RESOLUTION NO. 2011-12

A RESOLUTION OF THE BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY, FLORIDA, APPROVING THE TERMS AND CONDITIONS OF THE CONTRACT RENEWAL WITH INTERNATIONAL SPECIALTY UNDERWRITERS FOR STOP LOSS INSURANCE, AND ST. JOHNS COUNTY, FLORIDA, AND AUTHORIZING THE COUNTY ADMINISTRATOR TO EXECUTE THE AGREEMENT ON BEHALF OF THE COUNTY

WHEREAS, the County and International Specialty Underwriters entered into an Agreement for stop loss insurance on January 18, 2011; and

WHEREAS, the County has reviewed the terms and conditions associated with the Agreement for stop loss insurance (attached hereto, and incorporated herein); and

WHEREAS, the County has determined that extending the term of the Agreement for stop loss insurance with International Specialty Underwriters will serve the interests of the County.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY, FLORIDA, AS FOLLOWS:

Section 1. The above Recitals are hereby incorporated into the body of this Resolution, and are adopted as Findings of Fact.

Section 2. The Board of County Commissioners hereby approves the terms, and conditions of the Agreement for stop loss insurance between St. Johns County, Florida, and International Specialty Underwriters, and authorize the County Administrator to execute the Agreement on behalf of the County.

PASSED AND ADOPTED by the Board of County Commissioners of St. Johns County, Florida, this 18th day of January, 2011.

BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY, FLORIDA

BY: [signature]
J. Ken Bryan, Chairman

ATTEST: Cheryl Strickland, Clerk

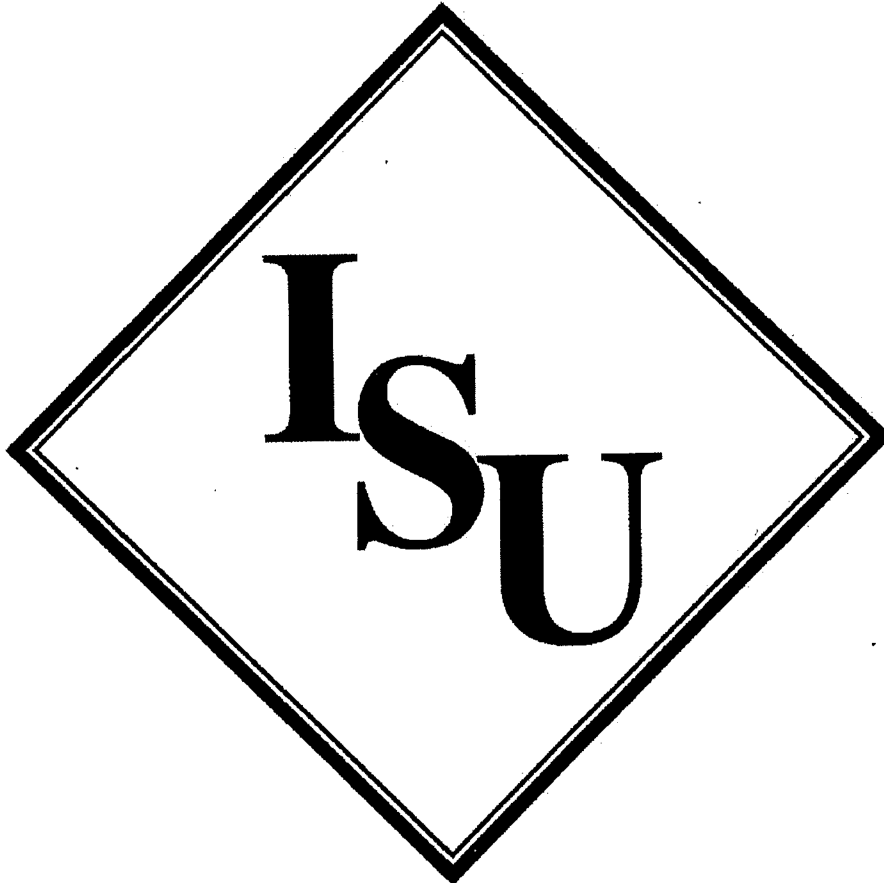
BY: Pam Halterman
Deputy Clerk

Effective Date: 1/18/11

RENDITION DATE 1/20/11

Proposal Prepared For

St. Johns County, St. Augustine, FL



Presented By

Companion Life Insurance Company, Columbia, SC

Underwritten By

Lynda Hutchins
International Specialty Underwriters, Jacksonville, FL

International Specialty Underwriters

6621 Southpoint Dr., N. Suite 325 Jacksonville, FL 32216 Telephone: (904) 281-2151 Facsimile: (904) 281-0384

Issuing Carrier	**Companion Life Insurance Company**			Proposal No	**1**
Underwriter	**Lynda Hutchins**	Proposal	**11/17/2010**	Valid Thru	**01/11/2011**
Group	**St. Johns County**	Effective	**01/01/2011**	Expiration	**12/31/2011**
Administrator	**Blue Cross Blue Shield of Florida**				

INDIVIDUAL EXCESS LOSS COVERAGE

	Enrollment		Option 1
☒ Advance Reimbursement			
Coverages			**Medical, Rx Card**
Contract Type			**Paid**
Annual Specific Deductible per Individual		$	**200,000**
Maximum Annual Reimbursement			**800,000**
Maximum Lifetime Reimbursement			**Unlimited**
Rate Per Month			
Composite	**2,075**	$	**17.99**
Estimated Annual Premium		$	**447,951**

PROPOSAL QUALIFICATIONS AND CONTINGENCIES

The following conditions and terms are in (or assumed to be in) the Employer's Self-Insured Plan Document. This reinsurance will consider only these or less liberal terms under the Stop-Loss.

Our proposal assumes the use of the Blue Cross Blue Shield of Florida network. If this network is not used, ISU reserves the right to change our rates and factors.

Individuals currently eligible under the plan that were formerly ineligible due to meeting their lifetime maximum in the past will need to be disclosed.

Subject to updated paid claims and enrollment through the proposed effective date. ISU reserves the right to recalculate the rates and factors if the final month of claims exceed the average of the prior 11 months by 5%.

Any unfunded claims balance must be disclosed, otherwise such claims will not be considered eligible under the Stop Loss Policy.

We reserve the right to change the rates and factors should the initial enrollment vary by 10% or more from the enrollment shown on our proposal.

ISU will accept a disclosure statement 30 days or less before the effective date and no later than 15 days after the effective date.

The quotation will require additional information, and may require adjustments (including lasers), regarding any claimant with serious condition(s) that may be expected to exceed the selected retention or any claimant with expenses (paid or incurred) in excess of 50% of the retention selected.

Our quote is subject to current shock loss information including amount, diagnosis, disposition and prognosis through the proposed effective date.

Minimum participation level of 75% of all eligible employees is required.

Retirees are covered under the plan.

COBRA participation is limited to 5% or less.

Actively-at-Work provision is waived as follows: For individuals identified and approved by BCBSFL and all other individuals covered on the Effective Date except for those individuals with serious claims known by the employer or the administrator, COBRA individuals terminated individuals pending COBRA status, or Disabled individuals who have not been disclosed to BCBSFL in writing.

Minimum specific/aggregate premium is 95% of the annualized premium.

In the event a plan participant receives health care services in the state of New York, which are subject to the New York Health Care Reform Act, we will cover the bad debt and charity surcharge under the stop loss agreements.

Massachusetts State surcharges are covered under both Specific and Aggregate coverages.

If the group acquires a new entity and adds those members to our policy, a disclosure statement must be presented to BCBSFL for approval. Approval must be received before BCBSFL will assume risk for the new members.

Group **St. Johns County** Proposal No **1**

Initial the selected proposal option: Option 1

Specific $200,000

Aggregate N/A

The Premium and Aggregate Deductible are based on the data submitted. Any inaccurate or incomplete data submitted may require changes at final underwriting. We will not be bound by any typographical errors or omissions contained herein.

Date: 12-29-10 By: ______________________
Agent of Record or Administrator

This proposal expires if applications are not requested before the valid through date.

LEGALLY SUFFICIENT
Name
Date

APPLICATION TO
COMPANION LIFE INSURANCE COMPANY
FOR
AGGREGATE AND SPECIFIC REINSURANCE

Application is hereby made for Aggregate and Specific Insurance to Companion Life Insurance Company ("Company" or "Insurer"). This Application must be accepted and approved by the Company or its authorized representative prior to any Contract being in existence.

1.Full Legal Name of Applicant (Insured) St. Johns County

2.Address: 500 San Sebastian View

City: St. Augustine State: Florida Zip Code: 32084

3. If employee benefit plans of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal name and addresses of such companies.

4. Enter the full name of your Employee Benefit Plan(s) - (A copy of such Employee Benefit Plan(s) must be attached to and shall form a part of this Application.)

5. Name and address of Designated Third Party Administrator:

   Blue Cross/Blue Shield of Florida – P.O. Box 1798 Jacksonville, Florida 32231

6. Effective Date: January 1, 2011

7. Estimated Initial Enrollment (will be used as the Number of Covered Units during the first Contract Month):

   _2,075_ Composite

8. GENERAL SCHEDULE OPTIONS:

   (a) Disabled Persons [X] are [ ] are not covered.
   Retired Employees [X] are [ ] are not covered.

   (b) Aggregate Benefit [ ] Yes [X] No

   Aggregate Contract Basis: Employee Benefit Plan Expenses must be
   Incurred from _N/A_ through _N/A_, and
   Paid from _N/A_ through _N/A_.

   Claims Incurred prior to the Contract Effective Date are limited to

   $_N/A_____________.

8. GENERAL SCHEDULE OPTIONS: (Continued)

Aggregate eligible expenses include: N/A

[ ] Medical
[ ] Dental Care
[ ] Vision Care
[ ] Prescription Card Service
[ ] Weekly (Disability) Income
[ ] Other

Aggregate Deductible Per Month, per single Employee:		$ N/A
	Family:	$ N/A
	Composite:	$ N/A
Aggregate Payable Percentage (excess of Deductible):		N/A %
Maximum Eligible Claim Expense Per Covered Person:		$ N/A
Annual Minimum Aggregate Deductible:		$ N/A
Maximum Aggregate Benefit (excess of Deductible):		$ N/A

[ ] Monthly Aggregate Accommodation Addendum (Optional)
Separate premiums, if elected

(c) Specific Benefit [X] Yes [ ] No
Specific Contract Basis: Employee Benefit Plan expenses must be
Incurred from 1/1/07 through 12/31/11.
Paid from 1/1/11 through 12/31/11.
Claims Incurred prior to the Contract Effective Date are limited to $ N/A.

Specific Eligible Expense: Medical & RX	
Specific Deductible (per person):	$ 200,000
Specific Payable Percentage (excess of Deductible):	100 %
Maximum Annual Reimbursement	$ 800,000
Maximum Annual Reimbursement	$ UNLIMITED

9. PREMIUMS:

(a) Aggregate Premium

Premium Per Month Per Unit:		$ N/A
Minimum Annual Aggregate Premium		$ N/A

Monthly Aggregate Accommodation

Annual Premium in Advance		$ N/A
Premium Per Month Per Unit:		$ N/A

(b) Specific Premium

Premium Per Month Per	Composite:	$ 17.99
Minimum Monthly Specific Premium:		$ 35,464

10. SPECIAL RISK LIMITATIONS:

Contract will be based upon the current employee benefits as defined in the Employee Benefit Plan which is a part of this Application by reference or by attachment, except as noted below:

Specific: None
Aggregate: N/A

 Applicant Initials ___________

11. It is understood and agreed, as conditions precedent to the approval of this Application, that:

(a) The maximum amount of payable expenses under this Contract arising out of any treatment or an illness or injury resulting from a mental or nervous disorder, drug abuse, or alcohol abuse, shall be $25,000 per Covered Person under the Employee Benefit Plan, regardless of the number of years the Covered Person is eligible under the Employee Benefit Plan and regardless of whether expenses for this Covered Person were Incurred and/or Paid during this Contract Year.

(b) All documentation requested by the Company must be submitted prior to any approval of this Application and must be received by the Company within ninety (90) days of the requested Effective Date.

(c) If the Schedule shows disabled persons are not covered, no benefits will be paid under the Contract for expenses Incurred or Paid under the Employee Benefit Plan for a disabled person until:

(1) if an employee, he or she returns to active, full-time employment for at least one (1) full working day; or

(2) if a dependent or Continuation Beneficiary, he or she is able to perform the normal functions of a person of like sex and age.

(d) Issuance of Insurance is in reliance upon the information provided by the Applicant or its Agent. Should subsequent information become known which, if known prior to issuance of Insurance, would have affected the rates, deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms or conditions as of the Effective Date of issuance, by providing written notice to the Insured.

(e) The Contract, if issued, may be void, if whether before or after a claim or loss, any material fact or circumstance was concealed or misrepresented on behalf of the Applicant, or if the Applicant or its Agent, committed fraud.

(f) Receipt of a premium and its deposit in connection with the Application shall not constitute an acceptance of liability. In the event that Companion Life Insurance Company disapproves this Application, its sole obligation shall be to refund such sum to the Applicant.

(g) If a Contract is issued and later rescinded, the sum of all benefits paid will be deducted from the sum of all premiums paid. If the result is positive, such amount will be paid by the Company to the Applicant. If the result is negative, such amount will be paid by the Applicant to the Company.

(h) The initial premium will be paid on or before the Effective Date, and subsequent premiums are due no later than the first day of each calendar month during the Policy Year.

(i) Applicant acknowledges that the Insurance Policy which is the subject of this Application is a reimbursement contract. Applicant must first pay claims before submitting them for reimbursement.

(j) Oral Statements not expressly incorporated herein are not part of this Contract. Only the President, a Vice President, or the Secretary of the Company may make changes to the Contract Form or Addenda on behalf of the Company. All changes to this Contract must be in writing and attached to this Contract.

(k) NEITHER THIS APPLICATION NOR THE TERMS OF THIS APPLICATION MAY BE ALTERED.

In making this Application, the Applicant represents that, to the best of its knowledge and belief, such information accurately reflects the true facts and that the undersigned has authority to bind the Applicant to the proposed Contract. Accordingly, this Application will be a part of the Contract if accepted by the Company or its authorized representative.

Dated at ______________________ this _____ day of ______________________, 2011.

Witness: ______________________ Applicant: St. Johns County
Signature of Licensed Resident Agent (if required)
(Insured)
Tax ID #: 59-6000825

By: ______________________
(Officer/Partner)

Title: ______________________

Licensed Resident Agent: Mark F. Bailey
(Type or Print)

Address: 1200 Plantation Island Drive Suite 210

City: St. Augustine State: Florida Zip: 32080

Social Security or Tax ID # 59-3391619

ACCEPTANCE (to be completed by insurance company)

Accepted on behalf of the Company, this _______ day of ________________, 2011.

By: ______________________

Title: Vice President of Underwriting/ISU

Contract No.: CLI 50,321 Effective Date: January 1, 2011

ISU

6621 Southpoint Drive N, #325, Jacksonville, FL 32216
(904) 281-2151/Fax (904) 281-0384
Companion Life Insurance Company

SPECIFIC EXCESS MEDICAL EXPENSE COVERAGE DISCLOSURE STATEMENT

For: St. Johns County Proposed Effective: 1/1/2011

"We agree the proposed coverage is subject to the terms and provisions of Companion Life Insurance Company's Excess contract of which this statement is a part. Below, we have disclosed all individuals (including employees and dependents) known by us or our administrator to be **not Actively at Work,** facility confined (hospital, SNF, etc), or disabled. We have listed below all individuals identified, as of the signature date, as having a Serious Claim diagnosis, including, but not limited to, those individuals currently eligible under the plan that were formerly ineligible due to meeting their lifetime maximum in the past. The amount of claim payments on these individuals along with their current status has been indicated. Also include all individuals who are currently on COBRA, have been terminated but have yet to elect COBRA, and all dependents known to be unable to perform as those of like age or sex. Individuals previously disclosed to ISU, must be included and updated.

A Serious Claim is any claim known by us (the employer) or by our Administrator, which:

1. **Whether incurred or paid, has exceeded 50% of the Specific Deductible or $50,000 (whichever is less) as of the signature date below; or** *(must complete or indicate None)*

Claimant	Diagnosis	Prognosis/Additional Treatment Anticipated	Reported Paid Claims	Add'l. Claims Pd. Or Pended
	See attached high cost claims report			

2. **Might be expected to exceed the excess loss retention due to the nature of the illness or injury, including, but not limited to, those individuals currently eligible that were formerly ineligible due to meeting their lifetime maximum in the past; or** *(must complete or indicate None)*

Claimant	Diagnosis	Prognosis/Additional Treatment Anticipated	Paid Claims	Pd. Or Pended
	See attached high cost claims report			

3. **Is a condition which currently disables any employee or dependent. (including but not limited to: STD, LTD, salary continuance, FMLA, extension of benefits, COBRA, leave of absence).** *(must complete or indicate None)*

Claimant	Diagnosis	Prognosis/Additional Treatment Anticipated	Paid Claims	Pd. Or Pended
Arlene Curtis	5300, 389	Pending	$61,958.06	n/a

We acknowledge that ISU, Inc., on behalf of Companion Life Insurance Company, retains the right to re-underwrite any individual whose actual claims (paid or pending) are greater than the amounts reported above to ISU, Inc. by more than $5,000 **as of the signature date below**. We acknowledge that any individual known by us (the employer) or by our Third Party Administrator, who has incurred a Serious Claim, or has become disabled, may be excluded from coverage unless disclosed by us and approved by ISU, Inc. ***Our due diligence included a review of pre-certification, disability, utilization review, medical case management, salary continuance, or other reasonable means by which to obtain the required information.***

Employer: ______________________ TPA: ______________________

By: ______________________ By: ______________________

Date: ______________________ Date: ______________________