Consolidated Bill Invoice

Superior Court of Frenso - SCF

Consolidated Billing Invoice
April 2022

Totals:

ADP Pays	Premium Total	Adjustment Total	Grand Total
$633,404.85	$629,795.44	$3,609.41	$633,404.85

Vendor Totals

Kaiser (List Bill)

Plan Name	Policy Number	Enrollment Count	Premium Amount	Adjustment Amount	Plan Total	ADP Pays
Plan: COBRA Kaiser HDHP		1	$685.68	$0.00	$685.68	$685.68
Plan: Kaiser HDHP		27	$28,647.75	$438.83	$29,086.58	$29,086.58
Plan: Kaiser HMO Includes Vision		288	$344,464.95	$3,315.58	$347,780.53	$347,780.53
Premium Total:	$373,798.38					
Adjustment Total:	$3,754.41					
Total ADP Paid:	$377,552.79					
Kaiser (List Bill) Total:	**$377,552.79**					

Blue Shield (List Bill)

Plan Name	Policy Number	Enrollment Count	Premium Amount	Adjustment Amount	Plan Total	ADP Pays
Plan: Blue Shield HMO		86	$152,883.87	$0.00	$152,883.87	$152,883.87
Plan: Blue Shield PPO		17	$31,001.93	$0.00	$31,001.93	$31,001.93
Plan: BlueShield HDHP		26	$30,442.21	$0.00	$30,442.21	$30,442.21
Plan: COBRA - Blue Shield HMO		1	$1,180.80	$0.00	$1,180.80	$1,180.80
Plan: COBRA - Blue Shield PPO		1	$2,086.29	$0.00	$2,086.29	$2,086.29
Premium Total:	$217,595.10					
Adjustment Total:	$0.00					
Total ADP Paid:	$217,595.10					
Blue Shield (List Bill) Total:	**$217,595.10**					

CIGNA (Self Bill)

Plan Name	Policy Number	Enrollment Count	Premium Amount	Adjustment Amount	Plan Total	ADP Pays
Plan: Cigna Basic Life/AD and D $15,000		416	$1,123.20	($5.40)	$1,117.80	$1,117.80
Plan: Cigna Basic Life/AD and D ($50,000)		44	$396.00	$0.00	$396.00	$396.00
Plan: Long Term Disability		44	$566.72	$0.00	$566.72	$566.72
Premium Total:	$2,085.92					
Adjustment Total:	($5.40)					
Total ADP Paid:	$2,080.52					
CIGNA (Self Bill) Total:	**$2,080.52**					

Magellan EAP (Self Bill)

Plan Name	Policy Number	Enrollment Count	Premium Amount	Adjustment Amount	Plan Total	ADP Pays
Plan: Employee Assistance Program		462	$1,432.20	($6.20)	$1,426.00	$1,426.00
Premium Total:	$1,432.20					
Adjustment Total:	($6.20)					
Total ADP Paid:	$1,426.00					
Magellan EAP (Self Bill) Total:	**$1,426.00**					

Metlife (List Bill)

Plan Name	Policy Number	Enrollment Count	Premium Amount	Adjustment Amount	Plan Total	ADP Pays
Plan: COBRA MetLife Dental DHMO		1	$30.11	($30.11)	$0.00	$0.00
Plan: Metlife DHMO w/ Kaiser HDHP		5	$316.15	$0.00	$316.15	$316.15
Plan: Metlife DHMO w/Blue Shield HDHP		1	$60.22	$0.00	$60.22	$60.22
Plan: Metlife DHMO w/Blue Shield HMO		14	$707.58	($60.22)	$647.36	$647.36
Plan: Metlife DHMO w/Kaiser HMO		52	$2,435.88	($90.33)	$2,345.55	$2,345.55
Premium Total:	$3,549.94					
Adjustment Total:	($180.66)					
Total ADP Paid:	$3,369.28					
Metlife (List Bill) Total:	**$3,369.28**					

Delta Dental (List Bill)

Plan Name	Policy Number	Enrollment Count	Premium Amount	Adjustment Amount	Plan Total	ADP Pays
Plan: COBRA Delta Dental PPO		4	$265.07	($118.68)	$146.39	$146.39
Plan: Delta Dental PPO w/Blue Shield HDHP		25	$1,671.36	$0.00	$1,671.36	$1,671.36
Plan: Delta Dental PPO w/Blue Shield HMO		72	$6,077.78	$0.00	$6,077.78	$6,077.78
Plan: Delta Dental PPO w/Blue Shield PPO		17	$1,319.21	$0.00	$1,319.21	$1,319.21
Plan: Delta Dental PPO w/Kaiser HDHP		22	$1,813.64	$51.53	$1,865.17	$1,865.17
Plan: Delta Dental PPO w/Kaiser HMO		236	$18,332.07	$87.05	$18,419.12	$18,419.12
Premium Total:	$29,479.13					
Adjustment Total:	$19.90					
Total ADP Paid:	$29,499.03					
Delta Dental (List Bill) Total:	**$29,499.03**					

Superior Vision (List Bill)

Plan Name	Policy Number	Enrollment Count	Premium Amount	Adjustment Amount	Plan Total	ADP Pays
Plan: 1*Superior Vision w/Delta DPPO w/BS HMO		72	$901.01	$41.13	$942.14	$942.14
Plan: 1*Superior Vision w/MetLife DHMO w/BS HMO		14	$166.80	$0.00	$166.80	$166.80
Plan: 2*Superior Vision w/Delta DPPO w/BS PPO		17	$187.72	$0.00	$187.72	$187.72
Plan: 2*Superior Vision w/MetLife DHMO w/BS PPO		1	$7.06	$7.06	$14.12	$14.12
Plan: 3*Superior Vision w/Delta DPPO w/BS HDHP		25	$217.13	$0.00	$217.13	$217.13
Plan: 3*Superior Vision w/MetLife DHMO w/BS HDHP		1	$13.71	$0.00	$13.71	$13.71
Plan: 4*Superior Vision w/Delta DPPO w/Kaiser HDHP		22	$277.68	($6.71)	$270.97	$270.97
Plan: 4*Superior Vision w/MetLife DHMO w/Kaiser HDHP		4	$55.83	$0.00	$55.83	$55.83
Plan: COBRA Superior Vision		3	$27.83	($14.12)	$13.71	$13.71
Premium Total:	$1,854.77					
Adjustment Total:	$27.36					
Total ADP Paid:	$1,882.13					
Superior Vision (List Bill) Total:	**$1,882.13**					

Totals:

Premium Total	Adjustment Total	ADP Pays	Grand Total
$629,795.44	$3,609.41	$633,404.85	$633,404.85

KAISER PERMANENTE®

P.O. Box 629028
EL Dorado Hills, CA 95762-9028

SUPERIOR COURT OF CALIFORNIA,
COUNTY OF FRESNO
Customer ID: 7582139475
Statement ID. 758213966165
April 2022

SUPERIOR COURT OF CALIFORNIA, COUNTY OF FRESNO
1100 VAN NESS AVE
FRESNO, CA 93724-2016

Any activity processed after 03/16/2022 will appear on your next bill.

Summary of Amount Due

Previous Balance	$738,440.38
Payments	$-733,497.10
Amount Past Due	**$4,943.28**
Current Activity	$373,798.38
Retro & Other Activity	$3,754.41
Total Current Charges	**$377,552.79**

Total Amount Due $382,496.07

(Includes past due and current charges)

Due Before 04/15/2022

You are not signed up for autopay. Please go to account.kp.org to make a one-time payment or schedule monthly payments directly from your bank account.

Accounts included in this bill

Purchaser ID	Region	Billing Unit ID	Total Charges
603729	NCR	0002	$29,086.58
603729	NCR	0003	$347,780.53
603729	NCR	7002	$685.68
603729	NCR	7003	$0.00

Blue Shield of California
Installation & Billing
P.O. Box 629014
El Dorado Hills CA 95762-9014

blue of california
An Independent Member of the Blue Shield Association

------ manifest line ---------

FRESNO SUPERIOR COURT
1100 VAN NESS AVE
FRESNO CA 93724

Summary

Bill Date:		03/15/22
Billing Period:		04/01/22-04/30/22
Due Date:		04/01/22
Previous Amount Due:	$	442,640.99
Payments - thank you:		-442,640.99
Balance:		0.00
Current Charges:		217,595.10
Retroactive Adjustments:		0.00
Net Credits/Debits		0.00
Total Amount Due:	$	217,595.10

Account Number: W00025601000
Invoice Number: 220740000469

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000006 1/6

Blue Shield of California is a prepaid health plan. Payment is due by the Due Date referenced above.

Thank you for your continued membership with Blue Shield. We appreciate the opportunity to serve you and provide you with access to quality healthcare. Please contact us if you have any questions.

Please pay the Total Amount Due.

Your health plan is billing you for the cost of your health coverage. You must pay all amounts listed in this bill by the due date. If you do not pay this amount by the due date, your health coverage can be cancelled. You will receive a grace period before your plan can cancel your coverage for not paying the amount due. You can file a complaint with your plan and with the California Department of Managed Health Care if you think there is a mistake. Learn more about your health care rights and responsibilities in your plan Evidence of Coverage.

Sincerely,

continued on next page

Please return this portion with payment to the address listed below

blue of california
An Independent Member of the Blue Shield Association

Group Name: FRESNO SUPERIOR COURT
Account Number: W00025601000
Invoice Number: 220740000469

Payments made on this account will be credited first toward the Outstanding Balance amounts then to the current amount due.

Please remit payment to:

BLUE SHIELD OF CALIFORNIA
P.O. BOX 749415
LOS ANGELES CA 90074-9415

Total Due - please pay this amount	$ 217,595.10
Due Date	04/01/22
Amount Enclosed	

1320000000205060001000000999999999999999990000217595103

Invoice Summary **Provider: CIGNA 04/2022**

Plan: Cigna Basic Life/AD and D $15,000					
Coverage Level/Age Band	**Rate**		**Volume ($)**	**Enrollments**	**Premium ($)**
$15,000.00		$2.700	$6,240,000.00	416	$1,123.20
	Adjustments ($):		($30,000.00)		($5.40)
	Total ($):		**$6,210,000.00**	**416**	**$1,117.80**

Plan: Cigna Basic Life/AD and D ($50,000)					
Coverage Level/Age Band	**Rate**		**Volume ($)**	**Enrollments**	**Premium ($)**
$50,000.00		$9.000	$2,200,000.00	44	$396.00
	Adjustments ($):				$0.00
	Total ($):		**$2,200,000.00**	**44**	**$396.00**

Plan: Long Term Disability					
Coverage Level/Age Band	**Rate**		**Volume ($)**	**Enrollments**	**Premium ($)**
60% of earnings up to $2,666.00		$12.880	$117,304.00	44	$566.72
	Adjustments ($):				$0.00
	Total ($):		**$117,304.00**	**44**	**$566.72**

Grand Total ($):	**$2,080.52**

Invoice Summary	**Provider : Magellan EAP 04/2022**		
Plan: Employee Assistance Program			
Coverage Level/Age Band	**Rate**	**Enrollments**	**Premium ($)**
Enrolled	ELP	462	$1,432.20
	Adjustments ($):		($6.20)
	Total ($):	**462**	**$1,426.00**
Grand Total ($):			**$1,426.00**

Metropolitan Life Insurance Company

KM05985813 0001

BILL DUE DATE: 04 01 2022

'O: SUPERIOR COURT OF CALIFORNIA,
FRESNO COUNTY

PRINT DATE: 03 14 2022

FOR ADDITIONAL INFORMATION, SEE REVERSE SIDE

NAME OF INSURED / I.D. NUMBER	INSURED BIRTH MO. - YR.	CLASS # ADJ. DATE	BT CODE	BENEFIT TITLE	FAM. IND.	ADJ. CODE	PREMIUM	VOLUME	TOTAL PREMIUM

3,369.28

OUTSTANDING DUE AS OF 03/14/2022 3,760.71

***GRAND TOTAL DUE PLEASE PAY THIS AMOUNT ------> 7,129.99

AFTER CHANGES HAVE BEEN RECEIVED AND MADE IN OUR OFFICE,
PREMIUM ADJUSTMENTS WILL BE REFLECTED ON YOUR BILLING STATEMENT.

DELTA DENTAL

Invoice

Delta Dental of California
560 Mission Street, Suite 1300
San Francisco, CA 94105

Plan underwritten and administered by:
Delta Dental of California
560 Mission Street, Suite 1300
San Francisco, CA 94105

FRESNO SUPERIOR COURT
ATTENTION: FISCAL DEPARTMENT
1100 VAN NESS AVENUE
FRESNO, CA 93724

CAN WE HELP?
Visit our web site
deltadentalins.com
For eligibility inquiries call
1-800-632-8555
For billing inquiries call
1-800-632-8555

- **Invoice number:** BE004882150
- **Invoice date:** April 1, 2022

FRESNO SUPERIOR COURT

- **Account number:** 05-1556300001
- **Purchase Order**

Period of coverage:
April 1, 2022 to April 30, 2022

Enrollment

Enrollment changes not reflected on this invoice will be adjusted on your next invoice.

Total amount this period **$29,352.64**

Total amount $29,352.64

Remittance

CUSTOMER NAME	ACCOUNT NUMBER	AMOUNT DUE	AMOUNT ENCLOSED
FRESNO SUPERIOR COURT	05-1556300001	$ 29,352.64	$

Payment Options You have two options for sending your payment - by electronic funds transfer or by

By electronic funds transfer
Delta Dental of California
Wells Fargo Bank
A/C# 4031-014269
RTN# 121000248

By mail (Make your check payable

Delta Dental of California
PO Box 884460
Los Angeles, CA 90088-4460

For CA groups only: Your health plan is billing you for the cost of your health coverage. You must pay all amounts listed in this bill by the due date. If you do not pay this amount by the due date, your health coverage can be cancelled. You will receive a grace period before your plan can cancel your coverage for not paying the amount due. You can file a complaint with your plan and with the California Department of Managed Health Care if you think there is a mistake. Learn more about health care rights and responsibilities in your plan Evidence of

DELTA DENTAL

Invoice

Delta Dental of California
560 Mission Street, Suite 1300
San Francisco, CA 94105

Plan underwritten and administered by:
Delta Dental of California
560 Mission Street, Suite 1300
San Francisco, CA 94105

FRESNO SUPERIOR COURT
ATTENTION: FISCAL DEPARTMENT
1100 VAN NESS AVENUE
FRESNO, CA 93724

CAN WE HELP?
Visit our web site
deltadentalins.com
For eligibility inquiries call
1-800-632-8555
For billing inquiries call
1-800-632-8555

- **Invoice number:** BE004882368
- **Invoice date:** April 1, 2022

FRESNO SUPERIOR COURT

- **Account number:** 05-1556300003
- **Purchase Order**

Period of coverage:
April 1, 2022 to April 30, 2022

Enrollment

Enrollment changes not reflected on this invoice will be adjusted on your next invoice.

Total amount this period **$146.39**

Total amount $146.39

Remittance

CUSTOMER NAME	ACCOUNT NUMBER	AMOUNT DUE	AMOUNT ENCLOSED
FRESNO SUPERIOR COURT	05-1556300003	$ 146.39	$

Payment Options You have two options for sending your payment - by electronic funds transfer or by

By electronic funds transfer
Delta Dental of California
Wells Fargo Bank
A/C# 4031-014269
RTN# 121000248

By mail (Make your check payable

Delta Dental of California
PO Box 884460
Los Angeles, CA 90088-4460

For CA groups only: Your health plan is billing you for the cost of your health coverage. You must pay all amounts listed in this bill by the due date. If you do not pay this amount by the due date, your health coverage can be cancelled. You will receive a grace period before your plan can cancel your coverage for not paying the amount due. You can file a complaint with your plan and with the California Department of Managed Health Care if you think there is a mistake. Learn more about health care rights and responsibilities in your plan Evidence of

SuperiorVision™

Premium Statement

IMPORTANT MESSAGE

Please fax all new enrollments, Terms & Changes to (800)469-3888 Please Remit all payments to the address below

FISCAL DEPARTMENT
SUPERIOR COURT OF CA,FRESNO
1100 VAN NESS AVENUE
FRESNO, CA 93724

BILLING DETAIL

Invoice No.	Policyholder	Billing Period	Statement Date	Due Date
0000614227	03031901	04/01/2022	04/01/2022	04/01/2022

Previous Invoice Balance:	02/15/2022	$3,682.66
Posted Items Reconciled:		
Previous Payment(s) Received:		
Received on 02/23/2022	Check #: 2172022	($1,889.30)
New Invoice Charges:		$1,868.42
Total Invoice Balance:		$3,661.78
Outstanding Payment(s):		$0.00
Total Amount Due:		**$3,661.78**

Return This Portion With Your Payment

Group Name	Policyholder	Invoice No.
SUPERIOR COURT OF CA,FRESNO	03031901	0000614227

Statement Date: 04/01/2022
Due Date: 04/01/2022
Amount Paid: $_____

REMIT TO:

SUPERIOR VISION INSURANCE INC
NGLIC
PO BOX 841343
DALLAS, TX, 75284-1343

SuperiorVision™

Premium Statement

IMPORTANT MESSAGE

Please fax all new enrollments, Terms & Changes to (800)469-3888 Please Remit all payments to the address below

FISCAL DEPARTMENT
SUPERIOR COURT-COBRA
1100 VAN NESS AVENUE
FRESNO, CA 93724

BILLING DETAIL

Invoice No.	Policyholder	Billing Period	Statement Date	Due Date
0000614228	03031902	04/01/2022	04/01/2022	04/01/2022

Previous Invoice Balance:	02/15/2022	$62.87
Posted Items Reconciled:		
Previous Payment(s) Received:		$0.00
New Invoice Charges:		$13.71
Total Invoice Balance:		$76.58
Outstanding Payment(s):		$0.00
Total Amount Due:		**$76.58**

Return This Portion With Your Payment

Group Name	Policyholder	Invoice No.
SUPERIOR COURT-COBRA	03031902	0000614228

Statement Date: 04/01/2022
Due Date: 04/01/2022
Amount Paid: $_____

REMIT TO:

SUPERIOR VISION INSURANCE INC
NGLIC
PO BOX 841343
DALLAS, TX, 75284-1343