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THE CITIES OF GENEVA AND CANANDAIGUA THE FEASIBILITY OF COLLABORATIVELY PROVIDING HEALTH INSURANCE BENEFITS TO THE CITY'S EMPLOYEES AND RETIREES

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BACKGROUND

Ontario County is a geographically unique area of Central New York. In particular, the Cities of Geneva and Canandaigua serve as the only two Cities within the County and are integral to the successful future direction of all the municipal units located within the County. These two municipal entities provide vital services for the residents of the two Cities by employing a work force that serves the needs of the residents of both Cities. The total combined employment of all these two entities includes approximately 260 employees. Both of these entities do provide benefits to the employees that include a comprehensive health insurance plan that provides the employees with a benefit plan that includes both medical and prescription drug coverage. Currently, the Cities each use a variety of health benefit designs to provide coverage to their employees. The various plan designs have been effectively used by each entity to keep the costs associated with providing this coverage to a minimal level. However, through the availability of the Shared Municipal Services Grant Program, both entities have the ability to examine whether a cooperative approach to facing the issue of health insurance may present the Cities with greater cost savings opportunities for the combined unit than there was for each entity individually.

WHAT IS THE PROBLEM?

Stated quite simply, the cost of health insurance benefits is a significant issue for almost all municipalities. On average, the total cost of health insurance for the Cities of Geneva and Canandaigua was $11,090 per employee for the Calendar Year 2008 and was expected to cost $12,742 per employee in 2009. While the municipalities do have some form of premium contribution from their employees and other forms of monetary incentives to help mitigate this tremendous cost born by the municipalities, the cost of health insurance remains a significant cost issue that faces all municipalities including the Cities of Geneva and Canandaigua. Who are the stakeholders? Municipal employees, their dependents, retirees, politicians, municipal administrators, unions, health plan administrators, insurance companies, the local medical community, New York State, and, last but not least, local taxpayers. While all of these parties may have a different stake in this issue, all should be concerned about providing these benefits in the most cost efficient manner possible. To answer the question of how do we collectively

provide health insurance in the most cost effective manner goes a long way to addressing the base problem.

One of the key elements of insurance is the Law of Large Numbers. The larger the group that is being insured, the more stable the budget will be to provide that insurance. With both groups individually covering less than 200 employees, the ability to access some of the most cost effective forms of health insurance was very limited. By banding together, the group, as a whole, reached a size that unlocked some of the more cost effective insurance mechanisms that were available to mid-sized groups. These strategies were simply not available to smaller groups. The concept of self-funding the health benefits plan instead of fully insuring it through a community rated mechanism was the foundation of the cost benefit study that was conducted as part of this process.

ADDRESSING THE ISSUE

The State of New York recognized the importance and the complexity of providing affordable health insurance coverage to municipal employees and retirees and developed a grant program for local governments that encouraged and enabled inter-municipal cooperation to provide employee health benefits at a reduced cost to taxpayers. The state's 2006 Shared Municipal Services Incentives (SMSI) Program encouraged innovative solutions and offered financial incentives. The Cities of Geneva and Canandaigua jointly applied for a SMSI Grant seeking to drive down taxpayer costs while maintaining meaningful and affordable health benefits for its employees. It was also recognized that this cooperation could serve as a model for other communities throughout the state.

MUNICIPAL INVOLVEMENT

The initial challenge was to bring together representatives from both municipalities to discuss this topic. It was recognized that each municipality came with its own history and interests. To their credit, both municipalities expressed interest in this project. They realized that if the municipalities would group together, each would be strengthened by linking together common efforts and tackling common problems – in this case, providing for health benefits collectively.

A key element that must be realized by the municipalities involved in this process involved their commitment to this process. As we progressed through the early phases of this project, there was absolutely no binding commitment necessary by any of the municipalities to join the project. Down the road, there will come a day where we will ask for a formal commitment. However, this will be once we enter the final stages of this project. Prior to that time municipalities can participate in this project without any fear of a long term commitment, and at no cost to them.

GETTING ORGANIZED

In late Spring 2009, an organizational meeting was held. Representatives from both Cities attended this first of many meetings involved with this complex project. At that meeting we;

- Presented an overview of the entire project,
- Reviewed the information that we would need to proceed with the project,
- Discussed the timeline of the project, and
- Established an organizational structure of the project.

To facilitate all of the continuing work necessary to complete this project, it was decided that we would have regular meetings to discuss and review the ongoing analysis and work associated with the project.

ACCURATE AND TIMELY COMMUNICATION IS KEY

During each step in this process, representatives from both Cities received regular reports. In addition, all of the analysis and all of the documents being reviewed were completely distributed to all the parties involved in this project so that everyone associated with this project would have access to everything that was being done, whether they attended the meeting or not. We have included the most pertinent of the data reviewed to this point as a supplement to this report.

MULTI-PHASED PROJECT

As is described on the Project Timeline, which has been attached to this report, there were three main stages to this project:

- Phase I – Data Collection / Financial Analysis / Feasibility Study
- Phase II – Development of the Actual Structure of the Health Plan
- Phase III -Municipal Approval of the Health Plan and Implementation

These three phases divided the project into sections where realistic goals and objectives could be measured and achieved.

PHASE I: DATA COLLECTION / FINANCIAL ANALYSIS / FEASIBILITY STUDY

Before proceeding with the project, a key question needed to be asked and answered:

Q – "From a financial standpoint, does it make financial sense to work towards a cooperative health insurance plan for both the Cities of Canandaigua and Geneva?"

A- "Based on the information provided by the Cities, it does appear that there is an opportunity for the collective group to save money."

While the total dollars saved and the percentage of budget saved will varied from City to City, there was an opportunity to collectively save at least 10% of each City's Health Insurance Budget through this cooperative approach to self-funding the health plans. This project brought a significantly enhanced stability to the combined group's Health Insurance Budget. Through the combined enrollment numbers, a conversion from a Community Rated Health Insurance Environment to a more cost effective Self-Funded Approach to providing these benefits, and through a consortium based program, both Cities would not have to endure the uncertain premium proposals through the annual renewal process associated with its current program and should realize a more stable year-to-year budget flow associated with the health plan. Additionally, both Cities and the enrollees of the Plan could enjoy a more stable, long term plan of benefits which all parties could rely upon year after year. Gone were the days of ushering enrollees through multiple, disconnected benefit plans simply because the insurance companies were trying to direct enrollment to certain plans by using the cost of the premiums as the muscle to force enrollment in the direction that they wanted to reach the above conclusion and open a portal for advancing towards the second phase of this project, two

primary tasks needed to be completed; Data Collection which included the inventory, comparison and evaluation of the Cities current plans from both a cost and benefits perspective, and, the Feasibility Study which included the identification and evaluation of an alternative plan as well as discussed and laid out the administrative and coordination issues associated with a collaborative effort to provide the Cities Employees and Retirees with a comprehensive and cost effective health benefit plan. In addition to the above two topics, also included in this initial phase of the study was an overview of the current wellness provisions built into the current benefit plan as well as the identification of potential wellness initiatives that could be available under a collaborative health insurance program.

DATA COLLECTION

The first task involved in evaluating the opportunities that existed for the Cities was a thorough understanding of the health insurance plans that were available under each of the City's Health Benefits Programs. The following matrix provided a foundation for the entirety of the project by clearly laying out, side by side, the benefits that were offered and the corresponding premium and enrollment base.

FINGER LAKES TWIN CITIES HEALTH BENEFIT COMPARISON

City of Geneva						
Plan	**Blue Choice 25**	**Blue Choice Value**	**Blue Choice Select**	**Blue PPO**		**BCBS Preferred Blue Million**
	Out of Network Not Covered	**Out of Network Not Covered**	**Out of Network Not Covered**	**In Network**	**Out of Network**	**Nonparticipating Providers Priced at 50% of Allowance**
Deductible	None	None	None	None	$500/$1500	$100/$250
Out of Pocket Max	None	None	None	None	$1500/$4500	$600 per member
Lifetime Max	None	None	None	None	None	$1,000,000
Pre-existing				No	No	
PCP Required	Yes	Yes	Yes		No	No
Referrals Required	Yes	Yes	Yes	No	No	No
Precertification	Yes	Yes	Yes	Yes	Yes	Yes
Dependant Coverage to Age	26	26	26	26	26	26
Student Coverage to Age	26	26	26	26	26	26
Domestic Partner	Not Covered	Not Covered	Not Covered	Covered	Covered	
Office Visit Co-pay PCP	$25.00	$25.00	$15.00	$15.00	20%	
Office Visit Co-pay Specialist	$40.00	$25.00	$15.00	$20.00	20%	
Benefit						
Inpatient Services:						
Inpatient Facility	$250.00	$100 Co-pay	Covered in Full	$100 Co-pay	Ded/Coins	120 days Covered in full, then Ded/20%
Skilled Nursing	$250 per admit up to 45 days per admit, 360 life time max	Covered in full 120 days per CY/ 360 day life time max	Covered in full 120 days per CY/ 360 day life time max	$100 Co-pay/45 day CY max	Ded/Coins 45 day CY max	Two days for each unused hospital day covered in full. Remainder @ 20% after Ded.
Maternity Admission	$250.00	$100.00	Covered in full	$100 Copay	Ded/Coins	Covered in full
Newborn Nursery	Covered in full	Covered in full	Covered in full	Covered in full	Ded/Coins	Covered in full
Inpt Physical Rehab	$250 per admit-60 day max per CY	$100.00 per admit, 60 day max per CY	Covered in full - 60 days CY max	$100 Copay	Ded/Coins	
Surgery	$200 Copay or 20%, whichever is less	$100 Copay or 20%, whichever is less	Covered in full	Covered in full	Ded/Coins	120 days Covered in full, then Ded/20%
Inpatient Physician visits	Covered in full	Covered in full	Covered in full	Covered in full	Ded/Coins	Covered in full
Anesthesia	Covered in full	Covered in full	Covered in full	Covered in full	Ded/Coins	Covered in full
Inpatient MH	$250 - 30 days per CY	$100 - 30 days per CY	Covered in full - 30 day CY max	$100 Copay 30 day max	Ded/Coins -30 day max	Covered in full (60 day per CY max)
Inpatient Sub Abuse	$250 - 7 day Detox + 30 days per CY	$100 - 7 day Detox + 30 days per CY	Covered in full for up to 7 day detox only	$100 per Admit - 7 day Detox + 30 days per CY	Ded/Coins -7 day Detox + 30 days per CY	Covered in full (30 day per CY max, 2 occurrences per lifetime)

Plan	Blue Choice 25	Blue Choice Value	Blue Choice Select	Blue PPO		BCBS Preferred Million
	Out of Network Not Covered	Out of Network Not Covered	Out of Network Not Covered	In Network	Out of Network	Nonparticipating Providers Prices at 50% Allowance
OP Facility Services:						
Lab/Pathology services	$25.00	Covered in full	Covered in full	Covered in full	Ded/Coins	Covered in full
Diagnostic X-ray	$40.00	$20.00	$15.00	$20.00	Ded/Coins	Covered in full
Surgery - Facility	$50.00	$50.00	$15.00	$20.00	Ded/Coins	Covered in full
Surgery - Physician	$40.00	$20.00	$15.00	Covered in full	Ded/Coins	Covered in full
Diagnostic services	$40.00	$20.00	$15.00	$20.00	Ded/Coins	Covered in full
Radiation therapy	$25.00	$20.00	Covered in full	Covered in full	Ded/Coins	Covered in full
Kidney Dialysis				Covered in full	Ded/Coins	
Chemotherapy	$25.00	$20.00	$15.00	Covered in full	Ded/Coins	Covered in full
PT/OT/ST/Respiratory (Therapies)	$40.00 (30 visit CY combined max)	$20.00 (30 visit CY combined max)	$15.00 (30 visit CY combined max)	$20.00 (45visit CY combined max)	Ded/Coins (45 visit Y combined max)	Ded/20%
Emergency Room	$100.00	$50.00	$50.00	$50.00	$50.00	Covered in full
Emergency Room Physician	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Ded/20%
Urgent Care Center	$35.00	$25.00	$25.00	$25.00	Ded/Coins	Covered in full
Home Health Care	Covered in full (40 visits CY)	Covered in full - Unlimited visits	Covered in full - Unlimited visits	Covered in full	$50 Ded/20% Coins	Covered in full (90 day CY max)*Precert required
Routine Mammography	$25.00	$20.00	$15.00	Covered in full	Ded/Coins	
Hospice Care	$250 - 210 day lifetime max	Covered in full - unlimited days	Covered in full - unlimited days	Covered in full	Ded/Coins	
Ambulance	$100.00	$50.00	$25.00	$20.00	Ded/Coins	Ded/20%
Mental Health	$40.00 (20 visit CY)	$20.00 (20 visit CY)	$15.00 (20 visit CY)	$20.00 (20 visit CY)	Ded/Coins	Ded/50% (40 visit CY max)
Alcohol/Sub Abuse Rehab	$25.00 (60 visit CY)	$20.00 (60 visit CY)	$15.00 (60 visit CY)	$20.00 (60 visit CY)	Ded/Coins	Covered in full (60 visit CY max - Ded/50% for add'l 40 visits)
MED Surgical:						
Second Surg Opinion	$40.00	$20.00	$15.00	PCP/Specialist Copay	Ded/Coins	Dcd/20%
Anesthesia	Covered in full	Covered in full	Covered in full	Covered in full	Ded/Coins	Covered in full
In hosp medical care	Covered in full	Covered in full	Covered in full	Covered in full	Ded/Coins	120 days covered in full- than Ded/20%
X-Rays	$40.00	$20.00	$15.00	PCP/Specialist Copay	Ded/Coins	Covered in full
Lab tests	$25.00	Covered in full	Covered in full	Covered in full	Ded/Coins	Ded/20%
Pap smears	$25.00	$20.00	$15.00	Covered in full	Ded/Coins	Ded/20%
Maternity (Pre and Post Natal Care)	$5.00 Copay for each of first 10 visits-remainder in full	$5.00 Copay for each of first 10 visits-remainder in full	$5.00 Copay for each of first 10 visits-remainder in full	Covered in full	Ded/Coins	Covered in full
Consultations	$40.00	$20.00	$15.00	PCP/Specialist Copay	Ded/Coins	Ded/20%
Emergency care	$40.00	$20.00	$15.00	Covered in full (ER Physician)	Covered in full (ER Physician)	Ded/20%

Plan	Blue Choice 25	Blue Choice Value	Blue Choice Select	Blue PPO		BCBS Preferred Million
	Out of Network Not Covered	**Out of Network Not Covered**	**Out of Network Not Covered**	**In Network**	**Out of Network**	**Nonparticipating Provider Prices at 50% Allowance**
Well child care	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Routine GYN Exam	$25.00	$20.00	$15.00	Covered in full	Ded/Coins	Covered in full
Routine Mammogram	$25.00	$20.00	$15.00	Covered in full	Ded/Coins	20%
Adult Routine Physical	$25.00	$20.00	$15.00	PCP/Specialist Co-pay (1 per CY)	Ded/Coins	Not covered
Adult Immunizations	$25.00	$20.00	$15.00	Not Covered	Not Covered	Not covered
Prostate cancer screening	$25.00	$20.00	$15.00	PCP/Specialist Copay	Ded/Coins	
Chemotherapy	$25.00	$20.00	$15.00	Covered in full	Ded/Coins	Covered in full
Office Visits (PCP)	$25.00	$20.00	$15.00	$15.00	Ded/Coins	Ded/20%
Office Visits (Specialist)	$40.00	$20.00	$15.00	$20.00	Ded/Coins	Ded/20%
Chiropractic	$40.00	$20.00	$15.00	$15.00	Ded/Coins	Ded/20%
PT/OT/ST/Respiratory (Therapies)	$40.00 (30 visit CY combined max)	$20.00 (30 visit CY combined max)	$15.00 (30 visit CY combined max)	$20.00 (45 visit CY combined max)	Ded/Coins (45 visits CY combined max)	Ded/20%
DME	50% up to $5,000 per CY	50% up to $5,000 per CY	80% up to $5,000 per CY	20% Coinsurance	Ded/Coins	Ded/100% (Non-par @ 50% after Ded)
Acupuncture	Not covered	50%-10 visit CY max	50%-10 visit CY max	Not Covered	Not Covered	
External Prosthetics	50% up to $15,000 per CY	50% up to $15,000 per CY	80% up to $15,000 per CY	20% Coinsurance	Ded/Coins	80% up to $15,000 per CY
Mental Health	$40.00 Co-pay (20 visit CY)	$20.00 (20 visit CY)	$15.00 (20 visit CY)	$20.00 (20 visit max CY)	Ded/Coins (20 visit max CY)	Ded/50% (40 visit CY max)
Diabetic Equip/Supplies	$25.00 Co-pay-up to 30 day supply	$20.00 Co-pay-up to 30 day supply	$15.00 Co-pay-up to 30 day supply	$15.00	Ded/Coins	
Alcohol/Sub Abuse	$25.00 Co-pay (60 visit CY)	$20.00 (60 visit CY)	$15.00 (60 visit CY)	$20.00 (60 visit CY max)	Ded/Coins (60 visit CY max)	Covered in full (60 visit CY max - Ded/50% for add'l 40 visits)
Hearing Aids	Up to $600 for up to 2 hearing aids every 3 years-children to age 19	Up to $600 for up to 2 hearing aids every 3 years-children to age 19	Up to $600 for up to 2 hearing aids every 3 years-children to age 19	Not Covered	Not Covered	
Allergy Testing	PCP=$20.00 Co-pay, Specialist= $40.00 Copay	$20.00	$15.00			Ded/20%
Allergy Injections	PCP=$20.00 Co-pay, Specialist= $40.00 Co-pay	$20.00	$15.00			Ded/20%
Cardiac Rehab				$20.00	Ded/Coins	

Plan	Blue Choice 25	Blue Choice Value	Blue Choice Select	Blue PPO		BCBS Preferred Million
	Out of Network Not Covered	Out of Network Not Covered	Out of Network Not Covered	In Network	Out of Network	Nonparticipating Provider Prices at 50% Allowance
Routine Vision	$40 Copay - one exam every 2 years, every year for children to age 19	$20 Copay - one exam every 2 years, every year for children to age 19	$15 Copay - one exam every 2 years, every year for children to age 19	Not Covered	Not Covered	Not covered
Eyewear	$60 allowance every 2 years, Children to age 19 every year	$60 allowance every 2 years, Children to age 19 every year	$60 allowance every 2 years, Children to age 19 every year	Not Covered	Not Covered	Coverage only for lenses after cataract surgery (Ded/20%)
Prescription Drugs 90 Day mail order = two co-pays for most plans	$10/$30/$50	$10/$25/$40	$5/$20/$35	$10/$25/$40	Not Covered	Short term Rx = 50%. Maintenance = $2.00/$7.00
Enrollees						
Single	30	10	16	2		2
Two Person	10	4	15	0		0
Family No Spouse	1	2	1	0		0
Family	22	13	23	1		0
Totals	63	29	55	3		2
2009 Municipal Premiums						
Single	$351.74	$435.42	$553.49	$505.90		$861.46
Two Person	$808.82	$1,001.48	$1,272.77	$1,163.58		N/A
Family No Spouse	$886.65	$1,096.58	$1,393.68	$1,273.85		N/A
Family	$932.98	$1,153.82	$1,466.51	$1,346.63		$1,830.56

City of Canandaigua							
Plan	**MVP Basix 220-23**	**MVP Basix 220-26**	**MVP My Care 680-1**		**Preferred Care (Opportunity)**	**Excellus Blue Choice Value**	**BCBS Preferred Blue Million**
	Out of Network Not Covered	**Out of Network Not Covered**	**In Network**	**Out of Network**	**Out of Network Not Covered**	**Out of Network Not Covered**	**Non-participating providers priced at 50% of allowance**
Deductible	None	None	$1,300/$2,600	$1,300/$2,600		None	$100/$250
Out Pocket Max	None	None	$3,000/$6,000	$3,000/$6,000	None	$600 per member	
Lifetime Max						None	$1,000,00 0
PCP Required	Yes	Yes				Yes	No
Referrals Required	Yes	Yes				Yes	No
Pre-certification							Yes
Dependent Coverage to Age	19	19			26	26	26
Student Coverage to Age	23	26			26	26	26
Domestic Partner							
Office visit Co-pay PCP	$20.00	$20.00			$20.00	$20.00	
Office visit Co-pay Specialist	$20.00	$20.00			$20.00	$20.00	
Benefit							
Inpatient Services:							
Inpatient Facility	$250 Copay	$250 Copay	Ded/20% Coins	Ded/40% Coins	$100 Copay	$100 Copay	120 days Covered in full, then Ded/20%
Skilled Nursing			Ded/20% Coins (120 day max CY, 360 day lifetime max)	Ded/40% Coins (120 day max CY, 360 day lifetime max)	$100 per admit (120 day CY max, 360 day life time max)	$100 per admit (120 day CY max, 360 day life time max)	2 days for each unused hospital day covered in full. Remainder @ 20% after Ded.
Maternity Admission	$250.00	$250.00	$500.00	Ded/40%	$100.00	$100.00	Covered in full
Newborn Nursery	Covered in full	Covered in full	$500.00	Ded/40%	Covered in full		Covered in full
Inpatient Physical Rehab						$100 per admit (60 days CY max)	
Surgery	$20.00	$20.00	Ded/20% Coins	Ded/40% Coins	20% up to $100 Co-pay	20% up to $100 Copay	120 days Covered in full, then Ded/20%
Inpatient Physician Visits	Covered in full	Covered in full	Ded/20% Coins	Ded/40% Coins		Covered in full	Covered in full
Anesthesia	$20.00	$20.00	Ded/20% Coins	Ded/40% Coins	Covered in full	Covered in full	Covered in full

Plan	MVP Basix 220-23	MVP Basix 220-26	MVP My Care 680-1		Preferred Care (Opportunity)	Excellus Blue Choice Value	BCBS Preferred Blue Million
	Out of Network Not Covered	**Out of Network Not Covered**	**In Network**	**Out of Network**	**Out of Network Not Covered**	**Out of Network Not Covered**	**Non-participating providers priced at 50% of allowance**
Inpatient MH	$250 per admit (30 day CY max)	$250 per admit (30 day CY max)	Ded/20% Coins (30 day max per CY)	Ded/40% Coins (30 day max per CY)	$100.00 (30 day CY max)	$100.00 (30 day CY max)	Covered in full (60 day per CY max)
Inpatient Sub Abuse	$250 per Admit - 7 day Detox + 30 days per CY	$250 per Admit - 7 day Detox + 30 days per CY	Ded/20% Coins - 7 day Detox + 30 days per CY	Ded/40% Coins - 7 day Detox + 30 days per CY	$100.00 (7 day Detox only - no inpatient rehab coverage)	$100.00 (7 day Detox only - no inpatient rehab coverage)	Covered in full (30 day per CY max, 2 occurrenc es per lifetime)
OP Facility Services:							
Lab/Pathology services	$10.00	$10.00	Ded/20% Coins	Ded/40% Coins	$5.00	Covered in full	Covered in full
Diagnostic X-ray	$20.00	$20.00	Ded/20% Coins	Ded/40% Coins	$20.00	$20.00	Covered in full
Surgery - Facility	$100.00	$100.00	Ded/20% Coins	Ded/40% Coins	$50.00	$50.00	Covered in full
Surgery - Physician	$20.00	$20.00	Ded/20% Coins	Ded/40% Coins	$20.00	$20.00	Covered in full
Diagnostic services	$20.00	$20.00	Ded/20% Coins	Ded/40% Coins	$20.00	$20.00	Covered in full
Radiation therapy	$20.00	$20.00	Ded/20% Coins	Ded/40% Coins	Covered in full	$20.00	Covered in full
Kidney Dialysis			Ded/20% Coins	Ded/40% Coins			
Chemotherapy	$20.00	$20.00	Ded/20% Coins	Ded/40% Coins	$20.00	$20.00	Covered in full
PT/OT/ST/Respiratory (Therapies)	$20.00 (30 visit CY combined max)	$20.00 (30 visit CY combined max)	Ded/20% Coins (20 visit CY combined max)	Ded/40% Coins (20 visit CY combined max)	$20 Copay per visit (30 visit CY max)	$20 Copay per visit (30 visit CY max)	Ded/20%
Emergency Room	$50.00	$50.00	Ded/20% Coins	Ded/40% Coins	$50.00	$50.00	Covered in full
Emergency Room Physician			Ded/20% Coins	Ded/40% Coins			Ded/20%
Urgent Care Center			Ded/20% Coins	Ded/40% Coins	$25.00	$25.00	Covered in full
Home Health Care			Ded/25% per day (100 visit max per CY)	Ded/25% per day (100 visit max per CY)	$20 Copay per day (40 visit CY max)	Covered in full	Covered in full (90 day CY max) *Precert required
Routine Mammogram	$20.00	$20.00	Covered in full	40% Coins	Covered in full	$20.00	
Hospice Care	$20 per day210 day max	$20 per day210 day max	Ded/25% (210 max per CY)	Ded/25% (210 max per CY)	Covered in full (120 days)	Covered in full	
Ambulance	$50.00	$50.00	Ded/20% Coins	Ded/20% Coins	$50.00	$50.00	Ded/20%
Mental Health	$20.00 (20 visit CY)	$20.00 (20 visit CY)	Ded/20% Coins (30 visit max CY)	Ded/40% Coins (30 visit max CY)	50% (20 visit max per CY)	50% (20 visit max per CY)	Ded/50% (40 visit CY max)

Plan	MVP Basix 220-23	MVP Basix 220-26	MVP My Care 680-1		Preferred Care (Opportunity)	Excellus Blue Choice Value	BCBS Preferred Blue Million
	Out of Network Not Covered	**Out of Network Not Covered**	**In Network**	**Out of Network**	**Out of Network Not Covered**	**Out of Network Not Covered**	**Non-participating providers priced at 50% of allowance**
Alcohol/Sub Abuse Rehab	$20.00 (60 visit CY)	$20.00 (60 visit CY)	Ded/20% Coins (60 visit CY max)	Ded/40% Coins (60 visit CY max)	$20.00 Co-pay (60 visit CY max)	$20.00 Co-pay (60 visit CY max)	Covered in full (60 visit CY max - Ded/50% for add'l 40 visits)
MED Surgical:							
Second Surg Opinion			Ded/20% Coins	Ded/40% Coins	$20.00	$20.00	Ded/20%
Anesthesia	$20.00	$20.00	Ded/20% Coins	Ded/40% Coins	Covered in full	Covered in full	Covered in full
In hospital medical care	Covered in full	Covered in full	Ded/20% Coins	Ded/40% Coins		Covered in full	120 days covered in full- than Ded/20%
X-rays	$20.00	$20.00	Ded/20% Coins	Ded/40% Coins	$20.00	$20.00	Covered in full
Lab tests	$10.00	$10.00	Ded/20% Coins	Ded/40% Coins	$5.00	Covered in full	Ded/20%
Pap smears	$20.00	$20.00	Ded/20% Coins	Ded/40% Coins	$5.00	$20.00	Ded/20%
Maternity (Pre and Post Natal Care)	$50 Co-pay per pregnancy (Delivery add'l $50.00 Co-pay)	$50 Co-pay per pregnancy (Delivery add'l $50.00 Co-pay)	Ded/20% Coins	Ded/40% Coins	$50.00	$5.00 Co-pay for each of first 10 visits remainder in full	Covered in full
Consultations	$20.00	$20.00	Ded/20% Coins	Ded/40% Coins	$20.00	$20.00	Ded/20%
Emergency care			Ded/20% Coins	Ded/40% Coins	$20.00		Ded/20%
Well child care	Covered in full	Covered in full	Covered in full	40% Coins	Covered in full	Covered in full	Covered in full
Routine GYN Exam	$20.00	$20.00	Covered in full	40% Coins	$15.00	$20.00	Covered in full
Routine Mammogram	$20.00	$20.00	Covered in full	40% Coins	Covered in full	$20.00	20%
Adult Routine Physical	$20.00	$20.00	Covered in full	40% Coins	$15.00	$20.00	Not covered
Adult Immunizations	$20.00	$20.00	Covered in full	40% Coins		$20.00	Not covered
Prostate cancer screening			Covered in full	40% Coins	$5.00	$20.00	
Chemotherapy			Ded/20% Coins	Ded/40% Coins	Covered in full	$20.00	Covered in full
Office Visits PCP	$20.00	$20.00	Ded/20% Coins	Ded/40% Coins	$20.00	$20.00	Ded/20%
Office Visits (Specialist)	$20.00	$20.00	Ded/20% Coins	Ded/40% Coins	$20.00	$20.00	Ded/20%
Chiropractic	$20.00	$20.00	Ded/20% Coins	Ded/40% Coins	$20.00	$20.00	Ded/20%

Plan	MVP Basix 220-23	MVP Basix 220-26	MVP My Care 680-1		Preferred Care (Opportunity)	Excellus Blue Choice Value	BCBS Preferred Blue Million
	Out of Network Not Covered	**Out of Network Not Covered**	**In Network**	**Out of Network**	**Out of Network Not Covered**	**Out of Network Not Covered**	**Non-participating providers priced at 50% of allowance**
PT/OT/ST/Respiratory (Therapies)	$20.00 (30 visit CY combined max)	$20.00 (30 visit CY combined max)	Ded/20% Coins (20 visit CY combined max)	Ded/40% Coins (20 visit CY combined max)	$20.00 Copay (30 visit combined CY max)	$20.00 Copay (30 visit combined CY max)	Ded/20%
DME	50% -$5,000 CY max	50% -$5,000 CY max	Ded/20% Coins-$5,000 CY max	Ded/40% Coins$5,000 CY max	20% Coins - $15,000 CY max	50% $5,000 CY max	Ded/100% (Non-par @ 50% after Ded)
Acupuncture			Ded/50% Coins - 10 visit max CY	Ded/50% Coins - 10 visit max CY	50% Coins - 10 visit max	50% Coins -10 visit max	
External Prosthetics	50%-$15,000 per prosthetic per CY	50%-$15,000 per prosthetic per CY	Ded/20% Coins up to $15,000 per CY	Ded/40% Coins up to $15,000 per CY	20% Coins up to $15,000 per CY	50% up to $15,000 per CY	80% up to $15,000 per CY
Mental Health	$20.00 (20 visit CY)	$20.00 (20 visit CY)	Ded/20% Coins (30 visit max CY)	Ded/40% Coins (30 visit max CY)	50% (20 visit max per CY)	50% (20 visit max per CY)	Ded/50% (40 visit CY max)
Diabetic Equip/Supplies	$20.00	$20.00	$25 per 1 mo supply	$25 per 1 mo supply	$20 Copay for 30 day supply	$20.00	
Alcohol/Sub Abuse	$20.00 (60 visit CY)	$20.00 (60 visit CY)	Ded/20% Coins (60 visit CY max)	Ded/40% Coins (60 visit CY max)	$20.00 Co-pay (60 visit CY max)	$20.00 Co-pay (60 visit CY max)	Covered in full (60 visit CY max - Ded/50% for add'l 40 visits)
Hearing Aids			Up to $600 for 1 hearing aid every 3 years-children to age 19	Up to $600 for 1 hearing aid every 3 years-children to age 19	Up to $600 for 1 hearing aid every 3 years-children to age 19	Up to $600 for 1 hearing aid every 3 years-children to age 19	
Allergy Testing	$20.00	$20.00	Ded/20% Coins	Ded/40% Coins	$20.00	$20.00	Ded/20%
Allergy Injections	$20.00	$20.00	Ded/20% Coins	Ded/40% Coins	$20.00	$20.00	Ded/20%
Cardiac Rehab			Ded/20% Coins (36 visit max per CY)	Ded/40% Coins (36 visit max per CY)			
Routine Vision	$20.00 Co-pay once a year	$20.00 Co-pay once a year	Covered in full (1 per CY)	40% Coins (1 per CY)	$20 Co-pay (1 per CY max)	$20 Co-pay - one exam every 2 years, every year for children to age 19	Not covered
Eyewear	20% Discount	20% Discount				$60 allowance every 2 years, Children to age 19 every year	Coverage only for lenses after cataract surgery (Ded/20%)
Prescription Drugs - 90 Day mail order = two co-pays for most plans	$10/$25/$40 Mail order = $25/$62.50/$100	$10/$25/$40 Mail order = $25/$62.50/$100	$10/$25/$40 Mail order = $25/$62.50/$100	10%/30%/50%	$5/$20/$35	$10/$25/$ 40	Short term Rx = 50%. Maintenance =$2.00/$7.00

Plan	MVP Basix 220-23	MVP Basix 220-26	MVP My Care 680-1		Preferred Care (Opportunity)	Excellus Blue Choice Value	BCBS Preferred Blue Million
	Out of Network Not Covered	Out of Network Not Covered	In Network	Out of Network	Out of Network Not Covered	Out of Network Not Covered	Non-participating providers priced at 50% of allowance
Enrollees							
Single	4	0	1		1	8	2
2 Person	4	15	1		1	13	0
Family No Spouse	0	0	0		0	4	0
Family	6	19	7		0	25	5
Totals	14	34	9		2	50	7
2009 Municipal Premiums							
Single	$354.14	$354.14	$201.81		$437.18	$435.42	$937.74
2 Person	$796.92	$792.92	$464.13		$983.64	$1,001.48	N/A
Family No Spouse	N/A	N/A	N/A		N/A	$1,096.58	N/A
Family	$932.16	$923.46	$549.23		N/A	$1,153.82	$1,992.89

As soon as a Health Insurance Company would be chosen to administer the new combined plan, this document would serve as the basis for the creation of a new Plan Document along with all necessary Riders. This level of detail was necessary because the foundation of this project was that the new combined plan would provide all current enrollees in the various health insurance plans with the exact same benefits under the new plan. In other words, there would be NO BENEFIT CHANGES AS A RESULT OF THIS PROJECT.

FINANCIAL ANALYSIS – 2009 EXPENSES

Now that it was quite clear to all parties what the current benefit structure looked like and how it compared with all of the other plans offered, it was important to develop a base budget for the collaborative plan to serve as the basis for comparison for an alternate plan structure. Keep in mind, the alternative plan structure that the Cities were examining had nothing to do with the benefits offered to all of the enrollees of the plan due to the fact that these benefit levels were dictated by a collectively bargained process and, as a result, this project was not free to examine alternative plans unless there could be a guarantee of no diminishment of benefits. Due to the unique nature of the multiple benefit plans that were offered to the City's enrollees, this ruled out the process of an open market search for more cost effective alternatives. Instead, this project identified the alternate plans as a combined plan that could offer all the various benefit levels currently offered and targeted possible consolidation of plan

designs as a future goal of each individual City's labor negotiation process.

Before evaluating and explaining the alternative plan structures that were available to the Cities, a basis for comparison first had to be achieved. Once the current budget for both of the Cities was combined, we could examine the cost factors associated with each group and identify the opportunity cost associated with the current plan design so as to use it as a basis for building future cost projections. The cost structures for the Cities for 2009 were detailed as follows:

City of Canandaigua

	Current Enrolment				2009	
	Actives	**<65**	**>65**	**Total**	**Premium**	**Annual Premium**
PC Opportunity						
Single	1			1	$437.18	$5,246
2 Person	0	1		1	$983.64	$11,804
Family	0			0	$1,136.63	-
PC My Care (HSA)						
Single	1			1	$201.81	$2,422
2 Person	1			1	$464.13	$5,570
Family	7			7	$549.23	$46,135
PC Basix 23						
Single	4			4	$354.17	$17,000
2 Person	4			4	$792.92	$38,060
Family	6			6	$925.46	$66,633
PC Basix 26						
Single	0			0	$354.174	$0.00
2 Person	14	1		15	$796.92	$143,446
Family	19			19	$932.16	$212,532
Blue Choice Value						
Single	5	3		8	$435.42	$41,800
2 Person	9	4		13	$1,001.48	$156,231
Family No Spouse	3	1		4	$1,096.58	$52,636
Family	20	5		25	$11,53.82	$346,146
Blue Million						
Single	2			2	$937.74	$22,506
Family	5			5	$1,992.98	$119,573
Census	**94**	**22**	**0**	**116**	**2009 Total Premium (Canandaigua)**	**$1,287,740**

City of Geneva

Current Enrolment					2009	
	Actives	**<65**	**>65**	**Total**	**Premium**	**Annual Premium**
Blue Million						
Single	0	2	0	2	$861.46	$20,675
Family						
Blue PPO						
Single	0	2	0	2	$505.90	$12,142
2-Person	0	0	0	0	$1,163.58	0
Family no Spouse	0	0	0	0	$1,273.85	0
Family	0	1	0	1	$1,346.36	$16,160
Blue Choice Select						
Single	6	10	0	16	$553.49	$106,270
2-Person	2	13	0	15	$1,272.77	$229,099
Family no Spouse	0	1	0	1	$1,393.68	$16,724
Family	9	14	0	23	$1,466.51	$404,757
Blue Choice Value						
Single	8	2	0	12	$435.42	$52,250
2-Person	4	0	0	4	$1,001.48	$48,071
Family no Spouse	2	0	0	2	$1,096.58	$26,318
Family	13	0	0	13	$1,153.82	$179,996
Blue Choice 25						
Single	30	0	0	30	$351.74	$126,626
2-Person	10	0	0	10	$202.82	$97,058
Family no Spouse	1	0	0	1	$886.65	$10,640
Family	20	2	0	22	$932.98	$246,307
Census	**105**	**47**	**0**	**152**	**2009 Total Premiums (Geneva)**	**1,593,092**

Cities of Canandaigua/Geneva Consortium

Current Enrolment					2009	
	Actives	**<65**	**>65**	**Total**	**Premium**	**Annual Premium**
Census - Geneva + Canandaigua	**199**	**69**	**0**	**268**	**2009 Total Premiums**	**2,880,833**

This combined premium of $2,880,883 would serve as a basis for trying to identify the opportunity cost associated with a collaborative health insurance program. In other words, we were trying to identify the net income or loss that the insurance companies experienced on this group. Through the various insurance company renewals associated with each group and applying sound actuarial assumptions to the data included, we were able to determine the incurred expenses for the combined plan were $1,465,376 in medical claims and an additional $817,580 in prescription drug claims. In addition to the claims expense there were Pooling Expenses associated with the combined group of $78,750 and estimated administrative

expenses of $273,679. The total estimated actual costs (net of excess insurance company costs) associated with the combined plan was $2,635,385. This left an opportunity to save $245,447 (8.52%) in 2009 associated with a collaborative plan.

ADMINISTRATION AND COORDINATION

In order to take advantage of the potential cost savings, the Cities would have to examine an alternative administrative structure for their health insurance programs. The goal was instead of letting the insurance companies retain the potential savings associated with the collaborative health plan, the Cities would take on the insurance risk associated with the health plan and reap the benefits of the differential that existed between the premium base paid by the Cities and the actual expenses incurred by the Cities' combined health benefits plan. To achieve this, the Cities would be examining the formation of a Municipal Cooperative Organization and implementing a Minimum Premium / Premium Credit Self-Funded Benefit Plan. The educational process associated with understanding this was significant and involved numerous meetings to discuss the financial pros and cons associated with this type of arrangement. Also, a great deal of time was spent in examining the administrative structure of such a Plan and how that Plan would work as an entity that was controlled by a Board comprised of equal representatives from each group. Excerpts from the voluminous detail that was shared included the following summaries regarding self-funding in a minimum premium environment and the issues associated with self-insurance:

> *SELF-FUNDING*
> *This methodology of paying medical claims carries the highest risk and, for groups with favorable loss patterns, the greatest rewards. Self-funding is simple, the group pays for its claims directly and is responsible for all paid losses. There is no pool to soften catastrophic claims experience and the exposure to catastrophic losses is greater.*
>
> *One way to protect the financial integrity of a self-funded health plan is through the use of stop-loss insurance. This type of insurance policy comes in two forms, aggregate and specific. Aggregate stop-loss insurance protects the financial integrity of the entire group, while specific stop-loss insurance mitigates the individual catastrophic losses which will occur. This type of insurance does come at a price.*
>
> *In addition to stop-loss insurance, there are other considerations which must be made. There are liability issues which come about as a result of the employer becoming the "insurance carrier." In addition, an administrator must be hired to pay the claims. All of these factors add complexities to self-funding medical benefits and this methodology must be carefully reviewed before implementation.*

The threshold to self-funding varies based on some of the factors we spoke about previously. Demographic make-up and loss patterns are the two primary considerations. Typically, it takes a group of approximately 500 or more employees to successfully self-fund medical benefits in a cost-effective manner.

MINIMUM PREMIUM PLANS

A Minimum Premium Plan is a hybrid of a self-funded plan. This type of funding arrangement is a financial agreement between an insurance company and a group which enables a plan to take advantage of increased cash flows while still enjoying a certain degree of plan flexibility. The Minimum Premium agreement offers many of the advantages of a self-funded mechanism yet is defined as an insured program because the group contributes to the Statutory Reserves of the insurance company as part of the administrative fees it pays. Because of these contributions, the insurance company would be responsible for the run-out in claims should the group not be able to meet its obligations.

The basic premise of a Minimum Premium Plan is that there is a major transference of risk from the insurance company to the group. For groups, the major advantage is that instead of paying the insurance company monthly premiums, which includes reserve amounts for incurred but not reported (IBNR) claims, the group will be paying claims as they are incurred and will be able to invest the cash they hold for the group's IBNR claims they determine to be in their best interest.

Considering that a Minimum Premium Plan carries all the claims risk that a self-funded plan carries, the same parameters that guide whether groups are large enough to assume the risk for a self-funded plan should apply to Minimum Premium Plans. Generally those groups that are smaller than 500 employees assume a very large risk with the implementation of either a self-funded or a Minimum Premium Plan.

It should be noted that the larger the population the more stable the plan is from a cash flow perspective.

INSURANCE V. SELF-INSURANCE

There are some significant differences in the way employers purchase their health insurance benefits. In the following, we have provided information regarding several key differences associated with self-insured plans and insured plans. Some of the areas of discussion are:

ADMINISTRATIVE COSTS

Typically, self-insured plans carry a significantly reduced administrative cost as compared to insured plans. An insured plan can cost upwards of twice as much to administer as compared to self-insured plans. The primary reason is due to the added costs associated with the insurance company bearing the risk for the program. In addition, insured plans are required to pay certain premium taxes and other fees which self-insured plans are not required to pay.

In addition to the administrative costs associated with the adjudication of claims, there is a marked difference in the internal costs an employer bears associated with the operation of a self-insured plan as compared to an insured plan. In a self-insured environment, the employer must dedicate additional labor hours to the financial management of the plan. In addition, the employer can find itself involved in claim reviews and decisions on a fairly regular basis, which can add a significant number of internal labor hours being dedicated to the operation of a self-insured plan.

It is important to weigh all of the administrative costs, both internal and external, when comparing self-insured plans versus insured plans.

BENEFIT DECISIONS/LIABILITY

In a self-insured plan, the "plan" or "carrier" is the employer. As a result, all benefit decisions rest with the organization, as well as the liability for those decisions.

In an insured environment all benefit decisions are the responsibility of the insurance company. As a result, the insurance company would bear the liability of those decisions, not the employer.

In assessing the differences between self-insured and insured plans, an employer must consider the liability associated with the operation of the plan.

BENEFIT DESIGN

In a self-insured plan, the employer can create virtually any plan of benefits and the third party administrator (TPA) should be able to administer the plan.

In an insured environment, the design of the plan can be more restrictive, as each plan of benefits must be filed and approved with the State of New York. Also, the insurance

company must be willing to underwrite and administer the plan of benefits.

It is also important to note that insured plans require the inclusion of all state mandated coverage's and conformity with the minimum standards for health insurance, as set forth in the New York State Insurance Laws. Self-insured plans are not subject to these same requirements.

REGULATORY OVERSIGHT

An insured plan is operated pursuant to the laws established in the State of New York, most specifically the insurance laws and regulations. Self-Insured plans do not come under the same regulatory oversight. In the private sector, self-insured plans are subject to the protections and oversight of the Employment Retirement Security Act of 1974. This Act, commonly referred to as "ERISA," gives the United States Department of Labor the power to regulate self-insured health and welfare benefit plans.

RESERVING PRACTICES

Under the insurance laws in the State of New York, insurance companies are required to maintain a reserve for incurred but not reported claims. In addition, statutory reserves must be established. All reserves must be held by the insurance company in an amount deemed satisfactory by the New York State Insurance Department.

In a self-insured environment, a plan is not required to maintain a reserve for incurred but not reported claims. However, most self-insured plans create a reserve fund to cover the liability associated with incurred but not reported claims. In addition, many self-insured plans set aside additional funds to assist in those times when claims exceed expectations and cash-flows are affected.

In a self-insured environment, the employer has the opportunity to earn interest income from the reserve pool. In an insured plan, the insurance company maintains the reserve funds and has the ability to invest said funds as they see fit, thus earning additional monies for their company.

RISK V. REWARD DYNAMIC

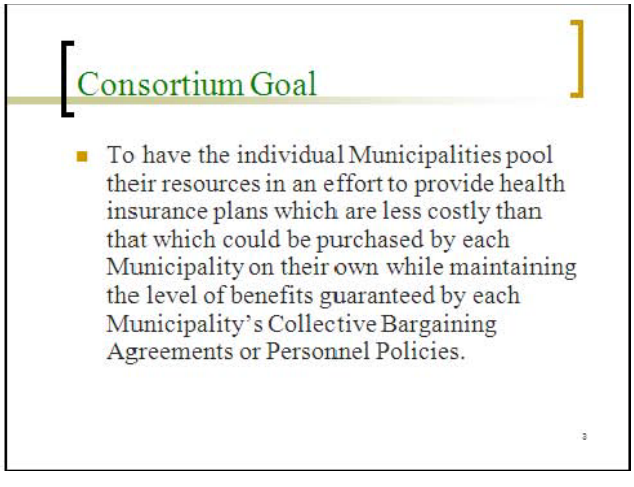
In a fully insured, experience rated environment there is literally no risk that the employer, in a given year, will exceed its budgeted amount provided there are no dramatic increases in the staff size. As a result, there is no reward felt for having a "good year" or lower than expected claims costs.

In a self-insured environment there is a risk that budgeted amounts could be exceeded and that monthly cash-flows might be effected. Most plans do purchase aggregate stop-loss insurance which does protect the employer should losses exceed expectations by more than 25%. However, the employer would be responsible for those paid claims above the budgeted amount until they reach that 25% threshold. The reward associated with self-insured plans provides the greatest potential to maximize a return. If a lower

than expected paid claims result is achieved, excess funds can be used to reduce future health insurance budgets, to increase reserves dedicated to health insurance, or for general fund purposes.

This is an example of the risk versus reward decision making model which an employer faces. Factors such as group size, demographic make-up, risk tolerance, budget levels, internal staffing assessments, and experience all play into this decision. This is a decision which must be weighed carefully before it is made.

Now that the financial structure of the proposed plan was understood, the next set of conversations took place regarding the actual administrative structure of how a collaborative health insurance program would actually work. Again, significant meeting time and tremendous review of documentation was necessary to have a solid working knowledge of a municipal cooperative arrangement. This included the formation of a proposed Municipal Cooperative Agreement which will be detailed later in this report. For the purposes of the educational process, this topic was summarized in a series of meetings with representatives from both Cities. The following is an excerpt of the presentation:



Who is in the Consortium?

- Consortium membership is initially being offered to the Cities of Canandaigua and Geneva. Later, depending on interest, other municipalities within certain geographical boundaries may be included.

Financial Impact of Consortium

- The Municipalities will reduce overall health insurance spending by:
  - Pooling Resources
  - Increasing Buying Power
  - Reducing Administrative Expenses
  - Minimizing Insurance Company Profits
  - Being Part of a Larger Risk Pool

What is the Financial Model?

- Minimum Premium
- Insured Policy
- Self Funded (Works Like Self Insurance)
- Premiums are Pooled
- Paying for Known Expenses
- Maintaining Reserve Accounts
- Investment Earnings

How Does this Affect My Costs?

- Lower Premium Equivalent Rates
- Lower Annual Increases in Premiums
- More Stable Annual Budget Process

Who Will Run the Consortium?

- Board of Directors
  - Meets Regularly
  - Manages the Plan
  - Defined in the Municipal Cooperative Agreement
  - Equal Representation from Both Cities

What Will My Benefits Be?

- Benefits Will Remain the Same as Your Existing Plan
- No Change in Out-of-Pocket Spending
- Multiple Plan Designs Available
- Collective Bargaining Process Unchanged
- Provider Network Will Be Inclusive

Who Will Administer the Plans?

- We will be beginning a Process of Selecting an Insurance Company who will:
  - Administer the Same Benefits That Are Currently in Place
  - Provide Top Notch Customer Service
  - Provide Professional Claims Services
  - Maintain a High Quality Provider Network
  - Provide Meaningful Data and Reports

Next Steps / Time Frame

- Request for Proposal Process for a Health Insurance Company (Summer 2010)
- Development of a Municipal Cooperative Agreement (Summer 2010)
- Development of a Plan Document (Fall 2010)
- Implementation & Education (Fall 2010)
- Start Date – January 1, 2011

Employee/Retiree Protections

- Benefits and Rights Protected by Collective Bargaining Agreements
- New York State Insurance Department Oversight
- Involvement in the Process
- Sharing of Information and Results

With the target of operating a self-funded, minimum premium health insurance plan and with having come to agreement on how that Plan would be administratively set up as a Municipal Cooperative Organization governed by a Municipal Cooperative Agreement, the Cities then looked to the financial aspect of running such a Plan by asking the question: "Is there a financial benefit to operating our collaborative health insurance plan in this manner?" To accomplish this, the project developed a combined budget for the municipalities.

FINANCIAL ANALYSIS – 2010 PROJECTED BUDGET

The combined projected budget assumes a 1/1/10 start date for a Municipal Cooperative Health Insurance Plan for the two Cities. Note that the 2009 Budget is a combined budget based on each of the City's being enrolled in the fully insured health plans in which they are currently enrolled. The 2010 Year represented the budget that would be in place for the combined, self-funded plan. Note that in 2009 it was projected that the insurance companies made an estimated $245,447 on the health insurance provided by the two Cities. Neither City was able to benefit from this favorable loss ratio that the insurance company enjoyed.

For 2010, had the plan been combined under a self-funded, fully insured arrangement, it is estimated that the Plan would have been able to achieve a positive level of Fund Balance in the first year of $244,473. This represents a net savings of 8% on the Plan's combined premium of just over $3 million. This savings was predicated on an increase in premiums of only 5% for 2010. So, when the Plan entered the 2010 Calendar Year under the current separate insured structure, the anticipated premium increase that they would be facing would be 13%. Creating the combined plan would decrease that level of increase down to just 5%, and would enable the combined plan to build a Fund Balance of $455,139, or 15% of projected total budget which was an amount more than adequate to fully fund the total liabilities of the combined plan by the end of its first year in operation.

CITIES OF CANANDAIGUA/GENEVA CONSORTIUM

2009 – 2010 Budget Estimates

	Actual 2009	Projected 2010	
Income			
Premiums	$2,880,832	$3,024,874	5.00%
Direct Pay Premiums	$0	$0	
Interest Income	$0	$0	
Total Income	$2,880,832	$3,024,874	5.00%
Expenses			
Claims			
Medical Claims	$1,465,376	$1,560,625	6.50%
Stop Loss Reimbursements	$817,580	$882,987	8.00%
Rx Drug Claims			
Vision Claims	$0	$0	
Lab Fees (Capitated)	$0	$0	
Pooling Expenses	$78,750	$84,381	7.15%
Total Claims	$2,361,706	$2,527,993	7.04%
Admin Expenses			
Plan Admin	$273,679	$112,560	-58.87%
PBM Admin	$0	$0	
Vision Admin	$0	$0	
Legal Fees	$0	$12,000	
Actuary Fees	$0	$0	
Accounting Fees	$0	$4,000	
Consulting Fees	$0	$28,800	
Stop Loss Insurance	$0	$90,048	
Other Insurance	$0	$0	
Banking Fees	$0	$0	
Miscellaneous Expenses	$0	$5,000	
Total Admin Expenses	$273,679	$252,408	-7.77%
Total Expenses	$2,635,385	$2,780,401	5.50%
Net Income / (Loss)	$245,447	$244,473	
Run-in Fund Balance		$210,666	
Year End Fund Balance		$455,139	
	8.52%	15.05%	

The final aspect of the financial analysis was to determine what the actual savings would be for the Cities based on the above premium increase for the Consortium Style Plan as opposed to the premiums that would have been paid under the current arrangement for 2010. The following analysis detailed this comparison as well as provided the Cities with the detailed effect of the premium structure for each benefit plan design and verified the budgeted Consortium Premium base of $3.02 million for 2010.

CITIES OF CANANDAIGUA/GENEVA CONSORTIUM

2010 Budget Comparison: Consortium vs. Individual

Canandaigua

	Current Enrollment				2010 Premiums		Adjusted Premium		Pct
	Actives	**<65**	**>65**	**Total**	**Premium**	**Annual Premium**	**Premium**	**Annual Premium**	
PC Opportunity									
Single	1	0	0	1	$502.40	$6,028.80	$467.96	$5,616	7.04%
2-Person	0	1	0	1	$1,130.42	$13,565.04	$1,047.67	$12,572	6.51%
Family	0	0	0	0	$1,306.26	-	-	-	-
PC My Care (HAS)									
Single	1	0	0	1	$252.71	$3,032.52	$201.81	$2,422	0%
2-Person	1	0	0	1	$581.24	$6,974.88	$464.13	$557	0%
Family	7	0	0	7	$687.88	$57,781.92	$549.23	$46,135	0%
PC Basix-23									
Single	4			4	$420.69	$20,193.12	$433.86	$20,825	22.5%
2-Person	4			4	$946.60	$45,436.80	$971.33	$46,624	22.5%
Family	6			6	$1,099.36	$79,152.92	$1,133.69	$81,626	22.5%
PC Basix-26									
Single	0			0	$426.69	-	$433.86	-	22.5%
2-Person	14	1		15	$946.60	$170,388	$976.23	$17,5721	22.5%
Family	19			19	$1,107.40	$252,487.20	$1,141.90	$26,0325	22.5%
Blue Choice Value									
Single	5	3		8	$513.29	$49,275.84	$436.20	$41,875	0.18%
2-Person	9	4		13	$1,180.55	$184,165.80	$976.57	$152,345	2.49%
Family no Spouse	3	1		4	$1,292.65	$62,047.20	$1,098.55	$52,730	0.18%
Family	20	5		25	$1,360.14	$408,042	$1,139.81	$341,943	1.21%
Blue Million									
Single		2		2	$1,040.89	$24,981.36	$585.71	$14,057	37.54%
Family		5		5	$2,212.11	$132,726.60	$1,530.48	$91,829	23.2%
Census	**94**	**22**	**0**	**116**	**2010 Total Premium**	**$1,561,281**	**2010 Total Adjusted Premium**	**$1,352,242**	**105.01%**

Geneva

	Current Enrollment				2010 Premiums		Adjusted Premium		Pct
	Actives	**<65**	**>65**	**Total**	**Premium**	**Annual Premium**	**Premium**	**Annual Premium**	
Blue Million									
Single	0	2	0	2	$1,040.89	$24,981.36	$635.91	$15,262	26.18%
Family									
Blue PPO									
Single	0	2	0	2	$541.30	$12,991.20	$481.13	$11,547	4.90%
2-Person	0	0	0	0	$1,245.01	-	$1,077.15	-	7.43%
Family no Spouse	0	0	0	0	$1,362.99	-	$1,211.47	-	4.90%
Family	0	1	0	1	$1,434.45	$17,213.40	$1,257.20	$15,086	6.64%
Blue Choice Select									
Single	6	10	0	16	$653.09	$125,393.28	$529.50	$101,665	4.33%
2-Person	2	13	0	15	$1,501.81	$270,325.80	$1,185.46	$213,328	6.86%
Family no Spouse	0	1	0	1	$1,644.47	$19,733.64	$1,333.28	$15,999	4.33%
Family	9	14	0	23	$1,730.44	$477,601.44	$1,383.61	$381,877	5.65%
Blue Choice Value									
Single	8	2	0	10	$513.29	$61,594.80	$473.64	$56,836	8.78%
2-Person	4	0	0	4	$1,180.55	$56,666.40	$1,060.38	$50,898	5.88%
Family no Spouse	2	0	0	2	$1,292.65	$31,023.60	$1,192.83	$28,628	8.78%
Family	13	0	0	13	$1,360.14	$212,181.84	$1,237.63	$193,071	7.26%
Blue Choice 25									
Single	30	0	0	30	$415.03	$149,410.80	$437.13	$157,367	24.28%
2-Person	10	0	0	10	$954.39	$114,526.80	$978.65	$117,438	21.00%
Family no Spouse	1	0	0	1	$1,046.35	$12,556.20	$1,101.90	$13,223	24.28%
Family	20	2	0	22	$1,101.03	$290,671.92	$1,142.24	$301,551	22.43%
Census	**105**	**47**	**0**	**152**	**2010 Total Premium**	**$1,876,872**	**2010 Total Adjusted Premium**	**$1,673,831**	**105.07%**

Cities of Canandaigua/Geneva Consortium

	Current Enrollment				2010 Premiums		Adjusted Premium		Pct
	Actives	**<65**	**>65**	**Total**	**Premium**	**Annual Premium**	**Premium**	**Annual Premium**	
Census	**199**	**69**	**0**	**268**	**2010 Total Premium**	**$3,393,153**	**2010 Total Adjusted Premium**	**$3,026,073**	**105.04%**
							2010 Savings	**$367,081**	**10.8%**

This chart presented the 2010 quoted premiums for the Cities separately for the insured plans that they currently had in place. The combined premium for this health insurance structure was $3,393,153. This chart also presented what the premium equivalent rates would be for the Cities should they combine their health programs. The combined premium for this health insurance structure was $3,026,073. The total savings that the combined plan offered the Cities of Geneva and Canandaigua was $367,080. These savings would be shared by the municipalities as well as the employees and retirees of the municipality through their contribution to lower premiums.

FINANCIAL CONCLUSIONS OF THE PHASE I FEASIBILITY STUDY

As identified above, the direct immediate savings for the two Cities combined would be a reduction in the premiums that they would pay in 2010 of $367,080. This savings was the result of the lower premiums that the Cities would pay to the Municipal Cooperative Health Insurance Plan as opposed to premiums that they would pay to the current insurance plans (Excellus & MVP). These were immediate savings that the Cities would budget for immediately.

In addition to the aforementioned savings, the new Municipal Cooperative Health Insurance Plan would be able to successfully operate in its initial year with a budget of just over $3 million. This budget would allow the Plan to operate successfully in its initial year and accumulate Fund Balance in the amount of $455,139, which would be more than adequate to meet the liabilities of the Plan at the end of its initial year without requiring either of the Cities to put up any initial capital contributions.

NEXT STEPS FOR THE PROJECT

As identified in the attached Initial Presentation, with the successful conclusion of the Phase I Feasibility Study, the next set of steps that needed to take place was the development of the structure of the Municipal Consortium. It was important to note that some of these steps had already taken place as additional steps in the Feasibility Study such as the development of the Municipal Cooperative Agreement and the discussion of the need for and potential structure of a Wellness Program. This entailed four main aspects to this Phase 2 of the Project:

1. Development and adoption of a Municipal Cooperative Agreement – This

document established the separate entity that is the Municipal Consortium. It identified the structure of the Consortium, the governance of the Consortium, and the operating procedures/rules of the Consortium.

2. A Request for Proposal Process to choose a Health Insurance Company to administer the new combined Plan.
3. The development of a Wellness Program which would incorporate members of both Cities to examine the resources that were available in general to members as well as the specific programs that were available through the administrator that would by chosen to run the health benefits program, educate members as to the opportunities that exist for them, and attempt to develop a measurement tool that could be used to gauge the success of the program.
4. Development of a new Plan Document – As soon as the new insurance company would be chosen, the current benefit structure that was detailed in the attached benefit summary needed to be incorporated into a standard plan document template that the new insurance company would put in place.

With the completion of these next steps, the Cities would have in place the infrastructure necessary to achieve the savings that have been identified through this process. The resources necessary to accomplish this were formidable. The Cities would require an immense commitment of staff time and resources to accomplish this or they would have to retain the services of an outside organization that had the capabilities to assist the Cities through this process. The idea of a further grant to provide the City with the financial resources necessary to achieve this new health benefits structure could be an ideal way to accomplish the desired task.

As a way of concluding this Study, we are attaching two Appendixes to this Report which detail the additional tasks that were assigned to this process. The first Appendix is the draft copy of the Municipal Cooperative Agreement that was developed through the collective efforts of both Cities. This final document is the result of numerous iterations that were discussed at great length through a series of committee meetings. The second Appendix is the outline of the recommended Wellness Program that provided all of the details necessary to implement a successful program for the Cities when they are in a position to launch the health benefits program under a single administrator.

Appendix A

Draft Municipal Cooperative Agreement

DRAFT – 6/11/09

MUNICIPAL COOPERATION AGREEMENT

THIS AGREEMENT (the "Agreement") made effective as of 1st day of January 2011 (the "Effective Date"), by and among each of the signatory municipal corporations hereto (collectively, the "Participants").

W H E R E A S:

1. Article 5-G of the New York General Municipal Law (the "General Municipal Law") authorizes municipal corporations to enter into cooperative agreements for the performance of those functions or activities in which they could engage individually;

2. Sections 92-a and 119-o of the General Municipal Law authorize municipalities to purchase a single health insurance policy, enter into group health plans, and establish a joint body to administer a health plan;

3. Article 47 of the New York Insurance Law (the "Insurance Law"), and the rules and regulations of the New York State Superintendent of Insurance (the "Superintendent") set forth certain requirements for governing self-insured municipal cooperative health insurance plans;

4. Section 4702(f) of the Insurance Law defines the term "municipal corporation" to include a county, city, town, village, fire district, school district, board of cooperative educational services, public library (as defined in Section 253 of the New York State Education Law) and district (as defined in Section 119-n of the General Municipal Law); and

5. The Participants have determined to their individual satisfaction that furnishing the health benefits (including, but not limited to, medical, surgical, hospital, prescription drug, dental, and/or vision) for their eligible officers, eligible employees (as defined by the Internal Revenue Code of 1986, as amended, and the Internal Revenue Service rules and regulations), eligible retirees, and the eligible dependents of eligible officers, employees and retirees (collectively, the "Enrollees") (such definition does not include independent contractors and/or consultants) through a municipal cooperative is in their best interests as it is more cost- effective and efficient. Eligibility requirements shall be determined by each Participant's collective bargaining agreements and/or their personnel policies and procedures; and

6. The Participants wish to designate themselves under this agreement as the Cities of Canandaigua and Geneva Municipal Medical Plan Fund (the “Fund”) and to provide health benefits for those employees that each Participant individually elects to include in the Cities of Canandaigua and Geneva Medical Plan (the “Plan”).

NOW, THEREFORE, the parties agree as follows:

A. PARTICIPANTS.

1. The undersigned Participants shall comprise the initial membership of the Consortium. Membership in the Consortium may be offered to any municipal corporation within the geographical boundaries of the County of Ontario; provided however, in the sole discretion of the Board (as defined below), the applicant provides satisfactory proof of its financial responsibility. Membership shall be subject to the terms and conditions set forth in this Agreement, any amendments hereto and applicable law.

2. Participation by some, but not all, collective bargaining units or employee groups of a Participant is not encouraged and shall not be permitted absent prior Board approval. Further, after obtaining approval, any Participant which negotiates an alternative health insurance plan offering other than the plan offerings of the Consortium with a collective bargaining unit or employee group may be subject to a risk charge as determined by the Board.

3. Initial membership of additional participants shall become effective on the first day of the Plan Year following the adoption by the Board of the resolution to accept a municipal corporation as a Participant. Such municipal corporation must agree to continue as a Participant for a minimum of three (3) years upon entry.

4. The Board, by a two-thirds (2/3) vote of the entire Board, may elect to permit a municipal corporation which is not located in the geographical or political boundaries of the County of Ontario to become a Participant subject to satisfactory proof, as determined by the Board, of such municipal corporation's financial responsibility. Such municipal corporation must agree to continue as a Participant for a minimum of three (3) years upon entry.

5. A municipal corporation that was previously a Participant, but is no longer a Participant, and which is otherwise eligible for membership in the Consortium, may apply for re-entry after a minimum of three (3) years has passed since it was last a Participant. Such re-entry shall be subject to the approval of two-thirds (2/3) of the entire Board. This re-entry waiting period may be waived by the approval of two-thirds (2/3) of the entire Board. In order to re-enter the Consortium, a municipal corporation employer must have satisfied in full all of its outstanding financial obligations to the Consortium. A municipal corporation must agree to continue as a Participant for a minimum of three (3) years upon re-entry.

B. PARTICIPANT LIABILITY.

1. The Participants shall share in the costs of, and assume the liabilities for benefits (including medical, surgical, and hospital) provided under the Plan(s) to covered officers, employees, retirees, and their dependents. Each Participant shall pay on demand such Participant's share of any assessment or additional contribution ordered by the Board, as set forth in Section K(4) of this Agreement. The pro rata share shall be based on the Participant's relative "premium" contribution to the Plan(s) as a percentage of the aggregate "premium" contribution to the Plan(s), as is appropriate based on the nature of the assessment or contribution.

2. New Participants (each a "New Participant") who enter the Consortium may be assessed a fee for additional financial costs above and beyond the premium contributions to the Plan(s). Any such additional financial obligations and any related terms and conditions associated with membership in the Consortium shall be determined by the Board, and shall be disclosed to the New Participant prior to its admission.

3. Each Participant shall be liable, on a pro rata basis, for any additional assessment required in the event the Consortium funding falls below those levels required by the Insurance law as follows:

a. In the event the Consortium does not have admitted assets (as defined in Insurance Law § 107) at least equal to the aggregate of its liabilities, reserves and minimum surplus required by the Insurance Law, the Board shall, within thirty (30) days, order an assessment (an "Assessment Order") for the amount that will provide sufficient funds to remove such impairment and collect from each Participant a pro-rata share of such assessed amount.

b. Each Participant that participated in the Consortium at any time during the two (2) year period prior to the issuing of an Assessment Order by the Board shall, if notified of such Assessment Order, pay its pro rata share of such assessment within ninety (90) days after the issuance of such Assessment Order. This provision shall survive termination of the Agreement of withdrawal of a Participant.

c. For purposes of this Section B(3), a Participant's pro-rata share of any assessment shall be determined by applying the ratio of the total assessment to the total contributions or premium equivalents earned during the period covered by the assessment on all Participants subject to the assessment to the contribution or premium equivalent earned during such period attributable to such Participant.

C. BOARD OF DIRECTORS.

1. The governing board of the Consortium, responsible for management, control and administration of the Consortium and the Plan(s), shall be referred to as the "Board of Directors" (the "Board"). The voting members of the Board shall be composed of one representative of each Participant, who shall have the authority to vote on any official action taken by the Board (each a "Director" or "voting Director"). Each Director shall be designated in writing by the governing body of the Participant.

2. If a Director cannot fulfill his/her obligations, for any reason, as set forth herein, and the Participant desires to designate a new Director, it must notify the Consortium's Chairperson in writing of its selection of a new designee to represent the Participant as a Director.

3. Directors shall receive no remuneration from the Consortium for their service and shall serve a term from January 1 through December 31 (the "Plan Year").

4. No Director may represent more than one Participant.

5. No Director, or any member of a Director's immediate family shall be an owner, officer, director, partner, or employee of any contractor or agency retained by the Consortium, including any third party contract administrator.

6. Except as otherwise provided in Section D of the Agreement, each Director shall be entitled to one vote. A majority of the entire Board, not simply those present, is required for the Board to take any official action, unless otherwise specified in this Agreement. The “entire Board”, as used herein and elsewhere in this Agreement, shall mean the total number of voting Directors when there are no vacancies.

7. Each Participant may designate in writing an alternate Director to attend the Board's meeting when its Director cannot attend. The alternate Director may participate in the discussions at the Board meeting and will, if so designated in writing by the Participant, be authorized to exercise the Participant’s voting authority. Only alternate Directors with voting authority shall be counted toward a quorum.

8. A majority of the voting Directors of the Board shall constitute a quorum. A quorum is a simple majority (more than half) of the entire Board. A quorum is required for the Board to conduct any business. This quorum requirement is independent of the voting requirements set forth in Section C(6). The Board shall meet on a regular basis, but not less than on a quarterly basis at a time and place within the State of New York determined by a vote of the Board. The Board shall hold an annual meeting (the “Annual Meeting”) between October 3rd and October 15thof each Plan Year.

9. Special meetings of the Board may be called at any time by the Chairperson or by any two (2) Directors. Whenever practicable, the person or persons calling such special meeting shall give at least three (3) day notice to all of the other Directors. Such notice shall set forth the time and place of the special meeting as well as a detailed agenda of the matters proposed to be acted upon. In the event three (3) days notice cannot be given, each Director shall be given such notice as is practicable under the circumstances.

10. In the event that a special meeting is impractical due to the nature and/or urgency of any action which, in the opinion of the Chairperson, is necessary or advisable to be taken on behalf of the Consortium, the Chairperson may send proposals regarding said actions via facsimile to each and all of the Directors. The Directors may then fax their approval or disapproval of said actions to the Chairperson. Upon receipt by the Chairperson of the requisite number of written approvals, the Chairperson may act on behalf of the Board in reliance upon such approvals. Any actions taken by the Chairperson pursuant to this paragraph shall be ratified at the next scheduled meeting of the Board.

11. In addition, the Board shall include a representative from each union who is the exclusive collective bargaining representative of any Enrollee or group of Enrollees covered by the Plan[s], for one or more of the Participants. Each union shall be entitled to one representative, regardless of the number of Participants that recognize the union as the exclusive collective bargaining representative for employees covered by the Plan. Each eligible union shall establish and agree to the procedures by which the representative is chosen and shall designate one representative in writing to the Chairman of the Board. Each representative designated under this section shall serve as a non-voting member of the Board (each a "Non-Voting Director"), who shall not have the authority to vote on any official action taken by the Board, nor move or second binding resolutions. The number of Non-Voting Directors shall not be taken into account when determining the existence of a quorum. Non-Voting Directors shall not be eligible to hold office in the Consortium. Notwithstanding the foregoing, Non-Voting Directors (a) may participate in Board deliberations; (b) may propose and submit non-binding recommendations and/or resolutions to the full Board; and (c) shall have such other rights and responsibilities as determined by the Board.

D.

E. ACTIONS BY THE BOARD.

Subject to the voting and quorum requirements set forth in this Agreement, the Board is authorized and/or required to take action on the following matters:

1. To fill any vacancy in any of the officers of the Consortium.

2. To fix the frequency, time and place of regular Board meetings.

3. To approve an annual budget for the Consortium, which shall be prepared and approved prior to October 15th of each year, and determine the annual premium equivalent rates to be paid by each Participant for each Enrollee classification in the Plan on the basis of a community rating methodology filed with and approved by the Superintendent.

4. To audit receipts and disbursements of the Consortium and provide for independent audits, and periodic financial and operational reports to Participants.

5. To establish a joint fund or funds to finance all Consortium expenditures, including claims, reserves, surplus, administration, stop-loss insurance and other expenses.

6. To select and approve the benefits provided by the Plan(s) including the plan document(s), insurance certificate(s), and/or summary plan description(s), a copy of the Plan(s) effective on the date of this Agreement is incorporated by reference into this Agreement.

7. To annually select a plan consultant (the "Plan Consultant") for the upcoming Plan Year, prior to October 15th of each year.

8. To review, consider and act on any recommendations made by the Plan Consultant.

9. To establish administrative guidelines for the efficient operation of the Plan.

10. To establish financial regulations for the entry of new Participants into the Consortium consistent with all applicable legal requirements and this Agreement.

11. To contract with third parties, which may include one or more Participants, for the furnishing of all goods and services reasonably needed in the efficient operation and administration of the Consortium, including, without limitation, accounting services, legal counsel, contract administration services, consulting services, purchase of insurances and actuarial services. Provided, however (a) the charges, fees and other compensation for any contracted services shall be clearly stated in written administrative services contracts, as required in Section 92-a(b) of the General Municipal Law; (b) payment for contracted services shall be made only after such services are rendered; (c) no Director or any member of such Director's immediate family shall be an owner, officer, director, partner or employee of any contract administrator retained by the Consortium; and (d) all such agreements shall otherwise comply with the requirements of Section 92-a(b) of the General Municipal Law.

12. To purchase stop-loss insurance on behalf of the Consortium and determine each year the insurance carrier or carriers who are to provide the stop- loss insurance coverage during the next Plan Year, as required by Section 4707 of the Insurance Law.

13. To determine and notify each Participant prior to October 15th of each Plan Year of the monthly premium equivalent for each enrollee classification during the next Plan Year commencing the following January

14. To designate the banks or trust companies in which joint funds, including reserve funds, are to be deposited and which shall be located in this state, duly chartered under federal law or the laws of this state and insured by the Federal Deposit Insurance Corporation, or any successor thereto.

15. To designate annually a treasurer (the "Treasurer") who may or may not be a Director and who shall be the treasurer, or equivalent financial officer, for one of the Participants. The Treasurer's duties shall be determined by the Chief Fiscal Officer to whom he/she will report.

16. To designate an Officer or Director to retain custody of all reports, statements and other documents of the Consortium and take minutes of each Board meeting which shall be acted on by the Board at a subsequent meeting.

17. To choose the certified public accountant and the actuary to provide the reports required by this Agreement and any applicable law.

18. To designate an attorney-in-fact to receive summons or other legal process in any action, suit or proceeding arising out of any contract, agreement or transaction involving the Consortium. The Board designates John G. Powers, Esq. as the Consortium's initial attorney-in-fact.

19. To take all necessary action to ensure that the Consortium obtains and maintains a Certificate of Authority in accordance with the Insurance Law.

20. To take all necessary action to ensure the Consortium is operated and administered in accordance with the law of the State of New York.

21. To take any other action authorized by law and deemed necessary to accomplish the purposes of this Agreement.

F. EXECUTIVE COMMITTEE.

1. The Executive Committee of the Consortium shall consist of the Chairperson, the Vice-Chairperson, and the Chief Fiscal Officer of the Consortium.

2. The Executive Committee may meet at anytime between meetings of the Board, at the discretion of the Chairperson. The Executive Committee shall make recommendations to the Board.

3. The Executive Committee shall manage the Consortium between meetings of the Board, subject to such approval by the Board as may be required by this Agreement.

G. OFFICERS.

1. At the Annual Meeting, the Board shall elect from its Directors a Chairperson, Vice Chairperson, Chief Fiscal Officer, and Secretary, who shall serve for a term of one (1) year or until their Successors are elected and qualified. Any vacancy in an officer's position shall be filled at the next meeting of the Board.

2. Officers of the Consortium and employees of any third party vendor, including without limitation the officers and employees of any Participant, who assist or participate in the operation of the Consortium, shall not be deemed employees of the Consortium. Each third party vendor shall provide for all necessary services and materials pursuant to annual contracts with the Consortium. The officers of the Consortium shall serve without compensation from the Consortium, but may be reimbursed for reasonable out-of-pocket expenses incurred in connection with the performance of such officers' duties.

3. Officers shall serve at the pleasure of the Board and may be removed or replaced upon a two-thirds (2/3) vote of the entire Board. This provision shall not be subject to the weighted voting alternative set forth in Section D.

H. CHAIRPERSON; VICE CHAIRPERSON.

1. The Chairperson shall be the chief executive officer of the Consortium.

2. The Chairperson, or in the absence of the Chairperson, the Vice Chairperson, shall preside at all meetings of the Board.

3. In the absence of the Chairperson, the Vice Chairperson shall perform all duties related to that office.

I. PLAN ADMINISTRATOR.

The Board, by a two-thirds (2/3) vote of the entire Board, may annually designate an administrator and/or insurance company of the Plan (the "Plan Administrator") and the other provider(s) who are deemed by the Board to be qualified to receive, investigate, and recommend or make payment of claims, provided that the charges, fees and other compensation for any contracted services shall be clearly stated in written administrative services and/or insurance contracts and payment for such contracted services shall be made only after such services are rendered or are reasonably expected to be rendered. All such contracts shall conform to the requirements of Section 92-a(6) of the General Municipal Law.

J. CHIEF FISCAL OFFICER.

1. The Chief Fiscal Officer shall act as the chief financial administrator of the Consortium and disbursing agent for all payments made by the Consortium, and shall have custody of all monies either received or expended by the Consortium. The Chief Fiscal Officer shall be a fiscal officer of a Participant. The Chief Fiscal Officer shall receive no remuneration from the Consortium, except that the Plan will reimburse reasonable and necessary out-of-pocket expenses incurred by the Chief Fiscal Officer in connection with the performance of his or her duties that relate to the Consortium.

2. All monies collected by the Chief Fiscal Officer relating to the Consortium, shall be maintained and administered as a common fund. The Chief Fiscal Officer shall, notwithstanding the provisions of the General Municipal Law, make payment in accordance with procedures developed by the Board and as deemed acceptable to the Superintendent.

3. The Chief Fiscal Officer shall be bonded for all monies received from the Participants. The amount of such bond shall be established annually by the Consortium in such monies and principal amount as may be required by the Superintendent.

4. All monies collected from the Participants by the Chief Fiscal Officer in connection with the Consortium shall be deposited in accordance with the policies of the Participant which regularly employs the Chief Fiscal Officer and shall be subject to the provisions of law governing the deposit of municipal funds.

5. The Chief Fiscal Officer may invest moneys not required for immediate expenditure in the types of investments specified in the General Municipal Law for temporary investments or as otherwise expressly permitted by the Superintendent.

6. The Chief Fiscal Officer shall account for the Consortium's reserve funds separate and apart from all other funds of the Consortium, and such accounting shall show:
   a. the purpose, source, date and amount of each sum paid into the fund;
   b. the interest earned by such funds;
   c. capital gains or losses resulting from the sale of investments of the Plan's reserve funds;
   d. the order, purpose, date and amount of each payment from the reserve fund; and
   e. the assets of the fund, indicating cash balance and schedule of investments.

7. The Chief Fiscal Officer shall cause to be prepared and shall furnish to the Board, to participating municipal corporations, to unions which are the exclusive bargaining representatives of Enrollees, the Board’s consultants, and to the Superintendent:
   a. an annual audit, and opinions thereon, by an independent certified public accountant, of the financial condition, accounting procedures and internal control systems of the municipal cooperative health benefit plan;
   b. an annual report and quarterly reports describing the Consortium’s current financial status; and
   c. an annual independent actuarial opinion on the financial soundness of the Consortium, including the actuarial soundness of contribution or premium equivalent rates and reserves, both as paid in the current Plan Year and projected for the next Plan Year.

K. PREMIUM CALCULATIONS/PAYMENT.

1. The annual premium equivalent rates shall be established and approved by a majority of the entire Board. The method used for the development of the premium equivalent rates may be changed from time to time by the approval of two-thirds (2/3) of the entire Board, subject to review and approval by the Superintendent. The premium equivalent rates shall consist of such rates and categories of benefits as is set forth in the Plan[s] that is determined and approved by the Board consistent with New York law.

2. The Consortium shall maintain reserves and stop-loss insurance to the level and extent required by the Insurance Law and as directed by the Superintendent.

3. Each Participant's monthly premium equivalent, by enrollee classification, shall be paid by the first day of each calendar month during the Plan Year. A late payment charge of one percent (1%) of the monthly installment then due will be charged by the Board for any payment not received by the first of each month, or the next business day when the first falls on a Saturday, Sunday, legal holiday or day observed as a legal holiday by the Participants.

The Consortium may waive the first penalty once per Plan Year for each Participant, but will strictly enforce the penalty thereafter. A repeated failure to make timely payments, including any applicable penalties, may be used by the Board as an adequate justification for the expulsion of the Participant from the Consortium.

4. The Board shall assess Participants for additional contributions, if actual and anticipated losses due to benefits paid out, administrative expenses, and reserve and surplus requirements exceed the amount in the joint funds, as set forth in Section B(3) above.

5. The Board, in its sole discretion, may refund amounts in excess of reserves and surplus, or retain such excess amounts and apply these amounts as an offset to amounts projected to be paid under the next Plan Year’s budget.

L. EMPLOYEE CONTRIBUTIONS.

If any Participant requires an Enrollee's contribution for benefits provided by the Consortium, the Participant shall collect such contributions at such time and in such amounts as it requires. However, the failure of a Participant to receive the Enrollee contribution on time shall not diminish or delay the payment of the Participant's monthly premium equivalent to the Consortium, as set forth in this Agreement.

M. ADDITIONAL BENEFITS.

Any Participant choosing to provide more benefits, coverages, or enrollment eligibility other than that provided under the Plan(s), will do so at its sole expense. This Agreement shall not be deemed to diminish such Participant's benefits, coverages or enrollment eligibility, the additional benefits and the payment for such additional benefits, shall not be part of the Plan(s) and shall be administered solely by and at the expense of the Participant.

N. REPORTING.

The Board, through its officers, agents, or delegatees, shall ensure that the follow reports are prepared and submitted:

1. Annually after the close of the Plan Year, not later than one-hundred twenty (120) days after the close of the Plan Year, the Board shall file a report with the Superintendent showing the financial condition and affairs of the Consortium, including an annual independent financial audit.

2. Annually after the close of the Plan Year, the Board shall have prepared a statement and independent actuarial opinion on the financial soundness of the Plan, including the contribution or premium equivalent rates and reserves, both as paid in the current Plan Year and projected for the next Plan Year.

3. The Board shall file reports with the Superintendent describing the Consortium's then current financial status within forty-five (45) days of the end of each quarter during the Plan year.

4. The Board shall provide the annual report to all Participants and all unions, which are the exclusive collective bargaining representatives of Enrollees, which shall be made available for review to all Enrollees.

5. The Board shall submit to the Superintendent a report describing any material changes in any information originally provided in the Certificate of Authority. Such reports, in addition to the reports described above, shall be in such form, and containing such additional content, as may be required by the Superintendent.

O. WITHDRAWAL OF PARTICIPANT.

1. Withdrawal of a Participant from the Consortium shall be effective only once annually on the last day of the Plan Year.

2. Notice of intention of a Participant withdraw must be given in writing to the Chairperson prior to October 3rd of each Plan Year. Failure to give such notice shall automatically extend the Participant's membership and obligations under the Agreement for another Plan Year, unless the Board shall consent to an earlier withdrawal by a two-thirds (2/3) vote.

3. Any withdrawing Participant shall be responsible for its pro rata share of any Plan deficit that exists on the date of the withdrawal, subject to the provisions of subsection "4" of this Section. The withdrawing Participant shall be entitled to any pro rata share of surplus that exists on the date of the withdrawal, subject to the provisions of subsection "4" of this Section. The Consortium surplus or deficit shall be based on the sum of actual expenses and the estimated liability of the Consortium as determined by the Board. These expenses and liabilities will be determined one (1) year after the end of the Plan Year in which the Participant last participated.

4. The surplus or deficit shall include recognition and offset of any claims, expenses, assets and/or penalties incurred at the time of withdrawal, but not yet paid. Such pro rata share shall be based on the Participant's relative premium contribution to the Consortium as a percentage of the aggregate premium contributions to the Consortium during the period of participation. This percentage amount may then be applied to the surplus or deficit which existed on the date of the Participant's withdrawal from the Consortium. Any pro rata surplus amount due the Participant shall be paid to the Participant one year after the effective date of the withdrawal. Any pro rata deficit amount shall be billed to the Participant by the Consortium one year after the effective date of the withdrawal and shall be due and payable within thirty (30) days after the date of such bill.

P. DISSOLUTION; RENEWAL; EXPULSION.

1. The Board at any time, by a two-thirds (2/3) vote of the entire Board, may determine that the Consortium shall be dissolved and terminated. If such determination is made, the Consortium shall be dissolved ninety (90) days after written notice to the Participants.

a. Upon determination to dissolve the Consortium, the Board shall provide notice of its determination to the Superintendent. The Board shall develop and submit to the Superintendent for approval a plan for winding-up the Consortium's affairs in an orderly manner designed to result in timely payment of all benefits.

b. Upon termination of this Agreement, or the Consortium, each Participant shall be responsible for its pro rata share of any deficit or shall be entitled to any pro rata share of surplus that exists, after the affairs of the Consortium are closed. No part of any funds of the Consortium shall be subject to the claims of general creditors of any Participant until all Consortium benefits and other Consortium obligations have been satisfied. The Consortium's surplus or deficit shall be based on actual expenses. These expenses will be determined one year after the end of the Plan Year in which this Agreement or the Consortium terminates.

c. Any surplus or deficit shall include recognition of any claims/expenses incurred at the time of termination, but not yet paid. Such pro rata share shall be based on each Participant's relative premium contribution to the Plan as a percentage of the aggregate premium contributions to the Plan during the period of participation. This percentage amount would then be applied to the surplus or deficit which exists at the time of termination.

2. The continuation of the Consortium under the terms and conditions of the Agreement, or any amendments or restatements thereto, shall be subject to Board review on the fifth (5th) anniversary of the Effective Date and on each fifth (5th) anniversary date thereafter (each a "Review Date").

a. At the annual meeting a year prior to the Review Date, the Board shall include as an agenda item a reminder of the Participants' coming obligation to review the terms and conditions of the Agreement.

b. During the calendar year preceding the Review Date, each Participant shall be responsible for independently conducting a review of the terms and conditions of the Agreement and submitting to the Board of Directors a written resolution containing any objection to the existing terms and conditions or any proposed modification or amendment to the existing Agreement, such written resolution shall be submitted to the Board on or before March 1st preceding the Review Date. Failure to submit any such resolution shall be deemed as each Participant's agreement and authorization to the continuation of the Consortium until the next Review Date under the existing terms and conditions of the Agreement.

c. As soon as practicable after March 1st, the Board shall circulate to all Participants copies of all resolutions submitted by the Participants. Subject to Section S hereof, any resolutions relating to the modification, amendment, or objection to the Agreement submitted prior to each Review Date shall be considered and voted on by the Participants at a special meeting called for such purpose. Such special meeting shall be held on or before July 1st preceding the Review Date.

d. Notwithstanding the foregoing or Section S hereof, if at the Annual Meeting following any scheduled Review Date the Board votes on and approves the budget and annual assessment for the next year, the Participants shall be deemed to have approved the continuation of the Consortium under the existing Agreement until the next Review Date.

3. The Participants acknowledge that it may be necessary in certain extraordinary circumstances to expel a Participant from the Consortium. In the event the Board determines that:

a. Participant has acted inconsistently with the provisions of the Agreement in a way that threatens the financial well-being or legal validity of the Consortium; or

b. Participant has acted fraudulently or has otherwise acted in bad faith with regards to the Consortium, or toward any individual Participant concerning matters relating to the Consortium, the Board may vote to conditionally terminate said Participant's membership in the Consortium. Upon such a finding by the affirmative vote of seventy-five percent (75%) of the Participants, the offending Participant shall be given sixty (60) days to correct or cure the alleged wrongdoing to the satisfaction of the Board. Upon the expiration of said sixty (60) day period, an absent satisfactory cure, to the Board may expel the Participant by an affirmative vote of seventy-five percent (75%) of the Participants (exclusive of the Participant under consideration). This section shall not be subject to the weighted voting provision provided in Section D. Any liabilities associated with the Participant's departure from the Consortium under this provision shall be determined by the procedures set forth in Paragraph O of this Agreement.

Q. REPRESENTATIONS AND WARRANTIES OF PARTICIPANTS.

Each Participant by its approval of the terms and conditions of this Agreement hereby represents and warrants to each of the other Participants as follows:

1. The Participant understands and acknowledges that its participation in the Consortium under the terms and conditions of this Agreement is strictly voluntary and may be terminated as set forth herein, at the discretion of the Participant.

2. The Participant understands and acknowledges that the duly authorized decisions of the Board constitute the collective will of each of the Participants as to those matters within the scope of the Agreement.

3. The Participant understands and acknowledges that the decisions of the Board made in the best interests of the Consortium may on occasion temporarily disadvantage one or more of the individual Participants.

4. The Participant represents and warrants that its designated Director or authorized representative understands the terms and conditions of this Agreement and is suitably experienced to understand the principles upon which this Consortium operates.

5. The Participant understands and acknowledges that all Directors, or their authorized representatives, are responsible for attending all scheduled meetings. Provided that the quorum rules are satisfied, non-attendance at any scheduled meeting is deemed acquiescence by the absent Participant to any duly authorized Board-approved action at the meeting. However, a Participant that was absent from a meeting will not be presumed to have acquiesced in a particular action taken at the meeting if, within fifteen (15) calendar days after learning of such action, the Participant delivers written notice to the Chairperson that it dissents from such action. The Participant shall also notify the other members of the Board of such dissent. The Chairperson shall direct the Secretary to file the notice with the minutes of the Board.

6. The Participant understands and acknowledges that, absent bad faith or fraud, any Participant's vote approving any Board action renders that Board action immune from later challenge by that Participant.

R. RECORDS.

The Board shall have the custody of all records and documents, including financial records, associated with the operation of the Consortium. Each Participant may request records and documents relative to their participation in the Consortium by providing a written request to the Chairperson and Chief Fiscal Officer. The Consortium shall respond to each request no later than thirty (30) days after its receipt thereof, and shall include all information which can be provided under applicable law.

S. CHANGES TO AGREEMENT.

Any change or amendment to this Agreement shall require the unanimous approval of the Participants, as authorized by their respective legislative bodies

T. CONFIDENTIALITY.

Nothing contained in this Agreement shall be construed to waive any right that a covered person possesses under the Plan with respect to the confidentiality of medical records and that such rights will only be waived upon the written consent of such covered person.

U. ALTERNATIVE DISPUTE RESOLUTION ("ADR").

1. General. The Participants acknowledge and agree that given their budgeting and fiscal constraints, it is imperative that any disputes arising out of the operation of the Consortium be limited and that any disputes which may arise be addressed as quickly as possible. Accordingly, the Participants agree that the procedures set forth in this Section U are intended to be the exclusive means through which disputes shall be resolved. The Participants also acknowledge and agree that by executing this Agreement each Participant is limiting its right to seek redress for certain types of disputes as hereinafter provided.

2. Disputes subject to ADR. Any dispute by any Participant arising out of or relating to a contention that:

a. the Board, the Board's designated agents, or any Participant has failed to adhere to the terms and conditions of this Agreement;

b. the Board, the Board's designated agents, or any Participant has acted in bad faith or fraudulently in undertaking any duty or action under the Agreement; or

c. any other dispute otherwise arising out of or relating to the terms or conditions of this Agreement or requiring the interpretation of this Agreement shall be resolved exclusively through the ADR procedure set forth in paragraph (3) below.

3. ADR Procedure. Any dispute subject to ADR, as described in subparagraph (2), shall be resolved exclusively by the following procedure:

a. Board Consideration: Within ninety (90) days of the occurrence of any dispute, the objecting party (the "Claimant") shall submit a written notice of the dispute to the Chairperson specifying in detail the nature of the dispute, the parties claimed to have been involved, the specific conduct claimed, the basis under the Agreement for the Participant's objection, the specific injury or damages claimed to have been caused by the objectionable conduct to the extent then ascertainable, and the requested action or

resolution of the dispute. A dispute shall be deemed to have occurred on the date the objecting party knew or reasonably should have known of the basis for the dispute.

(i) Within sixty (60) days of the submission of the written notice, the Executive Committee shall, as necessary, request further information from the Claimant, collect such other information from any other interested party or source, form a recommendation as to whether the Claimant has a valid objection or claim, and if so, recommend a fair resolution of said claim. During such period, each party shall provide the other with any reasonably requested information within such party's control. The Executive Committee shall present its recommendation to the Board in writing, including any underlying facts, conclusions or support upon which it is based, within such sixty (60) day period.

(ii) Within sixty (60) days of the submission of the Executive Committee's recommended resolution of the dispute, the Board shall convene in a special meeting to consider the dispute and the recommended resolution. The Claimant and the Executive Committee shall each be entitled to present any argument or material it deems pertinent to the matter before the Board. The Board shall hold discussion and/or debate as appropriate on the dispute and may question the Claimant and/or the Executive Committee on their respective submissions. Pursuant to its regular procedures, the Board shall vote on whether the Claimant has a valid claim, and if so, what the fair resolution should be. The weighted voting procedure set forth in Section D shall not apply to this provision. The Board's determination shall be deemed final subject to the Claimant's right to arbitrate as set forth below.

b. Arbitration. The Claimant may challenge any Board decision under subparagraph (U)(3)(a)(ii) by filing a demand for arbitration with the American Arbitration Association within thirty (30) days of the Board's vote (a "Demand"). In the event a Claimant shall fail to file a Demand within thirty (30) days, the Board's decision shall automatically be deemed final and conclusive. In the event the Participant files a timely Demand, the arbitrator or arbitration panel may consider the claim: provided however;

(i) in no event may the arbitrator review any action taken by the Board that occurred three (3) or more years prior to when the Chairperson received notice of the claim; and

(ii) in no event may the arbitrator award damages for any period that precedes the date the Chairperson received notice of the claim by more than twenty-four (24) months.

c. The Participants agree that the procedure set forth in this Section U shall constitute their exclusive remedy for disputes within the scope of this Section.

V. MISCELLANEOUS PROVISIONS.

1. This instrument constitutes the entire Agreement of the Participants with respect to the subject matter hereof, and contains the sole statement of the operating rules of the Consortium. This instrument supersedes any previous Agreement, whether oral or written.

2. Each Participant will perform all other acts and execute and deliver all other documents as may be necessary or appropriate to carry out the intended purposes of this Agreement.

3. If any article, section, subdivision, paragraph, sentence, clause, phrase, provision or portion of this Agreement shall for any reason be held or adjudged to be invalid or illegal or unenforceable by any court of competent jurisdiction, such article, section, subdivision, paragraph, sentence, clause, phrase, provision or portion so adjudged invalid, illegal or unenforceable shall be deemed separate, distinct and independent and the remainder of this Agreement shall be and remain in full force and effect and shall not be invalidated or rendered illegal or unenforceable or otherwise affected by such holding or adjudication.

4. This Agreement shall be governed by and construed in accordance with the laws of the State of New York. Any claims made under Section U(3)(b) except to the extent otherwise limited therein, shall be governed by New York substantive law.

5. All notices to any party hereunder shall be in writing, signed by the party giving it, shall be sufficiently given or served if sent by registered or certified mail, return receipt requested, hand delivery, or overnight courier service addressed to the parties at the address designated by each party in writing. Notice shall be deemed given when transmitted.

6. This Agreement may be executed in two or more counterparts each of which shall be deemed to be an original but all of which shall constitute the same Agreement and shall become binding upon the undersigned upon delivery to the Chairperson of an executed copy of this Agreement together with a certified copy of the resolution of the legislative body approving this Agreement and authorizing its execution.

7. The provisions of Section U shall survive termination of this Agreement, withdrawal or expulsion of a Participant, and/or dissolution of the Consortium.

8. Article and section headings in this Agreement are included for reference only and shall not constitute part of this Agreement.

W. APPROVAL, RATIFICATION, AND EXECUTION.

1. As a condition precedent to execution of this Municipal Cooperative Agreement and membership in the Consortium, each eligible municipal corporation desiring to be Participant shall obtain legislative approval of the terms and conditions of this Agreement by the municipality's governing body.

2. Prior to execution of this Agreement by a Participant, the Participant shall provide the Chairperson with the resolution approving the municipality's participation in this Consortium and expressly approving the terms and conditions of this Municipal Cooperative Agreement. Each presented resolution shall be attached to and considered a part of this Agreement.

3. By executing this Agreement, each signatory warrants that he/she has complied with the approval and ratification requirements herein and is otherwise properly authorized to bind the participating municipal corporation to the terms and conditions of this Agreement.

IN WITNESS WHEREOF, the undersigned has caused this Agreement to be executed as of the day and year first above written.

MUNICIPALITY	**MUNICIPALITY**
_____	_____
By: _____	By: _____
MUNICIPALITY	**MUNICIPALITY**
_____	_____

Appendix B

Draft Wellness Work Plan

Activity	Target	Goals	Tasks/Objectives	Target Date	Status	Outcome
Create a Wellness Committee	Strategy: To establish a strategic planning wellness committee for the the Cities of Geneva and Canandaigua	To solicit representatives from each City to participate on the committee. Consider employees from all aspects of the City Government.	To meet on a regular basis throughout the year to strategically plan and develop wellness initiatives			
Wellness Committee Training	Strategy: To assist in the development of the wellness committee	To train the committee in the *Wellness* capabilities within the new Plan Administrator	Provide a training session for the newly formed wellness committee			
Wellness Committee Kick Off	Strategy: Set meeting dates	To have 90% of the wellness committee participate	Brainstorm and develop collaborative efforts to develop a district-wide program involving employees, and community			
Health Assessment Campaign	Awareness: To determine overall health interest/need of the members and family members	To have 25% of the adult membership complete the Health Assessment	Promotional Campaign to encourage all members to complete the on-line Health Assessment. Promote via: Desk top flyers, payroll stuffers, e-mail blasts, incentives if possible			
Weight Management	Musculoskeletal and Cardiovascular: To create a supportive environment for healthy weight loss	To encourage participants to reduce their BMI by at least 10%.	Create a wellness newsletter via the advising of the resources and tools available to members. Encourage the Cities to promote "Healthy Lunch" days encouraging employees to bring healthy snacks/food to break rooms along with copies of healthy recipes. Consider publishing a Healthy Cookbook!			
	Circulatory (Diabetes/CVD): To create a supportive environment for healthy weight loss	To encourage participants to reduce their BMI by at least 10%.	Sponsor a Team Competition Weight Loss Program. Consider utilizing a "Lose to Win" Program			
	Circulatory (Diabetes/CVD): To create a supportive environment for healthy weight loss	To promote continuous weight management via the Healthy Behavioral Change programs , Jenny Craig discounted program on Health Allies, or establish Weight Watchers at Work throughout the Cities	Sponsor a raffle drawing of all participants who participated within the competition with giveaways such as the American Heart Association Cookbooks			

Activity	Target	Goals	Tasks/Objectives	Target Date	Status	Out-come
Flu Shot Clinics	Respiratory Ailments: To reduce absenteeism due to flu conditions	To demonstrate a reduction in absenteeism during the flu season	Contract with local hospital or national vendor to provide flu shot clinics			
Health Assessment Reporting	Strategy: To provide feedback for the success of the health assessment campaign via requesting the Participation Report and the Executive Summary Report	To have 25% of the adult membership complete the Health Assessment in 2008	Enter all names of those employees who completed the health assessment into a Raffle Competition. Deliver the Executive Summary to the wellness committee and other significant parties			
Healthy Pregnancy	Awareness: To promote the healthy pregnancy program and its value to the newly pregnant employee as well as the possible reduction in overall health costs by the delivery of a healthy baby	To have 85% of the pregnant employees enrolled into the Healthy Pregnancy Program	Promote via: Desk top flyers, payroll stuffers, email blasts, and newsletter article			
Educational Opportunity	Share with members resources and tools available to cope with "Holiday Stress" To provide employees with tips for managing stress during the holiday months	To have 5% of the employees participate in the program and via self-report express change in stress level	Provide brochures and other educational information regarding healthy pregnancy activities			
Cancer Resource Center	Neoplasms: To assist employees to be aware of the services provided by the Cancer Resource Center	To provide information regarding the Center Resource Center to all employees	Promotional Campaign to heighten awareness of the program via desk top flyers, payroll stuffers, email blasts, and possibly additional information at all department meetings			
Educational Opportunity	Early Detection of Cancer: To increase the number of screenings for the female population	Increase the percent of target population screened by 10%	Provide brochures and other educational information regarding Female related cancers. Promote community resources for screenings. Possibly schedule onsite Mobile Mammography Sessions			

Activity	Target	Goals	Tasks/Objectives	Target Date	Status	Out-come
Educational Opportunity	Early Detection of Cancer: To increase the number of screenings for the male population for prostate cancer.	Increase the percent of target population screened by 10%	Provide brochures and other educational information regarding prostate cancer. Promote community resources for screenings. Possibly schedule onsite Mobile Mammography Sessions			
Cardiac Resource Center	Circulatory (Diabetes/CVD): To assist members of to be aware of the services provided by the Cardiac Resource Center	To provide information regarding the Cardiac Resource Center to all employees	Promotional Campaign to heighten awareness of the program via desk top flyers, payroll stuffers, email blasts, and possibly additional information at all department meetings			
Cardiovascular Disease	Circulatory (Diabetes/CVD): To provide information to employees and/or their family members regarding the treatment of the disease as well as the ongoing management of the disease.	To have at least 15% of all identified diabetics participate in the seminars.	Sponsor Diabetes Information Seminars, educate members of diabetic resources available to them			
Physical Activity	Strategy: To incorporate a walking program for all members	To have 5% of the employees participate in the program	Enroll interested employees into the existing walking program in the Wellness Toolkit.			
Educational Opportunity	Strategy: To create a Family Wellness Day	To heighten awareness of family dynamics in developing health and wellness initiatives	Create a Family Wellness Day utilizing the resources within the Cities and the administrator and inviting educators, nurses, etc. to assist in the development of activities for the day			
Wellness Committee	Strategy: To develop a comprehensive report outlining success of wellness initiatives throughout the year.	To determine the value of past programming and begin planning for upcoming year	Consider following the guidelines from the Wellness Council of America Well Workplace Awards guidelines when evaluating the program			