



Insurance Agent for the City of Traverse City

Key Contact:

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QUALIFICATIONS

A. Organization and History

1. Please provide the name(s), title(s), address(es), email address, telephone and fax number(s) of the individual(s) responsible for responding to this request.

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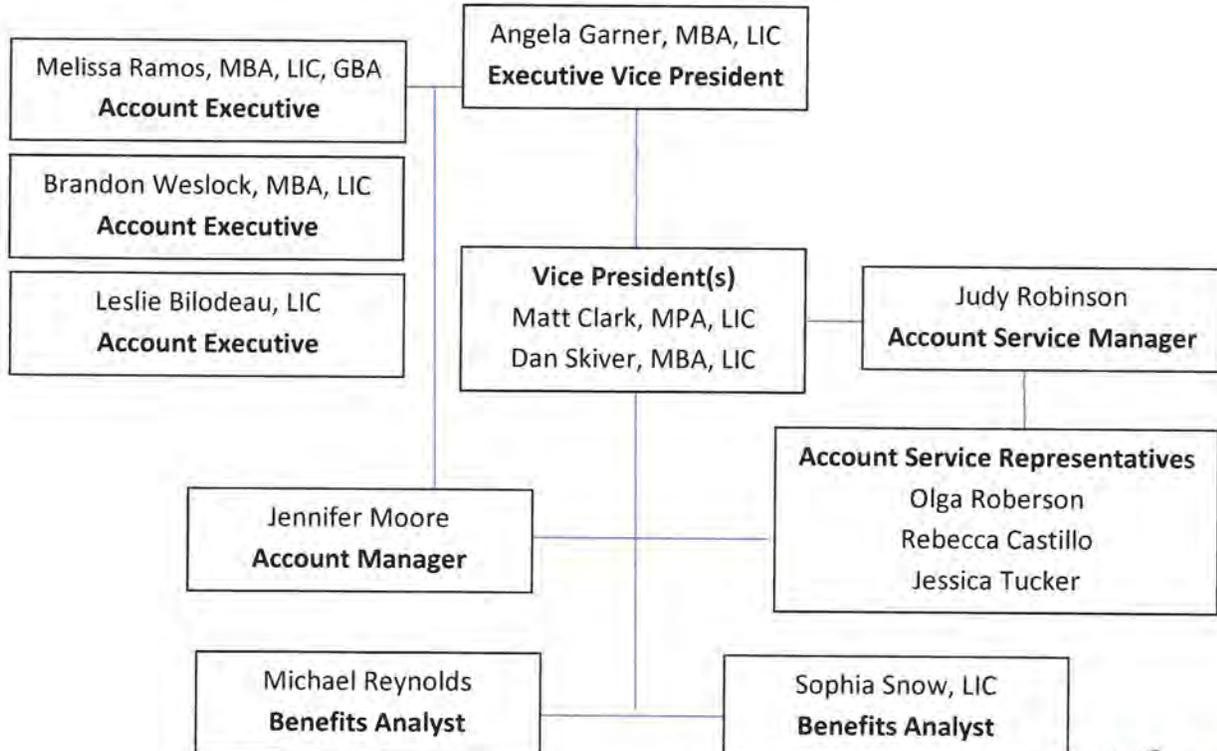
<http://www.bbinsurance.com/>

2. Provide a brief overview of your company and history of your organization including an organizational chart of your operations. (maximum 3 paragraphs) Please describe any parent/subsidiary/affiliate relationships.

Brown & Brown Insurance was founded in Daytona Beach, FL in 1939. The Saginaw office began as Public Employee Benefits Solutions in 2003 from our sister Agencies- National Employee Benefits Solutions and Employee Benefit Resources which began in the early 1980's. The Saginaw Office, Brown & Brown of Central Michigan (BBCM) was acquired by Brown & Brown in September of 2011. Brown & Brown is the 6th largest broker in the United States and is traded on the New York Stock Exchange under the symbol BRO (NYSE:BRO). In the State of Michigan, Brown & Brown is the third largest insurance agency as shown by Crain's for 2012.

Brown & Brown is made up of more than 250 insurance agency offices across the United States with approximately 7,800 employees. Services offered include employee benefits, commercial insurance, financial services, retirement planning and personal insurance. Brown & Brown is a meritocracy and each office operates on its own and structures itself to support its clients in the best manner possible.

BBCM's focus is servicing public sector clients. We have not changed our successful model and continue to excel in providing our public employer groups top-notch service and expertise, growing consistently as an agency every year.



3. Are you currently participating in any alliances or joint marketing efforts? If so, please describe in detail.

Brown & Brown of Central Michigan is not participating in any alliances or joint marketing efforts. We conduct all business for our clients based upon what is in the best interest for each individual client.

4. How many clients do you currently administer in the following categories?

Number of Employees	Number of Clients	Percentage of Total
Under 100	55	59.8%
100 – 500	29	31.5%
500-750	4	4.3%
750 +	4	4.3%
Total	92	100.0%

B. Client Service/Quality Assurance

1. Please describe the team that would deal directly with us during the transition and on an ongoing basis. Indicate staff size, experience and turnover rates. Indicate all state licenses and credentials of key personnel.

BBCM employs 14 team members in the Saginaw office and 2 in Sterling Heights. In the past three and a half years, we have had to terminate one employee, otherwise there has been zero turnover. Resumes of key personnel are also provided in the 3rd tab. There will be a variety of staff contributing to the transitional needs, as well as moving forward. All employees have a State Producer License in Life and Health.

Angela L. Garner, MBA, LIC, CEBS, GBA, RPA, Executive Vice President

Over 10 years in the insurance industry servicing large key accounts. Over 18 years working in the public sector. Masters in Business Administration. Certified Employee Benefits Specialist (CEBS) with GBA and RPA designations. Bachelor of Science in Business Administration with a major in Finance. Member of National Association of Health Underwriters.

Matthew Clark, MPA, LIC, Vice President, Worksite Wellness Specialist

Prior Key Account Manager for BCBS and Wellness and Care Management Consultant. Prior experience with Health Plan Accreditation and Manager of Health Management



Programs. Masters of Public Administration in Healthcare Administration and Bachelor of Science in Health Promotion, Prevention and Rehabilitation. Matt Clark would be your day-to-day contact.

Judy Robinson, Account Service Representative

Over 30 years of experience working within the insurance business at the capacity of Team Leader, Production Control Specialist and Account Service Representative. Specializing in resolving claim/billing issues within a timely manner.

Olga Roberson, Account Service Representative

Over 20 years working within the insurance business at the capacity of Account Service Representative and Customer Service Representative. Specializing in resolving claim/billing issues within a timely manner.

Rebecca Castillo, Account Service Representative

Over 18 years working within the insurance business at the capacity of Account Service Representative and Customer Service Representative. Specializing in resolving claim/billing issues within a timely manner.

Jessica Tucker, Account Service Representative

Worked in the medical field for multiple years. Assists personnel in their day-to-day business. Specializing in resolving claim/billing issues within a timely manner.

Jennifer Moore, Account Manager/Benefits Analyst

Over 11 years in the insurance industry working with multiple carriers including 7 years in small business with Priority Health. Specializing in marketing benefits and providing communications to our clients.

Sophia N. Snow, LIC, Benefits Analyst

Over eight years municipal government experience. Bachelor of Science in Business Administration with a major in Accounting.

Michael Reynolds, Benefits Analyst

Over three years in the insurance industry working with multiple carriers. Specializing in marketing benefits, creating renewals and providing communications to our clients.

2. What are your client retention statistics for each of the last three years?

In the last three and half years, BBCM has lost a total of four clients. Of those four, two were school districts that returned to MESSA for lower rates (MESSA doesn't allow for

agents). One was a school district with a change in administration. One was a township that left due to political reasons with new administration replacing a manager, finance director and human resources director. In that same period, we would like to note that we have had five clients return for our services after they had previously terminated. The clients who returned are a County, Road Commission, City and two Health Departments.

For those who left, what percentage left due to issues pertaining to services provided by your organization?

None.

For those who left, what percentage left due to software limitations?

None.

What is the average client relationship duration? Newest? Longest?

The majority of our clients in the 100 to 500 contract space have been with us for 6-10 years. Our longest relationship is with a client dating back to the mid-1980's who is still with us today. Our newest relationship is with a Medical Care Facility that was effective on 1-1-2015 with over 150 contracts. As stated earlier, we have very little turnover of clients and none for dissatisfaction with our services.

3. Describe your organization's commitment to quality and your philosophy/approach to client services.

The professionals at Brown & Brown of Central Michigan, Inc. (BBCM), and its licensed subsidiaries serve the insurance and financial needs of individuals, professionals, families and businesses with a simple customer-focused philosophy. Every client is unique. Every need is individual. Every plan is customized. There is no "one size fits all" solution. To be able to provide this exemplary and unique level of service involves a range of skills and knowledge drawn from more than 240 offices across the United States, and one in London.

The City of Traverse City would be serviced by multiple individuals consistently from year to year, including Angela Garner, Executive Vice President; Matt Clark, Vice President/Worksite Wellness Specialist; Jennifer Moore, Account Manager; Michael

Reynolds, Benefit Analyst; and Judy Robinson, Olga Roberson, Rebecca Castillo, and Jessica Tucker, Account Service Representatives.

BBCM provides:

- The strength and resources of one of the world's largest independent insurance brokerages, a publicly traded company (NYSE stock symbol BRO) with outstanding performance and profitability year after year.
- A collective corporate expertise in serving a total spectrum of clients from individuals to large public and corporate entities, ensuring that any potential shortfalls or gaps in current insurance are resolved competitively.
- Powerful partnerships with some of the industry's premier carriers, including regional and national carriers, as well as virtually every Lloyd's of London syndicate.
- Personal service as a trusted advisor, making sure clients are properly covered from the outset, and then seeking the most efficient and effective solutions at the most competitive price.
- Local knowledge and commitment from trained advisors who live and work in the communities they serve with the unique authority to make decisions based on the needs of their clients.

A well-designed employee benefit program can satisfy both the employer and employee needs. Even as costs of employee benefits rise, Brown & Brown employee benefits professionals continue to find ways for employers to provide excellent group benefits as part of a total compensation package.

4. Describe your customer service standards.

BBCM responds to all calls and emails within 24 hours. Your Account Manager is available by cell and email 24 hours a day and will respond ASAP. Our expectations of ourselves is quite high so that our groups never feel like they are waiting for an answer. We want to make our clients happy and ease their workloads if at all possible. If you aren't sure if we will do something, please ask.

BBCM's clients value our high customer service standards, and it's what sets us apart in our industry. Our team of experts will gather information from your existing insurance carriers and distill it into clear and concise data that is used to quantify your current plans and ensure accurate and "razor-sharp" annual renewals. BBCM will prepare Requests for Proposals (RFP's) for each line of coverage currently offered to employees including services provided by Third Party Administrators and in compliance with State Regulations like PA 106 of 2007 and our group's purchasing policies.

If the client desires, and based on meetings with key staff, lines of coverage will be bid as required by the client. BBCM has the capacity to electronically bid many lines of insurance once the employee census data is verified. Once those bids are received, BBCM will evaluate proposals received from the RFP's for accuracy and make comprehensive recommendations. BBCM will prepare a summary of the responses and prepare to negotiate with the carriers determined to be the best qualified. BBCM regularly leverages our large book of business to secure the lowest possible rates and premiums for our clients.

BBCM will make recommendations concerning changes in terms, conditions, and limits in the client's current plans. Having acted as employee benefits consultants for many public employers across the State of Michigan, past experience provides us with the broad knowledge necessary to provide the very best benefit consulting services to public entities. Our many years of practical experience and knowledge of the insurance markets allow us to make specific recommendations to ensure the benefits not only meet the needs of the specific communities, but are also compliant with any requirements set forth through collective bargaining agreements, and at the lowest cost possible.

Under our scope of services, BBCM will provide information on employee benefit issues, trends, proposed and new legislation like PA 54 and 152 of 2011 and how the Patient Protection and Affordable Care Act (PPACA/Health Care Reform) works with and against these regulations. Our agency works with multiple vendors in assisting with understanding the Affordable Care Act including Mary Bauman of Miller Johnson.

5. What are three reasons why your customers select your company over your competition?

1. Proven experience in the public, unionized environments is the main reason why our customers select BBCM over the competition. BBCM employees provide employee benefits consulting services to public entity clients, including various townships, counties, cities, public utilities, mental health authorities, 911 authorities, road commissions, community action committees, etc. Because of our experience working with public employers and as former managers in the public sector, we have enormous expertise in union environments, which includes negotiating union contracts for 312 and non-312 bargaining units. BBCM staff will be available to assist with developing viable negotiation strategies and will even attend negotiation sessions/union sessions to explain the very difficult issues surrounding health coverage changes and costs (at management's discretion). BBCM's unique understanding of public sector finances and the concerns of elected officials, managers and employees allow us to present creative solutions to contain cost while preserving benefits. We identify areas for potential cost savings and provide you with several options. We also work very effectively at communicating to employer groups and employees the impacts of state and federal regulations on the employer's benefit programs.
2. Ability to Effectively Negotiate and Communicate with Carriers and provide lowest cost options for our employer groups. BBCM is not generally subject to the same rules as public entities and has the ability to leverage one insurance carrier's rates against another's to secure the best possible pricing from qualified, top rated carriers or third party administrators. In addition, we can use the leverage of not only our office to garner competitive rates, but the whole Brown & Brown nationwide book. Angela Garner, our office Executive Vice President serves on many carrier agent boards along with serving on Brown & Brown's National Employee Benefit Committee. Ms. Garner has the capability of reaching up high up corporate ladders when needed to assist her clients.
3. Customer Service. Our customer service is beyond compare. We highly recommend you reach out to our references and ask about customer service and follow through, response time, and member (group and individual member) satisfaction. Customers may not know how deep this goes until after they have been with our agency for a little while, but we believe, we provide hands down, the



best customer service in the State of Michigan. Please review some of the comments made in our Third Party Client Satisfaction Survey in Tab 4.

C. Client Service/Quality Assurance

1. What processes/procedures do you have in place to interact with and approach a variety of vendors?

We routinely meet with vendors across the State and Nation to ensure that we are bringing quality and cost effective programs to our groups. We serve on multiple carrier agent boards and contacts at higher levels. Our recommendations are based upon multiple criteria. We evaluate the carrier's performance and customer service, ease of implementation and process for implementation, total cost and groups and our expectations of a carrier including their customer service. We recommend A- or better AM Best companies for our clients to insure their benefits. It isn't always about cost, as service and performance are major factors as well. We consider carrier networks, potential balance billing scenarios, customer service, ease of implementation, and carriers' claims processing abilities and discounts. The ultimate evaluation is client contentment and member satisfaction.

BBCM is generally not subject to same rules as public entities and has the ability to pit one insurance carrier against another to secure the best possible pricing from qualified carriers or third party administrators. We can leverage our large block of business to secure the lowest possible rates. Your jurisdiction is only one client to a carrier, while BBCM and our affiliated companies may have hundreds of clients with that carrier.

BBCM knows the carriers, and knows when a particular carrier has larger reserves and is more likely to use their "banked" dollars to guarantee a lower rate or meet sales quota goals and may be more likely to reduce rates or offer lower rates. We also regularly communicate with vendors via agent boards and through the vendor sales offices.

2. What is the process you would use when constructing the benefits recommendations to be made each year? How do you determine and communicate the timeline to the client?

Comprehensive Financial Analysis of Health Care and Other Benefits

BBCM unique understanding of public sector finances and of the concerns of elected officials, managers and employees allow us to present creative solutions to contain cost while preserving benefits. We break down your benefit costs and identify areas for potential cost savings, then provide you with cost analyses of several options that would achieve your financial objectives.

Market Knowledge and Ability to Secure Competitive Quotes

We will analyze your current employee benefits and make specific recommendations to standardize insurance coverages so that they can be competitively bid. BBCM will construct and solicit Requests for Proposals throughout the insurance carrier and broker networks. And, we will analyze RFP responses and make informed recommendations.

Sample timeline for Agent Services would be communicated as follows and agreed to upon by the client as found in the implementation section of this response.

3. List the top 5 vendors you use that have the largest share of your book of business (i.e.; Nationwide, BCBS, etc.).

Our Office's Top 5:

Blue Cross Blue Shield of Michigan

Delta Dental

Priority Health

Hartford

UNUM

2013 Brown & Brown Nationwide (top 20-alphabetically):

Aetna, Anthem, Blue Cross Blue Shield, Cigna, Delta Dental, Guardian, Horizon Healthcare Services, Humana, Independence Blue Cross, Kaiser Foundation, Lifetime Healthcare Group, Lincoln Financial, Metropolitan Life, Mutual of Omaha, Premera Group, Regence BlueShield, Standard, SunLife, United Healthcare, and Unum

4. Describe the services you provide related to compliance advice.

Being in the public sector for so many years, we have extensive experience with PA 312, PA 106, PA 152, and PA 54. We provide assistance to our clients consistently with their renewals and negotiation processes including all aspects of state laws that impact how you operate. Every RFP that is touched by PA 106 that we perform, we provide the full extent of services for you. We gather the data, submit the bids, respond to vendor questions, gather and analyze the results and make recommendations to our clients. For this type of analysis, we will often put in more than 100 hours of work to ensure when we meet with you, we have all of the comparisons in order including: benefits, network, discounts, and total cost. We can prepare analyses for our clients on both Fully Insured and Self-Funded within the same RFP. We can do this for medical, pharmacy, dental, vision, life, disability, voluntaries, Section 125, third party administrative services, COBRA, HIPAA, etc. We will do any of these RFP's for our clients at no additional cost as long as we are the named Agent of Record/Consultant for Medical and Pharmacy benefits

We provide renewal and negotiation options that are spread sheeted to include PA 152, PA 54 and PPACA fees and taxes. We understand your needs and ensure that when we provide information to you that our analysis is compliant with the regulations that guide you.

Included in what we do for our client's at no additional cost, we ensure that they are not only compliant with PA 106, but at any time they want to see how their benefits are priced to the marketplace we will conduct an RFP. While following our client's purchasing policies, we will create any request for proposal, market it to vendors, receive and analyze the responses, and prepare executive summaries for review of the responses. We also will work with the group to conduct further interviews if desired.

We provide Executive Summaries surrounding RFPs and renewals, illustrating a small portion of the work involved to ensure our client's comply with regulations and legislation on a State and Federal basis.

Our Executive Vice President is our in office compliance expert and spends hours weekly keeping updated with changes in legislation that affects our and our clients operations. BBCM Corporate also has compliance experts and provides guidance to our offices on best practices for client management and compliance. We also utilize the services of Mary Bauman with Miller Johnson. In the office, Ms. Garner spends anywhere from 10 to 25% of her time each week dedicated to compliance. Outside of the office, our corporate compliance personnel are dedicated strictly to compliance.

Corporate webinars, meetings, and subscriptions along with daily and breaking news alerts from many sources assist us in assisting our clients with assistance for all aspects of health care reform and the implementation of additional responsibilities our clients must perform in relation to Health Care Reform and State Regulations.

We provide client alerts in many forms including quarterly newsletters, email blasts and most importantly one on one meetings, as each client is not impacted the same way by each piece of regulations the government provides. This way, each client gets the specialized assistance with the different aspects of the law.

As a member of several Associations, BBCM receives daily updates regarding all legislation and regulations effecting our clients on both the National and State level. This information is interpreted and relayed to all of our clients as quickly as possible through emails and newsletters. If necessary, BBCM will also draft required employee notices in order for our clients to remain compliant with the most current legislation. Account Managers have met with all of our clients to discuss in more detail the current and pending changes to all group health plans due to Health Care Reform, CIP, PA 54 and PA 152. We also review and monitor your carriers and your benefit plans to ensure that the benefits being put in place are not only there, but put in correctly.

BBCM creates newsletters and power point presentations based upon current federal and state regulations. Included in our services also, are continuous updates from the carriers that you are insured with and any changes they may make to their plans or rulings that will affect you and/or your members. We also routinely meet with our clients to discuss items that are of concern to them and to ensure they are in compliance with all regulations. This includes presentations to Unions, Boards and Councils as needed.

See Tab 5 for our recent health care reform compliance update and our quarterly newsletters. We also provide monthly legislative updates and irregular email blasts regarding changes in benefits as needed. We don't typically monitor ADA and FMLA, but can provide those updates for you as well based upon guidance we receive through our multiple compliance vendors. Please note we are not attorney's and therefore cannot provide legal advice, however we can provide the materials and the resources needed in order to obtain those as necessary.

5. Do you offer any online enrollment services? If so, what is the cost to the employer for that service?

Brown & Brown utilizes various mediums of technology to accelerate communications and benefits counseling for its clients. Some of these methods include the use of third party administrators or the Brown & Brown Marketplace to gather information for the client, and from the employee, in order to collect data and make decisions on plan year benefits based on plan options determined by the client. In addition to face-to-face meetings scheduled with our client's employees, BBCM also works with its clients to draft and send email blasts regarding benefits counseling, wellness objectives, employer benefit surveys and updates. Our staff works closely with the client benefits team to develop literature and disseminate it via the method that best suits their employee's needs. In assisting members one on one, our CSR's or claim advocates have access to carrier tools to determine claims processing needs, payment, etc.

The costs for online enrollment are up to the group to pay for. Sometimes they are waived with a partner relationship, sometimes, depending upon a group's payroll system, there may be a method to do an 834 data feed for electronic enrollment. Further discussion of this topic is recommended.

6. Do you provide any Human Resources support of any kind? If so, what services do you offer?

BBCM will design and implement employee benefits communication pieces including conducting employee/retiree education meetings and be present at open enrollment meetings as desired and consistent to what the City desires. BBCM, as a standard practice, drafts literature to employees setting forth changes in employee benefits. BBCM staff will make themselves available to attend required employee meetings to explain any changes and to respond to all questions in person, via email, and by phone. BBCM will always be available to all of the employees and dependents to answer questions and resolve issues that arise during the year regarding employee benefits, contract administration, labor negotiations, and service issues. We can provide support with enrollment as needed. BBCM will provide anything created or desired by the City in an electronic format. We can help support enrollment functions with some carriers as well. We provide claims adjudication services for members wherein we have four employees in our office trained to review members' benefits, answer billing and claims issues, and work with providers and carriers when there are billing and claims issues.

7. Describe your services for Form 5500 filings.

Form 5500s are not typically required to be submitted by public employers are they are exempt. However, for those groups that are required to submit Form 5500s, we work with the carriers to request and receive them timely, providing them to our groups for their submission directly.

8. Describe your process for updating and disseminating SPD and Plan Documents as well as any other required notices.

Other than the SPD for a Section 125, public employers are not required to have or provide an SPD to their members for benefit purposes. However, we work with vendors who will provide groups with SPD's for a minimal fee. Other required annual notices for employee and retiree benefits are provided to a group for dissemination to its members every year in advance so that a group can properly meet its guidelines. We also provide guidance to groups on what they should keep records of for the reporting and notice purposes.

9. What is your process for assisting employees with claim resolution issues?

We have four employees in our office whose job it is to assist members with claims and billing issues. Members are welcome to call our toll free number (we provide our groups with cards-samples provided in binder) for our claims advocacy services. Our team will work with the carriers and providers to determine if a claim should have been paid and then get it paid, or work with the provider if it needs to be reprocessed, or explain to a member why it wasn't paid so it won't happen to them again. Our team lets the member know when they will return the call to the member as to the status of their claim and do to how they track their tasks, calls them back on that day if not before. We work with them if they decide they wish to appeal to the carrier or the State as well. Our team consistently gets thank you's for their efforts in providing this detailed and time consuming service. There is no other agency that goes as far as our office does in assisting members.

10. Describe the level of service you provide to support our HR staff with bill reconciliations and verification of changes

We've helped many groups with bill reconciliation and assistance. If there is a way that we can support this function to ease administration, we will. We do need proper notification of changes and access to enrollment to do a thorough job. We will not support or be responsible for changes that we were not notified of. When we are notified of a change, we let the group know we received the change request and when the request is complete. Without that response, you are not guaranteed that we received the request for change. With the correct paperwork, we can then review against billing if a group desires.

D. Employee Communication

1. Describe your approach to communicating benefits to new employees throughout the year, including methods, frequency, etc.

BBCM understands the truly diverse needs of public entities in assisting members in maximizing and understanding the benefits available and striving to minimize the financial impact of rising insurance premiums. Public Sector Entities are unique in the fact that you can have highly paid administrators and department heads while also having other lower compensated groups like clerical groups. The needs of each of these groups are different both in communication and in understanding their benefits. Where department heads may be more inclined to access the internet to assist them, a custodian or maintenance worker may not even have access to a computer. One day we may speak to a political board and the next day we may be presenting benefits to a smaller audience or union.

Working with municipalities for as long as we have, we have conducted separate meetings for the different groups in order to ensure that we are taking the time to answer the questions of each segment while respecting that some may need more time and have different questions than others. We have also done individualized education sessions just on the steps to access information only available on the web or how to save money in their own plans. We also have met in smaller groups where everyone's interests have been reflected and concerns addressed. We have worked through with employees in implementing a high deductible health plan with a health reimbursement arrangement and how it affects employees whose salaries may be three to four times less than their other employees. We are also available by phone during business hours and your assigned account manager is available by cell 24/7.

It isn't always easy, but we take the time and provide an empathetic ear where needed. This compassionate ear is needed ever more so when employers have to meet budget. We will provide open enrollment communications, required notices, sample contract

language, email blasts, wellness communications, newsletters, etc. as needed for your organization.

2. What is your approach to communicating benefits to employees during Open Enrollment?

BBCM will communicate with the group as to determine its communication preferences. We can and will do what we can to meet the needs of the group by creating and producing enrollment materials and forms. We can conduct meetings in person or recording a session so that it can be communicated later as needed. We allow the group to provide us with its feedback on communications and then provide them support for those functions. As indicated in the above question, we can do all of that as well for open enrollment.

3. Please share your typical process for client communication of benefit changes.

We typically produce and provide side by side benefit spreadsheets for members to see the differences, produce 60 day notice of material modifications as required, and conduct education sessions as needed. We also provide material for the group to disseminate or for us to communicate at meetings or online via employer intranet or via email/paper distribution. It is up to the client to determine the best ways to communicate and then we will support and create the tools necessary to notify members of upcoming benefit changes.

E. General

1. What other lines of coverage do you broker or administer (i.e., worker's compensation, professional liability, 401K, etc.?)

Please see attached communication piece at the end of tab 5 for services provided across the Brown & Brown spectrum. Internally, today, our office provides Worker's Compensation, Property & Casualty outside of the employee benefit spectrum.

2. Please provide the web address (and demo login information if necessary) to your client communication portal – if offered.

Not applicable.

3. The top two brokers selected in this RFP process will be asked to provide samples of employee communication materials.

Please see attached Brown & Brown sample group newsletters. We will provide sample emails/employee communication materials upon request.

F. Implementation

1. Explain your implementation process including time frame. What is the minimum time frame needed to ensure a smooth transition?

We will approach working with the City's staff as if we are an extension of your staff immediately upon award of Agent of Record status. Your account manager will be assisting in any way possible, and always available for questions and meetings. The transition can be smooth with a couple of meetings. First of which can be done by phone or in person in obtaining the materials we would need to create the agent of record letters for submission, as the group will need to sign the necessary wording in the proper format for us to begin working immediately with your carriers, and a second one or two to start working with the group on renewals/negotiations/compliance/communication, etc. We should be able to be fully function within 2 weeks to 1 month of receipt of AOR letters depending upon when a carrier provides us with information.

2. What involvement will be required from us during the implementation process? Be very specific.

BBCM will require meeting time in person and by phone with administration to determine desire of scope of agent services and group needs. We will require copies of invoices for all benefits that the group pays, and copies of all union contracts and personnel policies to verify benefit levels. If the group needs us to work on something major prior to the carrier being able to provide us with benefit information, we may need to request that information from the City, however, we try to pull as much as we can from the carrier first. We will require signatures on agent of record letters on City stationary and a signed Business Associate Agreement for HIPAA purposes. Time required for compliance could vary depending upon what group has already done. We spend time reviewing with client a list of items to determine what needs to be done ASAP and what can be done over the course of the next year. If you are looking for project specific items like a PA 106, we will need about 2 hours of time to review what you are looking for and what we would recommend to proceed. If you are in the process of negotiations, we would need time to review where you are at and what your short and long term goals/strategy are or determine where you may wish to be to be in future compliance with State and Federal Regulations including the Cadillac Tax. This could take some time and education as well with members, i.e., some of our groups have put in insurance committees or task forces with their union/management leaders as a communication tool for smoother negotiations. We are willing and able to moderate those sessions as a third party which assists groups as well.

3. Please provide a sample implementation project plan and timeline.

Day 1: Agent of Record Letters issued from invoice copies submitted to us from client. Requests for Policies, Union Contracts, and census (if needed for quoting) sent to Client.

Day 1-2: Agent of Record Letters submitted to carriers and requests for information submitted to carriers.

Day 1-30: Pull and review policies and contracts for benefit accuracy and Federal, PPACA and State Regulatory Compliance.

Day 1-90: Multiple initial meetings to discuss short and long term goals and cover items needed/desired immediately and longer term. Review policies and practices for compliance and continuance of existing services and correction of any discrepancies.

Day 1-270: RFP's and RFQ's as needed for compliance with PA 106 and for bidding out of benefit plans on a routine basis. Depends upon when negotiations and renewal is.

Day 30-120: Corrections of any discrepancies in the policies and employee benefits reviewed with management and corrected with carriers if needed.

Open Enrollment - Create communication information for boards, management and employees. Create hidden paychecks if desired, fill out implementation paperwork, work with carriers on enrollment and eligibility.

Daily: Assist clients and members with benefit issues and questions

Quarterly: Conduct review and planning for implementation changes

Annually: Bidding out benefits, open enrollment, annual reviews

As needed: Other duties as assigned or requested including employee meetings, negotiation assistance, communication materials, notices, etc.

G. References

1. Please provide 3 references of current clients who have similar demographics. At least 1 of the 3 should have converted within the last year. At least 2 of the 3 should be municipal or governmental clients. Please provide client name, address, phone number, services provided and year they became a client.

Grand Traverse County

Dave Benda, Administrator/Controller

400 Boardman Ave.

Traverse City, MI 49684

P: (231) 922-4780

Since 1/1/2014

City of Saginaw

Dennis Jordan, Human Resources Director

1315 South Washington Ave.

Saginaw, MI 48601

P: (989) 797-1577
Since 4/2006

City of Bay City

Dana Muscott, Deputy City Manager/City Clerk
301 Washington Ave.
Bay City, MI 48708
P: (989) 894-8168
Since 5/2013

Washtenaw County

Diane Heidt, HR/Labor Relations Director
220 N. Main St.
Ann Arbor, MI 48107
P: (734) 222-6741
Since 2005

City of Port Huron

Julie Davis, Human Resources Director
100 McMorran Blvd.
Port Huron, MI 48060
810-984-9723
Since 4/2011

2. Please provide 2 references of former clients who had similar plan demographics. At least 1 of the 3 should have left within the last year. At least 1 of the 3 should be municipal or governmental clients. Please provide former client name, contact name, address, phone number, services provided and year they became and the year they ceased to be a client and the reason(s). (Need start/stop dates)

St. Louis and Ithaca Public Schools

Julie Pierce (she now works for Bullock Creek Schools and was the Finance Director for both St. Louis Public Schools and Ithaca Public Schools)
Director of Business Services
Bullock Creek School District

(989)631-9022

St. Louis Public Schools (8/1/2013-11/1/2014) – New administrator switched to former agent when working with another school district

Ithaca Public Schools (8/1/2013-1/1/2014) – Group moved back to MESSA-MEA sponsored benefit plan which does not allow for agents.

Canton Township

Carolyn Cox, Budget, Benefits & Internal Audit Manager

1150 S. Canton Center Road

Canton, MI 48188

P: (734) 394-5100

(4/2008-2/2012)

Group had retirements of City Manager, HR Director, and Finance Director within the span of 3 months. New HR Director decided to term our Agent of Record and bring in the Agent she had been working with prior.

We have no other former clients with similar demographics.

H. Expenses

Describe your remuneration. Is it a commission paid by insurance companies, or flat fee structure? If flat fee, describe the basis of the payment (i.e., per employee, per month, etc.)

1. What are the start-up/conversion costs and the termination costs?

There are no start-up or termination costs. However, if consulting fees are paid as required in advance and paid we do not provide refunds. We would like to request a 30 day notice of termination of our services, or if a contract is required, we would mutually agree to those terms.

Brown & Brown of Central Michigan is proposing either standard agent commissions – which we can share with you or an annual consulting fee for all lines of employee benefits including Medical, Pharmacy, Dental, Vision, Life, and Disability. This is without any agent commissions being payable through those lines of business. Or, if commissions are unavailable on some items, we would work with a combination of commissions available and a consulting fee.

As required per the bid specifications, please find this as notice that Brown & Brown of Central Michigan does not provide the following services/benefits as defined within your Insurance Agent RFP: Mass Mutual and ICMA-RC Defined Contribution 457 plans, Municipal Employees' Retirement System (MERS) – Defined Benefit Plan and Health Care Savings Plan.

Some carriers cannot remove commissions from their policies and also will not lower the client's premiums, so we recommend as a method for the client to save money that those commissions be continued to be paid.

Consulting fees would be paid in advance on a monthly or quarterly basis through a professional services agreement approved by both Brown & Brown and The City of Traverse City. We will at all times disclose any commissions or fees received by insurance carriers and all RFP's for employee benefits would disclose the same.

In an effort to maintain full disclosure, please note that based upon our book of business, it is standard practice that some carriers pay agencies bonuses based upon the agent's books of business with that carrier including total contracts insured, total premiums paid, etc. These bonuses are typically not attached to any one group specifically, but overall across all of our groups. Any bonuses paid to us due to these arrangements, would not be subject to reducing the annual consulting fee.

2. Describe what consulting services are included, and related hourly charges and out of pocket expenses for additional services (for example, Form 5500 preparation, Plan Document, COBRA administration – if offered, bill reconciliation, etc.)

If the City of Traverse City chooses a service outside of our portfolio, but instead provided by a vendor partner (i.e. COBRA, Section 125, 5500 Preparation, Discrimination Testing, Dependent Audits, Claims Audits, etc.) we will disclose in advance and competitively bid such services for the City. Our fees for standard agent services are total encompassing.

3. In addition to the expense schedule, please identify any other fee for service or activity not covered on the "Service Activity" listing, i.e., postage, handling, supplies, servicing commissions, etc. Please be specific.

If the City wishes us to mass mail materials to members or retirees, we will have them pay postage/materials cost directly. Mailing documents to the group or individually as needed under our claims advocacy program is at no cost to the client.

4. What is your expected margin on a client our size?

This is proprietary information. It varies client by client depending upon the workload that is required. Some years, especially in the initial years, we make very little money due to how much time we spend analyzing and getting to know a group. BBCM bases our fees upon similarly structured groups and standard commissions. It is negotiable. BBCM is transparent in the commissions and fees we receive and will provide updates as requested.

Brown & Brown of Central Michigan, Inc.

REFERENCES: (include name of organization, address, contact person, daytime phone number, and length of time services have been performed)

Please also include as references, the clients and names listed in Question G.

City of Grand Haven since 5/2008

Contact information: Bonnie Suchecki, Human Resources Director
519 Washington Ave., Grand Haven, MI 49417
616-847-4887
bsuchecki@grandhaven.org

Bay County since 1/2000

Contact information: Tim Quinn, Human Resources Director
Suite G 102, 515 Center Ave., Bay City, MI 48708
989-895-4098
quinnt@baycounty.net

Eaton County since 12/2006

Contact information: John Fuentes, County Administrator
1045 Independence Boulevard, Charlotte, MI 48813
517-543-7500
jfuentes@eatoncounty.org

Ionia County since 11/2008

Contact information: Stephanie Hurlbut, County Administrator
100 West Main, Ionia, MI 48846
616-527-5300
shurlbut@ioniacounty.org

City of Midland since 3/2008

Contact information: Ken Arthur, Assistant Director of Human Resources
333 West Ellsworth Street, Midland, MI 48640
989-837-3361
karthur@midland-mi.com

SUBCONTRACTORS:

None



Vendor - Please complete and return

PROPOSAL SUMMARY

TITLE: INSURANCE AGENT FOR THE CITY OF TRAVERSE CITY

DUE DATE: WEDNESDAY, JANUARY 7, 2015 AT 10:00 AM

Having carefully examined the attached specifications and any other applicable information, the undersigned proposes to furnish all items necessary for and reasonably incidental to the proper completion of this proposal. Vendor submits this proposal and agrees to meet or exceed all requirements and specifications unless otherwise indicated in writing and attached hereto.

Vendor certifies that as of the date of this proposal the Company or he/she is not in arrears to the City of Traverse City for debt or contract and is in no way a defaulter as provided in Section 152, Chapter XVI of the Charter of the City of Traverse City.

Vendor understands and agrees, if selected as the successful Vendor, to accept a Purchase Order/Service Order/ Contract and to provide proof of the required insurance.

The Vendor shall comply with all applicable federal, state, local and building codes, laws, rules and regulations and obtain any required permits for this work.

The Vendor certifies that it is in compliance with the City's Nondiscrimination Policy as set forth in Administrative Order No. 47 and Chapter 605 of the City's Codified Ordinances.

The Vendor certifies that none of the following circumstances have occurred with respect to the Vendor, an officer of the Vendor, or an owner of a 25% or more share in the Vendor's business, within 3 years prior to the proposal:

- (a) conviction of a criminal offense incident to the application for or performance of a contract;
- (b) conviction of embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, or any other offense which currently, seriously and directly reflects on the Vendor's business integrity;
- (c) conviction under state or federal antitrust statutes;
- (d) attempting to influence a public employee to breach ethical conduct standards; or
- (e) conviction of a criminal offense or other violation of other state, local, or federal law, as determined by a court of competent jurisdiction or an administrative proceeding, which in the opinion of the City indicates that the vendor is unable to perform responsibility or which reflects a lack of integrity that could negatively impact or reflect upon the City of Traverse City, including but not limited to, any of the following offenses or violations of:

- i. The Natural Resources and Environmental Protection Act.
- ii. A persistent and knowing violation of the Michigan Consumer Protection Act.
- iii. Willful or persistent violations of the Michigan Occupational Health and Safety Act.
- iv. A violation of federal, local, or state civil rights, equal rights, or non-discrimination laws, rules, or regulations.
- v. Repeated or flagrant violations of laws related to the payment of wages and fringe benefits.

(f) the loss of a license or the right to do business or practice a profession, the loss or suspension of which indicates dishonesty, a lack of integrity, or a failure or refusal to perform in accordance with the ethical standards of the business or profession in question.

Vendor understands that the City reserves the right to accept any or all proposals in whole or part and to waive irregularities in any proposal in the best interest of the City. The proposal will be evaluated and awarded on the basis of the best value to the City. The criteria used by the City may include, but will not be limited to: ability, qualifications, timeframe, experience, price, type and amount of equipment, accessories, options, insurance, permits, licenses, other pertinent factors and overall capability to meet the needs of the City. The City is sales tax exempt – Government.

Vendor agrees that the proposal may not be withdrawn for a period of sixty (60) days from the actual date of the opening of the proposal.

Submitted by:

Angela Garner

Signature

Angela Garner, Executive Vice President

Name and Title (Print)

989-714-6592

Phone

989-607-2070

Fax

Brown & Brown of Central Michigan

Company Name

11605 Concentric Blvd., Ste 1

Company Address

Saginaw

City,

MI

State,

48604

Zip

Corporation

Sole proprietorship/partnership/corporation

Michigan on 8/9/2011

If corporation, state of corporation

As required, please find this as notice that Brown & Brown of Central Michigan does not provide the following services/benefits as defined within your Insurance Agent RFP:

Mass Mutual and ICMA-RC Defined Contribution 457 plans

Municipal Employees' Retirement System (MERS) – Defined Benefit Plan and Health Care Savings Plan



Angela Garner, Executive Vice President

January 5, 2015



Key Personnel

Angela L. Garner, Executive Vice President

Multiple years in the insurance industry servicing large key accounts. Over 18 years working in the public sector. Masters in Business Administration. Certified Employee Benefits Specialist (CEBS) with GBA and RPA designations. Bachelor of Science in Business Administration with a major in Finance. Member of National Association of Health Underwriters.

Daniel R. Skiver, Vice President

Over eight years working in the insurance industry serving government accounts designing and implementing health, life, and disability benefits. Over ten years municipal government experience with six+ years as County Administrator/Chief Administrative Officer. Masters in Public Administration. Bachelors in Political Science.

Matthew Clark, Vice President, Worksite Wellness Specialist

Prior Key Account Manager for BCBS and Wellness and Care Management Consultant. Prior experience with Health Plan Accreditation and Manager of Health Management Programs. Masters of Public Administration in Healthcare Administration and Bachelor of Science in Health Promotion, Prevention and Rehabilitation.

Melissa S. Alcock, Account Manager

Multiple years in the insurance business servicing small, mid, and large accounts in the public sector. Masters in Business Administration. Bachelor in Business Administration. Currently working towards CEBS certification, including the GBA and RPA designations.

Brandon Weslock, Account Manager

Multiple years experience working with union members with daily operations, and lean implementation projects. Multiple years experience in the insurance industry serving governmental accounts designing benefit packages. Masters in Business Administration, and a Bachelors degree in Engineering Technology Management. Certified Six Sigma Green Belt, and CEBS certification in progress.

Judy Robinson, Account Service Representative

Over 30 years experience working within the insurance business at the capacity of Team Leader, Production Control Specialist and Account Service Representative. Specializing in resolving claim/billing issues within a timely manner.

Olga Roberson, Account Service Representative

Over 20 years working within the insurance business at the capacity of Account Service Representative and Customer Service Representative. Specializing in resolving claim/billing issues within a timely manner.

Rebecca Castillo, Account Service Representative

Over 18 years working within the insurance business at the capacity of Account Service Representative and Customer Service Representative. Specializing in resolving claim/billing issues within a timely manner.

Jessica Tucker, Account Service Representative

Worked in the medical field for multiple years. Assists personnel in their day-to-day business. Specializing in resolving claim/billing issues within a timely manner.

Jennifer Moore, Account Manager/Benefits Analyst

Over ten years in the insurance industry working with multiple carriers including 7 years in small business with Priority Health. Specializing in marketing benefits and providing communications to our clients.

Sophia N. Snow, Benefits Analyst

Over seven years municipal government experience. Bachelor of Science in Business Administration with a major in Accounting.

Michael Reynolds, Benefits Analyst

Over three years in the insurance industry working with multiple carriers. Specializing in marketing benefits, creating renewals and providing communications to our clients.

Leslie Bilodeau, Benefits Analyst

Works with future and potential clients in analyzing their benefit programs and requesting, processing and making recommendations for benefit plans.

RESUMES

ANGELA L. GARNER, MBA, CEBS, GBA, RPA

1605 Concentric Blvd., Suite #1
Saginaw, MI 48604
(989) 249-5960 ext. 457 (Office)
(866) 421-0478 (Toll Free)
(989) 714-6592 (Cell)
(989) 607-2070 (Direct Fax)
(989) 249-5966 (Main Fax)
agarner@BBCMich.com

EDUCATION

May 2010 **Certified Employee Benefits Specialist (CEBS)** designation including
May 2010 **Retirement Plans Associate (RPA)**
Dec 2008 **Group Benefits Associate (GBA)**
May 2001 **Master of Business Administration**, Central Michigan University, Mt. Pleasant, MI.
May 1995 **Bachelor of Science in Business Administration**, Central Michigan University, Mt. Pleasant, MI. Major in Finance, Double Minors in Global Business and Spanish. Honors Program Graduate

EXPERIENCE

2010-Present Brown & Brown of Central Michigan, Inc.. Saginaw, MI
Executive Vice President. Chief Operating Officer, Responsible for the development and monitoring of existing and new key municipal accounts including the analysis of current programs, recommendations for changes in plan design, review of current costs and projecting future costs. Oversee day to day operation of office and management of employees and staff.

2004-2010 Public Employee Benefits Solutions. Saginaw, MI
Vice President. Responsible for the development and monitoring of existing and new municipal accounts including the analysis of current programs, recommendations for changes in plan design, review of current costs and projecting future costs. Responds to any inquiries or requests for services as appropriate. Trouble shooting and problem solving as requested by client or company principals.

1999-2004 County of Saginaw. Saginaw, MI
Management Assistant. Planned, organized, directed and controlled reports, presentations and documents that supported and benefited the County as a whole and gave form to the activities, actions and strategic planning in which the County endeavored. Served as County's Contract and FOIA Administrator. In charge of administration over the Saginaw County Event Center including \$14.3 million renovation of facility and web site. Wrote successful grant for an additional \$50,000 in renovations for Heritage Theater.

1997-1999 Neighborhood Renewal Services of Saginaw, Inc. Saginaw, MI
Accountant/Property Management. Monthly reconciliation of 5 bank accounts; AP/AR, collections, payroll, general ledger, trial balance, housing and credit counseling, screened loan applicants, deed preparation, cleared title work, performed title searches, accessed public documents. Knowledge of CDBG, HMDA, MSHDA, and HUD funding reporting and requirements. Wrote grant that funded \$3,550 for new computer equipment.

1995-1997 Bob Evans Farms, Inc. Owosso, MI
Restaurant Manager. Directed, operated, and controlled a full-service restaurant and its crew. Complete knowledge of computer inventory, ordering and payroll systems. Hired and trained employees. Managed food and labor costs to maintain at or below company goals. Involved with staffing, training, and construction of a new restaurant.

1992-1995 Alpha Phi Omega. Central Michigan University, Mt. Pleasant, MI

Vice-President of Service. Service Chair and Grievance Chair. Developed, created, organized and ran service projects for over 100 members of a service fraternity. Held many contacts and conducted activities with other service organizations in the Mt. Pleasant community.

1992-1995 Student Book Exchange. Mt. Pleasant, MI

Developed skills in employee supervision; training; customer service; purchasing; inventory; preparing computerized reports and flyers; accounting; and sales.

ADDITIONAL TRAINING

State of Michigan Producer License for Life, Accident and Health

Fund Accounting

Survey Research

Web Site Development

Loan Servicing and Collections

Credit Collections

Impacts of Credit Scoring

Compliance with Mortgage Regs

Internet Training

Food Sanitation Certification

MEMBERSHIPS and AFFILIATIONS

Saginaw County Chamber of Commerce

Agent Advisory Council – HealthPlus of Michigan

Platinum Agent –Blue Cross Blue Shield of Michigan

Elite Agent - Priority Health

National Association of Health Insurance Underwriters

Michigan Association of Health Insurance Underwriters

Past Member, Michigan Association of County Administrative Officers

Leadership Saginaw 2002

Leadership Saginaw Alumni Board and Selection Committee

Past Secretary -The Dow Event Center Advisory Board

Saginaw County Vision 2020-1000 Leaders Training

Past Member, Tri-County Economics Club

DANIEL R. SKIVER
1605 Concentric Blvd., Suite #1
989-249-5960, extension 456
Cell - 989-277-6410

EDUCATION Masters of Public Administration, Western Michigan University
Bachelor of Science in Public Administration, Western Michigan University

EXPERIENCE

BROWN & BROWN OF CENTRAL MICHIGAN, INC. DBA PUBLIC EMPLOYEE BENEFITS SOLUTIONS, VICE-PRESIDENT, (August 2010 - Present)

ACCOUNT MANAGER, (May 2006 – August 2010)

Serve as account manager for Large and Key Accounts. Responsible for assisting a wide range of public entities from 10 to over 1100 employee and retirees with designing and administering health, dental, vision, life, disability, and other group benefit programs.

GRATIOT COUNTY ADMINISTRATOR (October 1999 to May 2006)

Served as Chief Administrative Officer and Chief Fiscal Officer for the County of Gratiot. Responsible for management of a \$30 million budget and administration of the County with 170 employees and retirees. Served as the chief advisor to the Board of Commissioners to achieve policy, fiscal and service goals in all areas of county government.

PURCHASING/RISK MANAGER (December 1997 - October 1999)

Served as Purchasing Manager and Risk Manager for the County of Saginaw. Drafted all RFP's and administer over 200 vendor contracts. Managed Self-Insurance Program. Responsible for coordination and defense of all liability claims brought against the County.

MANAGEMENT ASSISTANT (January 1997 - December 1997)

County of Saginaw Controller's Office. Worked directly with Controller/Chief Administrative Officer on wide variety of projects including but not limited to retirement, program evaluation, budgeting, finance, and union negotiations.

HEALTH AND LIFE INSURANCE CONTINUATING EDUCATION

Includes COBRA, Consumer Directed Health Care and Ethics and Ethical Dilemmas

MEMBERSHIPS

- Past Member, Michigan Association of County Administrative Officers Board of Directors
- Past Member, Gratiot Area Chamber of Commerce Board of Directors
- Past Member, Greater Gratiot Development Board of Directors
- Past Member, Gratiot County Community Strategic Planning Board

PUBLICATIONS

- "Working Together, A Consideration Worth Dollars", Michigan Association of Counties (MAC) Newspaper
- "A Study of Urban Michigan Counties"
- "Mental Health Authority Issue Analysis for Saginaw County, Michigan"

ACHIEVEMENTS

Assisted with a proposed \$200 million project between developer, MEDC, local EDC, Gratiot County, and North Star Township for proposed electrical generating facility in North Star Township including zoning ordinance amendments, press releases, public relations, and property tax issues. Project was estimated to

Brown & Brown of Central Michigan, Inc., 1605 Concentric Blvd., Ste. 100, Saginaw, MI 48604 (866) 481-0478



increase General Fund tax revenue for Gratiot County by \$280,000 after all tax abatements upon completion of project.

Oversaw the administration and property sales within the Gratiot County Renaissance Zone/Industrial Park. Successfully bargained Police Officers Labor Counsel (POLC) and Governmental Employees Labor Counsel (GELC) labor agreements. Contracts allowed Gratiot County to consolidate health plans from five to two and refinance health insurance premiums saving an estimated \$125,000 annually. Contracts also allowed Gratiot County to implement a defined contribution retirement plan for all new employees.

Reduced structural budget deficit in the Gratiot County General Fund from \$2.1 million (23% of budget) to \$575,000 (7% of budget) by implementing a new pension system, restructuring health insurance financing, refinancing existing debt, revising liability, life, disability and dental insurance plans, reducing appropriations to outside agencies/funds, reducing or eliminating non-mandated services, increasing service fees and eliminating 10% of General Fund staffing.

Converted pension system for all new employees from a defined benefit plan to a defined contribution plan which reduced annual payments by over \$90,000 or 15% at time of conversion. Annual pension system payments were \$600,000.

Restructured financing of Gratiot County health insurance plans for all employees from fully insured to self-funded for 16% annual savings at time of conversion.

Revised Gratiot County property/casualty, life, disability, and dental insurance policies saving \$19,000 or 13%.

Coordinated the community partners in the strategic planning effort to complete the Leadership Gratiot program. The first community leadership program in over 10 years. Efforts involved the local school system, chamber of commerce, collaborative council, economic development, and local municipal government.

Developed first Gratiot County Comprehensive Policy Manual. Included complete updating of all personal policies and creation of over 20 new policies.

MATTHEW CLARK
1605 Concentric Blvd., Suite #1
989-249-5960, extension 463
Cell – 810-931-2994

Innovative goal oriented professional with excellent interpersonal communication, leadership and account management experience.

Leadership: Consistently selected to assume leadership/management roles. Proactively approach business challenges, applying problem-solving skills, persistence, teamwork and resourcefulness to achieve positive results. Experience includes department management; change facilitator; trainer and implementation lead.

Project Management: Ability to manage and monitor multiple projects simultaneously by establishing project plans and objectives to ensure goal attainment within defined parameters. Experience includes Key and large group account management, accreditation management, product development and implementation.

Business Development Adept in developing and executing strategies that increase awareness; identify and capitalize on growth opportunities through analysis, product expertise and sound business instincts. Experience includes RFP completion, worksite wellness plan design.

PROFESSIONAL EXPERIENCE

Brown and Brown of Central Michigan

Vice President/Worksite Wellness Specialist

May 2013 - Present

- Responsible for the development and successful acquisition of new business revenue, retention of existing book of business, and the development and implementation of wellness programs.
- Contact and qualify prospective and existing clients and explains features and merits of products offered, recommending benefit and product design based on analysis of prospect/clients circumstances.
- Develop long term relationships with clients and carriers.
- Advise, educate and make recommendations for accounts and market updates.
- Solicit and evaluate proposals from all available health, life, and disability, ancillary carriers, explain the product or policy to the client.
- Identify best practices related to employee health and wellness initiatives.
- Working closely with the Strategy and Delivery teams to build and implement successful employee engagement and wellness initiatives for clients.
- Researching wellness resources, writing content and developing custom communication pieces relating to health and wellness initiatives.
- Analyzing Health Risk Assessment data to implement appropriate initiatives tailored to individual needs.

Blue Cross Blue Shield of Michigan, Detroit, MI.

Key Account Manager

2011-May 2013

- Develop, implement and maintain effective and efficient face-to-face contact with executive level account management and decision-makers.
- Interface with various levels of internal and external customers explaining marketing concepts, resolving complex problems and administrative issues, and discussing proposals and retention activity.
- Identify and recognize individual customer characteristics, understand the decision-making process and gain trust from all labor, management, governmental decision-makers and independent agents.
- Provide the customer with information related to alternative methods of healthcare delivery (e.g., HMO, PPO, POS, and Traditional) which includes financial alternatives such as funding options.
- Using consultative selling skills to increase ancillary line of business sales.

Wellness and Care Management Consultant

2009-Aug 2011

- Working directly with accounts to identify their unique wellness & care management needs.
- Educate customers about resources offered by BCBSM and develop a wellness and care management tailored solutions.
- Manage and monitor multiple Accounts simultaneously by establishing project plans and objectives to ensure goal attainment within defined parameters.

- Investigate, review, recommend, communicate and implement solutions which identify root cause of issues.
- Identify and resolve challenges in order to fulfill key corporate objectives and respond to the demand of change management and initiate actions needed to plan, organize and control team activities.

Health Plan of Michigan - Detroit, MI.

Accreditation Manager

April 2009-Dec 2009

- Manage and monitor the quality improvement process as it relates to achieving and maintaining accreditation from the National Committee for Quality Assurance, HEDIS, CAHPS and State of Michigan requirements.
- Provide consultative advice to senior management on status of NCQA Accreditation.
- Oversee and coordinate NCQA preparation activities with internal departments including maintenance and accreditation to move the organization to a status of 'Continued Readiness.'
- Complete NCQA application to include collating and entering data in NCQA software system (ISS).
- Review and update all organization Policies and Procedures.
- Establish thresholds and benchmarks based on NCQA data along with ensuring criteria are met.
- Lead cross-departmental teams in research, analysis, identification and eval. of data.

Physicians Health Plan of Mid- Michigan, Lansing, MI.

Manager of Health Management Programs

2005-2009

- Development of organization's quality strategy, including planning process, building effective structure, written quality management/improvement plan, and implementation.
- Create and lead integrated work groups related to linking quality of care in Utilization management and Care coordination, including case and disease management.
- Present monthly performance and metrics reports to health plan executives.
- Develop, evaluate and implement member health management tools.
- Develop and market wellness products across all lines of business.
- Successful in building strong internal networks and facilitating involvement from multiple layers of departments.
- Mentor and coach direct reports (5) and foster innovation, empowerment and acceptance of change
- Accountable for staff's performance against organization's standards for quality, achieving strategic goals and exceeding accreditation requirements and customer service.

EDUCATION

Masters of Public Administration-Healthcare Administration
Western Michigan University, Kalamazoo, MI.

Bachelor of Science in Health Promotion, Prevention and Rehabilitation
Central Michigan University, Mt. Pleasant, MI.

SKILLS/CERTIFICATIONS

American College of Healthcare Executives (ACHE)
Life Insurance Producer- State of Michigan
Accident and Health Insurance Producer- State of Michigan

**THIRD PARTY CLIENT SATISFACTION SURVEY
CUSTOMERVILLE-BBLISTENS**

In the last year, through Customerville (who set up a BB Listens Survey portal for Brown & Brown), we asked our clients to complete a survey on our employee benefit services and rate us on a scale from 1 to 5 with 5 being the highest rating. Our average rating across 55 responses is as follows:

Survey Question	Average Response
I'd recommend Brown & Brown to a friend or colleague.	4.87
Brown & Brown gets into the details of my business such that they can help me make great decisions.	5.00
My B & B contact goes to great lengths to understand my unique insurance needs.	5.00
Regarding employee benefits, B&B helps me make confident decisions for my company and my colleagues.	4.91
The people I work with at Brown & Brown are great at explaining insurance.	4.91
If I have questions, they take the time to listen carefully and offer useful, relevant, answers.	4.91
Brown & Brown always works proactively in my interest.	4.83
Whenever we're in contact, Brown & Brown has all the information needed to be sure our time together is productive.	4.80
The people with whom I work at Brown & Brown respect my time and always respond timely.	4.93

Forty of the individuals who responded to the survey also included comments (all positive) regarding our services. We did not receive one negative survey or comment regarding our services. I have included some of those comments on the following pages:

We have been more than pleased with the service provided by Brown & Brown. Their scope of expertise in guiding us through the changes related to Health Care Reform and all other employee benefits has more than met our expectations. BCBS and HealthPlus both spoke highly of Brown & Brown and we appreciate the opportunity to have access to such a broad base of knowledge and experience related to Employee Benefits. Thank You!

Angela Garner is professional, experienced, smart, and always responsive. She is a great asset to your company.

Since we began working with PEBS and Brown and Brown, we have had excellent experiences and communication. The staff is well informed and provides the most detailed and accurate information to our county. Not only are the staff helpful to our county but they have also been presenters at the annual MACAO conference and provide excellent training and information. I would, without hesitation,

recommend Brown and Brown to any company in need of your services. I look forward to continuing our relationship into the future. Thank you.

All of the employees that I have worked with at Brown and Brown in Saginaw have been extremely efficient and professional. Not once as any employee from Brown and Brown made me feel that I should have known something that maybe I didn't or something that might have been explained before. Even if a Brown and Brown employee did not know and answer immediately, they would take the time to find the answer out and call me back as soon as possible. I would definitely suggest Brown and Brown to other organizations.

Angela Garner is a gem and always provides exceptional customer service! Always willing to listen to questions/concerns and assists in improving my understanding of benefits offered and costs associated with them as well as our concerns as an employer of our approach to funding the costs.

Angela and Matt are wonderful. In fact, the entire support staff could not be better. I recommend them without qualification -- I don't know what we would do without them. This is the most service oriented group I have ever dealt with.

In my years in dealing mainly with Dan then Melissa, we've have had an extremely good rapport with concerns and issues being handle professionally and promptly. Currently Melissa is very proactive in following up with BCBSM when items have not been addressed within a reasonable time frame. Recently we submitted a Benefits RFP via Melissa. Her handling of the RFP was excellent as well, she was able to assist in comparison analysis of the returned quotes. Response from the gals in the Claims Advocacy Services (Olga and Judy) is always great with most inquiries being handle within the day of the initial call. Kudos to all and thank you for exceptional service.

Angela, Dan, Judy, Olga, Becky...everyone we've worked with at the Saginaw office has been outstanding. Reponses are fast, they are understanding, and always pleasant and welcoming. They've made a positive impact on our organization.

Everyone at B&B is great to work with. If they don't know the answer to my question(s), they always find out and let me know right away! I have confidence in their office and they understand what I do and how important it is for me to be able to rely on them. I would highly recommend them to anyone in the insurance market!

In the last 3 years I have had the pleasure to work with many employees with Brown and Brown and have always been confident with their choice and their quick response to help our company and employees out. Keep up the great work! Thank you and I look forward to many more years with you by our side.

We deal primarily with Angela Garner and Judy Robinson. They are always very helpful, knowledgeable and pleasant to speak with. I cannot think of one time when they weren't able and willing to help with any questions or concerns either the Human Resource department had or our employees when and if they call the office regarding claims. Both of these individuals should be commended on their dedication to their job and because of their diligence I cannot imagine we would ever stop using Brown & Brown.



1605 Concentric Blvd., Suite #1, Saginaw, MI 48604 ~ Phone: 989-249-5960 ~ FAX: 989-249-5966
Angela Garner, Executive Vice President
agarner@bbcmich.com

Health Care Reform: What Employers Need to Know

Congress enacted the Patient Protection and Affordable Care Act in March 2010, overhauling the United States health care system. The law is also referred to as PPACA, the ACA, the Affordable Care Act and Health Care Reform. For employers, the new law represents the most significant changes to their health benefit plan since the passage of ERISA.

Many provisions of Health Care Reform are already in effect. The purpose of this bulletin is to summarize key changes that became effective in 2013 and become effective in 2014. It is based upon federal regulations and other guidance published as of October 1, 2014.

Plan Changes

Employers will be required to make several changes to their health plans for 2013 and 2014 to comply with Health Care Reform. The changes include the following:

1. Medical FSAs

- a. Limit on Contributions For plan years beginning in 2013, a participant is not permitted to contribute more than \$2,500 to his or her medical flexible spending account (FSA) under an employer's Section 125 cafeteria plan. An employer is required to amend its Section 125 plan to include this limit no later than December 31, 2014.
- b. Optional Medical FSA Carryover Beginning as early as the 2013 plan year, an employer can amend its Section 125 plan to allow an employee to carryover up to \$500 of his or her unused medical FSA balance for reimbursement in the following plan year. This optional provision is an alternative to the 2½ month grace period rule for medical FSAs. An employer can offer one provision or the other, but not both. Like the 2½ month grace period, the \$500 carryover rule creates complexity for employees enrolling in a high deductible health plan (HDHP) with an HSA. Employers offering an HDHP with an HSA need to design the 2½ month grace period or \$500 carryover in a way to ensure employees will still be HSA eligible.
- c. Eligibility of Part-Timers Beginning in 2014, only employees who are eligible for the employer's group health plan should be allowed to participate in the medical FSA. If an employee (e.g., a part-timer) is allowed to participate in the medical FSA but not the employer's group health plan, the medical FSA will not be an "excepted benefit." Excepted benefits that aren't grandfathered under

Health Care Reform must offer first-dollar preventive care. Since medical FSAs typically aren't employer-funded, this creates a seemingly impossible compliance requirement.

2. Health Reimbursement Arrangements (“HRAs”)

HRAs reimburse employees for uninsured health expenses up to an annual dollar limit. These dollar limits will be considered to violate the prohibition on annual limits under Health Care Reform effective as of plan years beginning in 2014 unless the HRA:

- a. Is a retiree only HRA;
- b. Is “integrated” with a group health plan; or
- c. Restricts reimbursement only to certain dental and/or vision expenses.

Employers must affirmatively amend their HRA plans to establish qualification under one of these exceptions.

3. Pre-Existing Condition Exclusions/Certificates of Creditable Coverage

Employer group health plans can no longer impose a pre-existing condition exclusion with respect to any participant as of the first day of the 2014 plan year. Plans have been required to issue terminating participants a HIPAA certificate of creditable coverage to demonstrate prior coverage to offset any pre-existing condition exclusion in the next plan in which the individual enrolls. Because pre-existing condition exclusions will no longer be permitted, HIPAA certificates of creditable coverage are no longer necessary and are not required to be issued after December 31, 2014.

4. Waiting Period

For plan years beginning in 2014, group health plans generally cannot impose a waiting period longer than 90 days for newly eligible employees, with coverage taking effect no later than the first day after the 90-day waiting period has been satisfied. Before the up to 90-day waiting period begins, employers may impose a “reasonable bona fide” employment-based orientation period for up to one calendar month less one calendar day.

However, beginning in 2015, use of an orientation period in addition to a 90-day waiting period creates a problem for large employers under the pay or play penalty. To address this issue, the final regulations permit large employers to adopt an orientation period followed by a waiting period, but to provide that in no event will coverage take effect later than the first day of the month after three months of employment. Such a provision will comply with both the 90-day waiting period rule and the pay or play penalty.

5. Cap on Maximum Out-of-Pocket Limits

For plan years beginning in 2014, the maximum out-of-pocket limits on medical and prescription drug expenses for all non-grandfathered plans cannot exceed certain maximum out-of-pocket limits. The new out-of-pocket limits must consider deductibles, copays and coinsurance. For 2014, the limits are \$6,350 for single coverage and \$12,700

for two-person or family coverage. For 2015, the limits are \$6,600 for single coverage and \$13,200 for two-person or family coverage. (If the health plan is a qualified high deductible health plan offered with a health savings account the maximum out-of-pocket limit was the same as the above limit for 2014 but in 2015 and later years will be lower. For example, for 2015, the lower limit is \$6,450 for single coverage and \$12,900 for two-person or family coverage.)

The maximum out-of-pocket limits apply on a cumulative basis to all health benefits under a non-grandfathered plan. However, for the 2014 plan year only, if a non-grandfathered plan's major medical coverage complies with the maximum out-of-pocket limits, the plan may impose separate out-of-pocket limits on other benefits, such as prescription drug expenses, if the separate out-of-pocket limits individually comply with the maximum out-of-pocket limits. For subsequent years if a plan has separate medical and prescription drug providers the limits can be divided. For example, for 2015, if the MOOP for the medical benefit for single coverage is \$3,000, the MOOP for the prescription drug benefit for single coverage can be as high \$3,600 (\$6,600 total).

6. **Nondiscrimination Rules**

For many years, the Internal Revenue Code has imposed nondiscrimination rules on self-insured group health plans that prohibit discrimination in favor of the highly compensated with respect to eligibility, benefits and required contributions. Health Care Reform extends the nondiscrimination rules to non-grandfathered, fully-insured plans. These rules were initially set to take effect during 2011, but the IRS has not yet published regulations regarding the new requirements. So the effective date of the new nondiscrimination rules for non-grandfathered, fully-insured plans has been delayed until plan years beginning after regulations are published.

7. **Automatic Enrollment**

Employers with more than 200 full-time employees will be required to automatically enroll newly-eligible individuals and reenroll existing employees. No regulations have been issued regarding this requirement. The requirement will not take effect until after the regulations are issued.

New Participant Notices

Health Care Reform requires employers to provide additional notices to participants in their health plans. These notices include the following:

1. **Notice Regarding Grandfathered Plan Status**

Plans that were in effect prior to the enactment of Health Care Reform are exempt from some of the insurance market reforms under Health Care Reform so long as they retain "grandfathered plan" status. One of the requirements to retain grandfathered plan status is including certain disclosures in SPDs and other plan materials (such as annual open enrollment materials) provided to participants describing the plan's benefits. The disclosure must state that the plan is grandfathered and must provide contact information for questions and complaints. Model notice language is available on the DOL website.

2. **Summary of Benefits and Coverage**

The purpose of the Summary of Benefits and Coverage (SBC) is to provide information in a prescribed format to participants so they can easily compare the information with other plans for which they are eligible, including coverage available on an exchange. The SBC was originally required during 2012, and must be updated annually. The SBC must be provided to a new participant upon initial eligibility, to all participants at open enrollment, and to a participant upon request.

For group health plans beginning on or after January 1, 2014, the SBC must include additional information regarding whether the group health plan provides “minimum essential coverage” and whether the group health plan meets the “minimum value” requirement.

3. **Notice of Exchange Availability**

By October 1, 2013, employers were required to provide current employees with a one-time notice regarding the availability of the exchanges. The notice is not required to be reissued annually to ongoing employees. However, new hires after October 1, 2013 must be provided with the notice within 14 days of their start date. This notice must include information regarding the premium credits and cost sharing subsidies available to low income individuals if they enroll in coverage on an exchange. The DOL published model notices during May 2013.

Additional Reporting Requirements

Employers have new reporting requirements to governmental agencies under Health Care Reform. These requirements include the following:

1. **W-2 Reporting of Health Benefit Costs** Employers must include the aggregate cost of employer-sponsored health benefits on the W-2 statements issued annually to employees. This new reporting requirement initially applied to W-2s issued in January 2013 (for 2012). It is not applicable to employers with fewer than 250 individuals to whom the employer must issue a W-2. Since the cost is based upon the coverage tier in which an employee is enrolled and the cost must account for any changes in the employee’s coverage during the year, employers should have systems to track an employee’s health benefit coverage elections so this information can be captured when preparing W-2s. The cost is generally based on either the premium charged by the plan’s insurer or the applicable COBRA premium minus the 2% administrative charge. Both the employer’s and the employee’s contribution toward the cost are reported.

2. **Individual Mandate Reporting**

Insurers of fully-insured group health plans and plan sponsors of self-funded group health plans must report information about what months employees and their dependents are enrolled in a plan that provides minimum essential coverage. This reporting will help the IRS administer the individual mandate penalty and it applies to all employers, not just large employers. Reporting is optional for 2014 and is required for 2015. It applies on an a calendar year basis, regardless of the plan year. So, for 2015, information must be

reported to the IRS by February 28, 2016 (or March 31, 2016 if filed electronically). The same information must also be reported to employees by January 31, 2016. Employers will use IRS Forms 1094-B and 1095-B to complete the individual mandate reporting. The IRS published these forms in draft form in July 2014. Draft instructions were issued in August 2014.

3. **Pay or Play Reporting**

This reporting requirement only applies to large employers with 50 or more full-time employees and is intended to help the IRS administer the employer pay or play penalty. Again, information must be furnished to both the IRS and employees including certain information about the employer, certification that the employer offers full-time employees and their dependents the opportunity to enroll in minimum essential coverage, the months coverage was available, the employee's premium share for self-only coverage in the lowest cost plan providing minimum value, the number of full-time employees for each month and certain information about the full-time employees. The reporting deadlines are the same as the reporting deadlines for individual mandate reporting. The IRS has recognized that this creates some duplicative reporting requirements. Employers will use IRS Forms 1094-C and 1095-C to complete pay or play reporting. Employers that are subject to both individual mandate reporting and pay or play reporting will be able to use Form 1095-C to complete both requirements with respect to full-time employees. The IRS published these forms in draft form in July 2014. Draft instructions were issued in August 2014.

New Taxes and Fees

Health Care Reform imposes a series of new taxes and fees on individuals and plans. Here is a summary:

1. **Increased Medicare Taxes**

Beginning in 2013, an employer is required to withhold additional Medicare taxes in the amount of 0.9% of the amounts paid to an employee in excess of \$200,000 during a year. The new withholding obligation is "triggered" when the employee's income from that employer exceeds \$200,000. However, the employer is not required to pay additional Medicare taxes.

2. **PCORI Fee**

For plan years ending on or after October 1, 2012 (and before October 1, 2019), a fee will be assessed to finance comparative clinical effectiveness research through the Patient-Centered Outcomes Research Institute (PCORI). The amount of the fee is based upon the average number of covered lives (including both employees and dependents) under a health plan during the plan year.

The PCORI fee for the first plan year is \$1 per covered life. The fee increases to \$2 per covered life for the next plan year (ending on or after October 1, 2013 and before October 1, 2014), \$2.08 for the next plan year (ending on or after October 1, 2014 and before October 1, 2015) and will be increased for future plan years based upon increases

in national health spending. If the employer's plan is fully-insured, the fee is payable by the insurer. If the employer's plan is self-funded, the fee is payable by the employer.

For self-funded plans, the fee is reported on IRS Form 720 and is paid by July 31 of the calendar year immediately following the last day of the plan year for which the fee is owed. As a result, an employer with a calendar year plan was required to pay its first PCORI fee by July 31, 2013. On the other hand, if the employer's first plan year ending on or after October 1, 2012 ended on May 31, 2013, the first PCORI fee must be paid by July 31, 2014.

3. Temporary Reinsurance Program

A new fee is imposed on group health plans that provide major medical coverage. The purpose of the fee is to fund reinsurance for insurers in the individual market. This fee is imposed during 2014, 2015 and 2016. A plan's annual enrollment counts must be submitted, using pay.gov, by November 15 of the applicable year. The required payment is due by January 15 of the following year. However, payment is permitted to be made in two installments. The first installment is also due on January 15 of the following year. The second installment is due in the fourth quarter of the following year. The total fee is not divided equally between the two installments.

The goal is to raise \$25 billion, but it is front-end loaded. It will raise \$12 billion during 2014, \$8 billion in 2015 and \$5 billion in 2016.

For **2014** the fee is **\$63 per covered person** (employees and dependents). The annual enrollment count is due using pay.gov on November 15, 2014. The first payment of \$52.50 per covered person is due on January 15, 2015. The second installment of \$10.50 per covered person is due in the fourth quarter of 2015. Alternatively, the total fee of \$63 per covered person may be paid by January 15, 2015.

For **2015** it will be **\$44 per covered person**. The fee for 2016 is expected to be lower. This fee applies on a calendar year basis even if the plan has a different plan year.

If the employer's plan is fully-insured, the fee is reported and paid by the insurer. If the employer's plan is self-insured, the fee is imposed on the plan (i.e., the employer-plan sponsor). But, a third party administrator may report and pay the fee on behalf of a self-insured plan.

Health Care Exchanges

One of the key components of Health Care Reform is the establishment of exchanges to help individuals and small groups shop for health coverage in a more efficient and comprehensive manner. It was anticipated that each state would have its own exchange, but most states have declined to establish an exchange. So the federal government has established and will operate the exchanges for these states. The exchanges began operation during the Fall of 2013 with coverage available as of January 1, 2014.

Health Care Reform also provides that low income individuals will receive premium credits to reduce their cost of purchasing health insurance on the exchange. For this purpose, a premium

credit is available if the individual's household income is between 100% and 400% of the federal poverty level. The amount of the premium credit decreases as household income increases.

Health Care Reform also provides for the expansion of individuals eligible to receive free Medicaid coverage. At the current time, the eligibility requirements vary by state but generally, certain individuals with household income of up to 100% of the federal poverty level are eligible for Medicaid. Health Care Reform would have increased this eligibility to all individuals with household income of up to 138% of the federal poverty level. An individual who receives Medicaid coverage does not need to purchase health coverage on an exchange in order to avoid the individual mandate penalty. Further, individuals who are eligible for Medicaid are not eligible for a premium credit from an exchange.

But based upon the U.S. Supreme Court case during June 2012, states are not required to expand Medicaid. For states where Medicaid is not expanded, more individuals will be eligible for the premium credit on the exchange. This potentially exposes employers to larger play or pay penalties.

Individual Mandate

A second important component of Health Care Reform is the individual mandate. An individual must obtain health insurance that provides minimum essential coverage or pay a penalty. This health insurance can be provided through Medicaid, Medicare, other public programs (for example, CHIP or Tricare), the exchange or an employer plan.

The penalty is the greater of a flat dollar amount or a percentage of the household income:

- The flat dollar amount is \$95 for 2014, \$325 for 2015 and \$695 for 2016. For later years, the flat dollar amount will be increased for changes in the cost of living.
- The percentage of household income is 1% for 2014, 2% for 2015 and 2.5% for 2016 and later years.

Health Plan Identifier

In an effort to reduce inefficiencies and increase automation in processing health plans' electronic transactions, Health Care Reform requires certain health plans to apply for a health plan identifier (HPID). The HPID will be used to identify a health plan when it engages in a HIPAA standard transaction, such as electronic funds transfer or electronic remittance advice. For fully-insured plans, the insurer is responsible for obtaining the HPID. For self-funded plans, the plan sponsor must obtain the HPID. The HPID application must be completed by November 5, 2014 for large plans. Small plans, however, have until November 5, 2015 to apply for an HPID. A "small" plan is defined as a health plan that pays less than \$5 million in benefits per year. While a self-funded plan's TPA can assist the plan sponsor in applying for an HPID, the application must ultimately be submitted by the plan sponsor. The HPID is not required to be used by health plans, large or small, until November 7, 2016. Plan sponsors will need to use an electronic system maintained by the Department of Health and Human Services called the "Health Plan and Other Entity Enumeration System" (HPOES) to apply for an HPID.

Employer Mandate - Play or Pay

A third key component of Health Care Reform is the employer mandate. Under this mandate, large employers will be required to offer health care coverage to full-time employees and their dependents or pay a penalty. The penalty was set to take effect in 2014 but the IRS delayed the effective date to 2015.

1. Play or Pay Rules Only Apply to Large Employers

Health Care Reform imposes the “play or pay” rules on a “large employer” - an employer that averages at least 50 full-time employees.

- This determination is made separately for each year based upon the average number of full-time employees during the prior year.
- For this purpose, full-time means at least 30 hours a week.
- The number of full-time employees is based upon the number of full-time employees plus full-time equivalent employees (FTEs).
- To convert the number of part-time employees to FTEs, determine the total hours worked during each month of the prior year by the employees who average less than 30 hours per week during the month and divide by 120. (In determining the total hours of these part-time employees, the employer should not count more than 120 hours in a month for any employee.) After making this calculation, add the sum of full-time employees and FTEs for each month, and then divide by 12 to determine the average for the prior year.

If companies are under common ownership, they are treated as a single employer for purposes of determining whether there are 50 FTEs. So an employer cannot avoid the rules by dividing its company into multiple companies.

2. Key Transition Rules

First, there is a special transition rule that applies for determining whether an employer is a “large employer” for 2015. An employer may determine whether it is a large employer for 2015 based upon the average number of FTEs during a six-month consecutive period during 2014 (for example, January 2014 through June 2014), instead of the entire calendar year. By using this shorter period to determine whether the employer is a large employer, an employer that is subject to the play or pay rules has more time to bring its plan into compliance with Health Care Reform by the start of 2015.

Second, the pay or play penalty will not apply until the first day of an employer’s 2016 plan year for employers with an average of 50 - 99 full-time employees and FTEs in 2014 (the six-month consecutive period discussed above may be used to calculate this average), if the employer satisfies certain conditions, including maintaining its workforce size and maintaining the existing level of any health coverage.

3. **The Potential Tax Penalties**

Health Care Reform has two separate penalties that may apply to a large employer under the play or pay rules:

- **The \$2,000 Penalty** The first penalty is a tax equal to \$2,000 multiplied by the employer's full-time employees (less the first 30 full-time employees). For example, if this penalty applies and the employer has 200 full-time employees, the tax is equal to \$2,000 x 170 employees (200 - 30 = 170), or \$340,000. This penalty applies if two requirements are satisfied:
 - The employer fails to offer health coverage to substantially all (at least 95%) of the employer's full-time employees, and their dependents (but not spouses); and
 - The employer has at least one full-time employee who enrolls in health insurance coverage through an exchange and receives a premium credit.

This penalty is typically thought to be limited to employers who choose to "pay" instead of "play." But, because coverage must be offered to 95% of the employer's full-time employees to avoid the penalty, an employer will need to be very careful to identify all its full-time employees. Otherwise, an employer who chooses to "play" may still be at risk with respect to the \$2,000 penalty.

Here are some other important rules relating to this tax penalty:

- For the initial year (2015), two important modifications have been made to the \$2,000 penalty. The first is that the penalty can be avoided if the employer offers coverage to 70% (rather than at least 95%) of its full-time employees. Second, if an employer is subject to the penalty, it may calculate the total penalty amount by disregarding its first 80 full-time employees (rather than its first 30 full-time employees). After the 2015 plan year these transition rules no longer apply.
 - Health coverage must also be offered to the employee's dependent children (natural born and adopted) at least through the end of the month the child attains age 26. This requirement will not apply in 2015 provided the employer is taking steps to arrange for such coverage by 2016.
 - If there is more than one company under common ownership, the tax penalties are determined separately for each company. However, in calculating the \$2,000 penalty, the 30 employees (80 for 2015) that are subtracted in calculating the penalty are allocated among the companies that are commonly owned in proportion to the number of their full-time employees. Each company is not permitted to subtract 30 employees (80 for 2015) in calculating the penalty.
- **The \$3,000 Penalty** The second penalty is a tax equal to \$3,000 multiplied by the number of an employer's full-time employees who enroll in health insurance

coverage through an exchange and receive a premium credit. This penalty applies if:

- The employer's plan doesn't provide minimum value. This occurs if the plan pays less than 60% of the total allowed cost of benefits provided under the plan; or
- The employer's plan isn't affordable to the employee. For this purpose, a plan is not affordable if the cost of employee-only coverage is more than 9.5% of the employee's household income.
 - Because an employer doesn't know an employee's household income, the regulations provide three safe harbors that can be used to determine whether a plan is affordable. The three safe harbors are based on the employee's Box 1 W-2 wages, the employee's rate of pay and the federal poverty line for households with one individual. The affordability test is satisfied if the employee's required contribution for single coverage under the least expensive medical option the employer offers providing minimum value does not exceed 9.5% of the safe harbor amount.
 - The safe harbor that may be most helpful to employers is based upon the employee's rate of pay at the beginning of the year. The monthly premium is affordable if it does not exceed 9.5% of the employee's hourly rate of pay at the beginning of the year multiplied by 130. If the employee's hourly rate is reduced, the rate of pay safe harbor is applied separately to each calendar month based on the employee's rate of pay for that month. The rate of pay safe harbor is not available with respect to salaried employees for any year during which their salary is reduced.
 - There are special rules for wellness incentives. A premium surcharge for tobacco users is disregarded in determining whether coverage is affordable, but premium surcharges for other wellness reasons (for example, BMI, cholesterol or blood pressure) are counted.

The \$3,000 penalty also could apply if the full-time employee isn't offered coverage under the employer's plan and instead enrolls in health insurance coverage through an exchange and receives a premium credit. This could occur, for example, if the full-time employee was part of the less than 5% of full-time employees who are not offered coverage (less than 30% for 2015).

Although \$3,000 is greater than \$2,000, the \$3,000 penalty is likely to be smaller than the \$2,000 penalty in total because it only applies based upon the number of the employer's full-time employees who purchase health insurance coverage through the exchange and receive a premium credit. It is not based upon the total

number of the employer's full-time employees, as is the situation for the \$2,000 tax.

4. **Identifying Full-Time Employees**

For purposes of the play or pay rules, an employee is full-time if the employee averages 30 or more hours of service per week. An "hour of service" includes all hours for which an employee is paid (not the actual number of hours worked by the employee). Hours of service must also be credited for unpaid leave periods due to FMLA, USERRA or jury duty (or those periods must be disregarded in determining the employee's average weekly hours). IRS regulations treat 130 hours of service during a month as the equivalent of 30 hours of service per week.

- **Newly-hired Full-Time Employees** In many situations, an employer can readily determine whether a new employee is full-time. If the employer reasonably expects the new employee to work an average of 30 hours per week, the employee should be treated as full-time. The employer can then avoid any play or pay penalty for the new full-time employee by offering health coverage that is effective by no later than the first day of the fourth full calendar month after the employee's start date.
- **Newly-hired Variable Hours or Seasonal Employees** The determination of whether an employee is full-time may be more difficult if the employee works variable hours or is seasonal. If the employer cannot reasonably determine when the employee is hired whether the employee will average 30 hours of service per week, the employer may use a safe harbor approach to determine whether the employee is, in fact, a full-time employee or a variable hours employee for purposes of the pay or play penalty. An employee will be considered seasonal for this purpose if he or she works in a position for which the customary annual employment period is six months or less, with the employment period beginning at approximately the same time each year.
- **Initial Measurement Period for Variable Hours, Part-time and Seasonal Employees** New hires who are variable hours, part-time or seasonal employees may be subject to a "measurement period" before coverage is required to be offered. Under this safe harbor, the employer can determine whether a newly-hired variable hours, part-time or seasonal employee averages at least 30 hours of service per week during a measurement period that lasts from 3 to 12 months (as determined by the employer). If the employee averages at least 30 hours of service per week during the measurement period, the employee is then treated as a full-time employee for a subsequent period of time called the "stability period." The stability period must be a period of 6 to 12 months after the initial measurement period. However, the stability period can't be shorter than the measurement period.

Further, the employer is permitted to have an administrative period between the measurement period and stability period. The purpose of the administrative period is to determine whether the employee satisfied the requirements to be a

full-time employee and, if so, to offer coverage to the employee that will become effective at the beginning of the stability period.

On the other hand, if the variable hours, part-time or seasonal employee does not average at least 30 hours of service per week during the measurement period, the employer is not required to offer health coverage to the employee during the stability period. This rule applies even if the employee subsequently changes status and becomes full-time during the stability period.

For example, assume an employee is hired on May 15, 2014 and the employer cannot reasonably determine at that time whether the employee is likely to average 30 hours of service per week. The employer could use a measurement period for this new variable hours employee from May 15, 2014 through May 14, 2015. If the employee averaged at least 30 hours of service per week during this measurement period, the employee would be eligible for health coverage for the stability period from July 1, 2015 through June 30, 2016. (The period from May 15, 2015 through June 30, 2015 is the administrative period.) However, if the employee did not average at least 30 hours of service per week during the May 15, 2014 through May 14, 2015 measurement period, the employer would not be required to offer health coverage to the employee during his or her July 1, 2015 through June 30, 2016 stability period.

- **Ongoing Employees** While only new hires who are part-time, variable hours or seasonal can be subject to an initial measurement period when they are hired before being offered health coverage, all ongoing employees, including full-timers, can be subject to a measurement period to maintain eligibility on an ongoing basis. For example, if an employer's health plan operates on a calendar year basis, the employer could use the period from October 15 through the following October 14 as a measurement period that can be used to determine whether all employees are full-time. If the employee is full-time during the measurement period, the employee would be offered health insurance coverage as of the immediately following January 1, for the next plan year. But if the employee did not average 30 hours of service per week during the measurement period, the employee would be ineligible for health coverage during the next plan year. This cycle repeats annually.

5. **Transition Rule for Determining Full-Time Employees**

The measurement period and stability period rules for ongoing employees create time constraints for employers that want to use a 12-month stability period for 2015 because the measurement period must then also be 12 months. So the final regulations permit a special transition rule for the 2015 stability period. An employer may use a measurement period that is shorter than 12 months and still use a 12-month stability period, if the following requirements are satisfied:

- The measurement period is at least six months; and
- The measurement period begins no later than July 1, 2014 and ends no earlier than 90 days before the first day of the 2015 stability period.

For example, a calendar year plan could have a measurement period from May 1, 2014 through October 31, 2014 and then use the 2015 calendar year as the stability period. However, for subsequent plan years a 12-month measurement period would be required.

6. **Transition Rule for Fiscal Year Plans**

Although the play or pay rules generally are effective January 1, 2015, the final regulations provide a delayed effective date for a large employer with a non-calendar year plan that was in effect on December 27, 2012 and has not been subsequently amended to delay the start of the plan year until later in the calendar year. No penalty will be owed until the first day of the 2015 plan year for an employee who was eligible to participate in the plan under its terms as in effect as of February 9, 2014 (regardless of whether the employee actually enrolled).

However, if the employer doesn't offer group health coverage to all employees working at least 30 hours per week, the above transitional rule may not apply to those ineligible employees who will be considered full-time under the pay or play penalty. As a result, there are two additional transition rules providing a delayed effective date until the first day of the employer's 2015 plan year:

- First, the postponed effective date is available for all employees provided that at least one-quarter of all of the employer's employees were covered under the employer's non-calendar year plan as of a date chosen by the employer during the 12 months ending on February 9, 2014, or least one-third of all of the employer's employees were offered coverage under the employer's non-calendar year plan during the most recent open enrollment period that ended before February 9, 2014.
- Second, transition relief is available for all full-time employees if the employer either had, as of any date it selects during the 12 months ending on February 9, 2014, at least one-third of its full-time employees covered under its non-calendar year plan or offered coverage to at least one-half of its full-time employees during the most recent open enrollment period that ended before February 9, 2014.

7. **Other New Rules Added by the Final Regulations**

The final regulations regarding the pay or play issued in February 2014 also address the following issues:

- In general, no employee may be excluded in applying the pay or play rules. However, employees whose compensation is from sources outside the U.S. may be disregarded, regardless of the employee's citizenship. On the other hand, employees that are holders of an H-2A or H-2B visa must be considered and cannot be disregarded. Similarly, students working as a paid intern or extern or for an educational institution cannot be disregarded. However, with respect to students, if they are working in a federal work study program or another similar program of a state or other governmental entity, those hours will not be counted for purposes of the pay or play.

- The hours of service of a bona-fide volunteer will not be counted under the pay or play rules. To qualify, the individual must work as an employee of a governmental entity or a tax-exempt organization and may only receive expense reimbursements or allowances, or reasonable benefits and nominal fees paid for similar services by volunteers.
- The IRS recognizes that certain employees are not paid on an hourly or salaried basis and so tracking their hours creates challenges. This includes individuals such as commissioned salespeople, adjunct faculty and on-call employees. Until further guidance is issued, any reasonable method may be used to track the hours of these types of employees. With respect to adjuncts, the final regulations offer a safe harbor to credit these employees with 2.25 hours of service for each credit hour taught during a week plus credit for additional hours outside the classroom spent performing required duties such as office hours and faculty meetings (this safe harbor only applies until the IRS issues further guidance). For on-call employees, the reasonable method must include each hour for which the on-call employee is paid, each hour for which the on-call employee is required to remain on the employer's premises and each hour for which the employee's activities are significantly limited because of being on call.
- If an employee has a break in service and returns to work, he or she may not be treated as a new employee unless the break is at least 13 weeks (26 weeks in the case of an employee of an educational institution). There is an alternative break in service rule known as the rule of parity that permits certain employees to be treated as a new employee even if the employee has a break in service that is less than 13 (or 26) weeks.
- The final regulations did not provide much additional guidance regarding how to treat employees of a temporary staffing agency under the pay or play. However, the final regulations offer a useful tool to large employers who lease full-time employees through a temporary staffing agency. Where the client-employer retains the right to direct and control the employees, the employees will likely be considered the common-law employees of the client employer as opposed to the temporary staffing agency for purposes of the pay or play. However, if the temporary staffing agency offers the leased employees group health coverage, the offer will be treated as an offer of coverage made by the client-employer for purposes of avoiding the pay or play penalty. This relief is contingent on the temporary staffing agency charging the client-employer a higher fee with respect to leased employees enrolling in its health plan.

8. Considerations Before Discontinuing Health Insurance Coverage

Some employers may prefer to “pay” instead of trying to comply with the many new requirements of Health Care Reform. However, before an employer makes this decision, the employer should consider the following:

- The pay or play penalty is not tax deductible.

- It still is important for an employer to attract and retain good employees. If an employer discontinues health insurance coverage, will the employer pay additional compensation to assist employees in purchasing health insurance coverage on the exchange? If so, here are some issues for the employer to consider:
 - Any additional compensation must be provided on an after-tax basis. The IRS will not permit employers to reimburse employees for individual exchange coverage on a tax-free basis.
 - The cost of coverage on the exchange depends on the insured's age. Will the employer vary the amount based upon the employee's age?
 - Will the employer vary the amount depending on whether the employee has a family?
 - The premium subsidy for purchasing insurance on the exchange depends on the household income and "phases-out" as household income nears four times the federal poverty level (the federal poverty level depends on the number of people in the family).
 - The additional compensation paid to the employee to purchase health insurance coverage will reduce the amount of premium credit available to the employee because the employee's household income will be larger.
 - The employer's executives will likely be paying the full cost of coverage on the exchange.
- The cost of other pay-related taxes (such as FICA) and pay related benefits (such as disability insurance and life insurance) will increase.
- Will the employees be happy with the coverage that is available on the exchange?

9. **How to Modify an Employer's Health Plan to Minimize the Risk of Taxes Under the Play or Pay Rules**

A large employer may want to take action during 2014 to minimize the risk that the play or pay penalties will apply to the employer. Here are some actions that should be considered by the employer:

- For 2015, the employer should make sure that coverage is offered to at least 70% of its full-time employees (95% by 2016). If the employer employs variable hour, part-time or seasonal employees, the employer may need to establish measurement periods and stability periods to make sure that health coverage is offered to all full-time employees. The employer should also make sure that no individuals who are providing services to the employer as independent contractors are actually employees.

- The employer should make sure that coverage under its health plan is affordable. This is important in avoiding the \$3,000 tax, discussed above. Because affordability is based upon the cost of employee-only coverage, an employer may want to consider adding a low cost medical plan option with an affordable single coverage premium tier.

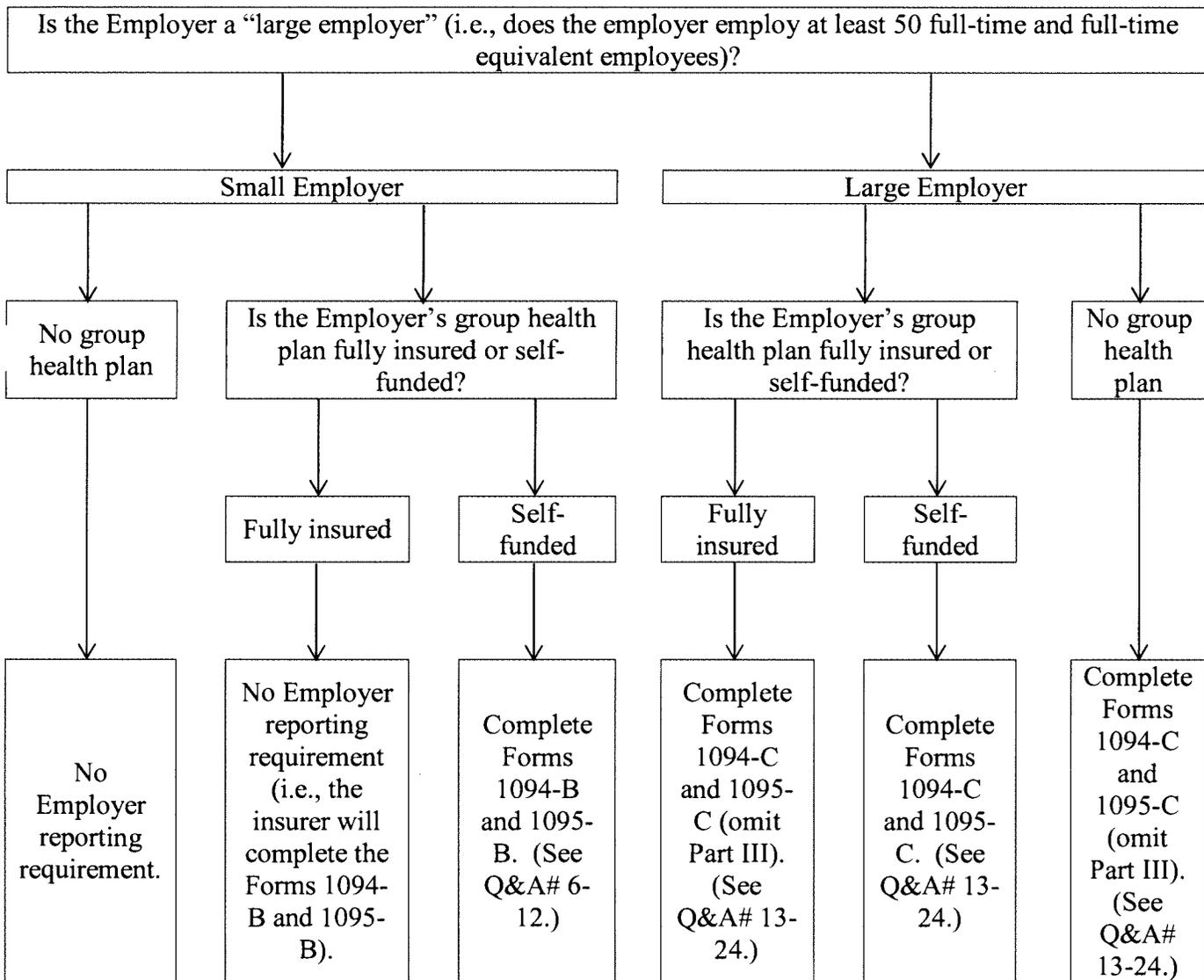


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EMPLOYER REPORTING REQUIREMENT FORMS

This update is part of a Brown & Brown series summarizing new guidance issued in connection with the Patient Protection and Affordable Care Act (also known as Health Care Reform). We are joining forces with our business partner, the law firm of Miller Johnson, to provide these updates to you. For this edition, we are focusing on the forms used to comply with the individual mandate and pay or play reporting requirements. Draft forms and draft instructions were recently released.

Overview



General

1. **When are entities required to comply with the individual mandate and pay or play reporting requirements?**

Both the individual mandate and pay or play reporting requirements first apply for health coverage provided in the 2015 calendar year. This means that the first informational returns (discussed below) for individual mandate reporting and pay or play reporting are due in the first quarter of the 2016 calendar year.

2. Is individual mandate and pay or play reporting required for supplemental health coverage (e.g., medical FSAs, HRAs, EAPs, etc.)?

No. Individual mandate reporting and pay or play reporting is only required for group health plans that provide “minimum essential coverage.” In the group health plan context, minimum essential coverage is defined quite broadly. Having said that, minimum essential coverage excludes “excepted benefits.” Many supplemental health coverage arrangements are “excepted benefits” and are, therefore, not subject to the individual mandate or pay or play reporting requirements.

With respect to individual mandate reporting, supplemental health coverage is not subject to individual mandate reporting, if the supplemental health coverage has the same plan sponsor as a group health plan providing major medical coverage. With respect to pay or play reporting, employers are only required to report for its group health plan(s) that comply with the pay or play penalty. Typically, that will be the employer’s group health plan(s) that provides major medical coverage.

3. Is electronic filing with the IRS permissible?

Yes. In addition, entities that file 250 or more Forms 1095-B in a calendar year must file Form 1095-B and Form 1094-B with the IRS electronically. Similarly, entities that file 250 or more Forms 1095-C in a calendar year must file Form 1095-C and Form 1094-C with the IRS electronically.

4. Is electronic distribution of statements (i.e., Forms 1095-B and 1095-C) to individuals permissible?

Yes. Similar to the Form W-2 rules, the regulations permit, but do not require, entities to provide statements to individuals electronically, if the following requirements are met:

- The individual affirmatively consents to receiving these statements electronically in a manner that reasonably demonstrates that the individual can access the statement in the electronic format in which it will be distributed (an individual may consent using paper if the individual is required to confirm consent electronically in a matter that reasonably demonstrates that the individual can access the statement in the electronic format which it will be distributed).
- Before, or at the time of, an individual’s consent to receive these statements electronically, the individual must be provided with a notice that states the following:
 - The individual will receive the statement in paper format if the individual does not receive the statement electronically;
 - The scope and duration of the consent;
 - The procedure to request the statement in paper format after consent for electronic distribution is given and whether such a request will be treated as a withdrawal of consent;
 - The individual may withdraw consent by writing (electronically or on paper) to the person or department whose name, mailing address, telephone number and e-mail address are also included;

- The conditions under which statements will cease being distributed electronically (e.g., if the individual terminates employment with the employer);
 - The procedures for the individual to update information necessary to provide the statement electronically; and
 - The hardware and software requirements to access, print and retain the statement and, if the statement is maintained on a website, the date that the statement will no longer be available on the website.
- The electronic statement must contain all of the required information.
 - If the electronic statement is furnished on a website, the entity must satisfy the following requirements:
 - The individual must receive notification by mail, e-mail or in person (this notice is in addition to the notice that is provided when the individual consents to receive these statements electronically). The notice must provide instructions on how to access and print the statement and include the following statement in all capital letters: “IMPORTANT TAX RETURN DOCUMENT AVAILABLE.” (If the notice is provided by e-mail, this statement must be included in the subject line of the e-mail and the notice must be provided by mail or in person if the notice is returned as undeliverable.)
 - The statement must be retained on the website through first business day on or after October 15 of the year following calendar year for which the statement relates. For example, for coverage provided in 2015, the electronic statement must be maintained on the website until October 15, 2016.

There are additional requirements to provide “corrected statements” electronically.

5. Is there any penalty relief for incomplete or incorrect Forms 1094-B, 1095-B, 1094-C or 1095-C provided in 2016 for coverage provided in 2015?

Yes. The IRS will not impose penalties for incomplete or incorrect Forms 1094-B, 1095-B, 1094-C or 1095-C provided in 2016 for coverage provided in 2015, if the entity can show that it has made “good faith” efforts to comply with the individual mandate and pay or play reporting requirements. No relief is available to entities that cannot show “good faith” efforts were made to comply with the individual mandate or pay or play reporting requirements or for entities that fail to timely file these information returns (see Q&A# 10 & 20) or for subsequent years.

Individual Mandate Reporting (Section 6055 Reporting)

6. With respect to group health plans, which entities must complete individual mandate reporting?

- Health insurance issuers (i.e., insurers or carriers) of fully insured group health plans providing minimum essential coverage.
- Employer-sponsors of self-funded group health plans providing minimum essential coverage, if the employer is not a “large employer” (i.e., a “large employer” is an employer that employs at least 50 full-time and full-time equivalent employees and is subject to the pay or play penalty). Large employer-sponsors of self-funded group health plans will use Forms 1094-C and 1095-C to comply with the individual mandate reporting requirements. See Q&A# 14.

7. **What information is required to be reported under the individual mandate reporting requirement?**

Individual mandate reporting requires that information about all “covered individuals” enrolled in a group health plan (i.e., this includes, employees, spouses and/or dependents) be reported to: (a) the IRS; and (b) “responsible individuals.” Individual mandate reporting requires the following information to be included on the following forms:

Form 1094-B (transmittal form):

- Filer’s name, employer identification number and street address.
- Name and telephone number of a contact person.
- Total number of Forms 1095-B submitted with Form 1094-B.
- The Form 1094-B must be signed under the penalties of perjury.

Form 1095-B (employee statements):

- Part I: Responsible Individual’s name, Social Security number (but see Part IV below), date of birth and street address. (A “responsible individual” is generally the person who enrolls one or more individuals—including himself or herself—in a group health plan. In other words, the “responsible individual” is typically the employee or former employee in the group health plan, but could also include a surviving spouse, retiree or COBRA qualified beneficiary.)

The “origin” of the group health plan (i.e., SHOP coverage or employer-sponsored coverage).

- Part II: The employer-sponsor’s name, employer identification number and street address.
- Part III: The issuer’s name (for fully insured group health plans) or plan sponsor’s name (for self-funded group health plans), employer identification number, contact telephone number and street address.
- Part IV: Covered individual’s name, Social Security number, and months of the calendar year that the individual was enrolled in the group health plan. (A “covered individual” is the responsible individual and any other individuals enrolled in the group health plan through the responsible individual, such as a spouse or dependents.)

Entities that are subject to individual mandate reporting may use a covered individual’s date of birth instead of the covered individual’s Social Security number, only if the entity makes a “reasonable effort” to obtain the covered individual’s Social Security number. In order to make a “reasonable effort,” an entity must comply with all of the following steps:

- The entity must request the covered individual’s Social Security number at the time that the relationship between the entity and the covered individual began (i.e., at the time the covered individual enrolls in the group health plan).
- The entity must again request the covered individual’s Social Security number by December 31 of the year in which the relationship between the entity and the covered individual began (or January 31 of the following year if the relationship began in December).

- The entity must again request the covered individual's Social Security number by December 31 of the year following the year in which the relationship began.

If a covered individual fails to provide his or her Social Security number after requesting it as described above, the entity may stop requesting the covered individual's Social Security number. Although it is not entirely clear in the regulations, it appears an entity may use a covered individual's date of birth (vs. Social Security number) while it is completing the steps described above.

8. **Is individual mandate reporting required for individuals receiving COBRA continuation coverage or retiree coverage?**

Yes. An entity that is subject to the individual mandate reporting requirement must also report the required information on behalf of individuals who are receiving health coverage from a group health plan as a COBRA qualified beneficiary or a retiree. This includes health coverage provided by "retiree-only" plans that provide minimum essential coverage, even though retiree-only plans are generally not considered to be group health plans.

9. **Is individual mandate reporting required on a calendar year basis or a plan year basis?**

Even if a group health plan operates on a non-calendar basis (i.e., maintains a plan year other than the calendar year), individual mandate reporting must be reported on a calendar year basis.

10. **When must individual mandate reporting be completed?**

Similar to Form W-2 reporting, Form 1095-B must be provided to responsible individuals by the first business day on or after January 31 of the calendar year following the calendar year for which coverage is provided. For example, for coverage provided in 2015, Form 1095-B must be provided to responsible individuals by February 1, 2016 because January 31, 2016 is a Sunday.

Form 1094-B and Forms 1095-B must be filed with the IRS by the first business day on or after March 31 of the calendar year following the calendar year for which coverage is provided, if the forms are filed electronically. For example, for coverage provided in 2015, Forms 1094-B and 1095-B must be electronically filed with the IRS by March 31, 2016. However, if the forms are "paper" filed, the deadline is the first business day on or after February 28 of the calendar year following the calendar year for which coverage is provided.

11. **How does the individual mandate reporting requirement apply to entities that are part of a controlled group?**

Employer-sponsors in a controlled group that are not "large employers" may complete the individual mandate reporting as separate entities or have one entity in the controlled group complete the individual mandate reporting for all entities in the controlled group. This situation may be rare because typically entities that belong to a controlled group will be "large employers." (**Note:** this is different than the application of the pay or play reporting requirements to entities in a controlled group. See Q&A #21.)

12. **May a third-party administrator complete the individual mandate reporting?**

Yes. Entities that are subject to individual mandate reporting may enter into an arrangement with a third-party administrator to complete the individual mandate reporting. But, these arrangements do not transfer any potential liability for failing to comply with the individual mandate reporting requirements to the third-party administrator.

Pay or Play Reporting (Section 6056 Reporting)

13. Which entities must complete pay or play reporting?

Large employers that are subject to Health Care Reform's pay or play penalty are required to complete pay or play reporting, regardless of whether the entity sponsors a group health plan.

A large employer is an employer that employs at least 50 full-time and full-time equivalent employees in the previous calendar year.

14. What information is required to be reported under the pay or play reporting requirement?

The information required to be reported under the pay or play reporting requirement varies based on whether or not the employer provides a group health plan and, if so, whether the group health plan is fully insured or self-funded. Pay or play reporting requires the following information to be included on the following forms:

1094-C (transmittal form): Must be completed by all large employers.

- Part I: The employer's name, employer identification number, street address, and a contact person's name and telephone number.

If the employer is a governmental employer that designates another governmental entity to complete the pay or play reporting on its behalf (see Q&A#24), the designated governmental entity's name, employer identification number, street address, and a contact person's name and telephone number must also be included.

- Part II:
 - Whether the Form 1094-C is an "authoritative transmittal" (see Q&A# 23).
 - Total number of Forms 1095-C filed by or on behalf of the employer.
 - Whether the employer is part of a controlled group of entities.
 - Whether the employer qualifies for: (1) the "Qualifying Offer" method (see Q&A# 15); (2) the "2015 Qualifying Offer" method (see Q&A# 16); (3) transition relief from the pay or play penalty for "mid-size" employers or non-calendar year plans; or (4) the "98% Offer" method (see Q&A# 17).
- Part III:
 - Whether minimum essential coverage was offered in all 12 calendar months, and if not, which months minimum essential coverage was and was not offered.
 - The number of full-time employees in each calendar month, not including full-time employees in a "limited non-assessment period" (e.g., a full-time employee during the months the employee was subject to the group health plan's waiting period).
 - The total number of employees in each calendar month (this includes, full-time and non-full-time employees).
 - Whether the employer was part of a controlled group in each calendar month.
 - Whether the employer was subject to transition relief from the pay or play penalty for "mid-size" employers or non-calendar year plans in each calendar month.

- Part IV: The names and employer identification numbers of every other entity that was in the same controlled group at any point during the calendar year.
- Form 1094-C must be signed under the penalties of perjury.

1095-C (employee statements): Must be completed by all large employers on behalf of all full-time employees, regardless of whether the full-time employee is enrolled in a group health plan. For fully insured plans, Part III is not required.

- Part I:
 - Employee’s name, Social Security number, and street address.
 - Employer’s name, employer identification number, street address and contact telephone number.
- Part II:
 - Whether an “offer of coverage” was made for all 12 calendar months and, if not, which months an “offer of coverage” was made.
 - The full-time employee’s cost for “self-only” coverage in the lowest cost group health plan providing minimum essential coverage.
 - Any applicable safe harbor relied on by the employer (e.g., the applicable “affordability” safe harbor).

Part III (Employer-sponsors of fully insured plans are not required to complete this information): Covered individual’s name, Social Security number, and months of the calendar year that the individual was enrolled in the self-funded group health plan. (A “covered individual” is any individual enrolled in the group health plan. This includes both full-time and part-time employees, employees’ spouses and dependents, retirees, COBRA qualified beneficiaries, etc.) This information must be provided by large employer-sponsors of self-funded group health plans to comply with the individual mandate reporting requirements. See Q&A# 6.

15. What is a “Qualifying Offer” and how does this affect the employer reporting requirements under pay or play reporting?

A “Qualifying Offer” is an offer of coverage that provides minimum value at an employee cost for “self-only” coverage that does not exceed 9.5% of the “mainland single federal poverty” level to one or more full-time employees for all months during the year for which the employee was a full-time employee. (This definition of affordability is narrower than the definition under the pay or play penalty regulations.) A “Qualifying Offer” must include an offer of coverage to the employee’s spouse and dependents, if any.

For each full-time employee that the employer provides a “Qualifying Offer,” the employer:

- Should check the box entitled “Qualifying Offer Method” in item 22 on Form 1094-C.
- May include indicator code “1A” in item 14 on Form 1095-C (i.e., Part II) for each month (or all 12 calendar months, if applicable) that a qualifying offer was made to the full-time employee.
- May omit the full-time employee’s cost for “self-only” coverage in the lowest cost group health plan providing minimum essential coverage in item 15 on Form 1095-C (i.e., Part II).

The employer may provide an alternative statement to each full-time employee for which a “Qualifying Offer” was made for all 12 calendar months, instead of a copy of Form 1095-C, that includes the following information:

- The employer’s name, employer identification number and street address.
- Contact name and telephone number of an individual at the employer that is responsible for answering questions regarding the employer’s group health plan.
- A statement indicating that for all 12 months of the calendar year, the employee and his or her spouse and dependents, if any, received a Qualifying Offer and are not eligible for a premium tax credit.

16. **What is a “2015 Qualifying Offer” and how does it affect the employer reporting requirements under pay or play reporting?**

If an employer makes a “Qualifying Offer” (see Q&A# 15), to 95% of its full-time employees in 2015 (but not the full-time employee’s spouse or dependents), the employer:

- Should check the box entitled “Qualifying Offer Method Transition Relief” in item 22 on Form 1094-C.
- May include indicator code “1I” in item 14 on Form 1095-C (i.e., Part II) for each month (or all 12 calendar months, if applicable) that a 2015 Qualifying Offer was made to the full-time employee.
- May omit the full-time employee’s cost for “self-only” coverage in the lowest cost group health plan providing minimum essential coverage in item 15 on Form 1095-C (i.e., Part II).

The employer may provide an alternative statement to each employee, instead of a copy of Form 1095-C, that includes the following information:

- The employer’s name, employer identification number and street address.
- Contact name and telephone number of an individual at the employer that is responsible for answering questions regarding the employer’s group health plan.
- A statement indicating that the employee and his or her spouse and dependents, if any, may be eligible for a premium tax credit.
-

The alternative reporting method for 2015 Qualifying Offers does not apply to employees who receive a “Qualifying Offer” (see Q&A# 15) and is only applicable for coverage provided in 2015 (i.e., Forms 1095-C provided to employees by January 31, 2016). In other words, if a full-time employee receives a “Qualifying Offer” in 2015 the employer should use the alternative reporting for “Qualifying Offers” not “2015 Qualifying Offers.”

17. **What is a “98% Offer” and how does it affect the employer reporting requirements under pay or play reporting?**

A “98% Offer” is an offer of coverage that provides minimum value and is affordable (under one of the “affordability” safe harbors) to at least 98% of the employer’s full-time employees (and their dependents).

If a large employer provides a “98% Offer” it is not required to include the number of its full-time employees in each calendar month in Part III of Form 1094-C.

18. **Is pay or play reporting required for individuals receiving COBRA continuation coverage or retiree coverage?**

Former employees, including COBRA qualified beneficiaries and retirees, are not “full-time employees.” So, generally, no pay or play reporting is required for these individuals. However, the instructions to Forms 1094-C and 1095-C state, if “the retiree was a full-time employee for any month of the calendar year (for example, before retiring mid-year), the employer must complete information for all twelve months of the calendar year.” Presumably, this would also apply to COBRA qualified beneficiaries.

For purposes of individual mandate reporting, employer-sponsors of self-funded group health plans must report the required information under the individual mandate reporting requirement on behalf of individuals who are receiving health coverage from a self-funded group health plan as a COBRA qualified beneficiary or a retiree. It appears that in this case, the employer-sponsor can use Form 1095-C (instead of Form 1095-B) to complete the individual mandate reporting requirement by completing Parts I and III.

19. **Is pay or play reporting required on a calendar year basis or a plan year basis?**

Even if a group health plan operates on a non-calendar basis (i.e., maintains a plan year other than the calendar year), pay or play must be reported on a calendar year basis. (But, in months that the employer qualifies for transitional relief from the pay or play penalty, the employer need only indicate the form of transitional relief which it relies on. See Q&A# 14.)

20. **When must pay or play reporting be completed?**

The deadline for pay or play reporting is the same as the individual mandate reporting. Form 1095-C must be provided to all full-time employees (and, for self-funded plans, all employees enrolled in the self-funded group health plan) by the first business day on or after January 31 of the calendar year following the calendar year for which coverage is provided. For example, for coverage provided in 2015, Form 1095-C must be provided to employees by February 1, 2016 because January 31, 2016 is a Sunday.

Form 1094-C and Forms 1095-C must be filed with the IRS by the first business day on or after March 31 of the calendar year following the calendar year for which coverage is provided, if the forms are filed electronically. For example, for coverage provided in 2015, Forms 1094-C and 1095-C must be electronically filed with the IRS by March 31, 2016. However, if the forms are “paper” filed, the deadline is the first business day on or after February 28 of the calendar year following the calendar year for which coverage is provided.

21. **How does the pay or play reporting requirement apply to entities that are part of a controlled group?**

Each entity of the controlled group must separately file Form 1094-C and Forms 1095-C with the IRS. Further, each entity of the controlled group must separately provide employees with Form 1095-C. The different entities of the controlled group should use their own employer identification numbers when completing the pay or play reporting requirements. In other words, the pay or play reporting requirement cannot be completed for multiple entities within the same controlled group on a combined basis.

Having said that, there is nothing prohibiting one entity within a controlled group from assisting another entity within the same controlled group complete the pay or play reporting requirements. In fact, this may be typical if different entities within a controlled group participate in the same group health plan. In this arrangement, the entity that is the “plan sponsor” of the group health plan is likely the entity that maintains much of the information necessary to complete the pay or play reporting requirements.

22. May a third-party administrator complete the pay or play reporting?

Yes. Entities that are subject to pay or play penalty reporting may enter into an arrangement with a third-party administrator to complete the pay or play reporting. But, these arrangements do not transfer any potential liability for failing to comply with the pay or play reporting requirements to the third-party administrator. Further, this does not remove the requirement that each entity in a controlled group must separately comply with the pay or play reporting requirements (see Q&A# 21).

23. May an entity that is subject to the pay or play reporting requirements file multiple Forms 1094-C?

Yes, the instructions indicate that an entity that is subject to the pay or play reporting requirements may file multiple Forms 1094-C, provided that one Form 1094-C is also filed that reports the aggregate data reported on all Forms 1094-C. The Form 1094-C with the aggregate data should be marked the “authoritative transmittal” in item 19 of Form 1094-C (i.e. Part II). (See Q&A# 14.)

An example of when multiple Forms 1094-C may be used is if an entity wants to report separately for different divisions within the same entity. In this situation, each division may file a separate Form 1094-C (along with the applicable Forms 1095-C). However, the entity must submit one Form 1094-C that combines all information filed on all Forms 1094-C and is marked the “authoritative transmittal.”

Note: Entities that file one Form 1094-C should always mark that Form 1094-C the “authoritative transmittal.” Further, a Form 1094-C should not be filed that combines the information of Forms 1094-C filed by multiple entities within a controlled group (see Q&A# 21).

24. May an employer that is a governmental employer designate a third-party to complete the pay or play reporting?

Yes. A governmental employer (which is the government of the United States, any State, a political subdivision of any State, an Indian tribal government or a political subdivision of any Indian tribal government) may designate another governmental unit that is part of or related to the governmental employer to complete the pay or play reporting. This does not remove the requirement that each entity within a controlled group of governmental employers must separately comply with the pay or play reporting requirements.

Unlike entering an agreement with a third-party administrator to complete the pay or play reporting (see Q&A# 22), the designated third-party governmental unit must agree to be responsible for pay or play reporting and is subject to any potential penalties for failing to satisfy the pay or play penalty reporting requirements. (However, the governmental employer that designates the third-party governmental unit is still subject to any applicable pay or play penalties.)

The City of Traverse City

Insurance Agent Services

January 7, 2015



Arthur J. Gallagher & Co.

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This proposal of coverage is intended to facilitate your understanding of the insurance program we have arranged on your behalf. It is not intended to replace or supersede your insurance policies.

The City of Traverse City RFP

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The City of Traverse City RFP

Introduction

Dear Ms. Dalton,

Arthur J. Gallagher & Co. (hereafter “Gallagher”) appreciates the opportunity to submit a proposal for Health and Welfare Consulting Services for The City of Traverse City (hereafter “the City”). We agree to accept all terms, conditions and requirements contained in the RFP. We do not foresee any areas of possible “conflict of interest,” with the City officials and employees.

As a leading public entity partner with over 1,700 similar clients across the country, we are confident in our ability to meet and exceed the City’s goals. In Michigan alone, we currently partner with over 100 public entity clients and will recommend a team to manage your programs that has intimate knowledge of the Michigan statutes that impact your organization. Given our footprint in the public entity sector, we are uniquely positioned to help the City navigate the complexities surrounding regulation, financial impacts and myriad of choices available.

Gallagher was the first insurance broker named to the Ethisphere® Institute’s annual list of the World’s Most Ethical Companies in 2012 – and was again recognized in 2013 and most recently, 2014. This honorable accomplishment simply demonstrates our commitment to putting our clients’ needs first.

Our proposal provides the City with a strong partner in today’s marketplace. We pride ourselves on our ability to deliver a unique, thorough package of solutions. We go beyond the typical brokerage approach, and look at all aspects of your rewards program. This strategic perspective allows us to help the City best attract, retain and engage employees while meeting cost containment goals. We offer:

- **Unmatched Public Sector Experience**
- **Proprietary Reporting and Benchmarking Capabilities**
- **Strategy and Design in Conjunction with Proven Results**
- **Innovative Wellbeing, Employee Engagement and Communication Solutions**
- **Cost Containment Strategies**
- **Compliance and Healthcare Reform Planning and Risk Mitigation**

Should you have any questions regarding our proposal, please contact me directly at 248.430.2778, or via email at Mary_Beth_Seger@AJG.com. We are excited about the opportunity to partner with the City and thank you for your consideration.

Sincerely,

Mary Beth Seger

Area Vice President

Gallagher Benefit Services, Inc.

30150 Telegraph Road, Suite 408

Bingham Farms, MI 48025

Email: Mary_Beth_Seger@ajg.com

Phone: 248.430.2778

Mobile: 248.505.3439

www.ajg.com

The City of Traverse City RFP

Executive Summary

We understand The City of Traverse City's needs

We work hard to understand your industry, your market, and the unique constraints and opportunities that can impact your long-term organizational success. We can help The City of Traverse City:

- Continue to grow as a micropolis – offering residents and visitors the small Midwestern town charm along with cosmopolitan options
- Maintain its reputation as an employer of choice in the Grand Traverse Area community

When it comes to managing your talent investment, we take pride in being a trusted business advocate helping maximize your return-on-investment, guiding you through an ever-changing compliance landscape and providing innovative ideas and thought leadership to best leverage your value proposition as an employer. Together, we will ensure your reward programs are properly aligned with larger business objectives, allowing the City to fuel growth and optimize outcomes such as employee engagement, top talent recruitment and attraction, and overall productivity.

Niche industry expertise

We understand that different industries face different challenges. With this in mind, we have dedicated teams that immerse themselves in some of the more unique industries we serve. We offer public entity industry-specific expertise, and with over 1,700 public entity clients across the country, we have the experience and understanding to provide the City with best practice solutions.

In addition to our niche expertise, the breadth of our benefits and human resources consulting practice ensures that our clients have access to industry leading solutions. Our core competencies include:

- Health & Welfare
- Human Resources & Compensation
- Multinational Benefits & Human Resources
- Institutional Investment & Fiduciary Services
- Healthcare Analytics
- Retirement Plan Consulting
- Voluntary Benefits
- Executive Benefits

Why Arthur J. Gallagher & Co.?

We believe that every organization must continually assess how they're measuring the success of their talent investment, their current and future talent requirements, and most importantly, how they're leveraging their value proposition to compete in an increasingly competitive labor market. Our team has the experience and the resources to help clients develop short and long-term strategies that support these specific objectives.

We recognize that your workforce represents one of your largest expenses, but that your people are also your greatest asset. Our consulting philosophy goes beyond traditional healthcare cost control and is focused on helping you strategically manage your talent investment, as well as helping you leverage the City's value proposition throughout the employee life cycle. By approaching your rewards programs through a holistic lens, assessing how your retirement, health and welfare, compensation, communication, wellness, voluntary, and other programs align, we can help you more efficiently focus your assets and energy based on the preferences of your employees. Our total rewards-driven approach results in optimal engagement, productivity and cost containment solutions.

Founded in 1927, we are one of the world's largest insurance brokerage and risk management services firms, and Gallagher has a long-track record of being an industry thought-leader. We believe in innovative solutions, and we lead the way with alternative healthcare solutions, such as our private exchange platform, Gallagher Marketplace. Ultimately, with the support of our local resources and depth of our national brand, we have the tools, resources and expertise to overcome any barriers the City may face.

Specifications

A. ORGANIZATION AND HISTORY

- 1. Please provide the name(s), address (es), email address, telephone and fax number(s) of the individual(s) responsible for responding to this request.**

The Account Director responsible for the City of Traverse City engagement will be Mary Beth Seger, Area Vice President. Her address is 30150 Telegraph Road, Suite 408, Bingham Farms, Michigan. Her email address is Mary_Beth_Seger@ajg.com, her telephone number is (248) 430.2278, and her fax number is (248) 540.6015.

Our website, www.AJG.com, provides a wealth of information for our clients, prospects and the industry as a whole.

- 2. Provide a brief overview of your company and history of your organization including an organizational chart of your operation.**

Founded in 1927, Arthur J. Gallagher & Co. (Gallagher) started out as a one-man operation and has grown into a global leader in our industry. Still under the direction of the founder's family, we have maintained the level of caring and teamwork one would expect to find in a small business. Although we recently passed two billion dollars in revenue, we are still very much a family company and maintain a small-business feel where interpersonal relationships are key and teamwork is essential to our success. Many important leaders within the company started out as college interns or account coordinators and worked their way up to the higher echelons of the company. Promoting from within and cultivating the talents of existing team members are important values that contribute to the cohesive, experienced, and dedicated workforce that will serve your account.

Gallagher's reputation as a highly ethical company and our commitment to transparency has also contributed to our growth by earning the trust of our clients. Gallagher was the first insurance broker to be named to the Ethisphere® Institute's annual list of the World's Most Ethical Companies in 2012, and was again recognized in 2013 and 2014. Companies selected for this honor "truly go beyond making statements about doing business ethically and translate those words into action."

Gallagher has a fruitful history working with municipalities large and small to optimize total rewards packages that align with organizational goals, both out of our local office as well as on a national level. The City's dedicated Gallagher team has vast experience crafting innovative customized programs to recruit, retain and engage top talent in these extremely competitive industries, all while navigating through the complex era of healthcare reform. The combination of the way our teams dive deep into our clients' culture with the vast experience of our supporting team has led to this successful history. We are confident in our ability to help tailor a rewards package for the City.

As an industry-leading provider of health & wellness benefits brokerage, consulting and administrative services for over 50 years, we are well positioned to develop and administer programs that support a marketplace advantage for the City. Today's complex marketplace requires a trusted partner who is committed to making a genuine difference in the health and welfare of both your valued team members and your bottom line. Gallagher combines innovative solutions and thoughtful advice with honest business practices to help fuel *your* growth and minimize risk.

Gallagher Benefit Services was founded in 1961 as a unit of Arthur J. Gallagher & Co. As one of the largest and most successful providers of health & wellness benefit brokerage, consulting, and administrative services, we are well positioned to help develop, monitor and administer programs that will enable the City to achieve its goal of providing benefits that are valuable, competitive and designed to maximize the coverage team members receive. Gallagher has been recognized nationally as a leader and innovator in the health & wellness benefit consulting and brokerage market.

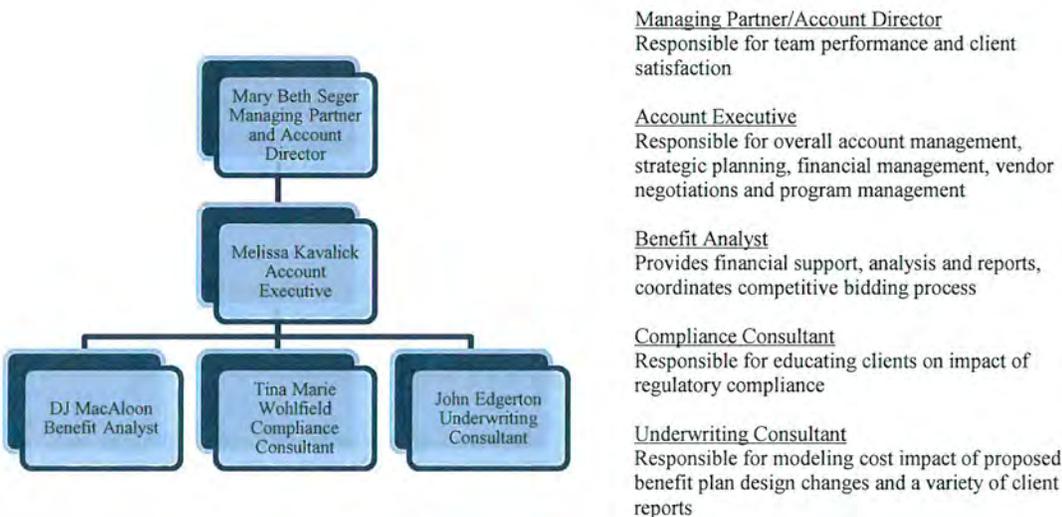
Our senior leadership team, including Pat Gallagher, Chairman and CEO of Arthur J. Gallagher & Co., and Jim Durkin, CEO of Gallagher's Benefits & HR Consulting Practice, operates out of our Itasca, Illinois headquarters. In total, Gallagher's Benefits & HR Consulting Practice has more than 1,700 team members and over 130 offices throughout the U.S.

The City of Traverse City RFP

Within Michigan, Gallagher has locations in Grand Rapids, Bingham Farms, Birmingham and Sault Saint Marie. Our main office in Michigan is located in Bingham Farms. Throughout Michigan, we have 85 highly experienced consultants and staff members who service our health and welfare benefit clients. Our team members come from various backgrounds, including underwriting and actuarial services, sales and marketing, customer service, claims management and consulting. Our office has been recognized locally as a premier place to work, having won the following awards:

- *Crain's Detroit Cool Places in Tough Times*
- *Detroit Free Press Top Places to Work*
- *MBPA's Metropolitan Detroit's 101 Best & Brightest Companies to Work For (13 consecutive years)*
- *American Heart Association Platinum Achievement Award for workplace wellness initiatives*

Customer service, innovation, experience and quality are the cornerstones of all client interactions at Gallagher. We anticipate meeting and exceeding the City's needs by engaging the following Gallagher colleagues. The primary contacts listed below will be responsible for day-to-day interaction with the City and are well-known for their responsiveness. The supporting team resources are also available to provide support, services and answer questions.



3. Are you currently participating in any alliances or joint marketing efforts? If so, please describe in detail.

Gallagher partnered with Western Michigan Public Entities to set up the first self-insured public sector medical pool in the State of Michigan. This pool has grown from 8 school districts to now over 50 Public Entities (including municipal and higher education) covering over 10,000 lives. We also oversee two Life and Disability pools, one is for school districts and represents over 12,000 lives and the other is municipal, representing over 2,000 lives.

4. How many clients do you currently administer in the following categories?

Number of Employees	# Clients	Percentage of Total
Under 100	387	64%
100-500	157	26%
500-750	28	5%
Over 750	32	5%
Total	604	100%

B. CLIENT SERVICE/QUALITY ASSURANCE

1. Please describe the team that would deal directly with us during the transition and on an ongoing basis. Indicate staff size, experience and turnover rates. Indicate all state licenses and credentials of key personnel.

The Client Service Team assigned to the City consists of five highly-qualified and experienced team members with a dedication to helping their clients with what matters most to them. This account team currently manages an account book consisting of 18 clients, 2 of which are self-insured. The average number of employees for this group of companies is approximately 300.

Your Client Service Team consists of an Account Director, an Account Executive, a Benefit Analyst, a Compliance Consultant, and an Underwriting Consultant. This team is also supported locally by the Benefit Advocate Center which is designed to help your employees resolve complex claim situations. Relying on the Benefit Advocate Center will save a great deal of your HR staff time that would otherwise be spent working with insurance carriers on behalf of employees. Finally, we have several subject matter experts who will be asked to provide assistance on projects for the City from time to time. We will draw upon the expertise of these staff members as needed to fully accommodate the City’s benefit consulting needs.

Because we have a dedication to providing the City with as many resources as needed, the City will also have an assigned Managing Director who is a senior leader in our office who provides support to the account team and is an executive level contact person for City personnel.

Mary Beth Seger, Area Vice President, Account Director

Mary Beth joined Gallagher in September, 2000 and has over 20 years of experience in the employee benefits industry. She is currently the Managing Director of our Public Entity & Scholastic Group. Prior to joining Gallagher, she was manager of the sales and service teams for a large local health carrier. Her responsibilities included market research, product development, purchasing cooperatives, and servicing national accounts and consulting firms.

In Michigan and across the country, Mary Beth works with public entities to create the link between their benefit strategies and their organizational strategies. She helps guide the process of objective setting, plan design, administration and funding of group benefit programs. In addition, she oversees vendor selection and ongoing vendor management as well as account management, financial forecasting and analysis. As a nationally recognized resource for creating employee benefit cooperatives for public employer groups, Mary Beth was named *2009 Power Broker* by Risk and Insurance Magazine. Additionally, she co-authored the following articles featured in PRIMA’s Public Risk magazine: "Employee Benefit Cooperatives; From C (concept) to A (application)", (March 2008) and "Public Entities Have a Variety of Options to Help Contain HealthCare Costs" (November, 2009). Mary Beth is a member of the following professional organizations: Association of School Business Officials, Michigan School Business Officials, National Public Employer Labor Relations Association, Government Finance Officers Association International, and Public Risk Management Association (PRIMA). Mary Beth received her Bachelor of Arts, Marketing & Communications from Oakland University.

Melissa Kavalick, Account Executive

Melissa joined Gallagher in September, 2000. She has over 15 years of insurance industry experience. Prior to joining Gallagher she gained valuable knowledge as a marketing assistant with a local insurance carrier. Additionally, her experience includes working for DaimlerChrysler in the benefits division, which required her to interface with various insurance carriers and consultants on Union, benefit and financial issues. Melissa's current responsibilities include working with our clients as an extension of their human resource team. The responsibilities in this role include plan management as well as managing coverage transfers, developing employee communications, wellness initiatives, reviewing contract amendments and carrier booklets, assisting with ongoing claim and billing issues, and providing clients with regulatory compliance updates including Healthcare Reform. Melissa also assists clients with union negotiations and facilitating benefit and wellness committees. Melissa was also the Project Manager to a local Michigan Municipal Purchasing Consortium for Life and Disability. Melissa holds a degree in Business Management and her State of Michigan Life & Health registered agent appointment. Melissa has been certified by the Wellness Council for America and is pursuing her certification as a Certified Labor Relations Professional (CLRP). In the community, she has volunteered for the Troy School's HOSTS (Help One Student Succeed) mentoring program.

Donald J. MacAloon, Jr., Benefit Analyst

Donald J. (DJ) brings over 9 years of experience in the financial services and insurance industry to his tenure at Gallagher which commenced in 2006. His varied background includes financial advising and investment allocation for individuals and 403(b) retirement plans as well as special niche health care "pooling" and "Cooperative Purchasing" projects in the State of Michigan. DJ's current responsibilities include working with his team to develop vendor selection strategies, data collection, creation of proposal requests, and management of vendors throughout the vendor search and selection process. Additional responsibilities include management of benefit and financial analysis, development of client presentations and preparation of all historical and prospective plan cost analysis including quarterly analysis and claim projections. DJ received his Bachelor of Science, Economics and Finance from Boston College. DJ holds his NASD series 7 and 63 licenses as well as the State of Michigan Life & Health registered agent appointment.

Tina Marie Wohlfield, HR and Compliance Consultant

Tina Marie is the local compliance resource for the City. Tina Marie's primary responsibility is to educate client companies about the impacts of regulatory compliance on their organizations. With over 20 years' experience in the human resources profession, and she works alongside Gallagher's regional and national compliance resources to ensure clients receive the individual compliance support they need. Tina Marie is well versed in the areas of compliance, employee benefits and plan documentation. Tina Marie is a regular presenter at industry conferences and Gallagher seminars and events.

John Edgerton, Area Vice President, Underwriting Consultant

John leads the Underwriting and Financial Reporting Unit for the North Central Region at GBS. This unit provides underwriting and technical support for a diverse group of clients, including municipalities, school districts and private sector companies. He and his team assist the local offices on projects including: modeling the cost impact of proposed benefit plan design changes, developing annual budget reports and monitoring of actual results against budget, developing COBRA rates, developing IBNR lag studies, underwriting renewals to compare against vendor renewal pricing, and comparing financial competitiveness of PPO networks. Prior to joining GBS, John was an advanced underwriter for Blue Cross Blue Shield of Illinois. During his time at Blue Cross Blue Shield, he underwrote many of its largest and most sensitive accounts. John has been working in the employee benefits field for more than 15 years. John received his Bachelor of Arts degree in Mathematics from the University of Illinois (Champaign/Urbana). He also received his CLU, ChFC, FLMI, ACS, FAHM, PAHM, REBC, RHU, and MHP designations and is currently pursuing his MBA from the Kellogg School of Management at Northwestern University.

Julie James, Claims Specialist (Benefit Advocate)

Julie James is an eligibility and claim resolution specialist for Gallagher. She manages eligibility services with multiple carriers on behalf of our clients. In addition to eligibility management, Julie works with our client companies and their plan participants to resolve health plan claim concerns. Julie is expert at unraveling complex claims involving multiple providers and dates of service. She interfaces with the plan participant, provider and health benefits administrator to verify that correct data and coding was used in the submission process and the claim is processed appropriately. Julie has worked in the group benefits industry for more than 20 years. She joined GBS in 1998.

W. Bryan Hirn, Area President

Bryan Hirn is the Michigan Area President of Gallagher and has the lead role in overall business operations, including operations management, strategic planning, new business sales & marketing and recruiting professional staff for the firm. Bryan has directed the sales, operations and client services development of Gallagher Michigan for the past ten years. In addition to his leadership responsibilities for the organization, Bryan maintains a direct working relationship with key Gallagher Michigan clients, giving first-hand knowledge of both strategic and day-to-day client concerns. Bryan holds a Bachelor of Arts in Political Science/Sociology from Indiana University and a Master's degree in Business Administration and Finance from Wayne State University.

2. What are your client retention statistics for each of the last three years?

Gallagher is very proud of the fact that over the past seven years, our retention rate (retention of current clients) has averaged 98%. We have multiple client relationships that have been in place for over 25 years.

For those who left, what percentage left due to issues pertaining to services provided by your organization?

There are times that a client will leave the firm and predominately these clients leave due to a merger/acquisition situation, the client going out of business, or a new decision maker having an existing relationship with another broker. Our annual client satisfaction survey has revealed no service concerns with our clients.

For those who left, what percentage left due to software limitations?

No clients have left Gallagher due to software limitations.

What is the average client relationship duration? Newest? Longest?

We are a growing organization and our newest clients joined us January 2015. Our longest client relationship have been with us for over 25 years.

3. Describe your organization's commitment to quality and your philosophy/approach to client services.

We accept nothing less from ourselves than the delivery of exceptional value to our clients by:

- Investing in knowledge of our clients' businesses and industries
- Listening closely for our clients' expressed and unexpressed needs
- Providing dedicated client service teams
- Offering proactive ideas that advance and protect our clients' businesses
- Being flexible to respond to changes in our clients' business needs
- Communicating candidly, directly and often with our clients
- Leveraging the best tools to realize efficiency and cost savings for our clients
- Paying attention to logistics: when we deliver is as important as what we deliver
- Doing what we promise
- Being accountable for our performance

We require these commitments of ourselves. You get smart, aggressive, cost-effective consulting, when you need it, as you need it, and consistent with our clients' commitment to high quality. We often conduct confidential interviews of our clients in order to learn their perspective on our services. We use in-house training, outside continuing education training, and in-house specialists to educate us and keep our consultants' knowledge "state of the art". We innovate on behalf of our clients, not only in making our consulting services the most creative and effective possible, but also in finding new ways to communicate with our clients in cost-effective and timely ways. Early analysis and definition of the issues – with a pragmatic determination of the right strategy aimed

at meeting your goals – allows us to help you avoid greater expense, lost time and spent resources that a less disciplined approach would incur. Our philosophy is to bring you superior consulting services at superior value.

4. Describe your customer service standards.

Customer service and quality are the cornerstones of all client interactions at Gallagher. As your partner, one of our first deliverables will be to develop the Strategic Service Plan, developing a full understanding of your employee benefits strategies and priorities; whether they are cost containment, employee satisfaction, or industry competitiveness, or a combination of each. We know that the right combination of benefits is different for every organization. As a result, we will develop plans that meet the needs of employees at all levels of your organization.

Our client management approach enables us to work closely with the City and be proactive when recommending plan design changes as well as stepping in to resolve unexpected issues. The following are the key components of this approach, tailored to best meet your needs:

- **Annual Stewardship:** Stewardship is a cornerstone of our client service philosophy and consists of a face-to-face meeting to accomplish two goals:
 - Gallagher’s *Planning and Stewardship Guide* is a complete record of the guiding principles, strategies, accomplishments, costs and key planning priorities for your employee benefits program. The Guide is your ongoing documentation of the strategies, tactics and outcomes associated with the management of your program.
 - An important part of learning is following up at the end of each year by sitting down and asking all team members to provide open feedback on Gallagher’s performance. We will openly discuss with you 1) whether value was added, and 2) what was learned from the process that can be applied to assist the engagement. A commitment to continuously improving is what you will come to expect from Gallagher.
- **Annual Strategic Planning:** Typically we would propose to conduct strategic planning with a series of face-to-face meetings generally following the process below:
 - Discovery
 - Goal-setting
 - Gaps and Opportunities Analysis
 - Strategic and Tactical Options Evaluation
 - Implementation and Ongoing Management
- **Quarterly Benefit Reviews:** We regularly meet with clients and vendor partners to evaluate program performance, service results and other administrative requirements. These are generally face-to-face meetings, and provide an ongoing forum to assure alignment with your performance expectations.

The client management components as described above will provide Gallagher with a strong understanding of the City’s people, culture and business and in turn, will allow us to recommend plan designs that align with employee needs as well as overarching business objectives.

5. What are three reasons why your customers select your company over your competition?

How are you measuring the success of your talent investment? What are your current and future talent requirements? How are you leveraging your value proposition as an employer to recruit, retain, engage and retire your key talent? At Gallagher, we believe these are questions that every organization must continually assess, and we differentiate ourselves by helping clients develop meaningful long-term solutions to support these specific objectives.

One of our key differentiators is our proprietary Workforce Evaluation tool, the method we use to design tailored benefit programs that are more cost-effective for you and more valued by your team members. In other words, the goal is to align company spend with the preferences and needs of your team members so as to eliminate unnecessary cost, improve the program’s efficiency, and align human capital to drive business success. Gallagher’s Workforce Evaluation delivers a profile of your entire workforce including life/career stage indicators, tenure, team member classes and performance indicators; a profile of your “typical” team member by title or division, or a profile of your “ideal” team member factoring in the performance indicators; and

benefit enrollment trends indicating implicit needs of your workforce, as well as distribution of your benefit dollars by employee type, tenure or performance. This is important for the City because our Workforce Evaluation will identify gaps where your current benefit strategy does not address the implicit needs of predominant populations or the target top talent resulting in potential reverse discrimination affecting key employees. The Workforce Evaluation also allows you to design benefit strategies in support of long-term recruitment and retention goals of specific population groups identified as the target workforce.

Another area of strength and differentiation is our corporate and regional staff of compliance experts who monitor legislative initiatives, court cases and industry changes and analyze their impact on your organization. These resources will assure that we apply our understanding of the latest developments to the ongoing management of your benefits program.

We will assist you to remain in compliance with state and federal regulations by evaluating the design of your benefits plans, reviewing all relevant documents, such as summary plan descriptions, benefit documents and contracts, and all of your employee communications to identify possible areas of litigation. Our compliance experts will also assess compliance with COBRA, FMLA, HIPAA, and other regulations. In addition to regular seminars and webinars, we will also keep you up-to-date on benefits issues with communications that include:

- *Technical Bulletins* – provide information on new and pending legislation
- *GBS Insight* – a powerful portal framework that provides secure, personalized access to the latest information plan administrators need, including the latest on legislative and regulatory issues
- *Directions* – a newsletter that offers valuable information relating to the benefit needs of your company and employees

Please visit <http://www.ajg.com/knowledge-center/> for additional examples of our client compliance communication tools.

We are also distinguished from our competition by the way we immerse ourselves in our client's culture in order to gain a deep understanding of their organizational goals and values. Our team integrates with yours to learn everything from business challenges to why your team members come to work every day. We combine this deep understanding of our client's culture with our vast benefits expertise and resources to optimize their total rewards package to align with organizational goals.

Summed up very simply, we believe that our greatest differentiator is our ability to deliver comprehensively structured health & welfare benefit services and solutions to clients. Often, our clients also point to their experience of that delivery – the way we do business with them – as one of our biggest differentiators.

The results of a 2012 Greenwich Associates Large Corporate Insurance Survey of 700 clients ranked Gallagher No.1 in "Overall Client Satisfaction" among the five largest brokers. We also placed first in 10 survey categories, including "Understanding Clients' Business Needs," "Ability to Innovate," "Thought Leadership," "Flexibility" and "Global Coordination and Management."

Gallagher's full suite of consulting resources provides clients with expertise in a wide range of human capital needs. Specific to health & welfare services, below are a number of ways in which we've come to truly differentiate ourselves:

- **Workforce Planning Approach:** We believe it's vital for us to have a deep understanding of your people, culture and business in order to help you design and implement a strategy and benefits program that aligns with your organizational and team member needs. Our goal in partnering with you is to develop creative ways to align company spend with the preferences and needs of your team members so as to eliminate unnecessary cost, improve the program's efficiency, and align human capital to drive business success.
- **Data Warehouse/Analytics:** In addition to a full suite of financial reporting prepared by our in-house underwriters (monthly reports, forecasting, network analysis, budget-to-actual and more), our real differentiator is in our proprietary data warehouse (GBSInsider) that comes at no additional charge to our full scope of services. Data from many of our self-funded clients is automatically fed into the warehouse. For you, this means we have the ability to look many layers deep into your data and identify plan cost, utilization issues and clinical risks. For example, if you're focused on wellness, we can evaluate the overall health of your population with our Health Index Score to measure the impact of your wellness programs. GBSInsider is a powerful tool to help you make decisions about how to control your costs and get the most out of your plans

- **Strategy and Design:** Taking the actionable data derived from our workforce evaluation assessment, financial underwriters and analytic tools, we're able to assist our clients in identifying and prioritizing short- and long-term goals to gain program efficiencies and drive engagement. Once we get the data, we gather our team of experts, including wellbeing, health and welfare, retirement, voluntary, communication, etc. and collectively strategize to get the City the best recommendation for enhanced employee engagement, productivity and cost containment.
- **Plan Management:** With thousands of clients nationwide, Gallagher has tremendous negotiating leverage with and knowledge of the range of health & welfare vendors both locally and nationally. This is invaluable to our clients as they continue to seek ways to ensure they're getting the most value for their dollar. Our team members serve on the advisory boards for many of the local and national insurance carriers including BCBSM/BCN, HAP, and Delta Dental. We stay close to the carriers so we are current on new product offerings, changes in underwriting or other things that affect our clients. We also share ideas from the marketplace and client feedback. We maintain high level contacts locally and nationally so we have leverage when it is needed.
- **Compliance:** Gallagher recognizes that maintaining health & welfare plan compliance is a dynamic endeavor. We have a team of ERISA attorneys that become a part of your service team. The goal is to work with our clients to facilitate a regimented annual review process using our comprehensive tools and checklists that act as a repository for documenting all action items, and/or confirm compliance. Gallagher maintains a corporate, regional, and local staff of compliance experts who monitor legislative initiatives, court cases and industry changes and analyzes their impact on your organization. These resources will assure that we apply our understanding of the latest developments to the ongoing management of your benefits program. We will ensure that you remain in compliance with state and federal regulations by evaluating the design of your benefit plans, reviewing all relevant documents, such as summary plan descriptions, benefit documents and contracts, and all of your Team Member communications to identify possible areas of non-compliance. Gallagher will also assess compliance with COBRA, FMLA, HIPAA, and other regulations. In addition, our local compliance expert, Tina Marie Wohlfield, will do an in-person compliance review with the City's staff.
- **Vendor Management:** The proposed Gallagher team uses a prospective look at the current vendors in recommending additional cost-saving measures that can be implemented. There is only so much that can be accomplished with changing deductibles, copays and out-of-pocket maximums.

C. BENEFIT ADMINISTRATION

1. What processes/procedures do you have in place to interact with and approach a variety of vendors?

Proper vendor management begins with the selection of the right partners for the City's employee benefits program. Therefore, we interact with vendors to truly understand their capabilities and offerings. You can be confident we recommend only the finest firms whose products and services have the broadest and most effective range of options for you. Your client team will negotiate performance guarantees as appropriate with each selected vendor and meet with them on a regularly scheduled basis to review their performance against the standards and resolve any issues. During our regular client meetings, we will always have vendor management on the agenda. This work will also include review of all applicable documentation as well. The financial stability of our vendors is also very important. We will only recommend vendors that have an A- (Excellent) or better rating from A.M. Best. We closely monitor our vendors' financial stability throughout the year and quickly communicate if a potential change might impact your program.

2. What is the process you would use when constructing the benefits recommendations to be made each year? How do you determine and communicate the timeline to the client?

Our expertise in the public entity market allows us to share leading market ideas and to be your expert in developing and managing focused cost-effective solutions around your goals and needs.

We proactively manage your program, as opposed to simply reacting to issues as they arise. We are recognized as a thought-leader in the market and will apply that expertise to ensure your programs integrate for optimal cost savings and employee engagement. Outside of the traditional marketing of your plan, we will provide the City with ongoing advisory service, planning,

and communication support. All of our practice area leaders will meet with the key stakeholders at the City to develop a holistic approach to the City's benefits program.

We are confident that no other broker has more overall experience in benefit plan design than Gallagher. We have been marketing plans under Michigan's Public Acts for all our public entity clients since the inception of the laws, and we not only ensure their compliance but develop strategic objectives for the process. We work with you and understand your organization's culture; a communication plan will be developed. When appropriate, we engage union leadership in the PA106 process. Since the benefits are for them, engaging them early assists in getting buy-in for solutions. We take the "mystery" out of benefits and educate both administrative and union leadership on the results so that both have the same understanding and negotiations are based on knowledge and fact and less on emotions.

Likewise, we are well versed in the complexities of PA152. We have developed several models for compliance, whether in an 80/20 or hard cap environment. It is common for us to run market results through our proprietary programs and model results back to administration and union groups when requested. We suggest that organizations have a benefit strategy first and then see how PA152 helps them to accomplish it. Recognizing that municipal groups can make decisions to opt out, we work with them to understand the ramifications and timing of these decisions. We have been successful in providing solutions that have moved Union groups from an 80/20 (or % premium co-pay) environment to a hard cap solution through plan selection and education with positive results. We provide analysis not only for the current year, but future years as well to allow for the best educated decision. We strive to create data that will ensure that you and your employee populations are not surprised by any future circumstance.

The Healthcare Analytics practice at Gallagher provides the City with actuarial services for testing assumptions about multiple enrollment scenarios, costs, trends and benefit plan design. Modeling allows us to analyze different plan design scenarios and determine which plan design will perform best for the City. As our partner, you will have access to the only benefits firm with consulting expertise and proprietary data warehousing under one roof.

Gallagher conducted a proprietary National Benefits Survey in 2013 and 2014. The survey includes the normal benefit benchmarking information to help provide a "look behind," as well as sections for future benefit planning and policies that will "look ahead" and help us identify market trends and make predictions regarding the future of benefits. As an example, the survey includes questions regarding organizational intent to discontinue or diminish employee benefit coverage over the next few years. This touches on a key question that many organizations are facing as healthcare reform is implemented. Gallagher's access to comparable community benchmarking data leads to productive conversations with staff and union groups. With this tool we have the ability to benchmark the City's benefits plan and contribution strategies against other entities of similar size in the Midwest, the state, and across the country.

The Bingham Farms office annually develops a benchmarking study report which provides a comprehensive review of plan provisions and costs of the most commonly offered health and welfare benefit programs currently being provided by employers. This data is not from a survey; the data represented in the benchmarking studies comes from the Gallagher BenefitPoint database. The data utilized comes from both national and local clients. The studies are broken down to identify cost and coverage statistics based on the number of benefit eligible employees, industry, plan funding strategies, plan types, and client sector. In January 2014, data was compiled from 181 Gallagher Michigan clients representing 434 different benefit plans. A copy of the Executive Summary is included with this proposal.

Beyond Gallagher's own resources, we subscribe to multiple national benchmarking studies and contract with globally recognized data repositories. Access to nationally accredited data banks typically used in the employee benefits industry expand and refine these capabilities. Various survey reports are available to provide clients with an in-depth look at current practices and emerging trends in employee benefits strategy and design. The insights clients gain can help them make effective, competitive near-term decisions and guide their intermediate and long-term strategic planning. We are also highly experienced in conducting client-specific benchmarking and can target the specific industries where you compete.

The chart below demonstrates our annual service model. Further in the RFP, we outline our implementation process. We believe in a proactive, ongoing service model to provide our clients with exceptional consulting services. We truly serve as an extension of your Human Resources Team.



3. List the top 5 vendors you use that have the largest share of your book of business (i.e., Nationwide, BCBS, etc.)?

Our top 5 vendors with the largest share of our book of business include Blue Cross Blue Shield of Michigan, Priority Health, Health Alliance Plan, Delta Dental and Guardian.

4. Describe the services you provide related to compliance advice.

Compliance requirements for employee benefits plans have exploded over the past 20 years. This increase in governmental regulation has impacted every area of human resources and employee benefits administration. Gallagher will take an active role in helping the City stay current on, and in compliance with, the multitude of local, state and federal laws and regulations.

Gallagher's compliance practice has a national canvas with a regional and local focus. We have 28 dedicated compliance professionals averaging more than a decade of benefits compliance experience, and 19 of them are licensed attorneys. They monitor legislative initiatives, regulatory developments, court cases and industry changes, and analyze their impact on your employee benefits plans. These resources will assure that we apply our understanding of the latest developments to help you manage your benefits program.

Gallagher's compliance experts will also keep you informed of the active legislative landscape. They will provide your organization with timely, accurate and concise information about the regulatory environment through various publications, including:

- Healthcare Reform Update – a monthly publication written by our own compliance experts on the latest healthcare reform developments and their potential impact on employers
- Gallagher Directions – a monthly publication featuring general interest articles on employee benefits and human resources
- Client Webinars – on-demand webinars offering updates on hot topics as well as reviews of major legislative developments
- Technical Bulletin – detailed white papers on proposed or new legislation

In addition, Gallagher will help you comply with state and federal laws and regulations. Our experts will evaluate the design of your benefits plans and review relevant documents such as summary plan descriptions, insurance contracts and your employee

benefits communications. Gallagher will help you identify potential problem areas and conduct a year-end review using our proprietary tools and resources to make certain that your benefits plans are in compliance with COBRA, FMLA, HIPAA, cafeteria plan rules, healthcare reform and all other relevant laws and regulations.

As benefits professionals we understand the regulatory environment is constantly changing and the pace of that change is accelerating. The challenges can be daunting. To ensure that Gallagher client teams are fully prepared to assist you, we maintain a complete compliance database for their use. Our compliance database contains summaries of federal requirements along with practical tools, such as models, sample forms and checklists in electronic form.

We have a dedicated compliance expert, Tina Marie Wohlfield, in our Bingham Farms office that is knowledgeable in healthcare reform compliance and legislation for public entities. Tina Marie spends the vast majority of her time researching and understanding federal and state legislation in order to ensure that our clients are in compliance. In addition, she will do an in-person compliance review with the City's staff.

Gallagher's team monitors the legislative landscape on a regional and national basis to identify issues that may be of concern to our clients. When a concern is identified, they develop client specific recommendations and assist with the implementation of new procedures or policies.

Gallagher will work to understand the specific challenges that Healthcare Reform brings to the City's benefit program, along with the unique opportunities that the law may present. In order to gain an understanding of how the ACA will impact both the administrative and financial aspects of your program, Gallagher has developed several consulting and evaluation tools.

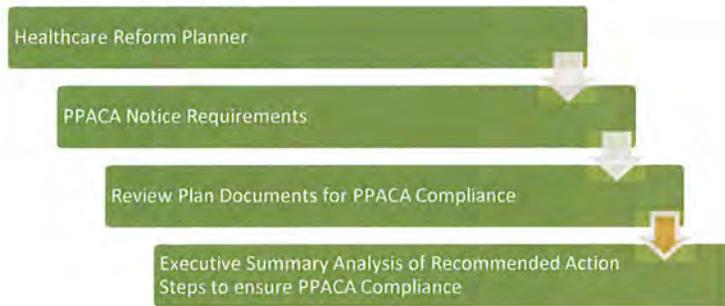
We maintain a staff of compliance experts locally and regionally who monitor legislative initiatives, court cases, and industry changes, and analyze their impact on your business. Our compliance support includes attorneys dedicated to servicing offices in Gallagher's North Central Region. This team works in conjunction with other compliance specialists throughout the country to research and produce regular technical bulletins and compliance updates. The compliance team maintains a complete compliance database for our advisors to use. Our compliance database contains summaries of federal requirements along with practical tools, such as models, sample forms, and checklists in electronic form. They regularly offer webinars on current issues (e.g., Healthcare Reform, regulatory updates on federal legislation) and have created a library of webinars which are available "on demand" to our customers via our website. They routinely participate in live seminars that we host locally in Michigan and they are available to conference or meet with our clients as needed.

Gallagher's Healthcare Reform compliance assessment consists of three individual deliverables. These reviews will assist the City in evaluating their compliance on the health & welfare programs regarding Healthcare Reform. Members of our compliance team will conduct a compliance audit for the City, present their findings, prepare a suggested strategy for correcting any uncovered points of exposure and are available to assist the City's team if necessary.

Overview of the Gallagher Compliance Assessment

Gallagher takes pride in the holistic and strategic approach it uses to help our clients "Plan Ahead". This process incorporates all of the current employee benefit programs and cultural messages that the City utilizes. All Healthcare Reform requirements will also be factored into this plan.

The following chart depicts the four components outlining how Gallagher will assist the City to identify, develop, and implement a compliant benefits strategy that aligns with the City's stated long-term organizational goals. Each component has several levels of detail and associated deliverable items.



5. Do you offer any online enrollment services? If so, what is the cost to the employer for that service?

Gallagher has extensive experience with electronic enrollment using the latest tools and techniques. We also have strategic relationships with leading online enrollment vendors in the industry. An assessment is recommended to determine the most suitable and effective enrollment method for the City. Your Gallagher team would first consider your current method and evaluate how effectively it meets your benefit objectives. In some cases, the combined use of digital and traditional formats, such as print, can work as well or better for enrollment than a single solution.

6. Do you provide any Human Resource support of any kind? If so, what services do you offer?

Yes, we can provide basic human resources consulting services to the City. If there is a need for a more extensive project, we may want to involve our human resources and compensation colleagues, who offer more focused expertise in the following areas:

- Assessments of your HR function’s effectiveness, efficiency, and alignment with your organization’s strategy, and practical recommendations to help improve the performance of the department
- Total compensation statements communicating the individualized salary and benefit value that your organization provides to each employee
- Extensive coaching, training and development programs designed by our experts for all levels of employees
- Recruitment solutions for the entire recruiting process, hiring and on-boarding to ensure new employees quickly contribute to your organization
- An interactive process to develop policies, practices, and procedures that fit your organization, with customized employee handbooks to communicate them
- Efficiency reviews for your HR function including affirmative action, absence management and performance management
- Employee surveys to diagnose your organization’s opportunities for improvement and benchmark your employees’ preferences and opinions
- Ongoing HR management tailored to meet your needs and provide assistance for your HR function
- HR professionals, deployed to your location to help manage your current HR function, design and implement any HR programs you might need.

We would be happy to provide you with more information on our human resources consulting services and support to the City.

7. Describe your services for Form 5500 filings.

One of the standard services that Gallagher provides is the ability to manage the Health & Welfare Form 5500 filing process from start to finish. To meet your needs, we have partnered with Wrangle LLC, a leading Form 5500 outsourcing firm. Wrangle has completed tens of thousands of Form 5500s and has both the experience and expertise to handle a wide variety of situations. Gallagher and Wrangle can eliminate the burden of the Form 5500 filing process so that you can spend your time performing more valuable work and gain some peace of mind. Our Public Sector clients have not typically utilized this service as they are exempt under ERISA.

8. Describe your process for updating and disseminating SPD and Plan Documents as well as any other required notices.

Gallagher will update, disseminate and maintain the City's online SPDs and plan documents on our secured servers. These resources can also be posted on your employee communication site and GBS Insight, our secure, proprietary client website. Your HR staff can access the documents they need on GBS Insight at any time. The GBS Insight platform uses a powerful portal framework to deliver HIPAA secure, personalized online access to information and tools that HR administrative staff needs to effectively manage human resources and Team Member benefits programs. GBS Insight offers the following core features:

- My Desktop – a personalized workspace that will conveniently provide access to recommended compliance Internet resources and your Gallagher account team. My Desktop also offers the latest industry updates through InsuranceNewsNet.com
- My Documents – a personalized directory of documents your administrative staff shares with your Gallagher account team and an entire archive of Gallagher compliance newsletters and bulletins
- Gallagher Highlights – access to recent newsletters and webcasts on important compliance topics and news items relative to Team Member benefits
- Resource Library – a powerful search engine and information repository that delivers human resource, Team Member benefits, compensation, employment and regulatory information

9. What is your process for assisting employees with claim resolution issues?

Our goal as your consultant, partner and resource is to make your job easier. Our Benefit Advocate Center works with our clients and their plan participants to resolve health plan claim concerns. This team is expert at unraveling complex claims involving multiple providers and dates of service. They interface with the plan participant, provider and health benefits administrator to verify correct coding data was used in the submission process and that the claim was processed appropriately. Our proposed account team has dozens of years of combined experience with insurance, brokerage and third party administration companies. We are accustomed to dealing with complicated issues and bringing them to successful resolution. Our teams are extremely collaborative and share ideas and best practices weekly. If the City's account team has not had experience with the issue at hand, it is likely that one of the other 12 account teams in the office has and can help to craft a solution. Our executive team also maintains high level relationships with the local and national carriers and those relationships can be a source of leverage in resolving difficult issues.

10. Describe the level of service you provide to support our HR staff with bill reconciliations and verification of charges.

Gallagher is able to provide some support for clients in this area; however we would need a better understanding the scope of service that the City is seeking in order to provide more details.

D. EMPLOYEE COMMUNICATION

1. Describe your approach to communicating benefits to new employees throughout the year, including methods, frequency, etc.

Two of your best opportunities to communicate how much the City cares about its employees' well-being coincide with two of the biggest jobs for your benefits administrative staff. Open enrollment and new hire orientation are key touch-points for influencing the employee experience, so they call for a carefully considered strategic approach. Designing programs specifically for your workforce and culture will return the greatest value on the time, effort and financials you invest in these priorities.

Gallagher can help you plan and carry out the most effective approaches to open enrollment and new hire orientation based on the City's unique communication style, including:

- Enrollment strategy
- Customized communications, such as announcement letters, letters from your City Manager, enrollment forms, open enrollment brochures, posters, articles for your internal newsletter and intranet, electronic information, payroll stuffers and other vehicles
- Customized presentation of open enrollment programs
- Open enrollment meetings
- Employee health fairs

We will work with you to develop comprehensive benefit guides that reflect your brand and culture and are easy for your staff to use. These guides not only can educate your employees about benefit choices, but also will give you helpful information for meeting your annual legal notification requirements.

Once your guides are printed, our in-house fulfillment center will assemble packets with any other required pieces, such as enrollment forms and voluntary benefits materials. Electronic copies of these custom materials will immediately be made available to your employees online. These e-copies can include a recorded presentation describing the plan choices and the enrollment process, which allow new hires or existing employees to view at their leisure and to share with their spouse if needed.

In addition to creating custom enrollment for the City, core support staff will deliver engaging, interactive presentations at onsite open enrollment meetings or benefit fairs. The objective is to enhance your employees' understanding of their benefits' value, while educating them on smart plan utilization and how to approach healthcare as a consumer. These meetings are also available through web conferencing.

You may also want to automate your open enrollment and new employee orientation, and then optimize the experience for your employees with 24/7 access to answers for their questions. These services are provided by one of Gallagher's preferred vendors. Flexible options can make it easier for the City to make a meaningful connection with your employees. Gallagher's ability to tailor each client's approach to its unique workforce and culture has helped thousands of employers more clearly, thoroughly and effectively communicate with their employees. By increasing the satisfaction and engagement of your workforce, you will support your competitive position as an employer-of-choice.

2. What is your approach to communicating benefits to employees during Open Enrollment?

Statistically, employees enrolled in an organization's benefit plan are more likely to remain with that organization longer than those who do not participate. And those who understand their benefits are more likely to report satisfaction with their benefit plans. One of the best opportunities to show your employees how much you care for their wellbeing, while at the same time one of the biggest jobs for the City's benefits administrative staff, is the annual open enrollment. Gallagher has helped thousands of organizations take advantage of this important employee communications opportunity.

Gallagher can help plan the most effective approach to open enrollment based on the City's unique communication style and implement the programs, including preparation of:

- Organization of vendors and applicable materials
- Announcement letters
- Enrollment forms, consolidation of such
- Open enrollment literature
- Posters/ flyers
- Articles for the company newsletter or Intranet
- Electronic information
- Payroll stuffers

As mentioned above, we will work with you to create your own branded communication benefit guide that will serve as not only a valuable tool for open enrollment, but also as a resource for employees all year long.

3. Please share your typical process for client communication of benefit changes.

Depending on the changes it may be a written communication or a presentation at an onsite meeting or benefit fair. We will work with the City to create the pieces and the plan/process needed to communicate all changes.

Many clients have started to request both live and pre-recorded messages for employees. Live webinars are most effective when there is a need to disseminate open enrollment information across several remote locations. In addition to live webinars, many of our employers offer pre-recorded webinars in order to provide employees that work alternate shifts with a way to experience the content provided during in-person enrollment meetings, giving these employees the ability to view the content at their own leisure. These webinars are also a useful way to deliver information to the employee’s home to a spouse or partner that may be the healthcare decision maker. Furthermore, human resources staff can utilize pre-recorded presentations during employee orientation to walk new hires through their employee benefits package. Employee meetings with live presentations are still a great venue to communicate changes and enhance employee relations. We encourage and will be available for these as well.

E. GENERAL

1. What other lines of coverage do you broker or administer (i.e., worker’s compensation, professional liability, 401(k), etc.)?

In addition to the health and welfare services that we are proposing for the City, we have a full suite of human capital consulting services available. We would be happy to further discuss these services with the City as needed. These services include:

Practice Area	Overview	Core Competencies
HR & Compensation	HRAvantage, a Gallagher subsidiary, was founded as a superior approach to human resources consulting, offering extensive experience and custom-designed tools to help organizations in the areas of compensation program design and renovation, custom internet-based salary and benefit surveys and outsourcing of a variety of human resource functions.	<ul style="list-style-type: none"> • Compensation Planning and Design • Ongoing HR Management • HR Efficiencies and Compliance • Training and Development • Employee Handbooks • Total Reward Statements • Recruitment Solutions • Workforce Planning • Custom Employee Surveys
Retirement	Gallagher Retirement Services has specialized in the retirement plan/investment services business since the division was established in 1978. Retirement plan committees engage the professionals of GRS as their trusted, advisor advocate to deliver fiduciary risk mitigation and management of overall plan governance for the sole benefit of plan participants and their beneficiaries.	<ul style="list-style-type: none"> • Qualified Plan Consulting • Non-Qualified Plan Consulting • Actuarial Consulting • Institutional Investment Consulting (Gallagher Fiduciary Advisors, LLC)

<p>Voluntary Benefits</p>	<p>The Gallagher voluntary benefit team has a unique combination of HR, legal, compliance, marketing, and group/affinity experience and enrollment services. They specialize in researching, designing, implementing, administering and enrolling voluntary benefits for mid-size and large public and private entity clients, 200 – 100,000 lives. This team brings total outsourcing solutions to employers for employee education, consolidated payroll & marketing, and enrollment services.</p>	<ul style="list-style-type: none"> • Managed Implementation • Enrollment • Education-Based Communication • Extensive Marketing Framework
<p>Property Casualty Worker's Compensation</p>	<p>Gallagher's Casualty Practice team is focused on developing and delivering the unique professional and general liability solutions you need, including primary and excess insurance coverage, to help you grow your business. It is a comprehensive evaluation of your risk exposure and a snapshot of your total cost of risk.</p>	<p>Our Casualty professionals will identify the most innovative, effective solutions for:</p> <ul style="list-style-type: none"> • Automobile liability • Captives • Excess liability • General liability • Product liability • Professional liability • Umbrella liability • Workers compensation <p>We have teams of Casualty specialists throughout the country ready to find the appropriate solution for your business needs. Our services include:</p> <ul style="list-style-type: none"> • Alternative risk solutions • Appraisal services • Captive services • Catastrophe modeling • Claims advocacy • Claims management • Cyber risk assessment • Environmental risk assessment • International risk management • Programs for Fortune 1000 companies • National risk management • Pooling • Private client services • Rent-a-captives • Risk control consulting • Safety compliance and training programs • Self-insurance programs

2. Please provide the web address (and demo login information if necessary) to your client communication portal – if offered.

Gallagher offers additional informational resources to our clients through GBSInsight. Please click [here](#) to view a demo of this site.

The GBSInsight platform uses a powerful portal framework to deliver HIPAA secure, personalized online access to information and tools that HR administrative staff needs to effectively manage human resources and Team Member benefits programs. GBSInsight offers the following core features:

- My Desktop – a personalized workspace that will conveniently provide access to recommended compliance Internet resources and your Gallagher account team. My Desktop also offers the latest industry updates through InsuranceNewsNet.com
- My Documents – a personalized directory of documents your administrative staff shares with your Gallagher account team and an entire archive of Gallagher compliance newsletters and bulletins
- Gallagher Highlights – access to recent newsletters and webcasts on important compliance topics and news items relative to Team Member benefits
- Resource Library – a powerful search engine and information repository that delivers human resource, Team Member benefits, compensation, employment and regulatory information

3. The top two brokers selected in this RFP process will be asked to provide samples of employee communication materials.

We are pleased to include samples of our employee communication tools, which can be found in the Appendix of this proposal response.

F. IMPLEMENTATION

1. Explain your implementation process including time frame. What is the minimum time frame needed to ensure a smooth transition?

Gallagher has developed a complete selection of solutions that are an important component of our benefits delivery process. You can count on these services and solutions to increase the quality of the City’s employee benefits programs, help reduce your benefits costs or both.



Step 1: Current State Analysis (e.g., Discovery)

- *Understand your general business environment* — Evaluate the degree to which your needs for union and non-union will increase/decrease in the next 3-5 years and the extent to which you will compete for staff within your industry and geographic location
- *Compensation and benefits philosophy* — Identify the appropriate percentile to use for benchmarking with peers, proportion of overall compensation that should be represented by benefits, and the balance among cost considerations, competitiveness, and employee satisfaction that define your success
- *Develop baseline costs and financial models*— Inventory programs and costs, and focus on key cost drivers, outcomes and comparison with benchmarks
- *Competitive Benefits Environment* —Determine the current comparative strength of your benefits program versus the benchmark group, ideal comparative strength – at, above, or below market, and reasonableness of plan cost sharing within your industry and geographic area
- *Program satisfaction* — Using either results from prior executive interviews, employee focus groups, experience at other employers and/or anecdotal information, provide qualitative assessment of program components that are most important to your employees, program understanding based on employee communications, and the extent to which employee satisfaction governs your benefit decisions
- *Project costs* — Estimate costs for the next five years assuming the status quo and translate costs into meaningful terms within the context of key company metrics

Step 2: Desired State and Goal Setting

- *Identify differences between current and desired future states* — Develop a construct that identifies key areas where meaningful changes are expected for your organization, its employees and/or the macro environment
- *Outline implications of future state* — Provide qualitative and/or quantitative evaluations on the impact of changing variables, for select programs and overall
- *Develop specific goals that are an extension of the benefits philosophy* — Outline goals that your organization hopes to achieve over the next three years, using tangible metrics where possible

Step 3: Gaps and Opportunities Analysis

- *Identify gaps* — Evaluate the current programs' synergies and gaps relative to the goals over the next five years, taking into account expected changes
- *Prioritize opportunities* — Provide relative rankings for each gap and construct a range of actions to close each gap

Step 4: Strategic and Tactical Options Evaluation

- *Develop two or three strategic alternatives* — Leveraging the gaps and opportunities analysis, layout strategic options for reaching goals over the next three years
- *Propose tactics to accompany strategic alternatives* — Scope out the specific tactics that will support each strategy, taking into consideration company culture, benchmarking data, and other factors

Step 5: Implementation and Ongoing Management

- *Select vendors* — Secure the most favorable terms (including outcomes-based performance guarantees) with the vendors who provide the highest proficiency in delivering the programs and designs as indicated through the strategy exercise
- *Implement programs, focusing on integration* — Implement programs that are customized for your organization and provide the necessary integration from an operations perspective and from an employee experience point of view
- *Build a measurement dashboard* — Identify key metrics that can be tracked on a regular basis to identify how the programs are performing and to provide insights for additional opportunities to improve upon the execution of the strategy
- *Create a communications/engagement strategy and roadmap* — Develop a cohesive plan to educate employees about the benefits strategy, engage individuals in programs and increase the perceived value of the program

The City of Traverse City RFP

This dynamic approach enables you to validate and define a long-term benefits strategy by aligning employer and employee needs to achieve success. We will develop a unique strategy that addresses the cost drivers that are specific to your plan and remain within culture and financial constraints, while providing a valued benefit package of the highest quality.

2. What involvement will be required from us during the implementation process? Be very specific.

Our initial planning meeting with the City will take 2-3 hours. After this meeting, upon better understanding of the short and long term goals of your organization, we can give more specific timing. If for example a compliance audit is needed then that will require a separate 2-3 hour meeting. A wellness discussion would also require a few additional meetings.

3. Please provide a sample implementation project plan and timeline

Gallagher is a full service consulting and brokerage firm, and all services described in the chart below are in scope. We work diligently to ensure that your plan is in “proactive” mode, and that we are not reacting to issues as they arise. Outside of the traditional marketing of your plan, we will provide you with ongoing service, planning, and communications. The following sample timeline provides an overview of anticipated annual activities and timeframes involved in the handling of a *January 1 renewal*.

Task	Due Date
New Client Implementation	January -- March 2015
Distribute Broker of Record appointment letter to carriers	
Provide Gallagher service team contact list	
Business Associate Agreement for client signature	
Invite client for a tour of Gallagher offices	
Collect current SPDs, plan documents, rate confirmations	
On-boarding assessment: Workforce Evaluation, Cultural Evaluation, Business Climate Assessment	
Wellness audit and strategy meeting	
Onsite clinic feasibility study begins	
PPACA compliance checklist	
Request early renewals from all vendors	
Perform a compliance audit	
Pre-Renewal Strategy Meeting	June 2015
Provide financial reporting and forecasts	
Finalize cost-centers for budgeting purposes	
PPACA pay or play analysis	
Strategic wellness planning	
Review market trends, innovative solutions and industry benchmarking	
Develop year-round client service plan and administrative support	
Discuss 1-3 year benefits strategy and top priorities	

The City of Traverse City RFP

Renewal Analysis

August 2015

- Comprehensive analysis of market review of all vendors
- Network discount and provider disruption analysis
- Employer contribution analysis and cost containment strategies
- Presentation of renewal and recommendations

Final Renewal Analysis

September 2015

- Finalize 2016 budget and renewal decisions
- Review draft "Total Health" open enrollment communications and messaging
- Lock-in stop-loss rates, if applicable
- Review IBNR reserves, if applicable
- Calculate fully-insured equivalents, rate tiers, and COBRA rates

Renewal Execution

October 2015

- Complete all carrier renewal applications
- Enrollment submission
- ID card distribution in December

Annual Open Enrollment

October/November 2015

- Communications campaign – may include in-person meetings, benefits fair, and webcasts (live or recorded)
- Customized written materials
- Promote Gallagher employee advocacy services

Renewal Effective Date

January 2016

- Contracts and booklets issued and amended
- Broker review of documents, carrier and legal agreements

Stewardship Meeting

March 2016

- Renew and update year-round client service plan and administrative support
- Confirm top priorities
- Provide historical and forecasted financial reporting
- Review of market trends
- Refine 2-4 year strategic plan
- Demographic and migration analysis
- Monitor legislative and regulatory updates

G. REFERENCES

1. Please provide 3 references of current clients who have similar demographics. At least 1 of the 3 should have converted within the last year. At least 2 of the 3 should be municipal or governmental clients. Please provide client name, contact name, address, phone number, services provided, and year they became a client.

Gallagher is proud of its roster of clients and is happy to provide the following seven References:

Client Name	Contact Name	Contact Information	Services Provided
Calhoun ISD (2009)	Russ Claggett Asst. Superintendent of Human Resources	claggetr@calhounisd.org (269) 789-2447	Complete Health & Welfare Benefits Consulting and Administration
City of Owosso (2013)	Jessica Unangst, Director of HR	jessica.unangst@ci.owosso.mi.us (989) 725-0552	Complete Health & Welfare Benefits Consulting and Administration
City of Battle Creek (2007)	Rick Hensley, Risk Manager	rlhensley@ci.battle-creek.mi.us (269) 966-3407	Complete Health & Welfare Benefits Consulting and Administration
City of Garden City (2009)	Cheryl Petty	cherylp@gardencitymi.org (734) 793-1642	Complete Health & Welfare Benefits Consulting and Administration
City of Rochester Hills (2000)	Pamela Gordon	gordonp@rochesterhills.org (248) 841-2521	Complete Health & Welfare Benefits Consulting and Administration
City of Troy (2012)	Jeannette Menig HR Director	menigje@troymi.gov (248) 680-7287	Complete Health & Welfare Benefits Consulting and Administration
City of Wayne (2005)	Carrie Venus	cvenus@ci.wayne.mi.us (734) 722-2000	Complete Health & Welfare Benefits Consulting and Administration

- 2. Please provide 3 references of former clients who had similar plan demographics. At least 1 of the 3 should have left within the last year. At least 1 of the 3 should be municipal or governmental clients. Please provide former client name, contact name, address, phone number, services provided, and year they became and the year they ceased to be a client and the reason(s).**

Gallagher is very proud of the fact that we have multiple client relationships that have been in place for over 25 years. Importantly, Gallagher's satisfaction and "willingness to refer to others" ratings increased from 99% of respondents to 100% in 2013. Over the past seven years, Gallagher's retention rating (retention of current clients) has averaged 98%. There are, however, times that a client will leave the firm and predominately these clients leave due to a merger/acquisition situation, the client going out of business, or a new decision maker having an existing relationship with another broker. The following was a former client of the firm:

Global Automotive Systems – (1,400 employees) Gallagher client was terminated in 2011 due to a merger with another company that was part of a Private Equity firm. Name of Contact: Sheila Clayton, Human Resources, (313) 268.7915, sheila.clayton@globalautosys.com.

Gallagher has not lost any additional clients fitting the criteria in the past 12 months.

H. EXPENSES

Describe your remuneration. Is it a commission paid by insurance companies, or flat fee structure? If flat fee, describe the basis of the payment (i.e., per employee, per month, etc.)

Gallagher customizes our compensation arrangements to meet the unique needs of each client and the nature of the services they have requested. Our general approach to compensation, however, never changes. We make these promises to all of our clients:

- Our compensation may be derived from fees or commissions, or a combination of both. The choice is made by each client based on their philosophical and budgetary considerations
- Our compensation will be a fair reflection of the services we are asked to provide
- Our compensation will be inclusive and agreed upon in advance
- We will fully disclose to our clients any and all compensation we receive each year

Under this arrangement, Gallagher would accept standard commissions from the current carrier's for your medical, dental, vision, life and disability coverages.

When considering costs, it is also important for organizations to weigh not just broker/consultant fees, but the overall cost of their benefits program. Your choice of advisor will impact the future overall cost of your program – a much larger cost line item than the broker/consultant cost component itself. The ability of your advisor to positively affect your overall benefits program is critical and we encourage you to talk with our client references about areas where we have helped them avoid cost increases, or actually reduced costs.

We welcome an opportunity to discuss the overall compensation structure, along with the identification of the key items to be included in the scope of services that best support the City's employee benefit objectives.

1. What are the start-up/conversion costs and the termination costs?

There are no additional start-up costs and we do not include additional costs in our contract termination language.

2. Describe what consulting services are included, and related hourly charges and out-of-pocket expenses for additional services (for example, Form 5500 preparation, Plan Document, COBRA administration – if offered, bill reconciliation, etc.)

Subject to any changes and additions as may be mutually agreed by the parties in writing, availability and delivery of data from the insurance carrier and other third party vendors, Gallagher will provide the following services:

RENEWAL ANALYSIS:

- Review and evaluate carrier projections
- Prepare “shadow” renewal projection
- Create financial modeling reports using proprietary Apex software
- Coordinate carrier negotiations
- Create employee contribution modeling reports
- Review identified benchmarks of projected plan costs
- Develop “working” rates for Client analysis and approval
- Assist with budget projections
- Provide renewal alternatives with cost impact of benefit plan changes

PERIODIC PLAN FINANCIAL REPORTS: (FREQUENCY TO BE MUTUALLY AGREED UPON)

- Summary of plan costs
- Analysis of actual vs. budget
- Employee contributions
- Identification of costs for specific line of coverage
- Utilization review
- Comparison to prior claim period
- Plan trends

ANNUAL FINANCIAL REPORTS (END OF YEAR ACCOUNTING):

- Executive summary of program expenses
- Comparison of current costs to renewal costs
- Future plan costs projections
- Dollars saved by contract negotiation
- Percent of benefit dollars paid by employee
- Benefits paid by type of service
- Plan funding/budget comparison
- Fixed expense comparison

LEGISLATIVE AND CORPORATE COMPLIANCE SUPPORT:

- Provide legislative updates, including Technical Bulletins and Directions newsletters
- Evaluate plan design to assist with compliance with state and federal regulations
- Review benefit plan documents, including summary plan descriptions, contracts, employee summaries, and policies/procedures
- Conduct periodic seminars on regulatory issues
- Assist with the review and evaluation of COBRA and HIPAA compliance procedures
- Provide general information and guidance to assist with compliance with FMLA, USERRA, Medicare Part D and other Federal legislation that directly affects the administration of plan benefits
- Provide template or sample compliance notices, certificates of creditable coverage and enrollment forms as reasonably requested by Client

CARRIER MARKETING AND NEGOTIATIONS, AS DIRECTED BY CLIENT:

- Work with Client to develop a strategy to identify goals, analyze program costs and review both current and alternative funding arrangements
- Manage the renewal process with the current carrier to control costs
- Implement carrier renewal strategies with Client
- Develop timeline covering every aspect from RFP preparation to the delivery of employee communications
- Provide analysis of employee disruption report and preparation of geo-access report
- Provide analysis of discounts offered by various carriers by using CPT codes and carrier pricing data
- Manage RFP development that tailors the RFP to the desires, needs and financial directions provided by Client
- Explore alternative funding solutions
- Evaluate vendor responses to track variations in coverage and costs as they are identified
- Conduct finalist interviews to investigate and document intangibles such as personalities, service orientation and responsiveness
- Draft renewal analysis report, based on renewal negotiation, covers program and claims cost projections as well as complete information on benefit designs
- Facilitate decision process by coordinating close collaboration and discussions among the GBS team and Client

DAY TO DAY ADMINISTRATIVE ASSISTANCE

EMPLOYEE EDUCATION PROGRAMS:

- Facilitate focus groups
- Monthly benefit communication directed to employees
- Educational meetings on coverage and trends

COMMUNICATION MATERIALS:

- Assist with the drafting and distribution of participant Satisfaction Surveys
- Assist with the drafting and distribution of Open Enrollment-New Member Orientation summary information and any other communications pertaining to the health and welfare program
- Provide annual open enrollment guidance and employee meeting materials
- Assist with participant wellness initiatives, as directed by Client

BENEFIT ADMINISTRATION ASSESSMENT:

- Periodic evaluation of internal plan enrollment and benefit termination processes
- Review, coordinate and implement Client agreed upon plan “best practices” to help limit plan liability and increase participant satisfaction
- Help identify opportunities for streamlining and improving administration procedures

MARKET BENCHMARKING STUDIES:

- Local Area Surveys
- Industry Surveys

BENEFIT PLAN DESIGN (OR REDESIGN):

- Help Client identify business and HR objectives that impact benefits
- Review with Client possible benefit strategies to meet their objectives
- Help Client evaluate/review current scope of benefits package – e.g., types & levels of coverage
- Work with Client to develop funding and contribution strategies
- Assist with budget projections for design alternatives

- 3. In addition to the expense schedule, please identify any other fee-for-service or activity not covered on the “Service Activity” listing, i.e., postage, handling, supplies, servicing commissions, etc. Please be specific.**

We will work with the City to market services and provide the best in class pricing for COBRA, Plan Documents and billing and reconciliation services, if needed.

- 4. What is your expected margin on a client our size?**

Margins vary based on client’s benefits offered, scope of services and carrier standard commission schedules.

Conclusion

Thank you for the opportunity to provide The City of Traverse City with this response to your Request for Proposal.

We differentiate ourselves from other consulting firms in a variety of tangible ways, the most obvious of which is our dedication and involvement in the Public Entity marketplace. Gallagher works with 1,700 Public Entity clients, significantly more than any other consulting firm in our marketplace. We are confident that Gallagher is the best consultant and partner for the City because the following reasons:

- Unmatched public sector experience
- Benefit plan design, cost trends and benchmarking
- Vendor bidding with regard to Michigan Public Acts
- Regulatory compliance assistance including COBRA, HIPAA, and PPACA
- Healthcare Reform compliance
- Financial analysis
- Retiree benefit design and retiree group medical plans
- Day-to-Day benefits manager for the City's employees
- Benefit analysis and cost projections for budget planning and labor negotiations
- Corporate wellness initiatives, support and tracking

Because of our extensive experience, we understand the unique opportunities and challenges that our municipal partners face and we are uniquely positioned to tackle those objectives and challenges. As your experienced benefits consultant who will partner with you to break barriers, we look forward to working with you to create and manage a comprehensive benefits program that meets the goals and objectives of The City of Traverse City.

Thank you for your consideration in the Request for Proposal process.

We look forward to speaking with you in the coming weeks.

Mary Beth Seger
Area Vice President
Gallagher Benefit Services, Inc.
30150 Telegraph Road, Suite 408
Bingham Farms, MI 48025
Email: Mary_Beth_Seger@ajg.com
Phone: 248.430.2778
www.ajg.com



Disclosure

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Vendor - Please complete and return

PROPOSAL SUMMARY

TITLE: **INSURANCE AGENT FOR THE CITY OF TRAVERSE CITY**

DUE DATE: **WEDNESDAY, JANUARY 7, 2015 AT 10:00 AM**

Having carefully examined the attached specifications and any other applicable information, the undersigned proposes to furnish all items necessary for and reasonably incidental to the proper completion of this proposal. Vendor submits this proposal and agrees to meet or exceed all requirements and specifications unless otherwise indicated in writing and attached hereto.

Vendor certifies that as of the date of this proposal the Company or he/she is not in arrears to the City of Traverse City for debt or contract and is in no way a defaulter as provided in Section 152, Chapter XVI of the Charter of the City of Traverse City.

Vendor understands and agrees, if selected as the successful Vendor, to accept a Purchase Order/Service Order/ Contract and to provide proof of the required insurance.

The Vendor shall comply with all applicable federal, state, local and building codes, laws, rules and regulations and obtain any required permits for this work.

The Vendor certifies that it is in compliance with the City's Nondiscrimination Policy as set forth in Administrative Order No. 47 and Chapter 605 of the City's Codified Ordinances.

The Vendor certifies that none of the following circumstances have occurred with respect to the Vendor, an officer of the Vendor, or an owner of a 25% or more share in the Vendor's business, within 3 years prior to the proposal:

- (a) conviction of a criminal offense incident to the application for or performance of a contract;
- (b) conviction of embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, or any other offense which currently, seriously and directly reflects on the Vendor's business integrity;
- (c) conviction under state or federal antitrust statutes;
- (d) attempting to influence a public employee to breach ethical conduct standards; or
- (e) conviction of a criminal offense or other violation of other state, local, or federal law, as determined by a court of competent jurisdiction or an administrative proceeding, which in the opinion of the City indicates that the vendor is unable to perform responsibility or which reflects a lack of integrity that could negatively impact or reflect upon the City of Traverse City, including but not limited to, any of the following offenses or violations of:

- i. The Natural Resources and Environmental Protection Act.
- ii. A persistent and knowing violation of the Michigan Consumer Protection Act.
- iii. Willful or persistent violations of the Michigan Occupational Health and Safety Act.
- iv. A violation of federal, local, or state civil rights, equal rights, or non-discrimination laws, rules, or regulations.
- v. Repeated or flagrant violations of laws related to the payment of wages and fringe benefits.

(f) the loss of a license or the right to do business or practice a profession, the loss or suspension of which indicates dishonesty, a lack of integrity, or a failure or refusal to perform in accordance with the ethical standards of the business or profession in question.

Vendor understands that the City reserves the right to accept any or all proposals in whole or part and to waive irregularities in any proposal in the best interest of the City. The proposal will be evaluated and awarded on the basis of the best value to the City. The criteria used by the City may include, but will not be limited to: ability, qualifications, timeframe, experience, price, type and amount of equipment, accessories, options, insurance, permits, licenses, other pertinent factors and overall capability to meet the needs of the City. The City is sales tax exempt – Government.

Vendor agrees that the proposal may not be withdrawn for a period of sixty (60) days from the actual date of the opening of the proposal.

Submitted by:


Signature

Mary Beth Seger, Area Vice President
Name and Title (Print)

248.430.2778
Phone Fax

Gallagher Benefit Services
Company Name

30150 Telegraph Road, Suite 408
Company Address

Bingham Farms, Michigan 48025
City, State, Zip

Sole proprietorship/partnership/corporation

Delaware
If corporation, state of corporation

REFERENCES: (include name of organization, address, contact person, daytime phone number, and length of time services have been performed).

1. **Calhoun ISD**, Russ Claggett, Assistant Superintendent of Human Resources, 269-789-2447
claggetr@calhounISD.org

2. **City of Owosso**, Jessica Unangst, Director of HR, 989-725-0552,
Jessica.unangst@ci.owosso.mi.us

3. **City of Troy**, Jeannette Menig, HR Director, 248-680-7287
cvenus@ci.wayne.mi.us

SUBCONTRACTORS: (include name of organization, address, contact person, daytime phone number, and services to be performed).

1. **None.**

2.

3.



2014
BENEFIT
SUMMARY &
DECISION
GUIDE

BENEFITS
DESIGNED TO
HELP YOU LIVE
A BETTER
LIFE



Open Enrollment time is here for the 2014 plan year at ABC Company. This benefit guide will provide you with an overview of things to come in 2014. There are many important topics to share with you for the upcoming year, including:

- Healthcare Reform
- Plan changes effective January 1, 2014 which include three new medical plans through BCN
- Costs for the 2014 benefits program

Healthcare Reform

Individual Mandate

The Healthcare Reform Law (also known as PPACA) requires all individuals to have health insurance starting in 2014. When filing 2014 taxes in 2015, individuals must indicate on their returns if they have health insurance coverage and, if not, pay a penalty. In 2014, the penalty is \$95 per uninsured person or 1% of household income over the filing threshold. This penalty increases in 2015 and 2016.

Individuals must have coverage that is deemed “affordable” and meet the “minimum value” standard. ABC Company’s medical plan meets these requirements as outlined in the Marketplace Exchange notice that was sent to all employees in September 2013.

Taxes and Fees

PPACA has created many new taxes and fees required of ABC Company including the following:

Clinical Effectiveness Research (CER) Fee: This is an annual fee that funds research on the effectiveness, risks and benefits of various medical treatments through the Patient-Centered Outcomes Research Institute (PCORI), a nonprofit created through PPACA. The fee is \$1 per covered person in 2013, and \$2 per covered person in 2014.

Transitional Reinsurance Program Fee: These are quarterly fees that will help fund a transitional reinsurance program for the health plans participating in the Healthcare Marketplace (Exchange). The fees are designed to stabilize individual health insurance premiums in 2014-2016—the first three years the exchanges will be operational. The Department of Health and Human Services (HHS) determines the fee, and estimates the 2014 fee will be \$63 per covered person on the health plan.





RESOURCES

The quickest way to find answers to your benefits questions is to go directly to the source. This resource list includes web addresses and phone numbers for the administrators of each of our benefit plans. Also included are the ABC Company plan numbers, which the administrators may request when you call. Having this information handy will enhance the level of customer service these vendors provide to you.

To navigate to provider websites, click on the bold-face websites.

You can also find extensive information on your benefits by using these ABC Company resources:

- **ABC Company Employee Handbook**
- **ABC Company Human Resources Page on ViewPoint**
- **ADP Portal: <https://portal.adp.com>**

BENEFIT	PROVIDER	WEBSITE	PHONE	PLAN #
Medical/Prescription Drugs	BCBSM BCN	www.bcbsm.com www.bcbsm.com	(800) 637-2227 (800) 662-6667	007019041 0254918
Mail Order Prescriptions	Express Scripts	www.express-scripts.com	(800) 778-0735	
Dental	Delta Dental	www.deltadentalmi.com	(800) 524-0149	0011
Vision	NVA	www.e-nva.com	(800) 672-7723	51227 0001 01
Blue Health Connection	BCBSM	www.bcbsm.com	(800) 775-BLUE	
Basic Life/AD&D Insurance	Cigna	www.cigna.com	(800) 362-4462	FLX96442
Optional & Dependent Life Insurance	Cigna	www.cigna.com	(800) 362-4462	FLX96442
STD & LTD	Cigna	www.cigna.com	(800) 362-4462	STD: LK751071 LTD: VDT961035
Flexible Spending Accounts	Discovery Benefits	www.discoverybenefits.com	(866) 451-3399	N/A
Ulliance—Employee Assistance Program	Ulliance	www.ulliance.com/eap	(800) 448-8326	N/A
401(K) Qualified Retirement Plan	Plan Administrator: ABC Company	www.abgmi.com	(866) 875-7510	N/A
	Trustee: Reliance Trust Company			
Family Medical Leave (FMLA)	ABC Company HR Department	N/A	(248) 432-9008 (Yia)	N/A

INTRODUCTION — cont'd

Required Medical Plan Benefit Changes

PPACA has many required plan changes effective 1/1/2014, but we will only cover those that impact ABC Company's medical plan.

Cost-Sharing Limitations: Cost-sharing refers to amounts you are required to pay when you incur eligible services including deductibles, co-insurance, and copays. This does not include expenses such as contributions, provider balance billing amounts or expenses for non-covered services. Simply put, it includes the services covered by your insurance carrier for which you share in the cost. PPACA has placed limitations on the amount of cost-sharing allowed under our medical plan. As a result, our medical plan will limit your cost sharing amounts.

Effective 1/1/2014, your cost-sharing will be a combination of your deductible, co-insurance and all copays resulting from office visits, urgent care visits, emergency room visits and prescription drugs. To help offset the cost of this required medical plan change, ABC Company has added plans with an increased deductible and out of pocket maximum.

Open Enrollment

During our open enrollment period—**November 11—November 22**—you are required to make decisions which will remain in effect for the 2014 plan year. For example, you may add or delete dependents, choose additional life coverage, elect or re-elect to participate in the FSA plan, etc. **Please carefully review this Benefit Highlight Booklet in its entirety.** It provides important information about your benefits to help you make informed decisions regarding your participation for the 2014 plan year.



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This Benefit Summary summarizes the ABC Company benefits program. Complete descriptions of each benefit are available in the actual plan documents. Every effort has been made to ensure this summary accurately describes these benefits. However, if there is a conflict between this information and the plan documents, the plan documents will govern. In addition, participation in the benefits program does not constitute a right to continued employment with the company. Nothing in this guide should be construed as a contract or offer to contract for employment for any specific time or under any particular terms and conditions. While it is the company's intent to continue these programs, we reserve the right to amend or terminate them at any time.

2014 BENEFITS: EMPLOYEE COST SUMMARY

Medical	Coverage Level	BCN HBL HMO 500	BCN HBL HMO 1000	BCN HBL HMO 2000	BCBSM PPO
Bi-Weekly (pre-tax)	Single	\$39.21	\$9.23	\$0.00	\$225.09
	Two Person	\$182.02	\$113.08	\$70.67	\$617.43
	Family	\$253.32	\$175.38	\$127.44	\$778.91

★ Slight decrease to Dental contributions for 2014

Dental	Single	Two Person	Family
Bi-Weekly (pre-tax)	\$16.17	\$30.10	\$56.95

★ Slight increase to Vision contributions for 2014

Vision	Single	Two Person	Family
Bi-Weekly (pre-tax)	\$2.90	\$5.22	\$7.54

★ No changes to Optional Life and Voluntary LTD for 2014

Optional & Dependent Life

Cost per \$1,000 per month

Employee and Spouse Optional Life Coverage		
Age	Employee Rate	Spouse Rate
<20	\$.044	\$.052
20-24	\$.044	\$.052
25-29	\$.053	\$.069
30-34	\$.070	\$.076
35-39	\$.079	\$.096
40-44	\$.088	\$.124
45-49	\$.132	\$.183
50-54	\$.203	\$.284
55-59	\$.379	\$.476
60-64	\$.581	\$.878
65-69	\$1.119	\$1.498
70+	\$1.815	\$1.815



Dependent Child Optional Life Coverage

\$.082 per \$1,000 of coverage

FITNESS CENTER

For \$5 per month, ABC Company employees gain access to our on-site fitness center which includes a raised track, basketball court, racquetball court, aerobics room, treadmills, elliptical machines, stationary bikes, a circuit system, free weights and other machines.

Membership also includes a variety of aerobics classes offered 4 days per week.



FLEXTIME

The Company offers a flextime schedule plan to all employees. This plan allows you to set your own working hours within certain constraints.

Your supervisor will discuss the flexible schedule policy with you. Once you have selected a starting time, it cannot be changed without your supervisor's approval. Management reserves the right to make changes to the flex schedule at any time.

FAMILY & MEDICAL LEAVE ACT

It is the policy of ABC Company to grant up to 12 weeks of family and medical leave during any 12-month period to eligible employees, in accordance with the federal Family and Medical Leave Act (FMLA).

Please refer to the Employee Handbook for complete plan provisions.



HOLIDAYS

2014 Holiday Schedule

A recognized holiday that falls on a Saturday will generally be observed on the preceding Friday. A recognized holiday that falls on a Sunday will generally be observed on the following Monday.

Holiday pay depends on employment status.

Wednesday, January 1	New Years Day
Monday, January 20	Martin Luther King Day
Monday, May 26	Memorial Day
Friday, July 4	Independence Day
Monday, September 1	Labor Day
Thursday, November 27	Thanksgiving Day
Friday, November 28	Friday after Thanksgiving
Thursday, December 25	Christmas Day

BENEFITS AT A GLANCE



Your ABC Company benefit program is made up of three parts designed to protect and enhance your total health: your physical, financial and personal health. These parts make up the whole to a better life at work and at home, for you and your family.

The charts on the next several pages quickly highlight the many benefits you have available as an employee at ABC Company. The more you know about them, the better you'll be at using the resources available when you need them. Take time to understand everything that ABC Company has to offer.

FOR PHYSICAL HEALTH

! Indicates when you need to take action

Benefit	Description	Eligibility & Participation
Medical Benefits with Prescription Drug Coverage Page 11	<ul style="list-style-type: none"> Providers: BCBSM & BCN Comprehensive coverage Four plans to choose from Encourages the use of network providers to save money — for you and the company Prescription coverage level based on generic, preferred or non-preferred brands 	<ul style="list-style-type: none"> Immediate eligibility for current employees Available to new employees the 1st of the month following 60 days of service ! Enroll to participate and designate your eligible dependents Changes can only be made during Annual Enrollment and within 30 days of qualified life events Contributions taken via pre-tax payroll deduction
Dental Benefits Page 22	<ul style="list-style-type: none"> Provider: Delta Dental Offers you the freedom to see any dentist you choose Encourages the use of network providers to save money 	<ul style="list-style-type: none"> Immediate eligibility for current employees Available to new employees the 1st of the month following 60 days of service ! Enroll to participate and designate your eligible dependents Changes can only be made during Annual Enrollment and within 30 days of qualified life events Contributions taken via pre-tax payroll deduction
Vision Plan Page 13	<ul style="list-style-type: none"> Provider: NVA Offers you the freedom to see any vision provider you choose Encourages the use of network providers to save money Provides coverage for eye exams, and glasses or contacts 	<ul style="list-style-type: none"> Immediate eligibility for current employees Available to new employees the 1st of the month following 60 days of service ! Enroll to participate and designate your eligible dependents Changes can only be made during Annual Enrollment and within 30 days of qualified life events Contributions taken via pre-tax payroll deduction

FOR FINANCIAL HEALTH

Benefit	Description	Eligibility & Participation
Flexible Spending Accounts (FSA) Page 24	<ul style="list-style-type: none"> Provider: Discovery Benefits Pay for eligible expenses with tax-free dollars Health Care FSA Dependent Care FSA 	<ul style="list-style-type: none"> Immediate eligibility for current employees Available to new employees the 1st of the month following 60 days of service Enroll to participate Contributions taken via pre-tax payroll deduction Changes can only be made during Annual Enrollment and within 30 days of qualified life events
Basic Group Life and AD&D Insurance Page 27	<ul style="list-style-type: none"> Provider: Cigna Basic: 1 times annual earnings up to \$100,000 AD&D: 1 times annual earnings up to \$100,000 	<ul style="list-style-type: none"> Immediate eligibility for current employees Available to new employees the 1st of the month following 60 days of service Automatic enrollment; company paid Complete beneficiary designation
Optional & Dependent Life Insurance Page 27	<ul style="list-style-type: none"> Provider: Cigna Employee: \$10,000 increments to \$300,000 Spouse: \$5,000 increments to \$150,000 Each eligible dependent child: \$10,000 	<ul style="list-style-type: none"> Immediate eligibility for current employees Available to new employees the 1st of the month following 60 days of service Enroll to participate Contributions taken via post-tax payroll deduction Coverage subject to Evidence of Insurability for current employees who previously waived coverage or for anyone currently insured who would like to increase amount above the Guaranteed Issue.
Disability Programs Page 28	<ul style="list-style-type: none"> Provider: Cigna In the event you are unable to work due to an illness or injury, ABC Company provides you with additional income replacement coverage 	<ul style="list-style-type: none"> Immediate eligibility for current employees Available to new employees the 1st of the month following 60 days of service Short-Term Disability coverage has automatic enrollment provided at no cost to you Voluntary Long-Term Disability coverage is subject to Evidence of Insurability Contributions are taken via payroll deduction Must enroll to participate
Cigna Value Add Programs Page 28	<ul style="list-style-type: none"> Cigna's group insurance products feature value programs for you at no additional cost 	<ul style="list-style-type: none"> Immediate eligibility for current employees Available to new employees the 1st of the month following 60 days of service Available to all benefit eligible employees
401(k) Profit Sharing Plan & Trust Page 29	<ul style="list-style-type: none"> Provider: Alliance Benefit Group of MI Variety of investment options 3% automatic enrollment Automatic increase of 1% each September until you reach a contribution of 6% You can stop contributing or change your contribution percentage at any time 	<ul style="list-style-type: none"> Immediate eligibility, if age 21 You will enter the Plan once you reach the Entry Date, which is the first day of the month following 60 days.

PAID TIME OFF (PTO)



Time off with pay is available to regular full-time employees. The purpose of paid time off (PTO) is twofold. It allows all our employees a chance to relax, take care of personal errands and spend time with their friends and family; and it allows the Company to benefit from employees recharging their batteries, and coming to work refreshed and with renewed energy. Thus, ACB Company has always encouraged its employees to take all the vacation time to which they are entitled.

In conjunction with the flexibility of this plan comes additional responsibility on the part of all employees. It is important that your time off is budgeted appropriately. There is no provision for any unpaid days off. Any additional absences beyond the time listed above will be considered possible grounds for disciplinary action up to and including termination.

All requests for time off should be submitted in writing at least two weeks in advance to your supervisors. The only exception to the advance notice would be a day needed as an emergency day off. Requests will be approved based on a number of factors, including business needs, PTO earned and staffing requirements. Priority in scheduling PTO is determined on a first come, first-serve basis. Employees will be allowed to carry over up to 5 PTO Days to the following year.

PTO is paid at the employee's base pay rate at the time it is used. It does not include overtime or any special forms of compensation such as incentives, commissions, bonuses, or shift differentials. A company holiday that falls during a PTO absence will be paid as a holiday and not as PTO. Paid time off will NOT be counted as hours worked for the purposes of determining overtime for nonexempt employees. PTO will be earned on a per pay basis according to the following schedule:

Annual PTO Allotment (Based on Seniority)	Per Pay Accrual Rate
10 days	3.08 hours
15 days	4.62 hours
20 days	6.15 hours
25 days	7.69 hours

ANNUAL PTO ALLOTTED TIME BASED ON SERVICE

Calendar Years of continuous Full-Time Service	Number of Days	
	Non-Exempt Staff	Exempt Staff
First Year:		
January 1— April 30	5	10
May 1— August 31	3	6
September 1— December 31	0	0
Second Year	10	15
In the 3rd year through the 5th year	15	20
In the 6th year or more	20	25



FOR PERSONAL HEALTH

WORKLIFE PROGRAM

Including Employee Assistance Program (EAP)

Contact: **ULLIANCE EAP**
www.ulliance.com/eap, (800) 448-8326

ULLIANCE EAP is a benefit offered by your company to their employees. This benefit is free to you and is totally confidential, beginning with your first phone call. The EAP benefit is available to you, to your spouse or live-in partner, and any dependent.

Call anytime with personal concerns, including:

- Personal and work stress
- Alcohol and drug abuse
- Family, child and parenting concerns
- Emotional difficulties— i.e. depression/anxiety
- Grief, loss, and death
- Legal and financial referrals
- Interpersonal relationships at work
- Marital or relationship concerns
- Goal setting and coaching
- Elder/child care referrals

ULLIANCE provides what they call “The Four C’s”:

- **Counseling** at ULLIANCE is short-term, and solution-focused. Individuals, couples and families have been helped by our services. The benefit is renewable, meaning you can return over and over for different issues. All counseling is confidential and free if you are seen by an EAP counselor.

- **Coaching** is available when you want help reaching a goal or when you want to develop a plan of action and stay on track. Coaching appointments are generally 30-minute phone conversations.
- **Crisis Intervention** means that ULLIANCE is available 24 hours a day, 7 days a week, 365 days a year. You will always be speaking with a live person, not being asked by a machine to leave a name and number while you wait for a return call.
- **Community Resources & Referrals** can make your life easier! ULLIANCE can assist you in finding these resources or you can login to our website for articles, services, assessments / tools, and more, on many different subject areas, including childcare, eldercare, legal referrals, and financial referrals.

Work-Life Resources

By calling ULLIANCE, you have access to free brochures, pamphlets, books and CD’s on a variety of topics such as:

- Money & Debt
- Stress Management
- Getting in Shape
- Creative Problem Solving
- Ergonomics
- Parenting & Step-Parenting
- Child Care
- Overcoming Anger
- Save Your Relationship
- Elder Care

TOOLS YOU CAN USE

To serve your individual needs, ULLIANCE can also find information and resources in your area to address your specific questions - including finding referrals outside the EAP to Lawyers and Financial resources. You can also check out ULLIANCE’s website for a wide variety of articles, lists of services and links to other websites.

FOR PERSONAL HEALTH

Benefit	Description	Eligibility & Participation
Ulliance Employee Assistance Program Page 30	<ul style="list-style-type: none"> • Phone, website and custom resources for work, home and life issues • Flexible number of free counseling sessions based on your personal issues 	<ul style="list-style-type: none"> • Immediate eligibility for all employees • No enrollment necessary
Paid Time Off Page 31	Time off is accrued on a per pay basis according to your years of service	Time off with pay is available to regular full-time and part-time employees following completion of 60 days. There is no waiting period for time to begin accruing.
Flextime Page 32	This plan allows you to set your own working hours within certain constraints	A flextime schedule plan is offered to all employees
Family Medical Leave Act Page 32	Leave of absence for serious health condition of employee or family member	See the Family and Medical Leave of Absence policy in ABC Company’s Employee Handbook
Holidays Page 32	ABC Company issues a holiday schedule for each year. Holiday pay depends on employment status.	Office will be closed in observance of certain Holidays. (See page 32 for 2014 Holiday Schedule). Full time employees are eligible for paid holiday time.
Fitness Center Page 32	ABC Company offers convenient on-site workout facilities for a low monthly cost	All employees

QUICK STEPS TO ENROLL IN BENEFITS ONLINE

1. Enroll at <https://portal.adp.com>
2. Once in the system, place your mouse over “Benefits” and click on “Open Enrollment”
3. Click on “Walk me through this process”, to proceed through the enrollment process, making personal changes as needed.
4. On the Finalize Enrollment page click on “submit to administrator”.
5. You will receive an approval of your elections via your ABC Company email address by the end of Annual Enrollment.





ELIGIBILITY FOR BENEFITS

Full-time Employees

You and your dependents are eligible to participate in the plans described in this guide if you are an active, full-time employee who works at least 30 hours per week (excluding interns and co-ops). As a new employee your coverage begins on the 1st of the month following 60 days of employment.

Dependents

The following dependents are typically eligible for medical and Rx drug insurance coverage:

- Spouse, legally married.
- Dependent child who is 26. Dependent children will remain covered through December 31 of the calendar year in which they reach the applicable age maximum.
- Child over age 26 who because of a mental or physical disability, remains wholly dependent on you. In this case, your child's coverage continues as long as your own coverage continues. Please see Human Resources for additional information about the criteria and documentation required.
- Dental, Vision and Voluntary Life coverage is available to dependents to age 19, or to age 25 if a full time student.

Making Changes to Your Coverage

The coverage you elect will be effective January 1, 2014 through December 31, 2014. Under federal tax regulations, you may change your benefit elections only when you have a qualified family status change and you must notify Human Resources within 30 days of the event. Samples of qualified family status changes appear on the next page. Changes made as the result of a qualified family status change will be made effective on the date of the event.

In addition, if you decline coverage for yourself and/or your dependents (including your spouse) now because you are covered by another health insurance plan, you may be able to enroll yourself or your dependents in this plan in the future.

It is your responsibility to notify Human Resources within 30 days if you have a dependent who is no longer eligible under the terms of the plan (for example, a child reaches age 26 and no longer meets the definition of a dependent, or you become divorced). Those dependents may have continuation rights for medical, dental and vision coverage under the federal law known as COBRA.

FOR DENTAL/VISION/ VOLUNTARY LIFE :

Dependent children can be covered to age 19. Coverage can continue for an unmarried child to the date he/she attains 25 years of age provided the child is a full-time student in an accredited school and is principally dependent on you for his/her support and maintenance.

FOR MEDICAL PLANS:

Adult children can be covered to age 26, regardless of student status, marital status, residence, or financial dependence on the employee or anyone else.

401(k) PROFIT SHARING PLAN & TRUST

Contact: Alliance Benefit Group of Michigan
www.abgmi.com, (866) 858-3863



Let's face it, saving is not always easy with today's demands on your money. But the ABC Company Employees' 401(k) Profit Sharing Plan & Trust offers a convenient way to get into the savings routine and save for one of the most important goals of your life – retirement.

Automatic Enrollment and Increase

- All new hires will be automatically enrolled, **unless you opt out.**
- The contribution amount will be 3% of compensation
- The contribution will be allocated to the appropriate target date fund based on your age (see chart below)
- The 3% contribution amount will be automatically increased by 1% each September until you reach a contribution of 6%

What if I don't want to contribute?

- If you decide you do not want to contribute, or would prefer to contribute something other than 3%, you have 2 ways to "opt out" or select a different percentage.
 1. Visit the plan's website at www.abgmi.com or
 2. Call the Voice Response System at 866-858-3863
- Your initial login to the website is your SS# and your initial password is the last four digits of your SS#.
- If you need assistance, you can call Alliance Benefit Group of Michigan at 800-875-7510, option 1.

If I am automatically enrolled, can I later stop my contributions?

Yes, you can stop contributing to the plan (or change your contribution percentage) at any time by visiting the website or calling the Voice Response System.

Ticker	Fund Name	Beginning Date	End Date
VTINX	Vanguard Target Retirement Income	Before 12/31/1939	12/31/1939
VTOVX	Vanguard Target Retirement 2005	1/1/1940	12/31/1944
VTENX	Vanguard Target Retirement 2010	1/1/1945	12/31/1949
VTXVX	Vanguard Target Retirement 2015	1/1/1950	12/31/1954
VTWNX	Vanguard Target Retirement 2020	1/1/1955	12/31/1959
VTTVX	Vanguard Target Retirement 2025	1/1/1960	12/31/1964
VTHRX	Vanguard Target Retirement 2030	1/1/1965	12/31/1969
VTTHX	Vanguard Target Retirement 2035	1/1/1970	12/31/1974
VFORX	Vanguard Target Retirement 2040	1/1/1975	12/31/1979
VTIVX	Vanguard Target Retirement 2045	1/1/1980	12/31/1984
VFIFX	Vanguard Target Retirement 2050	1/1/1985	Current

DISABILITY PROGRAMS

Contact: Cigna
www.cigna.com, (800) 362-4462

ABC Company's Short- and Long-Term Disability coverage provides income replacement if you become disabled and cannot work.

Short-Term Disability

A disability of a lengthy duration can devastate the financial and emotional status of an individual or family. To help protect you from the effects of the income loss that results from a serious disability, ABC Company provides coverage equal to 66 2/3% of monthly earnings (excluding overtime) to a maximum of \$1,000 per week for all employees for a maximum of 13 weeks. You must be continuously disabled for 14 days following a qualified accident or sickness. Benefits would then begin on the 15th day.

This benefit is provided at no cost to you. Benefits under this plan are taxable.

Voluntary Long-Term Disability

A disability of a lengthy duration can devastate the financial and emotional status of an individual or family. To help protect you from the effects of the income loss that results from a serious disability, ABC Company provides a Voluntary LTD option.

The benefit provides coverage equal to 60% of monthly earnings (excluding overtime) to a maximum of \$10,000 per month for all employees.

Benefits will begin 90 days following an accidental injury, sickness or pregnancy.

Please consider this voluntary benefit option carefully. If you were eligible for this coverage previously and declined, you will have to provide EOI and your coverage could be denied.

If you are a new hire, you can enroll without providing Evidence of Insurability.

A detailed explanation of these benefits can be found on the ADP Portal at <https://portal.adp.com>

Benefits under this plan are not taxable.

Cigna Value Added Programs

Cigna's group insurance products feature value programs for you at no additional cost.

Healthy Rewards

Provides discounts of up to 60% on health and wellness products and services such as weight management, nutrition, fitness, smoking cessation and more.

Identity Theft

Provides access to personal case managers who give step-by-step assistance and guidance if your identity is stolen.

Will Preparation

Cigna's online Will Preparation Service is secure and easy to use. Online forms, tools and advice are available to build state-specific customized wills, powers of attorney and other legal documents.

Cignaassurance Beneficiary Program

Family bereavement counseling with certified specialists, financial information and legal consultation services.

Secure Travel

Toll Free / 24 hour access to travel services available for yourself and dependents when traveling more than 100 miles from home.

A detailed explanation of these programs can be found on the ADP Portal at <https://portal.adp.com>.



Changing Your Benefits During the Year

Make your elections during your enrollment period carefully because you can only make changes during the year if you have a qualified life event according to IRS regulations. The following events qualify for a mid-year change in coverage:

- Marriage
- Divorce or legal separation
- Birth or placement for adoption of a child
- Death of a dependent
- Ineligibility of a dependent
- Loss of other coverage
- Change in your employment status or that of your spouse
- Significant change in health coverage attributable to your employment or that of your spouse
- A qualified domestic relations order or similar court order
- Entitlement to Medicare or Medicaid

FOR A GUIDE TO USING THE SYSTEM TO MAKE A CHANGE:

Go to the ADP Portal located on the HR Link on ViewPoint

TO MAKE AN ELIGIBLE CHANGE DUE TO A QUALIFIED LIFE EVENT:

Use ADP Portal at <https://portal.adp.com>

If you experience one of these events and want to change your benefits, you must make the change within 30 days after the event occurs. Changes cannot be made before the event occurs. If you miss the window for making a change, you will need to change your elections during the next Annual Enrollment period.

Benefits requiring a qualified life event to make a change:

- Medical
- Dental
- Vision
- Flexible Spending Accounts
- Life Insurance & LTD

As a result of a status change, you may choose to:

- Enroll for coverage (if you previously declined benefits coverage);
- Drop your benefits coverage;
- Add or remove covered dependents;
- Change your coverage level (for example changing from single to family coverage or increasing/decreasing medical/dependent spending account election);
- Changes must be consistent with the qualifying event type.

ENROLLMENT FOR NEWLY HIRED EMPLOYEES



For newly hired employees, benefits enrollment information will be given to you by Human Resources. You will enroll in your benefits for the first time through ABC Company's online ADP Portal. Steps to enroll can be found on page 7 of this booklet.

Enrollment Reminders

- All newly hired employees are required to complete online enrollment through ABC Company's ADP Portal. If you do not wish to participate in the benefit, please select "decline" or "waive."
- Keep copies of enrollment decisions for your records.

Questions?

If you have any questions or need help updating information, please contact your HR Department.



LEARN MORE ABOUT YOUR BENEFITS

Turn to ViewPoint for ABC Company HR and Benefit Information

The ABC Company homepage on ViewPoint is the primary resource for company news and Human Resources information, office locations and employee directories.

Your ABC Company homepage will take you directly to the Human Resources Link on ViewPoint.

Access the ADP Portal through ViewPoint or go directly to <https://portal.adp.com> for ABC Company benefit information.

Find the most commonly requested forms and information about ABC Company benefits; explore helpful decision-making tools; and learn more about managing your health, wealth and all aspects of your personal life. Here's just a small sampling of what you will find...get ready to know more!

- Benefit plan information
- Links to providers such as BCBSM and Cigna
- Other helpful decision-making tools found on provider websites
- Recent employee publications
- Health news (updated weekly!)
- Explanations of government benefits
- Links to retirement and financial calculators
- Articles to help you learn more about getting married, having a baby, planning for retirement and more

CHECK OUT OUR PROVIDER WEBSITES, TOO.

Go to the Resources section on page 34 for a complete list of providers and their websites.



LIFE/AD&D INSURANCE



Contact: Cigna
www.cigna.com, (800) 362-4462

Part of planning for the financial health of your family is to make sure they are taken care of, even in the event of death or accident.

To help you protect your family, ABC Company offers basic life insurance that is fully paid for by the company. You can choose to purchase additional voluntary life insurance for yourself and coverage for your spouse and dependents.

Company-Paid Coverage

Basic Life Insurance

Basic Life/AD&D insurance is an extremely important benefit. It offers financial security for your dependents should you pass away. All eligible employees receive a Life/AD&D insurance benefit equal to your annual salary to a maximum of \$100,000. These benefits are provided at no cost to you. This coverage is insured through Cigna.

In addition to the employer paid programs that are offered, ABC Company also offers the opportunity to participate in Optional and Dependent Life through Cigna.

Employee-Paid Coverage Options

Optional and Dependent Life

- Coverage provided by Cigna (www.cigna.com).
- You may purchase additional life insurance protection for you, your spouse and your dependent children through Cigna.
- When optional life insurance is purchased through a group plan, such as ABC Company, the insurance company will provide a level of coverage to employee when first eligible without asking for health information. This is referred to as Guarantee Issue. Evidence of Insurability (EOI) will be required if you elect to purchase optional life insurance after you were initially eligible, or request to increase the amount you have already been approved for over the Guarantee Issue amount.

► Coverage for You

Choose increments of \$10,000 to \$300,000, not to exceed five times your annual earnings. The Guarantee Issue amount is \$200,000. If you are currently insured under the Optional Life Insurance Portion of this Policy, you may increase your benefit amount up to \$200,000 without providing evidence of insurability through Cigna. An insured employee may increase coverage in excess of \$200,000 only if they satisfy the EOI requirements and are approved by Cigna underwriting.

► Coverage for Your Spouse

Choose increments of \$5,000 to \$150,000, not to exceed 50% of your Optional amount. The Guarantee Issue amount is \$30,000. All late entrants and those who wish to increase their spouse's benefit, must submit EOI on behalf of their spouse. New hires can get up to \$30,000 with no medical underwriting. You must purchase Optional Life for yourself before you can purchase coverage for your spouse.

► Coverage for Your Dependent Children

Coverage is available for all your children from 14 days to age 25 if a full time student for \$10,000 without medical underwriting. You must purchase Optional Life for yourself before you can purchase coverage for your children.

For your cost information, see page 33.

YOU CAN'T TAKE IT WITH YOU...SO MAKE SURE IT GOES TO THE RIGHT PEOPLE

Check your life insurance beneficiary designations regularly to make sure they are still in line with your wishes. Visit the ADP Portal to verify and/or make changes to your beneficiary designations. Be sure to do the same for your 401(k) account.





MARY CLIPS HER COSTS ON HEALTH CARE – BIG TIME!

Each year, Mary ends up paying about \$1,800 out of her pocket for health care for her family. That includes \$1,500 toward the deductible and about \$300 in her family's share for services received after the deductible is met. She pays roughly 30% of her income in taxes. By contributing \$1,800 to a Health Care FSA, she saves about \$540 a year. What motivates Mary to plan ahead? "It sure beats clipping 2,160 coupons worth 25 cents!"

SUPERSIZED SAVINGS

By looking even more carefully at the list of eligible expenses, Mary could save even more. Vision and dental expenses are also eligible. When Mary tallies these up, she adds another \$500 to her FSA for next year and will save another \$150. That's like a free trip to the grocery store!



WHY MIKE SHOULD BOTHER? 2,000 REASONS...

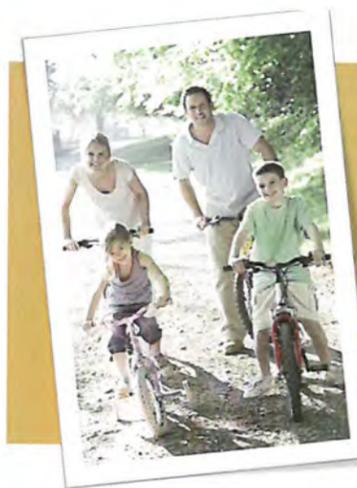
Mike doesn't think he has time to deal with an FSA. He has enough to worry about — a stressful job, a son just starting school, twin girls age two, and a wife busy with her career. Why should he bother enrolling in the Dependent Care FSA? That's when his wife, Jenny, steps in. "Why? Well, I have about 2,000 reasons — all with George Washington's face on them."



For Jenny, it's a no brainer. With what they pay for two girls in day care and considering their tax bracket, they save a few thousand dollars each year. She'll gladly spend a few minutes doing the paperwork to save that much money for her family.



Take the time to plan ahead and pay for these expenses with tax-free FSA dollars. It can really pay off for your family.



FOR PHYSICAL HEALTH

Maintaining good physical health can make a big difference in your life. You'll have more energy, feel better and be more productive. Use the ABC Company benefits and tools to make sure you and your loved ones live a healthier lifestyle.



MEDICAL BENEFITS

PPO Contact: **BCBSM**
www.bcbsm.com, (800) 637-2227 (BCBSM)

HMO Contact: **BCN**
www.bcbsm.com, (800) 662-6667 (BCN)

For your cost information, see [page 33](#).

ABC Company will offer four Medical Plans in 2014, so you can select the plan that best meets the needs of you and your family. The plans are insured by Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network (BCN).

The BCN Healthy Blue Living— Plans 500, 1000 and 2000 are Health Maintenance Organization Plans (HMOs). These plans are only available to Michigan residents. Under these plans, you must select a participating Primary Care Physician (PCP) through whom all your care will be directed. You are required to obtain a referral from your Primary Care Physician in the event that you need to see a specialist. Females using these plans may select a PCP as well as an OB/GYN and are not required to obtain referrals for routine OB/GYN services. If you seek services from a physician or hospital outside of the network, no benefits will be payable (unless specified as an emergency). To find a Blue Care Network provider or to change your PCP, log on to www.bcbsm.com. Additionally, BCN Healthy Blue Living plans have special qualifications in order to maintain the highest level of benefit. *Please refer to pages 12-14 for details.*

The BCBS PPO Plan is provided through a Preferred Provider Organization (PPO), where a network of pre-selected hospitals and doctors are available for your use. This is a national plan and is available to all U.S. residents. If you use the network, you will receive the highest level of benefits offered by the plan. While the network is available, you are not required to use it. You always have the complete freedom to select any provider whenever you need care. However, the out-of-network benefits are lower and your out-of-pocket costs are higher. To find a BCBSM PPO provider online, visit www.bcbsm.com. If you use a non-participating provider, you may also be billed the difference between the approved amount and the provider's charge.

Requirements for Enhanced Benefits

MUST COMPLETE THESE STEPS OR BENEFITS ARE SIGNIFICANTLY REDUCED!

STEP ONE:

Initial Requirements

Each plan year, you (and your covered spouse) must meet initial requirements for enhanced benefits:

BCN health assessment: Complete an online health assessment at bcbsm.com each plan year. Members cannot have this measurement waived. **Deadline:** 90 days from the start of the plan year.

Qualification Form: Once you receive the form from BCN, visit your Blue Care Network primary care physician to complete the form. **Deadline:** 90 days from the start of the plan year.

Take a cotinine test to confirm that you do not smoke. Your doctor will conduct a blood or urine test. **Deadline:** 90 days from the start of the plan year.

STEP TWO:

Follow-up Requirements

After the first doctor visit, you (and your covered spouse) may have additional requirements such as actively participate in Quit the Nic until you complete the program and stop using tobacco or enroll in a BCN-sponsored weight management program (Weight Watchers or WalkingSpree's Pocket Pedometer program) until your BMI falls below 30.

Qualification Form shows how you measure up

Blue Care Network tracks the status of each health measure on the *Qualification Form* using A, B or C. You must score As and Bs to receive enhanced benefits.

Status:

- A. You are meeting the wellness target.
- B. Your health condition may not be controlled but you are actively participating in treatment to improve the condition.
- C. You are not meeting the wellness target and you have not committed to treatment or are not following it.



Important!

You may also have these requirements within 120 days from the start of the plan year:

Quit the Nic: If you smoke, enroll in our Quit the Nic smoking cessation program (1-800-811-1764).

Weight management: If your BMI is 30 or above, you must enroll in Weight Watchers or WalkingSpree's Pocket Pedometer program. BCN will pay for the program you choose.

FSA Payment and Reimbursement Options



- **Debit card:** With the Discovery Benefits debit card, you can pay at the point of purchase at pharmacies and many other authorized retailers and providers. If you enroll, a debit card will be sent to you automatically.
- **You pay upfront, and then receive reimbursement:**
 - Direct deposit to the bank account of your choice
 - Check mailed to you: Submit a reimbursement form and documentation for your expenses. Find claim forms at www.discoverybenefits.com.
- **Direct payment to provider:** You can set up direct online payment to your provider, which can be extremely convenient and a real timesaver – especially with dependent care.

Contact Discovery Benefits for more information on payment options: www.discoverybenefits.com

Always save your FSA receipts and documentation

If you use your debit card and the expense is not clearly identified as an eligible expense, Discovery Benefits may ask you to substantiate your claim with additional documentation such as an Explanation of Benefits or receipt.

You may also need this documentation in the future for IRS purposes. If you do not substantiate your claim when requested, your debit card may be temporarily suspended.

Here's What You Could Save

	Using FSA	Without FSA
Gross salary	\$30,000	\$30,000
Pre-tax expenses	\$1,000	\$0
Taxable salary	\$29,000	\$30,000
Taxes owed	\$6,568	\$6,795
Net Income	\$22,432	\$23,205
After-tax expenses	\$0	\$1,000
Spendable Income	\$22,432	\$22,205
SAVINGS	\$227	\$0

Note: Assumes 15% federal income tax and 7.65% Social Security tax. Based on your personal tax situation, your savings will vary.

Health Care FSA

The Health Care FSA allows you to use tax-free money to pay for your annual deductible, coinsurance, copays, prescription drugs, and other medical, vision and dental expenses not covered by your benefit plans.

You may deposit up to \$2,500 into the Health Care FSA for 2014. Claims for services provided January 1, 2014 through March 15, 2015 must be submitted for reimbursement by March 31, 2015.

Dependent Care FSA

This account helps you pay for eligible child care or adult care with tax-free dollars. Reimbursable expenses may include care and even elder care in or out of your home.

You may deposit up to \$5,000 into the Dependent Care FSA (combined with your spouse's FSA election if applicable). Claims for services provided January 1, 2014 through March 15, 2015 must be submitted for reimbursement by March 31, 2015.

WHAT ARE ELIGIBLE EXPENSES?

Find a list of eligible (and ineligible) expenses and worksheets at www.discoverybenefits.com



FOR FINANCIAL HEALTH

PRE-TAX PREMIUMS

To help minimize your employee contribution for your medical plan, we will continue to offer an IRC (Internal Revenue Code) Section 125 Premium Conversion Plan. This allows you to pay for your medical, dental and vision coverage on a pre-tax (before taxes) basis. As a result, your net take home pay will be higher than if contributions were deducted on a post-tax (after tax) basis.

Contributions taken on a pre-tax basis are not subject to federal or state income taxes or FICA taxes. The amount of savings depends on your individual contribution and tax bracket.

FLEXIBLE SPENDING ACCOUNTS



Contact: **Discovery Benefits,**
www.discoverybenefits.com, (866) 451-3399

Looking for a way to save money on health care and/or dependent care? These days, who isn't? Flexible Spending Accounts (FSAs) save you money by reducing the taxes you pay. Your FSA contributions are deducted from each paycheck before federal, FICA and, in most cases, state taxes are calculated. So in effect, you do not pay taxes on your eligible FSA expenses.

Here's How an FSA Works

- FSA contributions are taken from your paycheck on a pre-tax basis according to your annual elections.
- When you have an eligible health care or dependent care expense, you can pay for it with tax-free money (see payment options on **page 25**).
- The accounts are separate: you pay for health care expenses and dependent care expenses with separate accounts.
- You must make elections for both the health care and dependent care accounts to participate. Your current election amounts will not rollover in 2014. Claims for services provided January 1, 2013 through March 15, 2014 must be submitted for reimbursement by March 31, 2014.
- You must use up your elected amount before the end of the year or you forfeit your leftover money. Plan carefully and this shouldn't be a problem. Many participants underestimate and wish they had deposited more.



BCN HEALTHY BLUE LIVING

Healthy Blue Living Qualifications

Healthy Blue Living continues to reward members with lower out-of-pocket costs for living healthy lifestyles and making healthy choices. There are no changes to the Healthy Blue Living requirements to qualify for enhanced benefits during the 2014 plan year.

Remember, if you and your covered spouse do not meet all the requirements, everyone on your contract will be moved to the standard level.

Health Measure	Wellness target	If a member does not meet the wellness target, how can he or she work to qualify for enhanced benefits?
Tobacco use	Nonsmoker	<ul style="list-style-type: none"> • Enroll in Quit the Nic • Actively participate until you complete the program and stop using tobacco.
Weight	Body mass index below 30	If your BMI is 30 or above you must enroll in Weight Watchers® or WalkingSpree Pocket Pedometer™ program.
Blood pressure	Below 140/90	Commit to and follow doctor's treatment plan.
Cholesterol	LDL-C below target (based on risk factors)	Commit to and follow doctor's treatment plan.
Depression	Depression is in full remission	Commit to and follow doctor's treatment plan.
Blood sugar	At or below target	Commit to and follow doctor's treatment plan.

For more information, refer to the HBL Member Guide or visit www.bcbsm.com

Test for nicotine: Cotinine testing, which confirms the presence of nicotine in the body, will be required for all new and renewing members. Your doctor can do a blood or urine test during your office visit. To confirm that you no longer smoke, testing will be conducted annually after the first year for members who tested positive for nicotine, indicate they have recently stopped smoking or have completed the Quit the Nic program.

Weight management programs help you succeed: If your body mass index is 30 or greater, BCN will cover the cost of one of the following weight-loss programs: Weight Watchers® or the web-based WalkingSpree's Pocket Pedometer™ program with online reporting. Weight Watchers participation requires you to attend 11 out of 13 weekly meetings per session, while the WalkingSpree program requires you to walk a daily average of 5,000 steps per three month period. After you sign up, you'll need to actively participate in one of those programs until your BMI falls below 30. If you don't participate in the Weight Watchers or pedometer program, you will move to the standard benefit level.



Frequently Asked Questions

1.	How do I complete the Health Assessment (HA)?	<p>Both you and your spouse need to complete a BlueHealthConnection HA.</p> <ul style="list-style-type: none"> - The HA can be found on the BCN website: www.bcbsm.com - Log into "Member Secured Services". You will need to register if you have not already done so. Your current identification card has all the information you will need to do this. - Click on the "BlueHealthConnection" link - From the "I Want" drop-down menu, select "Take a Health Risk Appraisal". - Complete the information requested (about 50 questions) and submit it. - After clicking "Submit", your certificate of completion will appear. You will see an overall wellness score and a report on what you're doing well and what you can do better. - Print the report for your records - This takes about 10 minutes to complete
2.	Where do I get the Qualification Form?	The Qualification Form will be sent to you by BCN after the enrollment process is completed.
3.	What if I don't complete my Qualification Form?	Employees who don't follow through on having their doctor submit the signed form within 90 days and/or don't commit to actively work toward their health goals will qualify for the Standard Plan and will pay more when they need
4.	What if my spouse does not want to work toward health goals?	Both adults on a contract have to qualify for the Enhanced Plan. Once they qualify, everyone on the contract, including dependent children, receive the Enhanced Plan.
5.	What happens if my spouse or I do not fill out the Health Assessment or have our doctor complete the Qualification Form?	If you both do not complete the Health Risk Assessment and/or visit your PCP and complete the qualification form you and your family will be moved down to the Standard Plan 90 days after the beginning of the Plan Year.
6.	What happens if I get married and enroll my spouse after enrollment?	Your spouse will adopt the same level of coverage as you until the following renewal period. At renewal time you and your enrolled spouse need to complete the steps again to qualify for the Enhanced Plan.
7.	What happens when my coverage is renewed next year?	This year and at future renewals, you and your spouse will remain in your existing plan for 90 days (Enhanced or Standard). You will both need to complete the Health Assessment, Qualification Form through your PCP and actively maintain a healthy lifestyle to maintain or increase your benefit coverage to the Enhanced Plan after the first 90 days of the Plan Year.



VOLUNTARY VISION PLAN

Contact: NVA
www.e-nva.com, (800) 672-7723
 For your cost information, see page 33.

The Vision plan provides coverage for eye exams, and glasses or contacts. You pay just a \$10 copayment for a network eye exam. Materials are paid up to certain limits (see chart below for details). To receive the highest coverage, you should see a network provider. Reimbursement is provided for out-of-network services according to the schedule below. If you are a new member, NVA provides ID cards in your welcome packet.

VISION PLAN COVERAGE

	Network Member Cost	Out-of-Network Reimbursement
Network Information	NVA network: Includes some private practice practitioners and national chains such as Wal-Mart and Sam's Club	For a provider not in the NVA network, the plan reimburses up to the amount shown below
Exam (covered once every calendar year)	\$10 copay	\$35
Eyeglass lenses	Once every calendar year	
Single vision	\$25 copay (one copay for lenses & frames)	\$25
Bifocal	\$25 copay (one copay for lenses & frames)	\$40
Trifocal	\$25 copay (one copay for lenses & frames)	\$55
Lenticular	\$25 copay (one copay for lenses & frames)	\$80
Progressive Lenses Standard	Up to \$50	n/a
UV treatment	Up to \$12	n/a
Standard Tint	Up to \$10	n/a
Standard plastic scratch	Up to \$10	n/a
Standard polycarbonate (Single Vision)	Up to \$25 (19 & over)	n/a
Standard polycarbonate (Multi-Focal)	Up to \$30 (19 & older)	n/a
Standard anti-reflective coating	Up to \$40	n/a
Frames (covered once every two calendar years)	\$120 allowance; 20% off balance over \$120	\$45
Contact lenses	Choose eyeglasses OR contacts once every calendar year	
Medically necessary	Covered in full	\$210
Elective: Conventional	\$120 allowance; 15% off balance over \$120	\$105
Elective: Disposable	\$120 allowance; 10% off balance over \$120	\$105
Fitting and follow-up	Included in \$120 allowance	Included in \$105 reimbursement

VOLUNTARY DENTAL PLAN

Contact: Delta Dental,
www.deltadentalmi.com, (800) 524-0149
 For your cost information, see page 33.



If you think having your teeth cleaned twice a year is painful, consider the alternatives — for example, would you rather have a routine cleaning or an invasive root canal? While going to the dentist isn't on anyone's list of favorite things to do, ABC Company dental benefits make it as painless as possible.

The Dental plan covers 100% of preventive care services. You pay a percentage of costs for the other types of dental care you receive. The percentage you pay depends on the type of care: Preventive, Basic, Major or Orthodontia.

Dental Benefits	You Pay
Preventive/Diagnostic (No deductible) (Ex. Oral Exams, X-Rays, Teeth Cleaning, Fluoride Treatment)	0%
Annual deductible	\$50 per person (In-Network) \$150 per family (In-Network) \$75 per person (Out-of-Network) \$225 per family (Out-of-Network)
Basic (Ex. Fillings, Crowns, Bridges, Root Canal, Extractions)	20% after deductible
Major (Ex. Removable Dentures & Partials, Fixed Bridges)	50% after deductible
Annual benefit maximum	\$1,000 per member
Orthodontia	50%
<ul style="list-style-type: none"> For children age 19 or younger when treatment begins Lifetime maximum of \$1,000 per member 	

VISIT ANY DENTIST YOU CHOOSE

Your costs will typically be lower if you choose a dentist in the **Delta Dental PPO or Premier network**, as shown below. Search for network providers at www.deltadentalmi.com

PPO Network	Premier Network	Out-of-Network
These dentists have agreed to a reduced fee schedule	These dentists have agreed to charge no more than the maximum allowed by Delta Dental	These dentists may charge above the maximum allowed by Delta Dental
Typically the lowest cost option	Likely more than a PPO dentist but less than out-of-network	You pay the dentist a percentage of eligible expenses and the entire amount above the plan's reimbursement level

If you see a network dentist, you can simply tell your provider you're a Delta Dental member and they will take care of the paperwork for your visit, no ID card is needed to confirm eligibility. If your out-of-network dentist requires you to pay upfront for services, you will need to submit a claim form for reimbursement for covered amounts. You can find claim forms on deltadentalmi.com. Follow the instructions on the form to have your claim paid.

MEDICAL PLAN HIGHLIGHTS (HMO)



	BCN Healthy Blue Living HMO 500		BCN Healthy Blue Living HMO 1000		BCN Healthy Blue Living HMO Plan 2000	
	Enhanced	Standard	Enhanced	Standard	Enhanced	Standard
Annual deductible	\$500 per person \$1,000 per family	\$2,000 per person \$4,000 per family	\$1,000 per person \$2,000 per family	\$3,000 per person \$6,000 per family	\$2,000 per person \$4,000 per family	\$4,000 per person \$8,000 per family
Coinsurance (you pay)	20%	30%	20%	30%	20%	30%
Annual out-of-pocket maximum (applies to deductibles, copays and coinsurance amounts for all covered services including Rx)	\$2,500 per person \$5,000 per family	\$4,000 per person \$8,000 per family	\$3,500 per person \$7,000 per family	\$6,350 per person \$12,700 per family	\$4,500 per person \$9,000 per family	\$6,350 per person \$12,700 per family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Office visit	<ul style="list-style-type: none"> \$20 copay for primary care physician \$20 copay after deductible for specialist 20%-50% other services after deductible 	<ul style="list-style-type: none"> \$20 copay for primary care physician \$20 copay after deductible for specialist 30%-50% other services after deductible 	<ul style="list-style-type: none"> \$25 copay for primary care physician \$35 copay after deductible for specialist 20%-50% other services after deductible 	<ul style="list-style-type: none"> \$30 copay for primary care physician \$40 copay after deductible for specialist 30%-50% other services after deductible 	<ul style="list-style-type: none"> \$30 copay for primary care physician \$40 copay after deductible for specialist 20%-50% other services after deductible 	<ul style="list-style-type: none"> \$35 copay for primary care physician \$45 copay after deductible for specialist 30%-50% other services after deductible
Preventive care	100% no deductible					
Inpatient hospital services (pre-authorization required)	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Emergency room Non-emergency visits Are not covered	\$75 copay after deductible	\$100 copay after deductible	\$100 copay after deductible	\$150 copay after deductible	\$150 copay after deductible	\$250 copay after deductible
Urgent Care	\$35 copay	\$50 copay	\$35 copay	\$50 copay	\$50 copay	\$60 copay
Therapy services (outpatient physical, Occupational and speech)	\$20 copay after deductible, 60 consecutive days/episode	\$20 copay after deductible, 60 consecutive days/episode	\$35 copay after deductible, 60 consecutive days/episode	\$40 copay after deductible, 60 consecutive days/episode	\$40 copay after deductible, 60 consecutive days/episode	\$45 copay after deductible, 60 consecutive day/episode
Mental health and Substance abuse treatment	<ul style="list-style-type: none"> \$20 copay after deductible for office visits 20% for other services, after deductible 	<ul style="list-style-type: none"> \$20 copay after deductible for office visits 30% for other services, after deductible 	<ul style="list-style-type: none"> \$25 copay after deductible for office visits 20% for other services, after deductible 	<ul style="list-style-type: none"> \$30 copay after deductible for office visits 30% for other services, after deductible 	<ul style="list-style-type: none"> \$30 copay after deductible for office visits 20% for other services, after deductible 	<ul style="list-style-type: none"> \$35 copay after deductible for office visits 30% for other services, after deductible

MEDICAL PLAN HIGHLIGHTS (PPO)

	BCBSM PPO	
	In Network	Out-of-Network
Annual deductible	\$500 per person \$1,000 per family	\$1,000 per person \$2,000 per family
Coinsurance (you pay)	25%	50%
Annual out-of-pocket maximum (applies to deductibles, copays and coinsurance amounts for all covered services including Rx)	\$3,000 per person \$6,000 per family	\$6,000 per person \$12,000 per family
Lifetime Maximum Benefit	Unlimited	Unlimited
Office visit	\$20 copay	50% after deductible
Preventive care	100% no deductible	Not Covered
Inpatient hospital services (pre-authorization required)	25% after deductible	50% after deductible
Emergency room Non-emergency visits Are not covered	\$100 copay	\$100 copay
Urgent Care	\$20 copay	50% after deductible
Therapy services (outpatient physical, Occupational and speech)	25% after deductible	50% after deductible
Mental health and Substance abuse treatment	25% after deductible	25% after deductible



PRESCRIPTION DRUG HIGHLIGHTS

Contact: Express Scripts
www.express-scripts.com, (800) 778-0735

Whether you choose the **PPO or HMO** medical plan, prescription drug coverage is also included. Your cost for a prescription depends on the type of drug you receive and where you obtain it (see the chart below). Prescriptions can be filled at any participating Express Scripts pharmacy, which includes most major chains and independent pharmacies. **For your convenience, you can use the mail-order service to order long-term prescriptions.**

Type of Drug	BCN HMO Plans		BCBSM PPO Plan
	Enhanced	Standard	
Generic	You pay \$10 copay	50% (\$5 min/\$100 max)	You pay \$15 copay
Preferred Brand	You pay \$40 copay	50% (\$5 min/\$100 max)	You pay \$50 copay
Non-Preferred Brand	Prior Authorization Required. If approved, you pay \$40 copay.	50% (\$5 min/\$100 max)	50% (\$70 min/\$100 max)
Contraceptives	Generic—100% Coverage		Generic—100% Coverage



To Find Approved Brands

You can find the BCBSM or BCN list of Preferred Brand name prescriptions by visiting www.bcbsm.com.

How to Save Money

Prescription drugs can be quite expensive, especially if you have one or more prescriptions for a long-term condition. There are several ways to save on prescription costs by understanding how the ABC Company prescription drug benefits work. The following are a few helpful hints.

- Generic drugs are the cheapest alternative. Ask your doctor if there is a generic option every time you are given a prescription.
- If a generic is not yet available, ask your doctor to prescribe a medication on the BCBSM Preferred Brand name list.
- For all long-term medications — generic or brand — use the mail-order program. Your prescription will be mailed directly to you. Download a mail-order service benefit brochure and order form at www.express-scripts.com
- Use the FSA health care account to pay for your out-of-pocket **prescription** expenses with tax-free money. You must enroll to take advantage of this benefit.

Step Therapy / Pre-Authorization

There is a certain list of prescription medications that will require a Step Therapy / Pre-Authorization process. If you are prescribed a medication on the step therapy list, your physician will need to satisfy a pre-authorization process before the drug will be approved.

For example, there are many prescription drugs on the market that help lower cholesterol. If you are prescribed a cholesterol drug that is a non-preferred medication, and it's the first time you've filled this type of prescription, it's likely that BCBSM or BCN will ask your doctor to pre-authorize this request. You may need to try a prescription that is in the generic or preferred brand category before BCBSM or BCN will allow you fill a non-preferred brand name prescription. This list is posted on ADP Self Service Portal.



Mail Order Prescriptions

If you are a member taking medication on a regular basis, you can purchase your prescriptions through Express Scripts. The advantage of this service is that you receive a 90-day supply of your medication, if authorized by your doctor, and you pay **2x your generic or brand copay** for each 90-day supply of your prescription or refill. Your medication is delivered to your home, postage-paid, within 10-14 days from the date you mailed your order.



Generic drugs are essentially the same as the brand-name drug in safety, strength, quality, performance and intended use. They also meet the same strict approval process by the Food and Drug Administration (FDA). But because generic drug manufacturers do not have expensive research and advertising costs, they can produce a drug for a fraction of the brand-name cost.



Save money while you stay healthy!

With our Healthy Blue Xtras savings program, you can access special member discounts on a variety of healthy products and services from companies across Michigan and businesses from around the U.S. through Blue365, our national savings program. You can even find coupons from well-known brands that you can print and use at your local retailer. Here is how it works:

Two ways to save
The health and wellness deals, designed just for you, will help you save on all you need to keep fit. Even better? You'll have access to two types of good-for-you deals: standing discounts (which you can redeem anytime you like) and exclusive, limited-time offers designed for living well – right in the moment.

Sign up for no-fuss emails
You'll be the first to know about the latest deals from Blue365. You won't get any spam and you'll only get one e-mail per week.

Choose the way you'd like to save
You can take advantage of most of the deals right on the Blue365 site. Some of the deals will direct you to healthy-living Vendors' websites, where you can apply coupons to your purchases. Either way, your savings are just a few clicks away.

Save locally or nationally
Besides great discounts on health and wellness offers around the country, you get the chance to save on brands and programs right in your area. (Because it's nice to have options.)

Earn your rewards
For each Blue Cross Blue Shield member you get to sign up for Blue 365, you'll earn \$10 to spend on a future offer, after the friend you've recommended purchases a deal.



Here are just a few samples of our Healthy Blue Xtras and Blue365 partners. Visit bcbsm.com/xtras to view all of our offers and find out how to redeem them.

Local Offers:



National Offers:

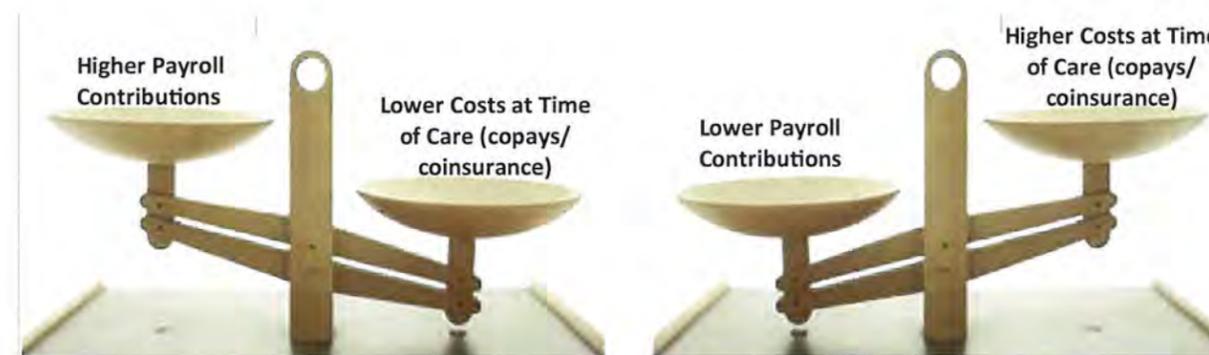


CHOOSING A HEALTH PLAN

When deciding which medical plan is right for you, it is important to look at your budget. For example, think about other insurance decisions you make. You likely think about:

- What level of coverage you need.
- How much the coverage costs.
- What you can afford.
- Whether you want to pay more up-front (through premiums) or at the time, if and when, you require the coverage (deductible and coinsurance.)

Typically, the more you pay up-front toward your premium (fixed costs), the lower your deductible requirement (variable costs)-meaning the less you pay if you need to make a claim. The same goes for your health coverage.



Higher Payroll Contributions

- Willing to pay more up-front through your paycheck so you can meet a lower deductible and can pay less at the time of care (copays and coinsurance).
- By paying up-front, you risk paying for care you won't use (the money comes out of your check whether or not you are healthy or sick; it's considered a "fixed cost").
- Out-of-pocket costs tend to be more predictable due to pre-set copays.

If this describes you, consider the BCN HBL 500 or BCBSM PPO Plan.

Lower Payroll Contributions

- Prefer to pay less up-front through your paycheck and pay more if, and when, you need to meet the deductible; or when you need care.
- Don't like to pay for care you may not end up using? The money saved in payroll deductions can be set aside to help pay for the deductible or copays if needed.

If you anticipate your healthcare costs to be on the lower side, the BCN HBL 1000 and BCN HBL 2000 are likely to meet your needs.

CHOOSING A HEALTH PLAN EXAMPLE



Example — Susan

Susan has family coverage for herself and her 2 children. She and her children tend to incur high medical expenses each year. Her annual expenses, including covered services and payroll deductions would look like this:

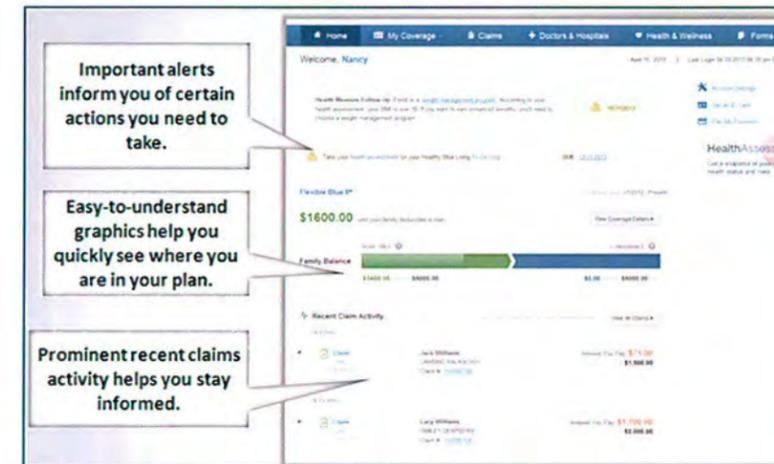
	CHARGES	BCN HBL 500	BCN HBL 1000	BCN HBL 2000
Hospital and Surgery Bill for Susan	\$21,000			
Deductible		\$500	\$1,000	\$2,000
Co-Insurance		\$2,000	\$2,500	\$2,500
3 Follow-up Visits for Susan	\$300	\$0	\$0	\$0
3 Generic Prescriptions for Susan	\$300	\$0	\$0	\$0
Office Visit (due to illness) for Child #1	\$100	\$20	\$25	\$30
Emergency Room Visit for Child #1	\$600	\$520	\$600	\$600
Preventive Office Visits for Children #1	\$600	\$0	\$0	\$0
Annual Payroll Deducted Premiums		\$6,586	\$4,560	\$3,313
Annual Plan Expenses		\$3,040	\$4,125	\$5,130
TOTAL		\$9,626	\$8,685	\$8,443

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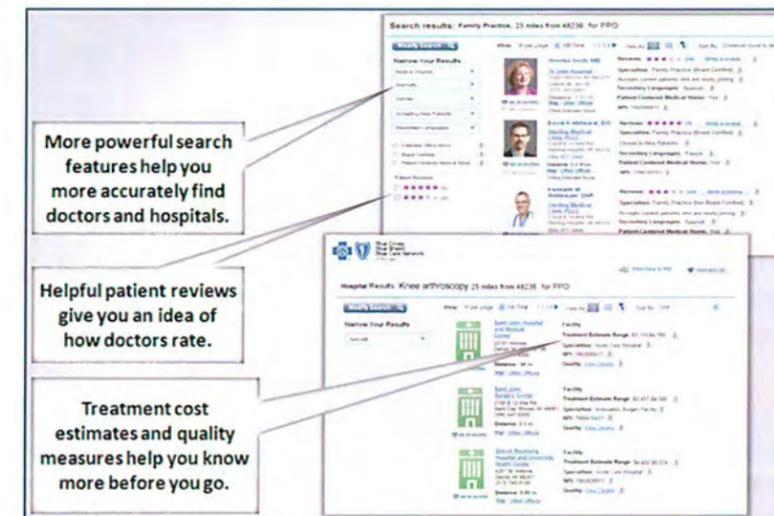


BCBSM offers a new, improved, and easy to use portal to be your single entry point for all of your benefit plan needs. Transparent in its nature, *bcbsm.com* empowers you to be engaged in every aspect of your personalized benefit plan. With the new member site, you will have access to:



One Site. One Stop.

- **Personal snapshot of your plan:** Check out easy-to-understand graphics that provide a quick snapshot of your deductibles, coinsurance and claims.
- **Single user ID for life:** Once registered, your personal ID stays with you, even if you switch plans, change jobs or retire.
- **Access to all Blue plans:** Members who have Blues medical, dental or vision coverage, can access plan information at a single site.



The power to compare

- **Powerful search capabilities:** We've added more search and filtering functionality, so you can find the doctors and hospitals that you prefer.
- **Extensive cost and quality comparisons:** Evaluate up to six doctors or hospitals side-by-side, comparing quality and costs for hundreds of services across the country.
- **Helpful patient reviews:** You can read reviews about specific doctors from other patients and even leave a review of your own.

On the go. Good to go.

- **24/7 Access:** With your mobile device, you have another way to access important plan information when you need it most, 24 hours a day, seven days a week.
- **On-the-spot doctor and hospital search:** Make decisions on where to go, when you're on the go.
- **Virtual ID card:** You can now access your virtual ID card right from your mobile device.

*Not all online information is available on mobile devices



Demographics

Category	Current	Prior 1	Prior 2
Average # of Enrolled Employees	152	152	152
Average Family Size	2.24	2.24	2.24
Average Member Age	37.8	37.8	37.8
% of Total Members that are Male	53.3%	53.3%	53.3%
Population Ratio to Benchmark (Avg. = 1.0)	1.17	1.17	1.17

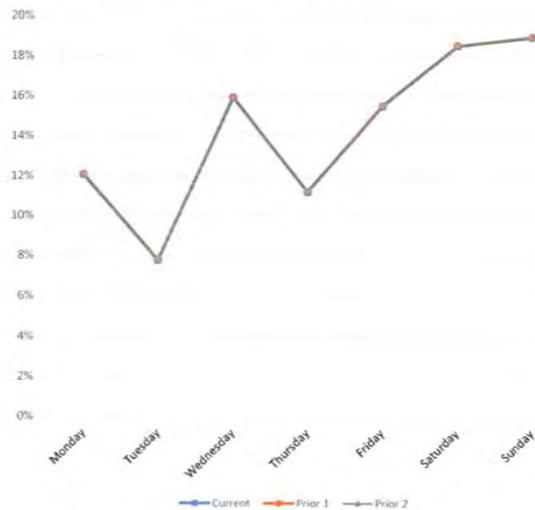
Preventive Screenings (Excluding Wellness Exams)

Category	Current	Prior 1	Prior 2
Total Unique Members	385	385	385
Total Unique Screened Participants	137	137	137
Overall Percentage of Screened Members	35.6%	35.6%	35.6%
Total Cost of Screenings	\$43,011	\$43,011	\$43,011
Total Screening Cost per Screened Member	\$314	\$314	\$314
Total Med and Rx Cost per Screened Member	\$5,902	\$5,902	\$5,902
Total Group Med and Rx Cost per all Members	\$3,569	\$3,569	\$3,569

of ER Visits by Day of Week

Day	Current	Prior 1	Prior 2
Monday	28	28	28
Tuesday	18	18	18
Wednesday	37	37	37
Thursday	26	26	26
Friday	36	36	36
Saturday	43	43	43
Sunday	44	44	44
Total	232	232	232

ER Visits by Day of Week



Utilization

Category	Current	Prior 1	Prior 2	Benchmark
Admissions per 1,000	55	55	55	49
Avg. Length of Stay	2.50	2.50	2.50	3.88
Cost per Inpatient Day	\$4,049	\$4,049	\$4,049	\$3,971
ER visits per 1,000	100	100	100	142
Cost per ER Visit	\$1,881	\$1,881	\$1,881	\$1,259
OP surgeries per 1,000	118	118	118	79
Cost per OP surgery	\$3,068	\$3,068	\$3,068	\$3,716
PCP Visits per 1,000	758	758	758	1,127
Spec. Visits per 1,000	2,228	2,228	2,228	1,253
Prev. Visits per 1,000	464	464	464	334
PT Visits per 1,000	5,803	5,803	5,803	1,311
MH Visits per 1,000	907	907	907	277
Chiro Visits per 1,000	1,571	1,571	1,571	489
Lab/Path Svcs per 1,000	5,865	5,865	5,865	3,776
Radiology Svcs per 1,000	1,114	1,114	1,114	984

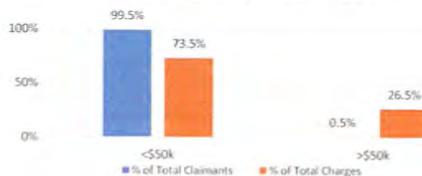
Top 5 Facilities by Paid Claims

Facility Name	Claims Paid	Admits
DELNOR COMMUNITY HOSPITAL	\$53,379	6
COPLEY MEMORIAL HOSPITAL	\$41,731	1
CHILDRENS HOSPITAL	\$25,100	4
ADVOCATE SHERMAN HOSPITAL	\$15,769	3
VALLEY WEST COMMUNITY HOSPITAL	\$15,305	2

Inpatient Utilization by Type of Admit

Category	Current	Prior 1	Prior 2	Benchmark
MEDICAL				
Admissions per 1,000	24	24	24	20
Cost per Inpatient Day	\$2,437	\$2,437	\$2,437	\$3,182
SURGICAL				
Admissions per 1,000	14	14	14	18
Cost per Inpatient Day	\$7,096	\$7,096	\$7,096	\$5,897
MATERNITY				
Admissions per 1,000	10	10	10	10
Cost per Inpatient Day	\$3,689	\$3,689	\$3,689	\$2,545

% of Claimants Above \$50k



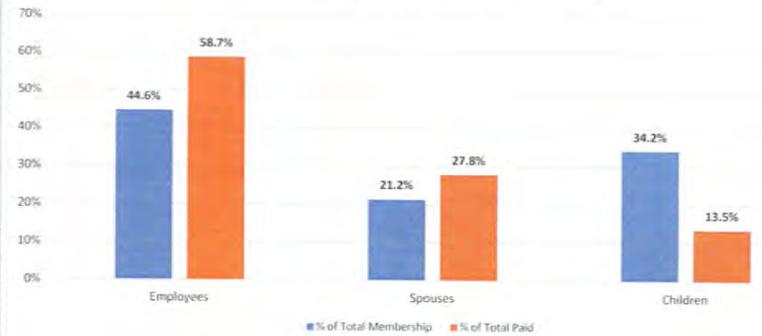
Top 5 ER Diagnoses by Paid Claims

Code Description	Unique Members	Visits	Services	Paid Amount
789.03 : ABDOMINAL PAIN RIGHT LOWER QUADRANT	2	2	32	\$8,448
816.12 : OPEN FRACTURE DISTAL PHALANX OR PHALANGES HAND	1	1	6	\$6,698
831.01 : CLOSED ANTERIOR DISLOCATION OF HUMERUS	2	2	10	\$5,825
780.79 : OTHER MALAISE AND FATIGUE	3	3	28	\$5,590
977.9 : POISONING UNSPECIFIED DRUG/MEDICINAL SUBSTANCE	1	1	39	\$4,596

Membership and Claims by Member Type

Category	Employees	Spouses	Children	Total Members
Member Months	1,819	866	1,397	4,082
% of Total Membership	44.6%	21.2%	34.2%	100.0%
Total Paid	\$806,517	\$381,725	\$186,003	\$1,374,245
% of Total Paid	58.7%	27.8%	13.5%	100.0%
Paid PMPM	\$443	\$441	\$133	\$337

% of Membership and Claims by Member Type



Eligible Charge Range

Eligible Charge Range	Eligible Charges	% of Total Charges	Number of Claimants	% of Total Claimants
\$0 - No Claims	\$0	0.0%	734	25.2%
\$1 - \$499	\$204,903	3.4%	929	31.8%
\$500 - \$999	\$283,687	4.7%	393	13.5%
\$1,000 - \$2,499	\$683,825	11.2%	425	14.6%
\$2,500 - \$4,999	\$747,619	12.3%	214	7.3%
\$5,000 - \$7,499	\$425,820	7.0%	69	2.4%
\$7,500 - \$9,999	\$386,215	6.4%	45	1.5%
\$10,000 - \$19,999	\$928,316	15.3%	67	2.3%
\$20,000 - \$49,999	\$809,999	13.3%	26	0.9%
\$50,000 - \$99,999	\$766,005	12.6%	11	0.4%
\$100,000 - \$249,999	\$422,040	6.9%	3	0.1%
\$250,000 - \$499,999	\$422,539	6.9%	1	0.0%
\$500,000+	\$0	0.0%	0	0.0%
Total	\$6,080,967	100.0%	2,917	100.0%

Current: Paid 7/1/2013 - 6/30/2014
Prior 1: Paid 7/1/2013 - 6/30/2014

Top 5 ER Diagn - Paid Claims

Code Description	Current				Code Description	Prior			
	Unique Members	Visits	Services	Paid Amount		Unique Members	Visits	Services	Paid Amount
789.03 : ABDOMINAL PAIN RIGHT LOWER QUADRANT	2	2	32	\$8,448	789.03 : ABDOMINAL PAIN RIGHT LOWER QUADRANT	2	2	32	\$8,448
816.12 : OPEN FRACTURE DISTAL PHALANX OR PHALANGES HAND	1	1	6	\$6,698	816.12 : OPEN FRACTURE DISTAL PHALANX OR PHALANGES HAND	1	1	6	\$6,698
831.01 : CLOSED ANTERIOR DISLOCATION OF HUMERUS	2	2	10	\$5,825	831.01 : CLOSED ANTERIOR DISLOCATION OF HUMERUS	2	2	10	\$5,825
780.79 : OTHER MALAISE AND FATIGUE	3	3	28	\$5,590	780.79 : OTHER MALAISE AND FATIGUE	3	3	28	\$5,590
977.9 : POISONING UNSPECIFIED DRUG/MEDICINAL SUBSTANCE	1	1	39	\$4,596	977.9 : POISONING UNSPECIFIED DRUG/MEDICINAL SUBSTANCE	1	1	39	\$4,596

Membership and Claims by Member Type

Category	Current				Category	Prior			
	Employees	Spouses	Children	Total Members		Employees	Spouses	Children	Total Members
Member Months	1,819	866	1,397	4,082	Member Months	1,819	866	1,397	4,082
% of Total Membership	44.6%	21.2%	34.2%	100.0%	% of Total Membership	44.6%	21.2%	34.2%	100.0%
Total Paid	\$806,517	\$381,725	\$186,003	\$1,374,245	Total Paid	\$806,517	\$381,725	\$186,003	\$1,374,245
% of Total Paid	58.7%	27.8%	13.5%	100.0%	% of Total Paid	58.7%	27.8%	13.5%	100.0%
Paid PMPM	\$443	\$441	\$133	\$337	Paid PMPM	\$443	\$441	\$133	\$337

Eligible Charge Range

Eligible Charge Range	Current				Eligible Charge Range	Prior			
	Eligible Charges	% of Total Charges	Number of Claimants	% of Total Claimants		Eligible Charges	% of Total Charges	Number of Claimants	% of Total Claimants
\$0 - No Claims	\$0	0.0%	734	25.2%	\$0 - No Claims	\$0	0.0%	734	25.2%
\$1 - \$499	\$204,903	3.4%	929	31.8%	\$1 - \$499	\$204,903	3.4%	929	31.8%
\$500 - \$999	\$283,687	4.7%	393	13.5%	\$500 - \$999	\$283,687	4.7%	393	13.5%
\$1,000 - \$2,499	\$683,825	11.2%	425	14.6%	\$1,000 - \$2,499	\$683,825	11.2%	425	14.6%
\$2,500 - \$4,999	\$747,619	12.3%	214	7.3%	\$2,500 - \$4,999	\$747,619	12.3%	214	7.3%
\$5,000 - \$7,499	\$425,820	7.0%	69	2.4%	\$5,000 - \$7,499	\$425,820	7.0%	69	2.4%
\$7,500 - \$9,999	\$386,215	6.4%	45	1.5%	\$7,500 - \$9,999	\$386,215	6.4%	45	1.5%
\$10,000 - \$19,999	\$928,316	15.3%	67	2.3%	\$10,000 - \$19,999	\$928,316	15.3%	67	2.3%
\$20,000 - \$49,999	\$809,999	13.3%	26	0.9%	\$20,000 - \$49,999	\$809,999	13.3%	26	0.9%
\$50,000 - \$99,999	\$766,005	12.6%	11	0.4%	\$50,000 - \$99,999	\$766,005	12.6%	11	0.4%
\$100,000 - \$249,999	\$422,040	6.9%	3	0.1%	\$100,000 - \$249,999	\$422,040	6.9%	3	0.1%
\$250,000 - \$499,999	\$422,539	6.9%	1	0.0%	\$250,000 - \$499,999	\$422,539	6.9%	1	0.0%
\$500,000+	\$0	0.0%	0	0.0%	\$500,000+	\$0	0.0%	0	0.0%
Total	\$6,080,967	100.0%	2,917	100.0%	Total	\$6,080,967	100.0%	2,917	100.0%

Top 5 Facilities by Paid Claims

Facility Name	Current		Facility Name	Prior	
	Claims Paid	Admits		Claims Paid	Admits
DELNOR COMMUNITY HOSPITAL	\$53,379	6	DELNOR COMMUNITY HOSPITAL	\$53,379	6
COPLEY MEMORIAL HOSPITAL	\$41,731	1	COPLEY MEMORIAL HOSPITAL	\$41,731	1
CHILDRENS HOSPITAL	\$25,100	4	CHILDRENS HOSPITAL	\$25,100	4
ADVOCATE SHERMAN HOSPITAL	\$15,769	3	ADVOCATE SHERMAN HOSPITAL	\$15,769	3
VALLEY WEST COMMUNITY HOSPITAL	\$15,305	2	VALLEY WEST COMMUNITY HOSPITAL	\$15,305	2

Network Utilization

Service Location	Current				Service Location	Prior			
	Eligible Charges	% of Total Eligible	Discounts	Discount %		Eligible Charges	% of Total Eligible	Discounts	Discount %
In-Network	\$1,000,000	90.9%	\$550,000	55.0%	In-Network	\$1,000,000	90.9%	\$550,000	55.0%
Out-Of-Network	\$100,000	9.1%	\$5,000	5.0%	Out-Of-Network	\$100,000	9.1%	\$5,000	5.0%
Total	\$1,100,000	100.0%	\$555,000	50.5%	Total	\$1,100,000	100.0%	\$555,000	50.5%

Top 10 Clinical Categories by Claim Dollars

Detailed Clinical Categorization Description	Analysis Period Claimants	% of Total Claimants	Analysis Period Claims	% of Total Claims	Prior Year Rank
Healthy Claimant	2,128	53.2%	\$2,260,504	23.5%	1
Pancreatic Malignancy Level - 2	1	0.0%	\$383,018	4.0%	2
1 Significant Acute Illness Excluding ENT	124	3.1%	\$272,313	2.8%	3
Hodgkin's Lymphoma Level - 3	1	0.0%	\$255,099	2.7%	4
Cerebrovascular Disease with Infarction or Intracranial	1	0.0%	\$236,317	2.5%	5
Breast Malignancy Level - 2 (Single Dominant or Moderate	3	0.1%	\$218,414	2.3%	6
One Other Dominant Chronic Disease and One or More	3	0.1%	\$217,522	2.3%	7
1 Significant Acute Illness - Span 90 Excluding ENT	57	1.4%	\$203,172	2.1%	8
Two Other Moderate Chronic Diseases Level - 6	1	0.0%	\$196,068	2.0%	9
Dialysis without Diabetes Level - 1	2	0.1%	\$184,129	1.9%	10

Top 10 Clinical Categories by Health Risk Index

Clinical Category Description	Prior 2	Prior 1	Current	Prospective
Malignancies - Metastatic, Dominant or Complicated	16.8837	16.8837	16.8837	10.5110
Malignancies with Other Chronic Disease	6.7978	6.7978	6.7978	3.8851
Two Other Chronic Diseases - Both Dominant	4.6965	4.6965	4.6965	3.6635
Mental Illness or Substance Abuse with Other Chronic Disease	4.5853	4.5853	4.5853	3.5039
Two Other Chronic Diseases - One Dominant	4.5229	4.5229	4.5229	3.7973
Neurological Disease - Dominant or Moderate	3.4923	3.4923	3.4923	2.4751
Malignancies - Non-Metastatic	2.9264	2.9264	2.9264	2.6184
Two Other Chronic Diseases - at Least One Moderate	2.5849	2.5849	2.5849	2.1116
Diabetes with HTN or Other Chronic Disease	1.8169	1.8169	1.8169	2.0516
Mental Illness or Substance Abuse - Dominant or Moderate	1.7583	1.7583	1.7583	1.5814
Total Health Risk Index	0.9971	0.9971	0.9971	1.0067

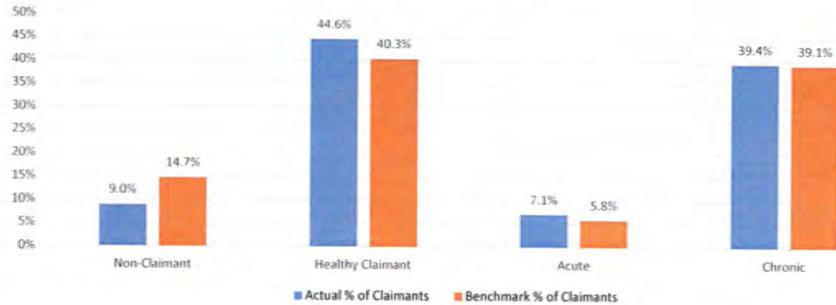
Health Risk Index by Type of Claimant

Clinical Category Description	# of Claimants	Actual % of Claimants	Benchmark % of Claimants	% of Total Claim Cost	Retrospective HRI	Prospective HRI
Non-Claimant	136	9.0%	14.7%	0.0%	0.0000	0.3108
Healthy Claimant	676	44.6%	40.3%	16.0%	0.2811	0.4476
Acute	107	7.1%	5.8%	5.2%	0.7945	0.7182
Chronic	598	39.4%	39.1%	78.8%	1.9815	1.6903
Total	1,517	100.0%	100.0%	100.0%	0.9624	0.9443

Health Risk Index



% of Claimants by Type of Claimant



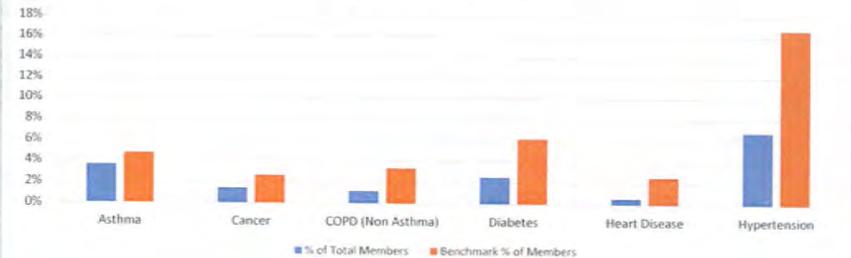
Disease Management

Chronic Condition	DM Members	% of Non-Healthy Claimants	% of Total Members	Benchmark % of Members
Asthma	98	8.1%	3.6%	4.8%
Cancer	39	3.2%	1.4%	2.6%
COPD (Non Asthma)	33	2.7%	1.2%	3.4%
Diabetes	69	5.7%	2.6%	6.2%
Heart Disease	16	1.3%	0.6%	2.6%
Hypertension	186	15.3%	6.9%	16.7%

Top 5 Disease Categories by Ratio of Actual to Expected

Clinical Category Description	Number of Claimants	Actual % of Non Healthy Claimants	Expected % of Non Healthy Claimants	Ratio of Actual to Expected
Congenital Quadriplegia, Spina Bifida, Muscular Dystrophy or Cystic Fibrosis	1	0.9%	0.1%	9.82
History of Two or More Significant Acute Non-ENT Illnesses from Different MDCs	3	2.8%	0.8%	3.51
Mental Illness or Substance Abuse - Dominant or Moderate	4	3.7%	1.1%	3.38
Mental Illness or Substance Abuse with Other Chronic Disease	3	2.8%	1.0%	2.72
History of Significant Acute Procedure	3	2.8%	1.0%	2.71

Disease Management



Current: Paid 07/01/2013 to 06/30/2014
Prior 1: Paid 07/01/2012 to 06/30/2013

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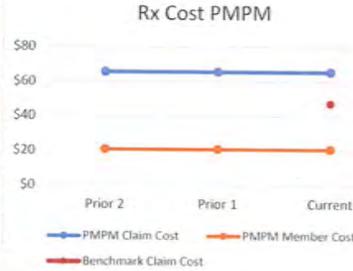
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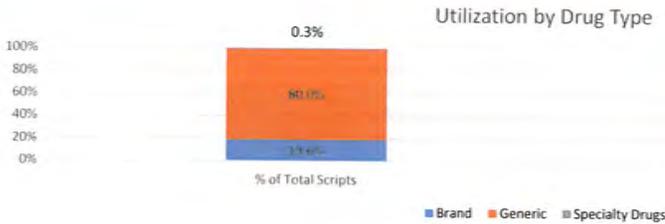
Utilization Summary

Category	Current	Prior 1	Prior 2	Benchmark
# of Prescriptions per 1,000 Members	937	937	937	780
Average Cost per Prescription	\$95.04	\$95.04	\$95.04	\$60.09
PMPM Claim Cost	\$65.63	\$65.63	\$65.63	\$47.05
PMPM Member OOP Cost	\$20.78	\$20.78	\$20.78	
Generic Dispensing Rate	80.0%	80.0%	80.0%	



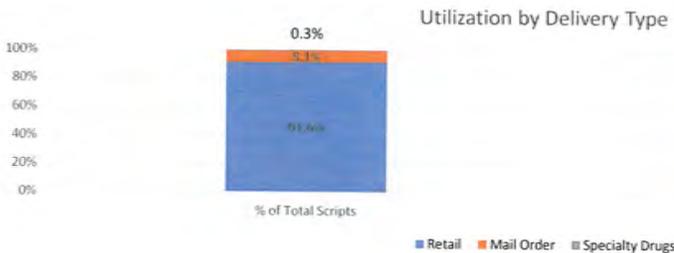
Utilization by Drug Type

Drug Type	Current				Prior			
	Number of Prescriptions	% of Total Scripts	Net Paid	% of Total Paid	Number of Prescriptions	% of Total Scripts	Net Paid	% of Total Paid
Brand	751	19.6%	\$210,257	81.3%	751	19.6%	\$210,257	81.3%
Generic	3,060	80.0%	\$42,832	16.6%	3,060	80.0%	\$42,832	16.6%
Specialty Drugs	12	0.3%	\$5,374	2.1%	12	0.3%	\$5,374	2.1%
Total	3,823	100.0%	\$258,463	100.0%	3,823	100.0%	\$258,463	100.0%



Utilization by Delivery Type

Category	Current				Prior			
	Number of Prescriptions	% of Total Scripts	Net Paid	% of Total Paid	Number of Prescriptions	% of Total Scripts	Net Paid	% of Total Paid
Retail	3,502	91.6%	\$213,083	82.4%	3,502	91.6%	\$213,083	82.4%
Mail Order	309	8.1%	\$40,006	15.5%	309	8.1%	\$40,006	15.5%
Specialty Drugs	12	0.3%	\$5,374	2.1%	12	0.3%	\$5,374	2.1%
Total	3,823	100.0%	\$258,463	100.0%	3,823	100.0%	\$258,463	100.0%



Top 15 Drugs by Paid Claims

Drug Name	Generic/Brand	Total Paid	% of Total Paid	Total Prescriptions	Prior Year Rank
FIRAZYR	Brand	\$66,838	25.9%	3	1
LANTUS SOLOSTAR	Brand	\$15,818	6.1%	37	2
HUMALOG KWIKPEN	Brand	\$10,128	3.9%	27	3
NEXIUM	Brand	\$8,137	3.1%	34	4
LEVEMIR FLEXPEN	Brand	\$6,887	2.7%	25	5
LYRICA	Brand	\$6,467	2.5%	15	6
NOVOLOG FLEXPEN	Brand	\$6,418	2.5%	20	7
FELBAMATE	Brand	\$5,781	2.2%	13	8
ENBREL SURECLICK	Brand	\$5,330	2.1%	2	9
AMPHETAMINE/DEXTRAMPHETA	Generic	\$4,738	1.8%	54	10
HYDROCODONE BITARTRATE/AC	Brand	\$4,512	1.7%	13	11
CRESTOR	Brand	\$4,314	1.7%	15	12
MONODOX	Brand	\$3,929	1.5%	8	13
NOVOLOG	Brand	\$3,821	1.5%	10	14
NUCYNTA	Brand	\$3,787	1.5%	13	15

Top 15 Drug Classes by Paid Claims

Therapeutic Class	Total Paid	% of Total Paid	Total Prescriptions	% of Total Prescriptions	Prior Year Rank
HEMATOLOGICAL AGENTS - MISC.	\$66,857	25.9%	21	0.5%	1
ANTIDIABETICS	\$55,904	21.6%	255	6.7%	2
ANTICONVULSANTS	\$15,412	6.0%	168	4.4%	3
ANTHYPERLIPIDEMICS	\$12,386	4.8%	332	8.7%	4
DIAGNOSTIC PRODUCTS	\$10,393	4.0%	57	1.5%	5
ULCER DRUGS	\$9,096	3.5%	138	3.6%	6
ANALGESICS - OPIOID	\$9,042	3.5%	178	4.7%	7
ANALGESICS - ANTI-INFLAMMATORY	\$8,467	3.3%	76	2.0%	8
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	\$7,532	2.9%	90	2.4%	9
DERMATOLOGICALS	\$7,510	2.9%	119	3.1%	10
TETRACYCLINES	\$6,077	2.4%	37	1.0%	11
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	\$5,034	1.9%	96	2.5%	12
MEDICAL DEVICES	\$4,499	1.7%	62	1.6%	13
CARDIOVASCULAR AGENTS - MISC.	\$4,009	1.6%	27	0.7%	14
CONTRACEPTIVES	\$3,976	1.5%	154	4.0%	15

Current: Paid 7/1/2013 - 6/30/2014
 Prior 1: Paid 7/1/2012 - 6/30/2013
 Prior 2: Paid 7/1/2011 - 6/30/2012

Top 15 Drug **id Claims**

Drug Name	Brand/Generic	Current		
		Total Paid	% of Total Paid	Total Prescriptions
FIRAZYR	Brand	\$66,838	25.9%	3
LANTUS SOLOSTAR	Brand	\$15,818	6.1%	37
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REACHING THE SUMMIT

PLANNING FOR EMPLOYEE REWARDS IN 2014 AND BEYOND

EXECUTIVE SUMMARY



BENEFITS | COMPENSATION | RETIREMENT | WELLNESS



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INTRODUCTION

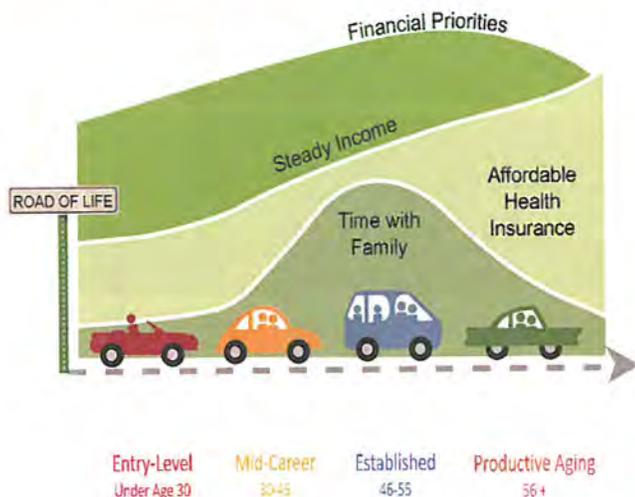
Gallagher Benefit Services (GBS) Michigan completed its 12th annual benchmarking analysis earlier this year. As in the past, we compiled benefit plan and cost statistics from our client database. This year, we also solicited employer opinions on a number of strategic issues. Our aggregate findings are highlighted in this report.

Survey respondents told us that their human resource concerns closely parallel their overall organization concerns. The most frequently cited business issues were:

1. Controlling employee benefit costs
2. Government regulation
3. Attracting and retaining a competitive workforce

Complicating these challenges is our current multi-generational workforce with employees at various life stages that are looking for different things from their employment relationship. Human Resources professionals need to consider whether the current employee rewards allocation is aligned with employee needs and wants and whether it supports the organization's recruiting, retention and engagement goals.

Understanding Employee Needs

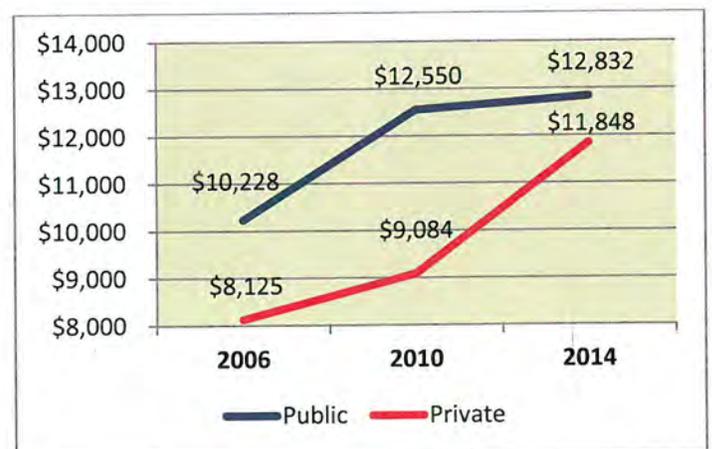


During our Benchmarking "Reaching The Summit" Seminars, our panel addressed many aspects of employee rewards and these are summarized in the following sections.

HIGHLIGHTS FROM THE 2014 SURVEY

As healthcare expenditures continue to grow, employers are still turning to conventional cost-shifting methods to curtail increases. The 2014 GBS benefit survey found that almost 90 percent of respondents intend to increase employee contributions in 2014 and more than 50 percent plan to increase deductibles in order to reduce costs. 51 percent of survey respondents also expect Healthcare Reform to substantially affect the cost of their benefit plans. However, even in the face of rising costs, the survey also reported that employers are still overwhelmingly committed to providing healthcare benefits for the foreseeable future.

Gross Average Healthcare Cost per Employee



DATA AND FINANCIAL CONSIDERATIONS

Employers continue to shift costs to employees through higher deductibles and copayments and through higher payroll contributions, but increasingly they are looking to control costs through managing payments to providers and changing member demand for services.

REACHING THE SUMMIT – EXECUTIVE SUMMARY

Private insurance carriers and third party administrators are looking to Medicare and borrowing some of its provider reimbursement ideas, including reference-based pricing and outcomes-based pricing. The idea behind both of these strategies is to move away from simply reimbursing based on quantity of service and toward paying based on value provided.

Employers are also trying to influence member behavior through the use of focused or narrower provider networks and plan designs that reward members who are compliant in their treatment plans for chronic disease. Look for expanded use of pricing and quality transparency tools to help members make informed healthcare choices.

Some employers are adopting the defined contribution model from their retirement plans and applying it to healthcare benefits. Private exchanges which allow employers to cap financial contributions while offering expanded choice to employees will continue to expand across the country.



MOVING BEYOND WELLNESS TO WELLBEING

Wellness programs continue to evolve and expand. Successful program sponsors are focusing on ways to engage employees and dependents at the highest level. This involves thoroughly understanding health status of the workforce and having insight into intrinsic and extrinsic motivators that will lead to participation. Wellness programs are moving beyond a strict focus on physical health and now include elements to support employees' emotional and financial health, as well as supporting their career development and their need to be connected with the community.



Successful programs enjoy management support and high levels of employee engagement and are customized so that there is something available for everyone. Solid programs offer opportunities for employees to engage and succeed on multiple levels throughout the year.

FINANCIAL WELLNESS

Employees are not retiring at the same rate that they have historically and this poses unique challenges for employers. Creating a culture of financial wellness will help employers ensure that employees are able to retire well and at an appropriate time. Over the last several years, employers have shifted from a defined benefit world to a defined contribution world, where employees were empowered to make important decisions about saving for their future. The economic climate of the past few years highlighted the weakness of this strategy and employers are now looking to the past for guidance on how to better structure their retirement plans.

“Financial Wellness” is the balance between having a healthy state of well being today while preparing financially for tomorrow. It is not necessarily about being wealthy, but it is a state of psychological well being in which one feels they have control over their current finances and financial future.

REACHING THE SUMMIT – EXECUTIVE SUMMARY

The new thinking in defined contribution plans is to re-assume some of the decision making that had been passed on to employee to better help them prepare for retirement. Using techniques like automatic enrollment, automatic contribution escalation and target date funds as the default investment choice, employers are trying to make participation in the plan almost universal. Providing other resources, such as financial modeling tools and targeted communications, helps employers to create that culture of financial wellness that promotes informed and intentional savings for retirement.

COMPENSATION TRENDS, EMPLOYEE ENGAGEMENT AND COMMUNICATION

Most employers are now dealing with a multi-generational workforce that poses unique challenges to the HR professional. Developing a package of employee rewards that is meaningful to people at all life stages requires constant assessment of employee needs and wants and balancing that against the organization's goals and financial realities.

As the economy continues its slow recovery, employees are feeling more confident about their future job prospects and may either look for higher compensation in their current position or look outside for new opportunities. Employers still face fairly restricted salary increase budgets in 2014 and must deal with the reality that newly hired employees may demand higher salaries than those currently employed in comparable positions. This creates both recruiting and retention challenges.

Another key HR challenge is getting and keeping employees at a level of job satisfaction that translates into increase productivity and business success for the organization. A 2013 Gallup survey indicates that while only 13 percent of the workforce is highly engaged, nearly one quarter of the workforce is actively disengaged. HR professionals are charged with not only turning around the 24 percent of disengaged employees but also making sure the 63 percent of employees in the middle do not move into the disengaged

category. Many factors in the work environment can contribute toward those efforts, including the organization's overall culture and the employee's sense of emotional and social wellbeing at work.



24% of employees are actively disengaged, indicating they are unhappy and unproductive at work and are liable to spread negativity

One final HR challenge is successful communicating across generations. Younger employees prefer social networking and smart phone technology, but fewer than 10 percent of respondents to the GBS survey indicated that they are using these communication techniques. Employers are continuing to use the more traditional methods preferred by older employees, including group meetings and print communications. We expect to see a more balanced blending of all of these techniques in the next few years.

LOOKING AT THE WHOLE PICTURE

“Total Rewards” is not just the end product of deciding what combination of salary and benefits is optimal. Employers recognize that salary and benefits are very key components of overall compensation but studies show they are not the only rewards that contribute to an engaged workforce which can drive business success. It’s more about the process of evaluating and constantly re-evaluating what the employee perceives to be of value in the employment relationship. It’s what drives the employee to come to work every day and deliver his or her best to the organization.

Determining the right balance of compensation, benefits, work-life balance programs, wellness, career development and community engagement may become more challenging when developing program choices and customization across multiple generations. However, embracing a Total Rewards strategy impacts talent management, organization strategy and ultimately drives the performance of an organization.



REACHING THE SUMMIT – EXECUTIVE SUMMARY

BENCHMARKING SURVEY DATA -- POPULATION DEMOGRAPHICS

In January 2014, data was compiled from 181 Gallagher Benefit Services (GBS) Michigan clients representing 434 different benefit plans. The data represent employers located throughout Michigan.

Our national survey is being finalized now and data representing employers throughout the country will be available later this spring.

In this report, we have provided local aggregate information for PPO and HMO medical plans, as well as dental and vision plans. Data that is specific to your organization (size, industry, etc.) will be available through your GBS client service team at the same time the national data is available.

Client Size	Clients	Plans
MI Less than 50	27	47
MI 50-99	33	61
MI 100-499	84	218
MI 500-999	25	63
MI Greater than 1,000	12	45
MI All Clients	181	434
Client Industry		
MI Education	48	102
MI Financial	5	12
MI Government	20	53
MI Healthcare	12	24
MI Manufacturing	39	106
MI Service	39	96
MI Wholesale/Retail	18	41
Client Plan Funding Strategy		
MI Fully Insured	144	336
MI Self Insured	37	98
Client Plan Type		
MI Non Bargained	158	389
MI Bargained	23	45
Client Sector		
Private	62	138
Public	119	296

BENCHMARKING SURVEY DATA -- PPO PLANS – PRIVATE SECTOR

	GBS Michigan 2011 Mean	GBS Michigan 2012 Mean	GBS Michigan 2013 Mean	GBS Michigan 2014 Mean	GBS Michigan 2014 Mode
Deductible	\$615 / \$1,303	\$729 / \$1,488	\$843 / \$1,710	\$931 / \$1,917	\$500 / \$1,000
Coinsurance	88%	86%	85%	85%	80%
Out of Pocket Maximum	\$1,558 / \$3,034	\$1,636 / \$3,259	\$1,881 / \$3,794	\$2,501 / \$5,026	\$2,500 / \$5,000
Office Visit Copay	\$26	\$26	\$27	\$28	\$30
Emergency Room Copay	\$102	\$115	\$131	\$151	\$150
One Tier Rx Plan	\$10	-	\$7.50	\$10.71	\$10
Two Tier Rx Plan	\$11 / \$44	\$11 / \$43	\$12 / \$47	\$11 / \$45	\$10 / \$40
Three Tier Rx Plan	\$12 / \$36 / \$61	\$12 / \$40 / \$67	\$12 / \$39 / \$68	\$12 / \$39 / \$66	\$10 / \$40 / \$80
Gross Per Employee Per Year Plan Cost	\$9,619	\$10,377	\$11,003	\$11,848	N/A
Per Employee Per Year Contribution Cost	\$1,734	\$1,900	\$2,303	\$2,073	N/A

OBSERVATIONS:

- Deductibles and out-of-pocket maximums have increased significantly since 2011. In addition to normal inflationary trend increases, employers began to feel the financial impact of healthcare reform benefit mandates during these years and shifted costs to plan members.
- Office visit copayments have been gradually creeping up toward the 2014 mode of \$30.
- The most common emergency room copayment is now \$150, up from an average of about \$100 just three years ago.
- Many employers have now moved to a three-tier prescription drug program . Some insurance carriers are only offering three-tier programs to new clients. We are also seeing expanding tiering where generics and specialty medications are being split into preferred and non-preferred categories.

REACHING THE SUMMIT – EXECUTIVE SUMMARY

BENCHMARKING SURVEY DATA -- PPO PLANS – PUBLIC SECTOR

	GBS Michigan 2011 Mean	GBS Michigan 2012 Mean	GBS Michigan 2013 Mean	GBS Michigan 2014 Mean	GBS Michigan 2014 Mode
Deductible	\$63 / \$126	\$171 / \$341	\$328 / \$657	\$415 / \$820	\$250 / \$500
Coinsurance	97%	96%	95%	94%	100%
Out of Pocket Maximum	\$260 / \$508	\$515 / \$942	\$871 / \$1,752	\$1,280 / \$2,547	\$1,000 / \$2,000
Office Visit Copay	\$12	\$12	\$13	\$13	\$20
Emergency Room Copay	\$52	\$55	\$61	\$68	\$50
One Tier Rx Plan	\$4	\$4	\$12.50	\$10.83	\$10
Two Tier Rx Plan	\$10 / \$27	\$9 / \$29	\$9 / \$32	\$10 / \$35	\$10 / \$40
Three Tier Rx Plan	\$13 / \$27 / \$50	\$11 / \$25 / \$46	\$9 / \$26 / \$48	\$10 / \$32 / \$49	\$10 / \$20 / \$40
Gross Per Employee Per Year Plan Cost	\$14,456	\$13,745	\$13,473	\$12,832	N/A
Per Employee Per Year Contribution Cost	\$84	\$720	\$2,495	\$1,443	N/A

OBSERVATIONS:

- Public sector plans have seen dramatic increases in deductible and out-of-pocket costs over the past few years, largely in response to state legislation limiting a public employer's costs for providing healthcare benefits. Despite that, public employer plans still lag behind private sector plans in member cost sharing.
- The average cost per covered employee decreased in 2014 from 2013 as public employers moved to lower cost plan designs.
- Average employee contributions also decreased as employees demanded less expensive alternative healthcare plans.

BENCHMARKING SURVEY DATA -- HMO PLANS – PRIVATE SECTOR

	GBS Michigan 2011 Mean	GBS Michigan 2012 Mean	GBS Michigan 2013 Mean	GBS Michigan 2014 Mean	GBS Michigan 2014 Mode
Deductible	\$609 / \$1,228	\$574 / \$1,159	\$560 / \$1,134	\$947 / \$1,873	\$0 / \$0
Coinsurance	85%	85%	85%	86%	100%
Out of Pocket Maximum	\$1,232 / \$2,484	\$1,249 / \$2,526	\$1,441 / \$2,885	\$2,985 / \$5,981	\$1,500 / \$3,000
Office Visit Copay	\$21	\$23	\$23	\$25	\$30
Emergency Room Copay	\$91	\$103	\$106	\$120	\$150
One Tier Rx Plan	\$4	\$5	\$5	\$9	\$9
Two Tier Rx Plan	\$11 / \$40	\$12 / \$41	\$12 / \$42	\$11 / \$39	\$10 / \$40
Three Tier Rx Plan	\$13 / \$27 / \$52	\$14 / \$41 / \$73	\$14 / \$42 / \$68	\$14 / \$41 / \$74	\$15 / \$40 / \$80
Gross Per Employee Per Year Plan Cost	\$7,488	\$8,272	\$8,742	\$8,023	N/A
Per Employee Per Year Contribution Cost	\$1,553	\$1,596	\$2,329	\$2,190	N/A

OBSERVATIONS:

- There is an interesting difference between the 2014 mean average deductible and the 2014 mode. For plans that are including deductibles, they are increasing at a significant rate. But the majority of plans still do not require a deductible. Some of these plans actually do have a deductible but it is funded by the employer through a health reimbursement arrangement.
- The average office visit copayment and emergency room copayment mirror those in PPO plans.
- Three-tier prescription drug plans are becoming more prevalent and the average copayment for non-preferred brand name drugs has been steadily increasing while copayments for generic and preferred drugs have been stable.
- Average cost and contribution have decreased as a result of cost shifting in the benefit design.

REACHING THE SUMMIT – EXECUTIVE SUMMARY

HMO PLANS – PUBLIC SECTOR

	GBS Michigan 2011 Mean	GBS Michigan 2012 Mean	GBS Michigan 2013 Mean	GBS Michigan 2014 Mean	GBS Michigan 2014 Mode
Deductible	\$10 / \$20	\$117 / \$233	\$184 / \$368	\$204 / \$407	\$0 / \$0
Coinsurance	98%	96%	97%	95%	100%
Out of Pocket Maximum	\$20 / \$41	\$194 / \$387	\$772 / \$1,533	\$1,864 / \$3,651	\$1,500 / \$3,000
Office Visit Copay	\$12	\$15	\$19	\$19	\$20
Emergency Room Copay	\$51	\$65	\$81	\$73	\$100
One Tier Rx Plan	\$5	\$5	\$7.50	N/A	N/A
Two Tier Rx Plan	\$9 / \$19	\$9 / \$23	\$11 / \$30	\$10 / \$33	\$10 / \$40
Three Tier Rx Plan	\$10 / \$20 / \$38	\$11 / \$23 / \$41	\$11 / \$24 / \$45	\$10 / \$24 / \$45	\$10 / \$20 / \$40
Gross Per Employee Per Year Plan Cost	\$13,108	\$12,755	\$13,156	\$12,445	N/A
Per Employee Per Year Contribution Cost	\$187	\$1,179	\$1,699	\$2,231	N/A

OBSERVATIONS:

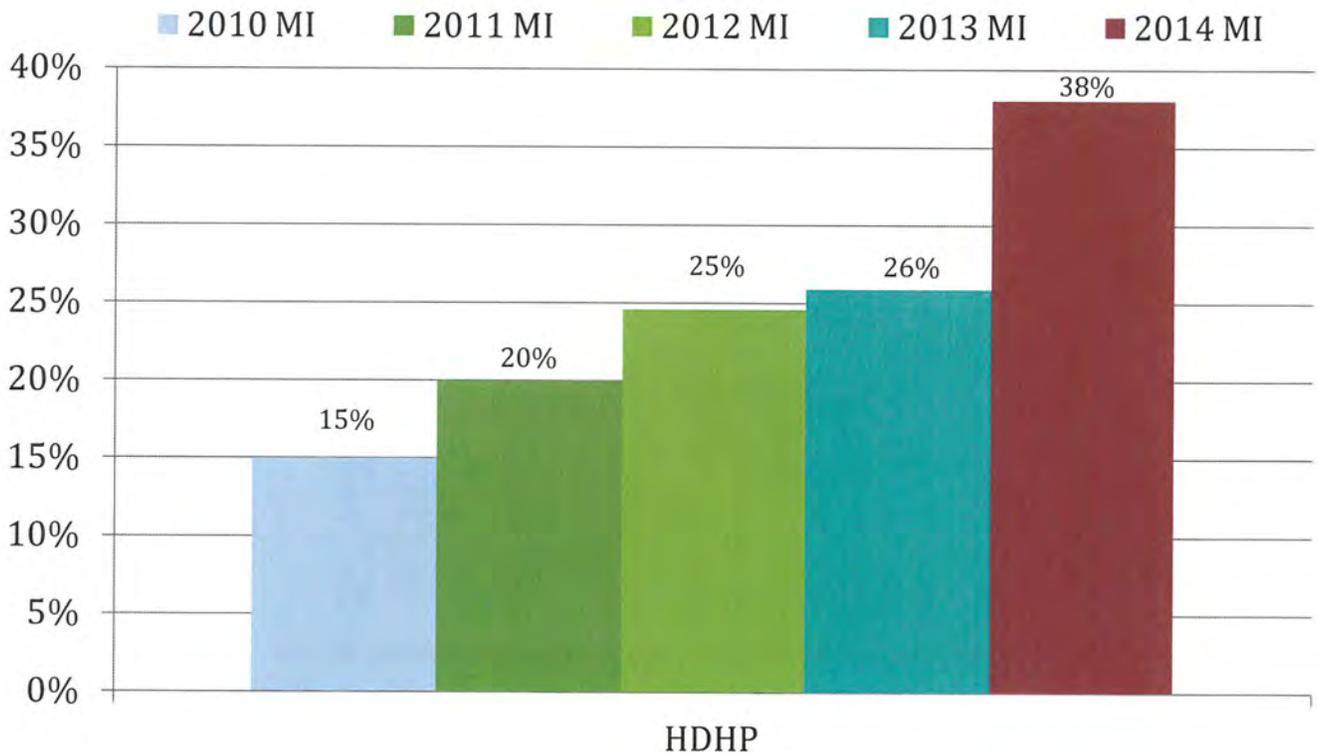
- Like public sector PPO plans, HMO plans have seen substantial increases in member cost sharing over the past few years.
- Employers have responded to employee requests for lower cost options by offering plans with higher member cost sharing, which has stabilized the average cost per employee.
- Although average cost per employee is quite close to the average cost figure for PPO plans, the average employee contribution is higher for HMO plans. This is likely due to employees with more dependents choosing the HMO options over the PPO option.

BENCHMARKING SURVEY DATA -- HIGH DEDUCTIBLE HEALTH PLANS (HDHPs)

CURRENT HDHP OFFERINGS

In Michigan, 38% of employers offer a high deductible health plan. This is a dramatic increase from previous years. This is a significant increase over 2013 when only 28% of employers offered this type of plan.

Current HDHP Offerings



REACHING THE SUMMIT – EXECUTIVE SUMMARY

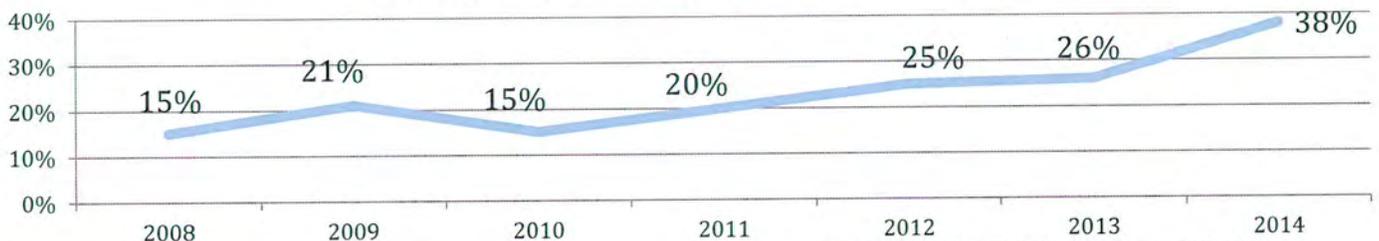
TYPE OF REIMBURSEMENT ACCOUNT

Among employers pairing a HDHP option with a reimbursement account in 2014, 76% are using a health savings account (HSA) while 24% offer a health reimbursement arrangement (HRA). Use of HSAs has stabilized after increasing incrementally over the previous three years.

HDHP Prevalence and Structure



Percentage of GBS Michigan Clients Offering HDHP

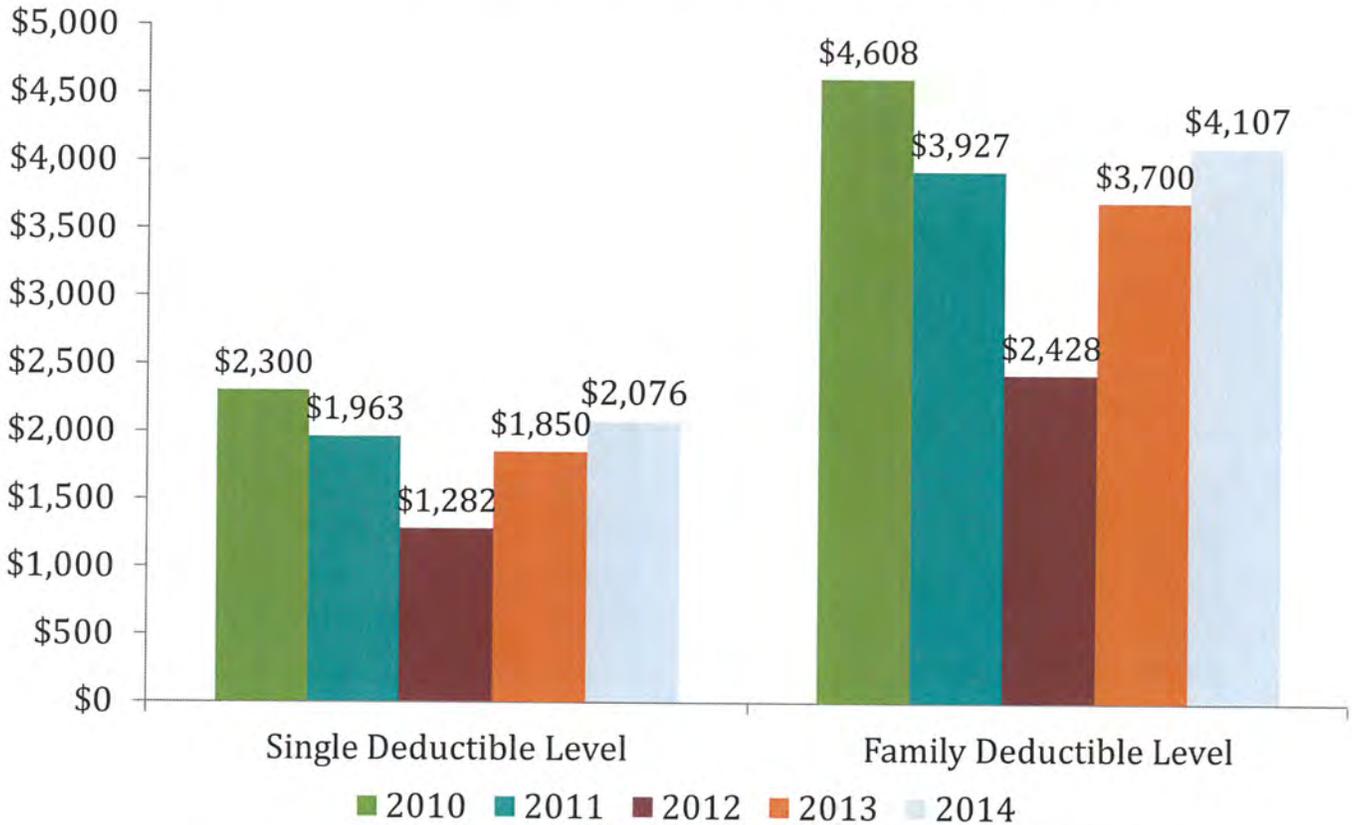


REACHING THE SUMMIT – EXECUTIVE SUMMARY

FULLY FUNDED HDHPS

In 2014, the average single deductible of a fully-funded HDHP was \$2,076 for an individual and \$4,107 for a family. After declining for three consecutive years, the deductibles have increased for two years in a row.

Average Deductible - Fully Funded HDHP

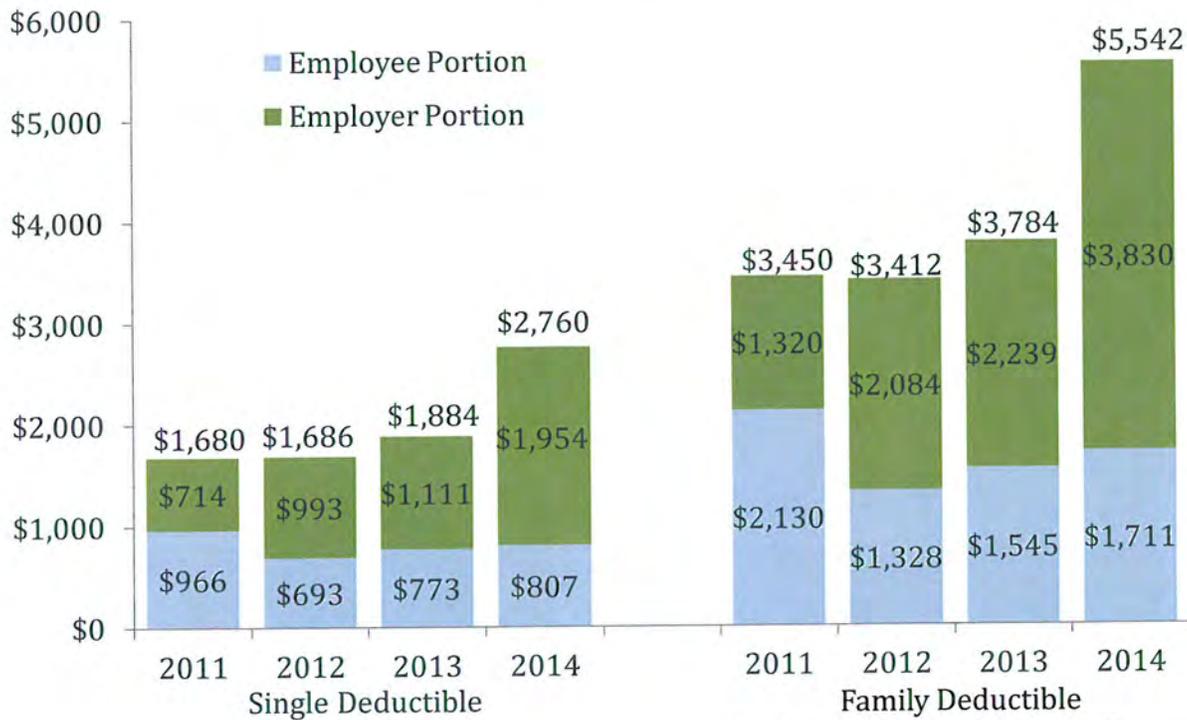


REACHING THE SUMMIT – EXECUTIVE SUMMARY

PARTIALLY FUNDED HDHPs

In 2014, the average employer contribution to a partially funded HDHP was \$1,954 for a single employee and \$3,830 for a family. These amounts have increased drastically from 2013. In addition, the employee portion increased significantly over last year as well.

Cost Sharing - Partially Funded HDHP



Dental Highlights

All Employers: Public and Private Sectors

	GBS Michigan 2012 Mean	GBS Michigan 2013 Mean	GBS Michigan 2014 Mean	GBS Michigan 2014 Mode
Deductible	\$13 / \$37	\$13 / \$37	\$19 / \$53	\$0 / \$0
Preventive Care	90%	90%	93%	100%
Basic Care	78%	79%	80%	80%
Major Care	59%	62%	60%	50%
Annual Maximum	\$1,196	\$1,172	\$1,213	\$1,000
Orthodontic Care	57%	59%	57%	50%
Lifetime Ortho Maximum	\$1,271	\$1,247	\$1,239	\$1,000
Gross Per Employee Per Year Plan Cost	\$852	\$881	\$867	N/A
Per Employee Per Year Contribution Cost	\$241	\$347	\$265	N/A

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Vision Highlights

All Employers: Public and Private Sectors

	GBS Michigan 2012 Mean	GBS Michigan 2013 Mean	GBS Michigan 2014 Mean	GBS Michigan 2014 Mode
Exam Copay	\$9	\$9	\$10	\$10
Material Copay	\$18	\$17	\$17	\$25
Exam Frequency	12 months	12 months	12 months	12 months
Lenses Frequency	12 months	12 months	12 months	12 months
Frames Frequency	12 months	12 months	12 months	12 months
Contacts Frequency	12 months	12 months	12 months	12 months
Gross Per Employee Per Year Plan Cost	\$116	\$103	\$131	N/A
Per Employee Per Year Contribution Cost	\$45	\$36	\$81	N/A

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REACHING THE SUMMIT – EXECUTIVE SUMMARY

BENCHMARK SURVEY DATA -- RETIREMENT PLAN

AUTOMATIC ENROLLMENT AND ESCALATION

For plans that include automatic enrollment, following is the average deferral percentage assigned to new participants.

Default Deferral Percentage			
	50-199 Employees	5,000+ Employees	All Plans
1%	2.5	3.3	2.3
2%	5.0	11.1	10.6
3%	62.5	46.7	51.8
4%	17.5	13.3	12.6
5%	2.5	11.1	10.6
6%	7.5	12.2	10.0
More than 6%	2.5	2.2	2.0

The percentage of plans that include automatic enrollment varies by industry, as shown in the following table.

Industry	Percentage of Plans
Construction / Engineering	40.6
Durable Goods Manufacturing	69.0
Financial	39.2
Healthcare	54.3
Insurance and Real Estate	51.8
Non-Durable Goods Manufacturing	69.8
Services	40.2
Tech and Telecommunications	41.4
Utility / Energy	43.5
Wholesale	44.1
Other	35.9

REACHING THE SUMMIT – EXECUTIVE SUMMARY

Employers using auto enrollment report the following impact on their plans:

	Average Contribution Rate	Plan Participation Rate	Non - Discrimination Rate	Participant Awareness
Positive	57%	86%	52%	62%
Negative	8%	1%	1%	1%
No Change	28%	9%	42%	30%
Too Soon to Tell	7%	4%	5%	7%

Employers are fairly evenly split in their decision to use automatic escalation of contributions. Larger employers are more likely to include this feature, as shown below.

	Plan Size		
	50-199 Employees	5,000 + Employees	All Plans
Automatic Escalation	32.5%	44.4%	39.8%
Voluntary Escalation	15.0%	22.2%	18.1%
No Escalation	52.2%	33.3%	42.1%

EMPLOYER MATCHING CONTRIBUTIONS

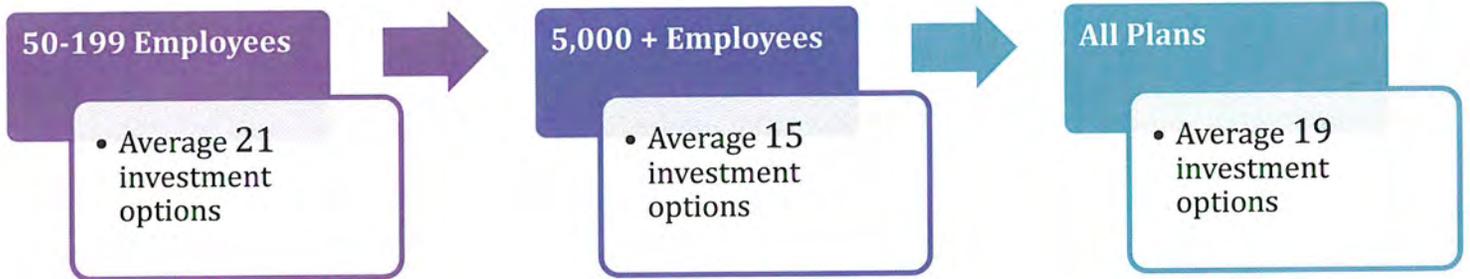
Employer matching contributions vary by industry, as indicated in the following table.

Industry	Cents Matched Per \$1.00	Maximum % of Pay Matched
Durable Goods Manufacturing	\$.55	5.0%
Non -Durable Goods Manufacturing	\$.65	6.1%
Wholesale Distribution and Retail Trade	\$.66	4.8%
Financial	\$.75	5.4%
Insurance and Real Estate	\$.67	5.4%
Services	\$.65	5.2%
All Plans (includes industries not listed above)	\$.71	5.3%

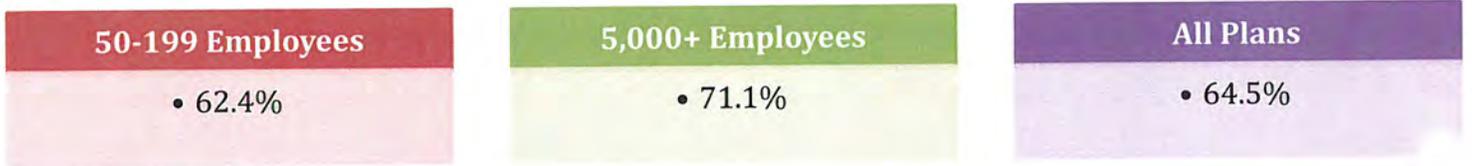
REACHING THE SUMMIT – EXECUTIVE SUMMARY

INVESTMENT OPTIONS

The average number of investment options offered varies by plan size:



Use of target date funds is widespread among employers of all sizes:



INVESTMENT ADVICE

Smaller plans are slightly more likely to offer advice services to employees. The percentage of employers offering this service is shown below.

Plan Size by Number of Participants		
50-199	5,000 +	All Plans
42.4%	35.9%	35%

REACHING THE SUMMIT – EXECUTIVE SUMMARY

Employee utilization of advice services is fairly low:

Plan Size by Number of Participants	Average Percentage of Participants Utilizing Advice
50-199	16.2
5000+	12.4
All Plans	17.6

Providers of advice include the following:

	Plan Size by Number of Participants		
	50-199	5,000+	All Plans
Certified Financial Planner	21.4%	5.8%	13.7%
Registered Investment Advisor	35.7%	7.7%	25.5%
Financial Advisor Affiliated with Plan Provider	33.3%	23.1%	25.0%
Web-Based Provider	7.1%	71.2%	38.2%

Data Sources for 401(k) Plans:

1. Profit Sharing Council of America's 56th Annual Survey
2. Deloitte 2013 Annual 401(k) Benchmarking Survey

REACHING THE SUMMIT – EXECUTIVE SUMMARY

GALLAGHER'S 12TH ANNUAL BENCHMARKING SURVEY REPORT

Disclosure

Consulting and insurance brokerage services to be provided by Gallagher Benefit Services, Inc. and/or its affiliate Gallagher Benefit Services (Canada) Group Inc. Gallagher Benefit Services, Inc., a non-investment firm and wholly owned subsidiary of Arthur J. Gallagher & Co., is a licensed insurance agency that does business in California as "Gallagher Benefit Services of California Insurance Services" and in Massachusetts as "Gallagher Benefit Insurance Services." Securities and Investment Advisory Services may be offered by GBS Retirement Services, Inc. and executed through NFP Securities, Inc., Member FINRA/SIPC. Investment advisory services and corresponding named fiduciary services may also be offered through Gallagher Fiduciary Advisors, LLC, a Registered Investment Adviser. Gallagher Fiduciary Advisors, LLC is a single-member, limited-liability company, with Gallagher Benefit Services, Inc. as its single member. Not all individuals of Gallagher and none of Gallagher Fiduciary Advisors, LLC individuals are registered to offer securities or investment advisory services through NFP Securities, Inc. NFP Securities, Inc. is not affiliated with Arthur J. Gallagher & Co., Gallagher Benefit Services, Inc. or Gallagher Fiduciary Advisors, LLC. Neither Arthur J. Gallagher & Co., NFP Securities, Inc., nor their affiliates provide accounting, legal, or tax advice.



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The Gallagher Way

Shared values at Arthur J. Gallagher & Co. are the rock foundation of the Company and our Culture. What is a Shared Value? These are concepts that the vast majority of the movers and shakers in the Company passionately adhere to. What are some of Arthur J. Gallagher & Co.'s Shared Values?

1. We are a Sales and Marketing Company dedicated to providing excellence in Risk Management Services to our clients.
2. We support one another. We believe in one another. We acknowledge and respect the ability of one another.
3. We push for professional excellence.
4. We can all improve and learn from one another.
5. There are no second-class citizens—everyone is important and everyone's job is important.
6. We're an open society.
7. Empathy for the other person is not a weakness.
8. Suspicion breeds more suspicion. To trust and be trusted is vital.
9. Leaders need followers. How leaders treat followers has a direct impact on the effectiveness of the leader.
10. Interpersonal business relationships should be built.
11. We all need one another. We are all cogs in a wheel.
12. No department or person is an island.
13. Professional courtesy is expected.
14. Never ask someone to do something you wouldn't do yourself.
15. I consider myself support for our Sales and Marketing. We can't make things happen without each other. We are a team.
16. Loyalty and respect are earned—not dictated.
17. Fear is a turnoff.
18. People skills are very important at Arthur J. Gallagher & Co.
19. We're a very competitive and aggressive Company.
20. We run to problems—not away from them.
21. We adhere to the highest standards of moral and ethical behavior.
22. People work harder and are more effective when they're turned on—not turned off.
23. We are a warm, close Company. This is a strength—not a weakness.
24. We must continue building a professional Company—together—as a team.
25. Shared values can be altered with circumstances—but carefully and with tact and consideration for one another's needs.

When accepted Shared Values are changed or challenged, the emotional impact and negative feelings can damage the Company.

– Robert E. Gallagher
May 1984

Response to Request for Proposal

The City of Traverse City

Prepared by
HUB International Limited

January 7, 2015



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HUB International Limited

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A.

ORGANIZATION & HISTORY

ORGANIZATION AND HISTORY

1. Please provide the names(s), title(s), address(es), e-mail address, telephone and fax number(s) of the individual(s) responsible for responding to this request.

Nicole Rodriguez
Senior Sales Executive
HUB International Midwest East
600 E Front Street
Traverse City, MI 49686
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nicole.rodriguez@HUBinternational.com

Websites:

www.HUBinternational.com/midwest/east

2. Provide a brief overview of your company and history of your organization including an organizational chart of your operations. (maximum 3 paragraphs) Please describe any parent/subsidiary/affiliate relationships.

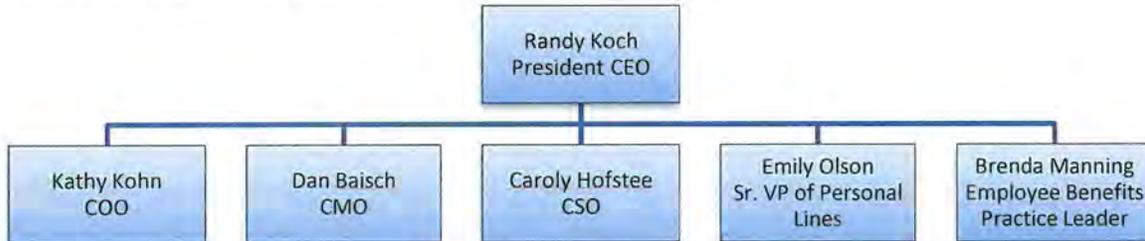
HUB International is a leading insurance brokerage providing a broad array of property, casualty, risk management, life and health, employee benefits, investment and wealth management products and services across North America. HUB International began in 1998 when 11 brokerages merged to form HUB International Limited. HUB International has over 6,500 employees in more than 260 offices. HUB is the 10th largest insurance brokerage firm in North America, and the largest privately held brokerage in North America. With nearly 1.2 billion in revenue, HUB International is a leader in providing targeted solutions to insurance and compliance problems.

HUB International Limited was purchased by Hellman & Freidman LLC from APEX in October of 2013. We are still a privately held company providing exceptional resources and services from a national and local perspective. The buyout allows HUB International to continue our growth strategy and enhance our customer's experience.

Locally, with 140 employees, HUB offers personal service, individual attention and has the ability to respond quickly to your changing needs. Collectively, the HUB's are a knowledge powerhouse providing you with tailor-made solutions that are designed by drawing upon our combined skills and expertise. HUB has over 50 risk management consultants and 65 claims consultants. We have a wide variety of specialties and expansive experience located throughout the United States and Canada.

Our Executive Management Structure for HUB Midwest East

We overlay our HUB structure with key areas of expertise at the corporate level that are leveraged through the organization to provide our customers with the best possible combination of local relationships and global resources. Collectively, our HUBs are a knowledge powerhouse providing clients with tailor-made solutions.



3. Are you currently participating in any alliances or joint marketing efforts? If so, please describe in detail.

Recently, HUB acquired the assets of Laurus Strategies based in Chicago, IL. Laurus is an employee benefits, human resources, and human resource information system (HRIS) global benefits consulting business.

Laurus offers global health and benefits consulting, including expertise in such areas as: private exchange, human capital development, international total rewards, property and casualty (P&C), non-profit and public affairs, and human resource information system (HRIS) consulting, which helps clients assess current systems and identify the best alternatives, enabling benefit solutions to integrate with existing HR systems, such as payroll.

HUB also recently acquired the assets of Intercare Insurance Solutions based out of San Diego, California. In addition to their reputable employee benefits consulting, they bring 401(k) retirement plan consulting.

4. How many clients do you currently administer in the following categories?

Number of Employees	# Clients	Percentage of Total
Under 100	385	81%
100-500	75	16%
500-750	10	2%
Over 750	4	1%
Total	474	100%

B.

CLIENT SERVICE / QUALITY ASSURANCE

CLIENT SERVICE / QUALITY ASSURANCE

1. Please describe the team that would deal directly with us during the transition and on an ongoing basis. Indicate staff size, experience and turnover rates. Indicate all state licenses and credentials of key personnel.

The City of Traverse City will have a specific dedicated team. The majority of your team is located in Traverse City, MI. However, each of your team members has access to statewide and national resources. The City of Traverse City team is cross trained with specialties in different areas. In [Appendix A](#) you will find biographies on each of your team members at HUB International. You will have a dedicated contact in the following areas:

- **Nicole Rodriguez** – The team lead and main contact. As the Senior Executive, she will be handling renewal and over all account management
- **Tonya Carmoney** – Client Manager handling day to day needs for HR Staff and Employees
- **Paula VanAmberg** – Client manager assisting with employee handbooks and renewal marketing
- **Kate Adams** – Claims resolution consultant
- **Claire Manz** – Dedicated open enrollment specialist
- **Connie McKeown** – Human Resource Compliance Partner
- **Karene Crane** – Technology Partner

Turnover for our Northern Michigan Team is 98%.

HUB International is licensed within all 50 states, Puerto Rico and Canada as a broker for employee benefits, property and casualty and personal lines insurance.

2. What are your client retention statistics for each of the last three years?

2014- 91% retention rate in the Employee Benefits Division

2013- 94% retention rate in the Employee Benefits Division

2012- 97% retention rate in the Employee Benefits Division

For those who left, what percentage left due to issues pertaining to services provided by your organization?

Our number one priority is our service to our clients. We offer a team of expertise that includes Chief Compliance Officers, Compliance Coordinators, Account Executives, On-staff Registered Nurse, Human Capital Specialist and Client Managers to ensure our clients' needs are met and they are in compliance with ACA. From the clients that parted ways in the past year the majority of them were due to uncontrollable circumstances such as mergers/acquisitions, buy-outs and closing's.

For those who left, what percentage left due to software limitations?

As indicated above, the organizations that left were largely due to merger's and acquisitions. At HUB International we provide our clients a vast array of online software solutions including online enrollment, education, employee training and HR support. As we continue to invest in growth and capabilities, online software is a priority to continue to support our clients and assist with compliance and regulations.

What is the average client relationship duration? Newest? Longest?

The average client relationship duration is 10 to 15 years

The newest relationship is 10.1.14 in Northern Michigan

The longest single contract that HUB International Midwest East has held in the employee benefits division began in 1990 and is still with us today.

3. Describe your organization's commitment to quality and your philosophy/approach to client services.

One can learn a lot about an organization by what they value most. At HUB Midwest East, we believe everything we do and value is centered around the client relationship. We are never satisfied in just delivering what is expected. Our goal is to exceed expectations which we believe is the core to developing true, long lasting partnerships.



We Exist For Relationships

We are passionate about creating moments where our connection with others makes a difference in their lives. By helping our clients, colleagues and community realize the best for themselves and their organizations; we will leave our relationships in a better place than we found them. We do this because for us, it is all that matters.

4. Describe your customer service standards.

As we strive to work as “One Team One Vision” we have the depth and breadth of resources and knowledge to provide our clients the most favorable outcome and program design specific to their needs. The majority of our staff is cross trained in a number of areas and able to support The City of Traverse City at any time. The City of Traverse City is referenced above. You will always have direct access to any team member at any time.

5. What are three reasons why your customers select your company over your competition?

- 1) **Compliance** - One of our most valuable assets includes our in-house team of full-time compliance attorneys who address and minimize exposures to audits, penalties, and lawsuits under state and federal laws affecting employee benefit plan sponsors. The HUB Legal Compliance Service attorneys have over 34 years combined experience advising employers in the public and private sectors.

Compliance services are strategic, varied, and practical. Our service is designed with the goal of taking you to the point of solution, rather than simply telling you what the law says. Periodic legal compliance updates inform clients, prospects, and our internal HUB specialists, while providing specific action steps, sample forms, suggested plan language, and other tools. Client-specific services include reviewing and amending documents for group health plans and other employee benefits, such as Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), cafeteria plans, and fringe benefit plans.

Our Legal Compliance team utilizes a variety of sources in communicating legislative and regulatory updates; including, but not limited to, client webinars, DOL Technical Releases, EEOC Publications, HHS Guidance, PPACA Final Rules and Amendments. Our client updates will include citations of the Federal or State agency that issued the guidance.

- 2) **Health Care Reform Analysis** - The Patient Protection and Affordable Care Act (PPACA) will impact every American and its complex and multi-faceted provisions present employers with an array of challenges. HUB understands its financial impact on your health plans and prepared a roadmap for 2014 and beyond that will enable you to avoid penalties and even take advantage of opportunities that may be available to you under Health Care Reform.
- 3) **Short & Long Term Strategic Planning** - As a true partner to The City of Traverse City, HUB International begins the planning process with discovery meetings that uncover your current and broadest level vision, long term goals and objectives. Within this discussion we review your growth plans, operational changes, the regulatory outlook, historical trends, emerging market strategies, risk appetite and funding alternatives. From this discussion we can prepare further specific analysis and develop plans that align with these goals.

Our firm is a pioneer in multi-year benefit consulting. We focus on not only the current year, but develop a long term strategy to achieve better benefit administration and cost management. Our strategy focuses on the three principles of cost management, human resource administrative support and effective employee communications and education. The HUB team works closely with Hope Network to assist in the development of a 3-to-5 year strategic plan.

HUB is committed to continually looking ahead at future strategies, informing, educating and preparing your team for opportunities that best support your needs such as markets, technology, alternative funding models and risk management strategies.

C.

BENEFIT ADMINISTRATION

BENEFIT ADMINISTRATION

1. What processes/procedures do you have in place to interact with and approach a variety of vendors?

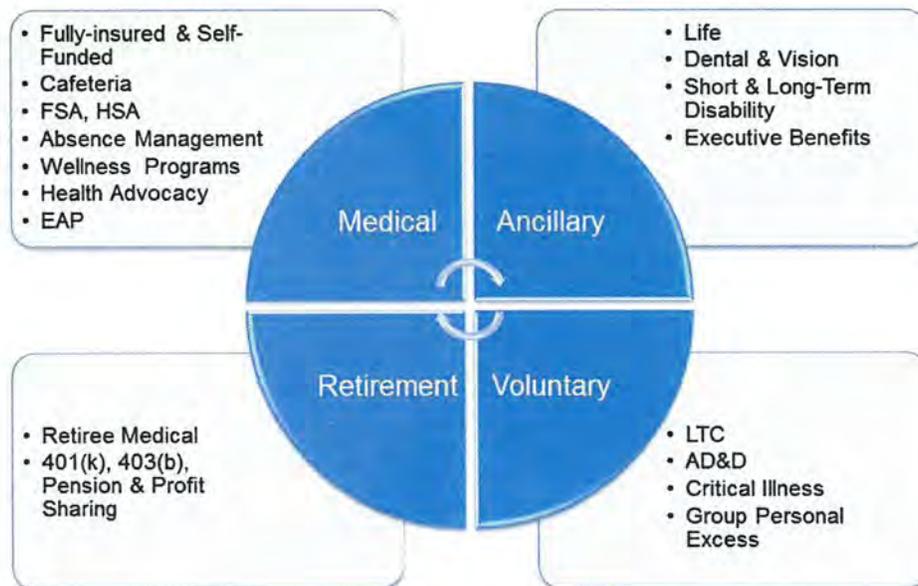
HUB's employee benefits leadership team sits on various Industry Advisory Boards for Aetna, Blue Cross, Blue Shield, Humana, Priority Health, United Healthcare, and Cigna. Our management team and our producers (agents), actively participate with insurance carriers to ensure that HUB is aware of market and legislative changes. More importantly, we strive to nurture and grow our relationships with vendors to assure the strongest negotiating power for our clients. Our status with carriers gives us access to their best and most senior people, affording you a better customer experience and a stronger partnership as issues arise.

2. What is the process you would use when constructing the benefits recommendations to be made each year? How do you determine and communicate the timeline to the client?

The marketing process begins with a pre-renewal strategy meeting conducted between 120 days 180 days.

Product Breadth & Scope

As your company faces the ongoing challenge of recruiting and retaining talent, employee benefits will continue to be a key strategic consideration. Working together, we will develop a comprehensive benefits package that provides your employees with stability and income protection. Through benchmarking and comparing your plans against similar employers, we will ensure that your programs meet employee expectations while achieving your financial objectives.



Strategic Planning Process

Our approach is designed to help you solve immediate, short-term challenges while developing a three to five year strategic plan that is based on the goals and objectives you determine. Throughout the year, we measure results against the goals you set and make adjustments as needed. This systematic process ensures that we are continually working toward achieving your goals and that the solutions we implement are compatible with your work culture and company philosophy.

Step 1 – Opportunity Assessment

Our first priority is to get to know you. It is important for your HUB team to understand your business objectives, the history of your benefit programs, and what drives your decision-making. Your HUB team will listen first and then work with you to develop solutions. During this process, you will quickly realize that your HUB team has depth of experience and broad perspective on key benefit issues. Additionally, each team member has a solid track record in managing complex projects along with the skill, knowledge, and resources to respond to your needs.

We use a proprietary planning tool to guide the conversation and enable us to develop a three to five year strategic plan. This plan becomes the road map for our future collaboration and success measurement.

Step 2 – Analyze and Develop Recommendations

The second step is to research and develop specific solutions to support the strategy. The solution will incorporate your short and long-term objectives. During this step we will:

- Analyze your data, where available
- Perform benchmarking analysis
- Research alternatives
- Recommend action steps

Our goal, whenever possible, is to utilize a data-driven, fact-based approach that enables you to identify potential costs and proactively develop targeted intervention programs. As part of this step, we will conduct audits to identify gaps in compliance as well as opportunities to enhance employee communication and improve efficiencies with regard to program administration.

Step 3 – Deliver Solutions

HUB will identify the services and tools needed to support your employee benefits strategy. Our recommended plan design and other program recommendations will focus on high-impact areas and the most significant cost-saving opportunities. Following your approval, we will present your program to pre-qualified carriers and administrators.

Once we have completed the marketing and negotiations, the next step is to implement the programs. Proper implementation is critical to the carrier's ability to administer the program. Attention to detail increases the likelihood of a smooth launch that will ultimately lead to satisfied employees.

Step 4 – Measure Results

We will measure performance against goals in several key areas including financial, compliance, wellness, and service. Both carrier/vendor service levels as well as HUB service to your team will be measured and reported.

On a quarterly basis, we provide reports on the following:

- High level cost illustration of claims paid out versus premium paid;
- Cost utilization by services type, identifying areas of potential exposure and recommendations to address potential over-utilization
- Pharmacy utilization analysis
- Provider discount analysis - actual vs. promised

Within our annual Stewardship Report, we identify all of the activities and achievements including projects, success stories, major issue resolution, and ongoing challenges. This report allows both parties the opportunity to review and validate our long-term strategic plan. It is used as a quality assurance tool to compare completed projects and accomplishments to stated goals.

Managing Your Benefit Plan Costs

Financial Analysis and Benefit Plan Design

We conduct a detailed analysis of your annual costs, benefit plan design and plan performance in order to validate that your employee benefits program is consistent with your organization's strategic goals. We will assist you in defining and prioritizing your health and welfare plan objectives.

Depending on your needs, our analysis may include the following:

- Forensic claims data analysis to uncover utilization by member class and service type, including in-patient hospital, primary care, specialist, x-ray/lab, and prescription drugs;
- Demographic analysis of your current enrollees and payroll contribution analysis. Evaluate population segments (employee, spouse, children) by region and present the best suitable design alternatives;
- Benchmark your benefits against industry norms, company size, and geographic region;
- Identify cost trends and disease management opportunities through utilization review and clinical data analysis in collaboration with our population health management specialists and consulting physician;
- Perform trend analysis from available diagnostic and normative data to forecast projected benefit costs;
- Analyze network discounts and geographic access;
- Assess current funding arrangements for appropriateness and assist in developing employee contributions levels;
- Conduct detailed plan modeling to gauge the impact of proposed plan changes;
- Review managed care expense and administrative service fees, where applicable;
- Prepare experience report analysis on a monthly and/or quarterly basis;
- Conduct feasibility study for captive insurer arrangements.

Health Care Reform Analysis

The Patient Protection and Affordable Care Act (PPACA) will impact every American and its complex and multi-faceted provisions present employers with an array of challenges. HUB can help you understand its financial impact on your health plans and prepare a roadmap for 2014 and beyond that will enable you to avoid penalties and even take advantage of opportunities that may be available to you under Health Care Reform.

HUB offers evaluation tools that illustrate the long-term impact of HCR as well as customized reports that pinpoint the most likely financial outcome for your plan. In conjunction with Milliman, Inc., HUB can help you project the following:

- Employee and dependent migration into and out of your plan and related costs due to the individual mandate, auto enrollment, and movement to the State Health Exchanges
- Future health plan costs through 2018, including how your current plan options compare to plans that would avoid the Cadillac Plan Excise tax
- Future cost projections through 2018 based on alternative employee contribution scenarios.

Vendor Marketing and Renewal Negotiations

We evaluate vendor performance and review your current contracts with a focus on ensuring maximum effectiveness and efficiency. Some of the ways we can assist you are as follows:

- Perform pre-marketing evaluation of census data, network service areas, and administrative needs
- Review vendor renewal methodology, experience data, and assumptions for accuracy and logic
- Develop plan specifications based on feedback from strategic planning meeting
- Develop and present alternative plan designs and provisions with associated financial and member impact analysis
- Jointly determine list of vendors best suited to meet your plan goals and objectives
- Evaluate client support services, financial ratings and accreditation
- Review provider network accessibility/employee match
- Review electronic data transfer processes
- Perform critical analysis and comparison of features and costs
- Assist in the scheduling of selected finalist site visits, conduct finalist and/or renewal negotiations and notify all bidders of final outcome
- Develop vendor performance guarantees as appropriate
- Finalize program design, rates, and fees prior to effective date

HUB will competitively market your plans annually. This includes consulting with you in the development of marketing specifications, identification of current market conditions and trends with benchmarking data, evaluation of carrier proposals including contract language, all negotiations, and placement of insurance contracts.

Through careful monitoring and ongoing analysis of monthly and year-to-date claim activity and other data analytics, we are able to approach annual renewals with a clear anticipation of appropriate carrier rate action.

Reduce Your Administrative Workload

Our intention is to deliver the highest level of benefit consulting services to our clients. Your HUB consulting team will act as an extension of your Human Resources department, so you can rely on us to reduce your administrative workload, insulate you from time-consuming service issues, and ensure that your plan remains compliant with federal and state regulations.

Regulatory Compliance

Our compliance team, headed by experienced, in-house ERISA attorneys, will help you establish a compliant platform and ensure your benefit programs are in good standing. HUB will conduct a compliance audit with your team and advise you on updates, changes and where there may be gaps in plan or communication compliance. On a regular basis, we provide timely, accurate updates on a wide range of legislative and regulatory issues so you can respond quickly to new developments. Your Benefit Consultant will meet with your HR team face-to-face to review legislation that affects your health plan. As a HUB client, you will be kept well-informed on state, regional and national trends in benefit plan design and administration.

The following services are available to you:

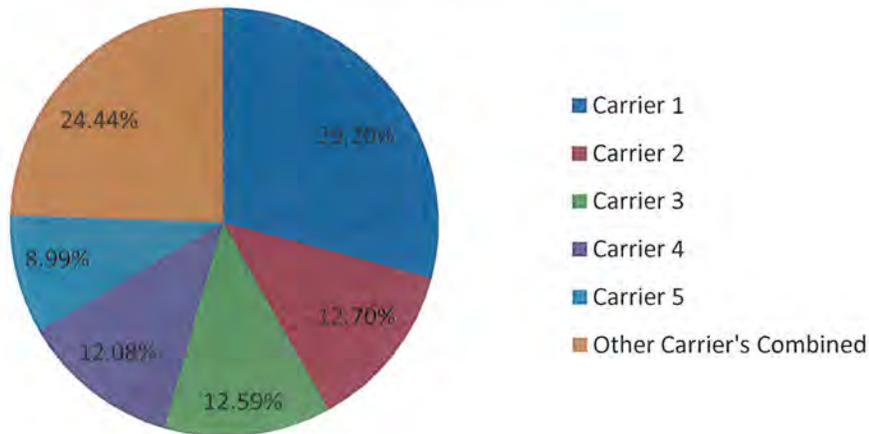
- In-House ERISA Attorneys for one-on-one consultation, client seminars and webinars
- Proprietary HUB Compliance Navigator tool provides you a comprehensive reference guide with annual timelines tailored to your specific plan needs.
- Online resource center, www.HUBhealthreform.com includes a complete library of guidance on Health Care Reform, available 24/7. Get access to the latest updates and information whenever you need it.
- Timely, accurate updates on a wide range of legislative and regulatory issues including but not limited to PPACA, ERISA, COBRA, HIPAA, FLMA, CFRA, ADA, Medicare, and IRS rules. As a client, you will be automatically subscribed to our email bulletins.
- External compliance resources to supplement state compliance issues
- Legal review of plan documents and correspondence

- Compliance audit for all City, State and Federal Regulations imposed by the DOL, ERISA, IRS
- Review of employee manual to ensure all policies and procedures are in compliance
- Review SPDs, contracts, employee policies, administration and communications of compliance practices
- Prepare signature-ready Form 5500 documents.

3. List the top 5 vendors you use that have the largest share of your book of business (i.e., Nationwide, BCBS, etc.)

HUB International has access to a number of different carriers and TPA firms to meet the needs of The City of Traverse City. Below is a break out by percentage of the **top 5 partner** carriers on medical and voluntary lines of coverage. Upon completion of a Non-disclosure Agreement we can share specific carrier name. See [Appendix B](#) for the Non-disclosure Agreement.

Top 5 Carrier's by Percentage of Revenue



4. Describe the services you provide related to compliance advice.

HUB International is a leader in compliance review and service. With three on-staff attorneys we are able to assist our clients with the ever changing regulations and laws. We help them manage the compliance risk inherent with just offering a benefits program.

Compliance Facts and Services

- Recently the DOL has begun increasing staff, and random audits are more prevalent than ever.
- During Mock Review we have found that 9 of 10 groups are out of compliance to the range of \$250,000 to \$500,000 in fines.
- Clients choose 3 of the following for a complete mock audit: HIPAA, ADA, FMLA, COBRA, ARRA, USERRA, Records Retention, and Plan Document compliance.
- Handbook compliance review.
- After the conclusion of the audit, which is done in two parts, we prepare a detailed analysis outlining the areas of concern in each discipline.
- We assist the client in compliance with each of the trouble areas.

5. Do you offer any online enrollment services? If so, what is the cost to the employer for that service?

Employee Navigator

Employee Navigator is a secure online enrollment and communication platform. Employees are presented with a list of plans on the online portal and/or mobile app for easy paperless enrollment. The rules engine only allows employees to see plans they are eligible for and the contributions can be customized to various classes. There is no cost for this service.

Features include:

- Compare medical benefits
- View plan related documents
- Drill into plan details prior to making selections
- Employees can check coverage and make changes due to a life event
- Employee can easily access all forms pertaining to the plans they are enrolled
- Company specific resource sites can be listed

Employee Navigator also supports the **HR department**. It easily consolidates multiple HR tasks into a simple and intuitive platform that will allow you to spend less time on paper work and more time supporting business growth. HR can manage almost every aspect of an employee. Employee data is easily accessible and benefit changes can be made for a life changing event and all benefit change

history is viewable with a click of the mouse. New hires and unfinished employee tasks can be managed and tracked for an easy enrollment process.

Benefit changes and profile changes that need approval will display on the HR home page of Employee Navigator. Tracking helps substantiate compliance, reduce corporate liabilities and itemizes tasks for your employees.

The report section is also a great feature. Commonly used reports include:

- Plan Enrollments
- Enrollment Cost (All Plans)
- Enrollment Cost Summary
- Enrollment Cost Detail
- Enrollment Status
- Enrollment Change
- Events
- Cafeteria Plan Enrollment
- Benefit Confirmation Statements
- Total Compensation Statements
- Payroll Deductions
- Cobra Summary
- Cobra Detail
- New Hire
- Termination
- Dependents
- Beneficiaries
- Missing Beneficiaries
- Ad-hoc Reports

6. Do you provide any Human Resource support of any kind? If so, what services do you offer?

ThinkHR: Advisory Services when you need it

Many organizations are facing a growing knowledge gap when it comes to understanding the complexities of federal and state regulations. When a Human Resource question arises, an accurate answer is often needed right away. We are committed to helping you reduce risk and liability as well as save time and resources.

Our partnership with ThinkHR, the leader in live HR support, provides you with a comprehensive platform of web-based services, including access to “live” HR consultants (where permitted by state regulations). As a supplement to HUB’s in-house compliance resources, ThinkHR provides an expert resource on a wide range of HR issues, including:

- State law issues - typically leave or payroll related employer obligations
- FMLA and other leave of absence questions
- Wage & Hour/Equal Pay Act
- Discrimination – EEO, ADA
- Statutory Compliance
- Workers’ Compensation
- Safety
- Policy & Procedure
- Employee behavior and relations

The following services are available:

- **ERISA Attorney's national telephone hotline providing immediate, live access** to PHR/SPHR certified consultants who will provide answers, advice and second opinions on pressing HR issues and situations. Consultants are available 11 hours every business day and have expertise in all 50 states. All calls are followed up with a written summary.
- **Online library with access** to thousands of documents, forms, templates, tools and guides that simplify your work day and help you comply with the law. The library is maintained by employment lawyers, accountants, and HR experts.
- **Over 200 employee training modules.** The training modules available to you are web-based trainings session's available 24/7. Each training section includes a quiz following along with a certificate of completion.

Please note **Appendix C** for all training modules.

HUB International has a variety of employee communication services, online capabilities and educational legislative and risk consulting webinars and seminars. When HUB is selected to service as your broker / consultant, we will provide you access to our HUB Online resource Library which assist with the following:

HUB Online Resource Library

- COBRA
- HIPAA
- HIPAA Privacy
- Section 125
- FMLA

Within each guide, sections include Related Articles, Q&A, Forms, and Quick Reference. A search function is also available to help you easily find information by allowing you to browse all or only particular sections within each guide.

HUB Online Resource Library provides useful links and articles to industry-related Web sites—all through the convenience of your "HUB Online Resource" homepage. In addition, use the helpful search function so you can promptly find all the information you are looking for.

Within these sites you have direct access to our HUB resource team. In addition if HUB is selected as your broker/consultant of choice, a needs analysis will be conducted to determine a comprehensive risk management protocol process.

HUB International provides our clients with an exclusive online portal, allowing them to have access to the following:

- Snapshot of limits
- OSHA/Tracking/Reporting
- Issue and request certificates
- Request changes and download drivers, vehicles, locations
- Store Documents

HUB Online Resource Library supplies you with *HealthShop* — comprehensive consumer information, in ready-to-print newsletters. Topics include: *At the Doctor's Office, At the Pharmacy, Home Care, and Your Health*. Use these newsletters to help your employees make smart and informed healthcare decisions. Additionally, our customized communication campaign can be tailored to include online materials as well as electronic media, such as CD's and DVD's to spread the message consistently.

7. Describe your services for Form 5500 filings.

HUB will track the requirements of 5500 filing for the client's health and welfare plan(s) on an annual basis. We will work with our vendor to gain the necessary information with the help of the client manager and complete the necessary documents. The filing(s) will be electronic. The client's signature will be necessary before the document is submitted. Once completed, the client will receive a confirmation of completion and a copy of the document along with the SAR to distribute to their employees.

8. Describe your process for updating and disseminating SPD and Plan Documents as well as any other required notices.

Upon being chosen as your agency of record. Our process begins with setting an expectation meeting with the HR Staff where we specifically go through all required documents in place today to review and confirm that they are meeting the DOL expectations as well as to identify those documents that may not be in place at current. We make certain to provide a benefits compliance package for the HR Director to house internally. This package does include the required documents necessary for the Corporations best interest as well as the employee notifications that are required. We then decide on the preferred process to disseminate those documents that have not been distributed to date, to the employees. Once all aspects have been reviewed, corrected if necessary and disseminated to the employees, we do review these documents and all requirements through the plan year and then again at each renewal.

9. What is your process for assisting employees with claim resolution issues?

Since approximately 3% of all claims are paid incorrectly, it is important to have an advocate for your members to assist with claims questions and problems.

We are very serious relative to overall employee assistance, including claim resolution. We have a designated service team that is responsible to assist your employees with any questions, and overall assistance needs for all vendors offered in the The City of Traverse City's benefit package. We do respectfully discuss this process at the time of the agency assignment to establish how the HR Department would like our services to be outlined and offered for the employees overall. Every employer group is different and we never want to assume this directive, so asking pro-actively regarding the role we play in this regard, has proven to show the best outcome. We are intentionally designed and happy to be the first contact for your employees, to take any and all questions, claims issues, pre-determination requests, etc. or if you prefer, we will customize accordingly based on your wishes.

10. Describe the level of service you provide to support our HR staff with bill reconciliations and verification of changes.

Your employee benefits team will assist in all vendor changes for those offered in the overall benefit package; from additions, deletions, birth, divorce, marriages, as well as annual open enrollment changes.

This team is also happy to assist with bill reconciliations when needed.

D.

EMPLOYEE COMMUNICATION

EMPLOYEE COMMUNICATION

1. Describe your approach to communicating benefits to new employees throughout the year, including methods, frequency, etc.

HUB International has a variety of employee communication services available. Benefit Guides are a one-stop reference to employee benefits, providing benefit and contact information, as well as important guidelines related to cost and eligibility and legal compliance notices.

HUB International can assist you in the following ways:

- Create a Needs & Interest Survey for employees
- Offer Wellness Program Best Practices Guide
- Flyers
- Payroll stuffers
- Posters
- Newsletters
- Custom built HR Connection website Please see example in [Appendix D](#)

2. What is your approach to communicating benefits to employees during Open Enrollment?

Our approach is always customized based on the client and the needs of the employee culture. We always ask the questions of what are your expectations, and how can we best execute those needs and expectations for the employee's best interest. We truly enjoy interacting with the employees of our clients and are happy to conduct annual employee meetings to communicate important plan changes and features, as well as host on-going meetings through the year if desired.

3. Please share your typical process for client communication of benefit changes.

Once the annual benefit decisions have been established, it is customary to update/create the existing plan year benefit guide. Guide includes all benefits and costs to employees in one place, as well as all required legal notices. The Benefit Guide streamlines the on boarding process for existing and new hires throughout the plan year. This also allows the HR director to have an annual documentation process for compliance measures to be met and will allow to not having to guess at which notices to give out or when.

Create or update a customized one form enrollment. This form will be accepted by all vendors which makes open enrollment and on boarding a simple process.

Build or update the Client Benefits Intranet Site (HR Connection). The site may include such things as SPD, employee handbook, benefit plan comparison, all ancillary benefit information, as well as any internal forms that may be helpful to house in one location for all employees, etc. This tool is specifically useful to clients with multiple locations, allowing them to have one centralized area to house all benefit information for use by employees and other HR team members.



Logo is personalized to specific employer

Benefit Guide 2014-2015

- **Medical**
- **Vision**
- **Voluntary Life**
- **Long-Term Disability**
- **Dental**
- **Life and AD&D**
- **Short-Term Disability**
- **Enrollment Considerations**



Live a healthy and happy life with help from Hub International

February 2014

625 Kenmoor Ave SE
Grand Rapids, MI 49546



Whether you are new to our organization or an existing member of Sample Client, we are excited that you have made us your employer of choice.

This booklet is to help inform you of the benefits available as a full-time active hourly employee. Ask your supervisor or contact person from the human resource department whenever questions arise.

The information in this enrollment guide is presented for illustrative purposes and was provided from various sources.

As you think about the benefit options that are right for you, consider your personal situation:

- Your marital and family status
- Your short-term future needs - for example, are you expecting a baby? Are you planning to buy a home?
- Your budget
- Your long term future needs - for example, your retirement plan and savings
- Your personal tax situation
- Your dependent benefit needs
- Other insurance coverage you have - for example, the coverage provided through a working spouse.

While every effort was taken to accurately report your benefits, discrepancies are always possible. In case of discrepancy, the actual SPD will prevail.

Sincerely,

Human Resource Manager

Table of Contents

Refer to this list when you need to contact one of your benefit vendors. For general information contact the Human Resource Department.

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<u>MEDICAL INSURANCE: Blue Cross Blue Shield of Michigan</u>	<u>PG 7</u>
<u>DENTAL INSURANCE: Lincoln Financial</u>	<u>PG 13</u>
<u>VISION INSURANCE: VSP</u>	<u>PG 13</u>
<u>BASIC LIFE INSURANCE, AD&D: CIGNA</u>	<u>PG 14</u>
<u>VOLUNTARY LIFE: CIGNA</u>	<u>PG 15</u>
<u>SHORT TERM DISABILITY: Self Funded</u>	<u>PG 17</u>
<u>LONG TERM DISABILITY:CIGNA</u>	<u>PG 18</u>
<u>FLEX REIMBURSEMENT ACCOUNTS: BASIC</u>	<u>PG 19</u>
<u>LEGAL NOTICES</u>	<u>PG 23</u>

If you have Medicare or will become eligible for Medicare in the next 12 months, a new federal law gives you more choices about your prescription drug coverage, starting in 2006. Please see pages 17-19 for more details.

The information in this Benefits Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

Contact Information

Blue Cross Blue Shield of Michigan

(800) 637-2227

www.bcbsm.com

Lincoln Financial Group

(800) 423-2765

www.lincolffinancial.com

VSP

(800) 852-7600

www.vsp.com

CIGNA

(800) 238-2125

www.cigna.com

Basic

(800) 444-1722

www.basiconline.com

Your Benefit Service Team

Client Manager

(616) 233-4111

clientmanager@hubinternational.com

Producer

(616) 233-4111

Producer@hubinternational.com

Toll Free

(800) 936-4236



Hub International is here to help you with any questions that you have regarding your benefits, claims issues, enrollment questions and more. Please feel free to contact any one of your benefit service team members.

Enrollment Considerations

Eligibility Requirements

Employees working the company required minimum hours per week are eligible for coverage following 90 days of employment.

Dependent Coverage

An eligible dependent is a dependent of the employee who is an employee's spouse or the child of the employee by birth, legal adoption, or legal guardianship. Please refer to each insurance carrier's summary plan description to determine when coverage ends for your dependents.

Effective Date

Coverage will become effective the 1st of the month/coinciding with 90 days of employment.

Termination Date

Coverage will terminate as of midnight the day of termination or lay-off from the employer.

Open Enrollment

The Plan offers an annual open enrollment period between December 1st and December 31st each year. Plan changes during open enrollment will be effective January 1st. Unless you have a qualifying event under special enrollment rights, you are not permitted to make any changes to your elections until the next open enrollment period.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents because you have other coverage, you will be able to enroll in this plan without waiting for the next open enrollment period if you lose the other coverage because of loss of eligibility or because employer contributions for your other coverage have been terminated. Loss of eligibility does not include loss of coverage because of failure to pay premiums on a timely basis. It also does not include voluntary termination of coverage under the plan (for example, due to a change in cost or benefits) nor does it include termination for cause, such as making a fraudulent claim or intentional misrepresentation of a material fact in connection with the coverage. To be eligible for the special enrollment, you must request enrollment within **30 days** after your coverage ends and provide satisfactory proof of the loss of other coverage.

If you **gain a new dependent** as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your dependents at that time, provided that you request enrollment within **30 days** after the marriage, birth, adoption or placement for adoption.

The Children's Health Insurance Program Reauthorization Act of 2009

You may also be eligible to enroll in your employer sponsored health plan if you or your dependent:

- lose coverage under Medicaid or a state child health insurance plan, and you request coverage under the group health plan within **60 days** of the loss of coverage, or
- become eligible for a premium assistance subsidy for the group health plan through Medicaid or a state child health insurance plan, and request coverage under the group health plan within **60 days** of becoming eligible for assistance.

Medical Insurance

Blue Cross Blue Shield of Michigan

Medical Benefits are an important part of your financial security. The impact that an unexpected medical expense may have on the financial well being of a family can be overwhelming. Medical Costs have continued to increase rapidly over the last several years.

Your medical coverage program offers you the opportunity to select the medical plan that best meets your individual and family needs.



Sample Client offers eligible employees and their dependents a PPO (Preferred Provider Organization) medical insurance plan. You are not required to select a Primary Care Physician. You will be able to see a specialist without a referral, and may also choose to see providers outside the Blue Cross Network, subject to additional out-of-pocket expenses. In order to receive Preferred Benefits, you must use a Blue Cross participating provider. Please refer to the following Benefit Summary for details. You may opt out of medical coverage under the Sample Client, Inc. plan if you have coverage available from another source, such as through your spouse's employer. **If you choose to opt out, you must provide Sample Client, with proof of insurance and complete the Medical Waiver Information form.**

Weekly Cost	
Single	\$14.40
Double	\$48.00
Family	\$48.00

Community BlueSM PPO Plan 15

Benefits-at-a-Glance



This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

In-network

Out-of-network

Deductible, copays and dollar maximums

Note: Services from a provider for which there is no PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

	In-network	Out-of-network
Deductible	\$2,500 for one member, \$5,000 for the family per calendar year Note: Deductible waived if service is performed in a PPO physician's office.	\$5,000 for one member, \$10,000 for the family per calendar year Note: Out-of-network deductible amounts also apply toward the in-network deductible.
Copays		
• Fixed dollar copays	\$30 for office visits and \$50 for emergency room visits	\$50 for emergency room visits
• Percent copays	20% for general services, waived if service is performed in a PPO physician's office , and 50% for mental health care, substance abuse treatment and private duty nursing	40% for general services and 50% for mental health care, substance abuse treatment and private duty nursing
Copay dollar maximums		
• Fixed dollar copays	None	None
• Percent copays – excludes mental health care, substance abuse treatment and private duty nursing copays	\$2,500 for one member, \$5,000 for two or more members per calendar year	\$5,000 for one member, \$10,000 for two or more members per calendar year Note: Out-of-network copays also apply toward the in-network maximum.
Dollar maximums	\$1 million lifetime per covered specified human organ transplant type and a separate \$5 million lifetime per member for all other covered services and as noted for individual services	

Preventive care services – *Payment for preventive services is limited to a combined maximum of \$500 per member per calendar year

Service	In-network	Out-of-network
Health maintenance exam – includes chest x-ray, EKG and select lab procedures	Covered – 100%*, one per calendar year	Not covered
Gynecological exam	Covered – 100%*, one per calendar year	Not covered
Pap smear screening – laboratory and pathology services	Covered – 100%*, one per calendar year	Not covered
Well-baby and child care	Covered – 100%* • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics	Covered – 100%*	Not covered
Fecal occult blood screening	Covered – 100%*, one per calendar year	Not covered
Flexible sigmoidoscopy exam	Covered – 100%*, one per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered – 100%*, one per calendar year	Not covered

Mammography

Service	In-network	Out-of-network
Mammography screening	Covered – 100%	Covered – 60% after deductible
	One per calendar year, no age restrictions	

Community BlueSM PPO Plan 15

Benefits-at-a-Glance



In-network

Out-of-network

Physician office services

Office visits	Covered – \$30 copay	Covered – 60% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 80% after deductible	Covered – 60% after deductible, must be medically necessary
Office consultations	Covered – \$30 copay	Covered – 60% after deductible, must be medically necessary
Urgent care visits	Covered – \$30 copay	Covered – 60% after deductible, must be medically necessary

Emergency medical care

Hospital emergency room	Covered – \$50 copay, waived if admitted or for an accidental injury	Covered – \$50 copay, waived if admitted or for an accidental injury
Ambulance services – medically necessary	Covered – 80% after deductible	Covered – 80% after deductible

Diagnostic services

Laboratory and pathology services	Covered – 80% after deductible	Covered – 60% after deductible
Diagnostic tests and x-rays	Covered – 80% after deductible	Covered – 60% after deductible
Therapeutic radiology	Covered – 80% after deductible	Covered – 60% after deductible

Maternity services provided by a physician

Prenatal and postnatal care	Covered – 100%	Covered – 60% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and nursery care	Covered – 80% after deductible	Covered – 60% after deductible
	Includes delivery provided by a certified nurse midwife	

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	Covered – 80% after deductible	Covered – 60% after deductible
Unlimited days		
Inpatient consultations	Covered – 80% after deductible	Covered – 60% after deductible
Chemotherapy	Covered – 80% after deductible	Covered – 60% after deductible

Alternatives to hospital care

Skilled nursing care	Covered – 80% after deductible	Covered – 80% after deductible
	Up to 120 days per calendar year	
Hospice care	Covered – 100%	Covered – 100%
	Limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – medically necessary	Covered – 80% after deductible	Covered – 80% after deductible
Home infusion therapy – medically necessary	Covered – 80% after deductible	Covered – 80% after deductible

Surgical services

Surgery – includes related surgical services	Covered – 80% after deductible	Covered – 60% after deductible
Presurgical consultations	Covered – 100%	Covered – 60% after deductible
Voluntary sterilization	Covered – 80% after deductible	Covered – 60% after deductible

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – in designated facilities only
	Limited to \$1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504); specific criteria applies	Covered – 80% after deductible	Covered – 60% after deductible
Kidney, cornea and skin	Covered – 80% after deductible	Covered – 60% after deductible

Community BlueSM PPO Plan 15 Benefits-at-a-Glance



In-network

Out-of-network

Mental health care and substance abuse treatment

Inpatient mental health care	Covered – 50% after deductible	Covered – 50% after deductible
	Unlimited days	
Inpatient substance abuse treatment	Covered – 50% after deductible	Covered – 50% after deductible
	Unlimited days, up to \$15,000 annual, \$30,000 lifetime maximum	
Outpatient mental health care • Facility and clinic • Physician's office	Covered – 50% after deductible	Covered – 50% after deductible
	Covered – 50%	Covered – 50% after deductible
Outpatient substance abuse treatment – in approved facilities	Covered – 50% after deductible	Covered – 50% after deductible
	Up to the state-dollar amount that is adjusted annually	

Other covered services

Outpatient Diabetes Management Program (ODMP)	Covered – 80% after deductible	Covered – 60% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 60% after deductible
Chiropractic spinal manipulation	Covered – \$30 copay	Covered – 60% after deductible
	Up to 24 visits per calendar year	
Outpatient physical, speech and occupational therapy	Covered – 80% after deductible	Covered – 60% after deductible
	Limited to a combined maximum of 60 visits per member per calendar year	
Durable medical equipment	Covered – 80% after deductible	Covered – 80% after deductible
Prosthetic and orthotic appliances	Covered – 80% after deductible	Covered – 80% after deductible
Private duty nursing	Covered – 50% after deductible	Covered – 50% after deductible

Generic prescription drugs	\$10 for each drug	\$10 for each drug plus 25% of the BCBSM approved amount for the drug
Prescribed over-the-counter drugs – when covered by BCBSM	\$10 for each drug	\$10 for each drug plus 25% of the BCBSM approved amount for the drug
Brand name prescription drugs	\$40 for each drug	\$40 for each drug plus 25% of the BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	Copay for up to a 34 day supply: • \$10 for each generic drug • \$40 for each brand name drug Copay for a 35 to 90 day supply: • \$20 for each generic drug • \$80 for each brand name drug	No coverage

Note: If your prescription is filled by any type of network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber has not indicated "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic **plus** the applicable copay.

Rider CI , contraceptive injections Rider PCD , prescription contraceptive devices Rider PD-CM , prescription contraceptive medications	Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and "Rx only" oral or injectable contraceptive medications.
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Medical Reimbursement Account

Sample Client has enhanced the medical plan with a **Medical Reimbursement Account**. Employees will be reimbursed for the following expenses:

- **ANNUAL DEDUCTIBLE AMOUNTS AFTER THE INSURED HAS PAID AN IN-NETWORK DEDUCTIBLE OF \$100 INDIVIDUAL/\$200 FAMILY. THE MAXIMUM REIMBURSEMENT WILL NOT EXCEED \$2,400 FOR AN INDIVIDUAL AND \$4,800 FOR A FAMILY DURING THE PLAN YEAR (In & Out-of - Network Combined).**

How Does the Health Reimbursement Account Work?

- Claims are submitted to Blue Cross for processing.
- Blue Cross sends the insured member an Explanation of Benefits (EOB) form showing how much of the claim was applied to their Deductible.
- The Employee sends the EOB and a completed Reimbursement form to ASR.
- ASR will reprocess the claim and reimburse the employee as follows:

<u>In-Network Calendar Year Deductible</u>	<u>Maximum Reimbursement Amount</u>	<u>Your Net Deductible</u>
Individual - \$2,500	\$2,400.00	\$100.00
Couple/Family - \$5,000	\$4,800.00	\$200.00

Prescription Mail-Order

Medco

Through the Mail Order Service, you can purchase up to a 90-day supply of most prescription medications and order refills for many of the medications you take on an on-going basis. All medications are delivered to your home.

To obtain a mail-order form, please see your Human Resource Department.



Instruction for ordering prescriptions through mail-order:

Please take a minute to make sure...

- You have included your doctor's signed prescription form and filled out the patient information on the front of the order form for each new prescription.
- You have either filled out the credit card section on the front of this order form or included a check or money order for the required co-payment.
- You have written your member ID number on any check or money order.
- You have filled out the Health, Allergy and Medication Questionnaire. This information will help Medco better serve your prescription drug needs.

Expedited shipping available.

You should allow 7-11 days for normal delivery of your medications. For an additional fee, your order will be shipped by an expedited service offered in your area. This option must be chosen when you make the order, and it cannot be applied after an order has already been processed.

If you elect to have this and all future orders automatically charged to your credit card (by checking the box on the front or enrolling by phone), bear in mind that the automated payment plan feature will apply to all mail orders, whether or not they are covered by your plan. Also note that we can only keep one credit card on record.

You may have a balance limit on your plan account. If so, once your unpaid balance exceeds that limit, no additional orders will be processed until the balance has been paid.

You can call 1-800-948-8779 anytime to enroll in our automated payment plan, change the credit card on file, check your account balance, or pay by phone using a credit card.

Get more information from our website.

Visit us at www.medco.com

Ohio law allows a less expensive, generically equivalent drug to be substituted for certain brand-name drugs unless you or your physician directs otherwise.

Medco By Mail Order Form

For New Prescriptions

Fill out one line of the Patient Information section for each new prescription you send. Be sure to include the patient's full name, date of birth, and address, along with the doctor's name and phone number.

For Refills

To order from our website: www.medco.com. Have your member ID number and prescription (Rx) number on hand. Your 12-digit prescription or Rx number can be found on your refill slip.

To order by phone: Call **1-800-4REFILL (1-800-473-3455)** to use the automated refill system. Have your member ID number and refill slip with the prescription information ready.

To order by mail: Include your refill slip(s) with this form. Do not complete the Patient Information section for refills.

For All Mail Orders

Place all prescriptions and refill slips together with this completed order form and your co-payment in the enclosed return envelope.

If You Need Additional Help

A pharmacist is available 24 hours a day, 7 days a week for emergency consultations. Call Member Services at **1-800-903-8346**. The best times to call are Tuesday through Friday afternoons.

Member Information

Member ID:

Group: **BCBSMLG**

Name: _____

Street Address: _____

Street Address: _____

Street Address: _____

City, ST, ZIP: _____

Daytime telephone

Evening telephone

Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:

_____@_____

Shipping address if different from your mailing address

Check if Temporary Permanent

Patient Information—Complete one line for each new prescription (Do not complete for refills)

Patient name	Patient's relation to plan member (fill in one)	Sex	Birth date M/D/YYYY	Doctor name and phone number	Does patient have any other prescription plan?
1	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No

Order Information

Total number of medications in this order (including all refills and new medications)

Subtotal of this order \$

Optional expedited shipping \$14.00 (subject to change)

Total enclosed (do not send cash) \$

Paying by credit card? Visa MC DISCOVER AmEx Diners

M Y

Check here to have all orders billed to your credit card. By doing so, you authorize Medco to keep your card number on file and bill all future orders and any outstanding balances directly to your credit card. To enroll by phone, please call 1-800-948-8779.

Paying by check? Write your member ID number on your check or money order made payable to Medco.

MEDCO
PO BOX 182050
COLUMBUS OH 43272-4404



FORM # HE31508M



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FOLD BACK HERE

Emergency and Urgent Care

As a Blue Care Network member, you can receive benefits when you are away from home. Your dependents are also covered when they are at school away from home.

As a BCN member you have access to Blue Plan physicians and hospitals nationwide. Your BCN coverage includes BlueCard, a program of the Blue Cross and Blue Shield Association. The chart below tells you how to access and arrange for care when you are away from home.



Always carry your ID card for easy reference and access to service. You should not have to complete claims forms or pay up front for health care expenses, except for your usual out-of-pocket expenses such as copayments, deductibles and coinsurance. You will be responsible for non-covered services.

Before you travel, please call Customer Service at 800-622-6667 for more details about your health care benefits away from home.

If you're traveling...	And you need...	Here's what you do...
In Michigan where BCN is offered	EMERGENCY CARE (The symptoms are severe enough that someone with average health knowledge believes immediate medical attention is needed)	Call 911 or go to the nearest emergency room.
	URGENT CARE (The condition requires a medical evaluation within 48 hours)	Call your primary care physician (PCP). BCN Member Services can help you locate a participating urgent care center. Call 800-662-6667.
	FOLLOW-UP CARE (For a medical condition that started before you left home)	Call 888-656-8276 to find a physician at your destination.
In Michigan where BCN is not offered (you are covered for emergency care only)	EMERGENCY CARE	Call 911 or go to the nearest hospital emergency room.
In the United States but outside Michigan	EMERGENCY CARE	Call 911 or go to the nearest hospital emergency room.
	URGENT CARE	Call BlueCard at 800-810-BLUE (2583)
	FOLLOW-UP CARE	Call BlueCard at 800-810-BLUE (2583) to find a physician
	ROUTINE CARE for members living away from home	Call BlueCard at 800-810-BLUE (2583)
Outside the United States	EMERGENCY CARE	Go to the nearest hospital emergency room (you may be required to pay for services and then seek reimbursement).

Dental Insurance

Lincoln Financial

Sample Client realizes the important of good dental care in the maintenance of your overall good health. Good dental care required regular checkups and preventive care. Your dental insurance options provide important insurance protection against the high cost of dental care for you and your family and are currently provided by Lincoln Financial. This chart shows how the plan works and how each type of service is covered.



Calendar Year Deductible	
Applies to Class II & III Services Single/Family	\$50/\$150
Type of Service	Plan Pays
Preventive Services (Class I) <ul style="list-style-type: none"> ○ Exams ○ Cleanings ○ X-Rays ○ Space Maintainers 	100%
Basic Services (Class II) <ul style="list-style-type: none"> ○ Fillings ○ Root Canals ○ Sealants ○ Extractions 	80%
Major Services (Class III) <ul style="list-style-type: none"> ○ Bridges & Dentures ○ Crowns ○ Inlays, Onlays, Veneers 	50%
Calendar Year Maximum for Class I, II, & III Services	\$1,000
Orthodontia (Class IV) <ul style="list-style-type: none"> ○ Children under age 19 	50%
Lifetime Maximum for Class IV	\$1,000

Vision Insurance

VSP



Eye Care is about more than just getting glasses or contacts. It's about health. Eye exams can catch early warning signs of serious health conditions, like diabetes, high blood pressure, and high cholesterol. This is why Sample Client is giving you vision insurance from Vision Service Plans (VSP is the largest vision provider in the country).

This chart shows how the plan works and how each type of service is covered.

Type of Service	In Network	Out of Network
Exam (once every 12 months)	\$20 Copay balance covered in full	Reimbursed up to \$35
Lenses (once every 12 months)	Copay is applied to lenses and frames	
Single Vision Lenses	\$20 Copay balance covered in full	Reimbursed up to \$25
Lined Bifocal Lenses	\$20 Copay balance covered in full	Reimbursed up to \$40
Lined Trifocal Lenses	\$20 Copay balance covered in full	Reimbursed up to \$55
Contacts (once every 12 months)	Covered up to \$140 allowance	Reimbursed up to \$105
Frames (once every 24 months)	Covered up to \$150 allowance	Reimbursed up to \$45

Services and materials obtained from a non-participating provider will be reimbursed up to amounts on the above schedule. If you receive an examination and/or materials from a non-participating provider, you are responsible for paying the provider in full, and submitting itemized receipts to VSP for reimbursement at 3333 Quality Drive, Rancho Cordova, CA 95670. It is important to note that the reimbursement schedule does not guarantee full payment.

Cost per week - \$0.00
Employer Paid Benefit

Basic Life and AD&D

CIGNA

Your Life and AD&D Insurance program provides an important source of income and financial security for your dependents in the event of your death. AD&D Insurance benefit provide additional insurance protection to you and your family in the case of your accidental death or a specific accidental injury.

Your Life and AD&D Insurance options are:

If you do not participate when you are initially eligible, future enrollment will be subject to proof of good health for any amount of coverage.

Life and AD&D Insurance Benefits*		
Employee Benefits	Amount	
Basic Life Benefits	Employee	\$50,000
	Spouse	\$10,000
	Child(ren) –Age 6 Months - 19	\$2,000
AD&D Benefits	The same as your employee basic life insurance benefit	

*Age Based Reductions – Benefit age reductions apply starting at age 65. Life Insurance Benefit for an employee age 65 and over will reduce to: 65% of the Life Insurance Benefit at age 65; 45% of the Life Insurance Benefit at age 70; 30% of the Life Insurance Benefit at age 75; and 20% at age 80.

Employer Paid Benefit



Voluntary Life

CIGNA

Your life and AD&D Insurance program provides an important source of income and financial security for your dependents in the event of your death. AD&D Insurance benefit provide additional insurance protection to you and your family in the case of your accidental death or a specific accidental injury. As a full-time employee working the required hours per week will be eligible for this benefit after 90 days of service.

Proof of good health is not required if you choose to participate in the plan when you are initially eligible. If you do not participate when you are initially eligible, future enrollment will be subject to proof of good health.

Benefit Summary:

Individual elections:

- **You** may elect benefit coverage ranging from five plans: \$150,000, \$100,000, \$75,000, \$50,000 or \$25,000.
- **A Spouse** is eligible for \$50,000, \$35,000, \$25,000 or \$10,000 based on the level the employee has chosen.
- **Dependent Child(ren)** age 6 months to 19 (or 25 if a full-time student) are eligible for \$10,000, \$7,500, \$5,000 or \$2,000 based level the employee has chosen. Birth to less than 6 months is eligible for \$500.

Plan Features:

- **Disability Waiver of Premium:** If an employee becomes totally and permanently disabled prior to age 60, their life insurance will continue in force without further payment of premium on a year-to-year basis but not beyond age 65. Subject to periodic submission of evidence of disability.

Portability/Conversions options are available. Please refer to your certificate of coverage for more details.

Age Reduction

Coverage Amounts for the employee reduced 65% of the Life Insurance Benefit at age 65; 45% of the Life Insurance Benefit at age 70; 30% of the Life Insurance Benefit at age 75; and 20% at age 80.

Guarantee Issue Underwriting

Coverage is guaranteed without proof of good health up to \$150,000 per employee, \$50,000 for a spouse and \$10,000 for Child(ren).



WEEKLY DEDUCTION

Plan A – Employee - \$150,000, Spouse - \$50,000, Child(ren) - \$10,000 – WEEKLY COST				
	Employee	Employee & Spouse	Employee & Child(ren)	Employee, Spouse & Child(ren)
<30	3.12	4.16	3.54	4.57
30 – 34	3.12	4.16	3.54	4.57
35 – 39	3.81	5.08	4.23	5.50
40 – 44	5.54	7.39	5.96	7.80
45 – 49	8.31	11.08	8.73	11.50
50 – 54	13.16	17.54	13.57	17.96
55 – 59	21.12	28.16	21.54	28.57
60 – 64	32.20	42.93	32.61	43.34
65 – 69	58.85	78.47	59.27	78.88
70 – 74	120.12	N/A	120.54	N/A
Plan B – Employee - \$100,000, Spouse - \$50,000, Child(ren) - \$10,000 – WEEKLY COST				
	Employee	Employee & Spouse	Employee & Child(ren)	Employee, Spouse & Child(ren)
<30	2.08	3.12	2.50	3.54
30 – 34	2.08	3.12	2.50	3.54
35 – 39	2.54	3.81	2.96	4.23
40 – 44	3.70	5.54	4.11	5.96
45 – 49	5.54	8.31	5.96	8.73
50 – 54	8.77	13.16	9.19	13.57
55 – 59	14.08	21.12	14.50	21.54
60 – 64	21.47	32.20	21.88	32.61
65 – 69	39.24	58.85	39.65	59.27
70 – 74	80.08	N/A	80.50	N/A
Plan C – Employee - \$75,000, Spouse - \$35,000, Child(ren) - \$7,500 – WEEKLY COST				
	Employee	Employee & Spouse	Employee & Child(ren)	Employee, Spouse & Child(ren)
<30	1.56	2.29	1.87	2.60
30 – 34	1.56	2.29	1.87	2.60
35 – 39	1.91	2.80	2.22	3.11
40 – 44	2.77	4.07	3.09	4.38
45 – 49	4.16	6.10	4.47	6.41
50 – 54	6.58	9.65	6.89	9.96
55 – 59	10.56	15.49	10.87	15.80
60 – 64	16.10	23.61	16.41	23.92
65 – 69	29.43	43.16	29.74	43.47
70 – 74	60.06	N/A	60.37	N/A
Plan D – Employee - \$50,000, Spouse - \$25,000, Child(ren) - \$5,000 – WEEKLY COST				
	Employee	Employee & Spouse	Employee & Child(ren)	Employee, Spouse & Child(ren)
<30	1.04	1.56	1.25	1.77
30 – 34	1.04	1.56	1.25	1.77
35 – 39	1.27	1.91	1.48	2.12
40 – 44	1.85	2.77	2.06	2.98
45 – 49	2.77	4.16	2.98	4.37
50 – 54	4.39	6.58	4.60	6.79
55 – 59	7.04	10.56	7.25	10.77
60 – 64	10.74	16.10	10.94	16.31
65 – 69	19.62	29.43	19.83	29.64
70 – 74	40.04	N/A	40.25	N/A
Plan E – Employee - \$25,000, Spouse - \$10,000, Child(ren) - \$2,000 – WEEKLY COST				
	Employee	Employee & Spouse	Employee & Child(ren)	Employee, Spouse & Child(ren)
<30	0.52	0.73	0.61	0.81
30 – 34	0.52	0.73	0.61	0.81
35 – 39	0.64	0.89	0.72	0.98
40 – 44	0.93	1.30	1.01	1.38
45 – 49	1.39	1.94	1.47	2.03
50 – 54	2.20	3.07	2.28	3.16
55 – 59	3.52	4.93	3.61	5.01
60 – 64	5.37	7.52	5.45	7.60
65 – 69	9.81	13.74	9.90	13.82
70 – 74	20.02	N/A	20.11	N/A

Short Term Disability Insurance

Self-Insured

Short Term Disability Income Benefits

Sample Client provides Short Term Disability insurance to all full time non-union eligible employees.

Plan Features:

- This plan covers **60%** of your basic weekly income if you suffer from a disabling accident or illness that is not work related.
- The maximum weekly benefit covered under this plan is **\$400.00**
- Benefit payments will begin after you have been disabled and unable to work for **1st day** accident or **8th day** illness.
- You will receive benefit payments for up to **90 days** while you are disabled.



- Short term disability benefits are paid with your normal payroll cycle **(ONLY IF SELF-FUNDED)**.
- Maternity is covered as any other illness.
- Pre –Existing conditions are covered.
- Benefits may be payable for a partial disability.

Short Term Disability Calculation Example:

If an employee makes \$40,000 a year, their Weekly STD benefit would be \$400.00

Employer Paid Benefit

Long Term Disability

CIGNA

Long Term Disability (LTD) Insurance provides an important source of income for full-time associates should you become disabled and unable to work for an extended period of time. The financial consequences of a long term disability can be disastrous to your financial security and that of your family.

Plan Features:

- This plan covers 60% of your current base earnings if you suffer from a disabling accident or illness.
- The maximum monthly benefit is \$3,500 for full-time Non-union and Unit #2 and #3 associates and \$1,500 for full-time Unit #1 associates.
- Benefit payments will begin after you have been unable to work for 90 days (elimination period) due to disability.
- You will receive your benefit payment on a monthly basis and until you are age 65, as long as you remain totally disabled.

Long Term Disability Limitations:

- This plan will not cover a disability caused by any pre-existing condition you had within 3 months before the effective date of your insurance under our plan. You can receive benefits for this condition if your disability begins after you have been insured under this plan for 12 months.



- You can receive benefits for a disability due to mental/nervous or alcohol/drug disorder for up to 24 months, combined, during your lifetime.
- Benefit payments will be reduced by any Social Security disability benefits that you or your family members are eligible to receive; benefits will also be reduced by other forms of income you receive, such as Workers' compensation and sick leave.

Long Term Disability Calculation Example:

An employee is making \$50,000 per year,
Monthly LTD benefit would be \$2,500

Employer Paid Benefit

Flexible Spending Accounts

BASIC

Health Care Spending Account



Through the use of the Health Care Spending Account, you can use pre-tax dollars to pay for uninsured medical, prescription, dental and vision expenses. A partial listing of eligible expenses is below.

The account operates much like a bank account. Deposits are made into your account through pre-tax payroll deductions. You may deposit annually a maximum of **\$2,500**. Withdrawals from the account are made using a Reimbursement Form. The Reimbursement Form, along with a copy of your receipt and/or bill, and a description of the expense should be submitted to Basic. A check will then be issued to you. **Insert language regarding termination of coverage and or run out period.**

Eligible Expenses (Partial Listing)

Acupuncture	Cosmetic Surgery (medically necessary)	Hypnosis (for treatment of disease)	Prescription Drugs
Arch supports	Crutches	Immunizations	Smoking Cessation Aids (prescription only)
Alcoholism or Drug Treatment costs	Deductibles and Co-payments	Lab Fees	Sterilization
Ambulance	Dental and Vision	Lasik Eye Surgery	Surgery (General)
Artificial Limbs	Diagnostic Tests	Learning Disability	Syringes
Birth Control Pills	Doctor's Fees	Lifetime Care	Television (closed captioned)
Car Controls (equipment for handicapped)	Eyeglasses (lenses, frames, and exams)	Nursing Home Costs	Well Baby Care
Chiropractors	Guide Dog	Optometrist	Wheelchairs
Clinic Costs	Health Care Equipment	Orthopedic Shoes	X-Rays
Contact Lenses (including insurance)	Hearing Aids	Pap Smears	Vaccines
		Physical Exams	Over the Counter Drugs (only if prescribed by a physician)
		Physical Therapy	

Ineligible Expenses (Partial Listing)

Any illegal treatment	Life insurance or disability insurance
Babysitting fees to enable you to visit a doctor	Marriage counseling
Cosmetic Surgery	Massage therapy (unless prescribed)
Dental bleaching/teeth whitening	Propecia or Rogaine
Ear piercing	Sonicare toothbrushes
Health club memberships	Vitamins & nutritional supplements
Len replacement insurance(warranties)	Weight loss treatment programs

EXPENSE	ESTIMATED COST
MEDICAL*	
Acupuncture	\$
Chiropractor	\$
Podiatrist	\$
Deductible	\$
Co-pays	\$
Doctor fees	\$
Office visit	\$
Prescriptions	\$
Hospital bills	\$
Laboratory fees	\$
Medic alert bracelet	\$
Dermatologist	\$
Immunizations	\$
Obstetrical expenses	\$
Routine physicals	\$
X-rays	\$
Well baby checkups	\$
HEARING*	
Hearing exam	\$
Hearing aids	\$
Special batteries	\$
VISION*	
Glasses	\$
Eye exam	\$
Contact lenses	\$
Contact lens solution	\$
Prescription sunglasses	\$
LASIK surgery	\$
Visine and eye drops	\$
DENTAL*	
Orthodontic	\$
Dentures/bridge/ crowns	\$
Fluoride treatments & seals	\$
Cleanings and fillings	\$
Root canals	\$
Extractions	\$
COLUMN #1 TOTAL	\$

EXPENSE	ESTIMATED COST
DIABETIC SUPPLIES*	
Insulin	\$
Glucometer	\$
Syringes/Needles	\$
Test Strips	\$
BIRTH CONTROL DEVICES*	
Condoms	\$
Prescriptions	\$
Sterilization	\$
Spermicidal foam	\$
THERAPY*	
Physical therapy	\$
Learning disability	\$
Psychologist fees for medical care	\$
Psychiatric care	\$
PHYSICAL IMPAIRMENTS*	
Wheelchair	\$
Crutches	\$
Walker	\$
Custom made orthopedic shoes and inserts	\$
SPECIAL NEEDS*	
Stop smoking programs	\$
Transportation to and from doctor/ hospital (call for current rates and guidelines)	\$
OVER-THE-COUNTER DRUGS*	
Allergy medicine	\$
Antacids	\$
Anti-diarrhea medicine	\$
Bactine	\$
Band-aids	\$
Bug bite medication (not bug spray)	\$
Calamine lotion	\$
Carpal tunnel wrist supports	\$
Cold medicines	\$
COLUMN #2 TOTAL	\$

EXPENSE	ESTIMATED COST
OVER-THE-COUNTER DRUGS CONT.*	
Cold/hot packs for injuries	\$
Cough drops	\$
Diaper rash ointments	\$
Fiber supplements	\$
First aid cream	\$
Glucosamin/ chondroitin	\$
Hemorrhoid medication	\$
Home pregnancy tests	\$
Incontinence supplies	\$
Laxatives	\$
Liquid adhesive for small cuts	\$
Menstrual cycle products for pain and cramp relief	\$
Motion sickness pills	\$
Nasal sinus sprays	\$
Nasal strips	\$
Nicotine gum or patches	\$
Pain reliever	\$
Pills for persons who are lactose intolerant	\$
Products for muscle pain i.e., Bengay	\$
Reading glasses	\$
Rubbing alcohol	\$
Sinus medications	\$
Sleeping aids used to treat occasional insomnia	\$
Special ointment/ cream for sunburn	\$
Wart remover treatments	\$
COLUMN #3 TOTAL	\$

EXPENSES THAT REQUIRE A LETTER OF MEDICAL NECESSITY	
The IRS allows reimbursement of the following with a copy of the physician's statement of medical necessity that includes length and frequency of treatment. Treatment cannot be for general health or well being. A copy needs to be submitted with every reimbursement request and a new letter needs to be obtained at the beginning of each plan year.	
EXPENSE	ESTIMATED COST
Health club fees/ gym	\$
Nutritional supplements/vitamins	\$
Massage therapy	\$
Acne medication	\$
Sunscreen/ Suntan lotion	\$
Weight loss programs (i.e. Weight Watchers and Jenny Craig) Program fees are	\$
COLUMN #4 TOTAL	\$
ESTIMATED EXPENSES	
COLUMN 1	\$
COLUMN 2	\$
COLUMN 3	\$
COLUMN 4	\$
TOTAL ESTIMATED EXPENSES	\$

Due to changes made with the Healthcare Reform Bill of 2010 effective January 1, 2011 all over-the-counter medications will no longer be eligible for reimbursement under a Flexible Spending Account without a prescription from a physician. Any over-the-counter medication purchased after December 31, 2010 must be accompanied by a letter or prescription from a physician stating the medical necessity of said medication. At this time it appears certain over-the-counter items deemed not medications (such as band-aids, syringes, wraps, etc.) will still be eligible. As clarifications are made regarding these distinctions we will provide participants with updates.

FLEXIBLE SPENDING ACCOUNTS

Dependent Care Flex Account

Through the use of a Dependent Care Flex Account, you can reduce your tax burden by using pre-tax dollars to pay for eligible child or dependent care expenses. Federal law also allows you to claim a direct credit against federal income taxes for eligible child or dependent care expenses. You may use this account or take a federal tax credit - but not both.

This plan operates much like a bank account. Deposits are made into your account through pre-tax payroll deductions. Withdrawals from the account are made using a reimbursement form, which is available through your Human Resources Department. The reimbursement form, along with a copy of your receipt and/or bill and a description of the expense should be submitted to Basic.



Dependent care expenses are expenses incurred by you to enable you to work. If you are married, the expenses must be to enable you and your spouse to work, or your spouse to attend school on a full time basis. The expenses must be for the care of your dependent that is under age thirteen (13) and for whom a personal-exemption deduction is allowed for federal income tax purposes; or for the care of your dependent or spouse who is physically or mentally incapable of self-care, or for household services in connection with the care of such a person.

If you are single or married filing a joint return, the maximum amount that can be reimbursed (i.e., deposited) is the lowest of your earned income or your spouse's earned income, or \$5,000. If you are married and you file a separate tax return, the maximum amount that can be reimbursed (i.e., deposited) is the lower of 100% of your spouse's income or \$2,500. If your spouse is a full-time student or is incapable of self-care, your spouse's earned income is assumed to be not less than \$3,000 if you provide care for one person and \$6,000 if you provide for two or more people.

Plan Carefully

Since funds going into your account are free from taxes, the IRS imposes some restrictions on the operation of this account. If any funds remain in your DCRA account at the end of the plan year, according to IRS regulations, **you will forfeit this amount**. You will receive a statement from Basic before the end of the plan year to help you manage this account.

Q & A on Dependent Care Reimbursement Account

Q. My child is cared for by a neighbor in her home. Can I set aside money in the dependent care account to cover these expenses?

A. Yes. As long as the child-care services are necessary to enable you and your spouse to work, the child is under 13 years of age and you can provide your neighbor's name, address and social security number.

Q. If my spouse and I both participate in the dependent care account plans, how does the \$5,000 limit apply?

A. The \$5,000 limit does not apply to each account separately, but rather applies to limit the total tax-free dependent care reimbursements that you can receive from all employer plans in the year. Accordingly, the maximum tax-free reimbursement you and your spouse can receive is \$5,000 if you file a joint return. If instead, you file separate returns, each of you will be entitled to receive \$2,500 of reimbursement tax free.

Q. Can the reimbursement account be used to cover the cost of a baby-sitter for social purposes?

A. No. You may only use the account to reimburse you for expenses for dependent care while you and your spouse (if married) are at work.

Q. I'm a little confused about the term "care that enables you and your spouse to work." Here is my situation: My 3 year old son attends nursery school 5 days a week. My spouse works full time and I work 3 days a week, but I am looking for a full time job. Does that 2 day discrepancy mean I can't fully participate in the dependent care program?

A. No, you are still eligible to participate; that's because the word "work" includes any time you are paid to work, whether full or part time as well as any time during which you are actively looking for work.

Q. My elderly mother lives in my home and requires care while I am at work. Can I make deposits to the dependent care account to cover the expenses of her care?

A. Yes. If she is a dependent for income tax purposes, spends at least 8 hours a day in your home and is incapable of self-care, the expenses qualify for reimbursement.

Q. Is the dollar limit under the dependent care account affected by the number of children that I have?

A. No. Unlike the dependent care tax credit, the dependent care account exclusion is not affected by the number of children you have. The dollar limit under the dependent care account, however, is determined by whether you file a separate or joint return. The dollar limit is \$5,000 if a joint return is filed and \$2,500 if separate returns are filed.

Legal Notices

Michelle's Law

Michelle's Law allows seriously ill college students, who are covered dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status.

Under the law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. Further, if any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

Notice of Privacy Practices Available

The U.S. Department of Health and Human Services has issued regulations as part of the Health Insurance Portability and Accountability Act of 1996. These regulations, known as the Standards for Privacy of Individually Identifiable Health Information, were effective April 14, 2003 (or April 14, 2004 for small health plans) and control how your medical information may be used and disclosed and how you can access this information. Please be advised that your health benefits plan maintains a current Notice of Privacy Practices to inform you of the policies that it has established to comply with the Standards for Privacy. This Notice describes the responsibilities of the plan and any third party assisting in the administration of claims regarding the use and disclosure of your protected health information, and your rights concerning the same.

This Notice is available to you upon request by contacting your company's Privacy Official or Human Resource Director.

Women's Health and Cancer Rights Act of 1998

Important Notice

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully. As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient.

Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under this plan.

The Newborn Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Important Notice from Sample Client About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Sample Client and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. Sample Client has determined that the prescription drug coverage offered by the Sample Client is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Sample Client coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Sample Client coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Sample Client and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Sample Client changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: **June 1st, 2014**

Name of Entity: **Sample Client**

Contact--Position/Office: Human Resources

Address: 1234 ABCD Drive

Traverse City, MI 49525

Phone Number: **(616) 555-5555**

The information in this Benefits Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

E.

GENERAL

GENERAL

1. **What other lines of coverage do you broker or administer (i.e., worker's compensation, professional liability, 401(k), etc.)**

Business Insurance and Risk Management Consulting. Our goal is to give you the risk management solutions you need to run your business more effectively based on your needs and expectations. Risk consulting, coverage analysis, loss control, and claims management are the cornerstones of our commercial property and casualty practice.

Personal Lines. We help individuals protect and preserve their personal, family and estate assets. As the largest and most sophisticated personal insurance practice in North America, we are a trusted resource for all personal insurance and risk management needs.

Select Business Unit. Small business owners are provided the benefit of cost-effective coverage solutions and local service in this specialized unit. We have the knowledge and experience to deliver solutions that are properly scaled to meet your needs regardless of company size, location or industry.

2. **Please provide the web address (and demo login information if necessary) to your client communication portal – if offered.**

HUB Online Resource Library:

HUBmidwest.accountportal.net

Think HR

thinkhr.com

username: email address

password: HUB2014

3. **The top two brokers selected in this RFP process will be asked to provide samples of employee communication materials.**

See Appendix D

F.

IMPLEMENTATION

IMPLEMENTATION

1. Explain your implementation process including time frame. What is the minimum time frame needed to ensure a smooth transition?

Once we are notified of being selected as the agency of record, we ask for the expectation meeting with the HR Staff. We intentionally try to keep this process as simple and comfortable as possible. During this meeting we ask all pertinent questions in regard to the benefit package in place, preferred methods of communication with HR and employees, and discuss what deliverables Human Resources would like us to implement in order of importance from their perspective.

We then proceed internally on our end by collecting all plan documents to create the formal benefit guide for HR review and approval; collecting the current SPD in place, employee handbook, Section 125, etc. for compliance review to establish and offer any recommended revisions.

We then complete the compliance binder, to be housed in HR offices, as well as setting the compliance audit date and time that works best for the HR Director. We ask the HR staff to attend the expectation meeting, which is approximately 1 hour. The remainder of the detail will be on our end.

HUB International will deliver the documents for review, and approval. Once approved by HR, we print and deliver directly to the HR offices. Sometimes, this process is done at the time of the employee renewal meetings. This point is relative to the discussions during the expectation meeting in regard to what the HR Staff feels is most appropriate from a timing perspective.

Typically, the outstanding details are when we complete the compliance audit. This is based on the HR Staff's availability and will last approximately 3 hours. It is simply question and answer, no documentation is required to be prepared prior to this meeting.

HUB International begins immediately upon notification of being awarded the business. The minimum timeframe needed to ensure a smooth transition begins after the expectation meeting with the HR Director/Team. We ask for approximately 30 days to deliver benefit guides, compliance binder/binder documents, set up compliance audit.

2. What involvement will be required from us during the implementation process? Be very specific.

HUB International feels strongly that this is an HR Team/Director decision. Based on that result, all that will be required of the HR Team will be to attend the initial expectation meeting. This will allow us the understanding of what deliverables by order of importance, establishing preferred methods of communication and how often you would like to see us in person for HR and overall staff needs. Once these key points are established, we take it from there and deliver each service as agreed and expected.

We do feel that the partnership is key in building a successful relationship. As an extension of your HR Department, we are comfortable with any level of interaction/direction from the HR Team. We never forget that you are the client and your expectations are our responsibility to deliver on-going.

- 3. Please provide a sample implementation project plan and timeline.**

See Appendix E

G.

REFERENCES

REFERENCES

1. Please provide 3 references of current clients who have similar demographics. At least 1 of the 3 should have converted within the last year. At least 2 of the 3 should be municipal or governmental clients. Please provide client name, contact name, address, phone number, services provided, and year they became a client.

Crawford County

Paul Compo- Controller

200 W. Michigan Ave. Grayling, MI 49738

989-344-3202

Employee Benefits which include: Medical, Dental, Vision, Life, FSA/LTD/STD, COBRA

March 2013 they became a HUB Client

Bay Area Transportation Authority

Kelly Yaroch -VP of Operations

3233 Cass Rd. Traverse City, MI 49694

231-933-5544

Employee Benefits which include: Medical, Dental, Vision, Life, FSA/LTD/STD, Telehealth

September 2012 they became a HUB Client

District Health Department #10

Becky Gaines- HR Director

521 Cobbs Street Cadillac, MI. 49601

231-876-3833

Employee Benefits which include: Medical, Dental, Vision, Life, FSA/LTD/STD, COBRA

July 2014 they became a HUB Client

2. Please provide 3 references of former clients who had similar plan demographics. At least 1 of the 3 should have left within the last year. At least 1 of the 3 should be municipal or governmental clients. Please provide former client name, contact name, address, phone number, services provided, and year they became and the year they ceased to be a client and the reason(s).

Spartan Nash

Kris Johnson – Director of Benefits

PO Box 8700

Grand Rapids, MI 49518

616-878-2882

Employee Benefits which include: Medical, Dental, Vision, Life, FSA/LTD/STD, COBRA

Client timeframe: 2002-2014

Reason: Buyout

City of Grandville

Ken Krombeen – City Manager

3195 Wilson Ave

Grandville, MI 49418

616-530-4980

Employee Benefits which include: Medical, Dental, Vision, Life, FSA/LTD, COBRA

Client timeframe: 2005-2013

Reason: Writing agent moved to another agency

Lamar Construction

Yvonne Bedolla – Director, Human Resources & Administration at GNS America

13441 Quincy Street

Holland, MI 49424

616-312-1009

Employee Benefits which include: Medical, Dental, Vision, Life, FSA/LTD/STD, COBRA

Client timeframe: 2011-2015

Reason: Lamar Construction went out of business

H.

EXPENSES

EXPENSES

Describe your remuneration. Is it a commission paid by insurance companies, or flat fee structure? If flat fee, describe the basis of the payment (i.e., per employee, per month, etc.)

We offer all deliverables inclusive in this RFP for the same level of commission that is in force today with the incumbent agent/agency for the employee benefits package.

We are able to collect directly from the insurance carrier either on a percentage of premium basis, established carrier commission scale that is non-negotiable, or a flat PEPM, if permitted. Due to our transparency model, we have this discussion directly with our clients to make certain that all are in agreement with the amount paid for the services rendered.

*Please note: a \$20,000 minimum commission level is required.

Transparency and Full Disclosure Our Client Commitment

HUB International is dedicated to maintaining and upholding the highest standards of ethical conduct and integrity. We desire to be your trusted advisor and as such, we must earn your confidence. So we make a promise, "The HUB Advantage" and we put our commitment in writing to you;

We strive to secure the most favorable terms from insurers, taking into account all the circumstances involved.

We are open and honest as to how we are paid for placing your insurance. Should we ever recommend a carrier change we will provide to you information on commission associated with such a product.

Our objective is to provide you with choices that meet your insurance requirements and to educate you so you can make an informed decision. Again, carrier compensation and bonus structures are fully disclosed.

We comply with every law of every jurisdiction in which we operate. Our ethics are beyond reproach and we will do it the right way, every time.

1. What are the start-up/conversion costs and the termination costs?

There are no startup/conversion costs or termination costs associated with working with HUB International.

2. Describe what consulting services are included, and related hourly charges and out-of-pocket expenses for additional services (for example, Form 5500 preparation, Plan Document, COBRA administration – if offered, bill reconciliation, etc.)

All of our services included in this RFP are all inclusive: including broker consulting, ERISA attorney consulting, ThinkHR consulting, annual 5500 preparation and filing, annual plan document preparation, and bill reconciliation when needed.

*Please note: a \$20,000 minimum commission level is required.

We do not offer COBRA administration in-house. However, we do have a strong, preferred COBRA vendor that includes special pricing to HUB International that we offer to our clients.

3. In addition to the expense schedule please identify any other fee-for-service or activity not covered on the "Service Activity" listing, i.e., postage, handling, supplies, servicing commissions, etc. Please be specific.

We do not charge any additional fees to our large clients for services included in this RFP. Postage, printing, handling, are all included as well.

The only time you may see an additional fee, is when the client chooses to move to an external vendor for more sophisticated enrollment vendors, COBRA Administration, etc.

4. What is your expected margin on a client our size?

Please review HUB's Transparency and Full Disclosure statement on page 36.

APPENDIX A

Biographies

The team lead and main contact will be **Nicole Rodriguez, Sales Executive for HUB International.**
Nicole works and resides in Traverse City, MI.



Nicole Rodriguez
Sales Executive, Employee Benefits

Nicole has over 15 years of experience in Employee Benefits and will be the lead contact with responsibilities to include, but not limited to, market analysis, renewal negotiation, product and service implementation, strategic development, compliance review and consulting and day-to-day service support. Prior to coming to HUB Nicole worked for a large commercial insurance carrier specializing in middle to large market clients (50-1,000 employees). She also specializes in benefit programs, claims and benefit analysis, cost projections, managed care network analysis and vendor negotiations for mid to large size companies with an emphasis on experience rating and alternative funding. Her experience allows her to effectively negotiate with underwriters on behalf of her underwritten clients.

Nicole's primary support person will be Tonya Carmoney, Account Manager for HUB International.
Tonya works and resides in Traverse City, MI.



Tonya Carmoney
Account Manager

Tonya began her career with HUB International in 1995 in the accounting department and has worked in the Employee Benefits division for the past 16 years. Tonya has been licensed in Life, Accident & Health since 2001 and obtained her "Chartered Benefits Consultant" (CBC) designation in 2007. As an Account Manager, Tonya is responsible for the day to day Employee Benefit account management which includes, contract review; underwriting, education and communication, claims analysis and creating customized Employee Benefits web-sites for corporate clients.

Paula VanAmberg- Client Manager for HUB International will also serve as part of Nicole's support team. Paula works and resides in Traverse City, MI.



Paula VanAmberg
Client Manager

Paula joined the Employee Benefits team at HUB International in September, 2014. She has worked in the insurance industry for 18 years, and has a diverse background in client services, human resources and agency management. Paula was licensed in Life, Accident & Health in 2005 and has since worked in employee benefits, human resources and practice management in the medical industry. At HUB, Paula is responsible for the day-to-day employee benefit account management, client education and communication, contract review, claims analysis and more.

The remainder of the service team is noted below. They all work and reside in Grand Rapids, Michigan, but serve the NMI Region daily.



Kristi Russo
Client Manager, Team Leader

Kristi joined the employee benefits team at HUB in September 2011. Prior to that, she worked at Old Kent Insurance Group, with Old Kent Bank being her primary account and Blue Cross Blue Shield of Michigan. At BCBSM, Kristi worked in several different areas from marketing to customer/provider service to training BCBSM employees. At Old Kent Insurance Group, Kristi was responsible for all the Old Kent employees in 26 states as well as assisting agents with claims resolution and employee open enrollment meetings. At HUB, Kristi is assisting in open enrollment meetings, client retention and all aspects of the Employee Benefits Department. Kristi has been in the insurance industry for 23 years.



Cory Cutler
Client Manager

Cory comes to HUB International with over 13 years of experience in Employee Benefits. Cory has been licensed in Life, Accident & Health since 2007 and obtained her "Accredited Customer Service Representative" (ACSR) designation in 2011. She possesses diverse experience with all aspects of employee benefits. Her responsibilities include day-to-day employee benefit account management, marketing, contract review, underwriting, claim analysis and creating customized employee communications and education material.



Katherine Adams
Associate Client Manager

Kate comes to HUB most recently from Blue Cross Blue Shield of MI with over 15 years customer service experience in various industries. As a part of the Employee Benefits team, she specializes in claim analysis. She also assists with all areas of service including account management, enrollments and file maintenance, and education and communication. Kate holds a Bachelor's degree in Business Management and a Masters certificate in Human Resources Management.



Claire Manz
Enrollment Specialist

Within the employee benefits department, Claire focuses on worksite products and employee benefit administration. She is Pinnacle's lead on the benefits administration software program that is used by many of our clients to coordinate their benefit program data needs.



Connie McKeown
Human Resource Compliance Partner

Connie is our in-house compliance coordinator and your compliance partner. She is responsible for compliance management in the Employee Benefits division which includes education and communication; conducting Compliance Reviews (12 available); 5500 and CMS Online filing assistance. Your partner for assistance with employee issues in the area of Human Resources and Employee Benefits.

Connie's experience consists of 20+ years as a Human Resource Manager. Responsible for various functions which include OSHA, worker's compensation, FMLA, hiring practices and strategy, employee development, strategic planning, records retention, ADA, FLSA, EEOC, and HIPAA. She is certified with HUB's exclusive twelve compliance training programs and is a member of the Society of Human Resource Management.



Karene Crane
Technology Partner

Karene Crane joined HUB in 2014 as the Client Technology Partner responsible for client technology including online enrollment. She has a self-driven work ethic that enables her to grow and learn along with the technology offered to clients. Karene previously worked for Blue Cross Blue Shield of Michigan as a Group Representative and also a trainer on claims processing systems. Her education includes a Bachelors of Science degree in Business Administration with a major in Marketing.

APPENDIX B

Non-disclosure Agreement

HUB International Financial Statement Request Form



Request Date:

HUB Requestor:

Requestor Location:

Requestor Phone:

Requestor Email:

Third Party Requestor/Company:

Requestor Phone:

Requestor Email:

Relationship to HUB:

Is a HUB Legal approved confidentiality agreement currently in place with the requesting third party? *

Please select ->

Please Select One:

* If an existing NDA is not in place, the requesting party will need to agree to our NDA via email before statements are issued.

Reason for Request:

Please Select One:

Type of Financials Requested:

Please Select One:

Location:

Please Select One:

Request Period:

Please Select One:

Comparative Statements?

Please Select One:

If yes, what is the comparison period?

Please Select One:

vs.

Please Select One:

If the request you received does not fit into the questions above, please provide the details below:

Request Deadline: *

* Please allow at least 2 business days for your request to be filled

Additional Comments:

Please email completed form to:

fsrequest@hubinternational.com

APPENDIX C

ThinkHR Training Modules

Performance Management Workplace Safety Wage and Hour, Equal Pay Act
 Standard Procedures Leaves of Absence - FMLA, PDL
 Recruiting and Hiring Statutory Compliance

thinkHR
The Right Answer. Right Now.

SIX TRAINING LIBRARIES... HUNDREDS OF COURSES... AT YOUR FINGERTIPS

ThinkHR Training Access Instructions: To access the full selection of online training courses, login to your ThinkHR Live website and click on the blue HR Training Access icon from there you will be provided with tools and prompts to create a training program for your employees. If you have any questions, please call the HR Hotline at 877-225-1101 to speak with a training specialist.

HR EMPLOYMENT

- Benefits and Leave**
- Affordable Care Act - What You Need to Know
- FMLA - What Supervisors Need to Know
- Compensation**
- FLSA - What Supervisors Need to Know
- Job Descriptions - How to Write Them Effectively
- Discrimination**
- Americans with Disabilities Act - What Supervisors Need to Know
- Diversity for All Employees
- Diversity - Legal Basics for Supervisors
- Preventing Sexual Harassment - A Guide for Employees
- Preventing Sexual Harassment - A Guide for Supervisors
- Sexual Harassment - What Employees Need to Know
- Sexual Harassment - What Supervisors Need to Know (Spanish)
- Sexual Harassment - What Supervisors Need to Know
- Workplace Harassment - What Supervisors Need to Know
- Health & Safety**
- Avoiding Back Injuries - NEW!
- Back Safety
- Back Safety (Spanish)
- Bloodborne Pathogens - General
- Defensive Driving for Noncommercial Motorists
- Defensive Driving - Commercial Motor Vehicles
- Disaster Planning - What Employees Need to Know
- Disaster Planning - What Supervisors Need to Know
- Emergency Action and Fire Prevention
- Emergency Action and Fire Prevention (Spanish)
- Exit Routes - Supervisors
- Fire Extinguishers
- Good Housekeeping
- Hazard Communication
- Hazard Communication (Spanish)
- Mold Hazards and Prevention
- Office Ergonomics
- Pandemic Flu - How to Prevent and Respond
- Preventing Workplace Violence - What Employees Need to Know
- Recordkeeping - Injury and Illness
- Slips, Trips, and Falls
- Slips, Trips, and Falls (Spanish)
- Stress Management
- Substance Abuse in the Workplace - What Employees Need to Know (Spanish)
- Workplace Safety for Employees
- Workplace Safety for Employees (Spanish)
- HR Management**
- Business Ethics - What Employees Need to Know
- Effective Meetings - How to for Supervisors
- Employment Law for Supervisors - What You Should & Shouldn't Do
- NLRB and Unions - What Supervisors Need to Know
- Teambuilding for Supervisors
- Violence in the Workplace - How to Prevent and Defuse for Supervisors
- Workers' Compensation - What Supervisors Need to Know
- Workplace Ethics for Supervisors
- Workplace Privacy - What Supervisors Need to Know
- Workplace Security for Employees
- Performance & Termination**
- Attendance Management - What Supervisors Need to Know
- Grounds for Termination - What Managers & Supervisors Need to Know
- How to Manage Challenging Employees
- Measuring Job Performance - What Supervisors Need to Know
- Performance Appraisals - How to Conduct Effectively
- Progressive Discipline
- Substance Abuse in the Workplace - What Employees Need to Know
- Substance Abuse in the Workplace - What Supervisors Need to Know
- Terminating Employees - The Process
- Staffing & Training**
- Coaching for Superior Employee Performance - Techniques for Supervisors
- Customer Service Skills - How We Can All Improve
- Effective Communication for Employees
- Hiring Legally
- How to Conduct New Employee Orientation - NEW!
- How to Manage Challenging Employees
- How to Manage Time Wisely - A Guide for Employees - NEW!
- Interviewing Skills for Supervisors
- Leadership Skills - What New Supervisors and Managers Need to Know
- Motivating Employees - Tips and Tactics for Supervisors
- New Employee Orientation - How To for Supervisors
- New Employee Safety Orientation
- Reducing Turnover and Increasing Retention
- Teambuilding for All Employees
- Time Management Skills for Employees
- Training the Trainer
- How to Conduct New Employee Orientation
- How to Manage Time Wisely - A Guide for Employees
- CA AB1825**
- Sexual Harassment Prevention & Response in California (AB 1825)

ENVIRONMENTAL COMPLIANCE

- Air Contaminants**
- Lead Safety - General Industry
- Mold Hazards and Prevention
- Asbestos**
- Asbestos Awareness
- Chemical Hygiene**
- Laboratory Safety
- Hazard Communication**
- PPE for Emergency Response
- Reactive Chemicals
- Safe Chemical Handling
- Working Safely with Corrosives
- Working Safely with Solvents
- Hazardous Waste**
- Hazardous Waste Container Management
- Hazardous Waste Emergency Response
- Hazardous Waste Introductory Training
- Hazardous Waste Manifests**
- Hazmat Transportation**
- Hazardous Materials Transportation
- HazMat Transport on Security Awareness
- HAZWOPER**
- HAZWOPER - First Responder Awareness Level
- HAZWOPER Facility Operations
- PPE**
- PPE - What Employees Need to Know
- PPE for Emergency Response
- SPCC**
- Spill Prevention, Control and Countermeasure Plan (SPCC Plan)
- Stormwater**
- Stormwater Pollution Prevention Plan (SWPPP)
- Underground Storage Tanks**
- Class C UST Operator Training - NEW!
- Universal Waste**
- Universal Wastes Large and Small Quantity Handlers

CUSTOMER SERVICE

- Challenging Situations**
- Conflict Resolution for Employees
- Problem Solving for Employees
- Communication Skills**
- Business Writing for Employees
- Effective Communication for Employees
- The Power of Listening
- Customer Communications**
- Email Best Practices for All Employees
- Phone Skills
- Customer Relationship Management**
- Connecting with Customers
- Customer Service Skills - How We Can All Improve
- How to Maintain Customer Loyalty
- Identifying Customers' Needs
- Making Customers Feel Special - NEW!
- Turn Satisfied Customers into Repeat Customers
- Employee Attitude**
- Maintaining a Positive Attitude
- Stress Management
- General Workplace Skills**
- How to Manage Time Wisely - A Guide for Employees - NEW!
- Teambuilding for All Employees
- Time Management Skills for Employees
- Supervising Customer Care Staff**
- Coaching for Superior Employee Performance - Techniques for Supervisors
- Customer Service - How to Promote Excellent Service Among Your Staff
- Motivating Employees - Tips and Tactics for Supervisors

WELLNESS

- Creating a Program**
- A Manager's Role in Wellness
- Creating a Successful Wellness Program - A Guide for Managers
- Workplace Wellness**
- All About Nutrition
- Avoiding Back Injuries - NEW!
- Back Safety
- Balancing Work and Home
- Driver Wellness
- Financial Wellness
- Fitness for Everyone
- Hazards of Smoking - How to Quit
- Healthy Aging
- Healthy Sleep Habits
- Heart Health
- Keeping Yourself and Your Family Healthy
- Office Ergonomics
- Pandemic Flu - How to Prevent and Respond
- Stress Management
- Substance Abuse in the Workplace - What Employees Need to Know
- Successful Weight Management
- Wellness and You
- What You Need to Know About Headaches

WORKPLACE SAFETY

- Construction**
- Crane Rigging in Construction
- Fall Protection in Construction
- Fall Protection in Construction (Spanish)
- Scaffolds in Construction
- Trenching - Competent Person
- Emergency Planning & Response**
- Disaster Planning - What Employees Need to Know
- Emergency Action and Fire Prevention
- Emergency Action and Fire Prevention (Spanish)
- Exit Routes - Supervisors
- Fire Extinguishers
- Good Housekeeping
- Pandemic Flu - How to Prevent and Respond
- Permit-Required Confined Spaces - Attendant (Spanish)
- Permit-Required Confined Spaces - Entrant
- Permit-Required Confined Spaces - Entrant (Spanish)
- Preventing Workplace Violence - What Employees Need to Know
- Violence in the Workplace - How to Prevent & Defuse for Supervisors
- Workplace Security for Employees
- Equipment & Process Safety**
- Arc Flash Safety
- Crane Rigging
- Electrical Safety - Unqualified Worker
- Forklift Operator Safety
- Introduction to Rough Terrain Forklift Safety
- Ladder Safety
- Lodging/Tagout - Authorized Employee
- Lodging/Tagout - Affected Employee
- Lodging/Tagout - Authorized Employee (Spanish)
- Machine Guarding
- Portable Power Tool Safety
- Safe Forklift Operation
- Hazardous Substance & Materials**
- Compressed Gases
- Flammable and Combustible Liquids
- Hazard Communication
- Hazard Communication (Spanish)
- Hazard Communication - Your Right to Know
- Hazard Communication - Healthcare Workers
- Laboratory Safety
- National Safety Data Sheets
- National Safety Data Sheets (Spanish)
- Mold Hazards and Prevention
- Understanding The Safety Data Sheet (SDS) - NEW!
- Welding, Cutting, and Brazing
- Health**
- Avoiding Back Injuries - NEW!
- Back Safety
- Back Safety (Spanish)
- Bloodborne Pathogens - General
- Bloodborne Pathogens - Healthcare Workers
- Ergonomics - Industrial
- Office Ergonomics
- Stress Management
- Substance Abuse in the Workplace - What Supervisors Need to Know
- Substance Abuse in the Workplace - What Employees Need to Know (Spanish)
- Working in Cold Conditions
- Working in Hot Conditions
- Personnel Safety**
- Aerial Lift Safety
- Eye Protection
- Foot Protection
- Noise and Hearing Conservation
- PPE - Hand Protection
- PPE - What Employees Need to Know
- PPE - Hand Protection (Spanish)
- Respiratory Protection
- Slips, Trips, and Falls
- Slips, Trips, and Falls (Spanish)
- Your Guide to Personal Protective Equipment
- Safety Management**
- Accident Investigations
- ADA - What Supervisors Need to Know
- New Employee Safety Orientation
- Recordkeeping - Injury and Illness
- Training the Trainer
- Workers' Compensation - What Supervisors Need to Know
- Workplace Safety for Employees
- Workplace Safety for Employees (Spanish)
- Transportation**
- Defensive Driving for Noncommercial Motorists
- Defensive Driving for Noncommercial Motorists (Spanish)
- Defensive Driving - Commercial Motor Vehicles
- Defensive Driving - Commercial Motor Vehicles (Spanish)
- DOT Alcohol and Drug Testing Rules - What Supervisors Need to Know
- Hazardous Materials Transportation
- Infectious Materials Transportation

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APPENDIX D

Employee Communication Materials

PORTAL OVERVIEW: FEATURES AND BENEFITS



PORTAL FEATURES

- Customization of portal look, feel and menu options
- Self-serve access to company and employee communication information including 's history, handbooks, forms, directories and policies
- Online benefits elections including standard and customizable reporting
- Anytime access to benefit plan information
- Time-off approval, tracking and reporting capabilities
- Database of employee information useful for reporting
- Select portal functionality is optional based on preferences
- Mobile capabilities allows employees to access important information anytime, anywhere

TRAINING AND SUPPORT

- A customized implementation and access to a dedicated HUB International Midwest consultant
- On-screen, context-sensitive Help
- Online Quick Reference Guides

APPENDIX E

Sample Implementation Timeline

Things to keep in mind when selecting a consultant/broker for your account:

All brokers are paid the same, choose based on service, technology and resources offered.

All brokers can bring you the same quote on insurance product as any other.

Since you pay your broker/consultant for their services all year, shouldn't you be getting services all year?

Receive Agent of Record Letters for all Benefits from District Health Department #10	June 1st, 2014
Meet Account Manger	Within 30 days
HUB will create custom benefit handout and enrollment forms and receive approval of final copies from District Health Department #10	Within 30-45 days
Discuss and implement newsletter or payroll stuffer campaign.	Within 30 days
HUB will set District Health Department #10 up with passwords for the Information Resource Library and provide company training	Within 30 days
Discuss implementation of wellness plan if desired.	Within 30 days
Compliance review, procedure review and recommendations to District Health Department #10	Within 60 days
HUB will begin to create Company website.	Within 90 days
HUB will roll Website out to District Health Department #10 Management	Within 90-180 days
HUB will provide District Health Department #10 with employee communication material on website	Within 180 days
Mid Year Review and Renewal Planning	180-120 days prior to renewal
Renewal Marketing Effort	120 days prior to renewal
Renewal Decision/Meeting	105 days prior to renewal
Enrollment Guides Updated/Employee Meetings	90 days prior to renewal

Employee Benefit Plans



CITY *of*
TRAVERSE CITY MICHIGAN

Presented By:
Michael A. DiLorenzo
January 23, 2014



MICHIGAN PLANNERS, INC.

42400 Garfield Road, Clinton Township, MI 48038

417 S. Union Street, Traverse City, MI 49684

Phone: 800-MPI-9235

www.miplanners.com

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10	Sample Book & Election Form

Vendor - Please complete and return

PROPOSAL SUMMARY

TITLE: INSURANCE AGENT FOR THE CITY OF TRAVERSE CITY

DUE DATE: WEDNESDAY, JANUARY 7, 2015 AT 10:00 AM

Having carefully examined the attached specifications and any other applicable information, the undersigned proposes to furnish all items necessary for and reasonably incidental to the proper completion of this proposal. Vendor submits this proposal and agrees to meet or exceed all requirements and specifications unless otherwise indicated in writing and attached hereto.

Vendor certifies that as of the date of this proposal the Company or he/she is not in arrears to the City of Traverse City for debt or contract and is in no way a defaulter as provided in Section 152, Chapter XVI of the Charter of the City of Traverse City.

Vendor understands and agrees, if selected as the successful Vendor, to accept a Purchase Order/Service Order/ Contract and to provide proof of the required insurance.

The Vendor shall comply with all applicable federal, state, local and building codes, laws, rules and regulations and obtain any required permits for this work.

The Vendor certifies that it is in compliance with the City's Nondiscrimination Policy as set forth in Administrative Order No. 47 and Chapter 605 of the City's Codified Ordinances.

The Vendor certifies that none of the following circumstances have occurred with respect to the Vendor, an officer of the Vendor, or an owner of a 25% or more share in the Vendor's business, within 3 years prior to the proposal:

- (a) conviction of a criminal offense incident to the application for or performance of a contract;
- (b) conviction of embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, or any other offense which currently, seriously and directly reflects on the Vendor's business integrity;
- (c) conviction under state or federal antitrust statutes;
- (d) attempting to influence a public employee to breach ethical conduct standards; or
- (e) conviction of a criminal offense or other violation of other state, local, or federal law, as determined by a court of competent jurisdiction or an administrative proceeding, which in the opinion of the City indicates that the vendor is unable to perform responsibility or which reflects a lack of integrity that could negatively impact or reflect upon the City of Traverse City, including but not limited to, any of the following offenses or violations of:

- i. The Natural Resources and Environmental Protection Act.
- ii. A persistent and knowing violation of the Michigan Consumer Protection Act.
- iii. Willful or persistent violations of the Michigan Occupational Health and Safety Act.
- iv. A violation of federal, local, or state civil rights, equal rights, or non-discrimination laws, rules, or regulations.
- v. Repeated or flagrant violations of laws related to the payment of wages and fringe benefits.

(f) the loss of a license or the right to do business or practice a profession, the loss or suspension of which indicates dishonesty, a lack of integrity, or a failure or refusal to perform in accordance with the ethical standards of the business or profession in question.

Vendor understands that the City reserves the right to accept any or all proposals in whole or part and to waive irregularities in any proposal in the best interest of the City. The proposal will be evaluated and awarded on the basis of the best value to the City. The criteria used by the City may include, but will not be limited to: ability, qualifications, timeframe, experience, price, type and amount of equipment, accessories, options, insurance, permits, licenses, other pertinent factors and overall capability to meet the needs of the City. The City is sales tax exempt – Government.

Vendor agrees that the proposal may not be withdrawn for a period of sixty (60) days from the actual date of the opening of the proposal.

Submitted by:

M. C. DiLorenzo
Signature

MICHAEL A. DILORRENZO, V.P.
Name and Title (Print)

800.674.9235 586.263.0690
Phone Fax

MICHIGAN PLANNERS, INC.
Company Name

MAIN: 42400 GARFIELD RD
TC: 417 S. UNION ST

Company Address
MAIN: CLINTON TWP, MI, 48038

TC: TRAVERSE CITY, MI, 49684
City, State, Zip

CORPORATION
Sole proprietorship/partnership/corporation

MICHIGAN
If corporation, state of corporation

ORGANIZATION AND HISTORY

1. Following is a list of names, titles and e-mail addresses for each individual assisting with this request:

John F. DiLorenzo, President	jdilorenzo@miplanners.com
Michael A. DiLorenzo, Vice President	mdilorenzo@miplanners.com
Diane O'Donnell, Office Manager	dodonnell@miplanners.com
Tracey Hilliker, Marketing Manager	thilliker@miplanners.com
Kurt Swartz, Client Retention Manager	kswartz@miplanners.com

Our Home Office number where all parties can be reached is 1-800-674-9235 and our main fax line is 586-263-0690. Our Northern Michigan office is located at 417 Union Street, in downtown Traverse City. Our website is www.miplanners.com.

2. Michigan Planners, Inc. was founded in 1962, with a focus on employee benefit plan design, implementation and the creation of long-term client relationships through unparalleled customer support. Throughout the years, Michigan Planners, Inc. has developed working relationships with all premier insurance carriers in the state of Michigan and around the country so that we can provide a solution to the needs of virtually any client. Michigan Planners, Inc. client base includes municipalities, charitable foundations, credit unions, automotive manufacturing suppliers, retail automotive dealerships, and various professional organizations.

Michigan Planners Retirement Services is a new division commencing January 1st, 2015, with a focus on both private and public employee retirement programs.

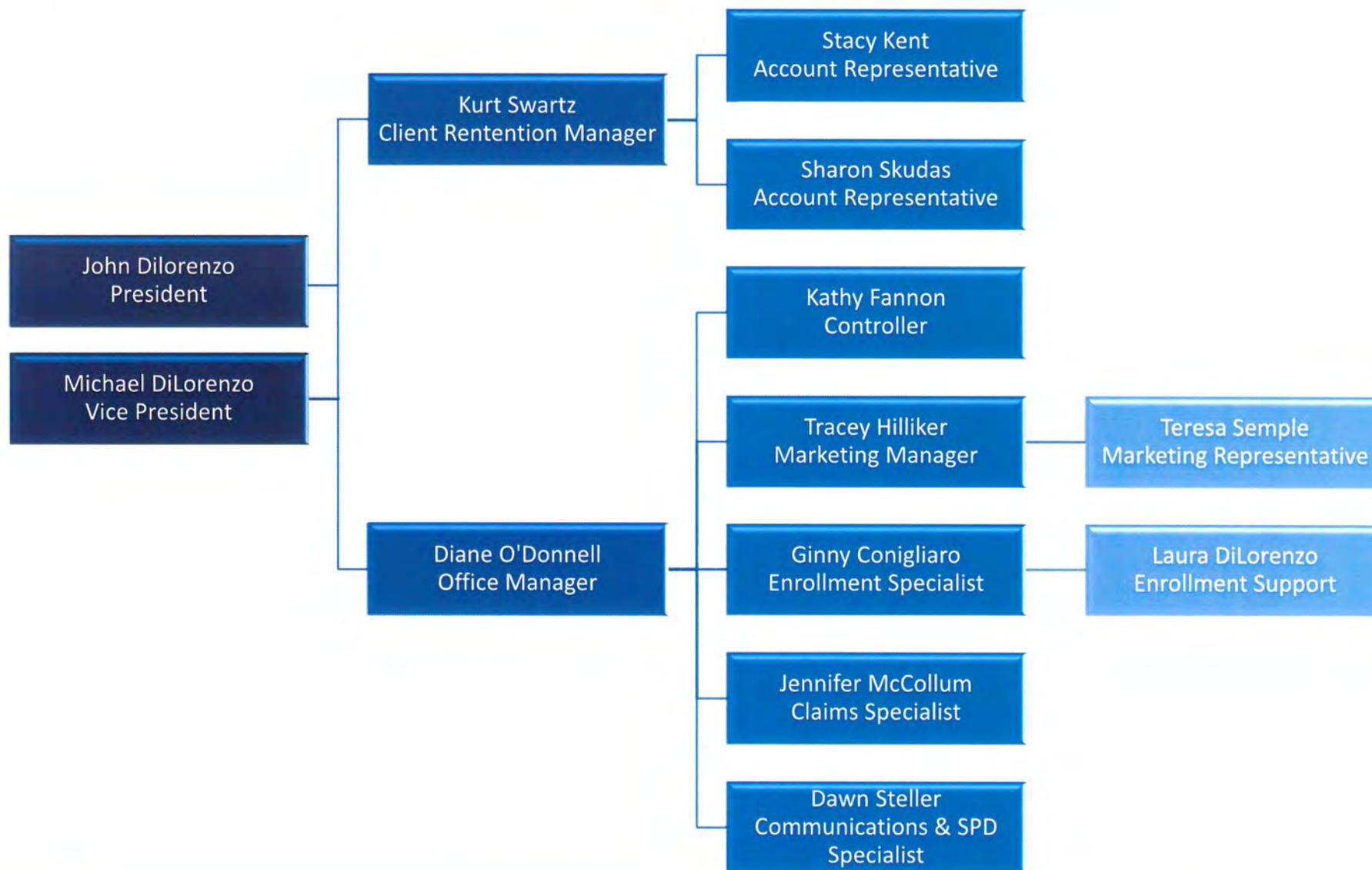
3. Michigan Planners, Inc. is not participating in any alliances or joint marketing efforts.
4. Michigan Planners, Inc. includes customer ranging in sizes from 2 - 500 employees. The table below illustrates the breakdown of customer size based on number of employees.

Number of Employees	# Clients	Percentage of Total
Under 100	167	85%
100 – 500	29	15%
500 – 750	N/A	N/A
Over 750	N/A	N/A
Total	196	100%



Michigan Planners, Inc.

Organizational structure



CLIENT SERVICE / QUALITY ASSURANCE

1. The Michigan Planners Inc. team assigned to the City of Traverse City program includes Michael DiLorenzo, Kurt Swartz, Tracey Hilliker, Stacy Kent, Dawn Steller, Jennifer McCollum, Ginny Conigliaro and Diane O'Donnell. Each individual plays a key role in providing the highest level of service to our clients. Michael DiLorenzo will serve as the agent of record, with over 30 years of industry experience in plan design and cost efficiency, and will recommend the optimum program for each plan year. Kurt Swartz will act as the retention manager, with 10 years of experience, responsible for renewing all customers year after year. Tracey Hilliker will be responsible for market research, securing competitive bids and summarizing the plan recommendation, with over 16 years of experience. Stacy Kent is responsible for, on-site and in house client service including employee meetings and administration inquiries, with over 14 years of industry experience. Dawn Steller, who has over 22 years of experience, will work in conjunction with Clark Hill to design the summary plan document and create the employee benefit guides. Jennifer McCollum has specialized in customer service for her entire career and has been in the health insurance field for nearly 10 years. Jennifer is responsible for employee and/or dependent claim inquiries and resolutions. Ginny Conigliaro will be responsible for employee and/or dependent enrollment, deletions or other contract changes, with over 15 years of customer support. Diane O'Donnell with 20+ years of HR experience is the office manager and will oversee the timely and accurate execution of all required services. Employee biographies are attached.
2. Michigan Planners, Inc. has long maintained a client retention rate in excess of 95%, year over year. We have had two groups this past year who left our agency for a different broker due to buy out by a larger corporation. One other group we lost recently left for better pricing with a different carrier, only to return to MPI after one year when service issues and carrier flaws could no longer be tolerated.

The average client relationship duration is over 10 years. Michigan Planners, Inc. has numerous clients that have been a customer in excess of 20 years. We have not experienced a loss of customer due to software limitations.

3. Michigan Planners is a privately owned, independent firm that has been operating in MI since 1962. As a result of our commitment to unparalleled customer satisfaction, we are very proud of the fact that more than 80% of our new business each year is the direct result of customer referral and we have enjoyed growth on an annual basis for more than 50 years! What could say more than that?

Our in-house philosophy is simple and to the point. Despite the numerous employee benefit programs that we market, 'Unparalleled Customer Service is our most important product!'

4. MPI has very stringent customer service standards, as we understand that it is these very standards that truly set us apart from the competition. Our customers have come to expect prompt, friendly and accurate service regardless of the nature of the matter.

5. Our customers select the service of MPI as opposed to that of the competition because of:
 - a. Our unparalleled commitment to customer service with a decades-old track record and references to verify it; consistent level of service year in and year out;
 - b. Our product and regulatory knowledge; the value of our all-encompassing service package;
 - c. Our immediate response time and never-ending sense of urgency.

MICHAEL DILORENZO

42400 Garfield Road, Suite A
Clinton Township, MI 48038
(800) MPI-9235
mdilorenzo@miplanners.com

417 S. Union Street
Traverse City, MI 49684
(800) MPI-9235

Work
Experience

Michigan Planners, Inc.
1984 to Present
Vice President

My primary responsibility is to develop new client relationships through prospecting and continuous marketing programs. I am equally responsible for maintaining existing client relationships through periodic meetings and annual plan evaluations.

I am also responsible for developing and maintaining strong BCBSM and commercial carrier relationships to ensure expedient attention to client needs as well as staying abreast of the continually evolving menu of programs that are available to employers.

I am regularly involved with client unions to communicate the intended path of the employee benefit programs and to ensure that they are in agreement with plan decision, enabling forward progress of adjustments to the employee benefit programs.

I have maintained a seat on a regional BCBSM advisory council for 15 years to provide input on the direction of Blue Cross and their product line and to evaluate current and new products that they offer in the benefit marketplace.

I have effectively worked with numerous municipalities to initiate the transition from Traditional medical plans to the more cost-effective PPO programs and won the support of their unions to allow the placement of these plans.

I maintain a Platinum Agency status with Blue Cross Blue Shield based upon the number of contracts administered through our office and the level of persistency in maintaining a sound working relationship with clients and their BCBSM programs.

KURT SWARTZ

42400 Garfield Road, Suite A
Clinton Township, MI 48038
(800) MPI-9235

kswartz@miplanners.com

417 S. Union Street
Traverse City, MI 49684
(800) MPI-9235

Work
Experience

Michigan Planners, Inc.
March 2014 to Present
Retention Manager

Management of MPI customer service representatives. Oversee the renewal of all groups. Strategies renewal solutions and review all viable options in the industry. Assist customer service representatives with escalated or ongoing issues. Utilize internal BCBSM and BCN connections to resolve issues quickly. Prospect and develop new business opportunities.

Blue Cross Blue Shield of Michigan
October 2011 – March 2014
Account Manager

Managed a block of 50 groups coordinating every aspect of their contact with BCBSM/BCN. Delivered renewals, quarterly settlements, annual settlements and quote proposals. Assisted with all escalated issues including service disruption, late payment and terminations.

Health Care Administrators
March 2006 – October 2011
Manager of Operations

As an exclusive independent managing agent for BCBSM and BCN Health Care Administrators assisted insurance agents with servicing of BCBSM and BCN individual and group business 1 to 99 in size. Worked up through the ranks at HCA first as an agent consultant manning the call center, to Corporate Trainer licensing agents to sell BCBSM and BCN products, and finally as Manager of Operations overseeing 30 employees all assisting to quote, enroll and resolve any escalated claim, benefit or billing issues.

TRACEY HILLIKER

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Clinton Township, MI 48038
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thilliker@miplanners.com

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Traverse City, MI 49684
(800) MPI-9235

Work Experience

Michigan Planners, Inc. **August 2003 to Present** **Marketing Manager**

Review and analyze all benefits for prospects and clients as well as responsible for bringing client/prospect data to marketplace. Work extensively with carriers to obtain best and lowest possible rates to suit group's specific needs.

Create proposals to illustrate current, renewal and proposed options for employee benefit programs in an easily understandable and logical format to help both clients and prospects readily grasp the benefit options that are available to them. Review and analyze client annual renewals.

Strategic Employee Benefit Services **November 1998 – August 2003** **Associate Employee Benefit Specialist**

Handled client quoting for bidding out employee benefit programs to carrier marketplace. Created proposals illustrating employee benefit programs. Created and assembled employee benefit booklets. Processed new business and group wide change paperwork.

Maintain up to date knowledge of evolving BCBSM plan designs through attendance of continuous training programs through BCBSM. Maintain current knowledge of competing market through regular meetings with industry leading commercial carriers.

STACY KENT

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Clinton Township, MI 48038
(800) MPI-9235
skent@miplanners.com

417 S. Union Street
Traverse City, MI 49684
(800) MPI-9235

Work Experience

Michigan Planners, Inc.
August 2005 to Present
Customer Service Representative

Management of employee benefit plans to existing clients and prospecting new implementation of benefit plans, employee meetings and hands on service. Oversee the seamless transfer of client coverage from client/carrier/administrator. Accountable for continuing education on government regulations and other issues as they pertain to health and welfare plans.

Extensive knowledge of BCBSM programs and operations as a result of continuous BCBSM training since career inception. Work with regional BCBSM offices around the state of Michigan to assist our client base, which is dispersed across the state and both peninsulas.

A.E. Mourad Agency, Inc.
March 2004 – August 2005
Account Manager

Serviced existing client base with claim issues, billing, enrollment and annual renewal reviews as well as accountable for administration of COBRA, billing and enrollment reports. Continually develop knowledge through customer meetings, research and training classes. Transitioned to A.E. Mourad Agency as a result of the sale of Corporate Insurance Management to A.E. Mourad Agency.

Corporate Insurance Management, Inc.
May 2001 - March 2004
Account Manager

Responsible for service and administration of employee benefit plans for Employee Benefit Manager's book of business. Included in duties were assisting employees with claim issues inquires with respect to coverage, plan limits, eligibility and billing inquires.

Commenced working relationship with billing, claims and administration department of BCBSM.

DAWN STELLER

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dsteller@miplanners.com

417 S. Union Street
Traverse City, MI 49684
(800) MPI-9235

Work
Experience

Michigan Planners, Inc.
January 1993 to Present
Employee Handbook and Plan Documentation Representative

Gather benefit information to design a customized Employee Handbook and Election form for each client and their employees. Provide other types of employee communications such as posters and memos. Work with Clark Hill to prepare Plan Documentation including a Summary Plan Description, a Summary of Material Modification and a Section 125 Premium Only Plan.

Experienced other aspects of Michigan Planners through marketing, customer service and claims service, providing a well-rounded knowledge of the insurance business.

JENNIFER MCCOLLUM

42400 Garfield Road, Suite A
Clinton Township, MI 48038
(800) MPI-9235

jmccollum@miplanners.com

417 S. Union Street
Traverse City, MI 49684
(800) MPI-9235

Work
Experience

Michigan Planners, Inc.
May 2014 to Present
Claims Specialist

Assists customers as a healthcare advocate assisting to resolve claim and benefit issues. Works directly with the carriers and provider offices in an effort to minimize the burden on the group and its employees.

The Energy Group
January 2010 – April 2014
Human Resource Generalist

Assisted managers with hiring process, screening candidates and coordinating interviews. Organized and maintained employee personal records. Conducted payroll for over 200 employees across four states. Reported claims for workers compensation and collision claims for company vehicles. Assisted with accounting. Provided customer service support to customers and vendors.

Capital Waste, Inc
May 2003 – December 2009
Administrative Associate

Primarily engaged in customer service and support, as well as quality control. Assisted with customer invoicing, payroll and maintaining of DOT files. Also assisted with sales.

VIRGINIA CONIGLIARO

42400 Garfield Road, Suite A
Clinton Township, MI 48038
(800) MPI-9235
gconigliaro@miplanners.com

417 S. Union Street
Traverse City, MI 49684
(800) MPI-9235

Work
Experience

Finney & Henderson Law Firm
January 2002 – December 2011
Legal Assistant and Office Manager

Responsible for communicating with clients and courts. Handled accounts payable, payroll, and general office administration.

Michigan Planners, Inc.
January 2012 to Present
On-Line Enrollment Representative

Responsible for web access set up of all carriers for our clients. Review and enter all employee information on enrollment forms into the carrier systems. Communicate with clients and employees on enrollment, changes and COBRA questions or concerns. I have 15 years experience specializing in customer support.

DIANE O'DONNELL

42400 Garfield Road, Suite A
Clinton Township, MI 48038
(800) MPI-9235

417 S. Union Street
Traverse City, MI 49684
(800) MPI-9235

dodonnell@miplanners.com

Work Experience

Michigan Planners, Inc. August 2003 to Present Office Manager

Manage operations of Michigan Planners Inc. by keeping employees on track to meet client deadlines and commitments.

Regularly review interlay stems to increase efficiencies in client plan management and administration.

Develop relationships with administrative staff and key management personnel at BCBSM and all commercial carriers to ensure a responsive working relationship in support of our client benefit programs.

Direct involvement with clients to develop client relationship and maintain a high level customer satisfaction throughout each plan year.

Proper Mold & Engineering, Inc. February 2002 to August 2003 Human Resource Manager

Designed and administered health benefits, policies and procedures. Processed all new hires, COBRA, termination, lay-off, short/long term disability, family medical leave, flex plans and unemployment documents for 250 employees. Responsibilities include keeping up to date with all new labor laws.

CE Technologies, Inc. June 1998 – February 2002 Human Resource Administrator

Communicated and administered all employee health benefits. Processed COBRA, lay-off and termination documents. Maintained all personnel files for 80 employees. Updated and distribute all benefit material.

Responsible for all legally required human resources obligations and maintained compliance with labor and benefit laws.

BENEFIT ADMINISTRATION

1. Michigan Planners, Inc. has specialized in the field of employee benefits for over 50 years and has a flawless reputation in the market. Consequently, we have established a tremendous rapport with all of the carriers we represent and have a dedicated service team at each and every one. Our strong carrier ties bolster our efficiency, product knowledge and ability to negotiate premiums and renewal offers. As an organization, we routinely evaluate the performance of each of our brands from both a pricing and customer satisfaction perspective to ensure that we are using the optimum solution for the customer.
2. In order to determine our process for recommending an employer sponsored package, we begin with in depth discussions with the client or prospect to determine their needs, satisfactions, dissatisfactions, union requirements, etc. In addition, we want to determine the clients' immediate as well as long-term goals. After the employer needs are determined, our MPI team will strategize about plan design and then begin the bidding process with the carriers we have determined are most ideal for the needs at hand. MPI staff remains in constant contact with the client or prospect to keep them abreast of our progress in the development of the final recommendation. A preliminary timeline is laid out for the customer, based upon certain deliverables and expectations.
3. The top 5 vendors that have the largest share of Michigan Planners book of business include: BCBSM, Priority Health, HealthPlus of Michigan, Guardian Insurance Company and MetLife.
4. MPI has a long-standing strategic partner relationship with Clark Hill, one of the largest legal firms specializing in ERISA laws as it governs the field of employee benefits. All of our plan documents and Summary Plan Descriptions are drafted and reviewed by Clark Hill to ensure our clients' compliance. Further, as employer-specific circumstances occur, Clark Hill is consulted whenever necessary, without the charge being passed on to our clients. ACA and regulatory matters in general are a swiftly moving, constantly changing target. For this reason, MPI feels comfortable that our customer's interests are well protected when being counseled by the best in the business.
5. Michigan Planners, Inc. uses a program called Employee Navigator to provide electronic enrollment services to our client base. We do not charge a fee for this service.

6. MPI provides several facets of Human Resource support to our clients. Our support services include but are not limited to:
 - a. COBRA administration via BASIC
 - b. Summary Plan Documents via the law firm of Clark Hill
 - c. Labor Unions negotiation support and benefit explanation
 - d. HR Administrative Inquiry support
 - e. Monthly HR newsletters
 - f. Employee Adds / Deletes via MPI personnel or electronically
 - g. Open enrollment communication and support
 - h. Form 5500 Filing via BASIC
 - i. FMLA service is available via BASIC on a direct billed basis

7. Form 5500 filing is a service provided by BASIC. MPI will assume the cost of the annual filing, based on our block discounted rate through BASIC.

8. SPD's, Plan Documents and other required notices are managed by MPI personnel, using a variety of sources. SPD's and Plan Documents are prepared in conjunction with ERISA attorneys at the law firm of Clark Hill, and are provided to our clients as needed or amended. MPI elected to outsource our SPD work to one of the leading ERISA law firms in an effort to ensure accuracy of such documents to our clients. Summaries of Benefits and Coverages (SBC's) are prepared in conjunction with our carriers and can be provided in hard copy as well as electronically.

9. MPI personnel will assist employees with claim resolution services as often as needed throughout the plan year. It is the goal of MPI staff to obtain the full value of the benefit program for all enrolled employees. A designated MPI claims specialist will work with the provider, carrier and even collection agencies (when necessary), in order to resolve claim issues. MPI claim resolution service is fully HIPAA compliant and very effective. We treat your employee's issues as if they were our own.

10. MPI personnel will assist with bill reconciliations by addressing billing concerns with the billing management team at the respective carrier. Our staff will follow up with carriers, as future billings are generated to ensure the proper corrections have been made and any due credits are received by our clients. If MPI staff is administering enrollment changes (add and deletes), our clients receive a confirmation of change activity via email upon completion of such change. MPI strives to have all changes completed within 24 hours of receipt from our clients.



Michigan Planners, Inc.

Employee Navigator - HRIS

Michigan Planners, Inc. is pleased to provide you with Employee Navigator, an integrated HR and benefits portal to help you manage your employees, improve communication and assist with disclosure and other compliance requirements.



Portal Features

Shared ID – Provide quick and easy access with a universal ID for your entire staff.

Individual ID – Provide a personalized experience by importing employees to allow HR to customize what documents employees can view.

White label – Customize your site with your company logos and colors.

Communication – At the heart of the system is a robust communication engine to help Michigan Planners and HR collaborate on the messaging for employee benefits or company perks. Features support:

- Policy summaries and documents
- Side-by-side plan comparisons
- Carrier phone numbers and websites
- Plan rates, eligibility and contributions
- Customizable contacts, documents, links and user defined text
- Custom alerts to employees
- Posting company articles or news

Employee self-service – Employees will have access to more company information than ever before including:

- Permit employees to update their address
- Track and approve changes
- Access the company directors
- Manage emergency contact

Virtual personnel file – Track and report critical HR data such as:

- Leave status and review dates
- EEOC and veteran status
- Payroll groups
- Salary history
- Birthdays and anniversaries

Enrollment

Online plan selection

This service level allows HR to roll out a complete self-service enrollment experience for their employees including new hire, open enrollment and life events. Changes made by your employee will be posted to your “Wall” or you can receive email notifications.

Carrier feeds

Larger organizations or companies with higher turnover may require carrier feeds. This requires configuration and carrier reconciliation prior to the beginning transmission of eligibility and may require the audit of error reports.

Enrollment Features

- Alerts for missing beneficiary, dependent information, etc.
- Cafeteria and HSA contingency support
- Over 40 standard reports
- COBRA tracking
- Evidence of Insurability
- Pending enrollments
- Beneficiary tracking

Mobile Apps

Employees and HR can securely access company resources on the go, helping you improve communication whether employees are across the country or across the street at the doctor’s office. HR managers can quickly access employee records, enrollment details (if configured), dependents as well as plan premiums and eligibility information.

Employee Navigator is available when Michigan Planners, Inc. is agent of record on all lines of coverage.

EMPLOYEE COMMUNICATION

1. Michigan Planners can communicate benefit plans to new enrollees through a variety of channels. We cater to the varying needs of our clients, so we can use whichever method of communication that works best for your work schedule and employee shift schedules. Depending on the situation, we can do monthly meetings with new employee groups, or as necessary. During new employee orientations, MPI personnel can review benefits as well as assist employees with enrollment form completion. Additionally, new employees can find their plan information electronically through our HRIS system and enroll electronically.
2. Michigan Planners conducts open enrollment communication in a tiered approach. Initially, employees are advised of pending open enrollment changes via email memo, payroll stuffer of both. Communications are designed by MPI personnel. As with new employees, MPI staff can conduct on site employee open enrollment meetings by shift, department or labor union, at which time a hard copy of the benefit booklet, required SBC and SPD's will be provided to the employees. Communication can be conducted electronically as well. All required forms of communication will also be available to employees electronically. During the employee orientations, MPI staff will advise your employees to reach out to us for any follow up questions or concerns regarding their plan, in order to minimize involvement by your staff.
3. Our typical client communication process for benefit changes is normally restricted to the open enrollment process, which has been summarized in item #2 under this section.

GENERAL

1. Michigan Planners provides all forms of employee benefit related programs, including but not limited to:

Voluntary Programs, including:

Life Insurance, including Dependent Life Insurance

Short and Long Term Disability

Long Term Care

Accident and Critical Illness

Cancer

Dental and Vision

Our subsidiary, Michigan Planners Retirement Services can assist with the servicing of the Mass Mutual and the ICMA-RC Defined Contribution plans.

2. Please see our full list of services as well as company profile and employee history at our website www.miplanners.com.
3. Michigan Planners has included, as a standard part of our introduction package, a sample of our employee benefits booklet and benefit id cards for a user-friendly affirmation of coverage at the point of service. In addition, we have included our sample unified enrollment form to be used for enrollment into all carrier plans.

IMPLEMENTATION

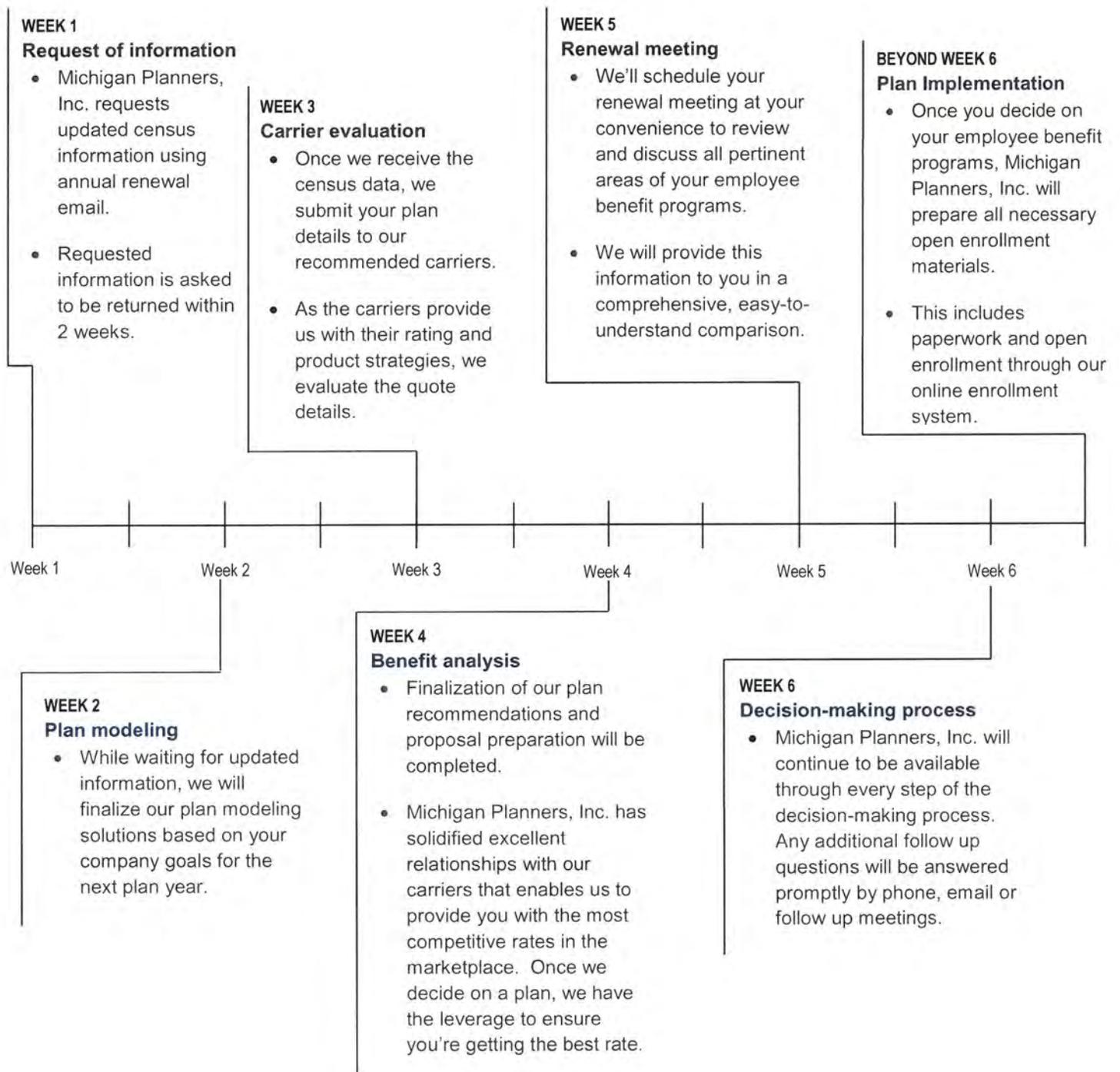
1. The implementation process to transition your benefit plan to Michigan Planners is a very short turnaround for most services. Upon receipt of an agent of record letter, we could provide service for billing, claim and administrative service issues within a few days. Full electronic enrollment can take up to 90 days to have established with the health insurance carrier. This time frame is dictated by the carrier, although MPI staff will push to have this up and running, as timely as possible. MPI personnel could assist with all other required duties in the meantime. Please allow 30 days for updated benefit booklets and Summary Plan Documents.
2. MPI personnel takes every step to minimize the involvement of our clients in plan transitions or group wide changes. In addition to the agent of record letters, we would request an updated employee census, copies of current Summary Plan Documents and Labor agreements in order to begin our work. In the initial implementation phase, we would hold a strategic planning meeting in order to gain a full understanding of what you wish to accomplish for the next plan year, as well as long-term planning, and how to minimize your future involvement in plan administration. We would also require the employer to review any communication prepared by MPI staff, prior to printing and distribution to your employees, including booklets, election forms and SPD's. Finally, the scheduling of enrollment meetings and collection of forms (if not using electronic enrollment) would be the responsibility of our client.
3. Please see attached implementation time line.



Michigan Planners, Inc.

Benefits analysis & planning

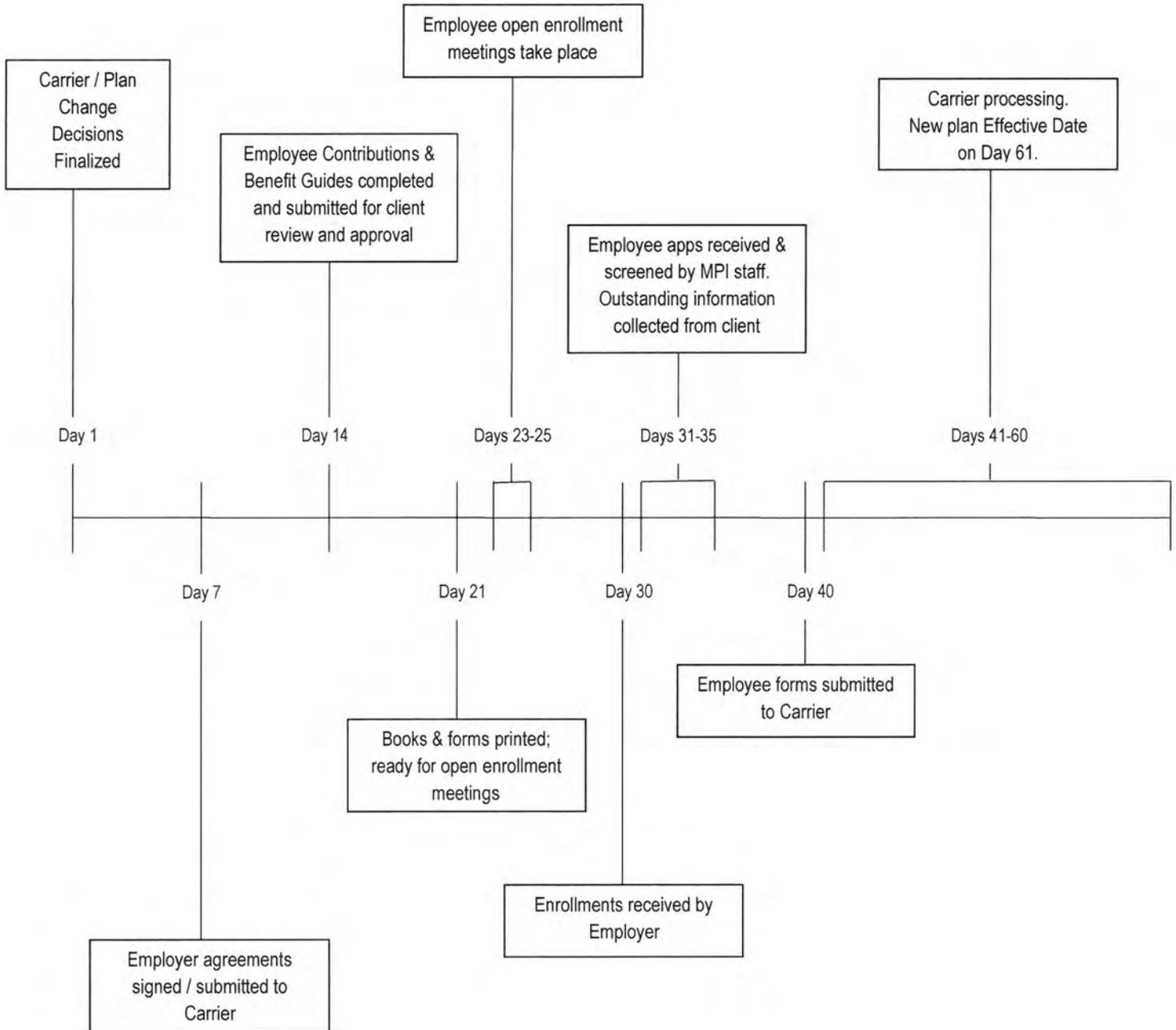
At Michigan Planners, Inc., we don't just support you at renewal, we provide the technology and solutions to support your needs and drive down costs year-round. With our data analytic tools, we can help you make informed benefit decisions to ultimately achieve a smarter, cost-efficient benefits plan.





Michigan Planners, Inc.

Plan implementation & open enrollment



Clients utilizing Electronic Enrollment System with Employee Navigator will experience significantly reduced timeframes.

REFERENCES / SUBCONTRACTORS

1. Current client references include, but are not limited to:

Dale Kerbyson / Tracey Russell
City of Lapeer
100+ employees
810.664.5231

Connie Youcker or Connie Deneweth
Traverse City State Bank
100+ employees
231.947.9700

Beth Tacaks
Charter Township of Flint
100+ employees
810.600.3231

In addition, Michigan Planners is proud to have the states' largest municipal associations as clients, as we strive to meet or exceed the expectations of municipal employers throughout the State of Michigan. The Michigan Municipal League (MML) and the Southeastern Michigan Council of Governments are valued clients of Michigan Planners. The reference information for both associations are listed below:

Mandy Reed
Michigan Municipal League
50+ employees
734.669.6361

Jody Egelton
SEMCOG
50+ employees
313.324.3423

Michael DiLorenzo is also an active member of the Traverse Area Human Resource Association (TAHRA) and has been one of their selected luncheon speakers due to his vast knowledge of the ACA law and it's ever-changing provisions.

2. Michigan Planners boasts a 95%+ client retention rate, year over year. However, some attrition is inherent within the industry and almost unavoidable for reasons outside of an agency's control.

The City of Owosso left Michigan Planners, as a result of a change in their city manager and his working relationship with another benefits agency. Our prior contact at the City of Owosso is Mr. Richard Williams, 989.725.0570. This was a 10+ year client of MPI. This occurred several years ago, and no other large municipality has left MPI since.

Southfield Auto Group just recently left Michigan Planners, as a result in being acquired by a national auto dealer network. Our prior contact at Southfield Auto Group is Debbie Kassak, 248.354.2950. This was a 20+ year client of MPI.

The City of Birch Run, although much smaller in demographics (only 7 contracts), recently left Michigan Planners, moving to a localized union plan. Our prior contact at Birch Run is Paul Moore, 989.624.5711. This was a 5+ year client of MPI.

Michigan Planners has not lost clients due to lack of client service or technological limitations.

3. Subcontractors include the following companies:

Connie Fox
BASIC
9246 Portage Industrial Drive
Portage, MI 49024
800-444-1922
Services Include: COBRA, HRA, HSA, FSA, FMLA, 5500 Filing Services

Ed Hammond
Clark Hill PLC
151 S. Old Woodward; Suite 200
Birmingham, MI 48009
Services: Legal Services, SPD, ACA Inquiries, HR Issue Resolution

EXPENSES

Michigan Planners' compensation is based on standardized commission levels, paid by each respective carrier, varying by group size or agency status with said carrier. Our MPI service package is offered at no additional cost to your premiums, assuming that MPI is assigned as broker of record on all lines of employee benefit programs.

1. Michigan Planners does not charge any start up fees, nor do we charge any fees upon termination of our services.
2. Michigan Planners, for the standard carrier commissions paid on all lines of employee benefit programs, will provide the following services at no additional cost to your premiums:

- ACA Education and Compliance Assistance
- ACA Affordability Testing
- COBRA Administration via BASIC
- Summary Plan Documents / Summary Plan Description via Clark Hill
- Customized Employee Benefit Booklets / Benefit ID Cards
- Unified Open Enrollment Forms
- Electronic Plan Administration (HRIS System)
- Employee Claims Resolution Services
- HR Billing and Administrative Service Resolution
- Form 5500 Filing via BASIC (current plans only)
- Monthly Claims Reporting Analysis
- Annual Plan Review / Market Analysis / Plan Recommendation
- Union Negotiation Assistance
- P.A. 152 Employee Contribution Recommendation (20% or Hard Cap)

FMLA Services are available through BASIC at our MPI negotiated discount rate of \$248 monthly, plus a \$600 start-up fee.

Michigan Planners does not charge a fee for normal postage, shipping, handling, supplies or printing.

Michigan Planners operates on the standard industry revenue / carrier compensation for all size employers. MPI has maintained profitability at this level since our inception, over 50 years ago. Unless there is a significant change within industry compensation levels, or required services, MPI would expect to continue to work for standardized carrier commission levels.

Benefit Enrollment Form

<input type="checkbox"/> New hire	<input type="checkbox"/> Rehire	<input type="checkbox"/> Return from layoff	<input type="checkbox"/> COBRA enrollment	<input type="checkbox"/> Loss of coverage
<input type="checkbox"/> Open enrollment	<input type="checkbox"/> Termination	<input type="checkbox"/> Retiree	<input type="checkbox"/> Hourly	<input type="checkbox"/> Salary
Effective date:		Terminating coverage (complete Enrollment/Change of Status Section)		
		<input type="checkbox"/> Contract	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependent(s)
EMPLOYEE INFORMATION				
Last name:		First name:		Middle initial:
Date of birth:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Social Security number:	
Street address: <input type="checkbox"/> Check here if new address		City:	State:	Zip code:
Primary phone number:	Email address:	Date of hire:	Work hours per week:	
Annual salary:	Pay period: Weekly			
COORDINATION OF BENEFITS INFORMATION				
Do you or your spouse or dependent(s) maintain other health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No				
J Check here if this applies to all members on the contract.				
Person covered (full name):	Employer or group name:	Carrier name:	Policy number:	
MEDICARE INFORMATION				
Any members enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Working aged <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD				
HIC number:		Medicare effective date:		
		<u>Medicare Part A</u>	<u>Medicare Part B</u>	

Any person, who with intent to defraud or knowing that he/she is facilitating a fraud against the insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.



ENROLLMENT OR CHANGE OF STATUS INFORMATION

Employee:

Add Terminate Change (explain) _____

Spouse name:

Gender:

Female
 Male

Date of birth:

Social Security number:

Add Terminate Change (explain) _____

Dependent name:

Gender:

Female
 Male

Date of birth:

Social Security number:

Add Terminate Change (explain) _____

Dependent name:

Gender:

Female
 Male

Date of birth:

Social Security number:

Add Terminate Change (explain) _____

Dependent name:

Gender:

Female
 Male

Date of birth:

Social Security number:

Add Terminate Change (explain) _____

Dependent name:

Gender:

Female
 Male

Date of birth:

Social Security number:

Add Terminate Change (explain) _____

Dependent name:

Gender:

Female
 Male

Date of birth:

Social Security number:

Add Terminate Change (explain) _____

SECTION 1 – Medical and Prescription Drug Program

Blue Cross Blue Shield of Michigan – *choose only one medical plan*

	Base PPO	Buy-up PPO
One person:	<input type="checkbox"/> \$	<input type="checkbox"/> \$
Two person:	<input type="checkbox"/> \$	<input type="checkbox"/> \$
Family:	<input type="checkbox"/> \$	<input type="checkbox"/> \$

Dependent children (students and non-students) are eligible until the end of the year in which they turn 26 years old.

List members to be included on the medical plan:

SECTION 1
Weekly Payroll
Deduction:

\$ _____

- Waiving medical coverage – I have coverage elsewhere. (Attach a copy of current insurance card.)
- Waiving medical coverage – I do not wish to enroll at this time.

SECTION 2 – Dental Program

Guardian

One person:	<input type="checkbox"/> \$
Two person:	<input type="checkbox"/> \$
Family:	<input type="checkbox"/> \$

Dependent children (students and non-students) are eligible until the end of the month in which they turn 26 years old.

SECTION 2
Weekly Payroll
Deduction:

\$ _____

- Waiving dental coverage (If you have coverage elsewhere, attach a copy of current insurance card)

SECTION 3 – Voluntary Vision Program

Vision Service Plan

One person:	<input type="checkbox"/> \$
Two person:	<input type="checkbox"/> \$
Family:	<input type="checkbox"/> \$

Dependent children (students and non-students) are eligible until the end of the month in which they turn 26 years old.

List members to be included on the voluntary vision plan:

SECTION 3
Weekly Payroll
Deduction:

\$ _____

- Waiving voluntary vision coverage (If you have coverage elsewhere, attach a copy of current insurance card)



SECTION 4 – Life Insurance

Guardian *This coverage is paid 100% by the employer and cannot be waived.*

Group Term Life and AD&D coverage

Group Term Dependent Life coverage Spouse (Name all children to be included.)

Dependents are eligible to age 23 or to age 25 if a full-time student. If not a full-time student, dependents are terminated on their date of birth. Child(ren)

Beneficiary Designation (Primary beneficiaries must total 100%)

In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit.

PRIMARY BENEFICIARIES

Full name (first, middle initial and last name):	Relationship:	Percentage:
Full name (first, middle initial and last name):	Relationship:	Percentage:

CONTINGENT BENEFICIARIES

Full name (first, middle initial and last name):	Relationship:	Percentage:
Full name (first, middle initial and last name):	Relationship:	Percentage:

SECTION 4
Weekly Payroll Deduction:
\$0

SECTION 5 – Voluntary Life Insurance

Guardian *This coverage is voluntary and may be waived.*

Employee Voluntary Life coverage – choose one benefit option \$25,000 \$50,000 \$75,000 \$100,000
 See the Guardian Benefits Plan package for premium information.
 \$ _____
 Waive coverage

Spouse Voluntary Life coverage 50% of the employee's amount to a maximum of \$50,000
 See the Guardian Benefits Plan package for premium information.
 \$ _____
 Waive coverage

Child Voluntary Life coverage
 Ages 14 days to 6 months: \$500
 Ages 6 months to 23 years: 10% of the employee's amount to a max of \$10,000
 (Name all children to be included.)

Dependents are eligible to age 23 or to age 25 if a full-time student. If not a full-time student, dependents are terminated on their date of birth.
 See the Guardian Benefits Plan package for premium information.
 \$ _____
 Waive coverage

SECTION 5
Weekly Payroll Deduction:
\$ _____

Complete beneficiary information for Voluntary Life Insurance on the next page.



SECTION 5 – Voluntary Life Insurance – Beneficiary Information

Beneficiary Designation (Primary beneficiaries must total 100%)

In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit.

PRIMARY BENEFICIARIES

Full name (first, middle initial and last name):

Relationship:

Percentage:

Full name (first, middle initial and last name):

Relationship:

Percentage:

CONTINGENT BENEFICIARIES

Full name (first, middle initial and last name):

Relationship:

Percentage:

Full name (first, middle initial and last name):

Relationship:

Percentage:

SECTION 6 – Short Term Disability

Guardian – choose one benefit option

Base benefit (\$350 maximum)

\$0

Buy-up benefit (\$750 maximum)

\$ _____

See the Guardian Benefits Plan package for premium information.

SECTION 6
Weekly Payroll
Deduction:

\$ _____

SECTION 7 – Voluntary Long Term Disability

Guardian

Voluntary LTD

\$ _____

See the Guardian Benefits Plan package for premium information.

SECTION 7
Weekly Payroll
Deduction:

\$ _____

SECTION 8 – Signature and Authorization

Total cost per payroll deduction (medical, dental and vision are deducted pre-tax):

\$ _____

While every effort has been made to assure accuracy in the plan definitions on this form, I understand that this is strictly an election form. The contracts that my employer has signed with the insurance carriers will be binding. I understand that this election may not be changed during the plan year unless I have a qualified status change and that unused allocations, if any, by law, will revert to my employer at the end of the plan year. If there is a pay period in which I do not receive a check (vacation, sick leave, etc.), I understand that my insurance deduction will be taken out of my first paycheck when I return. I authorize my employer to reduce my wages by the amounts required (if needed) to pay for the benefit options I have elected.

My signature below acknowledges my elections on all prior pages.

Signature _____

Date _____

Group services provided by [Michigan Planners, Inc.](#)

42400 Garfield Road, Suite A
Clinton Township, MI 48038



417 South Union Street
Traverse City, MI 49684

586-263-9000 or 800-MPI-9235

Main fax: 586-263-0690
Claims fax: 586-263-5961
www.miplanners.com

Michigan Planners also provides assistance with your individual insurance needs. We represent unlimited carriers and provide the most competitive pricing in:

Individual Life Insurance

Individual Long Term Disability

Individual Long Term Care

Tax Deferred Annuities

**Let us do the shopping for you!
It's our specialty.**

Why would you pay more somewhere else?

-SAMPLE-

Guide to Employee Benefits

Contract Year:
January 1, 2015 through December 31, 2015

Administrative Service

If you have any benefit questions or claim issues, please contact our claims department, at 1-800-MPI-9235 or claims@miplanners.com.

In compliance with HIPAA law, we are required to obtain a signed authorization for each claim in question. Please sign and fax the authorization prior to giving us personal information.

When faxing claims, please use our secure fax number: 1-586-263-5961.



**We are here to service your benefit programs
and help in any way we can.**

Contacting the Carrier

Blue Care Network

1-800-662-6667
www.bcbsm.com

Blue Cross Blue Shield of MI

1-800-637-2227
www.bcbsm.com

Vision Service Plan

1-800-877-7195
www.vsp.com

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Pages 7-10	Preventive Care Benefits
Pages 11-12	BCBSM and BCN In-Network Benefit Comparison
Pages 13-23	BCBSM PPO Medical Program
Pages 24-28	BCN HMO Medical Program
Pages 29-32	BCBSM Voluntary Dental Program
Pages 33-34	BCBSM/VSP Voluntary Vision Program
Pages 35-40	Qualifying Life Events, COBRA Continuation Coverage, HIPAA Privacy Overview, Social Security Privacy Act, Women's Health and Cancer Rights Act, Administrative Service, Contacting the Carrier

The benefit summaries found in this guide have been designed as an easy-to-use reference and are not intended as a contract. Please consult your coverage certificate for complete details. A certificate of coverage and master contract issued by the Insurance Company will always take precedence over any other benefit description.

Women's Health and Cancer Rights Act of 1998

Pursuant to federal law, the plan will pay for the following benefits for any participant who is receiving insured benefits under the plan covering a mastectomy and who elects breast reconstruction, subject to applicable annual and lifetime plan limits, copayments and deductibles:

- (1) reconstruction of the breast on which the mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses and physical complications of all stages of mastectomy, including lymphedemas.

These benefits will be provided in a manner as determined in consultation with the attending physician and the patient. The plan may not deny an eligible employee or an eligible dependent eligibility or continued eligibility to enroll or to renew coverage solely to avoid providing these benefits.

Wellness and Savings

HIPAA Privacy Overview

Health Insurance Portability and Accountability Act (HIPAA)

To administer your benefits, information requested for enrollment must be collected and shared with your group insurance carriers. This information on you as well as your eligible enrolled dependents includes personal information including name, social security number, birthdate, employee salary, address, telephone number, and possibly health history information, proof of dependent status, or other requested information specific to insurance plan provisions. In addition to the applicable insurance companies receiving your information, business partners including Michigan Planners, Inc., also receive necessary information to assist in processing and administering your benefits in compliance with policy service and law regulations.

What information is protected by HIPAA privacy rules?

Information is protected if it relates to an individual's past, present or future physical or mental condition, or to the provision or payment of health care. Under HIPAA, any electronic, paper or oral communication transmitted by a covered entity is considered protected health information, or PHI.

Covered entities subject to privacy rules include: hospitals, physicians and other health care providers, health plans and claim clearinghouses.

Rights of individuals

The privacy rules are intended to protect the rights of individual health care consumers. Individuals have the right to:

- * Confidential communication of their PHI
- * Inspect and copy their PHI
- * Receive written notice of health plans' privacy practices
- * Request restrictions on certain uses and disclosures of their PHI
- * Request amendments to their PHI
- * Receive an accounting of certain disclosures of their PHI

Social Security Privacy Act

Based on a new law enacted by the Michigan legislature, all business entities, including schools, should be taking steps to ensure the security of social security numbers, including those of its employees and if applicable, its patrons or students. Generally, the Social Security Number Privacy Act places restrictions on the use, display, and disclosure of social security numbers that are obtained in the ordinary course of business.



Prescription Drug Savings

Generic drugs are the bioequivalent of brand name drugs. This includes dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. Generic equivalents are chemically identical to the brand name drug.

New **prescription drugs** are developed under patent protection, protecting the brand name manufacturer's investment in the development by giving them the exclusive right to sell the drug while the patent is in effect. When the patent expires, other manufacturers can then apply to the Food and Drug Administration to sell a generic version of the same drug. Generic drugs are held to the same rigid standards as the brand name drug, as dictated by the FDA.

**70% of generic alternatives are available through a retail promotion.
Average cost \$0 to \$4 for a 30-day supply!!!**

These pharmacies, as well as others, offer generic drug promotions. Many independent pharmacies will also match a promotional price. See individual pharmacy websites for their Prescription Savings Program and a specific listing of prescription drugs.



When using a generic drug promotion, you DO NOT use the prescription benefit on your group health plan.

Check out these free online services!



Check www.theunadvertisedbrand.com to find drugs that are available in generic form.



A pharmacy search engine for discounted generic drug programs available at pharmacies throughout the USA.

- Visit www.medtipster.com
- Enter the drug name, dosage and your zip/address
- You can also search by drug category



Prescription drug prices vary from pharmacy to pharmacy. The Michigan Department of Community Health (MDCH) has created this website to help the citizens of Michigan compare prices among pharmacies.

If your plan has BlueHealthConnection as one of its benefits, you have a wealth of resources at your fingertips. BlueHealthConnection can help you get healthier, stay well and manage illness.

BlueHealthConnection is available 24 hours a day, every day, through Member Secured Services. It gives you the latest information on health and wellness as well as digital health coaching, a tailored health assessment and more.

24-Hour Nurse Line

Get answers to your most important health care questions with 24/7 telephone support from registered nurses.

Case Management

You do not have to go through difficult medical issues alone. Our case management programs can answer questions and provide the support and guidance you need.

Chronic Condition Management

Get the support you need to reduce costs and doctors visits and improve wellness as you manage chronic illness.

Connect 2Bfit

Link up with friends, family and co-workers to improve fitness and encourage healthy living.

Health Assessment

The Succeed™ health assessment is designed to help you understand your current health. It also provides tips and resources to help you reduce health risks.

Accessing the health assessment is easy. Here's how to get started.

1. Log in to Member Secured Services.
2. Click on *Health and Wellness*, and then on *My Health Assessment*.
3. Click *Start Now* to begin the questionnaire.

Wellness Programs

We offer programs for the workplace and home that help identify illness and improve health.

COBRA Continuation Coverage

What is COBRA continuation health coverage?*

Congress passed the landmark Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated.

What does COBRA do?*

COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available when coverage is lost due to certain specific events. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves.

Which employers are required to offer COBRA coverage?*

Employers with 20 or more employees are usually required to offer COBRA coverage and to notify their employees of the availability of such coverage. COBRA applies to plans maintained by private-sector employers and sponsored by most state and local governments.

Under COBRA, what benefits must be covered?*

Qualified beneficiaries must be offered coverage identical to that available to similarly situated beneficiaries who are not receiving COBRA coverage under the plan (generally, the same coverage that the qualified beneficiary had immediately before qualifying for continuation coverage). A change in the benefits under the plan for the active employees will also apply to qualified beneficiaries. Qualified beneficiaries must be allowed to make the same choices given to non-COBRA beneficiaries under the plan, such as during periods of open enrollment by the plan.

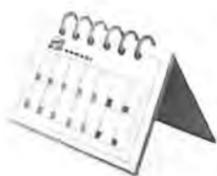
Who can answer other COBRA questions?*

COBRA administration is shared by three federal agencies. The U.S. Department of Labor handles questions about notification rights under COBRA for private-sector employees. The Department of Health and Human Services handles questions relating to state and local government workers. The Internal Revenue Service, Department of the Treasury, has other COBRA jurisdiction.

*The above information was taken from "Frequently Asked Questions about COBRA Continuation Health Coverage" on the Department of Labor website (dol.gov).

Important Note: The preceding is intended to provide a simplified overview of the COBRA law and is to be used for informational purposes only.

Qualifying Life Events



Should you experience any of the following life events, you must request to have your coverage changed within **30 days** of the event.

Birth of a child

Adoption or legal guardianship of a child

Marriage

Dependent stepchild due to marriage

Divorce or legal separation

Loss of child's dependent status due to age or eligible for other coverage

Death of a dependent

Dependents' loss of coverage through spouse's plan

Medicare eligible – if you or your dependents become eligible for Medicare

Any other life event not listed

Unless otherwise indicated, changes not reported within 30 days of an event can only be made at the annual open enrollment.

Healthybluextras / Blue365



This program offers big savings and special discounts to Blue Cross Blue Shield of Michigan and Blue Care Network members. Healthy Blue Xtras makes it easier and less expensive to get the balanced lifestyle you deserve. Enjoy exclusive savings on healthy products and services from companies across the great state of Michigan in these categories. You can even shop by region.

- **Food and nutrition:** Take advantage of great savings on Weight Watchers®, home meal delivery service and fresh produce at stores like Plum Market and Westborn Market.
- **Health and fitness:** Enjoy a massage at 20 percent off, and save on fitness club memberships, classes and consultations.
- **Home and garden:** Get discounts on plants, flowers and other products for your home.
- **Travel:** Pay less at Michigan's top resorts and destinations for budget-friendly vacations and getaways.
- **General:** Shopping for a home? Looking for a home security system? Healthy Blue Xtras has savings for you.
- **Recreation:** Save on family activities and outings like golf and kayaking, the Detroit Zoo and Michigan's Adventure.



As a member of Blue Cross Blue Shield of Michigan, you automatically have access to the content, tools and discounted offers available through Blue365. This program helps you find health and wellness information, support and services you need every day, all year. Here's what you'll find:

- **Health care resources:** Get info and tips about health care providers, prescriptions and supplies; hearing and vision; Medicare; insurance and more.
- **Healthy choices:** Test your health knowledge with a quiz and learn about fitness, food and nutrition, weight control, wellness, children and seniors.
- **Recreation and travel:** Access great resources for outdoor recreation, destination and travel tips, and arts and entertainment.

Hand over your complex health care coverage problems...

Health Advocate will take them on.



Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Health care can be complicated. There's a maze of care options, provider choices, plan details and more. That's why Blue Cross Blue Shield of Michigan and Blue Care Network are offering you Health Advocate. The personal advocacy service will help you navigate the whole health care system.

Health Advocate is available at no cost to you.

Blues customer service and care management teams are still available to give the same great service for routine questions. But if you don't have the time to sort through a complicated problem, hand it over to Health Advocate.

Don't know where to turn? Health Advocate points the way by:

- Sorting through information from doctors, dentists, specialists and other providers
- Scheduling appointments and second opinions, arranging for special treatments and tests
- Answering questions about test results, treatments and medications
- Researching newest treatments
- Helping you transfer medical records, X-rays and lab results

Overwhelmed by medical bills? Health Advocate goes to bat for you by:

- Negotiating payment plans
- Advising about your appeal rights for bills from doctors, hospitals and other health professionals

Need eldercare services? Health Advocate eases your burden by:

- Finding in-home care, adult day care, assisted living, long-term care
- Clarifying Medicare, Medicaid and Medicare Supplemental plans
- Coordinating care among multiple providers
- Researching transportation to appointments

Your whole family can use Health Advocate for free

You, your spouse, dependent children, parents and parents-in-law can call as often as needed, at no cost to you. Health Advocate will help even if they're not covered by your medical plan.

Your privacy is protected

Health Advocate follows careful business practices and all government privacy laws.

Health Advocate is just a phone call away

Health Advocate gives personal support Monday through Friday 8 a.m. to 9 p.m. Eastern Time. After hours and on weekends, an operator will take your message.

**Qualifying Life Events
COBRA Continuation Coverage
HIPAA Privacy Overview
Social Security Privacy Act
Women's Health and Cancer Rights Act
Administrative Service
Contacting the Carrier**

Just call toll-free 1-855-425-8585

Voluntary Vision Program



Blue VisionSM Voluntary Benefits-at-a-Glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call 1-800-877-7195 or log on to the VSP Web site at vsp.com.

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both.

	VSP network doctor	Non-VSP provider
Member's responsibility (copays)		
Eye exam	\$10 copay	\$10 copay applies to charge
Prescription glasses (lenses and/or frames)	Combined \$25 copay	Member responsible for difference between approved amount and provider's charge, after \$25 copay
Medically necessary contact lenses	\$25 copay	Member responsible for difference between approved amount and provider's charge, after \$25 copay

Eye exam		
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	\$10 copay	Reimbursement up to \$35 less \$10 copay (member responsible for any difference)
One eye exam in any period of 12 consecutive months		

Lenses and frames		
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	\$25 copay (one copay applies to both lenses and frames)	Reimbursement up to approved amount based on lens type less \$25 copay (member responsible for any difference)
One pair of lenses, with or without frames, in any period of 12 consecutive months		
Standard frames Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	\$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less \$25 copay (one copay applies to both frames and lenses)	Reimbursement up to \$45 less \$25 copay (member responsible for any difference)
One frame in any period of 24 consecutive months		

Contact lenses		
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	\$25 copay	Reimbursement up to \$210 less \$25 copay (member responsible for any difference)
One pair of contact lenses in any period of 12 consecutive months		
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	\$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	\$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
Contact lenses are covered up to allowance every 12 consecutive months		

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Preventive Care Benefits

Preventive Care Benefits

Part 1

Preventive health services for adults

Most health plans must cover a set of preventive services like shots and screening tests at no cost to you. This includes Marketplace private insurance plans.

Free preventive services

All Marketplace plans and many other plans must cover the following list of preventive services without charging you a copayment or coinsurance. This is true even if you haven't met your yearly deductible. This applies only when these services are delivered by an in-network provider.

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
2. Alcohol Misuse screening and counseling
3. Aspirin use to prevent cardiovascular disease for men and women of certain ages
4. Blood Pressure screening for all adults
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal Cancer screening for adults over 50
7. Depression screening for adults
8. Diabetes (Type 2) screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for everyone ages 15 to 65, and other ages at increased risk
11. Immunization vaccines for adults—doses, recommended ages, and recommended populations vary:
 - Hepatitis A
 - Hepatitis B
 - Herpes Zoster
 - Human Papillomavirus
 - Influenza (Flu Shot)
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Tetanus, Diphtheria, Pertussis
 - Varicella
12. Obesity screening and counseling for all adults
13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
14. Syphilis screening for adults at higher risk
15. Tobacco Use screening for all adults and cessation interventions for tobacco users

Part 2

Preventive health services for women

Most health plans must cover additional preventive health services for women, ensuring a comprehensive set of preventive services like breast cancer screenings to meet women's unique health care needs.

Comprehensive coverage for women's preventive care

All Marketplace health plans and many other plans must cover the following list of preventive services for women without charging you a copayment or coinsurance. This is true even if you haven't met your yearly deductible. This applies only when these services are delivered by an in-network provider.



Voluntary Vision Program

New hire eligibility period:

Employees will become eligible for benefits on the first day of the month following 60 days of employment.

Dependent eligibility:

Dependent children (students and non-students) are eligible until the end of the year in which they turn 26 years old.

Voluntary Dental Program



Class III services, *continued*

Repairs and adjustments of a partial or complete denture	50% of approved amount after deductible, six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	50% of approved amount after deductible, once per arch in any 36 consecutive months
Tissue conditioning	50% of approved amount after deductible, once per arch in any 36 consecutive months

Class IV services – Orthodontic services for dependents under age 19

Note: There is a 12-month waiting period for Class IV benefits when combination rider package with orthodontic coverage is selected. The waiting period will be satisfied on the last day of the 12-month period with benefits becoming effective on the first date following. For example, if the member's coverage becomes effective on January 1, 2014, the last date of the waiting period will be December 31, 2014, with benefits becoming active on January 1, 2015.

Minor treatment for tooth guidance appliances	Not covered
Minor treatment to control harmful habits	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered
Post-treatment stabilization	Not covered
Cephalometric film (skull) and diagnostic photos	Not covered

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination **before** treatment begins.

Preventive Care Benefits

Part 2

Preventive health services for women (continued)

1. Anemia screening on a routine basis for pregnant women
2. Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer
3. Breast Cancer Mammography screenings every 1 to 2 years for women over 40
4. Breast Cancer Chemoprevention counseling for women at higher risk
5. Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
6. Cervical Cancer screening for sexually active women
7. Chlamydia Infection screening for younger women and other women at higher risk
8. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."
9. Domestic and interpersonal violence screening and counseling for all women
10. Folic Acid supplements for women who may become pregnant
11. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
12. Gonorrhea screening for all women at higher risk
13. Hepatitis B screening for pregnant women at their first prenatal visit
14. HIV screening and counseling for sexually active women
15. Human Papillomavirus (HPV) DNA Test every 3 years for women with normal cytology results who are 30 or older
16. Osteoporosis screening for women over age 60 depending on risk factors
17. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
18. Sexually Transmitted Infections counseling for sexually active women
19. Syphilis screening for all pregnant women or other women at increased risk
20. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
21. Urinary tract or other infection screening for pregnant women
22. Well-woman visits to get recommended services for women under 65

Part 3

Preventive health services for children

Most health plans must cover a set of preventive health services for children at no cost when delivered by an in-network provider. This includes Marketplace and Medicaid coverage.

Coverage for children's preventive health services

All Marketplace health plans and many other plans must cover the following list of preventive services for children without charging you a copayment or coinsurance. This is true even if you haven't met your yearly deductible.

Preventive Care Benefits

Part 3

Preventive health services for children (continued)

1. Autism screening for children at 18 and 24 months
2. Behavioral assessments for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
3. Blood Pressure screening for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
4. Cervical Dysplasia screening for sexually active females
5. Depression screening for adolescents
6. Developmental screening for children under age 3
7. Dyslipidemia screening for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
8. Fluoride Chemoprevention supplements for children without fluoride in their water source
9. Gonorrhea preventive medication for the eyes of all newborns
10. Hearing screening for all newborns
11. Height, Weight and Body Mass Index measurements for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
12. Hematocrit or Hemoglobin screening for children
13. Hemoglobinopathies or sickle cell screening for newborns
14. HIV screening for adolescents at higher risk
15. Hypothyroidism screening for newborns
16. Immunization vaccines for children from birth to age 18—doses, recommended ages, and recommended populations vary:
 - Diphtheria, Tetanus, Pertussis
 - Haemophilus influenza type b
 - Hepatitis A
 - Hepatitis B
 - Human Papillomavirus
 - Inactivated Poliovirus
 - Influenza (Flu Shot)
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Rotavirus
 - Varicella
17. Iron supplements for children ages 6 to 12 months at risk for anemia
18. Lead screening for children at risk of exposure
19. Medical History for all children throughout development at the following ages: 0-11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
20. Obesity screening and counseling
21. Oral Health risk assessment for young children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years
22. Phenylketonuria (PKU) screening for this genetic disorder in newborns
23. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
24. Tuberculin testing for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
25. Vision screening for all children

Information found at www.healthcare.gov.

Voluntary Dental Program



Class I services

Oral exams	100% of approved amount, twice per calendar year
A set (up to 4 films) of bitewing x-rays <ul style="list-style-type: none"> • For members age 15 and younger • For members age 16 and older 	100% of approved amount, once per calendar year
Dental prophylaxis (teeth cleaning)	100% of approved amount, twice per calendar year
Fluoride treatment – for members age 14 and younger	100% of approved amount, once per calendar year

Class II services

Panoramic or full-mouth x-rays	80% of approved amount after deductible, once in any 84 consecutive months
Other diagnostic x-rays	80% of approved amount after deductible, any combination of 6 individual or sets of films per calendar year
Pit and fissure sealants – for members age 16 and younger	80% of approved amount after deductible, once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Palliative (emergency) treatment	80% of approved amount after deductible
Space maintainers – missing posterior (back) primary teeth – for members age 16 and younger	80% of approved amount after deductible, once per quadrant per lifetime
Fillings – permanent (adult) teeth	80% of approved amount after deductible, replacement fillings covered after 48 months or more after initial filling
Fillings – primary (child) teeth	80% of approved amount after deductible, replacement fillings covered after 24 months or more after initial filling
Recementation of crowns, veneers, inlays, onlays and bridges	80% of approved amount after deductible, three times per tooth per calendar year after six months from original restoration
General anesthesia or IV sedation	80% of approved amount after deductible, when medically necessary and performed with oral surgery
Periodontic maintenance (can replace dental prophylaxis)	80% of approved amount after deductible, twice per calendar year

Class III services

Note: There is a 12-month waiting period for Class III benefits. The waiting period will be satisfied on the last day of the 12-month period with benefits becoming effective on the first date following. For example, if the member's coverage becomes effective on January 1, 2014, the last date of the waiting period will be December 31, 2014, with benefits becoming active on January 1, 2015.

Root canals and simple extractions are not subject to the 12-month waiting period.

Root canal treatment – permanent tooth	50% of approved amount after deductible, once per tooth per lifetime; retreatment of previous root canal therapy (after 36 months from the date of the original therapy) once per tooth per lifetime.
Scaling and root planing	50% of approved amount after deductible, once per quadrant in any 36 consecutive months
Limited occlusal adjustments	50% of approved amount after deductible, limited adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	50% of approved amount after deductible, once in any 60 consecutive months (Repairs and relines to occlusal biteguard covered once in any 60 consecutive months)
Onlays, crowns and veneer fillings – permanent teeth – for members age 12 and older	50% of approved amount after deductible, once per tooth in any 84 consecutive months
Oral surgery including extractions	50% of approved amount after deductible
Removable dentures (complete and partial)	50% of approved amount after deductible, once in any 84 consecutive months
Bridges (fixed partial dentures) – for members age 16 and older	50% of approved amount after deductible, once in any 84 consecutive months
Endosteal implants – for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount after deductible, once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31
Bone replacement grafts – must be performed on the same date of service as osseous or gingival flap surgery	50% of approved amount after deductible
Localized delivery of antimicrobial agents	50% of approved amount after deductible, limited to three per quadrant with a maximum of 12 teeth per year

Voluntary Dental Program



Blue Dental PPO PlusSM Voluntary – \$50/\$150 Deductible, 100/80/50 Plan

Benefits-at-a-Glance \$1000 AnnualMax, XOrtho

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Network access information

With Blue Dental PPO Plus, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Dental Network of America (DNoA) Preferred Network of PPO dentists.

DNoA Preferred Network – Blue Dental members have unmatched access to PPO dentists through the DNoA Preferred Network, which offers more than 230,000 dentist locations* nationwide. DNoA Preferred Network dentists agree to accept our approved amount as payment in full and participate on all claims. Members also receive discounts on noncovered services when they use PPO dentists. To find a DNoA Preferred Network dentist near you, please visit BCBSM.com/bluedental or call 1-888-826-8152.

* A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.

Members who go to non-PPO dentists can still save money through our Blue Par Select arrangement.

Blue Par SelectSM arrangement – Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services – members pay only applicable copays and deductibles, along with any fees for noncovered services. To find a dentist who may participate with BCBSM, please visit BCBSM.com/bluedental.



In-Network Benefit Comparison

Choose only ONE medical plan for yourself and your family members.

Member's responsibility (deductible, copays and dollar maximums)

Deductible	\$50 per member, limited to \$150 per family each calendar year for Class II and Class III dental services provided by a non-network (non-PPO) dentist (deductible does not apply to Class I services)
Copays	
• Class I services	None (covered at 100% of approved amount)
• Class II services	20% of approved amount
• Class III services	50% of approved amount
• Class IV services	Not covered
Dollar maximums	
• Annual maximum for Class I, II and III services	Combined \$1,000 per member (no more than \$800 of this amount can be used for services provided by non-PPO dentists)
• Lifetime maximum for Class IV services	Not applicable
Waiting period	12 months for Class III services (except root canals and simple extractions) and 12 months for Class IV services when combination rider package with Class IV (orthodontic) services is selected by your group Note: Your group's waiting period(s) may be waived with proof of prior dental coverage. However, members who enroll after the initial enrollment period will be subject to the group's 12-month waiting period(s).

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

In-Network Benefit Comparison



BCBSM – PPO Medical Program		BCN – HMO Medical Program	
Deductibles			
One person:	\$2,500	\$3,000	
Family:	\$5,000	\$6,000	
Coinsurance		80% / 20%	
Out-of-Pocket Maximum			
One person:	\$5,000	\$6,350	
Family:	\$10,000	\$12,700	
<p>The out-of-pocket maximum (OOPM) is a “true” out-of-pocket maximum and includes all copays. This is the maximum amount you will be responsible for in a calendar year for your combined deductible, coinsurance and copay amounts. Once your OOPM is satisfied, approved services will be covered at 100% for the remainder of the calendar year.</p>			
Copays			
PCP Office visit :	\$40	\$30	
Specialist office visit:	\$60	\$50	
Chiropractic:	\$40	\$50	
Urgent care:	\$60	\$50	
Emergency room:	\$250	\$250 after deductible	
Ambulance:	20% coinsurance after deductible	20% copay after deductible	
<p>The copays do not apply to your deductible but do apply to your out-of-pocket maximum.</p>			
Prescription Drug Copays			
Tier 1:	\$20	\$6 value generic / \$40 generic	
Tier 2:	\$60	\$60	
Tier 3:	50% (\$80 min/\$100 max)	\$80	
Tier 4 Specialty:	20% (\$200 max)	20% (\$200 max)	
Tier 5 Specialty:	25% (\$300 max)	20% (\$300 max)	
Mail Order:	2 x copay	3 x copay minus \$10	



Voluntary Dental Program

New hire eligibility period:

Employees will become eligible for benefits on the first day of the month following 60 days of employment.

Dependent eligibility:

Dependent children (students and non-students) are eligible until the end of the year in which they turn 26 years old.

HMO Medical Program



Benefits-at-a-Glance for \$6/\$40/\$60/\$80/20%/20% Prescription Drug Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificate and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

Prescription Drugs

Tier 1A – Value Generics	\$6 Copayment
Tier 1B – Generics	\$40 Copayment
Tier 2 – Preferred Brand Drugs	\$60 Copayment
Tier 3 – Non-Preferred Drugs	\$80 Copayment
Tier 4 – Preferred Specialty	20% Coinsurance of the BCN Approved Amount (Maximum Copayment \$200)
Tier 5 Non-Preferred Specialty	20% Coinsurance of the BCN Approved Amount (Maximum Copayment \$300)
Sexual Dysfunction Drugs	50% Coinsurance of the BCN Approved Amount
Contraceptives Note: Your cost sharing may be waived for Tier 1B, Tier 2 or Tier 3 contraceptive drugs if there are no appropriate generic products or preferred drugs available.	<ul style="list-style-type: none"> • Tier 1A – Covered in Full • Tier 1B – \$40 Copay • Tier 2 – \$60 Copay • Tier 3 – \$80 Copay
Preventive Medications	<ul style="list-style-type: none"> • Tier 1A – Covered in Full • Tier 1B Generic – Covered in Full • Tier 2 Preferred Brand – Covered in Full • Tier 3 Non-Preferred Drugs – Covered in Full
31-90 day supply for Mail-Order Pharmacy	Three times applicable copay minus \$10
84-90 day supply for Retail Pharmacy	Three times applicable copay minus \$10
Out-of-Pocket Maximum	Your medical out-of-pocket maximum is integrated with your BCN covered Prescription Drugs. The out-of-pocket maximum amount is listed with your medical benefits.

Definitions

Brand Name Drug	<p>Manufactured and marketed under a registered trade name and trademark.</p> <ul style="list-style-type: none"> • Multi-source Brand Name Drug: a drug that is available from a brand name manufacturer and also has a generic version. • Single Source Brand Name Drug: the drug can only be produced by the company holding the patent; no generics are available.
Generic Drugs	Prescription drugs that have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark.
Non-Preferred Drugs	Prescription drugs that may not have a proven record for safety or their clinical record may not be as high as the BCN preferred alternatives.
Non-Preferred Specialty Drugs	Specialty drugs that may not have a proven record for safety or their clinical value may not be as high as the Specialty Drugs.
Out-of-Pocket Maximum	The highest amount of money you have to pay for covered services during the Calendar Year.
Preferred Brand Drugs	Prescription drugs that are Single Source Brand drugs that have a proven record for safety and effectiveness.
Preferred Specialty Drugs	Generic or Single Source Brand Specialty drugs that have a proven record for safety and effectiveness and offer the best value to our members.
Value Generic Drugs	Prescription drugs that have a proven clinical value essential for treatment of chronic conditions.



PPO Medical Program

Choose only ONE medical plan for yourself and your family members.

New hire eligibility period:

Employees will become eligible for benefits on the first day of the month following 60 days of employment.

Dependent eligibility:

Dependent children (students and non-students) are eligible until the end of the year in which they turn 26 years old.

PPO Medical Program



Simply BlueSM PPO LG – Plan 2500 Medical Coverage Benefits-at-a-Glance - w/XVA, SB-TCP-\$40

Effective for groups on their plan year beginning on or after January 1, 2014

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services – Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: To be eligible for coverage, the following services require your provider to obtain approval **before** they are provided – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analyses.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals – BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician **must** contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

In-network

Out-of-network *

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Note: If a PPO in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

Deductibles	\$2,500 for one member, \$5,000 for the family (when two or more members are covered under your contract) each calendar year	\$5,000 for one member, \$10,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	<ul style="list-style-type: none"> \$40 copay for office visits and office consultations with 'non-specialist' provider \$60 copay for office visits and office consultations with 'specialist' provider \$60 copay for urgent care visits \$40 copay for chiropractic services and osteopathic manipulative therapy \$250 copay for emergency room visits 	<ul style="list-style-type: none"> \$250 copay for emergency room visits
Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 20% of approved amount for most other covered services 	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 40% of approved amount for most other covered services
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if applicable	\$5,000 for one member, \$10,000 for two or more members each calendar year	\$10,000 for one member, \$20,000 for two or more members each calendar year Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

* Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

HMO Medical Program



Other Services

Allergy Testing and Therapy	Covered – 50% after deductible
Allergy Injections	Covered – \$5 copay
Chiropractic Spinal Manipulation – when referred	Covered – \$50 copay; up to 30 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy – subject to meaningful improvement within 60 days	Covered – \$50 copay after deductible; limited to a combined benefit maximum of 60 consecutive days per calendar year for a combination of therapies
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%
Diabetic Supplies	Covered – 80%

HMO Medical Program



Maternity Services Provided by a Physician

Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered – \$30 copay
Delivery and Nursery Care	Covered – 100% after deductible for professional services; see Hospital Care for facility charges

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible; unlimited days
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 80% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 80% after deductible up to 45 days per calendar year
Hospice Care	Covered – 100% after deductible when authorized
Home Health Care	Covered – \$50 copay after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 80% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – 50% after deductible
First Trimester Termination (One procedure per two year period of membership)	Covered – 50% after deductible
Human Organ Transplants (subject to medical criteria)	Covered – 80% after deductible
Reduction mammoplasty (subject to medical criteria)	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	Covered – 80% after deductible
Outpatient Mental Health Care	Covered – \$30 copay
Outpatient Substance Abuse Care	Covered – \$30 copay

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment Limited to 25 hours per week for line therapy for children through age 18	Covered – \$30 copay
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18	Covered – \$50 copay after deductible
Physical, speech and occupational therapy for autism spectrum disorder is unlimited.	
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit

PPO Medical Program



In-network

Out-of-network *

Preventive care services

Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
Colonoscopy – routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible

* Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

PPO Medical Program



In-network

Out-of-network *

Physician office services

Office visits/Office consultations with a "non-specialist" provider – must be medically necessary	\$40 copay per office visit Note: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible
Outpatient and home medical care visits – must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office visits/Office consultations with a "specialist" provider – must be medically necessary	\$60 copay per office visit Note: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible

Urgent care visits

Urgent care visits	\$60 copay per office visit Note: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible
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Emergency medical care

Hospital emergency room	\$250 copay per visit	\$250 copay per visit
Ambulance services – must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care	80% after in-network deductible	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

* Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

HMO Medical Program



BCN HMO \$3000/20%SM

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificate and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums

Note: The **Deductible** will apply to certain services as defined below.

Deductible Note: Coinsurance and select fixed dollar copays apply once the deductible has been met.	\$3,000 per individual/\$6,000 per family per calendar year
Fixed dollar copays	\$30 for office visits, \$50 for specialist visits, \$50 for urgent care visits, \$250 for emergency room visits, \$150 for high tech imaging and \$5 for allergy injections
Coinsurance	30% and 50% for select services as noted below
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays	\$6,350 per member/\$12,700 per family per calendar year

Preventive Services – as defined by the Affordable Care Act and included in your Certificate of Coverage

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Routine Colonoscopy	Covered – 100%
Mammography Screening	Covered – 100%
Voluntary Female Sterilization	Covered – 100%
Breast Pumps (DME guidelines apply. Limited to no more than one per 24 month period)	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%

Physician Office Services

PCP Office Visits	Covered – \$30 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – \$50 copay

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – \$250 copay after deductible
Urgent Care Center	Covered – \$50 copay
Ambulance Services – medically necessary	Covered – 80% after deductible

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100%
Diagnostic Tests and X-rays	Covered – 80% after deductible
High Technology Imaging (MRI, CAT, PET)	Covered – \$150 copay after deductible
Radiation Therapy	Covered – 80% after deductible



HMO Medical Program

Choose only ONE medical plan for yourself and your family members.

New hire eligibility period:

Employees will become eligible for benefits on the first day of the month following 60 days of employment.

Dependent eligibility:

Dependent children (students and non-students) are eligible until the end of the year in which they turn 26 years old.

PPO Medical Program



	In-network	Out-of-network *
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care – must be in a participating skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care: • must be medically necessary • must be provided by a participating home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization – consult with your doctor	80% after in-network deductible	80% after in-network deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males Note: For voluntary sterilizations for females, see "Preventive care services."	80% after in-network deductible	60% after out-of-network deductible
Human organ transplants		
Specified human organ transplants – must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) – in designated facilities only
Bone marrow transplants – must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials Note: BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

* Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

PPO Medical Program



In-network **Out-of-network ***

Mental health care and substance abuse treatment

Inpatient mental health care and inpatient substance abuse treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% after in-network deductible, in participating facilities only
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities only	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is limited to a maximum of 25 hours of direct line therapy per week per member, through age 18 Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment. ABA and AAEC services are not available outside of Michigan.	80% after in-network deductible	80% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
	Physical, speech and occupational therapy with an autism diagnosis is limited to the same annual combined limit as for physical, speech and occupational therapy for other diagnoses	
Other covered services, including mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

Other covered services

Outpatient Diabetes Management Program (ODMP) Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	80% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$40 copay per office visit Note: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Limited to a combined 12-visit maximum per member per calendar year	60% after out-of-network deductible
Outpatient physical, speech and occupational therapy – provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered. Limited to a combined 30-visit maximum per member per calendar year (visits are combined with therapies for autism spectrum disorder)

* Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

PPO Medical Program



Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the difference in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug plus your applicable copay regardless of whether you or your physician requests the brand name drug. Exception: If your physician requests and receives authorization for a nonpreferred brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. Note: This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Drug interchange and generic copay waiver	BCBSM's drug interchange and generic copay waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

PPO Medical Program



Covered services, continued

	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Other FDA-approved brand name prescription preventive drugs, supplements, and vitamins	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved generic and select brand name prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount less plan copay
Other FDA-approved brand name prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Features of your prescription drug plan

BCBSM Custom Formulary	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the formulary is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> ▪ Tier 1 (generic) – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. ▪ Tier 2 (preferred brand) – Tier 2 includes brand-name drugs from the Custom Formulary. Preferred brand name drugs are also safe and effective, but require a higher copay. ▪ Tier 3 (nonpreferred brand) – Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay for these drugs. ▪ Tier 4 (Generic and preferred brand-name specialty) – Tier 4 includes covered specialty drugs listed as generic drugs (Tier 1) or preferred brand-name drugs (Tier 2) from the Custom Formulary. These drugs have a proven record for safety and effectiveness, and offer the best value to our members. They have the lowest specialty drug copay. ▪ Tier 5 (Nonpreferred brand-name specialty) – Tier 5 includes covered specialty drugs listed as nonpreferred brand name (Tier 3). These drugs may not have a proven record for safety or their clinical value may not be as high as the specialty drugs in Tier 4. They have the highest specialty drug copay.
Prior authorization/step therapy	<p>A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. Step Therapy, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at bcbsm.com/pharmacy.</p>

PPO Medical Program



in-network

Out-of-network *

Other covered services, continued

Durable medical equipment Note: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM or visit web site, www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html .	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

Additional Riders Selected

Rider XVA, excludes voluntary abortions	Excludes benefits for voluntary abortions.
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PPO Medical Program



Blue Preferred[®] Rx Prescription Drug Coverage 5-Tier Copay, Open Formulary Benefits-at-a-Glance

Effective for groups on their plan year beginning on or after January 1, 2014

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible, copay and /or coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Specialty Pharmaceutical Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel[®] and Humira[®]) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com/pharmacy. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a **90-Day Retail Network provider** or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

Member's responsibility (copays)

Note: Your prescription drug copays, including mail order copays, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum:

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 – Generic or select prescribed over-the-counter drugs	1 to 30-day period	\$20 copay	\$20 copay	\$20 copay	\$20 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$40 copay	No coverage	No coverage
	84 to 90-day period	\$40 copay	\$40 copay	No coverage	No coverage
Tier 2 – Formulary (preferred) brand-name drugs	1 to 30-day period	\$60 copay	\$60 copay	\$60 copay	\$60 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$120 copay	No coverage	No coverage
	84 to 90-day period	\$120 copay	\$120 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

PPO Medical Program



Member's responsibility (copays), *continued*

		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 3 – Nonformulary (nonpreferred) brand-name drugs	1 to 30-day period	\$80 or 50% of approved amount (whichever is greater), but no more than \$100	\$80 or 50% of approved amount (whichever is greater), but no more than \$100	\$80 or 50% of approved amount (whichever is greater), but no more than \$100	\$80 or 50% of approved amount (whichever is greater), but no more than \$100 <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$160 or 50% of approved amount (whichever is greater), but no more than \$200	No coverage	No coverage
	84 to 90-day period	\$160 or 50% of approved amount (whichever is greater), but no more than \$200	\$160 or 50% of approved amount (whichever is greater), but no more than \$200	No coverage	No coverage
Tier 4 – Generic and formulary (preferred) brand-name specialty drugs	1 to 30-day period	20% of approved amount, but no more than \$200	20% of approved amount, but no more than \$200	20% of approved amount, but no more than \$200	20% of approved amount, but no more than \$200 <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage
Tier 5 – Nonformulary (nonpreferred) brand-name specialty drugs	1 to 30-day period	25% of approved amount, but no more than \$300	25% of approved amount, but no more than \$300	25% of approved amount, but no more than \$300	25% of approved amount, but no more than \$300 <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services

	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
FDA-approved generic and select brand name prescription preventive drugs, supplements, and vitamins	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount less plan copay