Revenue Code to clarify that the cost of coverage for a taxpayer's child is excluded from income through the end of the year in which the child turns 26.

Can I get coverage for my pre-existing condition? Health plans cannot deny benefits or limit coverage for a child under the age of 19 because the child has a pre-existing condition (that is, a health problem that developed before the child applied to join the plan). Effective for plan years beginning on and after Jan. 1, 2014, health plans cannot impose pre-existing condition exclusions on any enrollees. This applies to all non-grandfathered and grandfathered plans.

Prior to 2014, is there a special coverage option for individuals with pre-existing conditions? The health care reform law created a federal pre-existing condition insurance plan (PCIP) for individuals with pre-existing conditions who had been uninsured for at least six months. This was a temporary program and, due to funding limitations, it stopped accepting new enrollment applications as of Feb. 16, 2013. However, beginning in 2014, health plans will not be able to impose pre-existing condition exclusions on any enrollees.

Are my health benefits subject to lifetime or annual limits? The health care reform law prohibits health plans from placing lifetime limits on most benefits. A lifetime limit is the dollar amount on what the plan would spend for your covered benefits during the entire time you were enrolled in the plan.

The law restricts the annual dollar limits that health plans can put on most covered benefits. For plan years starting on or after Sept. 23, 2012, but before Jan. 1, 2014, the restricted annual limit is $2 million. Effective for plan years beginning on or after Jan. 1, 2014, no annual limits are allowed on most covered benefits.

Can my health plan or insurance company terminate my coverage if I get sick? Health plans and insurance companies are prohibited from retroactively dropping, or rescinding, your coverage when you get sick. Also, your coverage cannot be retroactively canceled solely because you or your employer made an honest mistake on your insurance application. Rescissions of coverage are allowed only in cases of

Health Care Reform: General Q&A for Employees

fraud or material misrepresentation. This rule applies to all non-grandfathered and grandfathered plans.

Is my plan required to provide free preventive care? All non-grandfathered group health plans and plans in the individual market must provide coverage for recommended preventive health services. If your plan is subject to this requirement, you should not have to pay a copayment, co-insurance or deductible to receive recommended preventive health services – such as screenings, vaccinations and counseling.

For example, depending on your age, you may access (at no cost) to preventive services such as:

Blood pressure, diabetes and cholesterol tests

Many cancer screenings, including mammograms and colonoscopies

Regular well-baby and well-child visits, from birth to age 21

Routine vaccinations against diseases such as measles, polio or meningitis

If your plan is grandfathered, these benefits may not be available to you. Also, if your health plan uses a network of providers, these benefits may only be available through a network provider. Your plan may allow you to receive these services from an out-of-network provider, but may charge you a fee.

In addition, effective for plan years beginning on or after Aug. 1, 2012, non-grandfathered health plans must provide additional preventive services for women without cost sharing, such as coverage for well woman visits, breastfeeding support and contraception. Exceptions to the contraceptive coverage requirement apply to religious employers.

How does the health care reform law make insurance companies more accountable for how they spend premium dollars? Health insurers, including insurers of grandfathered plans, must annually report on what percentage of premium dollars they spend on medical care, as opposed to profits, marketing and administrative expenses. You can see that information online and may be entitled to a rebate if your plan spent too much on overhead and profits. Health insurers must also post information about some rate increases along with a justification for them.

This information is available at: www.healthcare.gov.

Health Care Reform: General Q&A for Employees

Did the health care reform law eliminate COBRA? No. The health care reform law did not eliminate COBRA or change the COBRA rules.

How does the health care reform law help me learn more about my health plan coverage?

Under the health care reform law, your health insurance company or group health plan is required to provide you with an easy-to-understand summary about benefits and coverage. This requirement is designed to help you better understand and evaluate your health coverage choices. This summary is called a Summary of Benefits and Coverage, or SBC. You may also request a glossary of terms from your health plan or health insurer. The glossary includes definitions for commonly used terms in health insurance coverage, such as "deductible" and "copayment."

Also, your Form W-2 may include information on the total cost of employer-sponsored health coverage. This information is provided to let you know how much your coverage costs. It does not mean that the cost of coverage is taxable to you. If your employer filed fewer than 250 W-2 Forms last year, it was not required to provide this information on your Form W-2.

What is the new health insurance exchange, or Marketplace, and when will it be available?

The health insurance exchange is an online marketplace that is designed to help make buying health coverage easier and more affordable. Effective for 2014, the Marketplace will allow individuals and small businesses to compare health plans, get answers to questions and find out if they are eligible for tax credits for private insurance or health programs like the Children's Health Insurance Program (CHIP) and enroll in a health plan that meets their needs.

When will I be able to enroll in a health plan through the new Marketplace? The initial enrollment period for the Marketplace will begin on Oct. 1, 2013. Starting in October 2013, you will be able to get information from the Marketplace about the plans in your area. You will be able to enroll directly through the website or by calling a toll-free phone hotline. If you are having difficulty finding a plan that meets your needs and budget, there will be people available to help. These helpers will not be associated with a particular plan and will not receive any type of commission, so the help they provide will be unbiased. Your coverage through the Marketplace would begin as early as Jan. 1, 2014.

Health Care Reform: General Q&A for Employees

Will I receive more information about the Marketplace? You should receive a notice about the Marketplace from your employer by Oct. 1, 2013, which is when the Marketplace's initial enrollment period begins. The notice will include information on eligibility for the Marketplace's new tax credit, which helps lower monthly premiums. Also, the notice will tell you that if you purchase a health plan through the Marketplace, you may lose the employer contribution (if any) to any health plan offered by your employer and that all or a portion of such contribution may be excludable from income for federal income tax purposes.

What type of health plans will be available through the Marketplace? All health plans offered through the Marketplace will have limits on cost-sharing and cover a comprehensive package of items and services, which is known as the "essential health benefits" package. In general, the Marketplace will offer four levels of coverage for consumers. The levels are based on an actuarial value (AV) standard that measures the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an AV value of 70 percent, a consumer would be responsible for 30 percent of the costs for covered benefits. The Marketplace's coverage levels are bronze (AV – 60 percent), silver (AV – 70 percent), gold (AV- 80 percent) and platinum (AV – 90 percent).

How much will a health plan cost through the Marketplace? The premiums for health plans offered on the Marketplace will vary by type of plan and location. Different financial assistance programs will be linked to the Marketplace when enrollment begins, such as Medicaid and the Children's Health Insurance Program.

Also, when enrollment through the Marketplace starts in October 2013, some individuals will be eligible for a new kind of tax credit they can use right away to lower their monthly health plan premiums. The tax credit is sent directly to the insurance company and applied to the premium, so eligible individuals pay less out of their own pockets.

Who will be eligible for the Marketplace's premium tax credit? Eligibility for the tax credit depends on your income and family size and your eligibility for minimum essential coverage (such as coverage under your employer's plan). The amount of the credit also depends on how much income your family expects to earn. To be eligible for the tax credit, you must enroll in a health plan through the Marketplace and you:

Must have household income for the year between 100 percent and 400 percent of the federal poverty line for your family size

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May not be claimed as a tax dependent of another taxpayer

Must file a joint return, if married

Cannot be eligible for minimum essential coverage

If you are eligible to enroll in an employer's health plan that meets certain standards, you are eligible for minimum essential coverage. This would make you ineligible for the premium tax credit. An employer's plan does not provide minimum essential coverage if the cost for employee-only coverage is more than 9.5 percent of your income for the year, or if the coverage does not meet the "minimum value" standard set by the health care reform law.

More information on the health care reform law is available at: www.healthcare.gov.

Sources: Department of Labor, Department of Health and Human Services