

# IN PERSON & VIRTUAL BOARD MEETING

\*The Committee meeting will be held prior to the Board of Retirement meeting scheduled prior.



TO VIEW VIA WEB



TO PROVIDE PUBLIC COMMENT

Members of the public may address the Board orally and in writing. To provide Public Comment, please visit the above link and complete the request form.

**Attention:** If you have any questions, you may email [PublicComment@lacera.gov](mailto:PublicComment@lacera.gov).

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION  
300 N. LAKE AVENUE, SUITE 650, PASADENA, CA

## AGENDA

### A REGULAR MEETING OF THE INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE AND BOARD OF RETIREMENT\*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

8:00 A.M., WEDNESDAY, JUNE 3, 2026

*This meeting will be conducted by the Insurance, Benefits and Legislative Committee and Board of Retirement both in person and by teleconference under California Government Code Sections 54953.8.3.*

*Any person may view the meeting in person at LACERA's offices or online at <https://LACERA.com/leadership/board-meetings>.*

*The Committee may take action on any item on the agenda, and agenda items may be taken out of order.*

#### COMMITTEE TRUSTEES:

Les Robbins, Chair  
Aleen Langton, Vice Chair  
Shawn R. Kehoe, Trustee  
Ernesto J. Pantoja, Trustee  
Jason E. Green, Alternate Trustee

- I. CALL TO ORDER
- II. PROCEDURE FOR TELECONFERENCE MEETING ATTENDANCE UNDER SB 707
  - A. Just Cause (Section 54953.8.3)
  - B. Statement of Persons Present at SB 707 Teleconference Locations

### III. APPROVAL OF MINUTES

- A. Approval of the Minutes of the Regular Meeting of May 6, 2026

### IV. PUBLIC COMMENT

(Members of the public may address the Committee orally and in writing. To provide Public Comment, you should visit <https://LACERA.com/leadership/board-meetings> and complete the request [form](#).

If you select oral comment, we will contact you via email with information and instructions as to how to access the meeting as a speaker. You will have up to 3 minutes to address the Committee. Oral comment requests will be accepted up to the close of the Public Comment item on the agenda.

If you select written comment, please input your written public comment within the form as soon as possible and up to the close of the meeting. Written comment will be made part of the official record of the meeting. If you would like to remain anonymous at the meeting without stating your name, please leave the name field blank in the request form. If you have any questions, you may email [PublicComment@lacera.com](mailto:PublicComment@lacera.com).)

### V. REPORTS

- A. **Engagement Report for May 2026**  
Barry W. Lew, Legislative Affairs Officer  
(For Information Only)
- B. **Staff Activities Report for May 2026**  
Cassandra Smith, Director, Retiree Healthcare  
(For Information Only)
- C. **Anthem Blue Cross and Cigna Dental July 2024-June 2025 Annual Audit Findings**  
Cassandra Smith, Director, Retiree Healthcare  
Amber Turner, Segal Consulting  
Felicia Zhang, Segal Consulting  
(Presentation) (Memo dated May 14, 2026)
- D. **LACERA Claims Experience**  
Stephen Murphy, Segal Consulting  
(Presentation)

V. REPORTS (Continued)

E. **Federal Legislation**

Stephen Murphy, Segal Consulting  
(For Information Only)

VI. ITEMS FOR STAFF REVIEW

(This item summarizes requests and suggestions by individual trustees during the meeting for consideration by staff. These requests and suggestions do not constitute approval or formal action by the Board, which can only be made separately by motion on an agenda item at a future meeting.)

VII. ITEMS FOR FUTURE AGENDAS

(This item provides an opportunity for trustees to identify items to be included on a future agenda as permitted under the Board's Regulations.)

VIII. GOOD OF THE ORDER

(For Information Purposes Only)

IX. ADJOURNMENT

**The Board of Retirement has adopted a policy permitting any member of the Board to attend a standing committee meeting open to the public. In the event five or more members of the Board of Retirement (including members appointed to the Committee) are in attendance, the meeting shall constitute a joint meeting of the Committee and the Board of Retirement. Members of the Board of Retirement who are not members of the Committee may attend and participate in a meeting of a Board Committee but may not vote on any matter discussed at the meeting. The only action the Committee may take at the meeting is approval of a recommendation to take further action at a subsequent meeting of the Board.**

**Any documents subject to public disclosure that relate to an agenda item for an open session of the Committee, that are distributed to members of the Committee less than 72 hours prior to the meeting, will be available for public inspection at the time they are distributed to a majority of the Committee, at LACERA's offices at 300 North Lake Avenue, Suite 820, Pasadena, California during normal business hours from 9:00 a.m. to 5:00 p.m. Monday through Friday and will also be posted on [lacera.com](http://lacera.com) at the same time, [Board Meetings | LACERA](#).**

***Requests for reasonable modification or accommodation of the telephone public access and Public Comments procedures stated in this agenda from individuals with disabilities, consistent with the Americans with Disabilities Act of 1990, may call the Board Offices at (626) 564-6000, Ext. 4401/4402 from 8:30 a.m. to 5:00 p.m. Monday through Friday or email [PublicComment@lacera.com](mailto:PublicComment@lacera.com), but no later than 48 hours prior to the time the meeting is to commence.***

MINUTES OF THE REGULAR MEETING OF THE INSURANCE, BENEFITS &  
LEGISLATIVE COMMITTEE AND BOARD OF RETIREMENT\*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

8:16 A.M. – 8:28 A.M., WEDNESDAY, MAY 6, 2026

This meeting was conducted by the Insurance, Benefits & Legislative  
Committee both in person and by teleconference under California  
Government Code Section 54953.8.3.

COMMITTEE TRUSTEES

PRESENT: Les Robbins, Chair

Aleen Langton, Vice Chair *(arrived at 8:22 a.m.)*  
*(Teleconference Due to Just Cause under Section 54953.8.3)*

Shawn R. Kehoe, Trustee *(arrived at 8:20 a.m.)*

Ernesto J. Pantoja, Trustee

Jason E. Green, Alternate Trustee

OTHER BOARD OF RETIREMENT TRUSTEES

Elizabeth Ginsberg, Trustee

JP Harris, Trustee

Wayne Moore, Trustee

STAFF, ADVISORS AND PARTICIPANTS

Cassandra Smith, Director, Retiree Healthcare

JJ Popowich, Assistant Executive Officer

Jessica Baxter, Assistant Executive Officer

Barry W. Lew, Legislative Affairs Officer

Segal Consulting

Stephen Murphy, Sr. Vice President

Michael Szeto, Sr. Actuarial Associate

I. CALL TO ORDER

This meeting was called to order by Chair Robbins at 8:16 a.m.

II. PROCEDURE FOR TELECONFERENCE MEETING ATTENDANCE UNDER SB 707

A. Just Cause (Section 54953.8.3)

B. Statement of Persons Present at SB 707 Teleconference Locations

A physical quorum of the Committee was present at the noticed meeting location. There was one request received from Trustee Langton related to a physical condition under Section 54953.8.3(c)(3). Trustee Langton confirmed there were no individuals 18 years or older present at the teleconference location.

III. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of April 1, 2026

Trustee Green made a motion, Trustee Robbins seconded, to approve the minutes of the regular meeting of April 1, 2026. The motion passed by the following roll call vote:

Yes: Pantoja, Green, Robbins

No: None

Absent: Langton, Kehoe

*(Trustees Langton and Kehoe arrived after the vote had been taken)*

IV. PUBLIC COMMENT

There were no requests from the public to speak.

V. REPORTS

A. **Engagement Report for April 2026**

Barry W. Lew, Legislative Affairs Officer  
(For Information Only)

The engagement report was discussed. This item was received and filed.

B. **Staff Activities Report for April 2026**

Cassandra Smith, Director, Retiree Healthcare  
(For Information Only)

The staff activities report was discussed. This item was received and filed.

V. REPORTS (Continued)

C. **LACERA Claims Experience**

Stephen Murphy, Segal Consulting  
(Presentation)

The LACERA Claims Experience reports through March 2026 were discussed. This item was received and filed.

D. **Federal Legislation**

Stephen Murphy, Segal Consulting  
(For Information Only)

Segal Consulting gave an update on federal legislation. This item was received and filed.

VI. ITEMS FOR STAFF REVIEW

(This item summarizes requests and suggestions by individual trustees during the meeting for consideration by staff. These requests and suggestions do not constitute approval or formal action by the Board, which can only be made separately by motion on an agenda item at a future meeting.)

There was nothing to report.

VII. ITEMS FOR FUTURE AGENDAS

(This item provides an opportunity for trustees to identify items to be included on a future agenda as permitted under the Board's Regulations.)

There was nothing to report.

VIII. GOOD OF THE ORDER

(For Information Purposes Only)

There was nothing to report.

IX. ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 8:28 a.m.



**\*The Board of Retirement has adopted a policy permitting any member of the Board to attend a standing committee meeting open to the public. In the event five or more members of the Board of Retirement (including members appointed to the Committee) are in attendance, the meeting shall constitute a joint meeting of the Committee and the Board of Retirement. Members of the Board of Retirement who are not members of the Committee may attend and participate in a meeting of a Board Committee but may not vote on any matter discussed at the meeting. The only action the Committee may take at the meeting is approval of a recommendation to take further action at a subsequent meeting of the Board.**

**INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE  
ENGAGEMENT REPORT  
MAY 2026  
FOR INFORMATION ONLY**

**California’s Top-Two Primary System**

California adopted its “top-two” primary system through Proposition 14 in 2010, replacing party-based primaries with a single open ballot where all voters can choose any candidate. The two highest vote-getters—regardless of party—advance to the general election. Proposition 14 was a legislatively referred constitutional amendment that was placed on the ballot by a two-thirds vote of both houses of the California Legislature.

Supporters argued this system would expand voter choice, especially for independents, and encourage moderation. Opponents warned it could reduce general-election options and produce same-party runoff.

After more than a decade, outcomes have been mixed. The system has slightly encouraged moderation and increased competition in some primaries, but most voters still support candidates from their own party and incumbents remain strong. Turnout effects are unclear.

The 2026 election cycle is significant because a crowded Democratic field and two competitive Republicans have created a scenario—however unlikely—where two Republicans could advance in a heavily Democratic state. This has sparked renewed debate and proposals to repeal the system.

Despite this, public support for the top-two primary remains relatively strong, and widespread dissatisfaction with both major parties may make voters reluctant to return to traditional partisan primaries. ([Source](#))

**Alaska Pension Bill Vetoed, and Veto Override is Unlikely**

A proposed “pipeline-for-pension” deal collapsed in the Alaska Legislature, derailing two major policy efforts. Lawmakers failed to pass a tax break for the planned Alaska LNG pipeline, and in response, Gov. Mike Dunleavy vetoed House Bill 78, which was passed by the Legislature and would have restored a defined-benefit pension option for public employees. House Bill 78 would have allowed current employees and new hires to choose between the existing 401(k) plan and a new defined benefit plan.

The deal had been structured as a quid pro quo: Dunleavy would allow the pension bill to become law if legislators approved tax incentives for the pipeline. Alaska has not offered a traditional pension since 2006 and currently uses a 401(k)-style system.

The pipeline proposal is central to the governor’s agenda and would largely replace property taxes on pipeline infrastructure with a tax on gas transported through the system,

a change developers say is necessary to secure financing. However, legislators were hesitant due to limited cost data and uncertainty about whether the tax break was appropriate.

With the agreement dead, lawmakers are expected to continue pipeline negotiations in a special session, while public employees remain in the defined-contribution retirement system. According to one Alaska representative, there are not enough votes to move forward with an override of the Governor's veto of the pension bill. [\(Source\)](#) [\(Source\)](#)

### **Washington State Overfunded Pension Plan and Class Action Lawsuit**

Retired police officers and firefighters in Washington, led by former Congressman Dave Reichert, have filed a federal lawsuit to block a new state law that would redirect surplus funds from their pension system (LEOFF Plan 1) to address budget shortfalls.

The law would terminate the currently overfunded plan (160%) in 2029 and reinstate it at 110% of projected liabilities, allowing the state to divert nearly \$4 billion in excess assets for other uses, including backfilling a budget gap and replenishing reserves. The plan currently has fewer than 6,000 members with a handful who are active members. Contributions were suspended in 2000, as the plan became fully funded.

Plaintiffs argue this violates state and federal constitutional protections, asserting pension funds must be used exclusively for beneficiaries. They also warn that reducing the funding cushion could expose the plan to risk in a market downturn and potentially require future state contributions.

State officials and bill supporters contend the plan will remain fully funded and that pensions are guaranteed, emphasizing that most contributions came from the state and that the surplus can serve broader public purposes.

The closely passed law reflects ongoing fiscal pressures, with lawmakers seeking to address a multibillion-dollar deficit, but it has sparked significant legal and policy debate over pension protections and state authority. [\(Source\)](#)

### **California's Costs for State Workers' Pension Expected to Drop in Coming Years**

California's employer pension costs are projected to decline in coming years, primarily due to strong CalPERS investment returns and ongoing structural changes in the workforce. Recent gains—9.3% in 2024 and 11.6% in 2025—are being phased into actuarial calculations, lowering required employer contribution rates if returns continue to meet the 6.8% target.

For the largest group of state employees ("miscellaneous" workers), the employer contribution rate is expected to drop from about 31% of payroll today to 29% by 2030-31. Public safety rates are projected to fall more sharply (e.g., from roughly 49% to 43%),

although most categories will see increases through 2027-28 before declining as past investment losses are fully recognized.

A second driver is demographic: as newer, lower-benefit PEPRAs members replace “classic” members, overall normal costs decline. Improved funded status (rebounding from earlier losses) also supports lower rates. However, lower rates do not necessarily mean lower total costs, since rising payrolls may offset savings. Additionally, projections remain highly sensitive to future investment performance—rates could increase again if returns fall short of assumptions (which is 6.8% at CalPERS). [\(Source\)](#)

### **Census Bureau Releases 2025 Annual Survey of Public Pensions**

The Census Bureau released its latest dataset for 2025 on state and local defined benefit plans. The data provides revenues, expenditures, financial assets, and membership information. The following are key highlights of the data:

- State and local governments invest \$6.49 trillion in assets, up 8.46% from \$5.98 trillion in 2024.
- More than 37 million people (including inactive employees eligible for future benefits) participated in plans in 2025.
- Employees contributed 24.83% and governments contributed 75.17% of the \$315 billion contributions invested in state and local pension plans.
- Plans provided \$418.25 billion in benefit payments, up 3.40% from \$404.46 billion in 2024.

[\(Source\)](#)

**INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE  
RETIREE HEALTHCARE BENEFITS PROGRAM  
STAFF ACTIVITIES REPORT  
MAY 2026  
FOR INFORMATION ONLY**

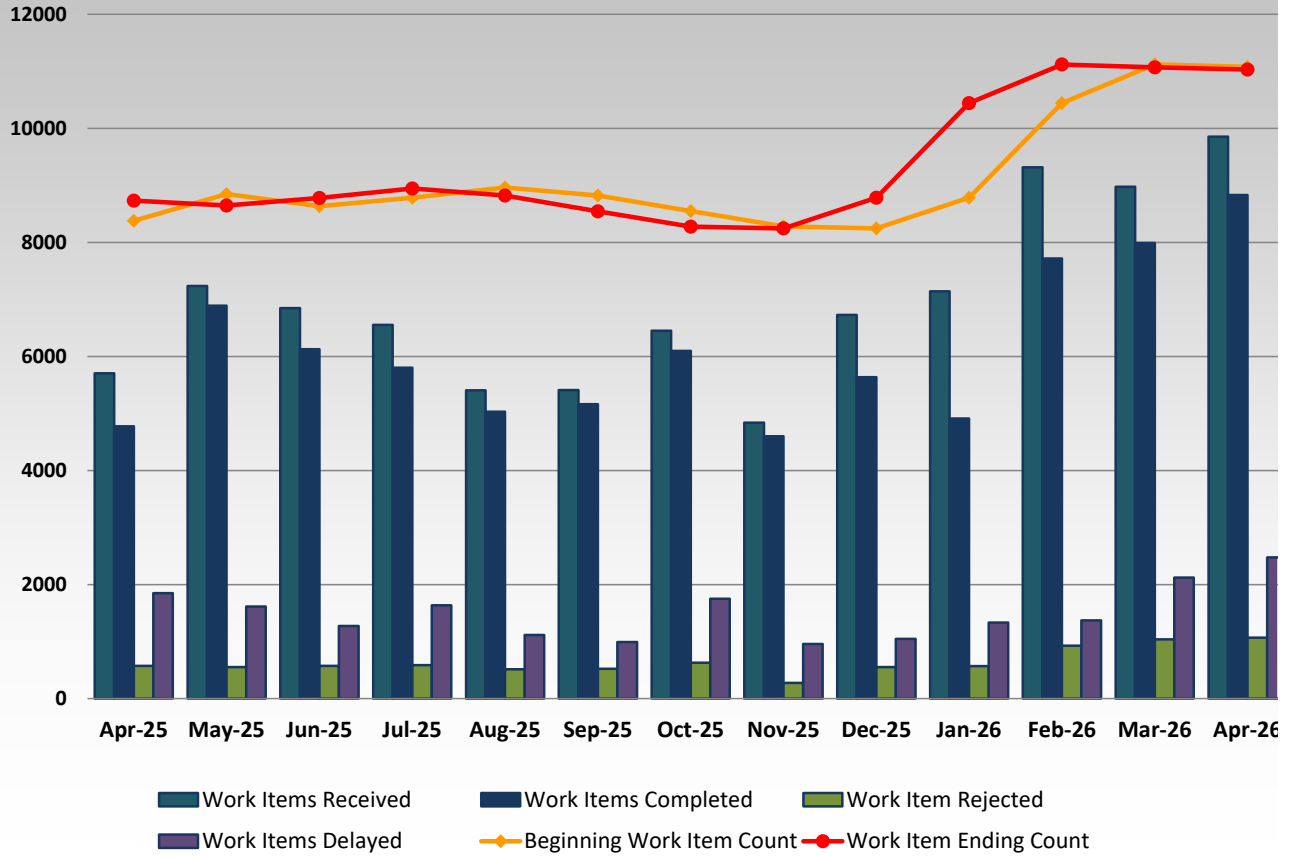
There is nothing to report this month.

# Retiree Healthcare Division

## Trend Report

APRIL 2025 - APRIL 2026

Updated: 5/26/2026

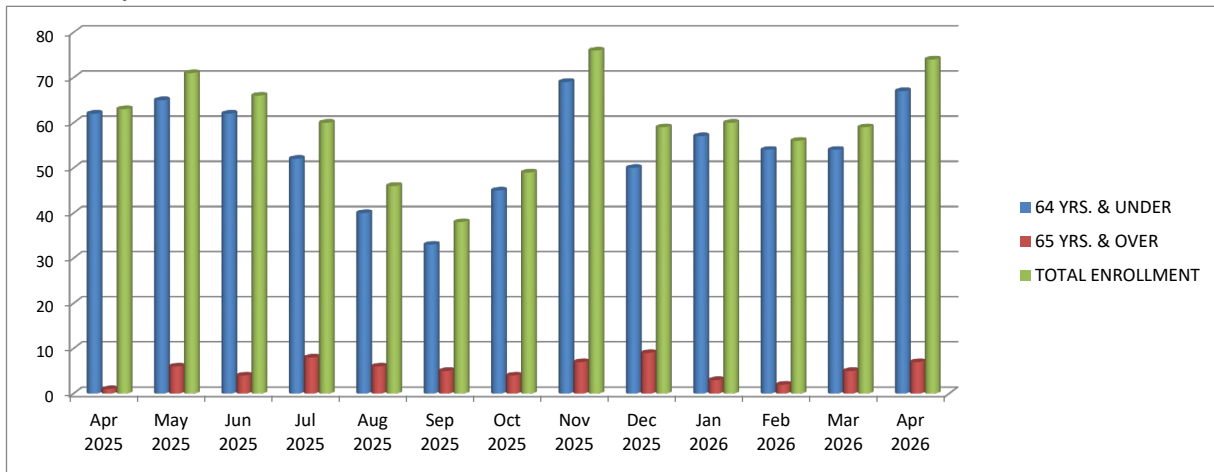


	Beginning Work Item Count	Work Items Received	Work Items Completed	Work Item Rejected	Work Items Delayed	Work Item Ending Count
Apr-25	8378	5702	4776	574	1849	8730
May-25	8849	7237	6888	553	1612	8645
Jun-25	8633	6847	6128	574	1272	8778
Jul-25	8783	6552	5803	586	1635	8946
Aug-25	8960	5405	5030	515	1116	8820
Sep-25	8821	5408	5161	524	992	8544
Oct-25	8550	6452	6098	630	1751	8274
Nov-25	8278	4840	4600	274	959	8244
Dec-25	8245	6729	5637	552	1045	8785
Jan-26	8785	7142	4912	571	1332	10444
Feb-26	10444	9315	7715	926	1370	11118
Mar-26	11121	8975	7989	1039	2121	11068
Apr-26	11077	9854	8832	1070	2476	11029

## Retirees Monthly Age Breakdown APRIL 2025 - APRIL 2026

### Disability Retirement

MONTH	64 YRS. & UNDER	65 YRS. & OVER	TOTAL ENROLLMENT
Apr 2025	62	1	63
May 2025	65	6	71
Jun 2025	62	4	66
Jul 2025	52	8	60
Aug 2025	40	6	46
Sep 2025	33	5	38
Oct 2025	45	4	49
Nov 2025	69	7	76
Dec 2025	50	9	59
Jan 2026	57	3	60
Feb 2026	54	2	56
Mar 2026	54	5	59
Apr 2026	67	7	74

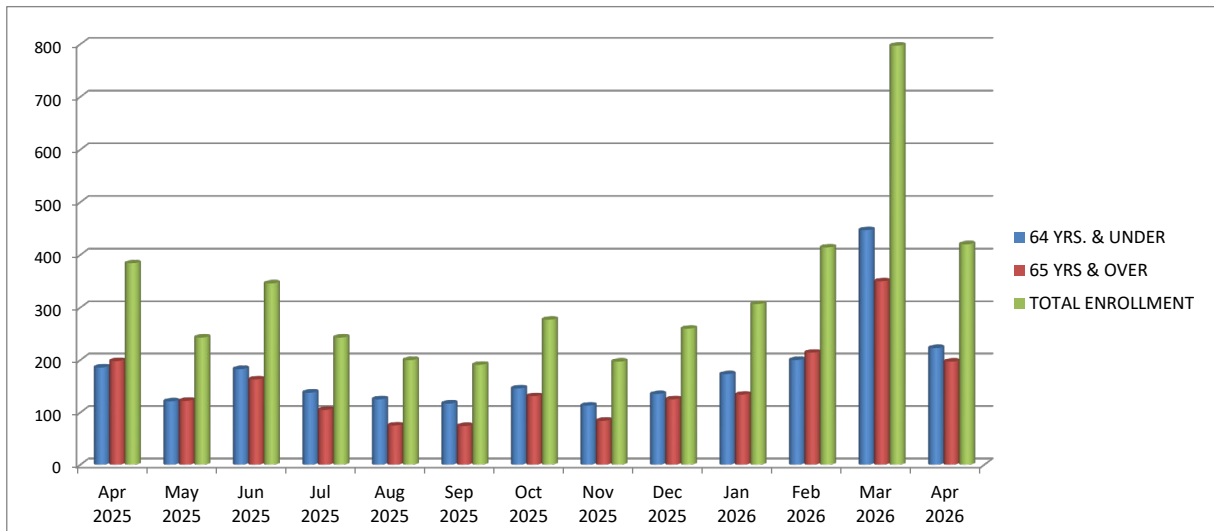


**PLEASE NOTE: Next Report will include the following dates: May 1, 2025, through May 31, 2026.**

## Retirees Monthly Age Breakdown APRIL 2025 - APRIL 2026

### Service Retirement

MONTH	64 YRS. & UNDER	65 YRS & OVER	TOTAL ENROLLMENT
Apr 2025	186	198	384
May 2025	121	122	243
Jun 2025	183	163	346
Jul 2025	138	105	243
Aug 2025	125	75	200
Sep 2025	117	74	191
Oct 2025	146	131	277
Nov 2025	113	84	197
Dec 2025	135	125	260
Jan 2026	173	134	307
Feb 2026	200	214	414
Mar 2026	447	350	797
Apr 2026	223	197	420



**PLEASE NOTE: Next Report will include the following dates: May 1, 2025, through May 31, 2026.**

**Medicare Part B Reimbursement and Penalty Report**  
**PAY PERIOD 5/31/2026**

<b>Deduction Code</b>	<b>No. of Members</b>	<b>Reimbursement Amount</b>	<b>No. of Penalties</b>	<b>Penalty Amount</b>
<b>ANTHEM BC III</b>				
240	8038	\$1,514,853.40	0	\$0.00
241	132	\$24,107.00	0	\$0.00
242	1058	\$205,277.30	0	\$0.00
243	4906	\$1,885,841.06	0	\$0.00
244	14	\$2,437.40	0	\$0.00
245	68	\$14,265.20	0	\$0.00
246	14	\$2,563.50	0	\$0.00
247	190	\$38,857.30	0	\$0.00
248	13	\$4,607.20	0	\$0.00
249	93	\$36,829.70	0	\$0.00
250	17	\$6,257.40	0	\$0.00
<b>Plan Total:</b>	<b>14,543</b>	<b>\$3,735,896.46</b>	<b>0</b>	<b>\$0.00</b>
<b>KAISER SR. ADVANTAGE</b>				
394	24	\$4,432.60	0	\$0.00
397	2	\$347.50	0	\$0.00
398	14	\$5,681.20	0	\$0.00
403	12586	\$2,316,383.76	0	\$0.00
413	1625	\$317,385.70	0	\$0.00
418	6581	\$2,493,296.77	1	\$51.50
419	199	\$33,689.70	0	\$0.00
426	257	\$47,520.70	0	\$0.00
445	2	\$405.80	0	\$0.00
451	39	\$7,106.60	0	\$0.00
455	6	\$1,217.40	0	\$0.00
457	18	\$7,013.70	0	\$0.00
459	2	\$811.60	0	\$0.00
462	93	\$17,981.90	0	\$0.00
465	2	\$405.80	0	\$0.00
466	26	\$10,015.10	0	\$0.00
472	27	\$5,129.90	0	\$0.00
476	4	\$811.60	0	\$0.00
478	14	\$5,521.70	0	\$0.00
479	1	\$144.60	0	\$0.00
482	73	\$12,596.80	0	\$0.00
486	3	\$608.70	0	\$0.00
488	31	\$11,765.90	0	\$0.00
491	1	\$148.50	0	\$0.00
492	1	\$202.90	0	\$0.00
493	1	\$202.90	0	\$0.00
<b>Plan Total:</b>	<b>21,632</b>	<b>\$5,300,829.33</b>	<b>1</b>	<b>\$51.50</b>

**Medicare Part B Reimbursement and Penalty Report**  
**PAY PERIOD 5/31/2026**

<b>Deduction Code</b>	<b>No. of Members</b>	<b>Reimbursement Amount</b>	<b>No. of Penalties</b>	<b>Penalty Amount</b>
<b>SCAN</b>				
611	355	\$68,287.00	0	\$0.00
613	156	\$61,477.90	0	\$0.00
620	28	\$5,136.60	0	\$0.00
621	14	\$5,952.40	0	\$0.00
622	28	\$5,875.90	0	\$0.00
623	9	\$3,339.60	0	\$0.00
<b>Plan Total:</b>	<b>590</b>	<b>\$150,069.40</b>	<b>0</b>	<b>\$0.00</b>
<b>UNITED HEALTHCARE GROUP MEDICARE ADV. HMO</b>				
701	2267	\$436,350.90	0	\$0.00
702	416	\$85,181.50	0	\$0.00
703	1417	\$550,152.00	0	\$0.00
704	111	\$22,584.20	0	\$0.00
705	54	\$20,909.60	0	\$0.00
<b>Plan Total:</b>	<b>4,265</b>	<b>\$1,115,178.20</b>	<b>0</b>	<b>\$0.00</b>
<b>Grand Total:</b>	<b>41,030</b>	<b>\$10,301,973.39</b>	<b>1</b>	<b>\$51.50</b>

**Medicare Part B Reimbursement and Penalty Report**  
**PAY PERIOD 5/31/2026**

<b>Deduction Code</b>	<b>No. of Members</b>	<b>Reimbursement Amount</b>	<b>No. of Penalties</b>	<b>Penalty Amount</b>
<b>ANTHEM BC III</b>				
240	8038	\$1,514,853.40	0	\$0.00
241	132	\$24,107.00	0	\$0.00
242	1058	\$205,277.30	0	\$0.00
243	4906	\$1,885,841.06	0	\$0.00
244	14	\$2,437.40	0	\$0.00
245	68	\$14,265.20	0	\$0.00
246	14	\$2,563.50	0	\$0.00
247	190	\$38,857.30	0	\$0.00
248	13	\$4,607.20	0	\$0.00
249	93	\$36,829.70	0	\$0.00
250	17	\$6,257.40	0	\$0.00
<b>Plan Total:</b>	<b>14,543</b>	<b>\$3,735,896.46</b>	<b>0</b>	<b>\$0.00</b>
<b>KAISER SR. ADVANTAGE</b>				
394	24	\$4,432.60	0	\$0.00
397	2	\$347.50	0	\$0.00
398	14	\$5,681.20	0	\$0.00
403	12586	\$2,316,383.76	0	\$0.00
413	1625	\$317,385.70	0	\$0.00
418	6581	\$2,493,296.77	1	\$51.50
419	199	\$33,689.70	0	\$0.00
426	257	\$47,520.70	0	\$0.00
445	2	\$405.80	0	\$0.00
451	39	\$7,106.60	0	\$0.00
455	6	\$1,217.40	0	\$0.00
457	18	\$7,013.70	0	\$0.00
459	2	\$811.60	0	\$0.00
462	93	\$17,981.90	0	\$0.00
465	2	\$405.80	0	\$0.00
466	26	\$10,015.10	0	\$0.00
472	27	\$5,129.90	0	\$0.00
476	4	\$811.60	0	\$0.00
478	14	\$5,521.70	0	\$0.00
479	1	\$144.60	0	\$0.00
482	73	\$12,596.80	0	\$0.00
486	3	\$608.70	0	\$0.00
488	31	\$11,765.90	0	\$0.00
491	1	\$148.50	0	\$0.00
492	1	\$202.90	0	\$0.00
493	1	\$202.90	0	\$0.00
<b>Plan Total:</b>	<b>21,632</b>	<b>\$5,300,829.33</b>	<b>1</b>	<b>\$51.50</b>

**Medicare Part B Reimbursement and Penalty Report**  
**PAY PERIOD 5/31/2026**

<b>Deduction Code</b>	<b>No. of Members</b>	<b>Reimbursement Amount</b>	<b>No. of Penalties</b>	<b>Penalty Amount</b>
<b>SCAN</b>				
611	355	\$68,287.00	0	\$0.00
613	156	\$61,477.90	0	\$0.00
620	28	\$5,136.60	0	\$0.00
621	14	\$5,952.40	0	\$0.00
622	28	\$5,875.90	0	\$0.00
623	9	\$3,339.60	0	\$0.00
<b>Plan Total:</b>	<b>590</b>	<b>\$150,069.40</b>	<b>0</b>	<b>\$0.00</b>
<b>UNITED HEALTHCARE GROUP MEDICARE ADV. HMO</b>				
701	2267	\$436,350.90	0	\$0.00
702	416	\$85,181.50	0	\$0.00
703	1417	\$550,152.00	0	\$0.00
704	111	\$22,584.20	0	\$0.00
705	54	\$20,909.60	0	\$0.00
<b>Plan Total:</b>	<b>4,265</b>	<b>\$1,115,178.20</b>	<b>0</b>	<b>\$0.00</b>
<b>LOCAL 1014</b>				
804	211	\$59,103.90	0	\$0.00
805	251	\$59,449.10	0	\$0.00
806	789	\$357,023.20	0	\$0.00
807	65	\$13,756.70	0	\$0.00
808	26	\$14,040.60	0	\$0.00
812	271	\$60,910.55	0	\$0.00
813	2	\$405.80	0	\$0.00
814	1	\$202.90	0	\$0.00
<b>Plan Total:</b>	<b>1,616</b>	<b>\$564,892.75</b>	<b>0</b>	<b>\$0.00</b>
<b>Grand Total:</b>	<b>42,646</b>	<b>\$10,866,866.14</b>	<b>1</b>	<b>\$51.50</b>

## Medical and Dental Vision Insurance Premiums June 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
<b>Medical Plan</b>							
<b>Anthem Blue Cross Prudent Buyer Plan</b>							
201	388	\$475,948.20	\$67,535.98	\$413,293.74	\$480,829.72	\$0.00	\$480,829.72
202	203	\$492,500.20	\$38,294.93	\$432,583.31	\$470,878.24	\$0.00	\$470,878.24
203	74	\$206,071.72	\$29,338.09	\$160,464.81	\$189,802.90	\$2,711.47	\$192,514.37
204	26	\$40,791.92	\$9,287.99	\$29,935.01	\$39,223.00	\$1,568.92	\$40,791.92
<b>SUBTOTAL</b>	<b>691</b>	<b>\$1,215,312.04</b>	<b>\$144,456.99</b>	<b>\$1,036,276.87</b>	<b>\$1,180,733.86</b>	<b>\$4,280.39</b>	<b>\$1,185,014.25</b>
<b>Anthem Blue Cross I</b>							
211	491	\$784,476.00	\$47,163.66	\$735,727.54	\$782,891.20	(\$1,584.80)	\$781,306.40
212	213	\$608,732.70	\$34,923.54	\$593,814.46	\$628,738.00	\$2,857.90	\$631,595.90
213	74	\$249,476.20	\$21,104.34	\$228,371.86	\$249,476.20	\$0.00	\$249,476.20
214	26	\$54,525.12	\$4,613.64	\$49,911.48	\$54,525.12	\$0.00	\$54,525.12
215	2	\$1,069.92	\$171.19	\$898.73	\$1,069.92	\$0.00	\$1,069.92
<b>SUBTOTAL</b>	<b>806</b>	<b>\$1,698,279.94</b>	<b>\$107,976.37</b>	<b>\$1,608,724.07</b>	<b>\$1,716,700.44</b>	<b>\$1,273.10</b>	<b>\$1,717,973.54</b>
<b>Anthem Blue Cross II</b>							
221	2,511	\$4,011,128.80	\$184,284.59	\$3,828,684.59	\$4,012,969.18	\$4.00	\$4,012,973.18
222	2,099	\$6,050,174.30	\$147,639.19	\$5,831,432.51	\$5,979,071.70	(\$2,857.90)	\$5,976,213.80
223	1,011	\$3,418,498.20	\$135,189.04	\$3,367,591.66	\$3,502,780.70	\$6,742.60	\$3,509,523.30
224	271	\$578,805.12	\$51,719.36	\$524,988.64	\$576,708.00	\$0.00	\$576,708.00
225	1	\$534.96	\$0.00	\$534.96	\$534.96	\$0.00	\$534.96
<b>SUBTOTAL</b>	<b>5,893</b>	<b>\$14,059,141.38</b>	<b>\$518,832.18</b>	<b>\$13,553,232.36</b>	<b>\$14,072,064.54</b>	<b>\$3,888.70</b>	<b>\$14,075,953.24</b>

## Medical and Dental Vision Insurance Premiums June 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
<b>Anthem Blue Cross III</b>							
240	8,078	\$5,200,418.10	\$649,496.08	\$4,640,202.06	\$5,289,698.14	(\$6,519.00)	\$5,283,179.14
241	131	\$271,562.28	\$18,639.00	\$250,865.99	\$269,504.99	\$0.00	\$269,504.99
242	1,048	\$2,188,956.56	\$113,413.02	\$2,063,199.80	\$2,176,612.82	\$2,057.29	\$2,178,670.11
243	4,922	\$6,314,982.12	\$633,702.20	\$5,662,144.75	\$6,295,846.95	(\$7,682.46)	\$6,288,164.49
244	14	\$16,125.62	\$1,336.13	\$14,789.49	\$16,125.62	\$0.00	\$16,125.62
245	69	\$79,476.27	\$5,643.97	\$80,743.28	\$86,387.25	\$0.00	\$86,387.25
246	15	\$38,490.75	\$3,284.54	\$32,640.16	\$35,924.70	\$0.00	\$35,924.70
247	197	\$508,077.90	\$22,273.31	\$478,106.44	\$500,379.75	\$0.00	\$500,379.75
248	13	\$23,258.04	\$2,111.13	\$22,935.99	\$25,047.12	\$0.00	\$25,047.12
249	94	\$168,173.52	\$13,567.04	\$152,787.40	\$166,354.44	\$0.00	\$166,354.44
250	17	\$34,087.04	\$2,606.65	\$31,480.39	\$34,087.04	\$0.00	\$34,087.04
<b>SUBTOTAL</b>	<b>14,598</b>	<b>\$14,843,608.20</b>	<b>\$1,466,073.07</b>	<b>\$13,429,895.75</b>	<b>\$14,895,968.82</b>	<b>(\$12,144.17)</b>	<b>\$14,883,824.65</b>
<b>CIGNA Network Model Plan</b>							
301	200	\$407,481.27	\$97,595.82	\$299,749.10	\$397,344.92	(\$2,027.27)	\$395,317.65
302	51	\$186,716.10	\$44,335.52	\$142,380.58	\$186,716.10	\$0.00	\$186,716.10
303	7	\$30,261.49	\$8,558.13	\$26,026.43	\$34,584.56	\$0.00	\$34,584.56
304	11	\$29,592.09	\$10,550.23	\$19,041.86	\$29,592.09	\$0.00	\$29,592.09
<b>SUBTOTAL</b>	<b>269</b>	<b>\$654,050.95</b>	<b>\$161,039.70</b>	<b>\$487,197.97</b>	<b>\$648,237.67</b>	<b>(\$2,027.27)</b>	<b>\$646,210.40</b>

## Medical and Dental Vision Insurance Premiums June 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
<b>Kaiser/Senior Advantage</b>							
401	1,676	\$2,394,076.69	\$162,604.83	\$2,252,573.79	\$2,415,178.62	\$4,232.31	\$2,419,410.93
403	12,588	\$3,691,248.96	\$314,521.80	\$3,401,187.44	\$3,715,709.24	(\$3,791.49)	\$3,711,917.75
404	436	\$596,025.08	\$9,733.22	\$593,127.01	\$602,860.23	(\$1,367.03)	\$601,493.20
405	1,491	\$2,114,423.35	\$16,773.96	\$2,084,920.42	\$2,101,694.38	\$0.00	\$2,101,694.38
411	2,053	\$5,854,976.74	\$214,690.70	\$5,550,372.00	\$5,765,062.70	(\$2,813.54)	\$5,762,249.16
413	1,607	\$2,775,476.34	\$128,499.33	\$2,624,949.42	\$2,753,448.75	\$1,694.43	\$2,755,143.18
414	43	\$119,101.40	\$332.37	\$115,999.23	\$116,331.60	\$0.00	\$116,331.60
418	6,545	\$3,787,906.88	\$264,609.92	\$3,526,115.60	\$3,790,725.52	(\$4,602.56)	\$3,786,122.96
419	204	\$338,391.45	\$4,159.77	\$330,930.30	\$335,090.07	\$0.00	\$335,090.07
420	89	\$242,619.34	\$1,308.50	\$241,310.84	\$242,619.34	(\$2,726.06)	\$239,893.28
421	9	\$12,696.93	\$733.59	\$17,336.42	\$18,070.01	\$0.00	\$18,070.01
422	274	\$785,970.90	\$2,929.78	\$760,504.32	\$763,434.10	\$0.00	\$763,434.10
426	255	\$438,081.42	\$4,414.80	\$430,270.64	\$434,685.44	\$0.00	\$434,685.44
428	39	\$108,161.04	\$554.67	\$107,606.37	\$108,161.04	\$0.00	\$108,161.04
430	140	\$394,892.40	\$1,974.47	\$392,917.93	\$394,892.40	\$0.00	\$394,892.40
<b>SUBTOTAL</b>	<b>27,449</b>	<b>\$23,654,048.92</b>	<b>\$1,127,841.71</b>	<b>\$22,430,121.73</b>	<b>\$23,557,963.44</b>	<b>(\$9,373.94)</b>	<b>\$23,548,589.50</b>
<b>Kaiser - Colorado</b>							
450	5	\$7,109.00	\$284.36	\$9,668.24	\$9,952.60	\$0.00	\$9,952.60
451	40	\$11,916.00	\$1,483.54	\$10,432.46	\$11,916.00	\$0.00	\$11,916.00
453	9	\$28,321.11	\$2,942.96	\$25,378.15	\$28,321.11	\$0.00	\$28,321.11
455	6	\$10,270.20	\$924.32	\$9,345.88	\$10,270.20	\$0.00	\$10,270.20
457	18	\$10,580.40	\$1,034.53	\$9,545.87	\$10,580.40	\$0.00	\$10,580.40
459	2	\$4,003.20	\$80.06	\$3,923.14	\$4,003.20	\$0.00	\$4,003.20
<b>SUBTOTAL</b>	<b>80</b>	<b>\$72,199.91</b>	<b>\$6,749.77</b>	<b>\$68,293.74</b>	<b>\$75,043.51</b>	<b>\$0.00</b>	<b>\$75,043.51</b>

## Medical and Dental Vision Insurance Premiums June 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
<b>Kaiser - Georgia</b>							
440	1	\$1,780.87	\$196.07	\$1,584.80	\$1,780.87	\$0.00	\$1,780.87
441	3	\$5,342.61	\$588.21	\$4,754.40	\$5,342.61	\$0.00	\$5,342.61
442	6	\$10,685.22	\$1,176.42	\$9,508.80	\$10,685.22	\$0.00	\$10,685.22
445	2	\$4,373.48	\$0.00	\$4,373.48	\$4,373.48	\$0.00	\$4,373.48
461	15	\$26,713.05	\$4,430.76	\$22,282.29	\$26,713.05	\$0.00	\$26,713.05
462	93	\$38,489.91	\$4,958.11	\$34,359.54	\$39,317.65	\$0.00	\$39,317.65
463	3	\$10,661.22	\$3,516.47	\$7,144.75	\$10,661.22	\$0.00	\$10,661.22
465	2	\$4,373.48	\$0.00	\$4,373.48	\$4,373.48	\$0.00	\$4,373.48
466	26	\$21,313.24	\$1,327.98	\$19,985.26	\$21,313.24	\$0.00	\$21,313.24
<b>SUBTOTAL</b>	<b>151</b>	<b>\$123,733.08</b>	<b>\$16,194.02</b>	<b>\$108,366.80</b>	<b>\$124,560.82</b>	<b>\$0.00</b>	<b>\$124,560.82</b>
<b>Kaiser - Hawaii</b>							
471	5	\$4,814.20	\$577.71	\$4,236.49	\$4,814.20	\$0.00	\$4,814.20
472	27	\$12,075.75	\$1,806.89	\$10,268.86	\$12,075.75	\$0.00	\$12,075.75
473	2	\$4,445.00	\$1,275.40	\$3,169.60	\$4,445.00	\$0.00	\$4,445.00
474	3	\$5,753.04	\$0.00	\$5,753.04	\$5,753.04	\$0.00	\$5,753.04
475	2	\$5,745.04	\$0.00	\$5,745.04	\$5,745.04	\$0.00	\$5,745.04
476	4	\$5,608.36	\$616.92	\$4,991.44	\$5,608.36	\$0.00	\$5,608.36
478	14	\$12,411.00	\$602.82	\$11,808.18	\$12,411.00	\$0.00	\$12,411.00
479	1	\$2,661.75	\$0.00	\$2,661.75	\$2,661.75	\$0.00	\$2,661.75
<b>SUBTOTAL</b>	<b>58</b>	<b>\$53,514.14</b>	<b>\$4,879.74</b>	<b>\$48,634.40</b>	<b>\$53,514.14</b>	<b>\$0.00</b>	<b>\$53,514.14</b>

## Medical and Dental Vision Insurance Premiums June 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
<b>Kaiser - Oregon</b>							
481	3	\$4,244.88	\$0.00	\$7,074.80	\$7,074.80	\$0.00	\$7,074.80
482	74	\$42,390.00	\$5,346.80	\$35,347.60	\$40,694.40	\$0.00	\$40,694.40
483	5	\$8,661.05	\$1,117.40	\$7,543.65	\$8,661.05	\$0.00	\$8,661.05
484	3	\$8,465.76	\$0.00	\$8,465.76	\$8,465.76	\$0.00	\$8,465.76
486	3	\$5,916.48	\$0.00	\$5,916.48	\$5,916.48	\$0.00	\$5,916.48
488	31	\$34,794.40	\$4,803.86	\$29,990.54	\$34,794.40	\$0.00	\$34,794.40
491	1	\$1,930.86	\$0.00	\$1,930.86	\$1,930.86	\$0.00	\$1,930.86
492	1	\$2,289.41	\$0.00	\$2,289.41	\$2,289.41	\$0.00	\$2,289.41
493	1	\$3,379.12	\$7.82	\$3,371.30	\$3,379.12	\$0.00	\$3,379.12
<b>SUBTOTAL</b>	<b>122</b>	<b>\$112,071.96</b>	<b>\$11,275.88</b>	<b>\$101,930.40</b>	<b>\$113,206.28</b>	<b>\$0.00</b>	<b>\$113,206.28</b>
<b>SCAN Health Plan</b>							
611	359	\$103,144.29	\$17,864.77	\$86,428.76	\$104,293.53	(\$287.31)	\$104,006.22
613	155	\$88,392.72	\$14,029.43	\$74,363.29	\$88,392.72	(\$566.62)	\$87,826.10
<b>SUBTOTAL</b>	<b>514</b>	<b>\$191,537.01</b>	<b>\$31,894.20</b>	<b>\$160,792.05</b>	<b>\$192,686.25</b>	<b>(\$853.93)</b>	<b>\$191,832.32</b>
<b>SCAN Health Plan, AZ</b>							
620	28	\$8,044.68	\$1,154.98	\$6,889.70	\$8,044.68	\$0.00	\$8,044.68
621	14	\$7,932.68	\$1,371.22	\$7,128.08	\$8,499.30	\$0.00	\$8,499.30
<b>SUBTOTAL</b>	<b>42</b>	<b>\$15,977.36</b>	<b>\$2,526.20</b>	<b>\$14,017.78</b>	<b>\$16,543.98</b>	<b>\$0.00</b>	<b>\$16,543.98</b>
<b>SCAN Health Plan, NV</b>							
622	28	\$8,331.99	\$1,419.30	\$7,487.31	\$8,906.61	\$0.00	\$8,906.61
623	9	\$5,099.58	\$634.61	\$4,464.97	\$5,099.58	\$0.00	\$5,099.58
<b>SUBTOTAL</b>	<b>37</b>	<b>\$13,431.57</b>	<b>\$2,053.91</b>	<b>\$11,952.28</b>	<b>\$14,006.19</b>	<b>\$0.00</b>	<b>\$14,006.19</b>

## Medical and Dental Vision Insurance Premiums June 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
<b>UHC Medicare Adv.</b>							
701	2,267	\$882,611.10	\$96,490.45	\$798,906.50	\$895,396.95	(\$387.45)	\$895,009.50
702	408	\$865,754.55	\$38,823.97	\$845,615.93	\$884,439.90	\$0.00	\$884,439.90
703	1,410	\$1,088,231.10	\$102,022.40	\$992,343.90	\$1,094,366.30	(\$1,533.80)	\$1,092,832.50
704	113	\$269,843.70	\$7,716.58	\$269,228.27	\$276,944.85	\$0.00	\$276,944.85
705	54	\$57,121.20	\$3,236.87	\$53,884.33	\$57,121.20	\$0.00	\$57,121.20
706	2	\$967.32	\$58.04	\$909.28	\$967.32	\$0.00	\$967.32
<b>SUBTOTAL</b>	<b>4,254</b>	<b>\$3,164,528.97</b>	<b>\$248,348.31</b>	<b>\$2,960,888.21</b>	<b>\$3,209,236.52</b>	<b>(\$1,921.25)</b>	<b>\$3,207,315.27</b>
<b>United Healthcare</b>							
707	546	\$948,455.30	\$114,434.59	\$827,233.91	\$941,668.50	\$0.00	\$941,668.50
708	461	\$1,460,227.17	\$160,964.39	\$1,262,119.54	\$1,423,083.93	\$0.00	\$1,423,083.93
709	339	\$1,260,970.90	\$149,135.63	\$1,078,748.57	\$1,227,884.20	\$0.00	\$1,227,884.20
<b>SUBTOTAL</b>	<b>1,346</b>	<b>\$3,669,653.37</b>	<b>\$424,534.61</b>	<b>\$3,168,102.02</b>	<b>\$3,592,636.63</b>	<b>\$0.00</b>	<b>\$3,592,636.63</b>

## Medical and Dental Vision Insurance Premiums June 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
<b>Local 1014 Firefighters</b>							
801	85	\$123,399.60	\$6,823.24	\$113,672.84	\$120,496.08	\$0.00	\$120,496.08
802	344	\$900,464.72	\$31,673.39	\$871,408.96	\$903,082.35	\$0.00	\$903,082.35
803	438	\$1,352,430.12	\$45,883.94	\$1,330,043.65	\$1,375,927.59	\$6,175.48	\$1,382,103.07
804	211	\$306,321.36	\$9,233.15	\$297,088.21	\$306,321.36	(\$59,103.90)	\$247,217.46
805	252	\$659,642.76	\$16,909.91	\$640,115.22	\$657,025.13	(\$59,449.10)	\$597,576.03
806	790	\$2,067,927.70	\$43,400.30	\$2,019,501.55	\$2,062,901.85	(\$364,876.09)	\$1,698,025.76
807	65	\$200,703.10	\$2,223.18	\$198,479.92	\$200,703.10	(\$13,756.70)	\$186,946.40
808	26	\$80,281.24	\$1,976.16	\$81,145.80	\$83,121.96	(\$14,040.60)	\$69,081.36
809	14	\$20,324.64	\$871.05	\$19,453.59	\$20,324.64	\$0.00	\$20,324.64
810	9	\$23,558.67	\$3,088.80	\$20,469.87	\$23,558.67	\$0.00	\$23,558.67
811	5	\$15,438.70	\$1,852.65	\$13,586.05	\$15,438.70	\$0.00	\$15,438.70
812	273	\$396,330.48	\$23,111.93	\$381,929.11	\$405,041.04	(\$60,910.55)	\$344,130.49
813	2	\$5,235.26	\$0.00	\$5,235.26	\$5,235.26	(\$405.80)	\$4,829.46
814	1	\$3,087.74	\$988.08	\$2,099.66	\$3,087.74	(\$202.90)	\$2,884.84
<b>SUBTOTAL</b>	<b>2,515</b>	<b>\$6,155,146.09</b>	<b>\$188,035.78</b>	<b>\$5,994,229.69</b>	<b>\$6,182,265.47</b>	<b>(\$566,570.16)</b>	<b>\$5,615,695.31</b>
<b>Kaiser - Washington</b>							
393	5	\$12,075.18	\$2,566.38	\$5,483.74	\$8,050.12	\$0.00	\$8,050.12
394	24	\$10,029.84	\$1,245.36	\$8,784.48	\$10,029.84	\$0.00	\$10,029.84
395	1	\$3,751.26	\$893.36	\$2,857.90	\$3,751.26	\$0.00	\$3,751.26
397	2	\$4,313.28	\$0.00	\$4,313.28	\$4,313.28	\$0.00	\$4,313.28
398	14	\$11,589.48	\$1,192.07	\$10,397.41	\$11,589.48	\$0.00	\$11,589.48
<b>SUBTOTAL</b>	<b>46</b>	<b>\$41,759.04</b>	<b>\$5,897.17</b>	<b>\$31,836.81</b>	<b>\$37,733.98</b>	<b>\$0.00</b>	<b>\$37,733.98</b>
<b>Medical Plan Total</b>	<b>58,871</b>	<b>\$69,737,993.93</b>	<b>\$4,468,609.61</b>	<b>\$65,214,492.93</b>	<b>\$69,683,102.54</b>	<b>(\$583,448.53)</b>	<b>\$69,099,654.01</b>

## Medical and Dental Vision Insurance Premiums June 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
<b>Dental/Vision Plan</b>							
<b>CIGNA Indemnity Dental/Vision</b>							
501	27,809	\$1,563,203.00	\$152,831.73	\$1,430,201.51	\$1,583,033.24	(\$1,451.64)	\$1,581,581.60
502	25,579	\$3,017,451.72	\$222,172.56	\$2,819,223.91	\$3,041,396.47	(\$2,379.04)	\$3,039,017.43
503	12	\$831.60	\$27.71	\$873.19	\$900.90	\$0.00	\$900.90
<b>SUBTOTAL</b>	<b>53,400</b>	<b>\$4,581,486.32</b>	<b>\$375,032.00</b>	<b>\$4,250,298.61</b>	<b>\$4,625,330.61</b>	<b>(\$3,830.68)</b>	<b>\$4,621,499.93</b>
<b>CIGNA Dental HMO/Vision</b>							
901	4,522	\$210,958.20	\$21,228.22	\$192,479.22	\$213,707.44	(\$46.60)	\$213,660.84
902	3,428	\$328,252.55	\$22,266.25	\$307,132.04	\$329,398.29	(\$286.35)	\$329,111.94
903	3	\$141.63	\$26.45	\$304.02	\$330.47	\$0.00	\$330.47
<b>SUBTOTAL</b>	<b>7,953</b>	<b>\$539,352.38</b>	<b>\$43,520.92</b>	<b>\$499,915.28</b>	<b>\$543,436.20</b>	<b>(\$332.95)</b>	<b>\$543,103.25</b>
<b>Dental/Vision Plan Total</b>	<b>61,353</b>	<b>\$5,120,838.70</b>	<b>\$418,552.92</b>	<b>\$4,750,213.89</b>	<b>\$5,168,766.81</b>	<b>(\$4,163.63)</b>	<b>\$5,164,603.18</b>
<b>GRAND TOTALS</b>	<b>120,224</b>	<b>\$74,858,832.63</b>	<b>\$4,887,162.53</b>	<b>\$69,964,706.82</b>	<b>\$74,851,869.35</b>	<b>(\$587,612.16)</b>	<b>\$74,264,257.19</b>

CARRIER DEDUCTION PREMIUMS*	CODES	DEDUCTION CODE DEFINITIONS
<b><u>Anthem Blue Cross Prudent Buyer Plan</u></b>		
\$1,220.38	201	Retiree Only
\$2,402.44	202	Retiree and Spouse/Domestic Partner
\$2,711.47	203	Retiree, Spouse/Domestic Partner and Children
\$1,568.92	204	Retiree and Children
\$331.92	205	Survivor Children Only Rates
<b><u>Anthem Blue Cross Plan I</u></b>		
<b>\$1,584.80</b>	211	Retiree Only
<b>\$2,857.90</b>	212	Retiree and Spouse/Domestic Partner
<b>\$3,371.30</b>	213	Retiree, Spouse/Domestic Partner and Children
<b>\$2,097.12</b>	214	Retiree and Children
\$534.96	215	Survivor Children Only Rates
<b><u>Anthem Blue Cross Plan II</u></b>		
<b>\$1,584.80</b>	221	Retiree Only
<b>\$2,857.90</b>	222	Retiree and Spouse/Domestic Partner
<b>\$3,371.30</b>	223	Retiree, Spouse/Domestic Partner and Children
<b>\$2,097.12</b>	224	Retiree and Children
\$534.96	225	Survivor Children Only Rates
<b><u>Anthem Blue Cross Plan III</u></b>		
\$642.90	240	Retiree Only with Medicare
\$2,057.29	241	Retiree and Spouse/Domestic Partner - One with Medicare (Non-Medicare has Anthem Blue Cross I)
\$2,057.29	242	Retiree and Spouse/Domestic Partner - One with Medicare (Non-Medicare has Anthem Blue Cross II)
\$1,280.41	243	Retiree and Spouse/Domestic Partner - Both with Medicare
\$1,151.83	244	Retiree and Children (Retiree has Medicare; Children have Anthem Blue Cross I)
\$1,151.83	245	Retiree and Children (Retiree has Medicare; Children have Anthem Blue Cross II)
\$2,566.05	246	Retiree, Spouse/Domestic Partner and Children - One with Medicare (Non-Medicare has Anthem Blue Cross I)
\$2,566.05	247	Retiree, Spouse/Domestic Partner and Children - One with Medicare (Non-Medicare has Anthem Blue Cross II)
\$1,789.08	248	Retiree, Spouse/Domestic Partner and Children - Two with Medicare (Children have Anthem Blue Cross I)
\$1,789.08	249	Retiree, Spouse/Domestic Partner and Children - Two with Medicare (Children have Anthem Blue Cross II)
\$2,005.12	250	Member, Spouse/Domestic Partner, Child (3 with Medicare)

\*Benchmark premiums are bolded.

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
<b><u>CIGNA Network Model Plan</u></b>		
\$2,027.27	301	Retiree Only
\$3,661.10	302	Retiree and Spouse/Domestic Partner
\$4,323.07	303	Retiree, Spouse/Domestic Partner and Children
\$2,690.19	304	Retiree and Children
\$670.42	305	Survivor Children Only Rates
<b><u>Kaiser</u></b>		
\$1,410.77	401	Retiree Only ("Basic")
\$291.66	403	Retiree Only ("Senior Advantage")
\$1,367.03	404	Retiree Only ("Excess I") <i>"Closed to New Entrants"</i>
\$1,414.33	405	Retiree Only - ("Excess II")
\$2,813.54	411	Retiree and Family (All family members are "Basic")
\$1,694.43	413	Retiree and Family (One family member is "Senior Advantage"; others are "Basic")
\$2,769.80	414	Retiree and Family (One family member is "Excess I"; others are "Basic") <i>"Closed to New Entrants"</i>
\$575.32	418	Retiree and Family (Two or more family members are "Senior Advantage")
\$1,650.69	419	Retiree and Family (One family member is "Excess I"; others are "Senior Advantage") <i>"Closed to New Entrants"</i>
\$2,726.06	420	Retiree and Family (Two or more family members are "Excess I") <i>"Closed to New Entrants"</i>
N/A	421	Survivor Children Only Rates
\$2,817.10	422	Retiree and Family (One family member is "Excess II"; others are "Basic")
\$1,697.99	426	Retiree and Family (One family member is "Senior Advantage"; others are "Excess II")
\$2,773.36	428	Retiree and Family (One family member is "Excess I"; others are "Excess II")
\$2,820.66	430	Retiree and Family (Two or more family members are "Excess II")
<b><u>Kaiser Colorado</u></b>		
\$1,421.80	450	Retiree Only ("Basic" under age 65)
\$297.90	451	Retiree Only ("Senior Advantage")
\$3,146.79	453	Retiree and Family (Two family members are "Basic")
\$4,249.55	454	Retiree and Family (Three or more family members are "Basic")
\$1,711.70	455	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic")
\$587.80	457	Retiree and Family (Two family members are "Senior Advantage")
\$3,043.28	458	Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic")
\$2,001.60	459	Retiree and Family (Two family members are "Senior Advantage"; one or more are "Basic")

\*Benchmark premiums are bolded.

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
<b><u>Kaiser Georgia</u></b>		
\$1,780.87	440	Retiree Only ("Basic" over age 65 with Medicare Part B only)
\$1,780.87	441	Retiree Only ("Basic over age 65 with Medicare Part A only)
\$1,780.87	442	Retiree Only ("Basic over age 65 without Medicare Part A or Medicare Part B)
\$413.87	443	Retiree Only ("Basic" over age 65 - Medicare eligible who is classified as having renal failure)
\$2,186.74	444	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic" over age 65 with Medicare Part B only)
\$2,186.74	445	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic" over age 65 with Medicare Part A only)
\$2,186.74	446	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic" over age 65 without Medicare Part A and B)
\$1,780.87	461	Retiree Only ("Basic" under age 65)
\$413.87	462	Retiree Only ("Senior Advantage")
\$3,553.74	463	Retiree and Family (Two family members are "Basic")
\$5,326.61	464	Retiree and Family (Three or more family members are "Basic")
\$2,186.74	465	Retiree and Family (One family member is "Senior Advantage"; one is "Basic")
\$819.74	466	Retiree and Family (Two family members are "Senior Advantage")
\$3,959.61	467	Retiree and Family ( One family member is "Senior Advantage"; two or more are "Basic")
\$2,592.61	468	Retiree and Family (Two family members are "Senior Advantage"; one is "Basic")
\$1,225.61	469	Retiree and Family (Three or more family members are "Senior Advantage"; one is "Basic")
\$3,959.61	470	Retiree and Family (Three or more family members are "Basic"; one is "Senior Advantage")
<b><u>Kaiser Hawaii</u></b>		
\$962.84	471	Retiree Only ("Basic" under age 65)
\$447.25	472	Retiree Only ("Senior Advantage")
\$2,222.50	473	Retiree Only (Over age 65 without Medicare Part A or Medicare Part B)
\$1,917.68	474	Retiree and Family (Two family members are "Basic")
\$2,872.52	475	Retiree and Family (Three or more family members are "Basic")
\$1,402.09	476	Retiree and Family (One family member is "Senior Advantage"; one is "Basic")
\$3,177.34	477	Retiree and Family (One family member is "Basic" under age 65; one is over age 65 without Medicare Part A or Medicare Part B)
\$886.50	478	Retiree and Family (Two family members are "Senior Advantage")
\$2,661.75	479	Retiree and Family (One family member is "Senior Advantage"; one is over age 65 without Medicare Part A or Medicare Part B)

\*Benchmark premiums are bolded.

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
<b><u>Kaiser Oregon</u></b>		
\$1,414.96	481	Retiree Only ("Basic" under age 65)
\$565.20	482	Retiree Only ("Senior Advantage")
\$1,732.21	483	Retiree Only (Over age 65 without Medicare Part A or Medicare Part B)
\$2,821.92	484	Retiree and Family (Two family members are "Basic")
\$4,228.88	485	Retiree and Family (Three or more family members are "Basic")
\$1,972.16	486	Retiree and Family (One family member is "Senior Advantage"; one is "Basic")
\$1,122.40	488	Retiree and Family (Two family members are "Senior Advantage")
\$1,732.21	490	Retiree Only (Over age 65 with Medicare Part B only)
\$1,930.86	491	Retiree and Family (One family member is "Senior Advantage"; one is over age 65 with Medicare Part A only)
\$2,289.41	492	Retiree and Family (One family member is "Senior Advantage"; one is over age 65 without Medicare Part A or Medicare Part B)
\$3,379.12	493	Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic")
\$2,529.36	494	Retiree and Family (Two family members are "Senior Advantage"; one is "Basic")
\$3,456.42	495	Retiree and Family (Two family members are over age 65 without Medicare Part A or Medicare Part B)
\$2,739.32	496	Retiree and Family (Two family members are over age 65 with Medicare Part A only)
\$2,780.62	497	Retiree and Family (One family member is "Basic"; one is over age 65 with Medicare Part A only)
\$3,139.17	498	Retiree and Family (One family member is "Basic"; one is over age 65 without Medicare Part A or Medicare Part B)
<b><u>Kaiser Washington</u></b>		
\$2,012.53	393	Retiree and Family ("Basic" under age 65)
\$417.92	394	Retiree Only ("Senior Advantage")
\$3,751.26	395	Retiree and Family (Two family members are "Basic")
\$6,275.96	396	Retiree and Family (Three or more family members are "Basic")
\$2,156.64	397	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic")
\$827.82	398	Retiree and Family (Two family members are "Senior Advantage")
\$4,681.34	399	Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic")
\$3,352.52	400	Retiree and Family (Two family members are "Senior Advantage"; one or more are "Basic")

\*Benchmark premiums are bolded.

<b>PREMIUMS*</b>	<b>CARRIER DEDUCTION CODES</b>	<b>DEDUCTION CODE DEFINITIONS</b>
------------------	--	-----------------------------------

---

**Kaiser Rate Category Definitions**

**"Basic"** - includes those who are under age 65

**"Senior Advantage"**

-Includes participants who are age 65 or older and who have assigned both Medicare Part A and Part B to Kaiser.

**"Excess II"**

-Is for participants in the Excess Plan who either have Medicare Part B only or are not eligible for Medicare.

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
<b><u>SCAN Health Plan</u></b>		
\$287.31	611	Retiree Only with SCAN
\$566.62	613	Retiree and 1 Dependent - Both with SCAN (Retiree and 1 Dependent = Retiree and Spouse/Domestic Partner OR Retiree and 1 Child. Both Retiree and Dependent must have Medicare.)
<b><u>SCAN Health Plan – Arizona (Maricopa, Pima, Pinal Counties)</u></b>		
\$287.31	620	Retiree Only
\$566.62	621	Retiree and Spouse/Domestic Partner or Retiree and One Child. Both Retiree and eligible dependent must be enrolled in Medicare Parts A & B.
<b><u>SCAN Health Plan – Nevada (Nye and Clark Counties)</u></b>		
\$287.31	622	Retiree Only
\$566.82	623	Retiree and Spouse/Domestic Partner or Retiree and One Child. Both Retiree and eligible dependent must be enrolled in Medicare Parts A & B
<b><u>United Healthcare Medicare Advantage (UHCMA)</u></b>		
(For both members and dependents who are enrolled in UHCMA, or a family combination of UHCMA/UHC)		
\$387.45	701	Retiree Only with Secure Horizons
\$2,076.15	702	Retiree and 1 Dependent - One with Secure Horizons (Retiree and 1 Dependent = Retiree and Spouse/Domestic Partner OR Retiree and 1 Child)
\$766.90	703	Retiree and 1 Dependent - Both with Secure Horizons (Retiree and 1 Dependent = Retiree and Spouse/Domestic Partner OR Retiree and 1 Child)
\$2,367.05	704	Retiree and 2 or More Dependents - One with Secure Horizons (Retiree and 2 or More Dependents = Retiree, Spouse/Domestic Partner and 1 or More Children OR Retiree and 2 or More Children)
\$1,057.80	705	Retiree and 2 or More Dependents - Two with Secure Horizons (Retiree and 2 or More Dependents = Retiree, Spouse/Domestic Partner and 1 or More Children OR Retiree and 2 or More Children)
\$483.66	706	Survivor Children Only Rates

\*Benchmark premiums are bolded.

CARRIER DEDUCTION PREMIUMS*	CODES	DEDUCTION CODE DEFINITIONS
-----------------------------------	-------	----------------------------

**United Healthcare (UHC)**

(For members and dependents under age 65 [no Medicare])

\$1,696.70	707	Retiree Only
\$3,100.27	708	Retiree and 1 Dependent
\$3,676.30	709	Retiree and 2 Or More Dependents

**Local 1014 Firefighters**

\$1,451.76	801	Member Under 65
\$2,617.63	802	Member + 1 Under 65
\$3,087.74	803	Member + 2 Under 65
\$1,451.76	804	Member with Medicare
\$2,617.63	805	Member + 1; 1 Medicare
\$2,617.63	806	Member + 1; 2 Medicare
\$3,087.74	807	Member + 2; 1 Medicare
\$3,087.74	808	Member + 2; 2 Medicare
\$1,451.76	809	Surviving Spouse Under 65
\$2,617.63	810	Surviving Spouse + 1; Under 65
\$3,087.74	811	Surviving Spouse + 2 Under 65
\$1,451.76	812	Surviving Spouse with Medicare
\$2,617.63	813	Surviving Spouse + 1; 1 Medicare
\$3,087.74	814	Spouse + 1; 1 Medicare
\$2,617.63	815	Surviving Spouse + 1; 2 Medicare

**CIGNA Indemnity - Dental/Vision**

<b>\$56.20</b>	501	Retiree Only
<b>\$117.86</b>	502	Retiree and Dependent(s)
\$69.30	503	Survivor Children Only Rates

**CIGNA HMO - Dental/Vision**

\$46.60	901	Retiree Only
\$95.45	902	Retiree and Dependent(s)
\$47.21	903	Survivor Children Only Rates

\*Benchmark premiums are bolded.



May 14, 2026

TO: Insurance, Benefits & Legislative Committee  
Les Robbins, Chair  
Aleen Langton, Vice Chair  
Ernesto Pantoja  
Shawn Kehoe  
Jason Green, Alternate

FROM: Cassandra Smith, Director   
Retiree Healthcare Division

FOR: June 3, 2026 Insurance, Benefits & Legislative Committee

SUBJECT: **ANTHEM BLUE CROSS AND CIGNA DENTAL JULY 2024 –  
JUNE 2025 ANNUAL AUDIT FINDINGS**

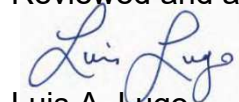
In administering the LACERA Retiree Healthcare Benefits Program (RHCBP), LACERA has a fiduciary obligation to ensure that participating health plans adjudicate incurred claims in accordance with approved plan benefits. To support contract compliance oversight, LACERA conducts an annual claims audit to identify potential discrepancies in vendor billing and claim payment activity affecting program participants.

Consistent with past practice, LACERA's Healthcare Consultant contract includes—within the Statement of Work—an annual claims audit of the LACERA-administered indemnity medical and dental plans: Anthem Blue Cross medical (Plans I, II, III, and Prudent Buyer) and the Cigna Indemnity dental PPO plan. These plans are included because claims are submitted and paid through paper and electronic claim transactions. By contrast, HMO medical plans (including Kaiser Permanente, SCAN, and United Health) are billed under different administrative arrangements and do not rely on paper claim submissions.

LACERA's healthcare consultants typically initiate the annual audit in late June or early July. The auditor performs a random sampling of claims incurred during the designated audit period to support ongoing monitoring of benefit compliance and to identify potential billing or payment variances, consistent with LACERA's responsibilities for program administration and cost stewardship.

Staff extends its appreciation to the Segal team for its continued collaboration and guidance in support of LACERA's retiree healthcare cost management and program administration.

Reviewed and approved:



Luis A. Lugo  
Chief Executive Officer

Attachments



Los Angeles County Employees Retirement Association

# Medical Claims Audit

**Audit Period: July 1, 2024, through June 30, 2025**

Final Report / March 23, 2026 / Benefit Audit Solutions



1501 West Fountainhead Parkway  
Suite 370  
Tempe, AZ 85282-1936  
T 602.381.4000  
segalco.com

March 23, 2026

Cassandra Smith  
Director, Retiree Healthcare Program  
Retiree Healthcare Division  
Los Angeles County Employees Retirement Association

**Re: Medical Claims Audit - July 2024 - June 2025**

Dear Cassandra:

On behalf of the Los Angeles County Employees Retirement Association, Segal's Benefit Audit Solutions Practice ("Segal") completed a review of the medical benefit plan processing and payment procedures utilized by Anthem Blue Cross ("Anthem"), for the period of July 1, 2024 through June 30, 2025 ("Audit Period"). The audit includes an assessment of Anthem's adjudication procedures, a random sampling of stratified statistical claims, and a targeted claim review.

The following report presents the details and results of the audit.

We look forward to discussing the outcome of the audit with you at your convenience.

Sincerely,

A handwritten signature in black ink that reads "Amber M. Turner".

Amber M. Turner, MBA, PMP  
Vice President, Audits

cc: Stephen Murphy, Segal  
Michael Szeto, Segal  
Felicia Zhang, Segal

# Table of Contents

Section 1 — Executive Summary .....	1
Statistical achievement categories .....	1
Key findings and recommendations .....	3
Section 2 — Audit Details .....	6
Review process .....	6
Section 3 — Statistical Review .....	8
Statistical claim sample error table .....	9
Section 4 — Target Review .....	18
Target claim sample error table .....	19
Section 5 — Time-to-Process Achievement .....	26
Section 6 — Adjudication Procedures Review .....	27
Appendix A — Anthem’s Formal Response to the Draft Report .....	30
Appendix B — Source Documentation .....	36

# Section 1 – Executive Summary

This report summarizes Segal Benefit Audit Solutions' ("Segal") review of the claims processing and payment procedures utilized by Anthem Blue Cross ("Anthem"), in its administration of the Los Angeles County Employees Retirement Association's medical benefits. Amber Turner and Felicia Zhang of Segal's Benefit Audit Solutions Practice conducted the remote audit during the week of October 20, 2025.

The audit encompassed a total sample of 255 claims consisting of 220 stratified and 35 target samples for the audit period of July 1, 2024 through June 30, 2025 ("Audit Period"). The 255 sample claims totaled \$7,645,894.71; or 4.06% of the total claims cost of \$188,449,781.74 for the Audit Period.

- \$6,780,995.92 for the random, stratified statistical claim sample (220) claims; and,
- \$864,898.79 for the target claim sample (35) claims.

Overall, Segal identified \$219,574.20 in overpayments and -\$9,672.90 in underpayments, which are outlined under the **Key Findings and Recommendation section and Sections 3 and 4 of this report.**

The audit included the following review components.

- A random, stratified sample of 220 statistical claims to measure validity in the financial dollar value and incidence; and,
- A claim sample of 35 target claims identified through electronic analyses that are designed to explore potential duplicate payments and/or sample various benefit applications (e.g., deductibles, employee cost-share amounts, and benefit limitations and exclusions).
- The measurement of claim "Time-To-Process" achievement based on the timing from the receipt of claim to the initial date processed for payment or denial.
- Adjudication Procedures Review to assess day-to-day processing guidelines and claim control measures.

## Statistical achievement categories

As illustrated in the chart below, Anthem's statistical achievement met the performance guarantees for procedural and time-to-process accuracy but fell below the performance guarantee for financial accuracy and the industry standard for payment and overall accuracy. The Audit Period's results in the table below, apart from Time-to-Process category, are based on the statistical sample and

do not include target or out-of-sample (OOS) claims. The Time-to-Process achievement was calculated using 100% of the claims processed during the Audit Period and does not differentiate between original and adjusted claims.

### Performance Guarantees Table

Category	Statistical Achievement	Performance Guarantees	Industry Standards
Financial Accuracy (dollar value)	98.41%	99.00%	99.00%
Payment Accuracy (free from financial error)	89.39%	N/A	97.00%
Procedural Accuracy (free from processing error)	100.00%	97.00%	95.00%
Overall Processing Accuracy (free from error)	89.39%	N/A	95.00%
Time-to-Process (within 14 calendar days)	99.11%	90.00%	95.00%
(within 30 calendar days)	99.18%	98.00%	100.00%

N/A = not applicable

## Key findings and recommendations

The following table summarizes the primary findings identified by Segal during the claims review. Anthem was presented with a draft report on January 23, 2026 for its review and comment.

Statistical and Target Audit Findings Summary Chart

Medical Audit Findings Summary Issue	Audit Findings (In and Out-of-Sample) Overpayments	Audit Findings (In and Out-of-Sample) Underpayments	Audit Findings (In and Out-of-Sample) Procedural Errors	Audit Findings (In and Out-of-Sample) Number of Sample Errors
Issue 1: Incorrect Medicare Coordination of Benefit (COB)	\$177,246.83	-\$27.82		15
Issue 2: Deductible Overapplied		-\$139.89		1
Issue 3: Ophthalmological Examination Missing Coinsurance	\$4.52			1
Issue 4: Surgery Coinsurance		-\$1,346.32		4
Issue 5: Incorrect Pricing		-\$8,158.87		2
Issue 6: Hearing Aids Payment Limit	\$38,130.60			6
Issue 7: Acupuncture Limit and Coinsurance	\$496.28			6
Issue 8: Foot Orthotics Exclusion	\$2,777.50			6
Issue 9: Out-of-Network (OON) Preventive	\$918.47			3
<b>Total</b>	<b>\$219,574.20</b>	<b>-\$9,672.90</b>		<b>44</b>

An out-of-sample (OOS) finding is identified as a claim that is not sampled but identified through a sampled member's claims history.

Details regarding the identified issues can be found in the Claim Sample Error Tables in Section 3 and Section 4 of this report.

## Summary Findings and recommendations

Based upon the claims review, Segal identified the following issues and applicable recommendations:

- **Issue 1: Incorrect Medicare Coordination of Benefit (COB)** – Coordination of benefits with Medicare was not paying at 100% of the members Medicare cost share. This is a recurring issue that was since resolved in late 2025.
  - Segal recommends that LACERA continue to monitor the changes that were implemented to the plan to ensure the Medicare supplement claims are being paid per LACERA's intent. Segal will review the new benefit application in the next audit.
- **Issue 2: Deductible Overapplied** – As in previous audit years, the deductible on one member's account was overapplied due to comingling of the pharmacy cost sharing.
  - Segal notes that it seems this is a lesser issue than in years previous. Segal recommends that LACERA continue to monitor this issue.
- **Issue 3: Ophthalmological Examination Missing Coinsurance** – An ophthalmological examination did not apply coinsurance. Anthem agreed to this issue and noted that it would research the root cause.
  - As Anthem did not provide a root cause to this issue, Segal recommends that LACERA request that Anthem provide a root cause and resolution to this issue.
- **Issue 4: Surgery Coinsurance** – Coinsurance was applied to surgery facility (Hospital and Ambulatory) and surgeon's claims when surgery is to pay 100% with no cost sharing. Anthem agreed to these recurring issues during the remote review and noted that a correction was made to the system on February 19, 2026.
  - Segal recommends that LACERA confirm with Anthem that claims from before the system correction was implemented are being adjusted accordingly.
- **Issue 5: Incorrect Pricing** – Incorrect pricing applied to manual claims. Anthem provided coaching and targeted training to its processors and is in the process of adjusting claims.
  - As Anthem has started to implement an action plan for this issue, no further intervention is necessary.
- **Issue 6: Hearing Aids Payment Limit** – Hearing aids paid beyond the \$300.00 payment limit. As this is a recurring issue, Anthem noted that it has increased monitoring of these claims to identify errors, address coaching, and adjust claims as necessary.
  - As Anthem has implemented corrective action for this issue, Segal recommends that LACERA continue to monitor this issue to ensure the remedy is correctly addressing the issue.
- **Issue 7: Acupuncture Limit and Coinsurance** – Acupuncture paid over the \$30.00 payment limit and in some cases did not apply coinsurance. Anthem agreed to these errors and noted that it has increased monitoring of these claims to identify errors, address coaching, and adjust claims as necessary.

- Segal notes that this is an ongoing issue. As Anthem has implemented corrective action for this issue, Segal recommends that LACERA continue to monitor this issue to ensure the remedy is correctly addressing the issue.
- **Issue 8: Foot Orthotics Exclusion** – Foot orthotics, which are an exclusion, were paid. Anthem agreed to these errors and noted that it has increased monitoring of these claims to identify errors, address coaching, and adjust claims as necessary.
  - Segal notes that this is an ongoing issue. As Anthem has implemented corrective action for this issue, Segal recommends that LACERA continue to monitor this issue to ensure the remedy is correctly addressing the issue.
- **Issue 9: OON Preventive** – Claims for OON preventive care, which is an exclusion, were paid. Anthem agreed to these errors and noted that additional guidance has been provided to its processors and use of the LACERA reference guide has been reinforced to support accurate application of plan benefits.
  - Segal recommends that LACERA request that Anthem perform ongoing monthly monitoring for this issue in addition to the corrective actions that are currently being applied.

## Section 2 – Audit Details

Anthem provided an electronic data file of all medical claims processed and paid during the 12-month Audit Period. The objective of the review was to ensure that claims were paid in accordance with the LACERA's plan provisions.

The auditors completed a form for each sampled claim serving as the primary documentation on which this report is based. To maintain patient confidentiality, claims addressed within this report are referred to as "Worksheets." These worksheets (1-220) are further distinguished with an alphabet character (A-K) that identifies the respective payment tier in the statistical analysis. Segal reviewed each claim from receipt to release for check disbursement to identify any variances in procedures and benefit determination.

Worksheets T1-T35 include a "T" to distinguish the "target" sampling of claims identified through electronic analyses. These claims were reviewed for the attribute selected for validation (e.g., copayment application, duplicate payment and benefit provision, etc.). Due to the focused review and selection of these claims, they are excluded from the overall calculation of processing performance.

### Review process

Anthem provided a copy of the sampled claim submissions and guided access to its claim system. Segal recalculated and reviewed each claim manually from initial receipt to final benefit determination seeking evidence of compliance with established adjudication procedures and benefit provisions. In addition to verifying the amount paid, evidence of the following processing tasks was explored.

- Claims were paid only on behalf of eligible individuals based on records contained in the claims system.
- Documentation (e.g., provider bills, physician statements, utilization review decisions or penalty findings, and surgical reports, etc.) is on file for claims paid and verified when necessary.
- Coordination of benefits (COB) and subrogation provisions were enforced, where applicable.
- Amounts paid were within the network discount fees or designated non-contracted allowances.
- Proper medical authorization is on file, as applicable.
- Benefits were paid under the proper classification, diagnostic, and procedure codes as an incorrect entry may affect payment accuracy or future benefit determinations.
- Appropriate benefit limitations, deductibles, copayments, coinsurance, and out-of-pocket maximums were applied.

- As appropriate, high-dollar claims were considered for care management and stop-loss notifications were filed timely, as applicable.
- Claims system logic for examiner edits and auto-adjudication capabilities.
- Arithmetic calculations were correct.
- Duplicate submissions were properly denied.
- Payment was made to the proper party (e.g., the provider of service if benefits were assigned; claimant if benefits were not assigned).
- Time-to-process for processing claims was within industry standards or applicable performance guarantees.

The 2023 and 2024 Summary Plan Description (SPD) served as references for the statistical and electronic analyses; please note that a full list of resources documents is included in *Appendix B*. For the target claims selection, reports from the electronic analysis provided a list of suspected errors that required the auditor's manual review to refine the analysis and identify any patterns of concern. A selection of claims was chosen to confirm suspected errors and identify appropriate query revisions.

All questions and potential errors were presented to Anthem's representatives; outstanding responses post-audit were provided on all but one inquiry. On January 21, 2026, Segal moved forward with the draft report and anticipated that Anthem would answer the second pass question within its formal response.

# Section 3 – Statistical Review

The selection of 220 random claims for Audit Period were stratified by dollar amount to provide large claims representation that is more valid in determining financial accuracy levels. The methodology of Segal’s stratified selection process utilizes a formula designed to take full advantage of statistical sampling procedures that allows a quantifiable degree of confidence, whereby results obtained in the audit sample are a true reflection of the way all claims were processed during the Audit Period.

A basic principle of the sampling technique is the premise that stratified audit findings are representative of all claims; therefore, the respective strata error rate is used to project the total errors for each stratum. The total projected errors are used to calculate the statistical accuracy levels in comparison to industry standards.

## Stratification Table

Below is the stratification table utilized for the audit.

Strata	Starting Dollar Range of Strata	to	Ending Dollar Range of Strata	Number of Claims in Range	Number of Claims in Selection	Dollar-Amount in Selection	Dollar-Amount in Strata
A	\$0.01	–	\$19.99	260,453	40	\$430.06	\$2,938,505.93
B	\$20.00	–	\$39.99	273,792	40	\$1,082.17	\$7,662,018.62
C	\$40.00	–	\$149.99	226,843	40	\$3,403.42	\$18,288,479.98
D	\$150.00	–	\$389.99	83,383	20	\$4,936.21	\$19,469,987.76
E	\$390.00	–	\$999.99	30,988	10	\$6,558.45	\$18,545,871.81
F	\$1,000.00	–	\$2,599.99	18,168	10	\$16,258.87	\$29,233,381.46
G	\$2,600.00	–	\$6,999.99	5,586	10	\$34,923.80	\$23,272,367.80
H	\$7,000.00	–	\$19,999.99	2,078	10	\$119,594.24	\$24,356,735.73
I	\$20,000.00	–	\$54,999.99	692	15	\$477,236.92	\$21,413,537.61
J	\$55,000.00	–	\$274,999.99	197	15	\$1,591,375.69	\$18,743,698.95
K	\$275,000.00	–	\$610,554.50	10	10	\$4,525,196.09	\$4,525,196.09
<b>Total</b>				<b>902,190</b>	<b>220</b>	<b>\$6,780,995.92</b>	<b>\$188,449,781.74</b>

## Statistical claim sample error table

The review of 220 statistical sample claims for the Audit Period identified twenty (20) in- sample errors:

- Four (4) overpayments totaling \$177,251.35; and,
- Seventeen (16) underpayments totaling -\$9,496.89.

**In addition to the above errors, one (1) out-of-sample (OOS) underpayment error totaling -\$139.89 was identified. OOS claims are identified as claims that are not sampled but identified through a sampled member’s claims history.**

Segal recommended that Anthem initiate overpayment recovery for claims identified in the following table and provide financial impact reports when noted in the table below. Anthem’s responses are summarized and italicized with formal response found in *Appendix A* of this report.

### Statistical Sample Findings

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Anthem’s Response/ Segal’s Request	Anthem’s Formal Response	Segal’s Final Comment
<b>Issue 1: Incorrect Medicare COB</b>					
6A	-\$0.26	Auto	<p>Claims were incorrectly coordinated with the other insurance.</p> <p><i>Anthem disagreed with these errors during the remote review and noted that it will only pay 20%.</i></p> <p>Segal disagreed with Anthem and noted that Page 6 (Plan III In-State) and Page 5 (Plan III Out-of-State) of the plan document states that “We will pay 100% of the difference between Medicare’s Allowable Charge(s) and the amount Medicare pays</p>	<p><i>Anthem disagrees with the audit findings. At the time the sample claims were processed, the LACERA Medicare Supplemental plans were designed to coordinate benefits by applying 20% of Medicare’s allowable charge, and a review of system configuration and coding confirms the system operated as designed. Following discussions with LACERA in late 2025 the benefits were amended to provide coverage at 100% of the member’s Medicare</i></p>	<p><b>Segal recommends that LACERA continue to monitor the changes that were implemented to the plan to ensure the Medicare supplement claims are being paid per LACERA’s intent. Segal will review the new benefit application in the next audit.</b></p>

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
			<p>for medically necessary Part B services and supplies". Accordingly, Anthem should pay the full patient responsibility as noted by Medicare. Segal noted that this issue was discussed in previous audits and is in the process of being corrected to ensure payments reflect 100%. Segal requested that Anthem provide confirmation that this issue has been corrected and testing has been completed.</p>	<p><i>coinsurance for Medicare Supplemental plans. System configuration updates reflecting this benefit amendment were completed on January 09, 2026. Additionally, sample 23A differs from the other samples, as it is not a Medicare Supplemental plan. The sample claim processed correctly under the Medicare methodology applicable to standard medical plans. When Anthem pays as secondary to Medicare under these plans, payment equals the Anthem allowed amount minus the amount paid by Medicare, not to exceed the amount Anthem would have paid as primary. For this claim, the calculation was as follows: Anthem allowance of \$85 minus Medicare payment of \$75.58 minus sequestration of \$1.54, resulting in an Anthem payment of \$7.88.</i></p>	
8A	-\$0.14	Auto	See worksheet 6A for explanation.	See worksheet 6A for explanation.	See worksheet 6A for explanation.
11A	-\$0.62	Auto	See worksheet 6A for explanation.	See worksheet 6A for explanation.	See worksheet 6A for explanation.

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
12A	-\$0.21	Auto	See worksheet 6A for explanation.	See worksheet 6A for explanation.	See worksheet 6A for explanation.
22A	-\$0.56	Auto	See worksheet 6A for explanation.	See worksheet 6A for explanation.	See worksheet 6A for explanation.
23A	-\$11.40	Auto	See worksheet 6A for explanation.	See worksheet 6A for explanation.	See worksheet 6A for explanation.
32A	-\$2.68	Auto	See worksheet 6A for explanation.	See worksheet 6A for explanation.	See worksheet 6A for explanation.
52B	-\$1.68	Auto	See worksheet 6A for explanation.	See worksheet 6A for explanation.	See worksheet 6A for explanation.
69B	-\$1.20	Auto	See worksheet 6A for explanation.	See worksheet 6A for explanation.	See worksheet 6A for explanation.
75B	-\$2.92	Auto	See worksheet 6A for explanation.	See worksheet 6A for explanation.	See worksheet 6A for explanation.
102C	-\$5.92	Auto	See worksheet 6A for explanation.	See worksheet 6A for explanation.	See worksheet 6A for explanation.
115C	\$0.38	Auto	See worksheet 6A for explanation.	See worksheet 6A for explanation.	See worksheet 6A for explanation.
120C	-\$0.23	Auto	See worksheet 6A for explanation.	See worksheet 6A for explanation.	See worksheet 6A for explanation.
124D	\$17.27	Auto	See worksheet 6A for explanation.	See worksheet 6A for explanation.	See worksheet 6A for explanation.
209J	\$177,229.18	Manual	Claim processed as primary but should have been processed secondary to Medicare. <i>Anthem disagreed with this error during the remote review and noted that the claim was adjusted to zero on July 25, 2025, to obtain</i>	<i>Anthem disagrees with the audit finding. At the time of the original adjudication, Medicare coverage information was not on file for this member. The Medicare information referenced by Segal was received on June 23, 2025,</i>	<b>As Segal was not able to see that the coverage started, then stopped, Segal upholds the error. As the claim was adjusted in July 2025, no further intervention is necessary.</b>

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
			<p><i>Medicare payment information.</i></p> <p>Segal upheld the error, as Anthem's system indicates that the member had Part A as primary since November 1, 2019. Segal requested that Anthem review this member's other claims to identify any claims that were paid as primary but should have been processed as secondary.</p>	<p><i>at which time Anthem updated the coordination of benefits record to reflect Medicare Part A and Part B coverage effective November 1, 2019 through January 31, 2020. Medicare Part B coverage was subsequently cancelled effective February 1, 2020 and later reinstated effective May 1, 2025. The sample claim was adjudicated based on the eligibility and coordination of benefits information available at the time of processing. Upon receipt of the updated Medicare information, Anthem updated the member's coordination of benefits record and adjusted the sample claim accordingly.</i></p>	
<b>Issue 2: Deductible Overapplied</b>					
81C	OOS: -\$139.89	Manual	<p>The annual deductible and/or out-of-pocket amount was overapplied.</p> <p><i>Anthem agreed to this error during the remote review and noted that it is due to the comingling of the cost sharing with the pharmacy.</i></p> <p>Segal noted that this error has been recurring and</p>	<p><i>This plan includes pharmacy integration, where pharmacy claims are recorded as history claims through data transmission between Anthem and the pharmacy vendor. During this process, there may be instances where an overage in out-of-pocket expenses occurs. Corrections to these</i></p>	<p><b>Segal notes that it seems this is a lesser issue than in years previous. Segal recommends that LACERA continue to monitor this issue.</b></p>

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
			<p>identified in previous audits but has receded in this audit with this error being the only finding for this issue. Segal requested that Anthem confirm it will continue reconciling the files going forward, as well as adjust this member's file.</p>	<p><i>overages are completed post -payment. Anthem utilizes a reporting process to identify out-of-pocket overages. The process for capturing and correcting these discrepancies is manual, which may occasionally result in delays in updating member records. Anthem is aware of this issue and continues to evaluate opportunities to improve the process. The member's claim history has been reviewed, and applicable claims have been placed into the adjustment process.</i></p>	
<p><b>Issue 3: Ophthalmological Examination Missing Coinsurance</b></p>					
126D	\$4.52	Auto	<p>An ophthalmological examination did not apply coinsurance. <i>Anthem agreed to this error during the remote review.</i> Segal requested that Anthem review and provide a root cause for this issue as well as financial impact reporting for this error.</p>	<p><i>Anthem agrees with the audit finding. The claim is under review to determine root cause and to assess the associated financial impact. Anthem conducts regular monitoring through monthly reporting to identify processing issues and review accuracy. Any errors identified are addressed through coaching and claim adjustment, as applicable. In addition, a LACERA -</i></p>	<p><b>As Anthem did not provide a root cause to this issue, Segal recommends that LACERA requests that Anthem provide a root cause and resolution to this issue.</b></p>

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
<b>Issue 4: Surgery Coinsurance</b>					
134D	-\$55.31	Auto	<p>Coinsurance was applied to surgery facility (Hospital and Ambulatory) claims when surgery is to pay 100% with no cost sharing.</p> <p><i>Anthem agreed to these errors during the remote review.</i></p> <p>Segal noted that this is a recurring error that was identified in previous audits. Segal requested that Anthem provide the root cause of this issue and generate financial impact reporting as systematic processing of claims for this issue was identified. Additionally, Segal requested that Anthem coordinate refunds to the members as well as provide</p>	<p><i>specific reference guide has been implemented to support claim s processors and reinforce accurate benefit administration. The sample claim is outside of the one-year recoupment period based on the adjudication date; therefore, recovery will not be pursued.</i></p> <p><i>Anthem agrees with the audit findings for Samples 134D and 1911. The claims are under review to determine root cause and to assess the associated financial impact, including evaluation of any impacted claims. Anthem has implemented enhanced monitoring through monthly reporting to identify processing issues and ensure continued accuracy. Identified errors are addressed through coaching and corrective claim adjustment . In addition, a LACERA - specific reference guide has been implemented to support claims processors</i></p>	<p><b>Segal notes that this is an ongoing issue. Per Anthem's response on samples T31 and T32 a system correction was implemented on February 19, 2026. Segal recommends that LACERA confirm with Anthem that claims from before the system correction was implemented are being adjusted accordingly.</b></p>

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
			additional coaching for its processors for this issue.	<i>and reinforce accurate benefit administration.</i>	
186I	Error Removed	Auto	See worksheet 134D for explanation.	<i>Anthem disagrees with the audit finding. Upon further review, the sample claim was determined to be processed correctly in accordance with the applicable plan provisions and reimbursement methodology.</i>	<b>Upon receiving additional information on the error with Anthem's formal response, Segal has removed this error. No further intervention is necessary.</b>
191I	-\$1,254.89	Manual	See worksheet 134D for explanation.	See worksheet 134D for explanation.	See worksheet 134D for explanation.
<b>Issue 5: Incorrect Pricing</b>					
203J	-\$5.90	Manual	Incorrect pricing applied to claims. <i>Anthem agreed to these errors during the remote review.</i> Segal requested that Anthem provide coaching to its processors for this issue.	<i>Anthem agrees with a manual processing error for Sample 203J. Coaching and targeted training have been provided to the claims team to reinforce accurate pricing application. The impacted claims have been placed into the adjustment process, as applicable.</i>	<b>As Anthem has started to implement an action plan for this issue, no further intervention is necessary.</b>
207J	-\$8,152.97	Manual	See worksheet 203J for explanation.	<i>Anthem disagrees with the error. Through Anthem's internal post-payment review process, conducted prior to the medical claims audit, a provider billing error was identified. The provider incorrectly billed revenue code 278 as a separately reimbursable charge; however, under applicable</i>	<b>Segal notes that the adjustment is outside of the audit period and the error still stands. As Anthem has started to implement an action plan for this issue, no further intervention is necessary.</b>

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
				<p><i>reimbursement rules, this revenue code is not eligible for separate reimbursement. As a result, \$16,708.87 in billed charges were determined to be ineligible, and an overpayment of \$7,402.03 was identified. Based on additional information received from the provider, an adjustment was subsequently completed on July 17, 2025, outside of the audit period, to recoup the identified overpayment. The adjustment was related solely to the provider billing error and not to an incorrect application of pricing.</i></p>	
216K	Error Removed	Manual	See worksheet 203J for explanation.	<p><i>Anthem disagrees. Upon further review, the claim was determined to have processed in accordance with applicable reimbursement methodology. Supporting documentation was sent to Segal on February 20, 2026, for consideration.</i></p>	<p><b>Upon receiving additional information on the error with Anthem's formal response, Segal has removed this error. No further intervention is necessary.</b></p>

## Summary of Statistical Sample Findings

Description	Amount
4 Overpayments	\$177,251.35
16 Underpayments	-\$9,496.89
1 OOS Underpayment*	-\$139.89

Segal does not guarantee the accuracy of the claims adjudication of the medical benefit plan or that the audit results will capture all differences in the plan's benefit documents and the Anthem's medical claims adjudication. The results in this report are based on information available to Segal at the time the audit was conducted and are not a guarantee of future results. Actual experience may differ due to numerous factors, including but not limited to changes in the regulatory environment, plan designs, claim volumes, and changes to contractual agreements. Segal's audit results and recommendations, as applicable are not legal advice. Issues involving the interpretation of laws/regulations should be referred to the plan's own legal counsel. Some materials provided may be deemed proprietary and confidential and may not be disclosed or shared with any third parties other than authorized employees, directors, or Trustees of the plan sponsor without the consent of your carrier.

\* OOS claims are identified as claims that are not sampled but identified through a sampled member's claims history.

## Section 4 – Target Review

Segal performed an electronic review of claims processed and paid during the Audit Period. The electronic review was designed to identify potential deficiencies in the benefit delivery system.

The random nature of statistical sampling does not ensure every benefit provision or plan variation was identified in the selection. Therefore, Segal's electronic analysis included exploration of scenarios that could suggest a systemic error in programming and/or administrative procedures with focus given to patterns suggesting a greater financial impact to the Plan. The query process included analyses of the following categories:

- Potential duplicate payments;
- Plan variables not represented in the random selection;
- Reimbursement of Plan exclusions, limitations, and prior authorization; and,
- Patient out-of-pocket expenses (deductible, copay, and coinsurance).

The remote review of target claims focused on the attribute(s) selected to gain confidence and to understand how a change in query programs could present more accurate results (e.g., minimize the number of false positives evidenced in such electronic reviews).

## Target claim sample error table

The review of 35 target sample claims for the Audit Period identified twenty-three (23) in- sample errors:

- Twenty-one (21) overpayments totaling \$42,322.85; and,
- Two (2) underpayment totaling -\$36.12.

Segal recommended that Anthem initiate overpayment recovery for claims identified in the following table and provide financial impact reports when noted in the table below. Anthem’s responses are summarized and italicized with formal response found in *Appendix A*.

### Target Sample Findings

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Anthem’s Response/ Segal’s Request	Anthem’s Formal Response	Segal’s Final Comment
<b>Issue 6: Hearing Aids Payment Limit</b>					
T4	\$8,640.00	Manual	Hearing aids were paid more than the \$300.00 limitation. <i>Anthem agreed to this error during the remote review.</i> Segal requested that Anthem adjust the claim in error and provide coaching to its processors regarding the \$300.00 hearing aid limitation as well as provide an action plan for avoiding this problem going forward as it is a recurring issue identified in the previous audit. Additionally, Segal requested that Anthem provide a financial impact report for this issue.	<i>Anthem agrees the audit findings resulted from manual processing errors. These issues were addressed with LACERA during a meeting held in September 2025, at which time it was determined that overpayments resulting from manual processing errors related to hearing aids, acupuncture, and foot orthotics would not be recouped for claims paid prior to September 2025 in order to minimize member abrasion.</i> <i>To address this issue and reduce recurrence, Anthem has implemented enhanced</i>	<b>Segal notes that this is an ongoing issue. As Anthem has implemented corrective action for this issue, Segal recommends that LACERA continue to monitor this issue to ensure the remedy is correctly addressing the issue.</b>

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
				<p><i>monitoring through monthly outlier reporting, with identified errors reviewed for accuracy, addressed through coaching, and claim adjustments as needed. In addition, a LACERA-specific claims reference guide has been implemented to support claims processors in applying unique benefit applications.</i></p> <p><i>Anthem's account management team is available to discuss this issue upon request.</i></p>	
T5	\$6,200.00	Manual	See worksheet T4 for explanation.	See worksheet T4 for explanation.	See worksheet T4 for explanation.
T6	\$8,698.80	Manual	See worksheet T4 for explanation.	See worksheet T4 for explanation.	See worksheet T4 for explanation.
T7	\$8,698.80	Auto	See worksheet T4 for explanation.	See worksheet T4 for explanation.	See worksheet T4 for explanation.
T8	\$2,700.00	Manual	See worksheet T4 for explanation.	See worksheet T4 for explanation.	See worksheet T4 for explanation.
T9	\$3,193.00	Manual	See worksheet T4 for explanation.	See worksheet T4 for explanation.	See worksheet T4 for explanation.
<b>Issue 7: Acupuncture Limit and Coinsurance</b>					
T10	\$80.37	Manual	Acupuncture paid over the \$30.00 payment limit and in some cases did not apply coinsurance.	<i>Anthem agrees the findings resulted from manual processing errors. During a meeting held in September 2025, recurring issues were discussed and it was</i>	<b>Segal notes that this is an ongoing issue. As Anthem has implemented corrective action for this issue, Segal recommends that LACERA continue to</b>

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
			<p><i>Anthem agreed to these errors during the remote review.</i></p> <p>Segal requested that Anthem adjust the claims in error and provide coaching to its processors regarding the \$30.00 acupuncture limitation and coinsurance as well as provide an action plan for avoiding this problem going forward as it is a recurring issue identified in the previous audit. Additionally, Segal requested that Anthem provide a financial impact report for this issue.</p>	<p><i>determined that overpayments related to hearing aids, acupuncture, and foot orthotics paid prior to September 2025 would not be recouped. Anthem has been actively working to support accurate administration of LACERA's unique benefit provisions and has implemented monthly claims monitoring, targeted coaching for claims identified as paid incorrectly, and the implementation of a LACERA specific reference guide to reinforce correct benefit application. Anthem's account management team is available to discuss this issue upon request.</i></p>	<p><b>monitor this issue to ensure the remedy is correctly addressing the issue.</b></p>
T11	\$116.58	Manual	See worksheet T10 for explanation.	See worksheet T10 for explanation.	See worksheet T10 for explanation.
T12	\$116.58	Manual	See worksheet T10 for explanation.	See worksheet T10 for explanation.	See worksheet T10 for explanation.
T13	\$46.00	Manual	See worksheet T10 for explanation.	See worksheet T10 for explanation.	See worksheet T10 for explanation.
T14	\$43.62	Manual	See worksheet T10 for explanation.	See worksheet T10 for explanation.	See worksheet T10 for explanation.
T15	\$93.13	Manual	See worksheet T10 for explanation.	See worksheet T10 for explanation.	See worksheet T10 for explanation.

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
<b>Issue 8: Foot Orthotics Exclusion</b>					
T16	\$328.96	Manual	<p>Foot orthotics, which are an exclusion, were paid.</p> <p><i>Anthem agreed with these errors during the remote review.</i></p> <p>Segal referenced page 56 (Plan II In-State) and page 53 (Plan I In-State) of the plan document under the section listing items not covered by the medical plan, which notes foot orthotics as an exclusion. Segal requested that Anthem adjust the claims in error and provide coaching to its processors as well as provide an action plan for avoiding this problem going forward as it is a recurring issue identified in the previous audit. Additionally, Segal requested that Anthem provide a financial impact report for this issue.</p>	<p><i>Anthem agrees the findings resulted from manual processing errors. During a meeting held in September 2025, recurring issues were discussed and it was determined that overpayments related to hearing aids, acupuncture, and foot orthotics paid prior to September 2025 would not be recouped. Anthem has been actively working to support accurate administration of LACERA's unique benefit provisions and has implemented monthly claims monitoring, targeted coaching for claims identified as paid incorrectly, and the implementation of a LACERA specific reference guide to reinforce correct benefit application. Anthem's account management team is available to discuss this issue upon request.</i></p>	<p><b>Segal notes that this is an ongoing issue. As Anthem has implemented corrective action for this issue, Segal recommends that LACERA continue to monitor this issue to ensure the remedy is correctly addressing the issue.</b></p>
T17	\$411.20	Manual	See worksheet T16 for explanation.	See worksheet T16 for explanation.	See worksheet T16 for explanation.
T18	\$428.52	Auto	See worksheet T16 for explanation.	See worksheet T16 for explanation.	See worksheet T16 for explanation.

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
T19	\$621.62	Manual	See worksheet T16 for explanation.	See worksheet T16 for explanation.	See worksheet T16 for explanation.
T20	\$576.00	Auto	See worksheet T16 for explanation.	See worksheet T16 for explanation.	See worksheet T16 for explanation.
T21	\$411.20	Manual	See worksheet T16 for explanation.	See worksheet T16 for explanation.	See worksheet T16 for explanation.
<b>Issue 9: OON Preventive</b>					
T23	\$458.00	Manual	<p>Claims for OON preventive care, which is an exclusion, were paid.</p> <p><i>Anthem agreed to these errors during the remote review.</i></p> <p>Segal requested that Anthem adjust the claims in error and provide coaching to its processors as well as provide an action plan for avoiding this problem going forward as it is a recurring issue identified in the previous audit. Additionally, Segal requested that Anthem provide a financial impact report for this issue.</p>	<p><i>Anthem agrees the finding resulted from a manual processing error. To address this issue and reduce the potential for recurrence, additional guidance has been provided and use of the LACERA reference guide has been reinforced to support accurate application of plan benefits.</i></p> <p><i>The impacted claims fall outside the one-year recoupment period based on the claim payment date, and as such, recoupment is not applicable. Anthem's account management team is available to discuss this issue upon request.</i></p>	<p><b>Segal notes that this is an ongoing issue. Segal recommends that LACERA request that Anthem perform ongoing monthly monitoring for this issue in addition to the corrective actions that are currently being applied.</b></p>
T24	\$197.27	Manual	See worksheet T23 for explanation.	See worksheet T23 for explanation.	See worksheet T23 for explanation.
T25	\$263.20	Manual	See worksheet T23 for explanation.	See worksheet T23 for explanation.	See worksheet T23 for explanation.

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
<b>Issue 4: Surgery Coinsurance</b>					
T31	-\$30.05	Manual	<p>Coinsurance was applied to surgeon's claims when surgery is to pay 100% with no cost sharing.</p> <p><i>Anthem disagreed with these errors during the remote review and noted that outpatient hospital surgeries are not included in the 100% payment.</i></p> <p>Segal notes that this is a recurring error that was identified in previous audits. Segal notes that page 15 (Plan II In-State) and page 12 (Plan II Out-of-State) state no cost sharing is required for services of the surgeon in connection with a surgery performed on an outpatient basis in the hospital, an ambulatory surgical center or in a physician's office. Segal requests that Anthem provide the root cause of this issue and generate financial impact reporting as systematic processing of claims for this issue was identified. Additionally, Segal requested that Anthem coordinate refunds to the members as well as</p>	<p><i>Anthem agrees with the audit findings and determined the issue resulted from a system configuration error. System coding was corrected on February 19, 2026. An impact analysis has been initiated to identify additional impacted claims, and the results will be shared upon completion. Anthem has implemented enhanced monitoring through monthly reporting to identify processing issues and ensure continued accuracy. Identified errors are addressed through coaching and corrective claim adjustment. In addition, a LACERA-specific reference guide has been implemented to support claims processors and reinforce accurate benefit administration.</i></p>	<p><b>Segal notes that this is an ongoing issue. Segal recommends that LACERA confirm with Anthem that members from before the system correction was implemented are being adjusted accordingly.</b></p>

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Anthem's Response/ Segal's Request	Anthem's Formal Response	Segal's Final Comment
			provide additional coaching for its processors for this issue.		
T32	-\$6.07	Auto	See worksheet T31 for explanation.	See worksheet T31 for explanation.	See worksheet T31 for explanation.

### Summary of Target Sample Findings

Description	Amount
21 Overpayments	\$42,322.85
2 Underpayments	-\$36.12

Segal does not guarantee the accuracy of the claims adjudication of the medical benefit plan or that the audit results will capture all differences in the plan's benefit documents and the Anthem's medical claims adjudication. The results of this report are based on information available to Segal at the time the audit was conducted and are not a guarantee of future results. Actual experience may differ due to numerous factors, including but not limited to changes in the regulatory environment, plan designs, claim volumes, and changes to contractual agreements. Segal's audit results and recommendations, as applicable, are not legal advice. Issues involving the interpretation of laws/regulations should be referred to the plan's own legal counsel. Some materials provided may be deemed proprietary and confidential and may not be disclosed or shared with any third parties other than authorized employees, directors, or Trustees of the plan sponsor without the consent of your carrier.

## Section 5 — Time-to-Process Achievement

There were no concerns with the time-to-process measurement for non-adjusted claims. Results from the electronic analyses of all medical claims processed during the Audit Period revealed Anthem processed 99.11% of the claims within fourteen (14) calendar days and 99.18% within thirty (30) calendar days.

Time-to-Process achievement is measured from the date a claim is first received to the initial date processed for payment or denial. Industry standards indicate 95% of all claims should be processed within fourteen (14) calendar days. Best practice, which follows U.S. Department of Labor, Employee Benefits Security Administration (EBSA), requires 100% within thirty (30) calendar days.\*

Segal's electronic calculations of all claims processed within the Audit Period did not allow for distinction of multiple processing events.

\* <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/filing-a-claim-for-your-health-benefits.pdf>.

# Section 6 – Adjudication Procedures Review

The objective of the review is to ensure that proper procedures are in place to ensure claims control measures. The processing guidelines are described from the perspective of Anthem in the Adjudications Procedures Review and evidenced by Segal within the 220 statistical and 35 target claim samples and/or confirmed through discussion with Anthem's personnel. While the list did not capture all administrative procedures and system functions, it supports that established guidelines are in place to control Plan costs.

- LACERA's claims are processed by a designated group of Anthem processors.
  - Anthem's claims workforce management teams have additional controls, and they manage, monitor, and assign claims through advanced inventory management tools.
  - Anthem's Member Services representatives (MSRs) process claims and make adjustments.
  - Processors who work from home are required to have a HIPAA compliant work area and sign a work-from-home agreement.
    - Prior to being allowed to work from home, Anthem's manager inspects the workspace.
    - Random inspections are conducted periodically throughout the year.
    - Anthem's employees who work from home use a virtual private network (VPN) security process to access the Anthem network.
- On average, Anthem receives 85,000 claims monthly for LACERA.
  - 98.49% of LACERA's claims are submitted electronically.
    - 98.78% of Anthem's claims companywide are submitted electronically.
  - 92.5% of LACERA's claims are auto adjudicated.
    - 92.0% of Anthem's claims companywide are auto adjudicated.
- Eligibility information is submitted to Anthem by LACERA via email.
  - Anthem reconciles this information on a monthly basis.
- Anthem does not utilize annual solicitation letters for Coordination of Benefits (COB).
  - Anthem utilizes Pay and Pursue for COB claims that require recovery.
  - Anthem notes it investigates all possible COB claims.
  - The birthday rule is followed for COB claims.
- Anthem's subrogation department is responsible for investigating and pursuing third-party liability (TPL) claims.

- For possible TPL claims, Anthem submits a questionnaire to the member based on diagnosis codes received on claims.
- Anthem’s claim system also has the capability to automatically identify possible TPL claims.
- The minimum amount of dollars to initiate TPL claim recoveries is \$750.00.
- If additional information is necessary to adjudicate claims, Anthem’s claim system has the capability to automate letters.
  - The following letters can be automatically generated:
    - Explanation of Benefits
    - Letter regarding other insurance
    - Provider remittance
    - Requests for medical records
- Facility and Professional Claims that are paying more than \$40,000 are sent for a high dollar claims review.
  - Claims paying higher than \$300,000 undergo a secondary end-to-end audit completed by an audit lead or senior auditor to confirm accuracy.
- The following criteria may trigger a case management referral.
  - Inpatient admission of 10 days or greater
  - NICU admissions
  - High risk on readmission predictive model
  - Carelon’s oncology management triggers to help Anthem identify and engage members with cancer sooner
  - An unplanned hospital admission by a member who was recently followed in care management (within the previous 30 days)
  - Catastrophic illnesses and injuries
  - High-dollar claims (greater than \$75,000)
  - Potential transplant candidates
  - Specialty high-cost drugs
- Anthem’s financial operations department manages overpayment recoveries.
  - All overpayments over the amount of \$30.00 are pursued.
- Anthem utilizes the FAIR Health database to determine reasonable and customary allowances.

- The following subcontractor provides service to Anthem Blue Cross for LACERA's claims:

- Excela

- Location: India, Philippines, Colorado, and Texas

Services: Mail pickup, batching and prepping imaging, and data entry

# Appendix A – Anthem’s Formal Response to the Draft Report



Anthem Blue Cross  
Customer Audit Services  
220 Virginia Avenue  
Indianapolis, IN 46204

February 25, 2026

**Via email only**

Amber M. Turner  
Vice President, Audits  
Segal Benefit Audit Solutions  
1501 W Fountainhead Pkwy Suite 730  
Tempe, AZ 85282

RE: Los Angeles County Employees Retirement Association

Anthem Blue Cross (Anthem) has reviewed the audit report prepared by Segal Benefit Audit Solutions (Segal) in connection with Segal’s review of Anthem’s administration of the Los Angeles County Employees Retirement Association (LACERA) medical benefit plans for the period of July 1, 2024 through June 30, 2025.

## **Executive Summary**

Segal reported \$586,980.70 in overpayments and \$10,007.39 in underpayments. In addition, Segal identified Out-of-Sample (OOS) errors. OOS claims are not included in Segal’s selected audit sample but are identified through a review of claim history associated with sampled members. As noted by Segal, OOS claims do not contribute to the statistical or financial accuracy measurement of the audit. Based on Anthem’s internal validation and review of the audit findings, Anthem has acknowledged 25 overpayments totaling \$42,327.37 and 5 underpayments totaling \$1,352.22. Anthem’s detailed responses to Segal’s findings and recommendations are presented in the sections that follow and reflect Anthem’s position, clarification of benefit application, where appropriate, and remediation actions taken or planned.

## **Statistical Review**

### **Issue 1: Incorrect Medicare COB**

**Samples 6A, 8A, 11A, 12A, 22A, 23A, 32A, 52B, 69B, 75B, 102C, 115C, 120C, and 124D:** Claims were incorrectly coordinated with the other insurance.

**Anthem’s Response:** Anthem disagrees with the audit findings. At the time the sample claims were processed, the LACERA Medicare Supplemental plans were designed to coordinate benefits by applying 20% of Medicare’s allowable charge, and a review of system configuration and coding confirms the system operated as designed. Following discussions with LACERA in late 2025 the benefits were amended to provide coverage at 100% of the member’s Medicare coinsurance for Medicare Supplemental plans. System configuration updates reflecting this benefit amendment were completed on January 09, 2026.

Additionally, Sample 23A differs from the other samples, as it is not a Medicare Supplemental plan. The sample claim processed correctly under the Medicare methodology applicable to standard medical plans. When Anthem pays as secondary to Medicare under these plans, payment equals the Anthem allowed amount minus the amount paid by Medicare, not to exceed the amount Anthem would have paid as primary. For this claim, the calculation was as follows: Anthem allowance of \$85 minus Medicare payment of \$75.58 minus sequestration of \$1.54, resulting in an Anthem payment of \$7.88.

**Sample 209J:** Claim processed as primary but should have been processed secondary to Medicare.

[anthem.com](https://www.anthem.com)



Anthem Blue Cross  
Customer Audit Services  
220 Virginia Avenue  
Indianapolis, IN 46204

**Anthem's Response:** Anthem disagrees with the audit finding. At the time of the original adjudication, Medicare coverage information was not on file for this member. The Medicare information referenced by Segal was received on June 23, 2025, at which time Anthem updated the coordination of benefits record to reflect Medicare Part A and Part B coverage effective November 1, 2019 through January 31, 2020. Medicare Part B coverage was subsequently cancelled effective February 1, 2020 and later reinstated effective May 1, 2025. The sample claim was adjudicated based on the eligibility and coordination of benefits information available at the time of processing. Upon receipt of the updated Medicare information, Anthem updated the member's coordination of benefits record and adjusted the sample claim accordingly.

#### **Issue 2: Deductible Overapplied**

**Sample 81C:** The annual deductible and/or out-of-pocket amount was overapplied.

**Anthem's Response:** This plan includes pharmacy integration, where pharmacy claims are recorded as history claims through data transmission between Anthem and the pharmacy vendor. During this process, there may be instances where an overage in out-of-pocket expenses occurs. Corrections to these overages are completed post-payment.

Anthem utilizes a reporting process to identify out-of-pocket overages. The process for capturing and correcting these discrepancies is manual, which may occasionally result in delays in updating member records. Anthem is aware of this issue and continues to evaluate opportunities to improve the process. The member's claim history has been reviewed, and applicable claims have been placed into the adjustment process.

#### **Issue 3: Ophthalmological Examination Missing Coinsurance**

**Sample 126D:** An ophthalmological examination did not apply coinsurance.

**Anthem's Response:** Anthem agrees with the audit finding. The claim is under review to determine root cause and to assess the associated financial impact. Anthem conducts regular monitoring through monthly reporting to identify processing issues and review accuracy. Any errors identified are addressed through coaching and claim adjustment, as applicable. In addition, a LACERA-specific reference guide has been implemented to support claims processors and reinforce accurate benefit administration. The sample claim is outside of the one-year recoupment period based on the adjudication date; therefore, recovery will not be pursued.

#### **Issue 4: Surgery Coinsurance**

**Samples 134D, 186I, and 191I:** Coinsurance was applied to surgery facility (Hospital and Ambulatory) claims when surgery is to pay 100% with no cost sharing.

**Anthem's Response:** Anthem agrees with the audit findings for Samples 134D and 191I. The claims are under review to determine root cause and to assess the associated financial impact, including evaluation of any impacted claims. Anthem has implemented enhanced monitoring through monthly reporting to identify processing issues and ensure continued accuracy. Identified errors are addressed through coaching and corrective claim adjustment. In addition, a LACERA-specific reference guide has been implemented to support claims processors and reinforce accurate benefit administration.

Sample 186I: Anthem disagrees with the audit finding. Upon further review, the sample claim was determined to be processed correctly in accordance with the applicable plan provisions and reimbursement methodology. Supporting documentation was provided to Segal on February 20, 2026, for consideration.

[anthem.com](https://www.anthem.com)



Anthem Blue Cross  
Customer Audit Services  
220 Virginia Avenue  
Indianapolis, IN 46204

#### **Issue 5: Incorrect Pricing**

**Samples 203J, 207J, and 216K:** Incorrect pricing applied to claims.

**Anthem's Response:** Anthem agrees with a manual processing error for Sample 203J. Coaching and targeted training have been provided to the claims team to reinforce accurate pricing application. The impacted claims have been placed into the adjustment process, as applicable.

*Sample 207J: Anthem disagrees with the error. Through Anthem's internal post-payment review process, conducted prior to the medical claims audit, a provider billing error was identified. The provider incorrectly billed revenue code 278 as a separately reimbursable charge; however, under applicable reimbursement rules, this revenue code is not eligible for separate reimbursement. As a result, \$16,708.87 in billed charges were determined to be ineligible, and an overpayment of \$7,402.03 was identified. Based on additional information received from the provider, an adjustment was subsequently completed on 07/17/2025, outside of the audit period, to recoup the identified overpayment. The adjustment was related solely to the provider billing error and not to an incorrect application of pricing.*

*Sample 216K: Anthem disagrees. Upon further review, the claim was determined to have processed in accordance with applicable reimbursement methodology. Supporting documentation was sent to Segal on February 20, 2026, for consideration.*

#### **Target Review**

#### **Issue 6: Hearing Aids Payment Limit**

**Samples T4, T5, T6, T7, T8, and T9:** Hearing aids were paid more than the \$300.00 limitation.

**Anthem's Response:** Anthem agrees the audit findings resulted from manual processing errors. These issues were addressed with LACERA during a meeting held in September 2025, at which time it was determined that overpayments resulting from manual processing errors related to hearing aids, acupuncture, and foot orthotics would not be recouped for claims paid prior to September 2025 in order to minimize member abrasion.

*To address this issue and reduce recurrence, Anthem has implemented enhanced monitoring through monthly outlier reporting, with identified errors reviewed for accuracy, addressed through coaching, and claim adjustments as needed. In addition, a LACERA-specific claims reference guide has been implemented to support claims processors in applying unique benefit applications. Anthem's account management team is available to discuss this issue upon request.*

#### **Issue 7: Acupuncture Limit and Coinsurance**

**Samples T10, T11, T12, T13, T14, and T15:** Acupuncture paid over the \$30.00 payment limit and in some cases did not apply coinsurance.

**Anthem's Response:** Anthem agrees the findings resulted from manual processing errors. During a meeting held in September 2025, recurring issues were discussed and it was determined that overpayments related to hearing aids, acupuncture, and foot orthotics paid prior to September 2025 would not be recouped. Anthem has been actively working to support accurate administration of LACERA's unique benefit provisions and has implemented monthly claims monitoring, targeted coaching for claims identified as paid incorrectly, and the implementation of a LACERA specific reference guide to reinforce correct benefit application. Anthem's account management team is available to discuss this issue upon request.

#### **Issue 8: Foot Orthotics Exclusion**

[anthem.com](http://anthem.com)



Anthem Blue Cross  
Customer Audit Services  
220 Virginia Avenue  
Indianapolis, IN 46204

**Samples T16, T17, T18, T19, T20, and T21:** Foot orthotics, which are an exclusion, were paid. Anthem agreed with these errors during the remote review.

**Anthem's Response:** Anthem agrees the findings resulted from manual processing errors. During a meeting held in September 2025, recurring issues were discussed and it was determined that overpayments related to hearing aids, acupuncture, and foot orthotics paid prior to September 2025 would not be recouped. Anthem has been actively working to support accurate administration of LACERA's unique benefit provisions and has implemented monthly claims monitoring, targeted coaching for claims identified as paid incorrectly, and the implementation of a LACERA specific reference guide to reinforce correct benefit application. Anthem's account management team is available to discuss this issue upon request.

**Issue 9: OON Preventive**

**Samples T23, T24, and T25:** Claims for OON preventive care, which is an exclusion, were paid.

**Anthem's Response:** Anthem agrees the finding resulted from a manual processing error. To address this issue and reduce the potential for recurrence, additional guidance has been provided and use of the LACERA reference guide has been reinforced to support accurate application of plan benefits. The impacted claims fall outside the one-year recoupment period based on the claim payment date, and as such, recoupment is not applicable. Anthem's account management team is available to discuss this issue upon request.

**Issue 4: Surgery Coinsurance**

**Samples T31 and T32:** Coinsurance was applied to surgeon's claims when surgery is to pay 100% with no cost sharing.

**Anthem's Response:** Anthem agrees with the audit findings and determined the issue resulted from a system configuration error. System coding was corrected on February 19, 2026. An impact analysis has been initiated to identify additional impacted claims, and the results will be shared upon completion. Anthem has implemented enhanced monitoring through monthly reporting to identify processing issues and ensure continued accuracy. Identified errors are addressed through coaching and corrective claim adjustment. In addition, a LACERA-specific reference guide has been implemented to support claims processors and reinforce accurate benefit administration.

Thank you for providing Anthem with the opportunity to respond to this audit report. Anthem representatives are available to discuss the results of this audit with Segal and LACERA upon request and we look forward to working with Segal and LACERA in the future.

Sincerely,

*Shaniqua Johnson*

Shaniqua Johnson  
External Audit Facilitator, Senior  
Customer Audit Services

cc: Karima Carr, Elevance Health  
Marijone Gaabury, Elevance Health

[anthem.com](https://www.anthem.com)



Anthem Blue Cross  
Customer Audit Services  
220 Virginia Avenue  
Indianapolis, IN 46204

Menchie Hall, Anthem  
Nicole Harber, Anthem  
Tina Griffin, Anthem  
LaTosha Harwell, Elevance Health  
Gerry Hayes, Anthem  
Bernard Mitchell, Anthem

[anthem.com](https://www.anthem.com)



# Appendix B – Source Documentation

The information below is a list of all documentation used as part of the review process for the medical health benefit review.

- Summary Plan Description, effective July 1, 2024, for the following plans:
  - Plan II In State
  - Plan III In State
  - Prudent Buyer
- Summary Plan Description, effective July 1, 2023, for the following plans:
  - Plan I In State
  - Plan I Out-of-State
  - Plan II Out-of-State
  - Plan III Out-Of-State



Los Angeles County Employees Retiree Association

# Analysis of Cigna Healthcare Dental Claims Processing and Payment Procedures

**Audit Period: July 1, 2024 through June 30, 2025**

Final Report / March 23, 2026 / Felicia Zhang

March 23, 2026

Cassandra Smith  
Director, Retiree Healthcare Program  
Retiree Healthcare Division  
Los Angeles County Employees Retirement Association

**Re: Dental Claims Audit July 1, 2024 - June 30, 2025**

Dear Cassandra:

On behalf of the Los Angeles County Employees Retirement Association, Segal's Benefit Audit Solutions Practice (Segal) completed a review of the dental benefit plan processing and payment procedures utilized by Cigna Healthcare (Cigna), for the period of July 1, 2024 through June 30, 2025 (Audit Period). The audit includes an assessment of Cigna's adjudication procedures and a random sampling of stratified statistical claims.

The following report presents the details and results of the audit.

We look forward to discussing the outcome of the audit with you at your convenience.

Sincerely,



Felicia Zhang  
Senior Health Benefits Data Analyst

cc: Stephen Murphy, Segal  
Michael Szeto, Segal

# Table of Contents

Section 1 — Executive Summary .....	1
Statistical achievement categories .....	2
Key findings and recommendations .....	3
Section 2 — Audit Details .....	5
Review process .....	5
Section 3 — Statistical Review .....	7
Statistical claim sample error table .....	8
Section 4 — Time-to-Process Achievement .....	19
Section 5 — Adjudication Procedures Review .....	20
Appendix A .....	22
Appendix B .....	30
Source documentation .....	30

# Section 1 – Executive Summary

This report summarizes Segal's review of the claims processing and payment procedures utilized by Cigna Healthcare (Cigna), in its administration of the Los Angeles County Employees Retirement Association's (LACERA) group dental benefits. Felicia Zhang and Nadine Boakye-Ansah of Segal's Benefit Audit Solutions (BAS) Practice conducted the remote audit during the week of October 27, 2025.

The audit encompassed a total sample of 225 claims for the audit period of July 1, 2024, through June 30, 2025 (Audit Period). The 225 sample claims equaling \$87,071.28; or 0.22% by cost, of the \$39,574,017.84 total claims for the audit period.

Overall, Segal identified \$143.20 in overpayments, which are outlined under **Key Findings and Recommendation section and Sections 3 of this report.**

Cigna, within its formal response in Appendix A of this report, agreed to the \$143.20 in overpayment errors. Cigna's responses to the findings from the remote review are summarized and italicized throughout this report.

Segal's audit included the following review components.

- A random, stratified sample of 225 statistical dental claims to measure validity in the financial dollar value and incidence.
- A measurement of the time-to-process claims from receipt of claim to the initial date processed for payment or denial.
- An adjudication procedure review to assess day-to-day processing guidelines and claim control measures.

## Statistical achievement categories

As illustrated in the chart below, Cigna met the performance guarantees and industry standards for Financial, Payment, Procedural, and Overall Processing Accuracies but fell below the 10-business day and 20-business day performance guarantee for Time-to-Process, per Segal’s calculation. The audit period accuracy results do not include out-of-sample claims.

Performance Guarantees Table

Category	Statistical Achievement	Performance Guarantees	Industry Standards
Financial Accuracy (dollar value)	99.91%	99.00%	99.00%
Payment Accuracy (free from financial error)	99.62%	95.00%	97.00%
Procedural Accuracy (free from processing error)	100.00%	N/A	95.00%
Overall Processing Accuracy (free from error)	99.62%	95.00%	95.00%
Time-to-Process (within 10-business days)	92.88%	93.00%	95.00%
(within 20-business days)	95.36%	98.00%	100.00%

**Note:** Time-to-Process achievement was calculated on 100% of the claim’s population for the audit period and does not take adjustments into account.

N/A = not applicable

Segal requested that Cigna provide its performance guarantee achievement for time-to-process as Segal’s calculation did not include multiple processing events (i.e., adjustments).

*Cigna confirmed with adjustments included, Cigna met 97.90% for 10-business days and 99.10% for 20-business days.*

*As the amount Cigna provided is confirmed to meet the performance guarantees, Segal can conclude that there are no issues with the time to process.*

## Key findings and recommendations

The following table summarize the primary findings identified by Segal during the claims review. Cigna’s responses to the findings from the remote review are summarized and italicized throughout the report. Cigna was presented with a draft report on December 5, 2025, for its review and comment. Cigna provided its formal response to the audit report on December 22, 2025, which can be found in Appendix A.

Statistical Audit Findings Summary Chart

Dental Audit Findings Summary Issue	Audit Findings (In and Out-of-Sample) Overpayments	Audit Findings (In and Out-of-Sample) Underpayments	Audit Findings (In and Out-of-Sample) Procedural Errors	Audit Findings (In and Out-of-Sample) Number of Sample Errors
Issue 1: Frequency Exceeded	\$84.80			1
Issue 2: Deductible applied to bitewings			28	28
Issue 3: Incorrect Coordination of Benefits	\$58.40			1
Issue 4: Major restorative services paid at 80%			25	25
<b>Total</b>	<b>\$143.20</b>		<b>53</b>	<b>55</b>

An out-of-sample (OOS) finding is identified as a claim that is not sampled but identified through a sampled member’s claims history.

Details regarding the identified issues can be found in the Claim Sample Error Table in Section 3 of this report.

### Summary Findings and Recommendations

Based upon the claims review, Segal identified the following issues and applicable recommendations:

- **Issue 1: Frequency Exceeded** – The frequency limitation for core build-up was exceeded. Cigna agreed to this error during the review, confirmed that coaching was provided to the processor, and confirmed that the claim has been corrected. Segal found this intervention was an appropriate course of action on Cigna’s behalf. No further intervention is necessary.
- **Issue 2: Deductible applied to bitewings** – Deductibles were applied to bitewings services; however, according to plan documents on LACERA’s website, bitewings are classified as a Class I service and do not require a deductible. Cigna disagreed with these errors during the remote review and provided confirmation from LACERA that bitewings require a deductible. Segal recommends that LACERA discuss updating the SPDs/Evidence of Coverage and benefit matrix with Cigna to provide updated language on the bitewings benefit.
- **Issue 3: Incorrect Coordination of Benefits** – The coordination of benefits was calculated incorrectly. Cigna agreed to this error during the review, confirmed that coaching was provided to the processor, and confirmed that the claim has been corrected. Segal found this intervention was an appropriate course of action on Cigna’s behalf. No further intervention is necessary
- **Issue 4: Major restorative services paid at 80%** – Major restorative services (crowns, onlays, dentures, abutments, core build-ups, etc.) were paid at 80%; however, according to plan documents on LACERA’s website, Cigna will pay 50% after deductible for major restorative services. Cigna disagreed with this error during the remote review and provided confirmation from LACERA that major restorative procedures are paid at 80%. Segal recommends that LACERA discuss updating the SPDs/Evidence of Coverage with Cigna to provide updated language on the major restorative service benefits.

## Section 2 – Audit Details

Cigna provided an electronic data file of all dental claims processed and paid during the 12-month Audit Period. The objective of the review was to ensure that claims were paid in accordance with the LACERA's plan provision.

The auditors completed a form for each sampled claim serving as the primary documentation on which the report is based. To maintain patient confidentiality, claims addressed within this report are referred to as "Worksheets". These worksheets (1-225) are further distinguished with an alphabet character (A-K) that identifies the respective payment tier in the statistical analysis. The auditors reviewed each claim from receipt to release for check disbursement to identify any variances in procedures and benefit determination.

### Review process

Cigna provided a copy of the sampled claim submissions and access through its Dentacom System. Auditors recalculated and reviewed each claim manually from initial receipt to final benefit determination seeking evidence of compliance with established adjudication procedures and benefit provisions. In addition to verifying the amount paid, evidence of the following processing tasks was explored.

- Claims were paid only on behalf of eligible individuals based on records contained in the claims system.
- Documentation (i.e., provider bills, statements, pre-determination decisions, x-ray reports, etc.) is on file for claims paid and verified when necessary.
- Coordination of benefits (COB) provisions were enforced, where applicable.
- Proper application of age-specific edits.
- Dental downgrades applied, as applicable.
- Amounts paid were within the network discount fees or designated non-contracted allowances.
- Proper dental necessity was investigated.
- Benefits were paid under the proper classification, diagnostic, and dental procedure codes, as an incorrect entry may affect payment accuracy or future benefit determinations.
- Appropriate benefit limitations, deductibles, cost-sharing, and annual maximums were applied.
- Claims system logic for examiner edits and auto-adjudication capabilities.

- Arithmetic calculations were correct.
- Duplicate submissions were properly denied.
- Payment was made to the proper party (i.e., the provider of service if benefits were assigned; claimant if benefits were not assigned).
- Time-to-process for processing of claims was within industry standards or established performance guarantees.

The 2024 Summary Plan Descriptions and 2024 Dental Benefit Summaries for Cigna Dental Preferred Provider Insurance and Cigna Dental Choice for Texas Retirees served as references for the statistical analyses; please note that a full list of resources documents has been added to the appendix.

All questions and potential errors were presented to Cigna's representatives; outstanding responses post-audit were provided through November 24, 2025.

# Section 3 – Statistical Review

The selection of 225 random claims for the Audit Period was stratified by dollar amount in order to provide large claims representation that is more valid in determining financial accuracy levels. The methodology of Segal's stratified selection process utilizes a formula designed to take full advantage of statistical sampling procedures that allows a quantifiable degree of confidence, whereby results obtained in the audit sample are a true reflection of the way all claims were processed during the audit period.

A basic principle of the sampling technique is the premise that stratified audit findings are representative of all claims; therefore, the respective strata error rate is used to project the total errors for each stratum. The total projected errors are used to calculate the statistical accuracy levels in comparison to industry standards.

## Stratification Table

Below is the stratification table utilized for the audit.

Strata	Starting Dollar Range of Strata	to	Ending Dollar Range of Strata	Number of Claims in Range	Number of Claims in Selection	Dollar-Amount in Selection	Dollar-Amount in Strata
A	\$0.01	–	\$59.99	18,475	40	\$1,640.18	\$763,076.14
B	\$60.00	–	\$89.99	25,911	40	\$2,949.52	\$1,950,060.08
C	\$90.00	–	\$119.99	24,784	40	\$4,214.92	\$2,585,859.67
D	\$120.00	–	\$159.99	23,241	30	\$4,156.00	\$3,197,119.82
E	\$160.00	–	\$219.99	21,018	12	\$2,244.24	\$3,920,484.57
F	\$220.00	–	\$389.99	22,726	12	\$3,566.40	\$6,544,177.65
G	\$390.00	–	\$824.99	15,444	11	\$6,934.40	\$8,725,932.09
H	\$825.00	–	\$1,199.99	6,398	10	\$10,094.29	\$6,419,495.78
I	\$1,200.00	–	\$1,499.99	2,957	10	\$13,256.00	\$3,899,194.11
J	\$1,500.00	–	\$1,949.99	1,029	10	\$15,000.00	\$1,545,602.60
K	\$1,950.00	–	\$2,760.00	10	10	\$23,015.33	\$23,015.33
<b>Total</b>				<b>161,993</b>	<b>225</b>	<b>\$87,071.28</b>	<b>\$39,574,017.84</b>

## Statistical claim sample error table

The review of 225 statistical sample claims for the Audit Period identified one (1) in- sample error:

- One (1) overpayment totaling \$58.40.

**In addition to the above error, fifty-three (53) plan notifications were identified and one (1) out-of-sample (OOS) error was identified. The OOS error was an overpayment of \$84.80. OOS claims are identified as claims that are not sampled but identified through a sampled member’s claims history.**

Segal requests that Cigna initiate overpayment recovery for claims identified in the following table and provide financial impact reports when noted in the table below. Cigna’s responses are summarized and italicized with formal response found in *Appendix A* of this report.

### Statistical Sample Findings

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Cigna’s Response/ Segal’s Request	Cigna’s Formal Response	Segal’s Final Comment
<b>Issue 1: Frequency Exceeded</b>					
16A	OOS: \$84.80	<b>Manual</b>	A benefit for core build-up was paid twice within one week, which exceeds the frequency limitation. <i>Cigna agreed with this error during the remote review.</i> Segal requested that Cigna provide coaching to its processor for this manual frequency payment issue.	<i>Cigna is in agreement with Segal’s audit findings on Out-of-Sample #016.</i> <i>It was determined that the root cause of the identified error was due to a manual claim processing error. The error has been thoroughly reviewed with the individual claim processor and details were also shared with the processing teams for further coaching opportunities, completed October 30, 2025.</i>	<b>No further intervention is necessary.</b>
<i>Reviews included:</i>					

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Cigna's Response/ Segal's Request	Cigna's Formal Response	Segal's Final Comment
<ul style="list-style-type: none"> <li>• Full review of claim submission details</li> <li>• Coaching on importance of reviewing entire claim history for claimant prior to finalizing claim</li> <li>• Review of Knowledge Article: Dental Checklist – Dentacom</li> <li>• Review of Knowledge Article: CDT2025 D2910 – D2999 Dental Advisory DIPPO Dental Guide</li> </ul> <p>Claim Correction Status: Out-of-Sample #016 – The overpayment was sent for recovery on December 5, 2025.</p>					
<b>Issue 2: Deductible applied to bitewings</b>					
52B	Plan Notification	<b>Auto</b>	<p>A deductible was applied to bitewings. According to page 13 of the SPD, bitewings are classified as a Class I service and do not require a deductible.</p> <p><i>Cigna disagreed with these errors during the remote review and confirmed with LACERA the plan intent to process bitewings as Class II services.</i></p>	<p><i>Cigna confirms that new LACERA retirees receive hard copies of the Summary Plan Description (SPD) and the benefit summary within their plan documents. To enhance clarity and accessibility, the account team servicing LACERA has included detailed explanations of many non-standard benefits in the benefit summary document</i></p>	<p><b>Segal notes that through the LACERA website (<a href="https://www.lacera.gov/healthcare-plans">https://www.lacera.gov/healthcare-plans</a>), the benefit matrix also states that a deductible does not apply to bitewings. Segal recommends that LACERA discuss updating the SPDs/Evidence of Coverage and benefit matrix with Cigna to</b></p>

Worksheet	Under/ Overpayment/ Procedural/ Plan Intent or Notification	Auto/ Manual	Initial Error/ Cigna's Response/ Segal's Request	Cigna's Formal Response	Segal's Final Comment
			Segal noted that this issue will be considered a plan notification as Cigna provided LACERA's confirmation of the benefit application. Segal requested that Cigna advise on whether LACERA members receive both the SPD and benefit summary.	<i>to facilitate a clearer understanding to retirees. SPDs are available on mycigna.com, and benefit information is also available to retirees on the LACERA website at <a href="https://www.lacera.gov/healthcare-plans">https://www.lacera.gov/healthcare-plans</a>.</i>	<b>provide updated language on the bitewings benefit.</b>
72B	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
74B	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
75B	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
78B	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
90C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
92C	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
94C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
97C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>

<b>Worksheet</b>	<b>Under/ Overpayment/ Procedural/ Plan Intent or Notification</b>	<b>Auto/ Manual</b>	<b>Initial Error/ Cigna's Response/ Segal's Request</b>	<b>Cigna's Formal Response</b>	<b>Segal's Final Comment</b>
99C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
103C	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
105C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
107C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
108C	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
113C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
115C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
118C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
121D	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
126D	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
134D	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>

<b>Worksheet</b>	<b>Under/ Overpayment/ Procedural/ Plan Intent or Notification</b>	<b>Auto/ Manual</b>	<b>Initial Error/ Cigna's Response/ Segal's Request</b>	<b>Cigna's Formal Response</b>	<b>Segal's Final Comment</b>
138D	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
140D	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
151E	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
155E	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
158E	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
161E	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
169F	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
181G	Plan Notification OOS	<b>Manual</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
72B	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
74B	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
75B	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
78B	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>

<b>Worksheet</b>	<b>Under/ Overpayment/ Procedural/ Plan Intent or Notification</b>	<b>Auto/ Manual</b>	<b>Initial Error/ Cigna's Response/ Segal's Request</b>	<b>Cigna's Formal Response</b>	<b>Segal's Final Comment</b>
90C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
92C	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
94C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
97C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
99C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
103C	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
105C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
107C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
108C	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
113C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
115C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>

<b>Worksheet</b>	<b>Under/ Overpayment/ Procedural/ Plan Intent or Notification</b>	<b>Auto/ Manual</b>	<b>Initial Error/ Cigna's Response/ Segal's Request</b>	<b>Cigna's Formal Response</b>	<b>Segal's Final Comment</b>
118C	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
121D	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
126D	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
134D	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
138D	Plan Notification OOS	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
140D	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
151E	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
155E	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
158E	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
161E	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
169F	Plan Notification	<b>Auto</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>
181G	Plan Notification OOS	<b>Manual</b>	See details in worksheet 52B.	See details in worksheet 52B.	<b>See details in worksheet 52B.</b>

**Issue 3: Incorrect COB**

106C	\$58.40	<b>Manual</b>	<p>Coordination of benefits was applied incorrectly.</p> <p><i>Cigna agreed with this error during the remote review that it paid as primary when it should have paid as secondary.</i></p> <p>Segal requested that Cigna provide coaching to its processor for this manual issue.</p>	<p><i>Cigna is in agreement with Segal's audit findings on Sample #106.</i></p> <p><i>It was determined that the root cause of the identified error was due to a manual claim processing error. The error has been thoroughly reviewed with the individual claim processor and details were also shared with the processing teams for further coaching opportunities, completed December 9, 2025.</i></p> <p><i>Reviews included:</i></p> <ul style="list-style-type: none"> <li><i>• Full review of the claim submission details</i></li> <li><i>• Coaching on primacy determination – specifically when there is dual coverage that involves a retiree and active plan</i></li> <li><i>• Review of Knowledge Article: Coordination of Benefits Dental Dentacom</i></li> </ul> <p><i>Claim Correction Status: Out-of-Sample #106 – The overpayment was sent for recovery on December 5, 2025.</i></p>	<b>No further intervention is necessary.</b>
------	---------	---------------	--	--	--

**Issue 4: Major restorative services paid at 80%**

142D	Plan Notification	<b>Auto</b>	Major restorative services (crowns, onlays, dentures, abutments, core build-ups,	<i>Cigna confirms that new LACERA retirees receive hard copies of the Summary</i>	<b>Segal recommends that LACERA discuss updating the</b>
------	-------------------	-------------	--	---	--

			<p>etc.) are classified as Class III services; it states on page 12 of the SPD that Cigna will pay 50% after deductible. Page 15 of the SPD explicitly lists these procedures as Class III. However, Cigna incorrectly paid these services as Class II services, meaning Cigna paid 80% after the deductible.</p> <p><i>Cigna disagreed with this error during the remote review and confirmed with LACERA the plan intent to pay these procedures at 80%.</i></p> <p>Segal notes that this issue will be considered a plan notification as Cigna provided LACERA's confirmation of the benefit application. Segal requests that Cigna advise on whether LACERA members receive both the SPD and benefit summary.</p>	<p><i>Plan Description (SPD) and the benefit summary within their plan documents. To enhance clarity and accessibility, the account team servicing LACERA has included detailed explanations of many non-standard benefits in the benefit summary document to facilitate a clearer understanding to retirees. SPDs are available on mycigna.com, and benefit information is also available to retirees on the LACERA website at <a href="https://www.lacera.gov/healthcare-plans">https://www.lacera.gov/healthcare-plans</a>.</i></p>	<p><b>SPDs/Evidence of Coverage with Cigna to provide updated language on the benefit for major restorative services.</b></p>
180G	Plan Notification	<b>Auto</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
181G	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
184G	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
186H	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
188H	Plan Notification	<b>Auto</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>

189H	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
190H	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
192H	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
196I	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
198I	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
200I	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
204I	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
206J	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
208J	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
210J	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
211J	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
214J	Plan Notification	<b>Auto</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
215J	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
216K	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
218K	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
220K	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
222K	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>

223K	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>
224K	Plan Notification	<b>Manual</b>	See details in worksheet 142D.	See details in worksheet 142D.	<b>See details in worksheet 142D.</b>

### Summary of Statistical Sample Findings

Description	Amount
1 Overpayments	\$58.40
1 OOS Overpayments <sup>1</sup>	\$84.80
53 Plan Notification Items	N/A

Segal does not guarantee the accuracy of the claims adjudication of the dental benefit plan or that the audit results will capture all differences in the plan's benefit documents and the Anthem's dental claims adjudication. The results in this report are based on information available to Segal at the time the audit was conducted and are not a guarantee of future results. Actual experience may differ due to numerous factors, including but not limited to changes in the regulatory environment, plan designs, claim volumes, and changes to contractual agreements. Segal's audit results and recommendations, as applicable are not legal advice. Issues involving the interpretation of laws/regulations should be referred to the plan's own legal counsel. Some materials provided may be deemed proprietary and confidential and may not be disclosed or shared with any third parties other than authorized employees, directors, or Trustees of the plan sponsor without the consent of your carrier.

<sup>1</sup> OOS claims are identified as claims that are not sampled but identified through a sampled member's claims history.

## Section 4 — Time-to-Process Achievement

Results from the electronic analysis of all dental claims processed during the Audit Period revealed Cigna processed 92.88% of the claims within fourteen (14) calendar days (10 business days) and 95.36% within thirty (30) calendar days (20 business days).

Time-to-process is measured from the date a claim is first received to the initial date processed for payment or denial. Industry standards indicate 95% of all claims should be processed within fourteen (14) calendar days. Best practice, which follows U.S. Department of Labor, Employee Benefits Security Administration (EBSA), requires 100% within thirty (30) calendar days.

Segal requested that Cigna provide its performance guarantee achievement for time-to-process as Segal's calculation did not include multiple processing events (i.e., adjustments).

*Cigna confirmed with adjustments included, Cigna met 97.90% for 10-business days and 99.10% for 20-business days.*

As the amount Cigna provided is confirmed to meet the performance guarantees, Segal can conclude that no issues with the time to process.

# Section 5 – Adjudication Procedures Review

The objective of the review is to ensure that proper procedures are in place to ensure claims control measures. The processing guidelines were described in the Adjudications Procedures Review and evidenced within the 225 statistical claim samples or confirmed through discussion with Cigna's personnel. While the list did not capture all administrative procedures and system functions, it does support that established guidelines are in place to control Plan costs.

- Claims for LACERA are processed by a designated claim processing team who are Work at Home (WAH) and located across the US. There are currently 7 claim processors on the designated team.
- Average monthly dental claim volume for LACERA during the scope period was approximately 15,888 claims per month.
- 71.44% of LACERA claims are auto-adjudicated by Cigna.
  - 81.61% of claims are auto-adjudicated business wide through Cigna.
- Business wide, Cigna receives 91.38% of dental claims through electronic submission.
- Cigna's Special Investigations Unit (SIU) analytics team uses multiple approaches to monitor and identify suspect patterns of behavior and schemes (e.g., link analysis, trend analysis, outlier analysis, social analytics, geospatial analytics, predictive modeling). In addition to internal monitoring, Cigna also utilizes the following programs to identify suspected fraudulent claims.
  - Dedicated Data Mart (Healthcare Fraud Shield)
  - Geospatial Analytics (ArcGis)
  - Social Media Monitoring (Synthesio)
  - Link Analysis (i2)
  - P&R Dental Fraud and Abuse Detection
  - RatStats
  - Statistical Sampling Software
  - Multiple Control Models (SAS Miner, SAS Enterprise Guide, SQL)
  - Other Enabling Technologies (Teradata Studio, Toad, CA Workstation, Tableau, Cognos)
- Cigna reports suspicious fraudulent provider claims activity to law enforcement, leadership within NHCAA (National Health Care Anti-Fraud Association), Health Care Fraud Prevention Partnership, and other fraud focused organizations. If evidence of fraud is identified, a referral may be made to the state's Department of Insurance. This process has not been adjusted since Segal started auditing.
- Pre-determinations are not required but are recommended for any services billed over \$200.00.

- Members eligibility information is received via paper, email, and phone calls from LACERA.
- Cigna's eligibility analyst review records to ensure that the records match the dental benefit option for each member.
- Cigna's system has the ability to automatically identify potential coordination of benefits (COB).
- COB investigations are triggered in the following instances:
  - If a claim is received for a dependent/spouse and other insurance investigation has not been updated within the past 12 months.
  - If a claim has an indication of other insurance.
  - Receipt of another insurance's explanation of benefits.
  - When a plan is changed.
    - If other insurance information is not received within 55 days, Cigna denies the claim (except in the case of North Carolina where members are allowed 90 days).
- Two external vendors are utilized for services related to LACERA's claims.
  - Firstsource is utilized for dental mail room and data entry.
  - Cotiviti is utilized for overpayment recoveries.

# Appendix A

## Los Angeles County Employees Retirement Association

Analysis of Cigna Healthcare Dental Claims Processing and  
Payment Procedures

December 2025



Confidential, unpublished property of Cigna Healthcare. Do not duplicate or distribute. Use and distribution limited solely to authorized personnel. © 2025 Cigna Healthcare

1



# Audit Overview

- Cigna would like to thank both LACERA and Segal for the opportunity to respond to the dental claim audit report provided.
- The claim review was conducted virtually the week of October 27, 2025.
- Scope Details –
  - Scope period July 1, 2024, through June 30, 2025
  - Claim Quality sample consisting of 225 random stratified dental claims
- Cigna can confirm a total of two (2) errors were identified during the audit.

Metric	Segal Reported Results
Financial Accuracy	99.91%
Payment Accuracy	99.62%
Processing Accuracy	99.62%

- Cigna appreciates the recommendations provided by Segal. We have thoroughly reviewed the feedback and included our comments regarding each recommendation in the following pages. Cigna considers LACERA a valued client and Segal a trusted business partner, and we sincerely appreciate the opportunity to share the findings of this audit with LACERA.



Segal Audit Findings	Cigna Response / Corrective Actions
<p><b>Finding 1:</b> A benefit for core build-up was paid twice within one week, which exceeds the frequency limitation. Cigna agreed with this error during the remote review. Segal requests that Cigna provide coaching to its processor for this manual frequency payment issue.</p> <p><b>Out-of-Sample #: 016</b>  <b>Overpayment: \$84.80</b></p>	<p>Cigna is in agreement with Segal's audit findings on Out-of-Sample #016.</p> <p>It was determined that the root cause of the identified error was due to a manual claim processing error. The error has been thoroughly reviewed with the individual claim processor and details were also shared with the processing teams for further coaching opportunities, completed October 30, 2025.</p> <p>Reviews included:</p> <ul style="list-style-type: none"> <li>• Full review of the claim submission details</li> <li>• Coaching on importance of reviewing entire claim history for claimant prior to finalizing claim</li> <li>• Review of Knowledge Article: Dental Checklist - Dentacom</li> <li>• Review of Knowledge Article: CDT2025 D2910 – D2999 Dental Advisory DIPPO Dental Guide</li> </ul> <p><b>Claim Correction Status:</b>  Out-of-Sample #016 – The overpayment was sent for recovery on 12/05/2025</p>



Segal Other Audit Findings	Cigna Response / Corrective Actions
<p><b>Plan Notifications</b></p> <p><b>Issue 2: Deductible applied to bitewings:</b> A deductible was applied to bitewings. According to page 13 of the SPD, bitewings are classified as a Class I service and do not require a deductible. Cigna disagreed with these errors during the remote review and confirmed with LACERA the plan intent to process bitewings as Class II services. Segal notes that this issue will be considered a plan notification as Cigna provided LACERA's confirmation on the benefit application. Segal requests that Cigna advise on whether LACERA members receive both the SPD and benefit summary.</p>	<p>Cigna confirms that new LACERA retirees receive hard copies of the Summary Plan Description (SPD) and the benefit summary within their plan documents. To enhance clarity and accessibility, the account team servicing LACERA has included detailed explanations of many non-standard benefits in the benefit summary document to facilitate a clearer understanding to retirees. SPDs are available on mycigna.com, and benefit information is also available to retirees on the LACERA website at <a href="https://www.lacera.gov/healthcare-plans">https://www.lacera.gov/healthcare-plans</a>.</p>



Segal Audit Findings	Cigna Response / Corrective Actions
<p><b>Finding 3:</b> Coordination of benefits was applied incorrectly. Cigna agreed with this error during the remote review that it paid as primary when it should have paid as secondary. Segal requests that Cigna provide coaching to its processor for this manual issue.</p> <p><b>Sample #: 106</b>  <b>Overpayment: \$58.40</b></p>	<p>Cigna is in agreement with Segal's audit findings on Sample #106.</p> <p>It was determined that the root cause of the identified error was due to a manual claim processing error. The error has been thoroughly reviewed with the individual claim processor and details were also shared with the processing teams for further coaching opportunities, completed December 9, 2025.</p> <p>Reviews included:</p> <ul style="list-style-type: none"> <li>• Full review of the claim submission details</li> <li>• Coaching on primacy determination – specifically when there is dual coverage that involves a retiree and active plan</li> <li>• Review of Knowledge Article: Coordination of Benefits Dental Dentacom</li> </ul> <p><u>Claim Correction Status:</u>  Sample #106 – The overpayment was sent for recovery on 12/05/2025</p>



Segal Other Audit Findings	Cigna Response / Corrective Actions
<p><b>Plan Notifications</b></p> <p><b>Issue 4: Major restorative services paid at 80%:</b> Major restorative services (crowns, onlays, dentures, abutments, core build-ups, etc.) are classified as Class III services; it states on page 12 of the SPD that Cigna will pay 50% after deductible. Page 15 of the SPD explicitly lists these procedures as Class III. However, Cigna incorrectly paid these services as Class II services, meaning Cigna paid 80% after the deductible. Cigna disagreed with this error during the remote review and confirmed with LACERA the plan intent to pay these procedures at 80%. Segal notes that this issue will be considered a plan notification as Cigna provided LACERA's confirmation of the benefit application. Segal requests that Cigna advise on whether LACERA members receive both the SPD and benefit summary.</p>	<p>Cigna confirms that new LACERA retirees receive hard copies of the Summary Plan Description (SPD) and the benefit summary within their plan documents. To enhance clarity and accessibility, the account team servicing LACERA has included detailed explanations of many non-standard benefits in the benefit summary document to facilitate a clearer understanding to retirees. SPDs are available on mycigna.com, and benefit information is also available to retirees on the LACERA website at <a href="https://www.lacera.gov/healthcare-plans">https://www.lacera.gov/healthcare-plans</a>.</p>



Segal Other Audit Findings	Cigna Response / Corrective Actions
<p><b>Time-to-Process Achievement</b></p> <p>Results from the electronic analysis of all dental claims processed during the audit period of July 1, 2024, through June 30, 2025, revealed Cigna processed 92.88% of the claims within fourteen (14) calendar days (10 business days) and 95.36% within thirty (30) calendar days (20 business days).</p> <p>Time-to-process is measured from the date a claim is received to the initial date of processed for payment or denial. Industry standards indicate 95% of all claims should be processed within fourteen (14) calendar days. Best practice, which follows U.S. Department of Labor, Employee Benefits Security Administration (EBSA), requires 100% within thirty (30) calendar days.</p> <p>Segal requested that Cigna provide its performance guarantee achievement for time-to-process as Segal's calculation did not include multiple processing events (i.e., adjustments).</p> <p>Cigna confirmed with adjustments included, Cigna met 97.90% for 10-business days and 99.10% for 20-business days.</p> <p>As the amount Cigna provided is confirmed to meet the performance guarantees, Segal can conclude that no issues with the time to process.</p>	<p>Cigna appreciates Segal's recognition that the Time-to-Process metrics were met for both the 10-business day and 20-business day performance guarantees for LACERA and that they have concluded there are no issues with the time to process.</p>



# Thank you for your partnership



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.  
Confidential, unpublished property of Cigna Healthcare. Do not duplicate or distribute. Use and distribution limited solely to authorized personnel. © 2025 Cigna Healthcare

8

# Appendix B

## Source documentation

The information below is a list of all documentation used as part of the review process for the dental health benefit review.

- LACERA Cigna Dental Preferred Provider Insurance Summary Plan Description, effective July 1, 2024
- LACERA Cigna Dental Choice Summary Plan Description for Texas Retirees, effective July 1, 2024
- LACERA Cigna Dental PPO Benefit Summary, effective July 1, 2024
- LACERA Cigna Dental Choice Benefit Summary, effective July 1, 2024



Los Angeles County Employees Retirement Association

# Group Dental and Medical Benefits Audit Results

Audit Period: July 1, 2024, through June 30, 2025

June 3, 2026 / Amber M. Turner, MBA, PMP/ Felicia Zhang

# Agenda

- **Dental Claims Audit**
  - Results
  - Key Findings
  - Dental - Next Steps
- **Medical Claims Audit**
  - Results
  - Key Findings
  - Medical – Next Steps

# Cigna Dental Audit - Results

Cigna provided data files for all dental claims processed and paid during the 12-month audit period of July 1, 2024, through June 30, 2025, representing \$39,574,017.84 in benefit payments. The review of 225 stratified claims identified \$143.20 in Overpayments.

Cigna met the performance guarantee standards and industry standards for the Financial, Payment, Procedural, and Overall Processing Accuracies, but fell below the 10-business day and 20-business day performance guarantee for Time-to-Process. The audit period accuracy results do not include out-of-sample claims.

Category	Statistical Achievement	Performance Guarantees	Industry Standards
<b>Financial Accuracy (dollar value)</b>	99.91%	99.00%	99.00%
<b>Payment Accuracy (Free from financial error)</b>	99.62%	95.00%	97.00%
<b>Procedural Accuracy (free from processing error)</b>	100.00%	N/A	95.00%
<b>Overall Processing Accuracy (Free from error)</b>	99.62%	95.00%	95.00%
<b>Time-to-Process</b>			
<b>(within 10 business days)</b>	92.88%	93.00%	95.00%
<b>(within 20 business days)</b>	95.36%	98.00%	100.00%

**Note:** Time-to-process achievement was calculated on 100% of the claim's population for the audit period and does not take adjustments into account.  
N/A= Not Applicable

# Cigna Dental Audit – Key Findings

The following chart represents the issues identified within the 225 Dental claims audit sample.

Dental Audit Findings Summary Issue	Audit Findings (In and Out of Sample) Overpayments	Audit Findings (In and Out of Sample) Underpayments	Audit Findings (In and Out of Sample) Procedural Errors	Audit Findings (In and Out of Sample) Number of Sample Claims
Issue 1: Frequency Exceeded	\$84.80			1
Issue 2: Deductible applied to bitewings			28	28
Issue 3: Incorrect Coordination of Benefits	\$58.40			1
Issue 4: Major restorative services paid at 80%			25	25
<b>Total</b>	<b>\$143.20</b>		<b>53</b>	<b>55</b>

# Dental – Next Steps

- **Issue 1: Frequency Exceeded** – The frequency limitation for core build-up was exceeded. Cigna agreed to this error during the review, confirmed that coaching was provided to the processor, and confirmed that the claim has been corrected. Segal found this intervention was an appropriate course of action on Cigna’s behalf. No further intervention is necessary.
- **Issue 2: Deductible applied to bitewings** – Deductibles were applied to bitewings services; however, according to plan documents on LACERA’s website, bitewings are classified as a Class I service and do not require a deductible. Cigna disagreed with these errors during the remote review and provided confirmation from LACERA that bitewings require a deductible. Segal recommends that LACERA discuss updating the SPDs/Evidence of Coverage and benefit matrix with Cigna to provide updated language on the bitewings benefit.
- **Issue 3: Incorrect Coordination of Benefits** – The coordination of benefits was calculated incorrectly. Cigna agreed to this error during the review, confirmed that coaching was provided to the processor, and confirmed that the claim has been corrected. Segal found this intervention was an appropriate course of action on Cigna’s behalf. No further intervention is necessary
- **Issue 4: Major restorative services paid at 80%** – Major restorative services (crowns, onlays, dentures, abutments, core build-ups, etc.) were paid at 80%; however, according to plan documents on LACERA’s website, Cigna will pay 50% after deductible for major restorative services. Cigna disagreed with this error during the remote review and provided confirmation from LACERA that major restorative procedures are paid at 80%. Segal recommends that LACERA discuss updating the SPDs/Evidence of Coverage with Cigna to provide updated language on the major restorative service benefits.

# Anthem Medical Audit - Results

Anthem provided data files for all medical claims processed and paid during the 12-month audit period of July 1, 2023, through June 30, 2024, representing \$188,449,781.74 in benefit payments. The review of 255 claims (220 Stratified and 35 Targeted) identified \$219,574.20 in Overpayments and -\$9,672.90 in Underpayments.

Anthem met the performance guarantees for procedural and time-to-process accuracy but fell below industry standard for payment and overall accuracy and below the performance guarantee for financial accuracy. Targeted and out of sample claims are not included in the statistical accuracy.

Category	Statistical Achievement	Performance Guarantees	Industry Standards
Financial Accuracy (dollar value)	98.41%	99.00%	99.00%
Payment Accuracy (Free from financial error)	89.39%	N/A	97.00%
Procedural Accuracy (free from processing error)	100.00%	97.00%	95.00%
Overall Processing Accuracy (Free from error)	89.39%	N/A	95.00%
<b>Time-to-Process</b>			
(within 10 business days)	99.11%	90.00%	95.00%
(within 20 business days)	99.18%	N/A	100.00%

**Note:** Time-to-process achievement was calculated on 100% of the claim's population for the audit period and does not take adjustments into account.  
N/A= Not Applicable

# Anthem Medical Audit – Key Findings

The following chart represents the issues identified within the medical claims audit. To note, all of the issues listed below, except for outpatient coinsurance, were identified in previous LACERA audits.

Medical Audit Findings Summary Issue	Audit Findings (In and Out of Sample) Overpayments	Audit Findings (In and Out of Sample) Underpayments	Audit Findings (In and Out of Sample) Procedural Error	Audit Findings (In and Out of Sample) Number of Sample Claims
Issue 1: Incorrect Medicare COB	\$177,246.83	-\$27.82		15
Issue 2: Deductible Overapplied		-\$139.89		1
Issue 3: Ophthalmological Examination Missing Coinsurance	\$4.52			1
Issue 4: Surgery Coinsurance		-\$1,346.32		4
Issue 5: Incorrect Pricing		-\$8,158.87		2
Issue 6: Hearing Aids Payment Limit	\$38,130.60			6
Issue 7: Acupuncture Limit and Coinsurance	\$496.28			6
Issue 8: Foot Orthotics Exclusion	\$2,777.50			6
Issue 9: Out-of-Network (OON) Preventive	\$918.47			3
<b>Total</b>	<b>\$219,574.20</b>	<b>-\$9,672.90</b>		<b>44</b>

# Medical - Next Steps

- **Issue 1: Incorrect Medicare Coordination of Benefit (COB)** – Coordination of benefits with Medicare was not paying at 100% of the members Medicare cost share. This is a recurring issue that was since resolved in late 2025. Segal recommends that LACERA continue to monitor the changes that were implemented to the plan to ensure the Medicare supplement claims are being paid per LACERA's intent. Segal will review the new benefit application in the next audit.
- **Issue 2: Deductible Overapplied** – As in previous audit years, the deductible on one member's account was overapplied due to comingling of the pharmacy cost sharing. Segal notes that it seems this is a lesser issue than in years previous. Segal recommends that LACERA continue to monitor this issue.
- **Issue 3: Ophthalmological Examination Missing Coinsurance** – An ophthalmological examination did not apply coinsurance. Anthem agreed to this issue and noted that it would research the root cause. As Anthem did not provide a root cause to this issue, Segal recommends that LACERA request that Anthem provide a root cause and resolution to this issue.
- **Issue 4: Surgery Coinsurance** – Coinsurance was applied to surgery facility (Hospital and Ambulatory) and surgeon's claims when surgery is to pay 100% with no cost sharing. Anthem agreed to these recurring issues during the remote review and noted that a correction was made to the system on February 19, 2026. Segal recommends that LACERA confirm with Anthem that claims from before the system correction was implemented are being adjusted accordingly.

# Medical - Next Steps, cont.

- **Issue 5: Incorrect Pricing** – Incorrect pricing applied to manual claims. Anthem provided coaching and targeted training to its processors and is in the process of adjusting claims. As Anthem has started to implement an action plan for this issue, no further intervention is necessary.
- **Issue 6: Hearing Aids Payment Limit** – Hearing aids paid beyond the \$300.00 payment limit. As this is a recurring issue, Anthem noted that it has increased monitoring of these claims to identify errors, address coaching, and adjust claims as necessary. As Anthem has implemented corrective action for this issue, Segal recommends that LACERA continue to monitor this issue to ensure the remedy is correctly addressing the issue.
- **Issue 7: Acupuncture Limit and Coinsurance** – Acupuncture paid over the \$30.00 payment limit and in some cases did not apply coinsurance. Anthem agreed to these errors and noted that it has increased monitoring of these claims to identify errors, address coaching, and adjust claims as necessary. Segal notes that this is an ongoing issue. As Anthem has implemented corrective action for this issue, Segal recommends that LACERA continue to monitor this issue to ensure the remedy is correctly addressing the issue.

# Medical - Next Steps, cont.

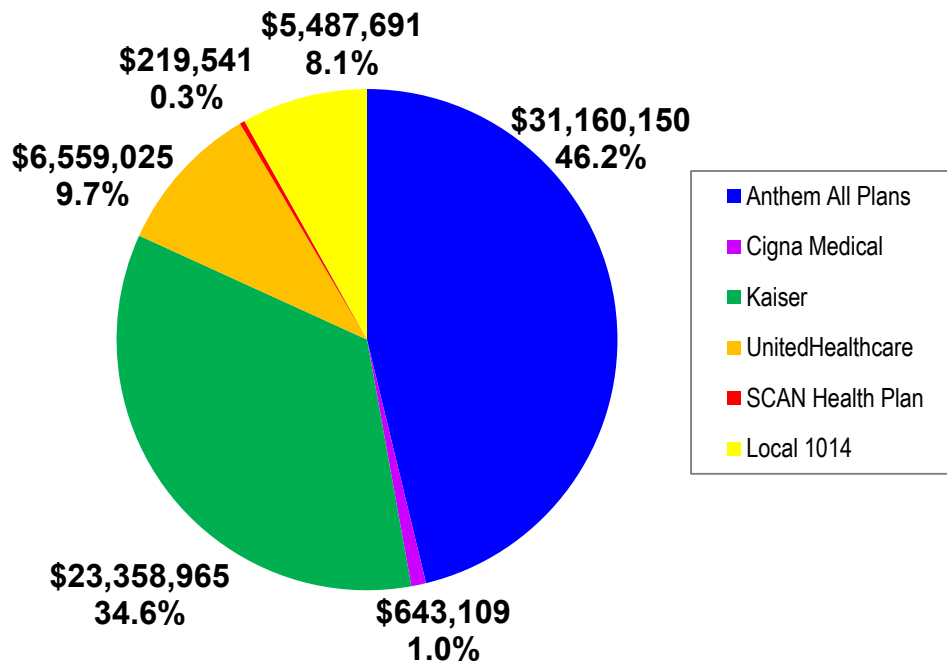
- **Issue 8: Foot Orthotics Exclusion** – Foot orthotics, which are an exclusion, were paid. Anthem agreed to these errors and noted that it has increased monitoring of these claims to identify errors, address coaching, and adjust claims as necessary. Segal notes that this is an ongoing issue. As Anthem has implemented corrective action for this issue, Segal recommends that LACERA continue to monitor this issue to ensure the remedy is correctly addressing the issue.
- **Issue 9: OON Preventive** – Claims for OON preventive care, which is an exclusion, were paid. Anthem agreed to these errors and noted that additional guidance has been provided to its processors and use of the LACERA reference guide has been reinforced to support accurate application of plan benefits. Segal recommends that LACERA request that Anthem perform ongoing monthly monitoring for this issue in addition to the corrective actions that are currently being applied.

**Los Angeles County Employees Retirement Association**  
**Premium & Enrollment**  
*Coverage Month Ending April 2026*

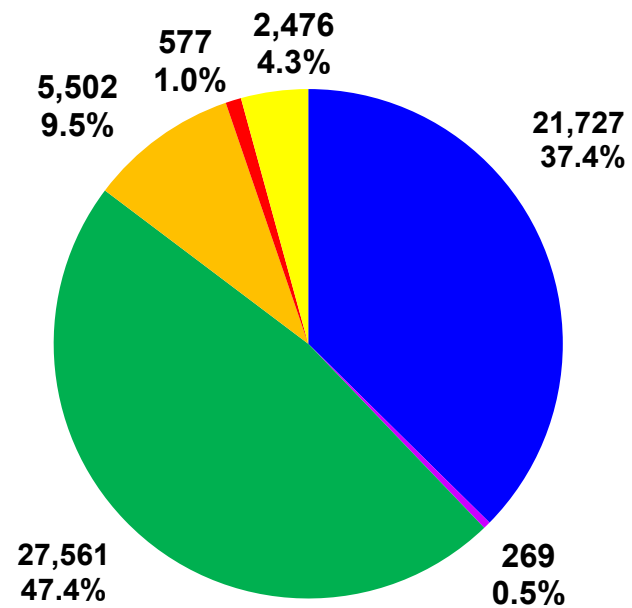
Carrier / Plan	Monthly Premium	Percent of Total	Retirees	Percent of Total
Anthem All Plans	\$31,160,150	46.2%	21,727	37.4%
Cigna Medical	\$643,109	1.0%	269	0.5%
Kaiser	\$23,358,965	34.7%	27,561	47.4%
UnitedHealthcare	\$6,559,025	9.7%	5,502	9.5%
SCAN Health Plan	\$219,541	0.3%	577	1.0%
Local 1014	\$5,487,691	8.1%	2,476	4.2%
<b>Combined Medical</b>	<b>\$67,428,481</b>	<b>100.0%</b>	<b>58,112</b>	<b>100.0%</b>

<b>Cigna Dental &amp; Vision (PPO and HMO)</b>	<b>\$5,064,007</b>	<b>60,621</b>
--	--------------------	---------------

**Monthly Premium**

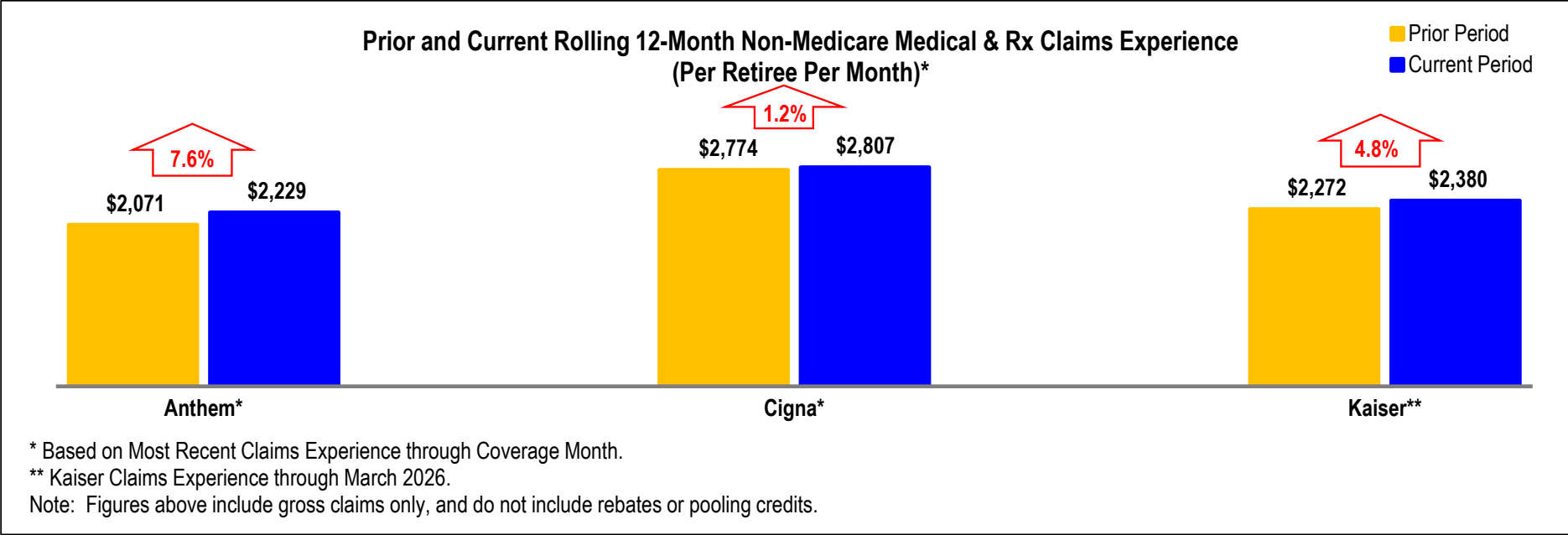
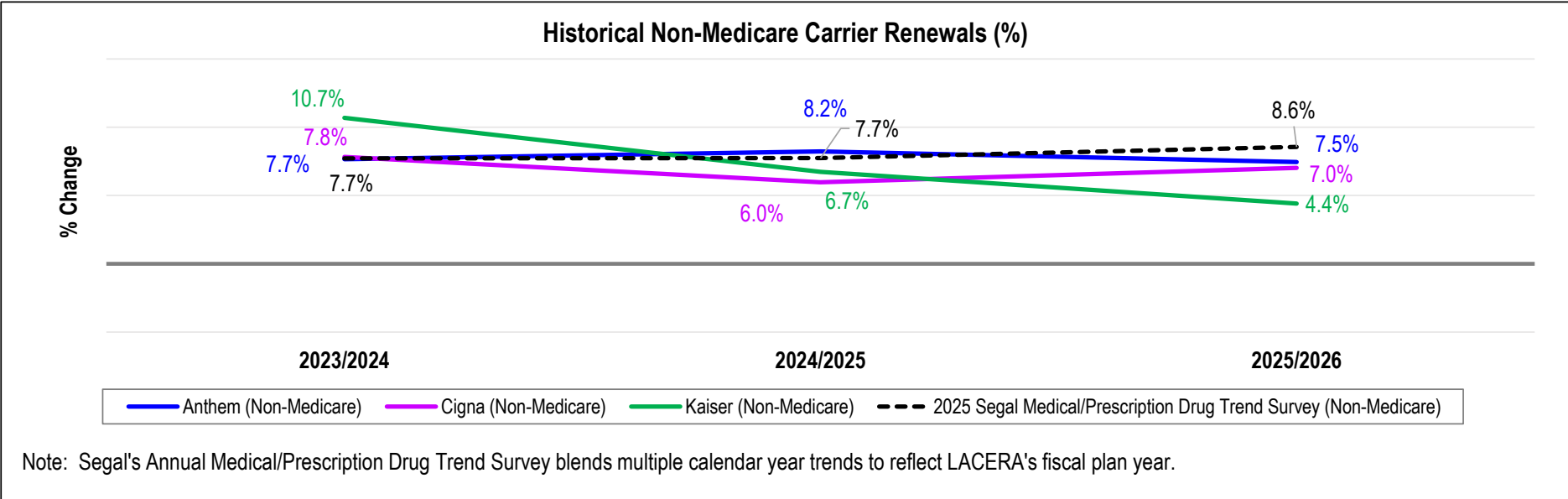


**Retirees**



Note: Premiums **include** LACERA's Administrative Fee of \$8.00 per member, per plan, per month.

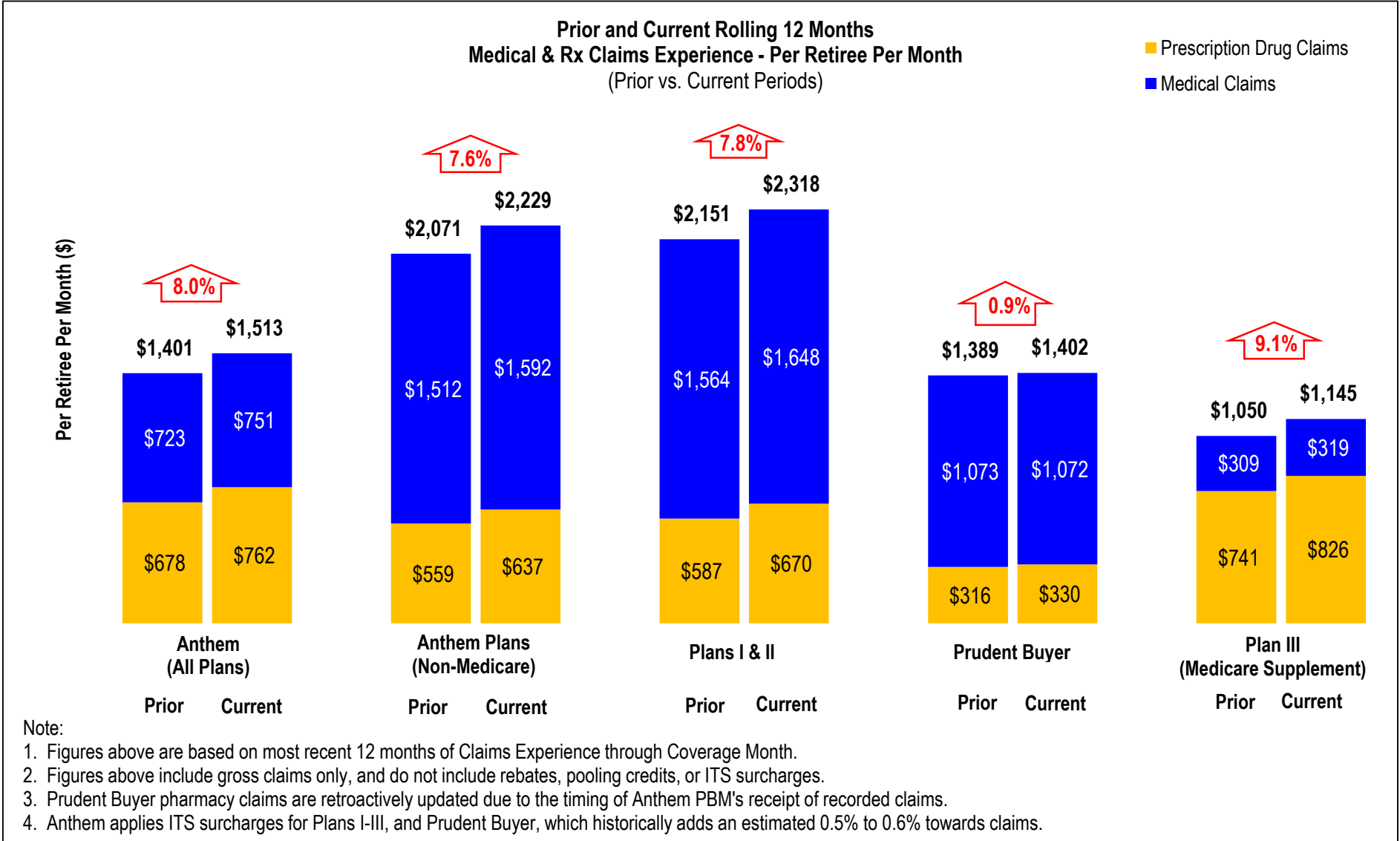
**Los Angeles County Employees Retirement Association**  
**Claims Experience by Carrier**  
*Coverage Month Ending April 2026*



# Los Angeles County Employees Retirement Association

## Anthem Claims Experience By Plan

Coverage Month Ending April 2026



Blended (Medical & Rx) Trend	2023/2024	2024/2025	2025/2026
Non-Medicare (80% Medical / 20% Rx)	7.7%	7.7%	8.6%
Medicare (20% Medical / 80% Rx)	6.9%	6.2%	8.1%

# Los Angeles County Employees Retirement Association

## Kaiser Utilization

### Coverage Month Ending April 2026

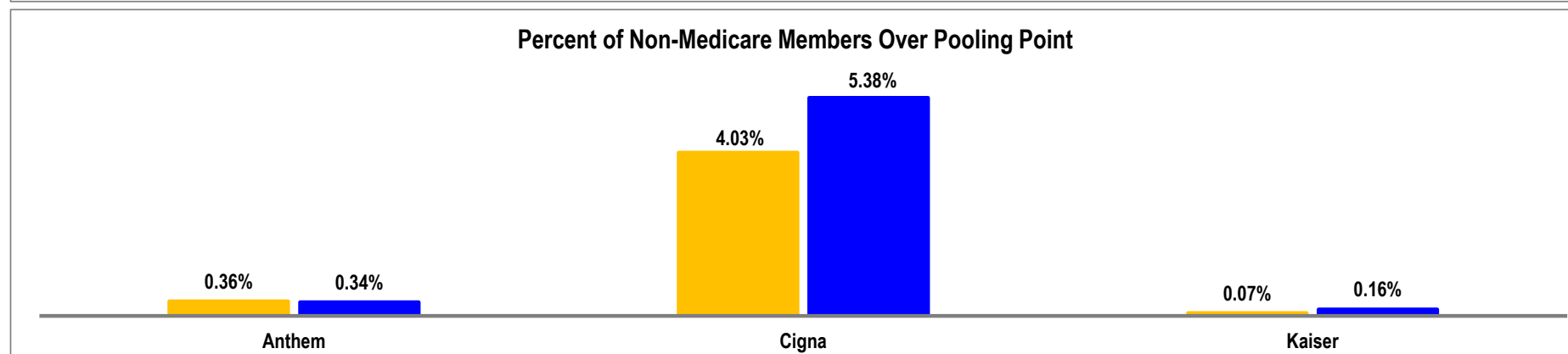
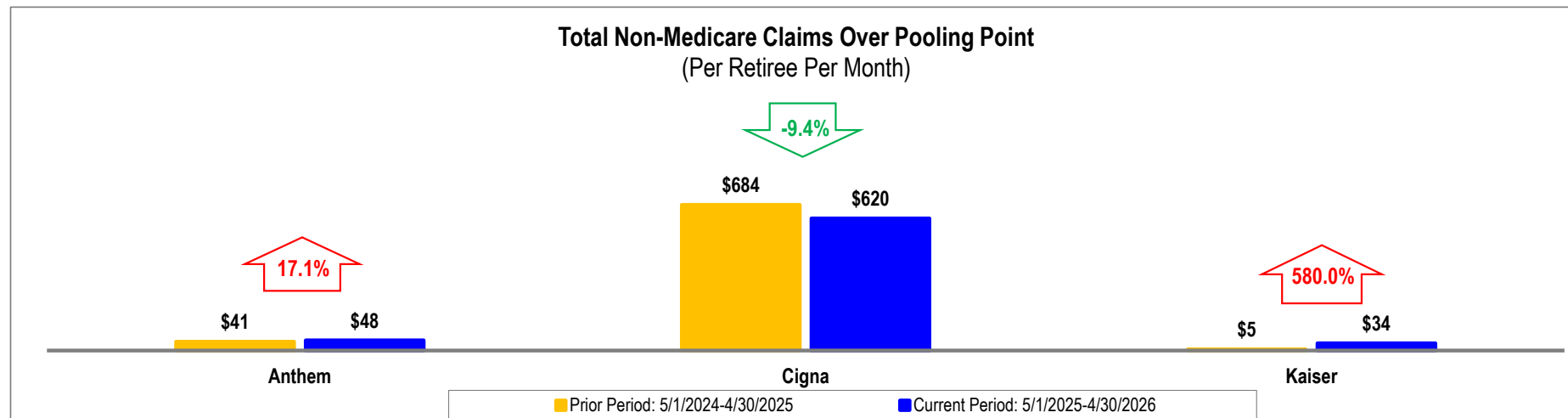
- Kaiser insures approximately 27,000 LACERA retirees with the majority enrolled in Medicare Advantage plans.
- Kaiser's Periodic Utilization Report (PUR) monitors utilization patterns of LACERA's non-Medicare population in California.

Category	Current Period 4/1/2025 - 3/31/2026	Prior Period 4/1/2024 - 3/31/2025	Change
<b>Average Contract Size</b>	<b>1.83</b>	<b>1.82</b>	<b>0.55%</b>
<b>Average Members</b>	<b>12,794</b>	<b>12,578</b>	<b>1.72%</b>
Inpatient Claims Per Member Per Month	\$319.70	\$321.30	-0.50%
Outpatient Claims Per Member Per Month	\$581.14	\$548.03	6.04%
Pharmacy Per Member Per Month	\$182.94	\$168.03	8.87%
Other Per Member Per Month	\$218.83	\$212.54	2.96%
<b>Total Claims Per Member Per Month</b>	<b>\$1,302.61</b>	<b>\$1,249.90</b>	<b>4.22%</b>
<b>Total Paid Claims</b>	<b>\$199,993,015</b>	<b>\$188,661,915</b>	<b>6.01%</b>
Large Claims over \$600,000 Pooling Point			
Number of Claims over Pooling Point	11	5	
Amount over Pooling Point	\$2,874,054	\$427,516	572.27%
% of Total Paid Claims	<b>1.44%</b>	<b>0.23%</b>	
Inpatient Days / 1000	906.7	672.7	34.79%
Inpatient Admits / 1000	96.4	96.0	0.42%
Outpatient Visits / 1000	16,676.4	16,636.9	0.24%
Pharmacy Scripts Per Member Per Year	14.2	14.1	0.71%

# Los Angeles County Employees Retirement Association

High Cost Claimants (Anthem, Cigna, & Kaiser)

Coverage Month Ending April 2026



**Stop-Loss & Pooling Points Overview:**

Plan sponsors mitigate the financial risk associated with individual large claimants through reinsurance. Claims exceeding the specified individual pooling threshold are deducted from the carrier's renewal calculation. The pooling credit is offset by the carrier's pooling expense, which is applied to all policyholders.

Anthem and Cigna figures are based on the most recent Claims Experience through Coverage Month. Kaiser's figures are based on Claims Experience period between April through March.

**Pooling Points by Carrier:**

1. Anthem's pooling points are \$400,000 for Plans I & II, and \$300,000 for Prudent Buyer.
2. Cigna's pooling point is \$100,000.
3. Kaiser's pooling point is \$600,000.

# Los Angeles County Employees Retirement Association

## Anthem Lifetime Max Accumulation Status By Plan

Coverage Month Ending April 2026

	Prior Calendar Year: December 2024 <sup>1,2</sup>			Current Calendar Year: December 2025 <sup>3,4</sup>		
Lifetime Claim Amount <sup>5</sup>	Plans I & II	Prudent Buyer	Combined	Plans I & II	Prudent Buyer	Combined
\$1.4M-\$1.5M	0	0	0	0	0	0
\$1.3M-\$1.4M	0	0	0	0	0	0
\$1.2M-\$1.3M	0	0	0	0	0	0
\$1.1M-\$1.2M	0	0	0	1	0	1
\$1.0M-\$1.1M	7	0	7	7	1	8
\$900K-\$999K	15	1	16	9	0	9
\$800K-\$899K	18	1	19	20	3	23
<b>Total</b>	<b>40</b>	<b>2</b>	<b>42</b>	<b>37</b>	<b>4</b>	<b>41</b>

	Prior Month: March 2026 <sup>3,6</sup>			Most Recent Month: April 2026 <sup>3,7</sup>		
Lifetime Claim Amount <sup>5</sup>	Plans I & II	Prudent Buyer	Combined	Plans I & II	Prudent Buyer	Combined
\$1.4M-\$1.5M	1	0	1	0	0	0
\$1.3M-\$1.4M	0	0	0	0	0	0
\$1.2M-\$1.3M	0	0	0	0	0	0
\$1.1M-\$1.2M	0	0	0	2	0	2
\$1.0M-\$1.1M	8	0	8	7	0	7
\$900K-\$999K	8	0	8	9	1	10
\$800K-\$899K	22	4	26	23	3	26
<b>Total</b>	<b>39</b>	<b>4</b>	<b>43</b>	<b>41</b>	<b>4</b>	<b>45</b>

The number of members reported will fluctuate period to period due to multiple factors including migration from an Anthem plan to another LACERA-administered plan or members passing away.

<sup>1</sup> Includes two years of historical data.

<sup>2</sup> Based on data provided by Anthem on January 22, 2025.

<sup>3</sup> Includes two months of historical data.

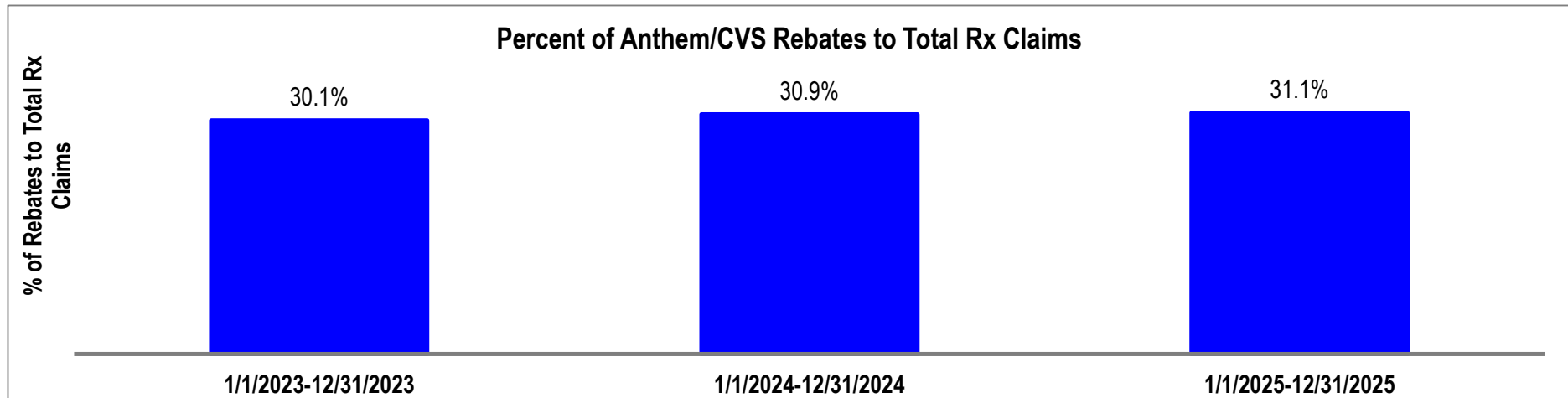
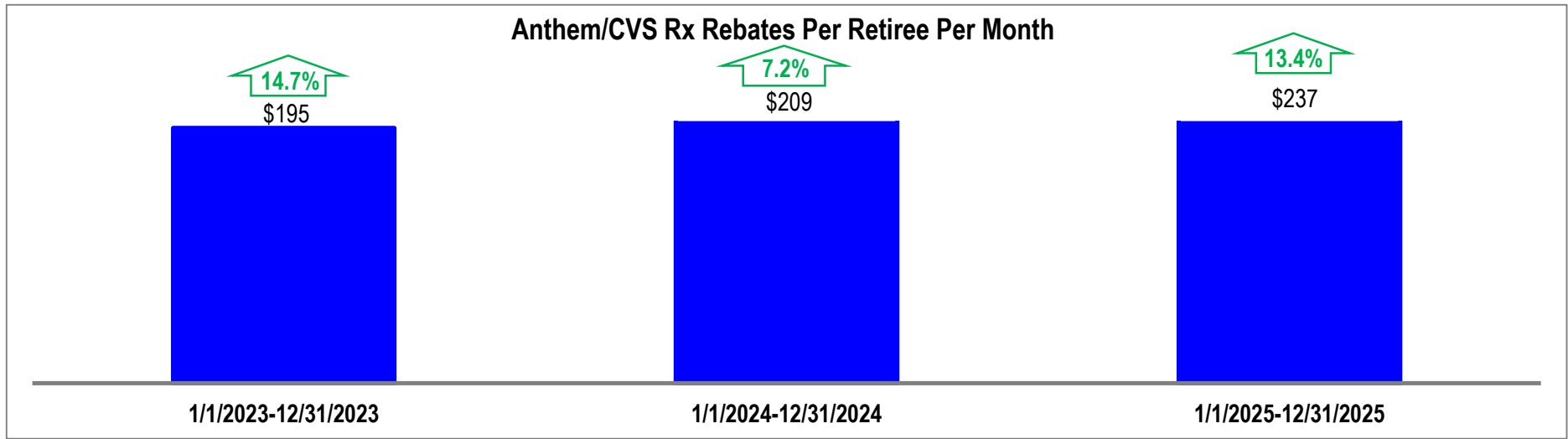
<sup>4</sup> Based on data provided by Anthem on January 14, 2026.

<sup>5</sup> Members identified by Anthem as terminated were excluded from the counts above.

<sup>6</sup> Based on data provided by Anthem on April 17, 2026.

<sup>7</sup> Based on data provided by Anthem on May 18, 2026.

**Los Angeles County Employees Retirement Association**  
**Prescription Drug Rebates (Anthem)**  
*Coverage Month Ending April 2026*



**Rebates Overview:**

Pharmacy Benefit Managers negotiate volume-based rebates with drug manufacturers of brand medications. Manufacturer rebates are passed on to plan sponsors and are used to offset pharmaceutical claims expenses.

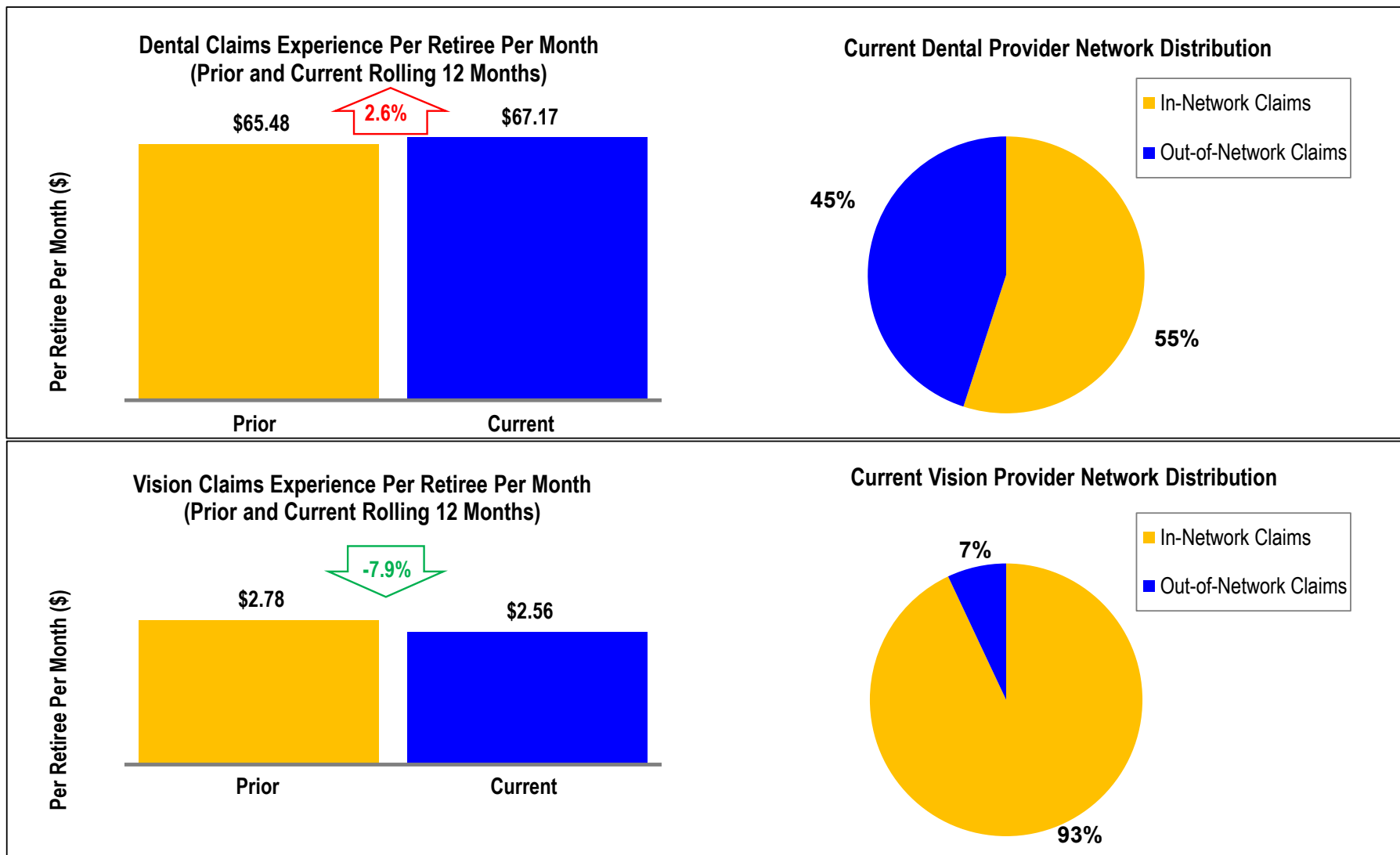
**Note:**

1. Prescription Claims and Rebates Data were provided by CVS.
2. Anthem Prudent Buyer prescription drugs are provided by CarelonRx and are not included in the charts above.

# Los Angeles County Employees Retirement Association

Cigna Dental & Vision Claims Experience

Coverage Month Ending April 2026



Notes:

1. Figures above are based on most recent 12 months of Claims Experience through Coverage Month.
2. Dental Claims Experience reflects passive use of Cigna's PPO Dental Network.

# DOL ERISA Enforcement Memo Reflects Changed Priorities

The DOL's Employee Benefits Security Administration (EBSA) has issued a memorandum to its enforcement staff that describes changed ERISA enforcement priorities:

- Focus enforcement on the most egregious conduct and on actions causing significant harm.
- Ensure, whenever possible and consistent with the DOL's mission, that EBSA does not regulate by enforcement and instead promotes fairness, prior notice and clarity to the regulated community.
- Obtain review by senior agency officials of critical enforcement initiatives.
- Commit to timely and responsive enforcement.



The memorandum, which has no legal effect, was issued by Daniel Aronowitz, Assistant Secretary for EBSA, and is consistent with actions taken by EBSA since he assumed leadership of the agency last fall and that he has been discussing in Congressional testimony and speeches. The fact that he issued it to the Director of Enforcement of field staff, as well as the field staff, underscores its importance, because the Director of Enforcement issued all prior Field Assistance Bulletins.

# Guiding principles for EBSA's changed enforcement priorities

The memorandum, which was issued as [Field Assistance Bulletin No. 2026-01 \(FAB 2026-01 or FAB\)](#), explains guiding principles to carry out the changed enforcement priorities.

## **EBSA will focus on the most egregious conduct and on actions causing significant harm**

EBSA conducts both criminal and civil investigations. EBSA will now prioritize criminal investigations that address the most significant harm to the employee benefits system.

With respect to civil enforcement, the FAB says that while ERISA's requirement that fiduciaries act with the care, skill, prudence and diligence under the circumstances that a "prudent man," acting in like capacity and familiar with such matters, would use (duty of prudence) remains important, emphasis will now be placed on violations of the duty of loyalty. EBSA will focus on conduct designed to enrich fiduciaries and other efforts deemed to be unrelated to participants' best interests, such as the promotion of environmental, social or governmental (ESG) objectives. While prudence remains a concern, the worst violations of the duty of prudence also violate ERISA's requirement that fiduciaries act solely in the interest of participants and beneficiaries (duty of loyalty). With respect to the duty of prudence, EBSA's emphasis will be on process, not results.

EBSA will also focus on direct evidence of non-exempt, prohibited transactions that involve impermissible conflicts of interest.

## **EBSA will avoid regulating through enforcement whenever possible**

To satisfy the fairness standard, EBSA will not regulate through enforcement or use enforcement to drive policy. Instead, EBSA will use notice-and-comment rulemaking and sub-regulatory guidance.

Unless the EBSA Director of Enforcement or the Assistant Secretary (or his delegate) provides advanced written approval to the contrary, EBSA enforcement will have a close nexus to the plain language of ERISA's text, clearly established guidance in final DOL regulations, prominently published sub-regulatory guidance or clearly established case law.

If there are exigent or novel circumstances necessary to protect participants and beneficiaries from significant harm, including cases applying novel legal theories, actions by field staff must be first vetted with EBSA senior officials.

## **EBSA's leadership will review all proposed significant enforcement activities**

The Deputy Assistant Secretary for Program Operations, the Director of Enforcement and each Regional Director will be required to inform the Assistant Secretary of significant enforcement activity, including proposed settlements and voluntary corrective action.

The FAB describes significant issues as including (but not limited to):

- Novel legal theories or novel areas of enforcement
- Issues that are, or reasonably likely to be, the subject of circuit court splits
- Issues that will be resolved by adopting a position that deviates from a prior EBSA position
- Any other issues that the reporting staff believe may be of interest or importance to the Assistant Secretary

## **EBSA's enforcement will be responsible and timely**

EBSA believes that, in the past, too many investigations were open-ended and continued too long. Consequently, EBSA is committing, absent exceptional circumstances, to complete investigations within reasonable time frames and to conduct enforcement activities properly and respectfully.

The FAB sets an 18-month goal for less complicated issues and a 30-month goal for more complex cases, unless there are exigent circumstances. To ensure these limits are applied, the Director of Enforcement (or a designee) will conduct quarterly reviews of civil investigations that last longer than these target time periods. The results of these reviews will be reported quarterly to the Deputy Assistant Secretary for Program Operations and the Assistant Secretary.

Additionally, EBSA staff are directed to take any available opportunities to provide timely compliance assistance to conscientious plan sponsors and service providers under ERISA's jurisdiction.

## **Another directive for EBSA staff addresses behavior**

The memorandum concludes with this final directive for EBSA staff:

EBSA investigators and professionals will not do anything that compromises the Department's independence, integrity and credibility with the regulated or participant communities. This includes eliminating any appearance that EBSA enforcement activities and priorities are being coordinated with plaintiff lawyers pursuing private actions.

## **The significance of FAB 2026-01**

The FAB has no legal standing; it serves as internal enforcement instructions. However, it makes clear the Assistant Secretary's (and the DOL's) priorities.

The switch from focusing on the duty of prudence to focusing on the duty of loyalty is consistent with the administration's concern about ESG being a factor in investment decisions.

The emphasis on not making law by litigation and reducing participant litigation that results only in big payouts for plaintiff class-action lawyers is something the Assistant Secretary wrote about even before being appointed to lead EBSA.

Criticism of the length and cost of DOL investigations is a long-term complaint of plan administrators.

This page is for informational purposes only and does not constitute legal, tax or investment advice. You are encouraged to discuss the issues raised here with your legal, tax and other advisors before determining how the issues apply to your specific situations.