Request for Proposal For

Employee Benefits Brokerage and Consulting Services

Presented by:
CBIZ Employee Services Organization
One Overton Park
3625 Cumberland Blvd SE, Suite 1100
Atlanta, GA 30339

CBIZ SERVICE PROMISE

WE PLEDGE TO PROVIDE AN EXCEPTIONAL SERVICE EXPERIENCE TO EVERY CBIZ CLIENT.

- **Individual Attention:** We will treat each client with the utmost care; we will develop and maintain a strong personal relationship; we will provide service with a commitment to professionalism, trust and the highest level of personal and professional integrity.

- **Responsive:** We will respond to a client's urgent need immediately; we will return all voicemail and e-mail communications within 24 hours; we will deliver and review all work product on a timely and as agreed basis.

- **Proactive:** We are committed to understanding the goals and needs of our clients, responding to such needs with our best service, advice and products. We will strive to provide our clients with innovative solutions and opportunities to improve and grow their business.

OUR GUARANTEE: IF YOU ARE NOT SATISFIED WITH OUR RESPONSIVENESS AND THE SERVICE WE HAVE PROVIDED, TELL US IMMEDIATELY–WE WILL CORRECT THE SITUATION TO YOUR SATISFACTION.

CBIZ®

Your Business Just Got Easier.

October 10, 2017

Molly Willey
Directory of Human Resources
Pike Enterprises, LLC
100 Pike Way
Mount Airy, NC 27030

Re: Employee Benefits Brokerage and Consulting Services

Thank you for inviting CBIZ to offer Pike Enterprises, LLC a proposal for employee benefits brokerage and consulting services. In our unique approach and comprehensive scope of services we are confident you will find that our unwavering commitment to all of our services align with Pike's needs.

CBIZ is ideally suited to provide these professional services to Pike.

When you engage CBIZ, you can count on:

- A collaborative and strategic partnership with a commitment to proactive client service;
- A team of very experienced benefit professionals, who have been actively involved in large case benefits consulting for more than 40 years with real Population Health Management experience; and
- An Innovative and creative strategy that will stream line the communications and administration of your benefits plans;

At CBIZ we are absolutely committed to excellence, innovation and superior service. We are ready to put our talent and expertise to work for you and your employees. We promise to be with you for the longer term. We will set expectations and develop a multi-year strategy.

Based on the RFP and your questionnaire responses, we understand the following are key objectives for this engagement:

1. Provide benefits that are valued by your employees in order to assist with recruitment and retention (reduce turnover)
2. Provide cost containment strategies which address the future growth of the organization with a focus on maintaining "grandfathered status"
3. Provide high quality enrollment and communication support
4. Create a strategic plan that puts Pike in the best possible position to continue to offer high quality and cost effective employee benefit plans while striving for continuous improvement
5. Provide consistent and flexible service that is dependable and cost effective

In support of these five objectives CBIZ has put together a service team that we believe is exceptionally well qualified to execute both the strategy and tactics required for you to succeed in accomplishing the goal of having Pike's employees be proud of being a part of the Pike team.

We believe there are a number of initiatives that can be taken that will accomplish your stated objectives. The following examples are provided:

- A comprehensive benefits communications and enrollment platform - case studies have shown that utilizing vendors specializing in this area can reduce turnover and create significant saving. A 1% reduction in turnover at Pike would generate annual savings estimated to be in excess of $1.8 million (see illustration in RFP response). The cost for a platform of this nature utilizing 5500 eligible employees would be less than .4% of your total benefit expenditures.
- Prescription Benefit Manager (PBM) carve out- estimated to reduce Rx spend by up to 15%
- Population (Health Management) and Data Analytics- studies indicate trend reduction of 2% to 3%
- Dependent Eligibility Audits at like industry employers have shown total plan cost reduction through elimination of ineligible covered dependents in the 4% range
- Network Efficacy Analysis and Administrative Fee Negotiations have shown medical plan savings in the 1% to 3% range
- Stop loss captive analysis with potential to reduce stop loss cost by 10% to 15% without increasing the ISL deductible
- ROI study for an onsite clinic at Pike headquarters. Typical ROI in the 1.5 to 2.5 times range
- Aggressive marketing of Life, Disability, Dental and Vision coverages have produced premium savings that are from 15% to 25%

All of these steps do not involve any plan design changes that could affect Pike's "grandfathered" status.

The following proposal has been prepared to demonstrate our dedication to meet your needs and goals, the proposal also portrays our in-depth resources and extensive experience in providing solutions to organizations facing similar issues as Pike.

Again, thank you for the opportunity to present this proposal.

Sincerely,

Frederick R. Schremp, CLU | Senior Vice President
CBIZ Employee Services Organization
A division of CBIZ Benefits & Insurance Services, Inc.

About CBIZ

1. **Briefly describe your firm's history and background. Does your firm specialize in a certain area?**

CBIZ has been operating as a professional services business since 1996, and built its professional services business through acquiring accounting, benefits, technology, valuation, medical billing and other service firms throughout the United States. Effective August 4, 2006, CBIZ transferred the listing of its common stock to the New York Stock Exchange ("NYSE") under the symbol "CBZ". Prior to August 4, 2006, CBIZ's common stock was traded on the NASDAQ National Market under the symbol "CBIZ".

As a national leader in employee benefit consulting we provide our clients strategic guidance, solid advice, best in class ongoing support and measurable outcomes. With a long history of supporting healthcare and companies, rest assured that we have the expertise to guide and support your team.

National Presence

CBIZ is a provider of professional business services to companies throughout the United States. CBIZ employs more than 4,100 professionals in 100 offices nationwide.

CBIZ is:

- Top Benefits Specialists in the U.S. as ranked by Business Insurance 2015.
- No. 1 America's Best Employer in Consulting and Accounting as ranked by Forbes Magazine in 2015.
- Business Insurance Best Places to Work 2017.
- 13th largest Property & Casualty firm in the U.S.
- 7th largest accounting firm in the U.S.
- One of the largest valuation firms in the U.S.

The Proposing CBIZ Team:

- 250 Clients
- Manages over $300 Million in Employer Sponsored Premiums
- Staff of over 20 Licensed Professionals
- Expertise in:
  - Population Health Management
  - Multiple location servicing, enrollment, and communication strategies
  - Mergers & Acquisitions
  - Regulatory Compliance
  - Insured Funding consulting to include Fully, Alternative, Partial, and Self-Funded
  - Pharmacy Benefit Management and Consulting

CBIZ Employee Services Organization
Scope of Services

2017

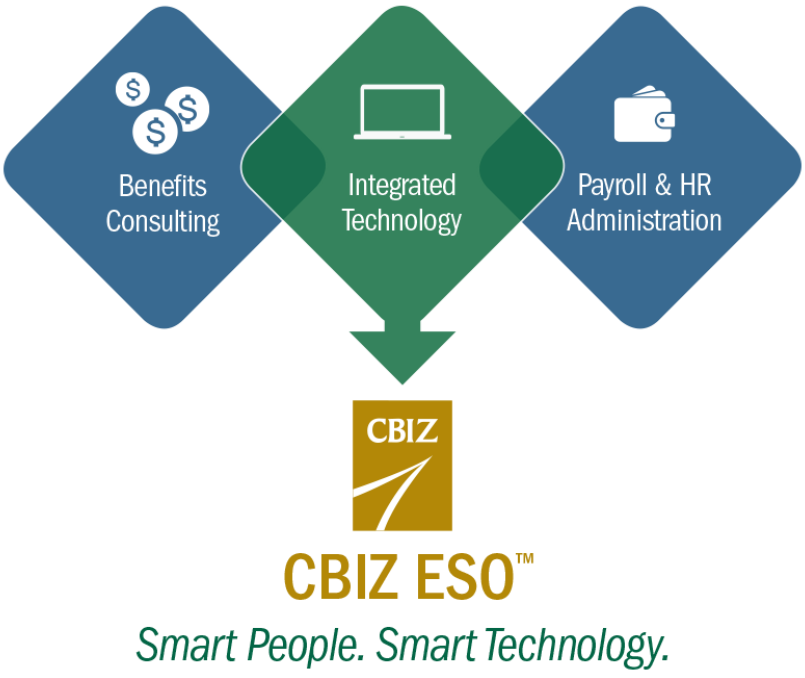
CBIZ ESO Delivers

CBIZ is a fully functional Employee Services Organization which makes available to its clients a wide variety of services that can be bundled together as a unified Benefits Consulting and Human Capital Management package or unbundled and tailored to each client's specific needs. The pages that follow highlight the breath and scope of these disciplines.

CBIZ is a publically traded corporation (NYSE: CBZ) that has experienced sustained growth as an organization and a significant increase in its market valuation. CBIZ currently ranks as a top twenty insurance broker of US business and CBIZ/MHM is a top ten US accounting firm. Our Atlanta benefits office is staffed by 21 professionals who manage 200+ health and welfare plans with annual expenditures exceeding $400 million.

This Summary is divided into three parts:

We look forward to sharing the many opportunities CBIZ offers with XYZ.



CBIZ Employee Services Organization Core Services

Benefits Consulting Core Services

Group Health & Welfare
- Employee Benefits Consulting
- Captive Insurance
- Private Exchanges

Benefits Administration
- Solutions for Enrollment, Communication, and Efficiency

Employee Health Risk Management
- Wellbeing Solutions
- On-site Clinic Consulting

Voluntary Benefits
- Reduce Out of Pocket Costs
- Enhance Employee Benefit Packages

Actuarial Services

Pharmacy Benefit Consulting

Regulatory Affairs & Compliance

Employee Engagement & Communication

Human Capital Management Core Services

Payroll
- Payentry (Cloud-based)
- M3 (Installed)

EMS (HRIS)
- Professional
- Premium

Applicant Tracker
Time & Attendance

Time & Labor Management
- Time Solutions
- Timeforce
- EMS Time & Attendance

COBRA
- Retiree Billing
- Leave of Absence
- COBRA Administration

FLEX
- Section 125
- HRA
- POP
- Section 132
- HSA

HRO
- HR Consulting
- HR Compliance
- Employee Onboarding
- Benefits & Leave of Absence Administration
- Payroll Processing
- Performance Management & Training

Ancillary
- Workers Compensation Pay-as-you-Go
- PayCards
- Paradigm
- Background Checks
- HR Solutions – online library and phone consult

Integrated Services
- 401K/403b retirement reporting
- General Ledger (GL)
- Point Of Sales (POS) system

Benefits Consulting Core Services

(Provided at no additional cost to negotiated commissions/fee structure)

Group Health & Welfare

Employee Benefits Consulting

Plan Review

- Strategy/Planning to include defining, prioritizing and documenting corporate and benefit plan objectives
  - Develop short and long term plans with project action timeline(s)
  - Develop History Document to evaluate past actions / decisions
- New Case Review
  - Efficacy of existing plan designs / actuarial values / premium rate steerage for plan(s) sustainability
  - Determine “at risk” elements and provide understanding of risk / liability / cost / reporting requirements
  - Review contracts, agreements, plan documents, certificates, SPDs, PDs, amendments, SBCs, etc.
    - Identify areas needed for negotiation to ensure all “client friendly” terms and provisions
    - Coordinate review to evaluate compliance with state and federal regulations / requirements
  - Evaluate administrative / billing practices (in accordance with policy provisions and benefits)
  - Evaluate and monitor financial ratings and accreditations
    - Identify underperforming vendor relationships and recommend “best in class” changes
    - Assess and monitor carrier / vendor service and support levels
    - Negotiate performance guarantees where possible
  - Define action plan(s) / implementation time tables for accountability / progress management

Financial Analysis / Data Analytics and Benchmarking

- Dedicated Finance Team (including underwriter and actuary, when needed)
- Review Monthly, Quarterly Claims and Financial Review to include Enrollment / Utilization Review
  - Provide detailed claims analysis / implications including review / monitoring of large claims activity
  - Illustrate claims experience / financial review and analysis against projections / budget
    - Based on availability of information from insurer / vendor(s)
  - Ongoing review of plan(s) for MEC and AV and appropriate pricing / modeling to avoid ACA penalties
  - Analyze available utilization data and cost containment results to create actionable items
  - Perform trend analysis from available diagnostic and normative data
    - Watch potential impact if Cadillac Tax not repealed
  - Provide reporting solutions based on internal information / budget needs
  - Projections of funding levels and contribution modeling
    - Attention to stability and sustainability of plan
  - Evaluate current cost of benefits verses effectiveness of plan design(s)
- Pre-renewal meeting 180 days in advance of renewal date
- Receive and negotiate renewal rates with carrier (request early releases)
- Negotiate renewal rates using alternate vendors for leverage or potential change
- Evaluate and model alternate plan design options and potential feasibility of self-funded option
- PharmD available to review pharmacy experience and clinical recommendations

Plan Marketing and Renewals

- Dedicated Marketing Manager and Team
- Establish annual calendar of events for plan(s) monitoring / compliance and renewal process
- Develop project action timelines
- Review carrier / vendor underwriting methodology, experience data, assumptions for accuracy and logic
  - Use internal underwriter's analysis for leverage with carrier / vendor's renewal action
  - Negotiate and perform critical analysis and comparison of any mandated or suggested benefit change(s)
- Draft bid specifications, evaluation criteria and analyze bid responses (marketing or for leverage)
  - Provide renewal recommendations including cost impact / alternative plan changes / network or pharmacy changes with financial and member impact analysis
  - Propose options for maintaining / improving competitiveness of benefit program
- Finalize program design(s), develop rates, employee / employer contributions
- Prepare renewal binder with Executive Summary, recommendations, cost impact and supporting data
- Skilled at addressing special needs or coverage issues
  - Medicare, coverage for part-time, non-benefit eligible needs or retiree coverage / assistance

Implementation, Communication and/or Annual Enrollment

- Construct project / enrollment timelines
- Conduct / arrange implementation meeting(s) with vendors for new / changes to program(s)
- Develop employee communication and enrollment strategy
  - Design announcement letters and benefit outline summaries
  - Coordinate carrier / vendor sponsored communication materials
  - Prepare custom presentations / webinars / benefit guide (electronic benefit guide for hand-held devices)
    - Develop Brainsharks / presentations geared to employee education
  - Conduct annual enrollment meetings / track attendance
  - Incorporate all required / mandated state and federal notices
  - Incorporate health / wellness events or strategies
- Finalize / coordinate information to be included in employee enrollment packets
- Complete all required documents and contracts
  - Review for accuracy and sold criteria (post implementation)
- Include technology solutions for communication and enrollment, if desired

Regulatory Affairs and Compliance

- In-house Regulatory Affairs Attorney and Staff
- Assist with federal and state requirements (COBRA, FMLA, ACA, etc.)
- Provide proactive updates on pending legislative issues with required actions / impact(s) identified
- Provide "For Your Benefit Booklet" for HR Department and staff
- Compliance checklists and review Regulatory Compliance Calendar
- Regulatory Updates – "Benefit Beat"
- Time Sensitive Communication – "At Issue"
- Periodic and timely access to webcast and compliance sessions
- Annual HIPAA Privacy and Security training webinar to comply with employer's annual compliance
- Health Care Reform Regulatory Updates

- Health Care Reform Analyzer
- Provide assistance with ERISA compliance, including needed document(s)
- Review or arrange non-discrimination testing for all applicable plan(s)
- Review Regulatory Compliance Calendar
- Review past Annual Form 5500s for completeness and compliance
  - Immediately determine if Annual Filings should be made prior to 2014
  - 2014 Forms need to be corrected
  - 2015 Forms need to be filed correctly (after / or along with 2014 amended)
    - Determine if Extension covers possible prior filings or if DFVC program needs to be utilized (1)
  - Prepare current SARs and determine how to distribute earlier versions
  - Collect data and present prepared "signature ready" Forms for review and submission

Account Management Services

- Dedicated Senior Account Manager
  - Manages day to day issues
    - Liaison between insurers / vendors
    - Reviews, confirms and manages changes to all agreements / documents, etc.
    - Reviews all post renewal / changes to assure negotiated items and changes are executed
    - Sets and monitors goals and performance and reports to client
    - Coordinates and reviews plan performance
  - Implementation, Enrollment and Technology Platform services
  - Claim, billing and service issues
  - Compliance assistance
  - "Quarterback" for all services needed

Employee Advocacy Services

- Dedicated Senior Employee Advocate
  - Liaison between employee and carrier / vendors for employee issues
  - Specializes in escalated issues
  - Dedicated access / email

Human Resource Support and Guidance

- CBIZ HR Solutions
  - Full team of Human Resource Specialists
  - Access to four (4) hours or HR assistance – via phone or mail
    - Benefits & Compensation
    - Compliance
    - Leaves of Absences
    - Performance and Productivity
    - Equal Employment Opportunity
    - Risk and Management Safety
    - Recruiting, Selection and Staffing

(1) Cost for compliance of previously filed 5500's – direct pass through from vendor to XYZ

- Model Documents and Forms
  - HR Policy Handbook
  - Personnel Forms
  - Promotion and Transfer Policies
  - Health and Safety Policy
  - Leave Policies and Forms
- Productivity Tools
  - Job Descriptions
  - Performance tool to facilitate preparation of employee reviews
- News and Articles
  - Current trends
  - Timely subjects
  - Best practices

Technology

- Top-tier consulting backed by our integrated, cloud-based HRIS platform to provide extensive automation for all HR-related activities
- Proficient knowledge experience with other technology providers based on individual client needs

CBIZ University *(outside Scope of Services, additional cost)*

- Cost effective way to deliver consistent employee training
- On-line learning management system which provides flexibility to offer training courses quickly and efficiently
- 400+ e-learning modules concluding with evaluation test
  - HR Compliance (Employees and Supervisors)
  - Communicating Effectively at Work
  - Leadership (Employees and Supervisors)
  - Sales Training
  - Wellness
  - Environmental Compliance and Regulatory Analysis
  - Workplace Safety

Employee Health Risk Management

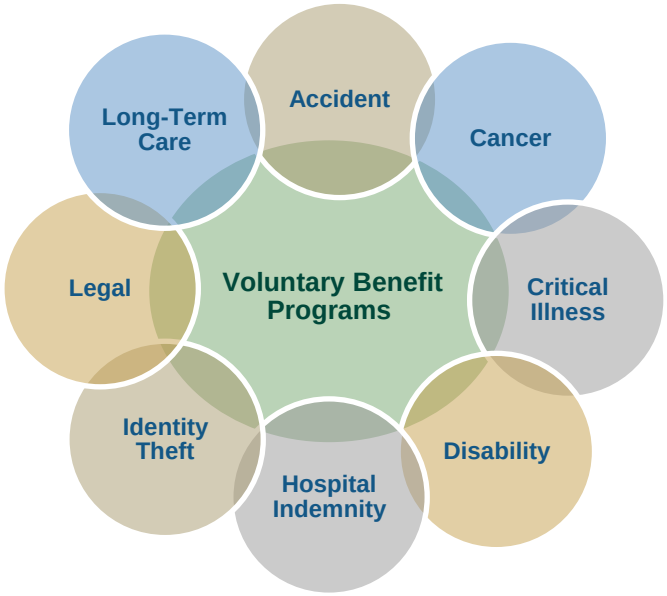
Wellbeing Solutions

- Dedicated Wellness Consultant
- Wellbeing Insights Newsletter
- Wellbeing and engagement strategy, calendar, and budget development
- Evidence-based tactics to reduce health and wellbeing risks
- On-site wellbeing coordinators to execute strategy
- RFP and oversight of vendor processes
- Return on Investment and Value of Investment analysis
- Skilled at negotiating Wellness Funds from certain insurers
- Resource for compliance with wellness regulatory issues

Voluntary Benefits

Benefits Solution

- Skilled Team Members for developing and helping implement benefits strategy and means to help Voluntary Benefits as part of an integrated healthcare solution.
  - Tool to help employees receive direct reimbursement for their out of pocket expenses under High deductible Health Plans (HDHP) and provide other benefits of value, e.g. Legal, Identity Theft, etc..
  - Tool to assist employers implement HDHP's generating benefit plan savings while continuing to provide employee options to enhance their benefit packages.



Private Exchanges

- Private Exchange consulting

Captive Insurance Programs

- Group captives review / evaluation

Human Capital Management Core Services

(Provided at additional cost)

Payroll

Features include

- Cloud based or PC based software for easy, fast and accurate processing.
- Paycheck/Statement printing and distribution
- Detailed management reports (payroll, tax, general ledger, census)
- Quarterly payroll tax return preparation and filing
- W-2 & 1099 preparation at year-end
- Garnishments
- Time-off Accrual tracking
- Direct Deposit; Check signing and handling
- Custom general ledger
- Retirement plan reporting
- New hire reporting
- Workers compensation reports
- Personnel data

EMS (HRIS)

Professional

- Integration with CBIZ Payroll
- **Benefits Management -** with online open enrollment - Allows employees to enroll in and administer their benefits in one central system - Allows administrators to approve and manage employee benefit information online.
- **Employee Portal** - Employees easily enroll in or change all aspects of their benefits and other HR related information.
- **Time off management** – Employees can request time off and view available time off balances from the Employee Portal. Automatically routes requests to the appropriate manager for approval.
- **Workflows** – Let's client define the necessary tasks involved in workflows, and assign those tasks to the appropriate resources.

Premium

All of the features included in the Professional version plus:

- **Applicant Tracking** - Provides applicants a professional looking site for searching and applying for jobs. Let's administrators easily view and compare applicant profiles according to job requisition.
- **Performance Management** - Allows you to automate the employee review process, and eliminates the need for paper-based review forms. Let's you assign measurable goals to your employees and allows you to easily monitor employee progress against the goals you set.
- **Training & Certification tracking** – Workflow reminders when a training item is coming up on expiration.
- **Wellness -** Allows you to monitor, track and run reports on employee progress toward wellness goals.
- **Surveys** - Permits you to easily and quickly develop meaningful surveys.

Time & Labor Management (requires CBIZ Payroll services)

Small Business & Enterprise Solutions

(Small Business Solution)

- Physical & web clocks, Employee Self Service, Time off Management & Scheduling

Premier Time and Labor Solutions

(Enterprise Solution)

- More robust functionality for large clients or complex scheduling
- Physical & web clocks, Employee Self Service, Time off Management & Scheduling

EMS Time and Attendance

(Fully Integrated Solution)

- Web clock or US 10 Biometric Physical Clock (Purchase only)
- Add on to CBIZ EMS Professional or Premium

COBRA

COBRA Administration

- Generally, companies with more than 20 employees are subject to COBRA
- CBIZ sends out initial COBRA notice, qualifying event notices and terminated employee notices
- Online employee and employer access
- Multiple payment options

Retiree Billing

- Welcome kit including summary of benefits, payment instructions and recurring ACH draft services
- Provide access to their account via secure member portal
- Provides employer with end of billing period reports and check (ACA) for payments received during billing period (month)

Leave of Absence Billing

- Provide employees with introductory instruction letter, payment coupons and ACH draft service
- Provide access to their account via secure member portal
- Provide the employer with end of billing period reports and check (ACA) for payments received during billing period (month)

Flex

Section 125

- Flexible Spending Account (FSA)
- Integrated with CBIZ Payroll
- Save pre-tax dollars for health care and/or dependent care
    - **Includes -** Plan Document, Non-Discrimination Testing, 5500 filing, and Debit Cards

HRA

- Health Reimbursement Arrangement
- Employer funded plan (no employee deductions)
- No IRS limit, unused balances roll forward
- Can be used with FSA's

POP

- Allows employees to pay their share of insurance premiums with pre-tax dollars

Section 132

- Allows employees to save pre-tax dollars to pay for parking or mass transit expenses
- Maximum monthly contributions are set

HSA (Health Savings Account)

- Must be enrolled in a high-deductible health plan to qualify
- Medical savings account in which you can set aside pre-tax dollars
- Unused funds are not forfeited, it continues to grow tax-deferred
- Withdrawals to pay qualified medical expenses are not taxed.

Human Resource Outsourcing (HRO)

Employee Onboarding

- Ensure an efficient on-boarding process
- Manage pre-employment requirements

HR Compliance

- Provides information on federal, state, and local laws
- Create and/or review Employee Handbook

Benefits and Leave of Absence Administration

- Manage new hire benefit elections
- Administer, coordinate, and track leaves of absence

Payroll Processing

- Enter child supports and garnishments
- Complete payroll data entry for client approval

Performance Management & Training

- Develop and manage performance reviews
- Assist with disciplinary action process

HR Consulting

- HR process review and improvements
- Employee engagement surveys

Ancillary/Other Services

The Hartford – Workers Compensation

- Integrated with CBIZ Payroll

Paycards: Skylight Financial

Paycard for employees without bank accounts

- Can be used at more than one million ATM's
- Employees will receive free Skylight check to pay bills or receive cash
- Funds are FDIC insured
- Request a second card and you can transfer money between accounts

Tax Credits: Paradigm

Tax credits for Federal and State returns for hiring employees that meet certain criteria.
These include:

- Work Opportunity Tax Credit (WOTC); HUD and Enterprise Zone credits
- Veteran hiring credits; State based hiring credits
- Paradigm handles screening and generates the credits to help clients utilize their tax return

Background Checks/Drug Testing: Aurico

Provides:

- Background screening & Drug Testing
- Selection assessments
- Electronic I-9 & e-verify
- Integrity & accident hotline

Workers Compensation Pay-as-you-Go

- Integrated with CBIZ Payroll
- Calculations based on actual client Payroll which reduces potential for year-end audit
- Does not require 20-30% upfront deposit typically required for workers compensation
- Sends alert prior to collecting payment and 24/7 access to premium calculation and payment history via secure sites

HR Solutions

- Online HR information portal that gives you quick access to resources and information
- Live Hotline included with 4 hours per month of live assistance with HR professionals

Risk and Advisory Services / Cybersecurity

- **Cost Recovery Services -** With the help of our proprietary programs, you can identify, assess and maintain the areas of your business where overcharges and financial leakage may occur.
- **Cybersecurity -** We help strengthen your protection against a potential cyber-attack through risk assessments and evaluations.

- **Enterprise Risk Management -** Our structured and disciplined approach to managing risk helps improve your company's ability to evaluate and manage the uncertainties it faces from unauthorized access, use, disclosure, disruption, modification or destruction to ensure its availability, confidentiality, and integrity.

Integrated Services

401K

- Basic
  - Company is configured with retirement setup (company match, employee deferrals, etc.)
  - Report/File created and installed for PC client
  - Report/File created, printed, and shipped for Web client
  - FTP (Setup + Monthly Fee)
  - Report/File/Data electronically sent to a secure FTP site
- Preferred
  - Data and Money sent securely to administrator
  - Vendors include: Voya (AETNA/ING), Ascensus, Empower, John Hancock, Mutual of Omaha, Nationwide, Principal Financial, CBIZ Benexx, and TransAmerica
  - Secure Stream (Setup + Per Processing Fee)
  - Data and Money sent securely to Administrator
  - Standard M3 report shipped or printed by client (.pdf format)
  - Employee changes from Administrator are updated in m3/Payentry.com

2. **What can you tell me about your firm and its culture?**

The purpose of CBIZ is to help our clients prosper by providing them with a wide array of professional business and individual services, products, and solutions to help them better manage their finances and employees. We endeavor to provide superior client service and build long-term client partnerships.

Our unwavering commitment to our clients is equaled by our commitment to our associates and our focus on improving shareholder value. With our clients as our central focus, CBIZ is committed to fostering a professional culture that is supportive and motivating to its associates by recognizing and rewarding high performance. We value our employees and have embraced programs that enhance our employee's experience, such as Great People Great Place (GP2) and CBIZ Women's Advantage. These programs focus on creating the environment for employee development and career advancement.

Our core principles further strengthen the capabilities of our staff, deepen our client partnerships, enhance the quality of our services and increase job satisfaction.

Mission Statement

To provide exceptional advice and solutions that help our clients achieve their goals.

Vision Statement

To be recognized by our clients as the premier provider of accounting, insurance and other professional business services and by our team members as their employer of choice.

Core Values

- We do the right thing.
- Our people matter.
- We are dedicated to the success of our clients.
- We want to win.
- We are One CBIZ

3. **We would like to confirm your firm's financial status and stability. Please include Federal Employer ID number and Dun & Bradstreet number.**

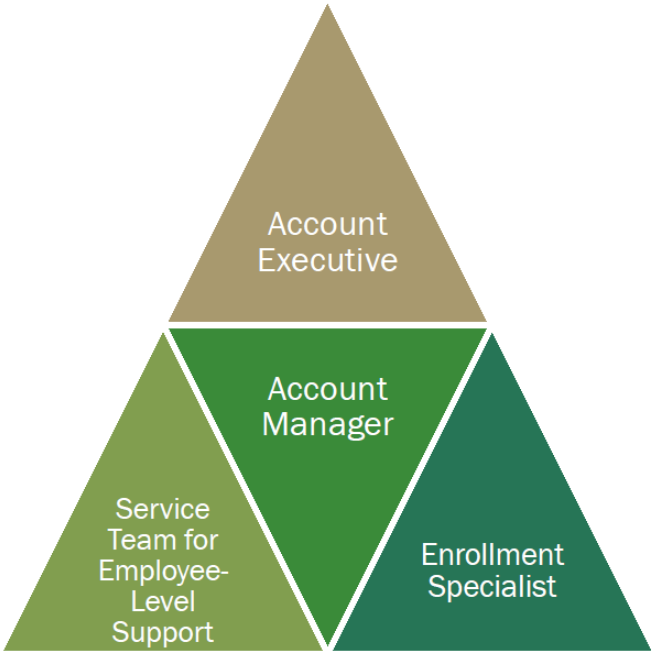
CBIZ's growth and unique consulting philosophy has caused the financials to outpace all of the competitors in their peer groups as reflective with the stock price outpacing the S&P 500. For more information, see our annual report at http://phx.corporate-ir.net/phoenix.zhtml?c=73481&p=irol-reports.

CBIZ's Federal Employer ID is 31-1582098 and our Dun and Bradstreet number is 96-573-8701.

4. **What unique offerings does your firm provide?**

We are a National employee benefits firm which specializes in finding the best way to maximize every benefit dollar spent. Our platform begins with the foundation of a mutually agreed upon month-by-month timeline of consulting and servicing activities coupled with an annually updated three-year benefits strategy (see examples in the appendix). The month-by-month activities will include, but not be limited to:

- Bi-Weekly calls with our Service Management team to discuss ongoing and closed service functions
  - Our service team is unique in structure through specialization:



- Monthly financial reporting through our Actuarial and Financial team.
  - Our team incorporates Verscend Technologies and Navigator MD platforms for Data analytics, benchmarking, forecasting, and wellness strategy
  - Predictive modeling 12, 24, 36, and 60 Months
- Wellness Strategies
  - Wellbeing team to include our relationship with many vetted vendors for price and contractual concessions
  - ROI development based on programs
  - Strategy based on needs and utilization of client
- Onsite Medical Clinic Analysis
  - Integrated CBIZ Clinical Analysis team with significant experience in setting and implementing onsite medical clinics
  - ROI development based on locations and structure
- Compliance updates and recommendations on a monthly or as-needed basis

  - Conduct compliance audit upon engagement
  - Provide annually updated “For Your Benefits” reference guideline
  - Educate regarding federal and state requirements (for example: COBRA, HIPAA, and Medicare Part D)
  - Provide updates and support compliance issues (“At Issue” publication)
  - Prepare 5500 forms
  - SPD & Wrap Document creation
  - Educational seminars and/ or webinars
  - Benefit Booklets to contain all required regulatory communications
- Communications
  - Benefit Booklets, Brainshark Enrollment Videos with hyperlink, In-Person Meetings, Bi-Lingual support, Flipping Book smart phone technology
- Cost-Containment and population health strategies
  - Over 30 years of expertise in the healthcare industry to include implementing Accountable Care Organizations. Strategies in Population health management, and cost containment leading to multimillion dollar savings in projected costs.
  - Successful management of clients’ utilization below the Price Water Cooper (PWC) trend-line with data backing beyond 10 years. Clients include Fortune 500 entities enjoying savings while keeping the integrity of the benefit design intact.
  - Successfully saved clients through Dependent Eligibility, Medical Plan, and Network audit
- Update to the Annual service timeline and three-year strategy on an annualized basis
- National Pharmacy Director to consult and provide National partnerships on various Pharmacy Benefit Managers for your benefits program
  - Through the creative strategies of our Pharm D., we were able to save over 1.2 Million through Pharmacy Consulting for a client with around 1,800 employees
- Successful implementation of communications and enrollment strategies that significantly aid in employee recruitment and reduction of turnover resulting in multimillion dollar savings

Our Practice

6. **Describe the proposed team that would work with Pike and provide information about the qualifications and expertise of each team member. Please include the size of the team and their responsibilities outside of this account.**

Account Management Team

Bios

The Biographical sketches that follow highlight the expertise and experience of the CBIZ team. Please note that the following individuals are CBIZ corporate resources: Karen McLeese, JD; David Rubadue, FSA, MAAA, CLU; and Mike Zucarelli, Pharm D. All others are Atlanta based.

Marion B. Schremp, CBIZ's Atlanta based Business Unit President leads the team members that would be assigned to PIKE.

The number of accounts these team members actively manage are limited and typically involve fewer than 10 clients.

Marion Schremp, RHU, REBC - Business Unit President
770.858.4521 mbschremp@cbiz.com

- Business Unit President – CBIZ Benefits & Insurance Services, Inc.
- Founder & CEO – Multiple Benefit Services, Inc.
- First Recipient of AAHU Lifetime Achievement Award
- Former President – Atlanta Association of Health Underwriters (AAHU)
- Account Manager – Marsh
- Regional Manager Flexible Benefits – Lincoln Financial Group
- Manager Member Service – AmeriPlan HMO
- Benefit Administrator – Crawford & Company – Atlanta, GA
- Claims Analyst – Excellus BCBS, Rochester, NY

Frederick R. Schremp, CLU - Senior Vice President of Consulting
770.858.4520 fschremp@cbiz.com

- Senior Vice President – CBIZ Benefits & Insurance Services, Inc.
- President – Multiple Benefit Services, Inc.
- Regional Director – Highmark Life & Casualty
- General Manager – Preferred Plan of GA (PPO)
- President – Lincoln National Health Plan (HMO)
- Vice President – S.E. Group Operations – Lincoln Financial Group
- Captain, U.S. Army 1967–1973
- M.A. Economics – University of California, 1973
- B.S. Engineering – United States Military Academy, 1967

Karin Pochmara - Assistant Vice President of Client Services
770.858.4519 kpochmara@cbiz.com

- Assistant Vice President – CBIZ Benefits & Insurance Services, Inc.
- Senior Account Manager – Multiple Benefit Services, Inc.
- Member of The Atlanta Association of Health Underwriters (AAHU)
- Specializes in the administration of multi–site plans including implementation, multi–year strategic and financial analysis, vendor management, and client compliance
- Account Manager – Great West Life
- B.S. – University of Alabama

Traci Blake - Senior Employee Advocate
770.858.4511 tblake@cbiz.com

- Senior Employee Advocate – CBIZ Benefits & Insurance Services, Inc.
- Employee Advocate – Multiple Benefit Services, Inc.
- Specializes in assisting employees with benefit questions related to escalated service issues
- Employee Advocate for clients and employees to resolve day– to–day enrollment, eligibility, and claim issues with carriers
- Over 20 years of experience in the health and insurance industry, including CIGNA Healthcare and Willis North America
- B.S. in Business Management – Shorter University, Rome, GA.

Ron Deterding, PHIAS, PAHM - Vice President of Underwriting and Finance
770.858.4513 rdeterding@cbiz.com

- Vice President – CBIZ Benefits & Insurance Services, Inc.
- Vice President, Underwriting and Finance – Multiple Benefit Services, Inc.
- Current member of the National Center for Policy Analysis, Freedom Works
- 2010 President's Council Award Recipient with the National Association of Health Underwriters (NAHU)
- 2009 Golden Eagle Award Recipient with the National Association of Health Underwriters (NAHU)
- 2008 Golden Eagle Award Recipient with the National Association of Health Underwriters (NAHU)
- Account Executive – Blue Cross Blue Shield of Iowa
- Senior Benefits Underwriter – Principal Life
- Professional, Health Insurance Advanced Studies from America's Health Insurance Plans (PHIAS)
- Professional, Academy for health Management from America's Health Insurance Plans (PAHM)
- M.B.A. in Corporate Financial Management – Upper Iowa University
- B.A. in Business Administration – Grand View College

Kelly Jayne Abbott, RHU - Vice President of Marketing
Certified PPACA and Self-Funding Professional
770.858.4510 kabbott@cbiz.com

- Vice President and Marketing Specialist – CBIZ Benefits & Insurance Services, Inc.
- Senior Marketing Manager – Multiple Benefit Services, Inc.
- Former Board Member and current member of The Atlanta Association of Health Underwriters (AAHU) and The National Association of Health Underwriters (NAHU)
- Specializes in the management of national and regional carrier relationships, enrollment platform.
- Registered Health Underwriter (RHU) – Certified in 2005

Joseph Shorter – Financial Analyst
770.858.4527 jshorter@cbiz.com

- Financial Analyst – CBIZ Benefits & Insurance Services, Inc.
- Senior Financial Analyst – Access Insurance Holdings
- Senior Reinsurance Specialist – Munich Re.
- Actuarial Analyst – Union Standard Insurance Co.
- Actuarial Analyst – LA Department of Insurance
- B.S. Mathematics – Tulane University

LaTonia McGinnis – Wellbeing Accountant Executive
404.821.1879 lmcginnis@cbiz.com

- Wellness Coordinator – CBIZ Benefits & Insurance Services, Inc./RaceTrac Petroleum
- Manager, Wellness and Work Life – Children's Healthcare of Atlanta
- Program Coordinator/Childhood Obesity-Children's Healthcare of Atlanta
- Master's of Public Health– University of Alabama at Birmingham
- B.S. in Health Promotion and Behavior – The University of Georgia

David Rubadue, FSA, MAAA, CLU – Senior Vice President, National Health Care Actuarial Services
614.793.7770 drubadue@cbiz.com

- Senior Vice President & National Director of Healthcare Actuarial Services – CBIZ Benefits & Insurance Services, Inc.
- Qualified Actuary – Audits and provides financial opinions on health and welfare plan liabilities
- Co-founder and President – EBS, Inc.
- Chief Actuary and CFO – The Physicians' Assurance Company
- Consulting Actuary – Coopers & Lybrand
- Former Speaker and Lecturer at Tri-State Actuarial Club and the Insurance, Accounting and Systems Association National meetings
- B.A. Accounting – Michigan State University

Howard Hyman, ASA, MAAA – Consulting Actuary
404.255.0808 hyman4521@aol.com

- Consulting Actuary – CBIZ Benefits & Insurance Services, Inc.
- Consulting Actuary – Multiple Benefit Services, Inc.
- Principal, Southeast Region Health and Welfare Operations Manager – Towers Perrin (Now Willis Towers Watson)
- Clients of note include: Delta Airlines, Genuine Parts Company, State of Georgia, Georgia Pacific, Emory University – Emory Healthcare, etc.
- Masters of Actuarial Science – Georgia State University
- M.B.A. – Georgia State University
- B.B.A.– University of Georgia

Karen R. McLeese, Esq. - Vice President of Employee Benefit Regulatory Affairs
913.234.1760 kmcleese@cbiz.com

- Vice President, Employee Benefit Regulatory Affairs – CBIZ Benefits & Insurance Services, Inc.
- Member of Kansas City Metropolitan Bar Association, Missouri Bar Association, and Kansas Bar Association
- Member of Health Law Forum and Labor & Employment Law Sections of the American Bar Association
- Author of *At Issue*, a CBIZ client newsletter that provides information of general interest regarding employee benefits law and legislation
- Author of *For Your Benefit,* a CBIZ compliance/reference guide to welfare benefits
- Author of *Benefit Beat,* a monthly CBIZ e-newsletter containing regulatory updates
- Reviews and interprets federal and state laws and regulations impacting employee benefits
- Provides technical support in response to employee benefit issues
- Follows and analyzes trends in employee benefits
- Monitors case law impacting employee benefits
- Juris Doctor – Duke University
- B.A. – University of Notre Dame

Michael Zucarelli, PharmD - National Pharmacy Practice Leader
602.308.6658 mzucarelli@cbiz.com

Michael Zucarelli is a practicing pharmacist and leads CBIZ's National Pharmacy Practice, a specialty practice within CBIZ's Benefits and Insurance Group. He serves as the lead pharmacy consultant for clients, providing financial and clinical guidance to optimize a group's pharmacy program and overall benefit strategy that is cost-effective, compliant and sustainable. Michael's approach focuses on client satisfaction with the pharmacy benefit value and PBM relationship. He assists clients with financial models, pharmacy program analysis, and clinical evaluation. Upon completion of this analysis, he presents these results concisely and offers strategic recommendations.

Expertise

- Pharmacy Benefit Plan Evaluation
- Pharmacy Benefit Strategy & Implementation
- Leveraging PBM and Carrier Relationships to advocate Vendor Accountability and Best Practices
- Proprietary Modeling Tools
- State and Federal Pharmacy Issues
- Pharmacy Benefit Operations, Clinical Programs, and Member Experience

Background

Education/Professional

- Bachelor's Degree in Chemistry, University of Arizona
- Doctorate Degree in Pharmacy, University of Arizona
- Licensed Pharmacist in Arizona, Missouri, and North Carolina
- Member, Academy of Managed Care

Recognition and Awards

- Contributed to the development of a whitepaper on best practices for Medicaid pharmacy that was published and presented to the State of New York (http://www.uhfnyc.org/publications/880758)
- Created reporting models used by State Medicaid departments and health plans to benchmark plan performance

7. **What do we need to know about the insurance policies you would recommend, and how you place them?**

CBIZ places insurance policies and service agreements with carriers and third party administrators that have been vetted at our corporate level for financial strength, track record of exceptional performance and independent agency ratings of excellent or higher e.g. A. M. Best ratings of A or higher.

8. **How often does your team meet with your clients and for what purposes?**

CBIZ would propose the following routine check interfaces/meetings post implementation:

a) Weekly Service Calls
   - Asses vendor performance
   - Discuss service related issues
   - Discuss industry/carrier developments
   - Explore areas where additional support is needed

b) Monthly Financial Reporting and Analysis Teleconference

c) Quarterly On-site Stewardship Meetings
   - Analyze quarterly financial results
   - Discuss utilization trends and high claimant incidence
   - Review program effectiveness, e.g., communications, employee advocacy, and data analytics
   - Discuss PIKE's corporate initiatives and results germane to existing and future health and welfare benefit needs

d) Renewal Planning Meetings On-site
   - Typically held three months after plan anniversary to plan for the next plan year, e.g. meet on or about October 1, 2018 to begin planning for July 1, 2019 plan year
   - Subsequent meetings as required to review results of RFP's, budget projections, plan design changes and communication and enrollment strategies

e) Annual Report Meeting On-Site
   - Typically scheduled along with first renewal planning meeting to review the results of prior year in relation to budget, program effectiveness, client and employee satisfaction, e.g.
   - Meet on or about October 1, 2018 to review results of July 1, 2018 plan year

f) Other meetings as needed or requested by PIKE

9. **Describe what makes your firm uniquely qualified to work on our account.**

In our opinion the expertise, experience and demonstrable results achieved by the actual personnel assigned to your account coupled with the resources of the organization supporting them are the key, critical elements that will determine the services of your benefit programs, i.e. attracting, retaining and motivating PIKE employees while controlling your costs.

We believe your analysis of the CBIZ team that will actually work with you on a daily basis, coupled with CBIZ's client first imperative uniquely qualifies us to work on your account.

10. **Describe your experience with clients with multiple locations in multiple states and countries. Examples in manufacturing environment preferred.**

    The CBIZ team that would be assigned to your account has considerable experience with clients that operate with employees in multiple states and countries. We have clients with a presence in every US state and territory. We have clients with employees in Europe, Asia, South America and Africa covering: expats, foreign nationals and third party nationals.

    These clients range in size from mid-market employers to the Fortune 300 with over 30,000 employees.

    CBIZ has a significant number of heavy industry and manufacturing clients across the nation.

11. **If your firm is selected, how would you propose we transition our account?**

    A timeline would be established based on notification of date of hire.

Phase I	Activity	Timeline
Review Analysis and Modeling	1. Conduct client meeting to determine goals, objectives, and budget parameters 2. Collect all relevant policies from client, carriers, and administrators 3. Collect all underwriting, loss experience, and rate histories from carriers, and administrators 4. Prepare written report detailing all plan benefits and costs 5. Identify current strengths, challenges and opportunities 6. Provide recommendations for plan design changes operational efficiencies, carrier/service providers and employer contribution strategies based on benchmarking and financial modeling 7. Client Input and decision(s) on go forward strategy	**TBD**
Phase II	**Activity**	**Timeline**
Marketing	1. Prepare Request for Proposal (RFP) based on Phase I results and client input 2. Prepare analysis of responses to RFP 3. Present findings to client to include financial results, executive summaries, and recommendations 4. Client decision(s)	**TBD**
Phase III	**Activity**	**Timeline**
Communications, Enrollment, and Administration	1. Development of Communication's Theme/Concept 2. Selection of Communication Materials 3. Review of Enrollment and HR/Benefit Administration Methodologies 4. Selection of Enrollment and Administration Processes 5. Coordination of enrollment and HR Platforms 6. Conduct Enrollment	**TBD**

Phase IV	Activity	Timeline
Implementation	1. Meetings with selected carriers/administrators 2. Establish implementation time tables by carrier/administrator 3. Coordination of electronic interface with selected carriers/vendors for eligibility and data transfer 4. Coordination of transmission of eligibility from enrollment to carriers/administrators 5. Coordination of eligibility and claim system testing 6. Delivery to Client of Draft contracts and SPD's 7. Delivery of ID cards to employees 8. Delivery of SPD's to employees 9. Client Staff Training	**TBD**
Phase V	**Activity**	**Timeline**
Stewardship	1. Monthly financial reports maintained 2. Client and member advocacy with carriers/administrators 3. Preparation of quarterly stewardship reports presented at quarterly client meeting 4. Government compliance and reporting assistance 5. Ongoing negotiations with carriers/administrators and vendors to ensure appropriate pricing, proper service levels, plan designs efficiencies, and regulatory compliance 6. Monthly conference call with major vendors to monitor performance efficiencies	**TBD**

Expertise

12. **Describe your approach to supporting our programs throughout the plan year.**

CBIZ believes in taking a proactive approach to insuring that PIKE's service needs and company goals and cost objectives are achieved.

We would propose:

a) Weekly Service Calls

b) Monthly Financial Reports and Analysis Teleconference

c) Quarterly Stewardship Meetings (on-site)

d) Annual Vendor Seminars where each PIKE insurer and administrator meets with the PIKE benefits team and CBIZ at PIKE headquarters to assess the success of their programs and service platforms and to make sure that there is the proper integration of all coverage and services across all vendors

e) Employee Surveys

f) Renewal planning meetings on site and telephonic

g) Prior year results annual review meetings on site

h) Employee Advocacy quarterly reports

13. **Do you have a process in place for tracking communication between you and yourclient?**

CBIZ has internal software applications for logging all client communications and tracking associated deliverable due dates. We provide our clients with meeting notes for all service and project related meetings both telephonic, video or in person. Here again the actions required by all parties: CBIZ, vendors and PIKE are logged, timelines established and tracked.

14. **How do you manage vendor relationships?**

CBIZ manages vendor relationship at two levels, corporate and local/Atlanta:

- At the corporate level CBIZ's Executive Vice President and General Counsel, Nancy Mellard, Esq, and her staff along with our actuaries vet, negotiate national contracts and service requirements with insurance carriers and service providers, e.g. TPA's, wellness companies, on site clinics, data analytic providers, etc.
- In Atlanta our Vice President of Marketing, Kelly Abbott, maintains relationships with insurance company and other vendor representatives assigned to our office and our clients. This includes routine meetings with all vendors, performance evaluation, attendance at vendor seminars and constant research into what vendors are operating as peak performers and initiating new client serving programs and service platforms.

15. **In your view, what are the key exposures/challenges Pike faces? How will your firm help meetthese challenges?**

Based on PIKE's responses to the RFP respondent questions and our analysis of your industry and your client's requirements we consider the following as your key exposures/challenges. They are listed in rank order of importance:

a) Given the mission essential tasks that PIKE needs to provide its clients with the demonstrably superior service needed to insure current client retention and top line financial growth through new business acquisition, it is imperative that PIKE attract, retain and motivate the industry's most competent work force.

Studies have indicated that the cost to replace a highly skilled technician can run up to $35,000. This figure takes into consideration the loss of productivity from the employee's absence, the cost of onboarding a replacement, training costs associated with bringing a new hire up to PIKE's standards and the divergence of internal resources until new hire is up to speed.

Studies also have shown that a comprehensive benefit program that is communicated in an excellent, multi-faceted, fully integrated methodology coupled with a robust enrollment platform can reduce turnover generating significant savings.

As an example based on average salary of $55,000:

- Assume PIKE turnover is 25%
- Average cost to replace employee is $33,000
- Total turnover replacement cost is $45,375,000 (5500 employees x 25% x $33,000)
- Each 1% of turnover reduction saves PIKE $1,815,000
- A turnover reduction of 6% down to the industry benchmark of 19% with a dedicated communication and enrollment process could generate an estimated savings of $10,890,000. (see attached)

We would propose that PIKE investigate an enrollment solution other than the Oracle application from a vendor that specializes in providing integrated communications and enrollment solutions. A significant number of large employers utilizing ERP/HRIS solutions like Oracle, Workday, SAP and UltiPro have elected to utilize third party solutions that are fully customizable to their needs. These services include print, video, social media and electronic communications, enrollment and new hire call centers along with a custom enrollment platform that fully integrates with Oracle.

b) Cost Containment

The following programs can be adopted by PIKE to generate significant cost reductions without endangering its "grandfathered status:"

i. PBM Carve Out – up to 15% reduction in pharmacy spend without plan design changes

ii. Life and Disability Marketing – up to 25% reduction in cost without plan design changes

iii. Dependent Eligibility Audit – assuming 5% of dependents are ineligible and removed from plan, a medical plan cost reduction of 4%

iv. Network Efficacy Study – utilized to negotiate more attractive admin fees, larger discounts and variable networks for potential medical plan savings of up to 3%

v. ROI study for onsite clinic at corporate headquarters. Typical ROI in the 1.5 to 2.5 times range

vi. Data mining and population health management, potential savings from chronic care and high cost claimant targeted protocols, potential savings of 2 to 3%

vii. Stop loss captive analysis with potential to reduce stop loss cost by 10% to 15% without increasing deductible

c) Consultancy Partnership

CBIZ is capable of providing a full range of HR services aimed at augmenting and supporting existing PIKE resources

i. Recruiting

ii. Compensation Analysis and Consulting

iii. Health and Welfare Consultancy

iv. Retirement Planning and Consultancy

v. Risk Management to include Cyber Risk Evaluation

vi. Human Resource Consultancy

Employee Turn Over - Bottom Line Impact & The Gain In Taking Action

2017 Company Data

5500	Total Number of Employee's
$ 55,000.00	Average Annual Salary + Benefits

Historical Turnover Data

2016		2015	
5500	# of Employee's	5500	# of Employee's
1400	# of Termed EE's	1400	# of Termed EE's
25%	Turnover %	25%	Turnover %

Ramp Up, Ramp Down - Productivity Opportunity Cost

2	# of Training Months Needed To Ramp Up
2	# of Months Needed To Identify & Manage An Underperformer Out
	Assumed Assimulation/Desimulation Production Curve

$ 9,166.67	EE cost in Ramp-up Period	$ 9,166.67	EE cost in Ramp-down
$ -	EE Productivity in Ramp-up	$ -	EE Productivity in Ramp-down
$ 9,166.67	Ramp-Up Differential	$ 9,166.67	Ramp-Down Differential

$ 18,333.33 **Total Productivity Opportunity Cost**

Cost of Turn Over

$ 4,200.00	Recuriting Cost per EE
$ 9,166.67	Gross Pay + Benefits (60 days)
$ 957.92	WC & Taxes (12%)
$ 528.85	Onboarding Training (20hrs)
$ 18,333.33	Lost Productivity - Opportunity Cost
$ 33,186.76	**Cost Per Termed Employee**
25%	Ave Turnover % (last 2 yrs)
1388	# of Termed Employee's Based on EE Count
$ 46,046,633.41	**Annual Company Cost From Turnover**

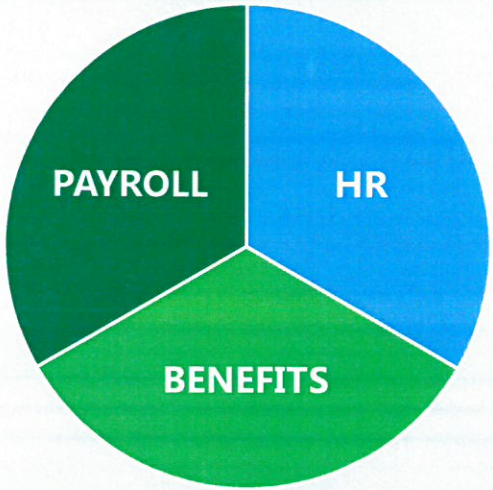
REDUCING TURNOVER - THE BOTTOM LINE IMPACT				
Reduction In Turnover By...	**New Turn Over Rate**	**Total Terminations**	**Total Cost of Turn Over**	**Annual Savings**
CURRENT	25%	1388	$ 46,046,633.41	CURRENT
1%	24%	1333	$ 44,221,361.46	$ (1,825,271.96)
2%	23%	1278	$ 42,396,089.50	$ (3,650,543.91)
3%	22%	1223	$ 40,570,817.55	$ (5,475,815.87)
4%	21%	1168	$ 38,745,545.59	$ (7,301,087.82)
5%	20%	1113	$ 36,920,273.64	$ (9,126,359.78)
6%	19%	1058	$ 35,095,001.68	$ (10,951,631.73)
7%	18%	1003	$ 33,269,729.73	$ (12,776,903.69)
8%	17%	948	$ 31,444,457.77	$ (14,602,175.64)
9%	16%	893	$ 29,619,185.82	$ (16,427,447.60)
10%	15%	838	$ 27,793,913.86	$ (18,252,719.55)

Industry Benchmark

Q

WHY AREN'T THE CURRENT SOLUTIONS WORKING?

Most systems struggle to support modern benefit strategies.



For most ERPs and HCMs, benefits are an afterthought due to competing initiatives.

Automation	✓
Integration	✓
Communication	✗
Decision Support	✗
Engagement	✗
Strategy	✗

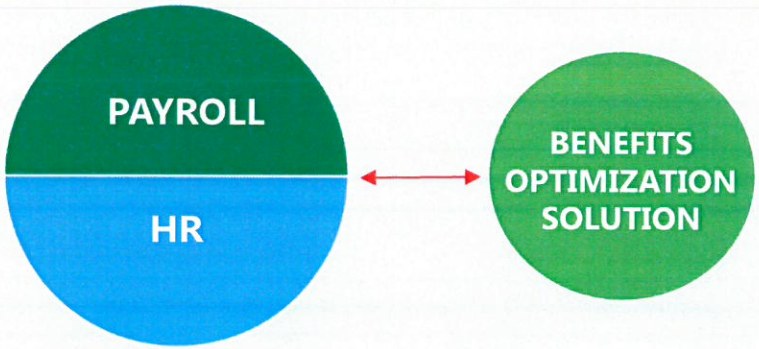
“IF YOU CHOOSE TO MANAGE BENEFITS THROUGH YOUR HCM *AND* GET THE IMPLEMENTATION RIGHT, YOU’LL FIND THAT, IN MANY CASES, YOU’RE ONLY A DECADE BEHIND IN ENROLLMENT, ADMINISTRATION, AND PROGRAM OPTIMIZATION.”

CEO, National Benefit Technology Consulting Firm

Q

WHAT SHOULD A MODERN SOLUTION LOOK LIKE ?

Point solutions address **administrative complexity** while enhancing the **employee experience.**



- Flexible configuration ✓
- Carrier & payroll integration ✓
- Consumer-friendly UX ✓
- Decision support ✓
- Personalized communications ✓
- Year-round engagement ✓

16. **Describe your process for negotiating renewals. Be prepared to share examples of your success in negotiating renewals.**

a) Here again CBIZ takes a proactive approach to carrier/administrator renewals. The process begins with client meetings 10 months prior to renewal anniversary to lay out a strategy for the coming plan year. This renewal plan would encompass changes to plan designs, adoption of new cost containment and or service platforms and client input on projected budget parameters

b) CBIZ along with client input has evaluated inforce carrier/administrator service during the preceeding 12 months and determines areas that need specific attention

c) CBIZ's underwriters and actuaries are constantly monitoring the clients claims experience and are aware of what potential renewal actions from the enforce carriers might be

d) CBIZ requires enforce carriers/administrators to provide their renewal proposals seven months prior to the next plan anniversary.

Based on items A, B, and C above CBIZ will have submitted RFPs to other appropriate carriers/administrators upon receipt of the enforce carriers renewal. Responses to the RFP are requested to be received from bidding vendors within six weeks.

Upon receipt of all RFP responses CBIZ conducts negotiations to secure the most competitive pricing and service platform. If needed finalist meetings are held.

e) Once decisions are made communications and enrollment planning are finalized.

A typical timeline for a 7/1 would look like:

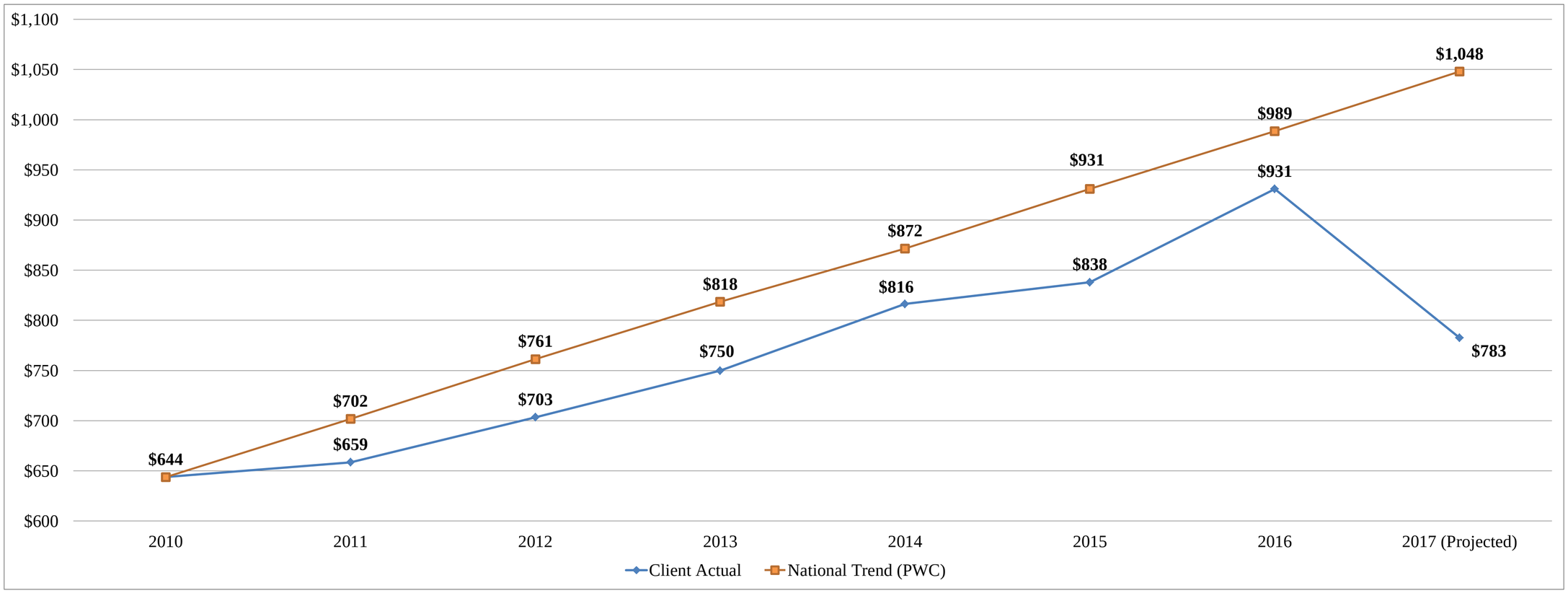
Date	Activity
10/1	Next Client Renewal Planning
12/1	Inforce carrier renewal received and RFP to elected vendors
1/15	RFP responses received and CBIZ/vendor negotiations begin
2/1	Negotiations completed and finalist meetings held
2/15	Final rates, fees and programs developed by CBIZ and presented to client
3/1	Client decisions made
3/1 – 4/30	Communications and enrollment strategy developed and completed
5/1 – 5/15	Annual Enrollments

f) See attached renewal example for a 20,000 employees, multi- state employer

Large Case Medical Renewal For 1/1/2017			
		Total	**Employer**
A	2017 Proposed Renewal	$192,353,325	$141,956,754
B	2017 Final Negotiated Renewal	$171,852,039	$129,887,184
C	**Savings (B-A)**	**($20,501,286)**	**($12,069,569)**
D	**% Savings (C/A)**	**-10.7%**	**-8.5%**

Large Case Medical Trend History

	2010	2011	2012	2013	2014	2015	2016	2017 (Projected)
Average Paid Medical and Rx Costs PEPM	$643.75	$658.56	$703.42	$749.79	$816.28	$837.99	$930.93	$782.64
Client Annual Increases	**N/A**	**2.3%**	**6.8%**	**6.6%**	**8.9%**	**2.7%**	**11.1%**	**-15.9%**
Trended Costs (Illustrated)	$643.75	$701.69	$761.34	$818.44	$871.63	$930.90	$988.62	$1,047.94
Trend Increases (PWC)	**N/A**	**9.0%**	**8.5%**	**7.5%**	**6.5%**	**6.8%**	**6.2%**	**6.0%**
Average Monthly Covered Employees	12,033	11,653	11,439	11,709	12,146	12,182	17,010	16,037
Annual Variance vs. Trend (Savings)	N/A	$6,030,920	$7,949,541	$9,645,912	$8,068,253	$13,582,635	$11,776,154	$51,053,404
Cummulative Variance vs. Trend (Savings)	N/A	$6,030,920	$13,980,461	$23,626,372	$31,694,625	$45,277,260	$57,053,415	$108,106,818



Large Case Life, Disability, and Dental Renewal For 1/1/2017		
	Proposed Renewal	**Final Negotiated Renewal**
Life Insurance	$9,232,017	$8,503,610
STD & LTD	$6,995,786	$6,233,285
Dental	$14,029,359	$12,991,785
Total	**$30,257,162**	**$27,728,680**

Savings	**$2,528,482**
Percent Savings	**9.1%**

17. **Describe your underwriting and actuarial resources.**

At the corporate level CBIZ employs numerous actuaries and underwriters. This team is headed by Dave Rubadue, FSA, MAAA, CLU whose bio sketch is included in question 6.

In Atlanta the PIKE team is supported by two underwriters, Ron Deterding and Joe Shorter (See bio sketch shown in question #6) and one consulting acutuary Howard Hyman (See bio sketch shown in question #6).

18. **Describe your experience supporting clients with mergers and acquisitions, including the due diligence process and integrating the acquired company's benefits plans with the client's benefit plans, communications to employees, etc.**

The Atlanta CBIZ team has had considerable experience in this area. We have performed due diligence valuations and integration processes for both large Fortune 500 companies as well as mid market employers.

The complete process consists of:

a) Due Diligence
   i. Receipt of all target company's policies, contracts, rate/fee history, plan design and change history, claims experience and premium history, enrollment by plan-by-tier-by month for the last 24 months, IBNR Reserve calculations for the last 2 years
   ii. A full compliance audit
   iii. A review of any pending litigation
   iv. Full report to the acquiring company of current target company's costs, liabilities, strengths, challenges and a one to three year proforma

b) Synergy Savings
   i. Presentation of the most effective plan for integration to meet the acquiring company's target synergy savings
   ii. Quantifying the results of their plan's implementation
   iii. Reviewing the plan with acquiring company's CFO and HR to determine any potential downside from a recruitment and personnel retention stand point

c) Communication and Enrollment
   i. Developing a clear, concise message to be communicated to both the target company and acquiring company's employees
   ii. Production of a video that highlights the positives attendant to the merger, changes in benefits and costs if any, new systems and programs improving the employee experience, etc.
   iii. Developing an enrollment strategy that would include both a web based enrollment platform and a call center to assist the newly acquired employees

19. **Describe any special analysis that you would provide to help manage our programs.**

CBIZ provides a state of the art data mining and analytic tool from Verscend Technologies. The capabilities and potential area of utilization are attached.

In addition CBIZ provides monthly tracking of all cash and accrual results to PIKE finance and HR.

performance analytics

Employer Performance Analytics

Answer complex questions about healthcare costs, quality, and utilization to successfully manage the clinical and financial risks of your employees

knowledge is power

To do what's right for your employees, you need to know what's wrong with your employees. Employer Performance Analytics from Verscend Technologies, offered in conjunction with CBIZ, provides the data services and advanced analytics to help you set the right strategy for health and productivity improvement and objectively measure results, ensuring program ROI.

Powered by DxCG Intelligence, the industry's gold standard in risk adjustment and predictive modeling, Employer Performance Analytics has been an essential component of employers' benefit plan strategies for decades, delivering proven outcomes.

deep and broad analytic capabilities

Employer Performance Analytics supports organizations with:

- Health and productivity data integration and warehousing
- Data-driven benefit design and program measurement
- Cost-driver reporting and analysis
- Plan modeling and budgeting
- Employee risk profiling and care-gap identification
- Vendor selection and management
- Benchmarking

data management excellence

Our track record of success in managing very large claim sets and other clinical data allows risk-bearing entities to create a true longitudinal record across many settings of care.

verscend + CBIZ

Gain the competitive edge with our deep healthcare data analytics expertise:

3B claim files processed across our solutions

14K health and productivity data sets

38M benchmark lives

200 clinicians on staff

3-6 months to full solution activation

support for your success

Working together, CBIZ and Verscend ensure your rapid, successful implementation and use of Employer Performance Analytics through:

- Data acquisition and mapping support
- Maintenance and hosting
- Access to the expertise of seasoned data scientists, statisticians, clinicians, and other subject-matter experts
- Seamless integration with other solutions

a partner you can trust

For decades, Verscend has been singularly focused on data management and analytics, which allows us to truly lay claim to broad and deep risk management expertise. We listen and learn, earning us the reputation for creating long, collaborative, and productive partnerships with our clients in which their success is always our top priority.

"[Verscend's solution] helps us to identify areas where minimal investment will reap large rewards. We can curtail wasteful spending on inefficient or ineffective programs and reinvest money to maximize access to quality care."

– *Kathleen Sullivan,*
former Executive Vice President,
First Service Administrators

SOCIETY OF ACTUARIES

superior predictive power

Verscend has been honored to advance the science of risk scoring by working with the Society of Actuaries (SOA) over the past two decades. SOA's rigor and effort to resolve potential disparities in the analysis ensure a comprehensive evaluation of commercial risk adjustment and predictive models.

SOA's latest study was published in 2016. Similar to their previous evaluation in 2007, DxCG models were top performers across the study.

DxCG is the clear industry leader in:

- Longevity
- Depth of validation
- Breadth of scope and models
- Model utility

building better healthcare together

Payment Accuracy

Claim Accuracy

Inpatient Accuracy

Dental Accuracy

Fraud Detection

Risk Adjustment

Commercial

Medicare

Medicaid

Performance Analytics

Payers

Employers

Providers

DxCG Intelligence

Quality Improvement

Quality Intelligence

Medical Record Retrieval

Medical Record Abstraction

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Medical Intelligence Report Sample

Employer Group ABC

Incurred: Apr 2014 thru Dec 2015
Paid: Apr 2014 thru Mar 2016

Custom Time Period

Presented By:

verscend

Table of Contents

Introduction

All the metrics are calculated based on the claims incurred from April 2014 to December 2015 which were paid between April 2014 and March 2016.

All quality and risk metrics like QRM compliance, RI, CGI and Risk Scores are calculated based on the full cycle irrespective of the selected time period.

Period-over-period comparisons are performed on selected sections within this report. The two periods selected for analysis are:

1. Current Period (P2)
    - Incurred from April 2015 through December 2015
    - Paid from April 2015 through March 2016
2. Previous Period (P1)
    - Incurred from April 2014 through December 2014
    - Paid from April 2014 through March 2015

Please Note:

1. This report displays Plan Paid Amounts unless otherwise specified.
2. Many dollar values are rounded to the nearest dollar for increased readability. However, calculated values (such as total sums) are calculated precisely and then rounded afterwards. This produces more accurate results, but may occasionally cause calculated fields to appear inexact.
3. Some sections in the Appendix are dependent on previous sections. If the underlying previous sections are not requested, then the corresponding sections in the Appendix will not be populated.
4. The information contained in report has been produced from data provided to Verscend, which has not been independently verified by Verscend for accuracy or completeness. Additional information, including, but not limited to, any claims that have been incurred but not paid as of the date of this report, or claims that were subject to subsequent adjustment, should be considered before any action is taken on the basis of the contents of this report. This report does not constitute the provision of medical or legal advice by Verscend to any party.

1. SUMMARY OF FINDINGS [1]

This report provides an analysis of the healthcare information for Employer Group ABC. The information is based on eligibility, medical claims, and pharmacy claims data for employees and their families on incurred and paid basis. The cost figures below reflect the time frame specified.

Summary of Expenses Paid by Plan

		Commercial Norms [2, 3]
Medical Claims	$135,149,394.48	
Pharmacy Claims	$0.00	
Total Claims	**$135,149,394.48**	
PMPM Medical Expenses	$405.59	$255.50
PMPM Pharmacy Expenses	$0.00	$59.52
Total PMPM Expenses	**$405.59**	**$315.02**

1 Source: Medical Intelligence : Executive Summary Module
2 The Commercial Norm values have been adjusted by Age-Gender-Geography
3 Norm or Verscend Norm in this report refers to the values from Verscend's Commercial Normative database.

2. POPULATION CHARACTERISTICS

This section explores the aggregate demographic, economic and clinical characteristics of the population.

Section 2.1 contains the population's demographic characteristics, including the change in total and current membership levels, and age and gender breakouts with associated economics.

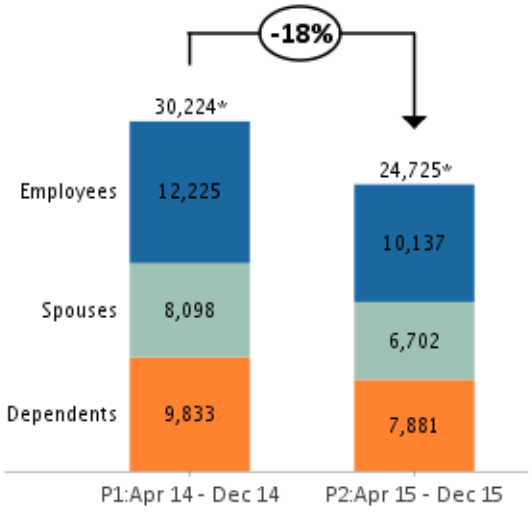
Section 2.2 details the population's high-level economic characteristics. This includes an assessment of the drivers of cost growth, such as change in enrollment, change in costs, and medical versus pharmacy PMPM. Trends in total and PMPM costs over time - both medical and pharmacy - are calculated. Finally, cost distribution by spending band is explored. Deeper economic analyses into the drivers of pharmacy and medical expenses are detailed in *Section 3: Economic Findings and Opportunities.*

Section 2.3 analyzes the population's high-level clinical characteristics. The first breakout shows the relationship between age and disease burden as quantified by the Relative Risk Score (RRS) and the related Care Gap Index (CGI). These are analyzed both relative to each other and relative to the Verscend book of business benchmark. The second breakout shows the distribution of diseases across the population - identifying what is large or growing rapidly from a prevalence standpoint. Prevalence of the ten most chronic diseases is then compared to benchmarks.

2.1 Demographics

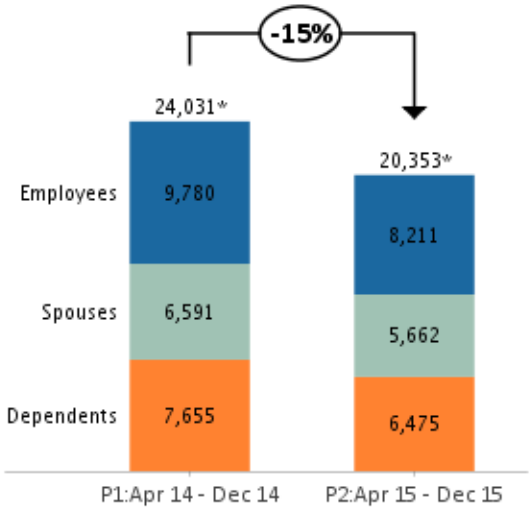
Figure 2.1.1 presents total membership change, by relationship status, from previous period to current period. The percentage changes are also provided so that period-over-period trends can be evaluated. Figure 2.1.2 presents the distribution of current members in that specific period. For both total and current members, average PMPM is provided, where dependents typically spend the least amount per month. Finally, Figure 2.1.3 and Table 2.1.1 show the total claims paid and membership profile by age group and gender; in absolute terms employees and spouses typically constitute proportionally more spend than dependents.

Figure 2.1.1 Total Member Count by relationship status [4, 5]



Member Growth	Average PMPM Apr 14 - Dec 14	Average PMPM Apr 15 - Dec 15	PMPM Growth
-17.1%	$919.17	$457.76	-50.2%
-17.2%	$507.86	$491.93	-3.1%
-19.9%	$155.49	$170.63	9.7%

Figure 2.1.2 Current Members



Member Growth	Average PMPM Apr 14 - Dec 14	Average PMPM Apr 15 - Dec 15	PMPM Growth
-16.0%	$844.97	$364.85	-56.8%
-14.1%	$502.79	$440.71	-12.3%
-15.4%	$148.69	$141.61	-4.8%

4 ***Note:*** *Totals included counts for the 'Unknown' category
Refer to Appendix 5.1 for more information on member expenses by relationship status.

5 Source: Medical Intelligence : Individuals Module. For Relationship, filter using Rel Flag (E = Employees, S=Spouses, D = Dependents). For Current Members, Current = 'Y'.

Figure 2.1.3 Claims Paid by Gender and Age [6]

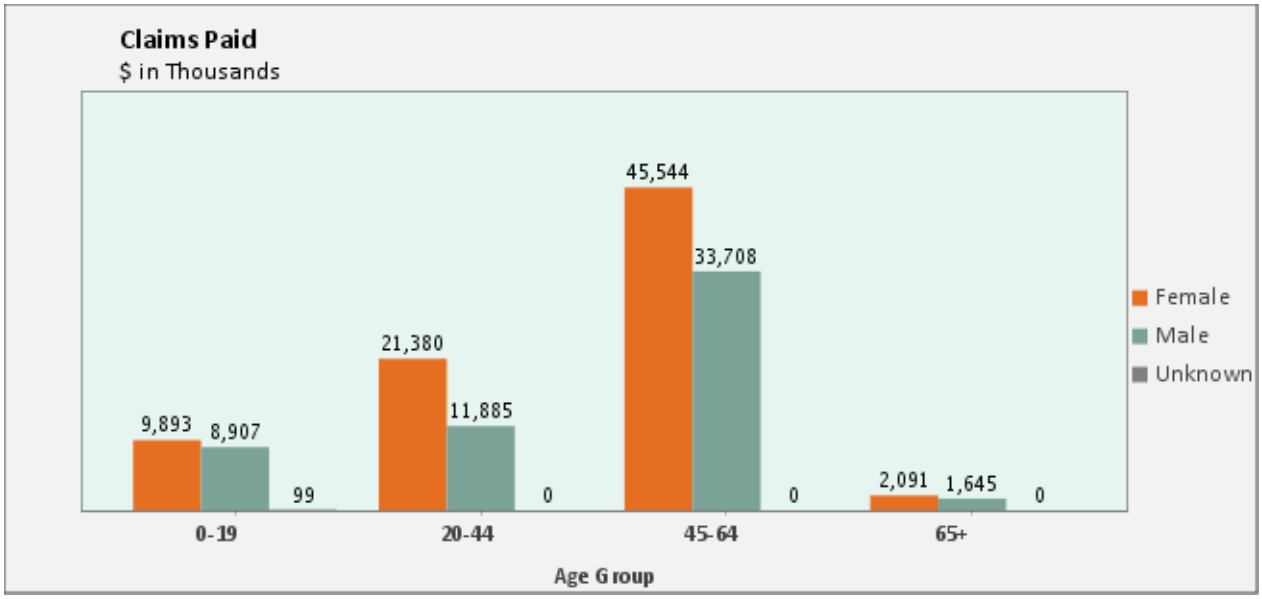


Table 2.1.1 Membership Profile [7]

	Female Member		Male Member		Unknown		Total Member	
	Count	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**
Employee	2,931	9.1%	9,990	30.9%	0	0.0%	12,921	40.0%
Spouse	7,811	24.2%	798	2.5%	0	0.0%	8,609	26.7%
Dependent	5,154	16.0%	5,488	17.0%	57	0.2%	10,699	33.1%
Unknown	37	0.1%	25	0.1%	6	0.0%	68	0.2%
Total	**15,933**	**49.3%**	**16,301**	**50.5%**	**63**	**0.2%**	**32,297**	**100%**

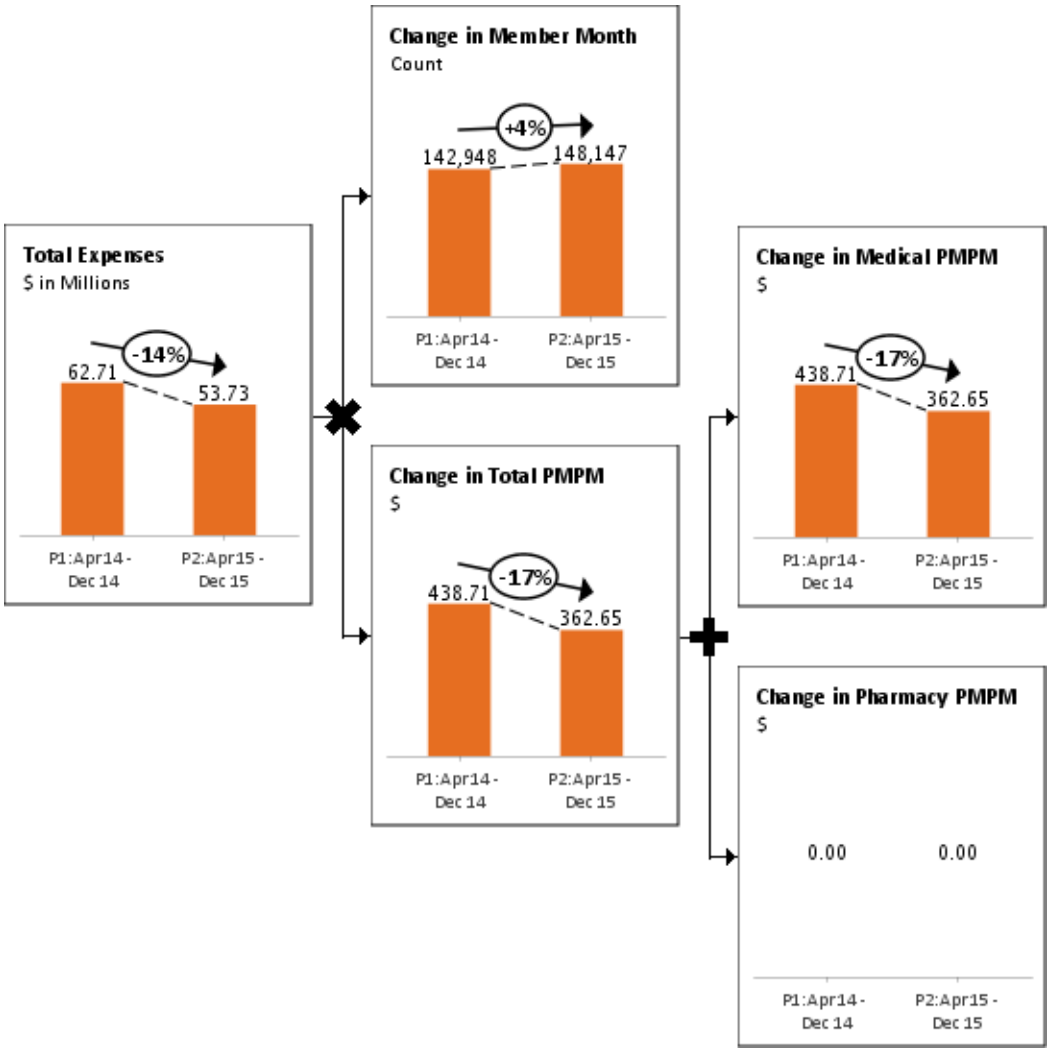
[6] ***Note:*** Unknown members will be displayed in graph if applicable.
Source: Medical Intelligence : Demography Module / Age Group

[7] Source: Medical Intelligence : Individuals Module / filter on Gender and Rel. Flag

2.2 Aggregate Economics

Figure 2.2.1 breaks out cost growth into discrete drivers, such as change in member volume, change in PMPM, and medical versus pharmacy PMPM. The change in Member Months will closely approximate the change in current members. This analysis helps delineate whether absolute costs are growing because the population is growing, or because the cost per member is growing. Further cost breakouts are present in *Section 3: Economic Findings and Opportunities.* Member Month is always Medical Member Month in the "Change in Member Month" graph of Figure 2.2.1.

Figure 2.2.1 Distribution of Expenses [8]



See Figure 3.1.1 for Detail

See Figure 3.2.1 for More Detail

[8] ***Note:***
Medical PMPM includes Non-PBM drug spend (J-Codes).
Source: Medical Intelligence : Claims Module / custom timeframes for medical and pharmacy expenses.

2.2.1 Monthly Comparison of Paid Claims

Figures 2.2.2 and 2.2.3 track monthly claim paid amounts for claims incurred during the period April 2014 through December 2015 and paid during the period April 2014 through March 2016. Seasonality in claims paid (in terms of date incurred) is expected, with the highest monthly claims generally occurring in the winter. Claim volumes may also rise just before or after installation of a new health plan. Claims are presented both as total and PMPM calculations.

Figure 2.2.2 Medical and Pharmacy Paid - Total [9]

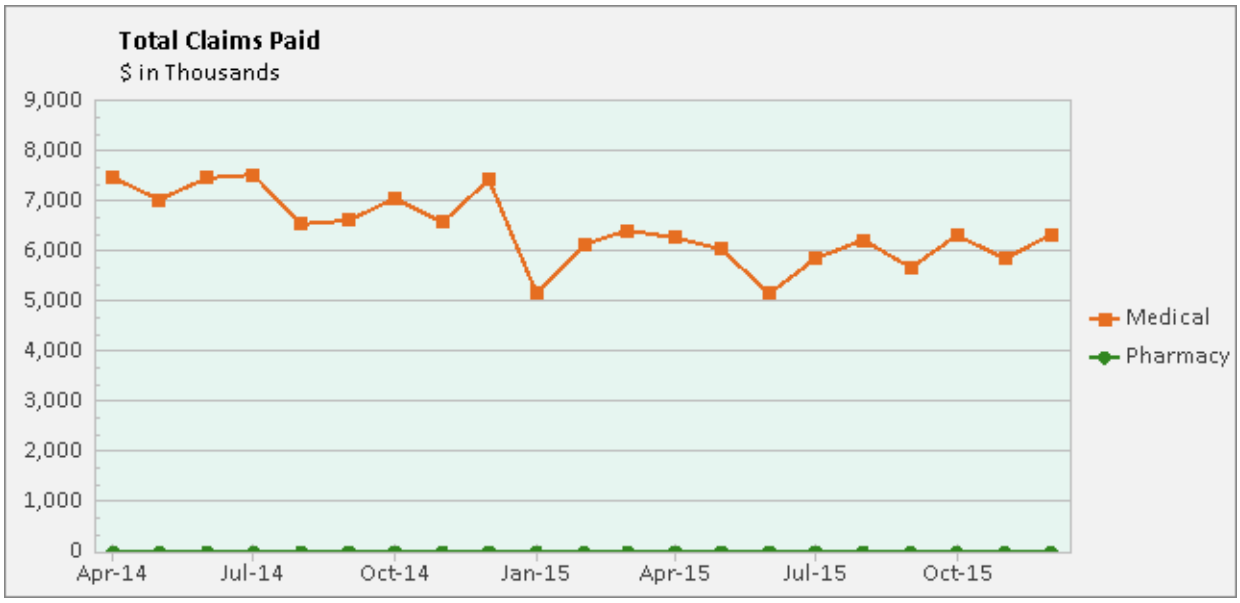
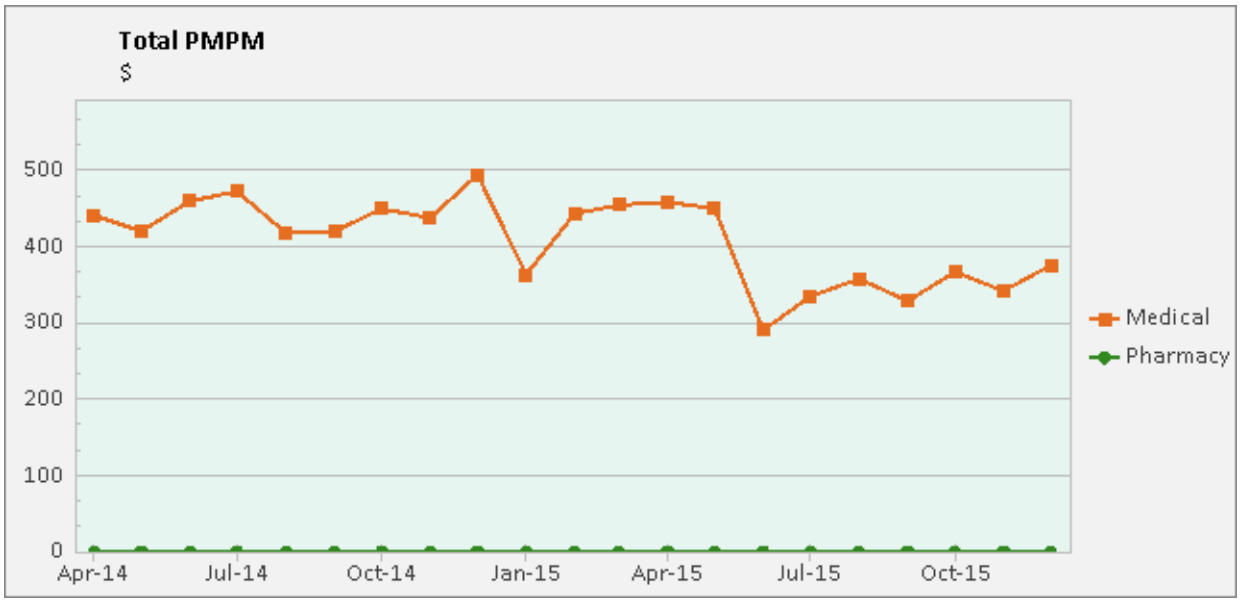


Figure 2.2.3 Medical and Pharmacy Paid - PMPM

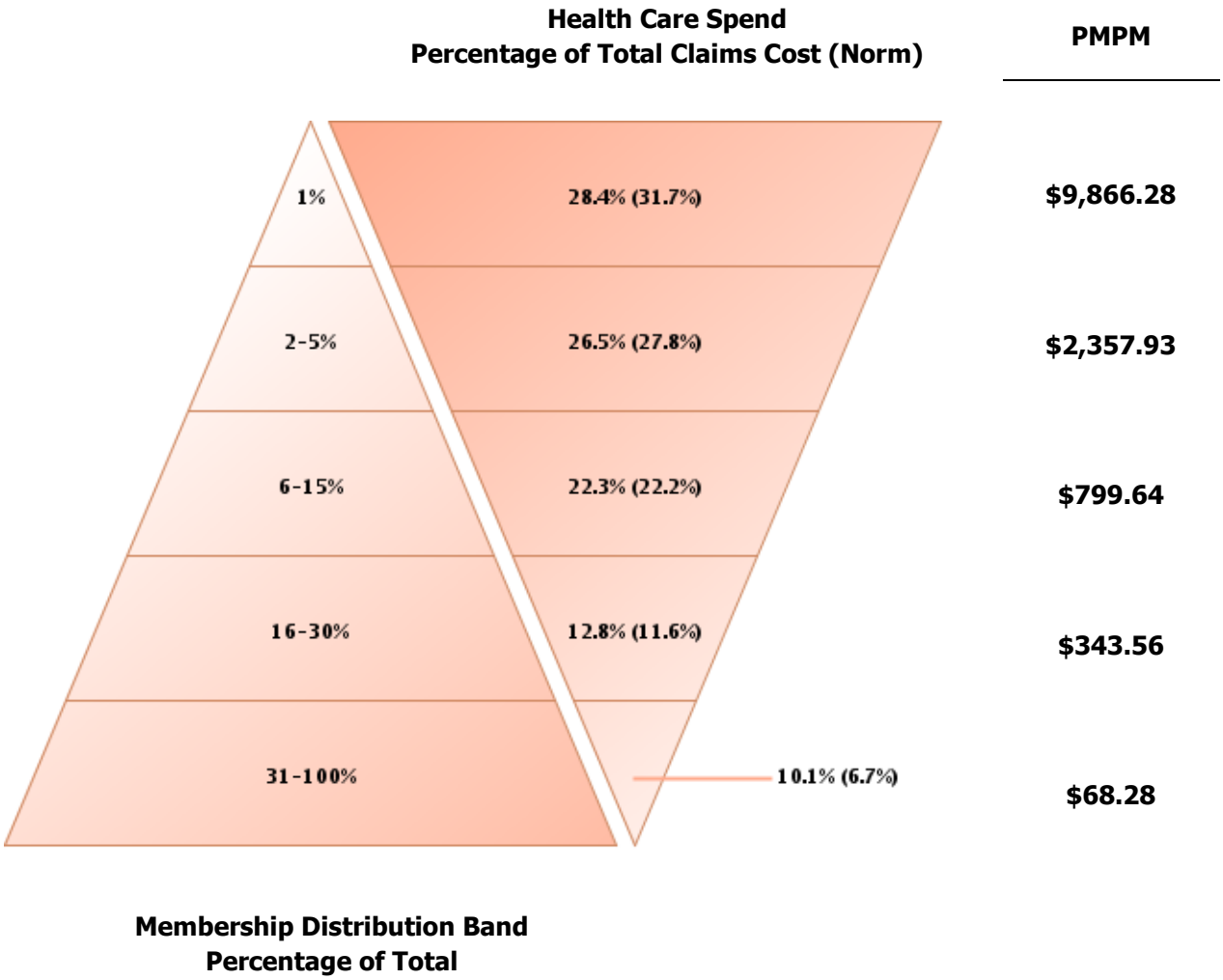


[9] ***Note:*** Refer to Table 5.2.1 and 5.2.2 in Appendix 5.2 for supporting monthly detail.
Source: Medical Intelligence : Claims Module / Medical or Pharmacy / Trend by Month.

2.2.2 Expense Distribution by Percent Spending Band

Figure 2.2.4 shows claim payments for five different population bands including both current and termed members. Members are ranked by total claims for purposes of creating the bands. For example, the band representing 1% of the population consists of the most expensive 1% of members; approximately one-third of the total claims expense is generally accounted for by this group. These members have extremely high claims expense and should be reviewed to verify their case management status. A significant number of members in the next two bands will be high risk members, often with multiple chronic conditions. The risk associated with these members, many of whom to date have not generated significant claims expense, can be further evaluated using the Medical Intelligence Expense Distribution module.

Figure 2.2.4 Claims Expense Distribution [10]



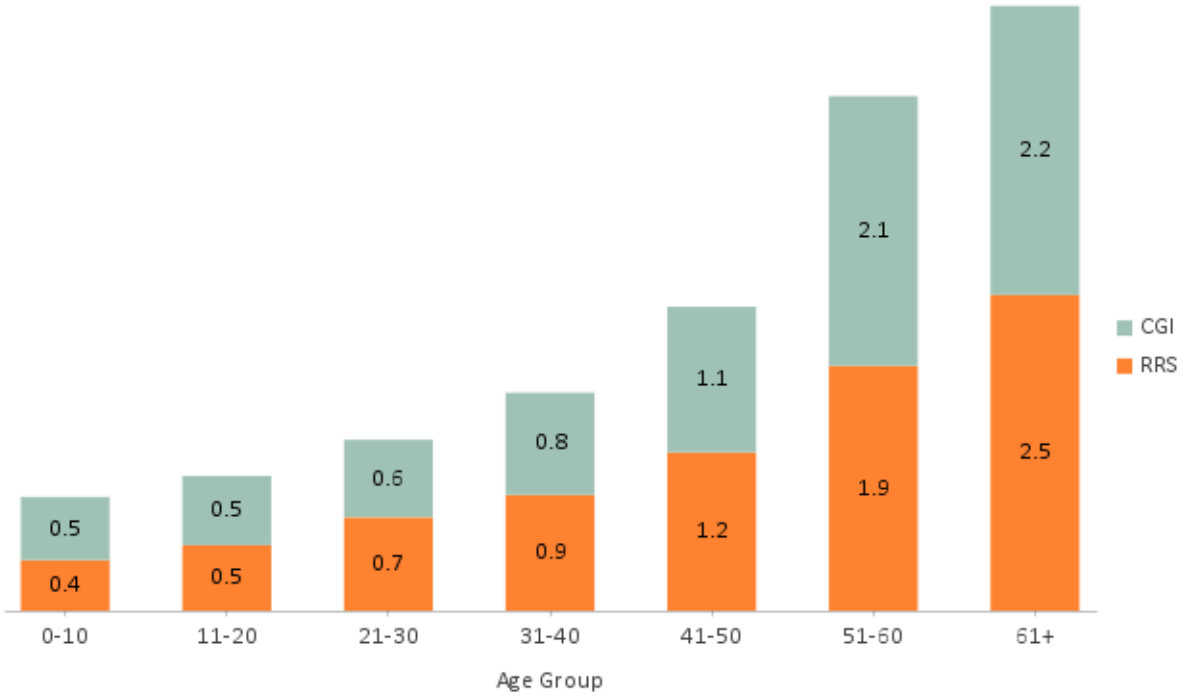
[10] ***Note:*** Refer to Table 5.2.3 in Appendix 5.2 for further detail.
Source: Medical Intelligence : Expense Distribution Module.
PMPM Source: Medical Intelligence : Expense Distribution Module / Individual

2.3 Clinical Disease Fingerprint

The Relative Risk Score (RRS) quantifies the disease burden of an individual member, while the Care Gap Index (CGI) quantifies the gaps in appropriate medical care that a member is receiving. Depending on the diseases that a member has, the extent of care gaps present serves as one assessment of the quality of care they receive.

Figures 2.3.1 show the relationship between the RRS and the CGI. As age increases, RRS and CGI usually increase proportionally. Figure 2.3.2 shows the RRS and CGI relative to benchmark performance and discusses how to determine the extent to which your CGI is driven by high disease burden or poor quality care.

Figure 2.3.1 Average Care Gap and RRS [11]



[11] Source: Medical Intelligence : Average of RRS and CGI fields, grouping members by age in the Individuals Module

Figure 2.3.2 shows the RRS and CGI relative to the Verscend Norm. Four scenarios are possible:

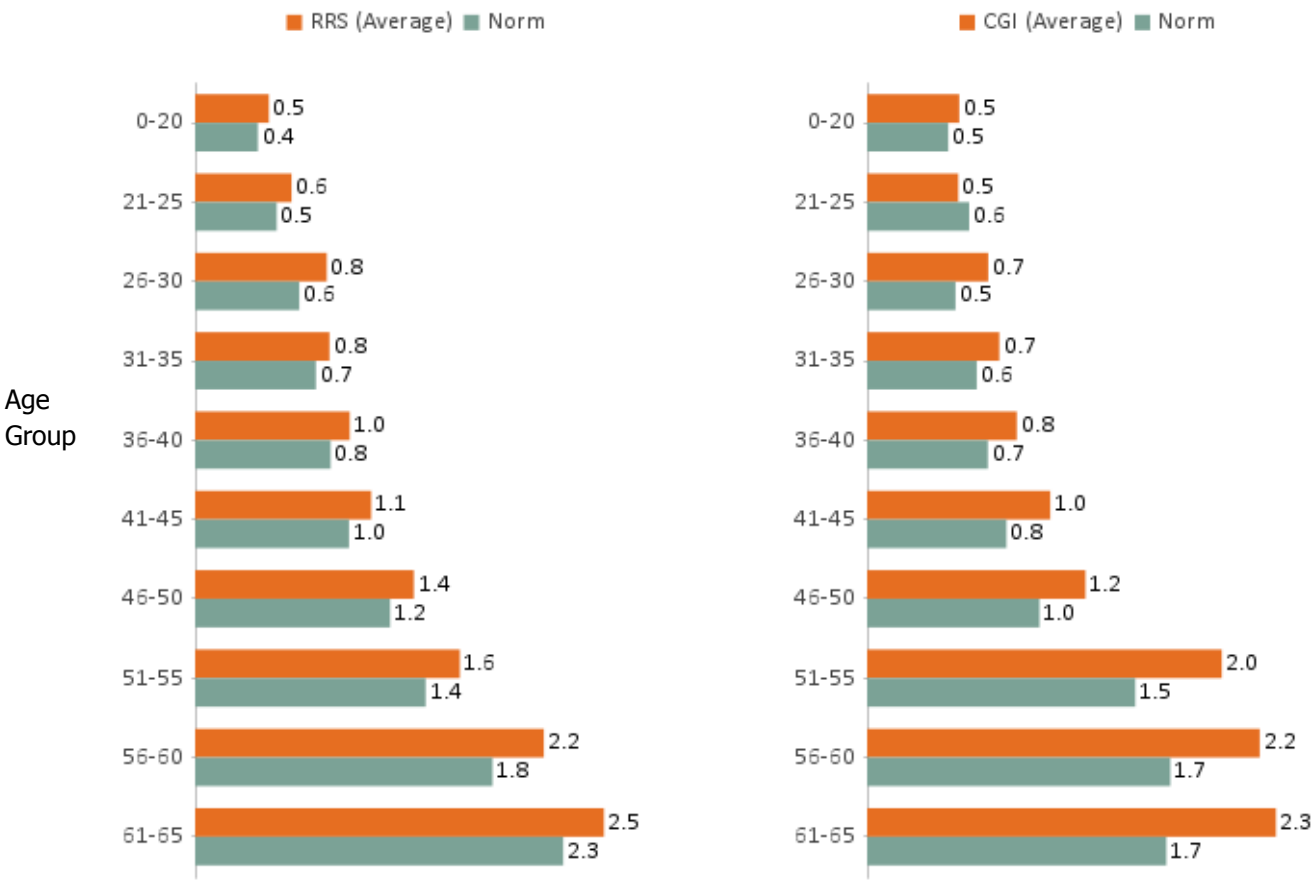
1. The population has a **higher RRS but a lower CGI** relative to the norm. This is a positive finding. The population has a higher disease burden, yet compliance with evidence-based medicine generates a CGI lower than the norm.

2. The population has a **higher RRS and a higher CGI** relative to the norm. This is a mixed finding. The population is sicker than the Verscend norm. Because it is sicker, we expect gaps in care to be more prevalent as well. This population presents an opportunity to reduce care gaps and claims cost through disease management.

3. The population has a **lower RRS and a lower CGI** relative to the norm. This is a positive finding. The population is healthier than the Verscend norm and also enjoys correspondingly fewer gaps in care.

4. The population has a **lower RRS but a higher CGI** relative to the norm. This is a negative finding. Although the illness burden is low for this population, there exist disproportionate gaps in compliance with evidence-based care guidelines - either through member non-compliance or poor provider quality.

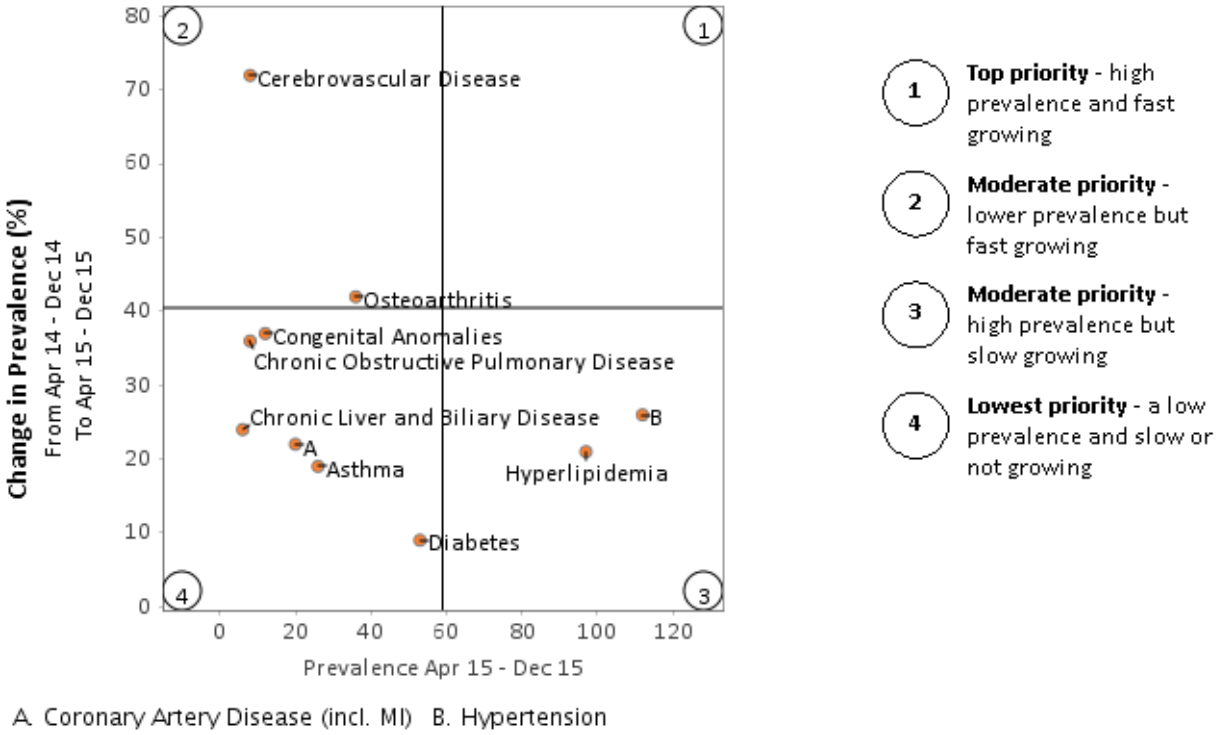
Figure 2.3.2 Spread of disease burden and gaps in care by age groups. [12]



[12] Norm or Verscend Norm in this report refers to the values from Verscend's Commercial Normative database.

Figure 2.3.3 presents the top ten chronic diseases using the Verscend Disease classification scheme - this is the population's "disease fingerprint". Reducing the cost associated with these diseases is typically achieved with Disease Management programs, which typically reduce absolute utilization, and shift utilization from high cost setting to low cost settings.

Figure 2.3.3 Prevalence and Growth of Top 10 Chronic Diseases [13]

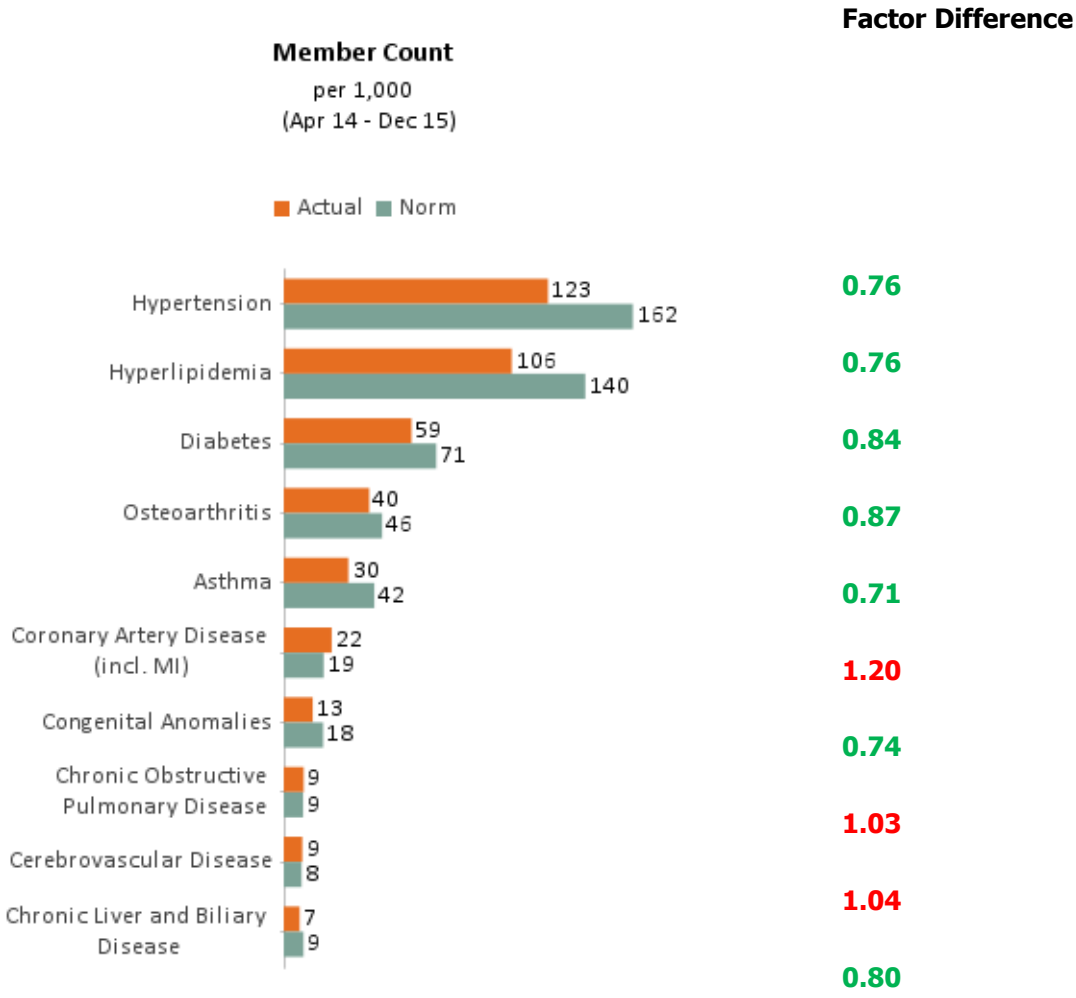


A. Coronary Artery Disease (incl. MI) B. Hypertension

[13] ***Note:*** Figure 2.3.3 is based on members having a qualifying primary diagnosis (ICD9 diagnosis code).
Source: Medical Intelligence : Disease Registry Module / sort by Actual Members per 1000 / Top 10 records

Figure 2.3.4 shows the prevalence of the population's top 10 chronic diseases relative to the Verscend Commercial Norm benchmark values. Diseases with a factor difference less than 1, labeled in green, have lower prevalence than the Verscend norm, while diseases labeled in red have higher prevalence. A high prevalence relative to the norm means that the high cost in claims is in part driven by intrinsic population disease burden, which can be addressed by Disease and Wellness Management programs.

Figure 2.3.4 Prevalence View of top 10 Chronic Diseases. [14, 15, 16]



[14] ***Note:*** Factor Difference = Actual Members per 1000 / Norm Members per 1000
Source: Medical Intelligence : Disease Registry Module / sort by Actual Members per 1000 / Top 10 records
[15] The Norm values in Figure 2.3.4 have been adjusted by Age-Gender-Geography
[16] Norm or Verscend Norm in this report refers to the values from Verscend's Commercial Normative database.

3. ECONOMIC FINDINGS AND OPPORTUNITIES

Economic findings are broken out into Medical and Pharmaceutical subsections.

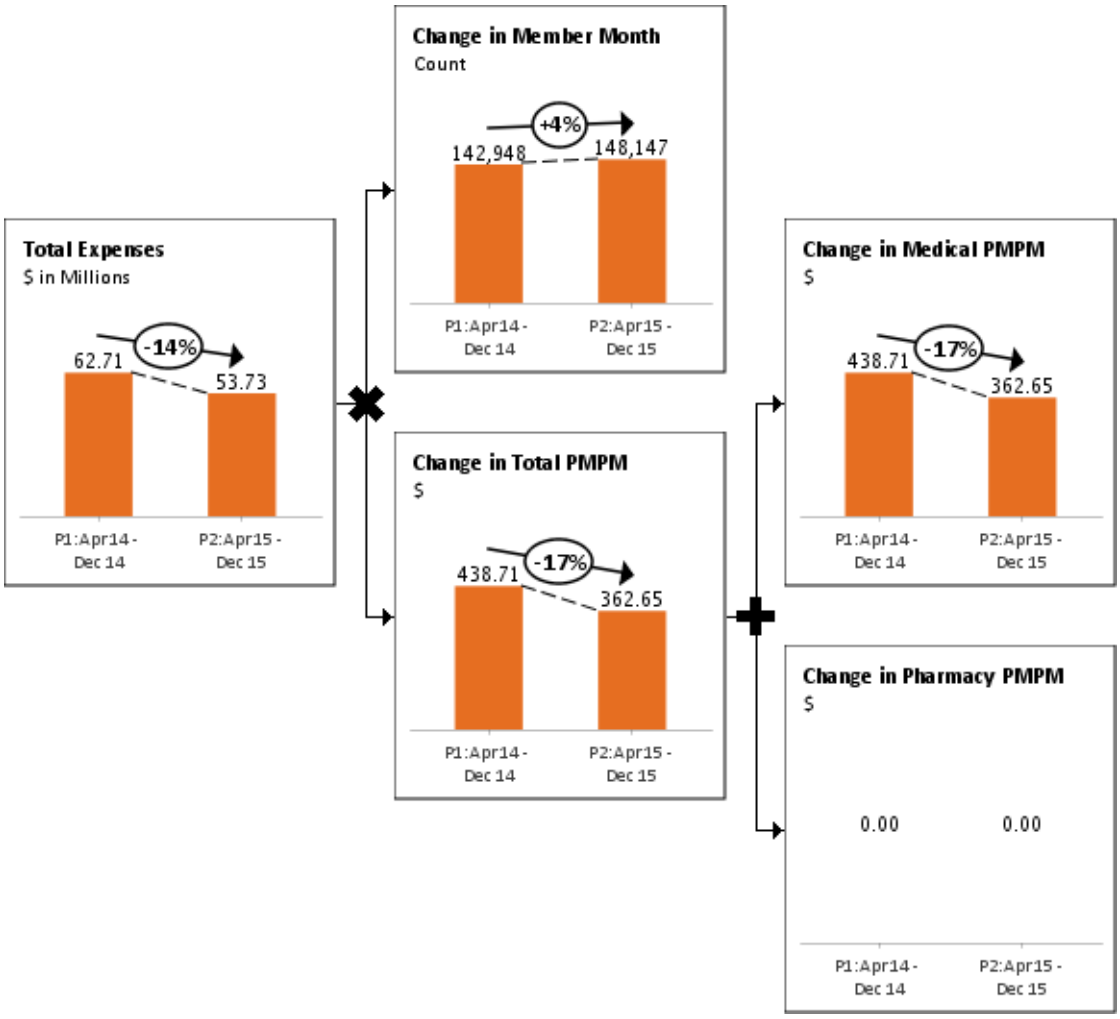
In section 3.1 - the Medical Economics subsection- this report examines:

- Factors that primarily impact *unit pricing,* including contract discount power and in versus out-of-network utilization rates. We also examine which geographic areas are associated with the most out-of-network spend.
- Factors that drive *utilization,* including specialty procedures and consultations, diagnostic testing, and the place of service. For these utilization-based drivers, we assess both changes in utilization and cost.

In section 3.2 - the Pharmaceutical section - this report examines:

- Drug classes that affect PBM drug spend, and whether the change in this spend is due to pricing growth or utilization growth. This section also details the highest cost drugs and opportunities for generic and branded switching.
- Overall Non-PBM drug spend: because this spend is a "medical" cost - not a PBM cost - the impact of these high-cost drugs is often hidden.

Figure 3.1 Expense Drivers [17]



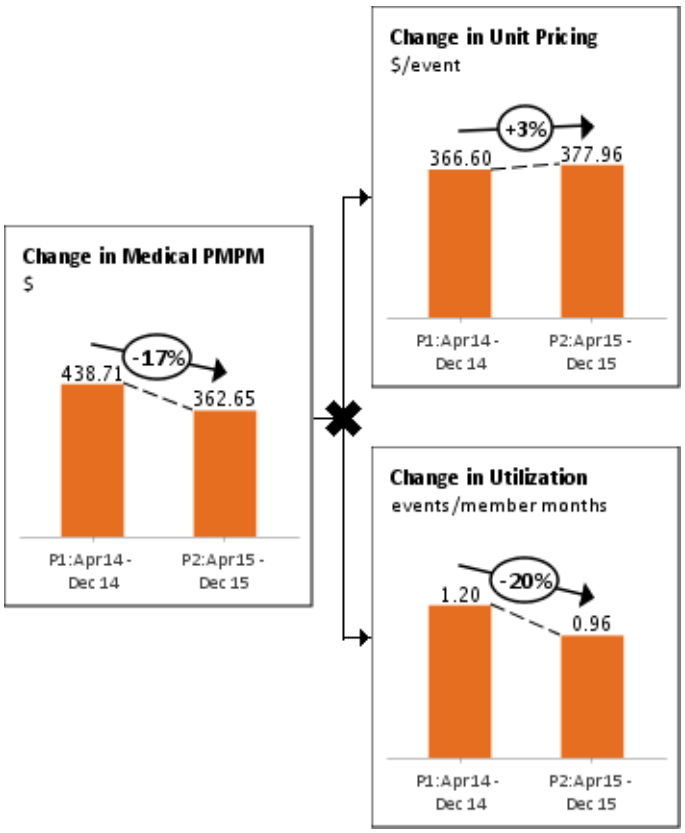
[17] ***Note:***
Medical PMPM includes Non-PBM drug spend (J-Codes).
Source: Medical Intelligence : Claims Module / Custom timeframes for medical and pharmacy expenses.

3.1 Medical Economics

Section 3.1 assesses medical economics - where cost increases are occurring, what is driving them, and how they can be controlled. While the areas and opportunities assessed are not additive, they are complementary. For example, managing Coronary Artery Disease more effectively can be expected to reduce the number of cardiac catheterizations, reduce the overall number of cardiology consultations, and move cardiology consultations from the inpatient setting to the lower-cost office setting.

Figure 3.1.1 shows the change in Medical expenses from previous period to current period. This chart is related to chart 2.2.1 from our assessment of aggregate economics.

Figure 3.1.1 Medical Expense Growth over Time (Refer to Figure 3.1) [18]



Changes in unit pricing are typically a function of overall medical inflation, Payor discount power, and the amount of services that are delivered in-network versus out-of-network. Payor contracting is the primary lever to control this cost driver.

Changes in utilization are typically a function of the overall disease burden of a population, benefits design and physician referral patterns. Disease and Wellness management programs, rational benefits structuring, and close network management are the primary levers to control this cost driver.

[18] ***Note:*** Events are a distinct count of Member ID and Date of Service for the reported population and reporting period. Source: Medical Intelligence : Claims Module / Custom timeframes for medical expenses.

Section 3.1 will analyze the five areas listed directly below.

	What the analysis assesses	How excessive costs are incurred
Contract discount power	• The percent discount that a payor is able to achieve from provider	• Payors with weaker networks - and lower network discount rates - will pay higher per-unit costs
Network utilization	• The percentage and location of out-of-network claims occurrences	• On a per-unit basis, out-of-network costs are generally higher than in-network costs
Specialty procedures & consultations **Diagnostic testing** **Place of service**	• Costs are prioritized by total amount and growth rate • Cost growth drivers are disaggregated into change-in-utilization and change-in-price drivers	• High rates of utilization will drive excessive costs; utilization is typically driven by excessive specialty procedures or diagnostic testing • Excessive costs can also be driven by inappropriate location of care; for example, if a disease is treated in the ER instead of clinic

3.1.1 Network utilization and contract discounts

Table 3.1.1 details in-network (Par) and out-of-network (Non-Par) costs, ranked by plan paid, for the various networks used by your plan participants. This analysis also provides a comparison of discounts for the top ten participating networks. Most benefit plans utilize a provider network where providers have agreed to accept lower reimbursements in return for inclusion on a preferred provider list. Some out-of-network utilization is expected; examples are members seeing a provider while away from home (out-of-area claims), or seeing an out-of-network provider for an urgent or emergent healthcare condition. Out-of-network claims result in higher than expected claims expense for the service provided. A high incidence of out-of-network provider visits is usually an indication that there are access issues. These access issues can be impacted through network restructuring. Improved in-network usage can be accomplished by limiting coverage for out-of-network services.

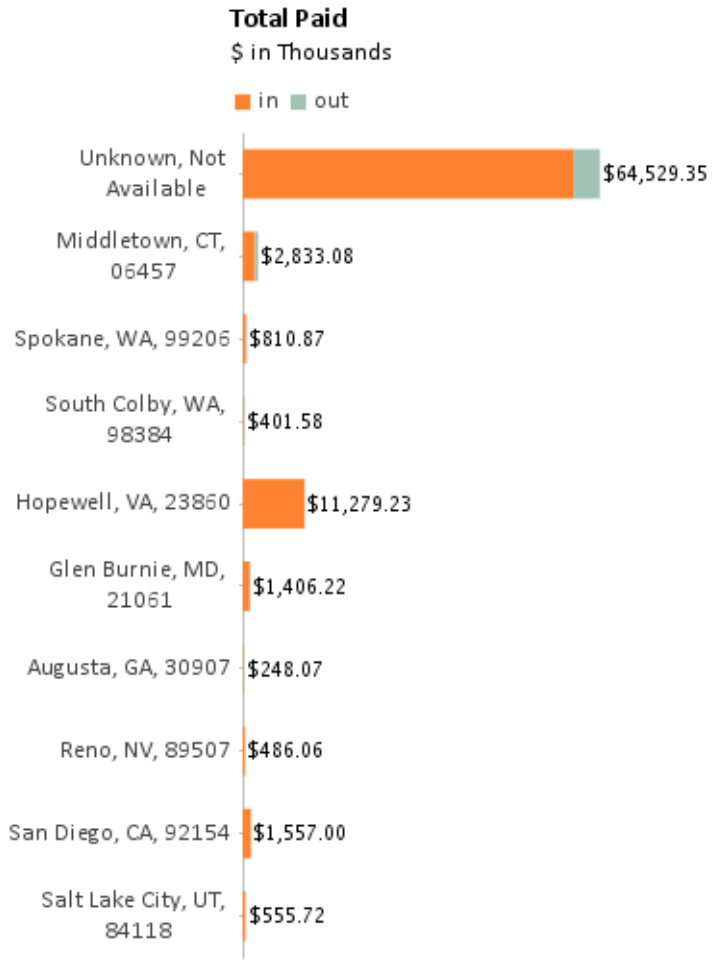
Table 3.1.1 Carrier Discounts and Network Utilization [19]

Network	Total					
	Claims Billed	Claims Allowed	Claims Paid	Employee Contribution	Network Discount	% Discount
Network - 440000608	$95,778,181	$39,957,421	$39,143,769	$6,258,957	$49,343,650	51.5%
Network - 440000605	$100,187,039	$37,426,006	$32,689,413	$4,736,593	$41,670,889	41.6%
Network - 440000596	$44,311,569	$18,934,122	$18,855,775	$1,210,010	$10,297,120	23.2%
Network - 440000601	$37,044,040	$13,645,974	$13,025,885	$1,929,002	$16,336,672	44.1%
Network - 440000158	$26,892,486	$11,546,941	$11,457,568	$780,285	$14,222,706	52.9%
Network - 440000602	$21,803,270	$8,132,633	$7,931,071	$895,704	$9,892,959	45.4%
Network - 440000613	$6,887,200	$2,756,779	$2,643,026	$23,558	$4,130,421	60.0%
Network - 440000614	$3,755,703	$2,950,112	$2,482,246	$318,874	$805,625	21.5%
Network - 440000586	($46,758)	$30,912	($14,246)	$18,509	($129,117)	276.1%
All Other Par (In Network)	**$0**	**$0**	**$0**	**$0**	**$0**	**0.0%**
All Non-Par (Out Of Network)	**$15,700,220**	**$7,624,470**	**$6,934,887**	**$1,976,699**	**$3,664,514**	**23.3%**
Total	**$352,312,949**	**$143,005,369**	**$135,149,394**	**$18,148,192**	**$150,235,439**	**42.6%**

[19] ***Note:*** Refer to Table 5.2.6 in Appendix 5.2 for network summary.
Source: Medical Intelligence : Network Utilization Module / Discount

Figure 3.1.2 shows the cost distribution by city and state for the members utilizing out-of-network providers. Efforts to move utilization in-network should begin with an understanding of why members located in these cities are seeing out-of-network (OON) providers.

Figure 3.1.2 Top 10 Zip Codes for Out-of-Network Claims Paid [20]



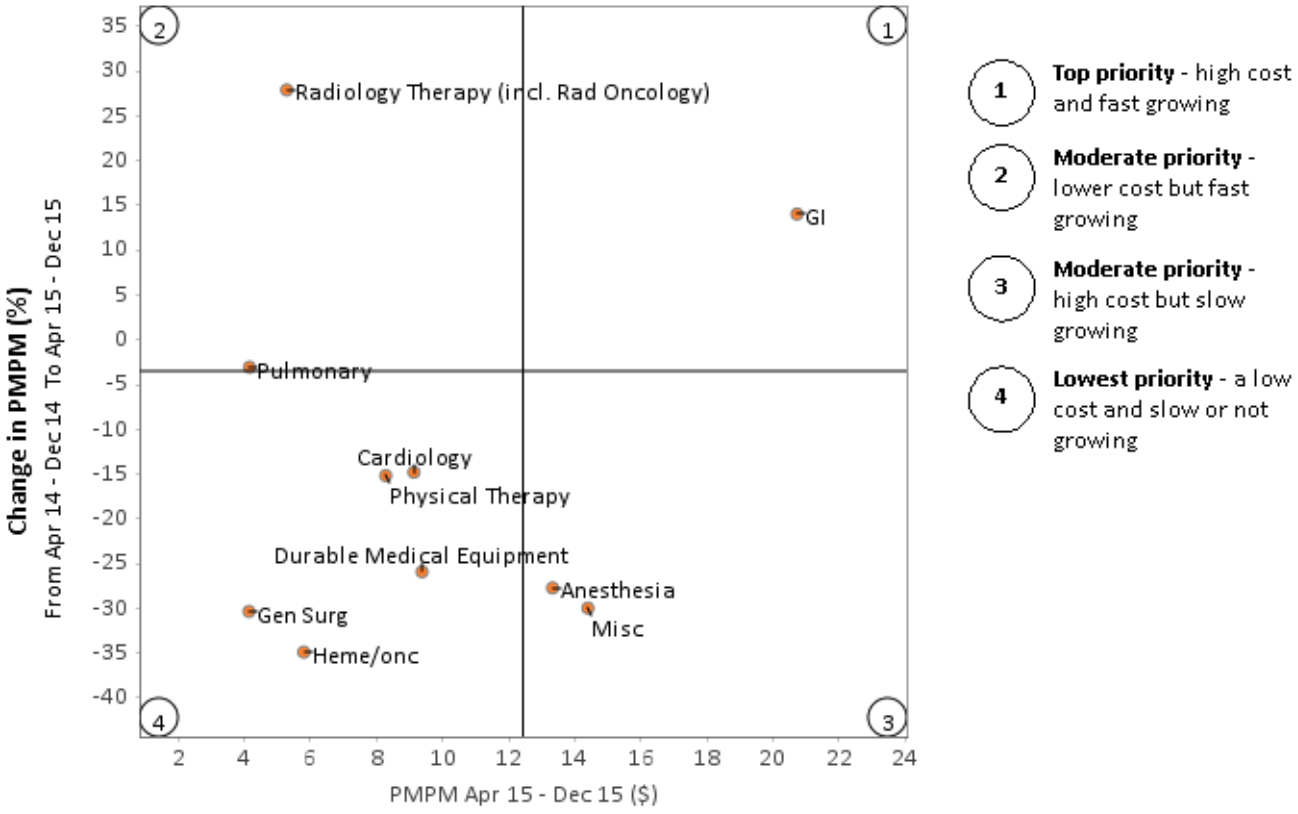
	OON Spend $ in Thousands	**OON Spend**	**all OON Spend**
Unknown, Not Available	$4,718.71	7.3%	3.5%
Middletown, CT, 06457	$608.50	21.5%	0.5%
Spokane, WA, 99206	$228.08	28.1%	0.2%
South Colby, WA, 98384	$188.58	47.0%	0.1%
Hopewell, VA, 23860	$149.73	1.3%	0.1%
Glen Burnie, MD, 21061	$98.44	7.0%	0.1%
Augusta, GA, 30907	$80.77	32.6%	0.1%
Reno, NV, 89507	$57.59	11.8%	0.0%
San Diego, CA, 92154	$56.88	3.7%	0.0%
Salt Lake City, UT, 84118	$55.19	9.9%	0.0%
Total = $6.24 M			

[20] Source: Medical Intelligence : Network Utilization Module / Drill by Zip / Top 10 Zip codes based on NON PAR Paid

3.1.2 Specialty procedures/consultations

Specialty procedures, and the consultations that lead to those procedures, are a common driver of excess utilization. The chart below shows what procedures are large and are growing fast. Moving left to right on the horizontal axis, total costs incurred get larger. Moving bottom to top on the vertical axis, growth from previous period through current period in costs increases. Therefore, specialties in the upper right corner are both large and growing fast.

Figure 3.1.3 Cost drivers: Areas of cost and cost growth for specialty procedures and consultations [21]



[21] ***Note:*** Figure 3.1.3 is based on select categories of Verscend Procedure Groups which utilize CPT4 Procedure Codes.
Source: Medical Intelligence : Claims Module / Trend / Medical / drill by Plan Type / Zoom Fwd / drill by Procedure Group

The table below breaks down the cost driver for each category analyzed in the prior chart. This allows you to understand whether the changes in cost are driven by a change in pricing or a change in utilization. Also displayed is the average cost from the Verscend Normative Database, and the population's cost rank relative to the Norm.

Table 3.1.2 Cost drivers: Change in unit price and change in utilization breakout for specialty procedures and consultations [22, 23]

Specialty Procedures/ Consultations	Current PMPM	Change in PMPM	Change in Utilization per 1,000	Change in Unit Pricing	Norm value of PMPM	Percent Rank (Norm value = 50%)
GI	$20.73	14.0%	-17.9%	38.9%	$15.63	-
Misc	$14.40	-30.0%	-19.2%	-13.4%	$8.45	-
Anesthesia	$13.33	-27.7%	-22.5%	-6.7%	$9.35	-
Durable Medical Equipment	$9.38	-25.9%	-25.2%	-1.0%	$4.51	-
Cardiology	$9.13	-14.8%	-4.3%	-11.0%	$5.61	-
Physical Therapy	$8.28	-15.2%	-16.3%	1.3%	$4.70	-
Heme/onc	$5.80	-34.9%	-13.3%	-24.9%	$3.52	-
Radiology Therapy (incl. Rad Oncology)	$5.28	27.9%	29.1%	-0.9%	$3.70	-
Pulmonary	$4.15	-3.1%	-27.4%	33.4%	$2.08	-
Gen Surg	$4.14	-30.4%	-19.6%	-13.4%	$4.18	-

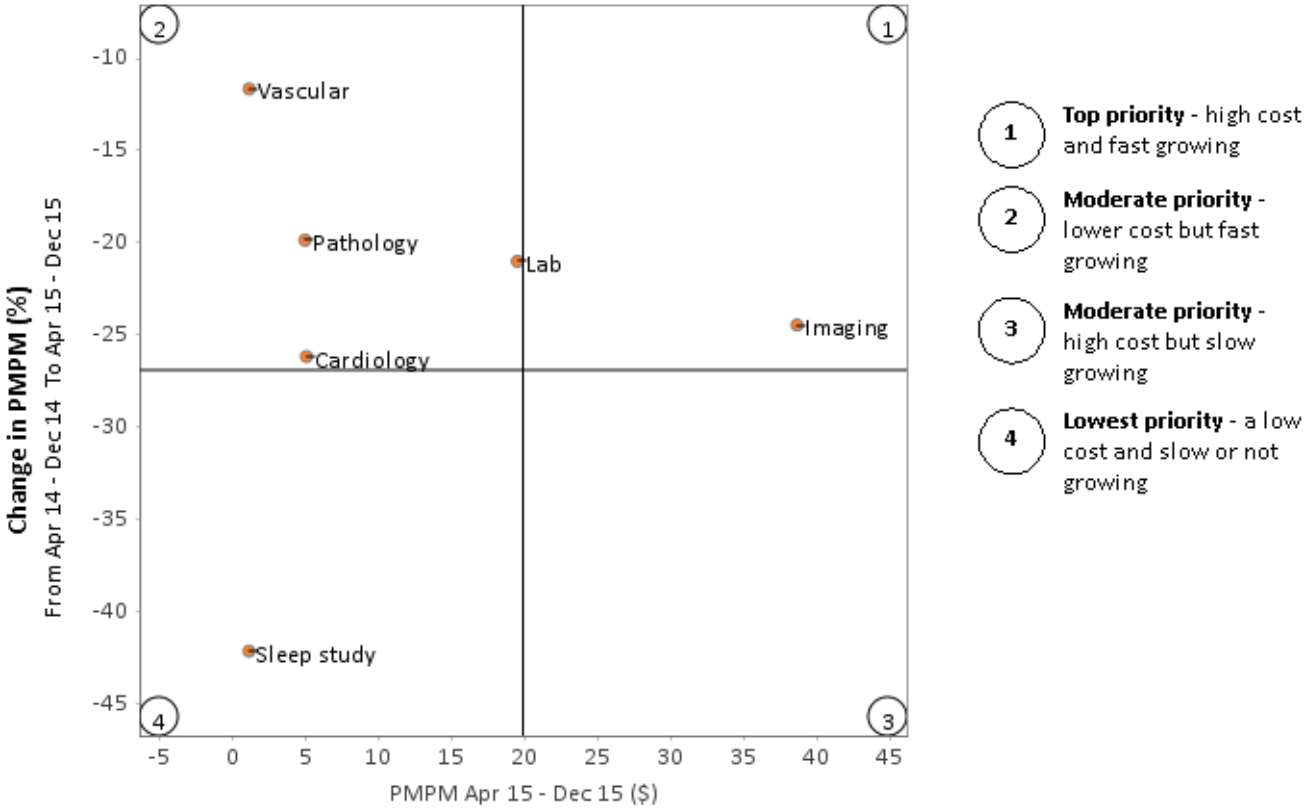
[22] ***Note:*** Table 3.1.2 is based on select categories of Verscend Procedure Groups which utilize CPT4 Procedure Codes.
Source: Medical Intelligence : Claims Module / Trend / Medical / drill by Plan Type / Zoom Fwd / drill by Procedure Group

[23] Norm or Verscend Norm in this report refers to the values from Verscend's Commercial Normative database.

3.1.3 Diagnostic Testing

The chart below shows what diagnostic tests are large and are growing fast. Moving left to right on the horizontal axis, total costs incurred get larger. Moving bottom to top on the vertical axis, growth from previous period through current period in costs increases. Therefore, tests in the upper right corner are both large and growing fast.

Figure 3.1.4 Cost drivers: Areas of cost and cost growth for diagnostic tests [24]



[24] ***Note:*** Figure 3.1.4 is based on select categories of Verscend Procedure Groups which utilize CPT4 Procedure Codes.
Source: Medical Intelligence : Claims Module / Trend / Medical / drill by Plan Type / Zoom Fwd / drill by Procedure Group

The table below breaks down the cost driver for each category analyzed in the prior chart. This allows you to understand whether the changes in cost are driven by a change in pricing or changes in utilization. Also displayed is the average cost from the Verscend Normative Database, and the population's cost rank relative to the Norm.

Table 3.1.3 Cost drivers: Change in unit price and change in utilization breakout for diagnostic tests [25, 26]

Testing Category	Subcategory	Current PMPM	Change in PMPM	Change in utilization per 1,000	Change in Unit pricing	Norm value of PMPM	Percent Rank(Norm value = 50%)
Cardiology	All	$5.05	-26.2%	-19.0%	-24.9%	$3.58	-
	Ultrasound/Doppler	$2.56	-15.6%	-15.8%	0.2%	$1.76	-
	Cardiography	$2.17	-30.3%	-19.5%	-13.5%	$1.38	-
	Electrophysiology	$0.32	-53.7%	-28.1%	-35.5%	$0.44	-
Imaging	All	$38.67	-24.5%	-22.6%	-7.5%	$22.56	-
	CT	$13.25	-15.9%	-14.0%	-2.3%	$6.56	-
	MRI	$9.77	-27.1%	-24.9%	-3.0%	$5.77	-
	Radiology Diagnostic (incl. Cardiology)	$4.68	-36.9%	-24.1%	-16.9%	$2.17	-
	US	$3.96	-22.0%	-20.6%	-1.8%	$3.34	-
	Plain film	$3.72	-21.6%	-23.9%	3.1%	$2.98	-
	Not classified	$3.28	-31.3%	-25.4%	-8.0%	$1.74	-
Lab	All	$19.51	-21.0%	-21.0%	-0.0%	$14.63	-
Pathology	All	$4.95	-19.9%	-22.3%	3.2%	$3.39	-
Sleep study	All	$1.11	-42.2%	-40.6%	-2.7%	$1.04	-
Vascular	All	$1.12	-11.7%	-23.7%	15.8%	$0.71	-

[25] ***Note:*** Table 3.1.3 is based on select categories of Verscend Procedure Groups which utilize CPT4 Procedure Codes. Source: Medical Intelligence : Claims Module / Trend / Medical / drill by Plan Type / Zoom Fwd / drill by Procedure Group

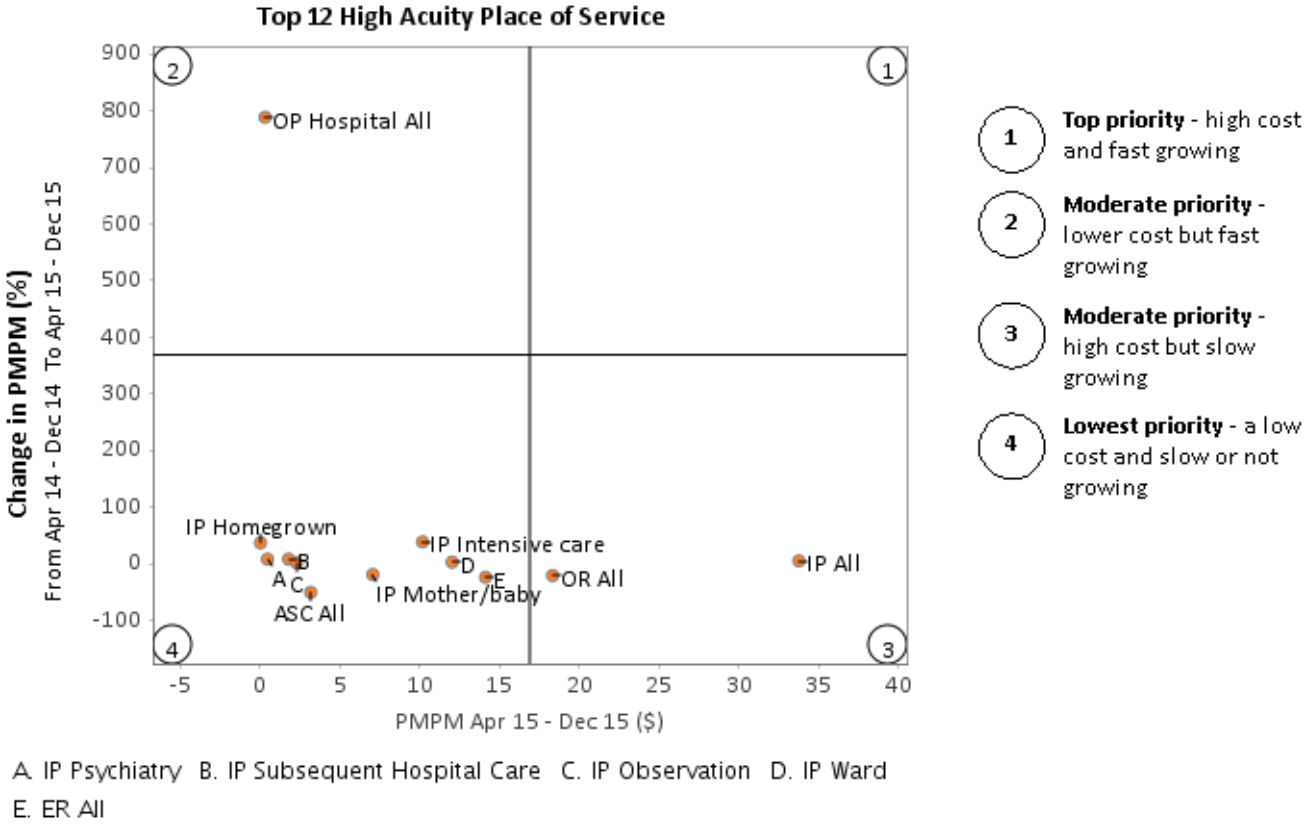
[26] Norm or Verscend Norm in this report refers to the values from Verscend's Commercial Normative database.

3.1.4 Place of service - Inpatient and high acuity

Monitoring the utilization patterns for chronic conditions offers valuable insight into benefit design and/or case and disease management program performance. In general, high utilization rates for such measures as inpatient admissions and emergency room services in these conditions bring into question the adequacy of outpatient care, plan design incentives to encourage outpatient care, and medical management performance.

The chart below shows which inpatient and high acuity places of service are large and are growing fast. Moving left to right on the horizontal axis, total costs incurred get larger. Moving bottom to top on the vertical axis, growth from previous period through current period in costs increases. Therefore, locations in the upper right corner are both large and growing fast.

Figure 3.1.5 Cost drivers: Areas of cost and cost growth for hospital and ASC based utilization [27]



A. IP Psychiatry B. IP Subsequent Hospital Care C. IP Observation D. IP Ward
E. ER All

[27] ***Note:*** Figure 3.1.5 is based on select categories of Verscend Procedure Groups which utilize CPT4 Procedure Codes.
Source: Medical Intelligence : Claims Module / Trend / Medical / drill by Plan Type / Zoom Fwd / drill by Procedure Group

The table below breaks down the cost driver for each category analyzed in the prior chart. This allows you to understand whether the changes in cost are driven by a change in pricing or a change in utilization. Also displayed is the average cost from the Verscend Normative Database, and the population's cost rank relative to the Norm.

Table 3.1.4 Cost drivers: Change in unit price and change in utilization breakout for Inpatient and high acuity locations of care [28, 29]

Category	Subcategory	Current PMPM	Change in PMPM	Change in utilization per 1,000	Change in Unit pricing	Norm value of PMPM	Percent Rank(Norm value = 50%)
ASC	All	$3.16	-50.8%	-39.1%	-19.2%	$1.28	-
ER	All	$14.12	-24.3%	-26.6%	3.1%	$11.73	-
IP	All	$33.78	5.0%	-11.1%	17.6%	$30.25	-
	Ward	$12.02	2.7%	-24.9%	36.7%	$9.23	-
	Intensive care	$10.18	38.1%	11.2%	24.2%	$6.01	-
	Mother/baby	$7.05	-19.6%	-26.1%	8.8%	$9.18	-
	Observation	$2.29	1.4%	-3.6%	5.2%	$0.79	-
	Subsequent Hospital Care	$1.77	7.9%	-0.5%	8.5%	$1.16	-
	Psychiatry	$0.45	7.6%	-7.9%	16.8%	$1.63	-
	Homegrown	$0.01	36.6%	84.4%	-25.9%	$2.24	-
OP Hospital	All	$0.30	788.5%	-11.1%	900.0%	$0.07	-
OR	All	$18.33	-21.1%	-24.6%	4.7%	$4.34	-

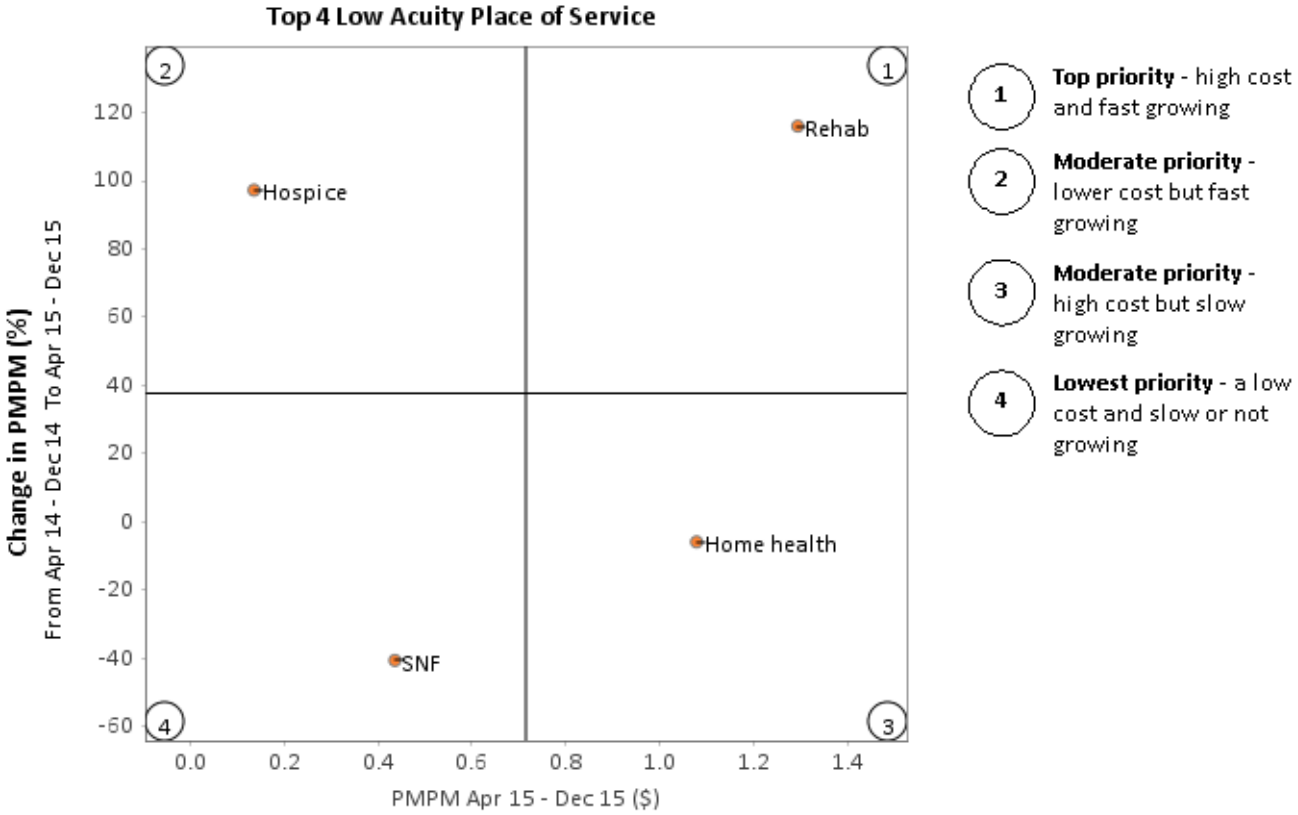
[28] ***Note:*** Table 3.1.4 is based on select categories of Verscend Procedure Groups which utilize CPT4 Procedure Codes.
Source: Medical Intelligence : Claims Module / Trend / Medical / drill by Plan Type / Zoom Fwd / drill by Procedure Group

[29] Norm or Verscend Norm in this report refers to the values from Verscend's Commercial Normative database.

3.1.5 Place of service - Outpatient and low acuity (excluding office visits)

The chart below shows which outpatient and low-acuity places of service are large and are growing fast. Moving left to right on the horizontal axis, costs incurred by location get larger. Moving bottom to top on the vertical axis, growth from previous period through current period in costs increases. Therefore, locations in the upper right corner are both large and growing fast.

Figure 3.1.6 Cost drivers: Areas of cost and cost growth for outpatient and community based utilization (excluding office visits) [30]



[30] ***Note:*** Figure 3.1.6 is based on select categories of Verscend Procedure Groups which utilize CPT4 Procedure Codes.
Source: Medical Intelligence : Claims Module / Trend / Medical / drill by Plan Type / Zoom Fwd / drill by Procedure Group

The table below breaks down the cost driver for each category analyzed in the prior chart. This allows you to understand whether the change in cost seen in chart 3.1.1 is driven by a change in unit price or a change in utilization. Also displayed is the average cost from the Verscend Normative Database and the population's cost rank relative to the Norm.

Table 3.1.5 Cost drivers: Change in unit price and change in utilization breakout for Outpatient and low acuity care (excluding office visits) [31, 32]

Category	Current PMPM	Change in PMPM	Change in Utilization per 1,000	Change in Unit Pricing	Norm value of PMPM	Percent Rank (Norm value = 50%)
Rehab	$1.29	116.0%	-27.6%	198.5%	$0.73	-
Home health	$1.08	-5.9%	1.0%	-6.8%	$1.18	-
SNF	$0.44	-40.6%	-33.7%	-10.3%	$0.41	-
Hospice	$0.14	97.3%	18.2%	66.9%	$0.14	-

[31] ***Note:*** Table 3.1.5 is based on select categories of Verscend Procedure Groups which utilize CPT4 Procedure Codes. Source: Medical Intelligence : Claims Module / Trend / Medical / drill by Plan Type / Zoom Fwd / drill by Procedure Group

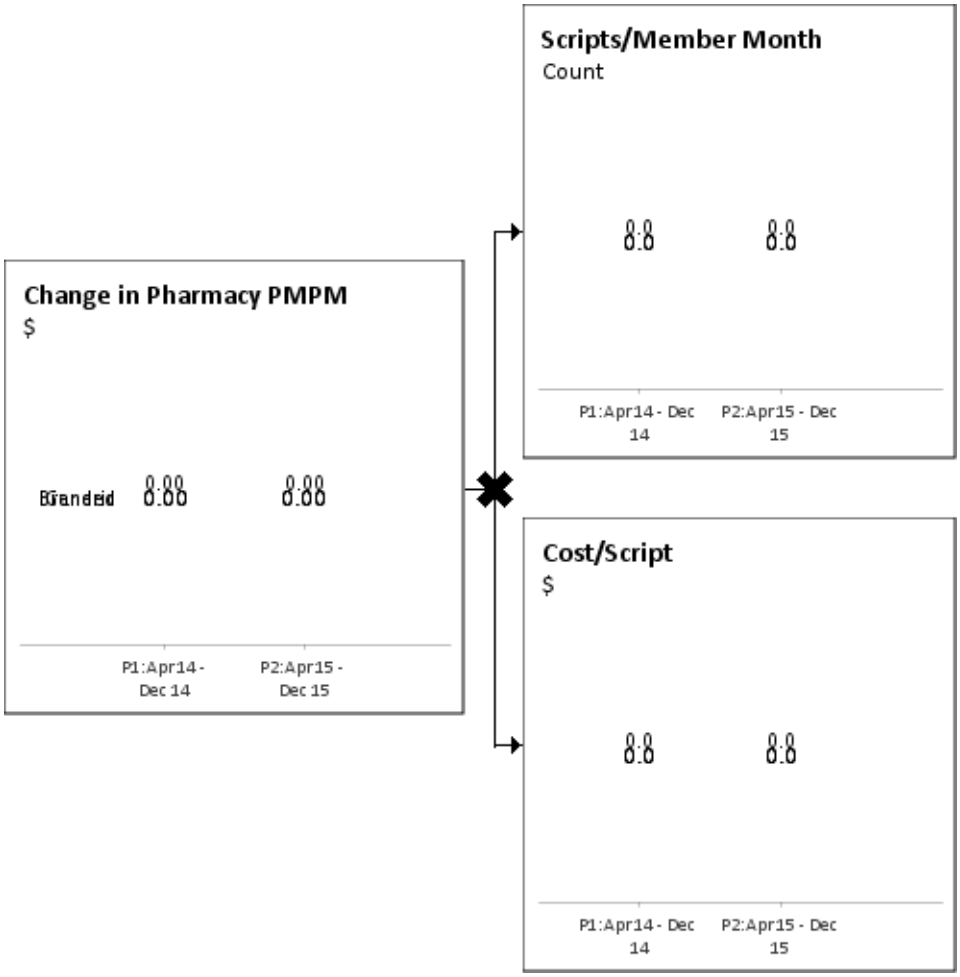
[32] Norm or Verscend Norm in this report refers to the values from Verscend's Commercial Normative database.

3.2 Pharmacy Economics

Growth from previous period through current period in pharmacy expenses can be attributed to changes in Member Months and pharmacy PMPM cost , as shown in chart 2.2.1 .

Increase or decrease of pharmacy PMPM is caused by changes in the number of prescriptions written per Member Month and changes in the cost per prescription.

Figure 3.2.1 Pharmacy Expenses (Refer to Figure 2.2.1) [33]



Changes in scripts per member reflect overall intensity of care and member compliance. Overall trends in volume are less important than the change on the ratios between branded and generic drugs.

Changes in cost/script reflect overall pharmaceutical industry pricing trends. This cost driver is best controlled through strong PBM contracting and tight formulary control.

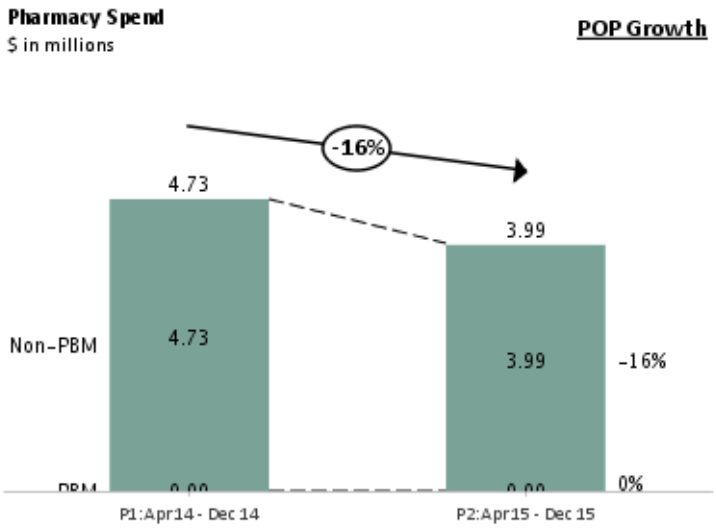
[33] ***Note:*** Pharmacy PMPM totals reflect branded, generic and non-drug costs. Non-drug costs include items like diabetic supplies and syringes which typically have low PMPM costs. Within the Medical Intelligence application, non-drug charges are located within the non-generic category.
Source: Medical Intelligence : Claims Module / Pharmacy / Plan Type

3.2.1 Non-PBM Drug Spend

Non-PBM spend on pharmaceuticals is paid by Health Plan, not the PBM. It is therefore included in medical expenses and usually includes the J-Codes. However, many non-PBM drugs are exceptionally expensive and deserve special attention. Non-PBM drug spend is often best controlled through the use of contracting Specialty Pharmacy networks.

Figure 3.2.2 shows the total pharmacy spend as seen in chart 3.2.1, now with the non-PBM spend added in.

Figure 3.2.2 Distribution of Pharmacy Spend (Refer to Figure 3.2.1) [34]



The top 10 drugs driving non-PBM spend are listed in table 3.2.1, with unit price and utilization values broken out.

Table 3.2.1 Top 10 drugs driving non-PBM spend [35, 36]

Drug	Current PMPM	Change in PMPM	Change in # Scripts	Change in Unit Pricing	Norm value of PMPM	Percent Rank (Norm value = 50%)
PHARMACY (ALSO SEE 063X, AN EXTENSION OF 025X) - GENERAL CLASSIFICATION	$7.19	3.9%	-13.9%	25.0%	$7.97	-
Pharmacy - Extension of 025X - Drugs Requiring Detailed Coding	$6.00	-13.5%	-8.5%	-2.0%	$1.77	-
Infliximab Injection	$1.82	-17.1%	-21.4%	9.3%	$1.34	-
Injection, Pegfilgrastim, 6 Mg	$1.48	-13.1%	-27.5%	24.2%	$0.96	-
Rituximab Cancer	$1.40	72.9%	69.6%	5.7%	$0.65	-

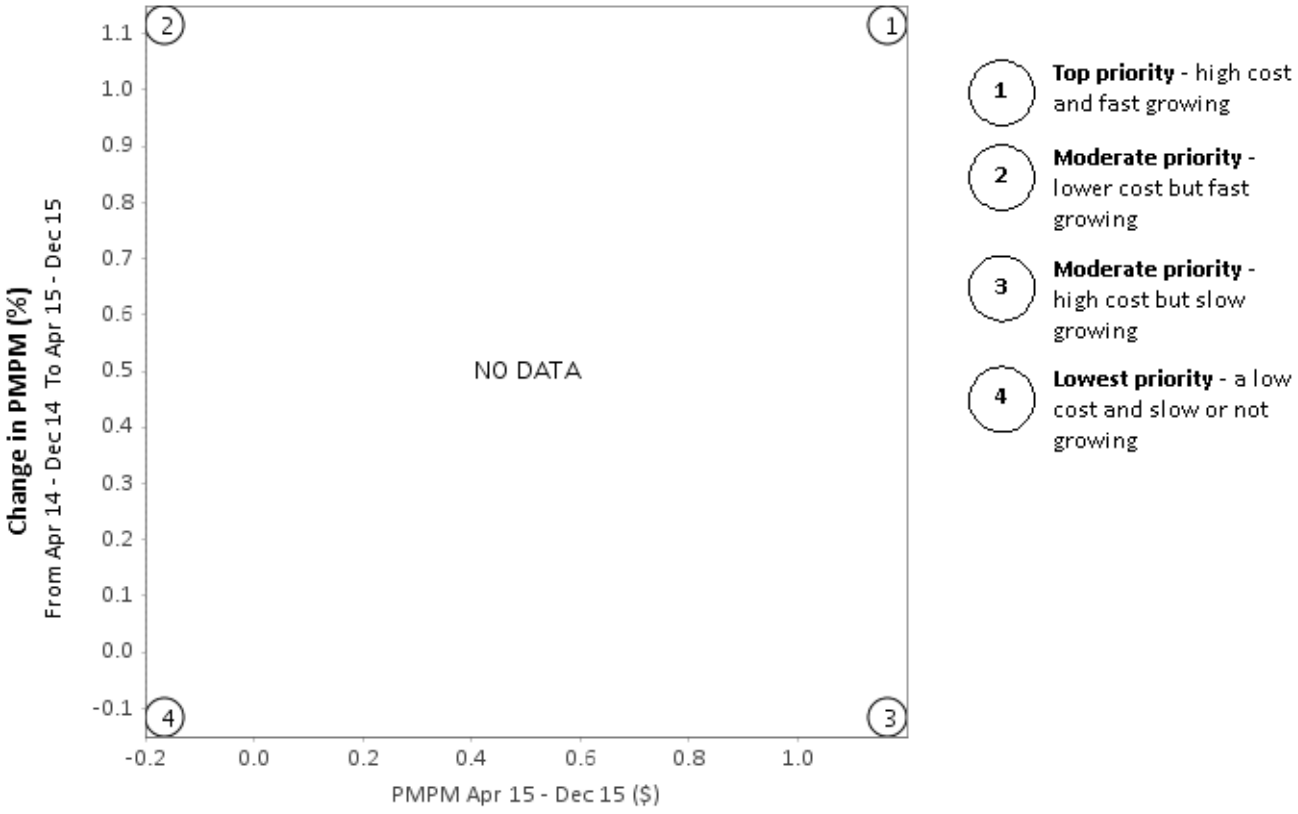
[34] Source: Medical Intelligence : PBM Cost: Claims Module / Pharmacy
Non PBM Cost: Claims Module / Medical / drill by Plan Type / Zoom Forward / drill by Procedure Group / Non-PBM Drug
[35] Source: Medical Intelligence : Claims module / Medical / Plan Type / Zoom Forward / drill by Procedure Group / Non-PBM Drug / Source
[36] Norm or Verscend Norm in this report refers to the values from Verscend's Commercial Normative database.

Drug	Current PMPM	Change in PMPM	Change in # Scripts	Change in Unit Pricing	Norm value of PMPM	Percent Rank (Norm value = 50%)
Treatment						
PHARMACY (ALSO SEE 063X, AN EXTENSION OF 025X) - IV SOLUTIONS	$1.17	29.8%	-23.6%	76.0%	$0.70	-
Injection, Ixabepilone, 1 Mg	$0.39	382.5%	1,500.0%	-68.7%	$0.03	-
Trastuzumab	$0.34	0.7%	-28.6%	46.1%	$0.69	-
Gemcitabine Hcl	$0.33	7.6%	23.1%	-9.4%	$0.10	-
Doxorubicin Hcl Liposome Inj	$0.32	779.3%	200.0%	203.8%	$0.01	-

3.2.2 PBM drug spend

The chart below shows which drugs are large and are growing fast. Moving left to right on the horizontal axis, total costs incurred by drug get larger. Moving bottom to top on the vertical axis, growth from previous period through current period in costs increases. Therefore, locations in the upper right corner are both large and growing fast. In general, drugs that do not have generic or branded substitutes will typically have the highest rates of cost inflation, but lower overall absolute costs.

Figure 3.2.3 Cost drivers: Areas of cost and cost growth by drug [37]



[37] Source: Medical Intelligence : Claims module / Trend / Pharmacy / drill by Plan Type / Zoom Forward / drill by Rx Class / drill by Drug

Table 3.2.2 Top 20 Drugs [38, 39]

"This Section is not applicable for selected population"

[38] Source: Medical Intelligence : Claims module / Trend / Pharmacy / drill by Plan Type / Zoom Forward / drill by Rx Class / drill by Drug
[39] Norm or Verscend Norm in this report refers to the values from Verscend's Commercial Normative database.

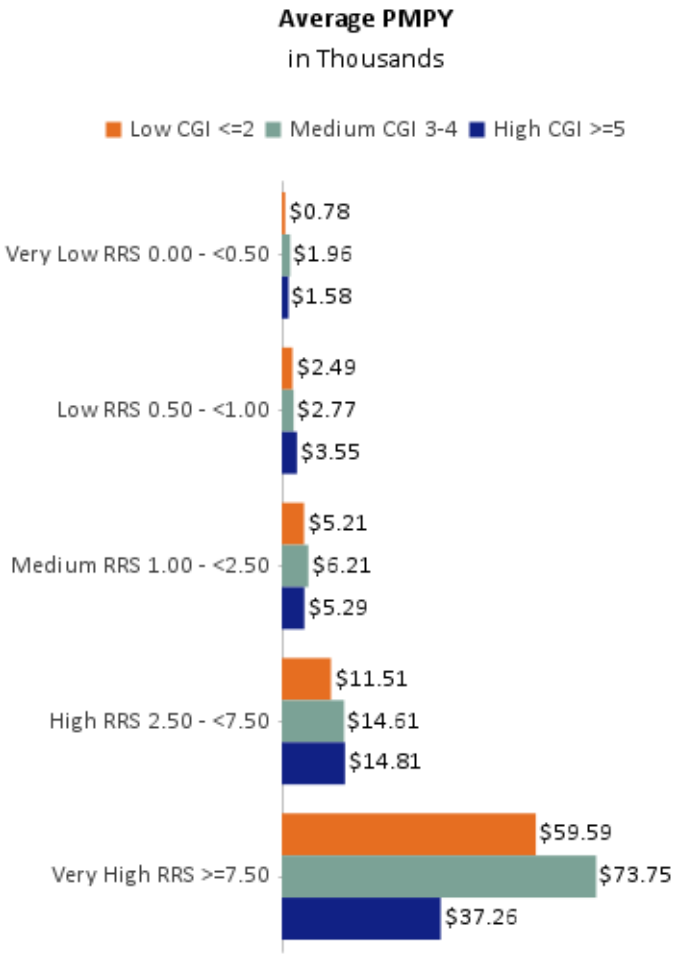
4 CLINICAL DEEP DIVES

4.1 General Clinical Quality Performance and Economic Opportunity

The Relative Risk Score (RRS) is a quantitative assessment of disease and risk burden at a population level. The Care Gap Index (CGI) quantifies the gaps identified for a population. Verscend utilizes these two factors to understand the association between disease burden, quality, and cost.

In figure 4.1.1, members are grouped by RRS, and then by CGI. The RRS categories are DxCG Aggregate Diagnostic Cost Groups (ADCG). ADCG categories allow for easy stratification of members into different ranges of risk and indicate the absolute level of predicted expenses at the individual level. By categorizing members with risk scores higher than 7.50 as "very high" you are able to stratify the riskiest members of your population from other members who are not as costly. For each RRS bucket, corresponding decreases in care gaps (and the CGI) are associated with decreases in the total medical spend.

Figure 4.1.1 Member costs by Risk and CGI buckets [40]

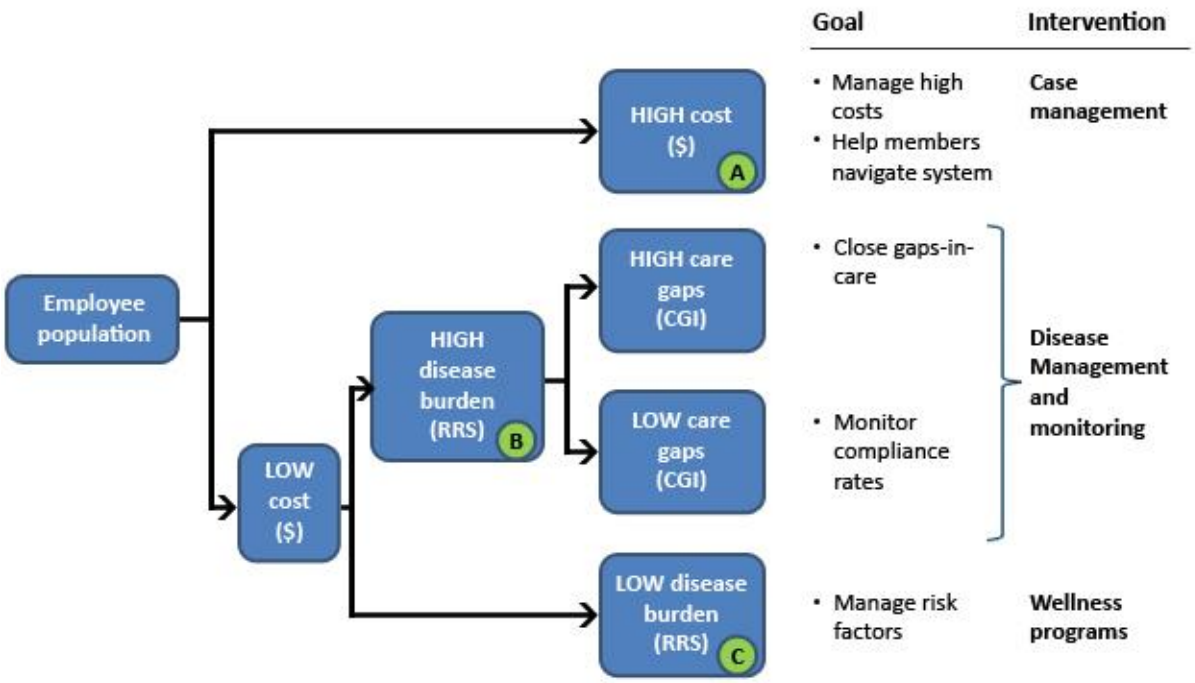


	Members Count	**Total Spend** $ in Millions
Very Low RRS 0.00 - <0.50	7,825	7.32
	361	0.75
	59	0.1
Low RRS 0.50 - <1.00	4,242	11.39
	1,007	2.25
	297	0.6
Medium RRS 1.00 - <2.50	2,870	16.73
	1,152	7.26
	700	4.2
High RRS 2.50 - <7.50	685	9.85
	466	9.29
	478	9.35
Very High RRS >=7.50	67	5.53
	58	6.24
	86	4.83
	20,353	**95.70**

[40] ***Note:*** Refer to Table 5.5.1 in Appendix 5.5 for further detail about RRS buckets.

To stratify a total population for health management, we use the RRS (disease burden), the CGI (gaps in clinical care), and cost. Using these factors, any population can be comprehensively categorized into the mutually exclusive categories, each with specific interventions. Below is a graphical representation of the Verscend recommended classification approach. Sections 4.2 through 4.4 correspond to the recommended category-based interventions.

Figure 4.1.2 Framework for Population based Health Management [41]



A: Case Management opportunities:
Members with annual total spend greater than $25,000 are considered high cost and should be managed closely. The cut-off value of $25,000 can be modified while doing stratification within Medical Intelligence; we recommend choosing a cutoff point that is consistent with ones individual reinsurance threshold.

B: Disease Management opportunities:
Members with annual spending less than $25,000 are considered low cost. Of the low cost members, those with a disease burden greater than 95% of the population are considered high disease burden, and should be addressed through Disease Management monitoring and intervention. (As with the total cost cutoff, the disease burden cutoff that is chosen can be modified in Medical Intelligence).

Those with a high disease burden and numerous gaps in care (a high CGI) require disease management to reduce gaps and prevent high cost claims. On the other hand, members with high compliance rates - as manifest by a low care gap index should be monitored for continued compliance.

C: Wellness opportunities:
Members with low cost and low disease burden should be primarily addressed through Wellness Programs that reduce the risk factors for developing chronic diseases.

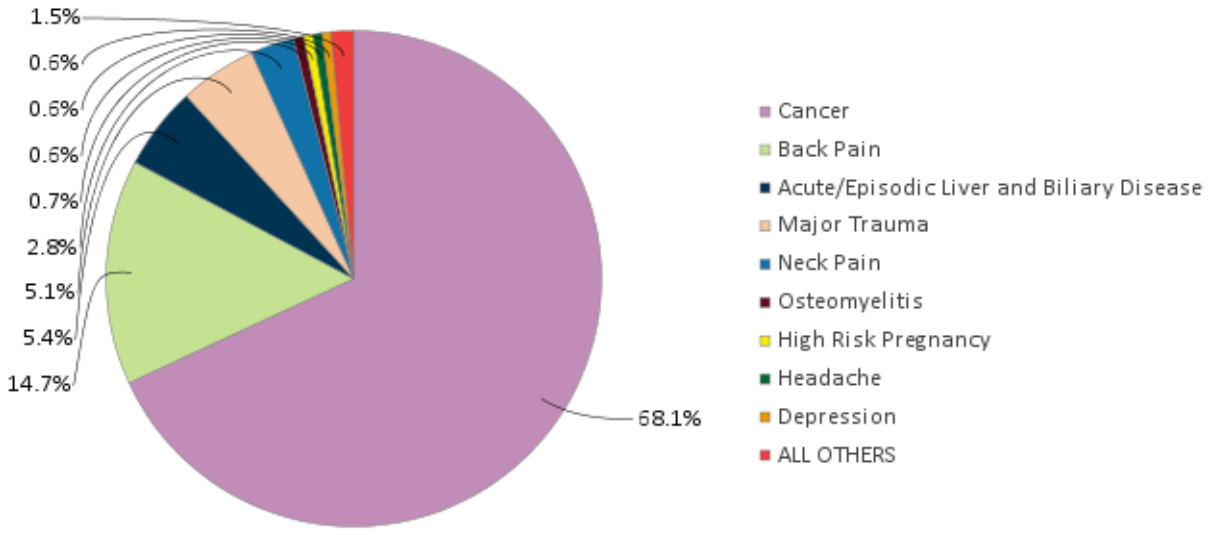
[41] Source: Medical Intelligence : Individuals module / filter on RRS, CGI and Total Paid

4.2 Case Management Opportunities

As discussed in Figure 4.1.2, Verscend uses the RRS, CGI and total cost to stratify a population for Disease Management. Patients who have incurred a high total spend (>$25,000 PMPY) will generally benefit from Case Management. This corresponds to Category "A" in Figure 4.1.2. If the data is sent to Verscend, Medical Intelligence can be used to assess what proportion of high-cost members is currently enrolled in Case Management.

Figure 4.2.1 displays the highest paid diagnoses for members of this population.

Figure 4.2.1 Frequency of primary diagnosis of high cost members (>$25,000 PMPY)



4.3 Disease Management Opportunities

As discussed in Figure 4.1.2, Verscend uses the RRS, CGI and total cost to stratify a population for Disease management. Patients who are low cost, have a high RRS, and have a numerous addressable gaps in care (i.e., have a high CGI) will generally benefit from Disease Management. This corresponds to Category "B" in Figure 4.1.2.

Table 4.3.1 synthesizes the 'clinical condition'/disease severity and the associated Care Gap Index for the entire population across key 'clinical condition'/disease categories into a "heat map". Focused intervention (e.g. an initiative to increase compliance with ace-inhibitors and beta-blockers in patients with heart failure) based on this information can significantly improve health plan performance over time. These Quality & Risk Measures can become the basis for identification and stratification of plan participants for disease management and case management program participation.

Table 4.3.1 Verscend Quality & Risk Measures [42, 43]

	Comparison to Norm	
Clinical Condition	**Risk Variance**	**Care Gap Variance**
Asthma	-5.2%	10.7%
Behavioral Health	-16.8%	2.7%
Cardiac	47.7%	13.2%
COPD	-1.9%	0.2%
Diabetes	23.0%	18.9%
Geriatric	-61.8%	53.4%
Pediatric	-57.0%	56.8%
Pregnancy	-21.4%	106.1%
Renal Failure	57.5%	40.5%

Performance Relative to Norms	**Ranges for Risk Variance**	**Ranges for Care Gap Variance**
Good	<=-10%	<=-5%
Average	>-10% and <10%	>-5% and <5%
Poor	>=10%	>=5%

Risk Variance - Weighted % variance between "Actual % individuals with Risk" and "Norm % individuals with Risk" for all risk related QRMs within a specific clinical condition

Care Gap Variance - Weighted % variance between "Actual % individuals with Care Gap" and "Norm % individuals with Care Gap" for all care gap related QRMs within a specific clinical condition

Please Note: If the underlying CPT codes for each laboratory test or panel are not submitted to Verscend in the medical claims then the compliance in the Quality and Risk Measures will appear lower than they actually are.

[42] ***Note:*** Refer to Table 5.5.3 and 5.5.4 in Appendix 5.5 for further detail.

1. The Risk Variance and Care Gap Variance values are calculated for the members who are eligible on the last day of the custom time period and whether or not they are in a QRM is calculated on the members' full cycle data
2. The results displayed in this table are based on members who were eligible on the last day of the custom time period selected for the group specified by the user (selection on business levels)
3. COPD: Chronic Obstructive Pulmonary Disease

[43] Norm or Verscend Norm in this report refers to the values from Verscend's Commercial Normative database.

Table 4.3.2 identifies the top 25 QRMs that have the highest variance between 'Actual' value and 'Norm' value for '% of Individual with Care Gap'. These QRMs indicate opportunities for better disease management to reduce gaps and prevent high cost claims.

Table 4.3.2 Top 25 QRMs for Gaps in Care [44]

Gaps in Care				% of Individual with Gap/Risk	
Clinical Condition		**Members with Condition**	**Description**	**Actual**	**Norm**
Geriatric	>= 65 years old (E)	279	Patients without long office visit in the last 12 months.	67.74%	20.70%
Misc	Patients with Intervertebral disc disorder or back pain or neck pain, with seizure medication, muscle relaxants, benzodiazepines or opiates	442	Patients with more than 5 prescribing providers for the mentioned drugs	39.59%	0.00%
Pediatric	Pediatric patients with depression started on non-SSRI therapy (E)	6	Patients who did not receive a psychiatrist referral near the time of starting non-SSRI therapy.	50.00%	16.11%
Pediatric	Pediatric patients with depression started on non-SSRI therapy	6	Patients who did not receive a psychiatrist referral near the time of starting non-SSRI therapy.	50.00%	16.15%
Behavioral	Lithium in the last 6 months (E)	16	Patients without serum creatinine test in the last 6 months.	75.00%	44.23%
Behavioral	Behavioral health-related admission in last 6 months (E)	13	Patients without a behavioral health office visit during the last 6 months.	30.77%	5.29%
Behavioral	Lithium in the last 6 months (E)	16	Patients without lithium level in the last 6 months.	81.25%	55.83%
Behavioral	Behavioral health-related admission in last 6 months	13	Patients without a behavioral health office visit during the last 6 months.	30.77%	5.39%
RF	Renal Failure/ESRD-on Dialysis (E)	22	Patients without serum albumin test in the last 12 months.	50.00%	26.31%
Misc	GI bleed-related admission (E)	8	Patients without CBC or hematocrit within 6 weeks of discharge from GI	62.50%	40.56%

[44] ***Note:*** Excluding QRMs related to flu shots and pneumonia and the ones having members with condition less than 5.

Gaps in Care				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
			bleed hospitalization.		
Misc	GI bleed-related admission	8	Patients without CBC or hematocrit within 6 weeks of discharge from GI bleed hospitalization.	62.50%	40.91%
Behavioral	Dilantin in the last 12 months (E)	23	Patients without dilantin level in the last 12 months.	69.57%	48.76%
Behavioral	Patients >=18 y/o with at least one active substance abuse related visit in the last 24 months (E)	7	Patients with only one visit to a behavioral health professional in the last 12 months.	42.86%	22.58%
Behavioral	Depression-related ER visit (E)	35	Patients without outpatient behavioral health office visit(s) during 12 months prior to the ER visit	57.14%	37.62%
Misc	Patients with >= 6 events of otitis media in the last 12 months (E)	22	Patients not receiving a tympanostomy tube in the last 12 months.	68.18%	48.83%
Misc	Patients with >= 6 events of otitis media in the last 12 months	25	Patients not receiving a tympanostomy tube in the last 12 months.	68.00%	48.83%
RF	Renal Failure/ESRD (E)	100	Patients without serum creatinine test in the last 12 months.	31.00%	12.83%
Gen	Diuretic (E)	1,190	Patients without serum potassium level in the last 12 months.	43.45%	25.99%
Gen	Diuretic	1,250	Patients without serum potassium level in the last 12 months.	44.08%	27.06%
Cardiac	CHF (E)	49	Patients without LDL-C or lipid profile test in the last 12 months.	53.06%	36.75%
DM	Diabetes (E)	963	Patients without serum creatinine in the last 12 months.	32.61%	16.45%
Misc	Patients taking Methotrexate in the last 12 months (E)	71	Patients without liver function in the last 12 months	26.76%	11.08%
Behavioral	Depression-related admission (E)	10	Patients without behavioral health office visit within 14 days of discharge.	30.00%	14.40%
RF	Renal Failure/ESRD (E)	100	Patients without lipid profile test in the last 12 months.	51.00%	35.83%
DM	Diabetes (E)	963	Patients without HbA1c test in the last	30.94%	16.23%

Gaps in Care				% of Individual with Gap/Risk	
Clinical Condition		Members with Condition	Description	Actual	Norm
			12 months.		

4.4 Wellness Management Opportunities

As discussed in Figure 4.1.2, Verscend uses the RRS, CGI and total cost to stratify a population for Disease management. Patients who are well are most efficiently addressed through Wellness Programs. This corresponds to Category "C" in Figure 4.1.2.

Table 4.4.1 details screening and preventative tests - and the associated compliance with these tests - for the entire population. These data are benchmarked against the Verscend Commercial Norm. Wellness programs (e.g. an initiative to increase mammogram compliance rates) based on this information can significantly improve health plan performance on these measures.

Table 4.4.1 Preventative Measures [45, 46]

Performance Relative to Verscend Norms	
Good	<=-5%
Average	>-5% and <5%
Poor	>=5%

Group	Condition	Screening/Preventive	Variation from Norm
Both	>= 51 years old (E)	Patients without long office visit in the last 2 years.	27.7%
	>=50 years old (E)	Patients without any colorectal cancer screening in the last 24 months.	1.6%
Male	Men >50 years old (E)	Men without PSA level in the last 2 years (controversial test).	4.5%
Female	Women between 40 and 49 y/o (E)	Women without mammogram in the last 24 months.	0.5%
	Women between 49 and 69 y/o (E)	Women without mammogram in the last 18 months.	2.4%
	Women between 21 and 65 y/o (E)	Women without pap smear in the last 24 months.	0.3%
	Women >20 y/o (E)	Women without pap smear in the last two years.	0.7%
	Women between 40 and 49 y/o (E)	Women without mammogram in the last 2 years.	0.5%
	Women >=49 y/o (E)	Women without mammogram in last 12 months.	2.2%

Please Note: If the underlying CPT codes for each laboratory test or panel are not submitted to Verscend in the medical claims then the compliance in the Quality and Risk Measures will appear lower than they actually are.

*(E) = Enrollment criterion is applied to the Quality and Risk Measure and its Condition

[45] ***Note:*** Refer to Table 5.5.2 in Appendix 5.5 for further detail.

1. The percentage of members for a specific Group, Condition and Screening combination are calculated for the members who are eligible on the last day of the custom time period and whether or not they are in a particular Screening is calculated on the members' full cycle data
2. The results displayed in this table are based on members who were eligible on the last day of the custom time period selected for the group specified by the user (selection on business levels)

[46] Norm or Verscend Norm in this report refers to the values from Verscend's Commercial Normative database.

5 APPENDIX

5.1 Demographics

Table 5.1.1 Breakdown of membership by relationship

	Avg. Age	Members		Total Amount Billed	Employee Paid	Member Expenses	
		Total	Current			Total	% of Total
Employee	47.8	12,921	8,211	$170,667,759	$8,595,466	$62,612,137	46.3%
Spouse	48.4	8,609	5,662	$131,310,549	$6,203,835	$50,698,897	37.5%
Dependent	12.6	10,699	6,475	$50,309,315	$3,348,053	$21,826,970	16.2%
Unknown	21.1	68	5	$25,326	$838	$11,391	0.0%
Total	**36.2**	**32,297**	**20,353**	**$352,312,949**	**$18,148,192**	**$135,149,394**	**100.0%**

5.2 Financial Analyses [47]

Table 5.2.1 Medical and Pharmacy Claims by Month (Apr 14 - Dec 14)

Service Date	Category					
	Medical	Medical PMPM	Pharmacy	Pharmacy PMPM	Total	Total PMPM
Apr-14	$7,439,201	$439	$0	$0	$7,439,201	$439
May-14	$6,955,405	$416	$0	$0	$6,955,405	$416
Jun-14	$7,443,233	$459	$0	$0	$7,443,233	$459
Jul-14	$7,487,985	$470	$0	$0	$7,487,985	$470
Aug-14	$6,478,106	$414	$0	$0	$6,478,106	$414
Sep-14	$6,627,535	$421	$0	$0	$6,627,535	$421
Oct-14	$6,780,810	$433	$0	$0	$6,780,810	$433
Nov-14	$6,382,041	$425	$0	$0	$6,382,041	$425
Dec-14	$7,117,782	$474	$0	$0	$7,117,782	$474
Total	$62,712,098	$439	$0	$0	$62,712,098	$439

Table 5.2.2 Medical and Pharmacy Claims by Month (Apr 15 - Dec 15)

Service Date	Category					
	Medical	Medical PMPM	Pharmacy	Pharmacy PMPM	Total	Total PMPM
Apr-15	$6,272,035	$459	$0	$0	$6,272,035	$459
May-15	$6,041,726	$450	$0	$0	$6,041,726	$450
Jun-15	$5,155,410	$290	$0	$0	$5,155,410	$290
Jul-15	$5,854,421	$335	$0	$0	$5,854,421	$335
Aug-15	$6,227,403	$358	$0	$0	$6,227,403	$358
Sep-15	$5,671,783	$329	$0	$0	$5,671,783	$329
Oct-15	$6,320,678	$367	$0	$0	$6,320,678	$367
Nov-15	$5,850,229	$342	$0	$0	$5,850,229	$342
Dec-15	$6,331,701	$376	$0	$0	$6,331,701	$376
Total	$53,725,386	$363	$0	$0	$53,725,386	$363

[47] ***Note:*** In any of the months or 'Total' column, when Medical MM is not equal to Rx MM in one or both time period(s) (current or prior), Total PMPM is not equal to sum of Medical PMPM and Rx PMPM for that/those time period(s).
Medical PMPM includes Non-PBM drug spend (J-Codes).

Table 5.2.3 Expense Distribution [48]

Band	# Members	Total Member Expenses	Avg. Expense per Member	% Total Paid	
				Actual	Norm
1%	268	$38,429,159	$143,392	28.4%	31.7%
2-5%	1,072	$35,762,674	$33,361	26.5%	27.8%
6-15%	2,681	$30,076,027	$11,218	22.3%	22.2%
16-30%	4,022	$17,244,361	$4,288	12.8%	11.6%
31-60%	8,042	$10,999,132	$1,368	8.1%	6.1%
61-100%	10,724	$2,638,042	$246	2.0%	0.6%
Total	**26,809**	**$135,149,394**	**$5,041**	**100.0%**	**100.0%**

[48] Norm or Verscend Norm in this report refers to the values from Verscend's Commercial Normative database.

This table shows medical claim payments in relation to the date when the claims were incurred (date of service). The table is useful for developing completion factors which allow forward projections of monthly payments and for estimating incurred but not reported (IBNR) claims.

Table 5.2.4 Medical Claim Lag Report [49]

Paid Date	Service Date													
	All Prior	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Total
Apr-15	**$4,875,382**	$1,884,779												**$6,760,161**
May-15	**$1,805,291**	$2,706,685	$1,840,790											**$6,352,765**
Jun-15	**$635,338**	$884,086	$2,935,479	$1,769,395										**$6,224,298**
Jul-15	**$433,455**	$355,992	$586,604	$2,492,938	$1,884,466									**$5,753,454**
Aug-15	**$274,873**	$156,229	$410,628	$468,254	$2,448,305	$1,964,031								**$5,722,321**
Sep-15	**$343,565**	$112,010	$105,601	$202,562	$865,480	$2,814,703	$1,644,737							**$6,088,659**
Oct-15	**$54,386**	$52,691	$74,435	$82,551	$230,527	$639,214	$2,860,470	$2,021,821						**$6,016,096**
Nov-15	**$124,359**	$35,403	$19,585	$68,331	$71,441	$358,587	$615,814	$3,193,531	$1,974,759					**$6,461,808**
Dec-15	**$53,776**	$38,822	$24,460	$29,826	$61,778	$408,936	$192,436	$684,402	$3,082,148	$2,288,820				**$6,865,404**
Jan-16	**$1,365**	$22,271	$15,429	$21,678	$143,389	$24,436	$143,004	$290,169	$427,727	$2,895,397	$1,543,945			**$5,528,811**
Feb-16	**$54,102**	$8,610	$4,941	$17,811	$134,957	$41,617	$138,336	$37,502	$186,293	$654,486	$2,739,596	$1,465,364		**$5,483,613**
Mar-16	**$89,215**	$14,456	$23,776	$2,065	$14,077	($24,120)	$76,986	$93,252	$179,302	$492,998	$823,451	$2,584,625	$1,793,803	**$6,163,887**
Total Plan Paid Medical	**$8,745,108**	**$6,272,035**	**$6,041,726**	**$5,155,410**	**$5,854,421**	**$6,227,403**	**$5,671,783**	**$6,320,678**	**$5,850,229**	**$6,331,701**	**$5,106,992**	**$4,049,988**	**$1,793,803**	**$73,421,277**

[49] ***Note:***

1. Utilization metrics are always calculated on an incurred basis.
2. The last two or three months of the year will show decreased values due to 'claims lag', and should be interpreted with caution.

Table 5.2.5: Medical Claim Lag Report and IBNR

Paid	Incurred													Monthly Paid			Lag	
	0Mths	1Mths	2Mths	3Mths	4Mths	5Mths	6Mths	7Mths	8Mths	9Mths	10Mths	11Mths	12+ Mths	Total	Current 12Mths	Prior 12Mths	Mthly	Qtly
Apr-15	$1,884,779	$3,159,649	$792,377	$413,268	$133,718	$168,187	$49,344	$15,598	$17,116	$32,736	$6,052	$49,962	$37,376	$6,760,161	$1,884,779	$4,875,382	1.37	
May-15	$1,840,790	$2,706,685	$680,997	$846,231	$136,053	$84,693	$14,770	$28,015	($89,536)	$13,185	$5,738	$2,084	$83,061	$6,352,765	$4,547,475	$1,805,291	1.31	
Jun-15	$1,769,395	$2,935,479	$884,086	$251,494	$225,157	$77,970	($868)	$1,795	$9,024	$41,453	$24,744	$2,483	$2,085	$6,224,298	$5,588,960	$635,338	1.21	1.30
Jul-15	$1,884,466	$2,492,938	$586,604	$355,992	$107,786	$43,345	$100,496	$23,127	$36,857	$12,341	($642)	$1,961	$108,185	$5,753,454	$5,319,999	$433,455	1.37	
Aug-15	$1,964,031	$2,448,305	$468,254	$410,628	$156,229	$108,293	$25,308	$8,781	$998	$4,988	$26,558	$1,079	$98,869	$5,722,321	$5,447,447	$274,873	1.31	
Sep-15	$1,644,737	$2,814,703	$865,480	$202,562	$105,601	$112,010	$22,987	$306,781	($6,200)	$34,503	($52,894)	$14,477	$23,912	$6,088,659	$5,745,094	$343,565	1.41	1.37
Oct-15	$2,021,821	$2,860,470	$639,214	$230,527	$82,551	$74,435	$52,691	$21,384	$21,140	$14,436	$14,664	$2,934	($20,172)	$6,016,096	$5,961,709	$54,386	1.04	
Nov-15	$1,974,759	$3,193,531	$615,814	$358,587	$71,441	$68,331	$19,585	$35,403	$82,190	$913	($612)	$2,000	$39,867	$6,461,808	$6,337,449	$124,359	1.18	
Dec-15	$2,288,820	$3,082,148	$684,402	$192,436	$408,936	$61,778	$29,826	$24,460	$38,822	$9,986	$21,490	$4,990	$17,311	$6,865,404	$6,811,628	$53,776	1.19	1.14
Jan-16	$1,543,945	$2,895,397	$427,727	$290,169	$143,004	$24,436	$143,389	$21,678	$15,429	$22,271	$20,978	$11,051	($30,664)	$5,528,811	$5,527,446	$1,365	1.20	
Feb-16	$1,465,364	$2,739,596	$654,486	$186,293	$37,502	$138,336	$41,617	$134,957	$17,811	$4,941	$8,610	$24,276	$29,825	$5,483,613	$5,429,511	$54,102	1.38	
Mar-16	$1,793,803	$2,584,625	$823,451	$492,998	$179,302	$93,252	$76,986	($24,120)	$14,077	$2,065	$23,776	$14,456	$89,215	$6,163,887	$6,074,672	$89,215	1.43	1.34
Total														**$73,421,277**	**$64,676,169**	**$8,745,108**		
Average Monthly Paid														**$6,118,440**				
IBNR in Months																	**1.28**	

	Projected IBNR Based on Last Month's Lag	Projected IBNR Based on Last Quarter's Lag	Projected IBNR Based on Last Year's Average Lag
Incurred and Paid in Current Period	$64,676,169	$64,676,169	$64,676,169
Lag Factor	1.43	1.34	1.28
Incurred and Paid as a % of Total	0.88	0.89	0.89
Total Incurred	$73,393,751	$72,776,697	$72,410,326
Projected IBNR	$8,717,582	$8,100,528	$7,734,157

Table 5.2.6 Network Utilization and Contract Discount Summary

Network	Total					
	Claims Billed	Claims Allowed	Claims Paid	Employee Contribution	Network Discount	% Discount
All In Network	$336,612,730	$135,380,899	$128,214,508	$16,171,494	$146,570,926	43.5%
All Out-of-Network	$15,700,220	$7,624,470	$6,934,887	$1,976,699	$3,664,514	23.3%
Total	**$352,312,949**	**$143,005,369**	**$135,149,394**	**$18,148,192**	**$150,235,439**	**42.6%**

5.3 Disease Fingerprint

Table 5.3.1 presents utilization patterns of members with chronic conditions, ranked by number of members, for total office visits, emergency room visits and hospital admissions.

Table 5.3.1 Chronic Conditions Utilization Summary

Chronic Condition	# of Members	Members per 1000	Office Visits per 1000	ER Visits per 1000	Admissions per 1000	PMPY
Hypertension	1,951	123.0	7,046.4	288.2	112.6	$7,716.09
Hyperlipidemia	1,683	106.1	7,006.9	217.9	75.8	$6,389.88
Diabetes	943	59.4	8,075.9	346.0	155.9	$11,083.29
Osteoarthritis	631	39.8	10,722.9	395.1	202.1	$13,046.46
Asthma	477	30.1	7,830.3	477.5	126.7	$7,566.68
Coronary Artery Disease (incl. MI)	354	22.3	8,670.9	530.1	261.1	$14,806.04
Congenital Anomalies	214	13.5	8,620.9	370.8	192.9	$14,514.58
Chronic Obstructive Pulmonary Disease	147	9.3	10,742.2	644.6	349.8	$15,573.03
Cerebrovascular Disease	137	8.6	9,929.8	895.3	429.4	$21,608.24
Chronic Liver and Biliary Disease	117	7.4	9,936.9	746.4	357.7	$19,147.11
Rheumatoid Arthritis	105	6.6	10,912.0	303.1	157.0	$13,216.27
Atrial Fibrillation	90	5.7	10,281.3	669.1	411.3	$17,858.53
Inflammatory Bowel Diseases	85	5.4	8,878.4	711.2	381.8	$22,252.10
Chronic Renal Failure	80	5.0	10,235.3	698.8	416.5	$29,044.80
Osteoporosis	73	4.6	12,288.8	531.1	232.9	$16,817.56
Coagulopathy	71	4.5	11,822.4	977.1	657.3	$42,403.50
Bipolar Disorder	63	4.0	14,809.0	1,257.6	340.8	$12,658.16
Immune Disorders	48	3.0	17,235.2	764.8	778.0	$65,683.52
Congestive Heart Failure	45	2.8	12,726.5	1,304.9	941.7	$36,197.78
Demyelinating Diseases	43	2.7	8,663.4	117.1	14.6	$19,604.92
Ulcerative Colitis	39	2.5	8,098.3	468.2	260.1	$12,175.16
Cirrhosis	23	1.4	7,422.7	587.6	556.7	$19,886.19
Major Organ Transplant	16	1.0	9,383.9	568.7	540.3	$44,475.55
HIV/Aids	9	0.6	6,702.7	270.3	162.2	$16,539.76
Schizophrenia	8	0.5	16,714.3	214.3	142.9	$6,125.36
Parkinson's Disease	5	0.3	9,391.3	208.7	0.0	$13,942.84
Chronic Pancreatitis	4	0.3	10,392.9	750.0	428.6	$16,246.32
Cystic Fibrosis	2	0.1	8,571.4	571.4	571.4	$83,587.28
Gaucher's Disease	1	0.1	4,000.0	800.0	800.0	$9,653.48
Sickle Cell Anemia	1	0.1	8,000.0	4,000.0	0.0	$11,553.44

Note:

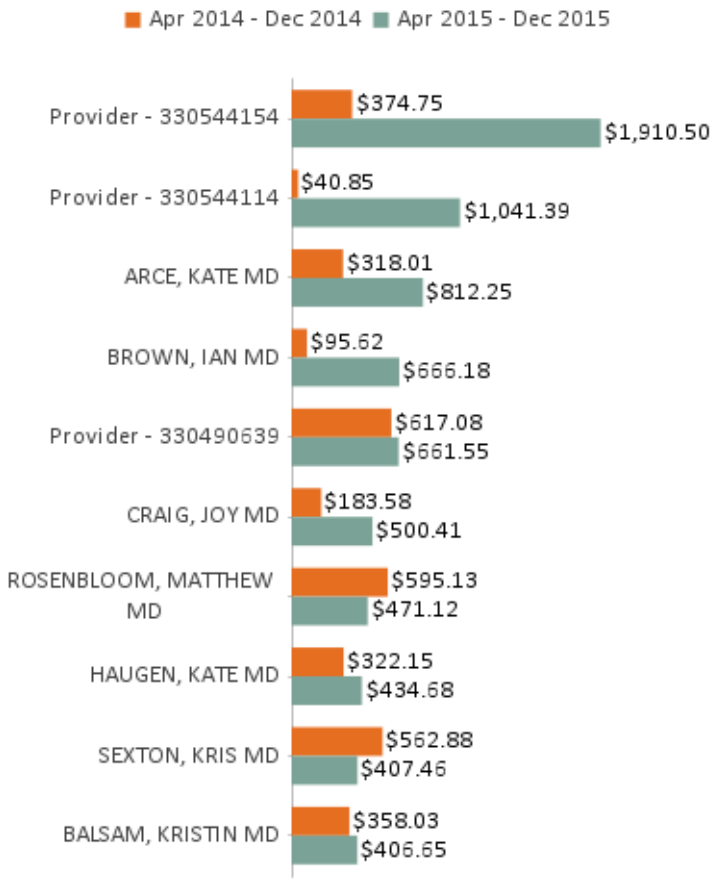
1. In this table a member can have multiple chronic conditions.
2. The results displayed in this table are based on claims incurred.

5.4 "Top 10" Analysis

5.4.1 Providers

Table 5.4.1 shows the top 10 providers, based on medical claim expenses, providing services to the members of your population. The providers generating the most claim expenses are usually institutional. Network changes or changes in provider reimbursement strategy may cause previous period to current period percentage changes.

Table 5.4.1 Total Plan Paid ($K) by Providers



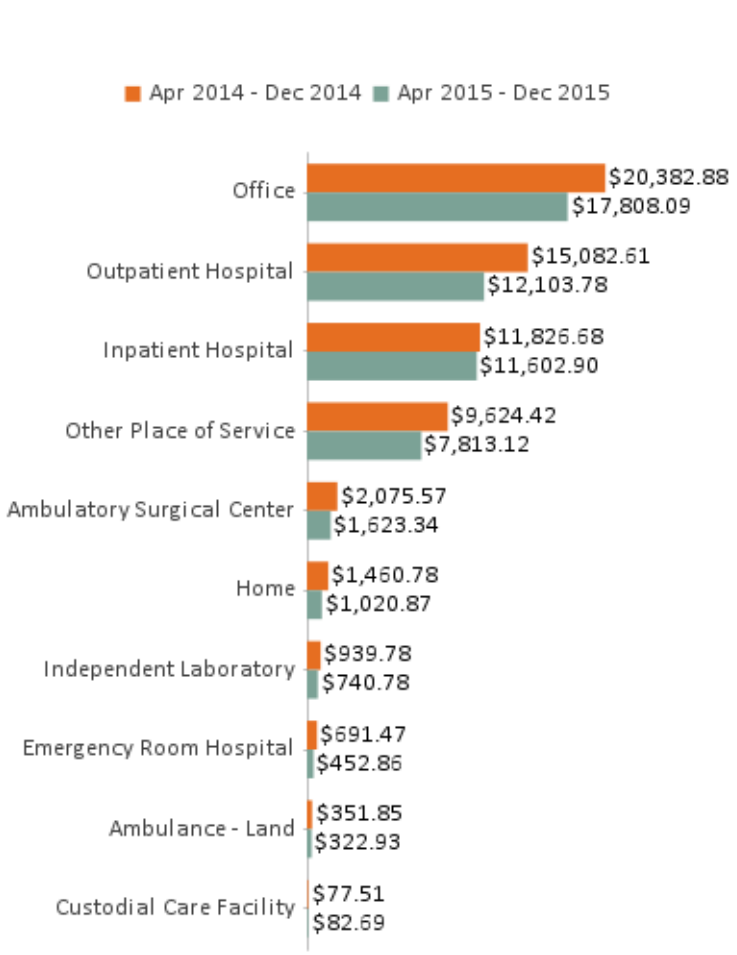
% of Total Plan Paid Apr 2015 - Dec 2015	% Change in Plan Paid
3.6%	**409.8%**
1.9%	**2,449.5%**
1.5%	**155.4%**
1.2%	**596.7%**
1.2%	**7.2%**
0.9%	**172.6%**
0.9%	**-20.8%**
0.8%	**34.9%**
0.8%	**-27.6%**
0.8%	**13.6%**

Provider	Apr 2014 - Dec 2014		Apr 2015 - Dec 2015		% Change in Plan Paid
	Plan Paid	% of Total Plan Paid	Plan Paid	% of Total Plan Paid	
Subtotal	$3,468,074	5.5%	$7,312,222	13.6%	110.8%
All Others	$59,244,024	94.5%	$46,413,164	86.4%	-21.7%
Total	$62,712,098	100.0%	$53,725,386	100.0%	-14.3%

5.4.2 Places of Service

Table 5.4.2 shows places of service ranked according to medical claim expenses. Previous period to current period percentage changes in Place of Service can be helpful when investigating changes in utilization patterns or when trying to understand the impact of plan design change. Increases in some categories may be appropriate. For example, outpatient hospital experience and office visits may increase as inpatient hospital services are more efficiently provided in the outpatient setting. Places of service experiencing large increases for many employers are Emergency Room, Outpatient Hospital, and Laboratory services.

Table 5.4.2 Total Plan Paid ($K) by Place of Service



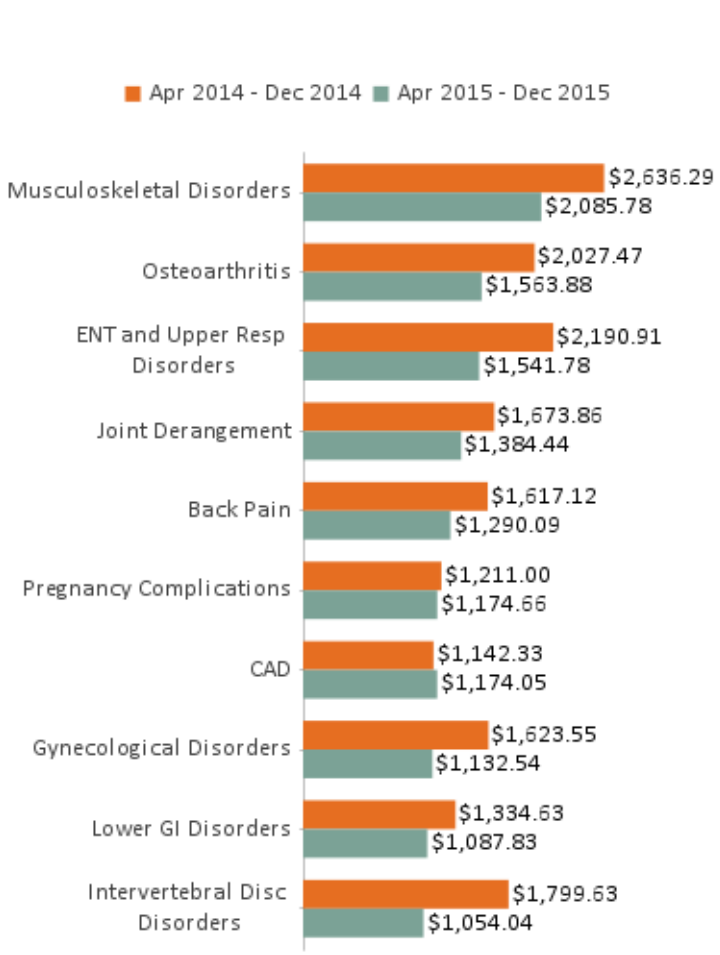
% of Total Plan Paid Apr 2015 - Dec 2015	% Change in Plan Paid
33.1%	**-12.6%**
22.5%	**-19.8%**
21.6%	**-1.9%**
14.5%	**-18.8%**
3.0%	**-21.8%**
1.9%	**-30.1%**
1.4%	**-21.2%**
0.8%	**-34.5%**
0.6%	**-8.2%**
0.2%	**6.7%**

Service	Apr 2014 - Dec 2014		Apr 2015 - Dec 2015		% Change in Plan Paid
	Plan Paid	% of Total Plan Paid	Plan Paid	% of Total Plan Paid	
Subtotal	$62,513,550	99.7%	$53,571,352	99.7%	-14.3%
All Others	$198,548	0.3%	$154,034	0.3%	-22.4%
Total	$62,712,098	100.0%	$53,725,386	100.0%	-14.3%

5.4.3 Diagnostic groups

Table 5.4.3 shows the top 10 diagnostic groups ranked according to medical claim expenses. Grouping of data into broad diagnostic categories assists in the identification of illness patterns that are unique to your population. Diagnostic groups with significant previous period to current period increases should be examined in more detail. The distribution will be different depending on whether the group in question is Medicaid, Medicare or commercial. For a commercial population, diagnostic groups usually at or near the top of the list include ENT and upper respiratory disorders, gynecological disorders, and musculoskeletal conditions.

Table 5.4.3 Total Plan Paid ($K) by Diagnostic Groups



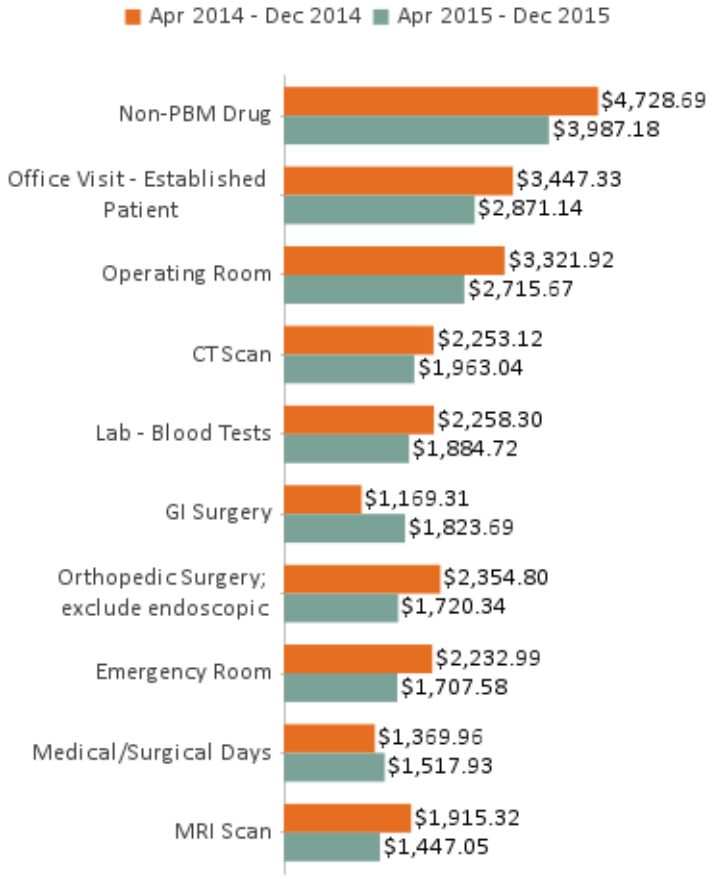
% of Total Plan Paid Apr 2015 - Dec 2015	% Change in Plan Paid
3.9%	**-20.9%**
2.9%	**-22.9%**
2.9%	**-29.6%**
2.6%	**-17.3%**
2.4%	**-20.2%**
2.2%	**-3.0%**
2.2%	**2.8%**
2.1%	**-30.2%**
2.0%	**-18.5%**
2.0%	**-41.4%**

Diagnostic Group	Apr 2014 - Dec 2014		Apr 2015 - Dec 2015		% Change in Plan Paid
	Plan Paid	% of Total Plan Paid	Plan Paid	% of Total Plan Paid	
Subtotal	$17,256,790	27.5%	$13,489,086	25.1%	-21.8%
All Others	$45,455,308	72.5%	$40,236,300	74.9%	-11.5%
Total	$62,712,098	100.0%	$53,725,386	100.0%	-14.3%

5.4.4 Procedure groups

Table 5.4.4 shows the top 10 procedures, ranked according to medical claim expenses. For purposes of health plan analysis, previous period to current period percentage changes may be more important than absolute dollars. Changes in membership must be considered when any such analysis is performed. Many employers are considering contracting with free-standing lab/x-ray facilities to better manage the growth in these areas.

Table 5.4.4 Total Plan Paid ($K) by Procedure Groups



% of Total Plan Paid Apr 2015 - Dec 2015	% Change in Plan Paid
7.4%	**-15.7%**
5.3%	**-16.7%**
5.1%	**-18.2%**
3.7%	**-12.9%**
3.5%	**-16.5%**
3.4%	**56.0%**
3.2%	**-26.9%**
3.2%	**-23.5%**
2.8%	**10.8%**
2.7%	**-24.4%**

Procedure Group	Apr 2014 - Dec 2014		Apr 2015 - Dec 2015		% Change in Plan Paid
	Plan Paid	% of Total Plan Paid	Plan Paid	% of Total Plan Paid	
Subtotal	$25,051,738	39.9%	$21,638,335	40.3%	-13.6%
All Others	$37,660,360	60.1%	$32,087,051	59.7%	-14.8%
Total	$62,712,098	100.0%	$53,725,386	100.0%	-14.3%

20. **What resources do you use to analyze medical and pharmacy claims?**

    We utilize Verscend Technologies to analyze medical and pharmacy claims. See full description of this in attachment to question 19.

21. **Describe your experience managing employee claims escalation.**

    Each client is assigned a CBIZ employee advocate whose responsibility is to assist covered employees and dependents with their claims issues. The advocate will:

    - Collect all relevant data from effected individual
    - Determine any extenuating circumstances
    - Develop plan for resolution
    - Contact all involved carriers, administrators, vendors and providers
    - Determines possibility of successful resolution
    - Work through to resolution
    - If no favorable resolutions assist with appeal filing and process through to find judgement
    - Maintain case log

22. **Describe your experience assisting clients with complicated administrative issues and fostering positive resolution.**

    All of our clients refer conflicted administrative issues to us for resolution:

    - We take over immediately
    - We contact vendor and drill down on the particulars, i.e. the who, what, where and why of it
    - We develop best possible scenarios for the client
    - We negotiate with the vendor as needed
    - We develop work around solutions if needed
    - We maintain a weekly activity log
    - We provide necessary training if needed
    - We document all final resolutions

23. **Describe experience with hourly employees and benefits administration.**

    A significant number of CBIZ clients have both bargaining and non-bargaining unit hourly employees.

    - We assist employer in preparing for any CBA negotiations to include projected modeling for plan designs and cost
    - Employee advocates are assigned
    - Payroll practices are reviewed and benefit payroll deductions integrated into the HRIS platform
    - Variable hourly ACA testing practices and procedures are discussed and formalized
    - Customized communication and enrollment practices are developed

Special Services

24. **Describe your standard package of employee communications services. Please provide samples.**

The role of employee communication is to educate, inform, and promote employee goodwill. It can inject a consumer focus and foster a sense of shared responsibility. Most importantly, it can change perceptions and influence employee actions. At the outset, we will identify specific short-term and long-term communication objectives, and identify ways to make small but measurable change now that will ultimately lead to long-term, sustained change. Your dedicated Account Executive will develop customized employee communications and is supported by our national marketing team and resources. It is important to recognize that there will likely be several different segments of the Pike employee population, and each segment might require a different approach with respect to employee communications.

Communication Strategy

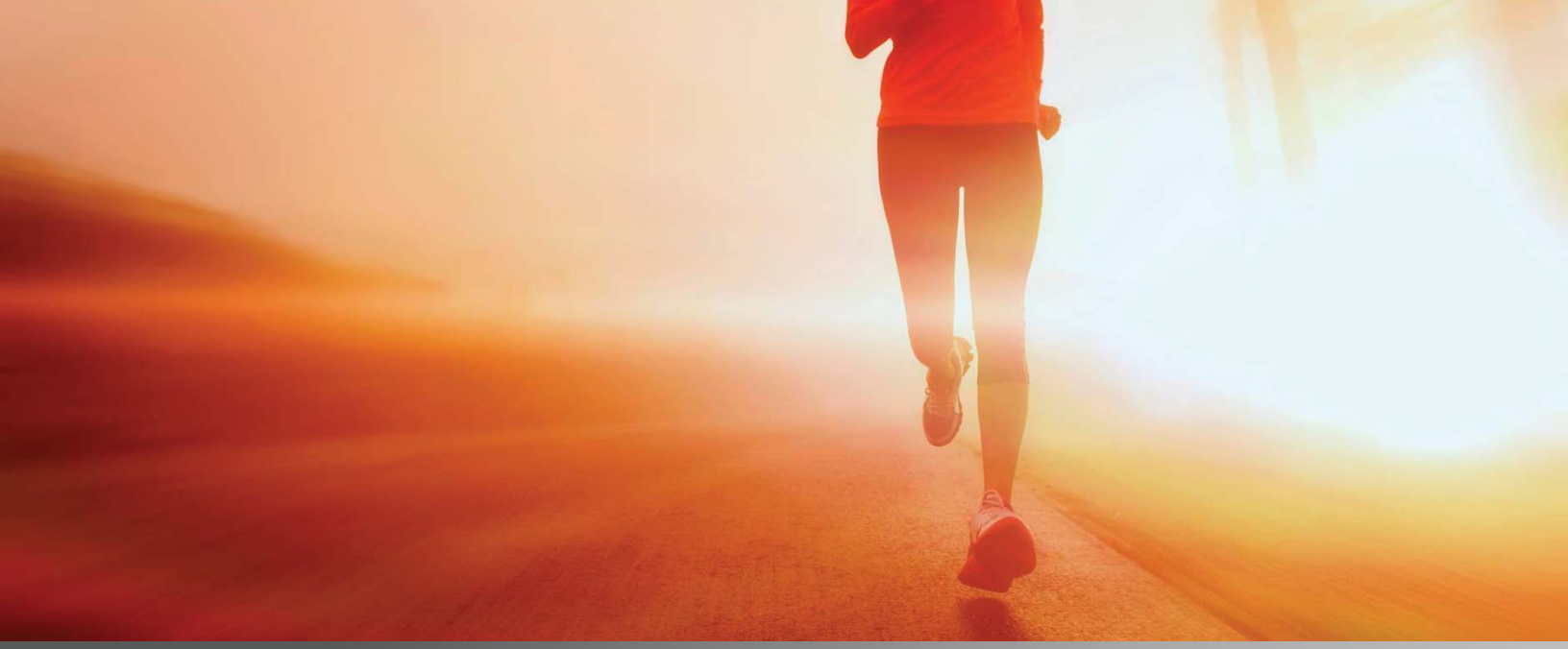
In devising a communication strategy, we will:

- Examine your business and benefits landscape including demographics, culture, mission, and values
- Define objectives and desired outcomes, i.e. employee engagement and accountability, enrollment and utilization
- Assess recent communication efforts – what works and why?
- Explore available communication channels including online resources at home and at work
- Develop messaging and identify appropriate mix of media (where appropriate, link benefit messages to organizational values and vision)
- Leverage internal resources/peer opinion leaders to enhance credibility and ensure consistent messages

Available media include printed materials, web content, audio-visual, and face-to-face meetings, depending upon your preference and your internal capabilities. Materials may include newsletters, benefit decision guides, benefit books, announcement campaigns, wellness bulletins, summary plan descriptions, web blast announcements, online summaries. CBIZ will design customized communications for Summit Medical Group's employee population based on HR's feedback and input.

We take a multi-faceted approach to communications to ensure outreach to all levels of employees at all locations. The following are tools we employ to ensure maximum outreach:

- Benefit Contact Cards – a plastic ID card which serves as a single resource with contact information for any or all Summit Medical Group carriers.
- Brainshark – a web based tool we are able to embed into your Oracle Benefit Administration system which provides an open enrollment video presentation for the viewing pleasure of the employees and spouses. The system has the ability to include common questions in the middle of the presentation to ensure attentiveness. The resource is valuable at time of orientation or open enrollment and at no cost.
- FlippingBook Publisher - An interactive publication created to streamline communications. Please see line for an example. https://user-O8AIbHk.cld.bz/CBIZ-ESO-Atlanta
- Direct or E-mail Custom Communications – As needed we are able to create custom pieces to fit the topic of discussion
- Benefit Booklets – a comprehensive booklet to include all of the required compliance language, and benefits provided by Summit Medical Group
- In-Person Meetings – As required and needed
- Bi-Lingual Communications – As required and needed



2017 Benefit Guide

An Overview of Your Benefits

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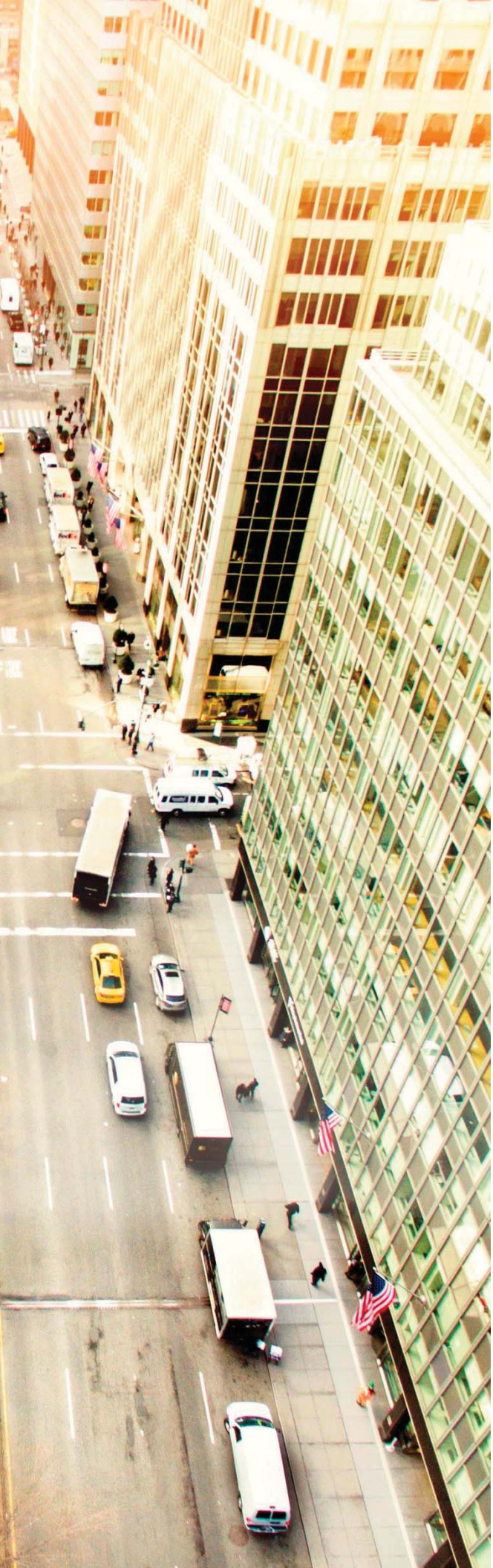

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Welcome to your 2017 Employee Benefits

We recognize the important role employee benefits play as a critical component of overall compensation. We continue to make every effort to target the best quality benefit plans for our staff and their families. Our program offers a range of plan options to meet the needs of our diverse workforce. We know that your benefits are important to you and your family. This program is designed to assist in providing for the health, well-being and financial security of you and your covered dependents.

Benefits Guide Overview

XYZ is proud to be able to offer a high quality menu of benefit choices, and the freedom to select coverage that will fit your insurance needs and your budget. This Benefit Guide, along with your benefit plan summaries provides an outline of the XYZ benefits that are available to you and your family.

Please elect your benefits carefully since, in most cases, changes in your enrollment can only be made during the annual open enrollment period. The benefit elections you select during open enrollment remain in effect for the entire calendar year, unless you have an IRS qualified change in status. Qualifying events include a change in marital status, dependent status, employment status and other IRS defined events. You must make your new election within 30 days of the date of the qualifying event.

We are constantly striving to provide you and your families with a superior enrollment process and benefit packages. Please keep this book as an employee benefits reference guide. It contains general information regarding your benefits and important carrier information.

Your XYZ Benefits

XYZ offers both 100% company-paid and voluntary health and welfare benefits. If you choose to participate in the voluntary plans, you pay the cost through payroll deductions.

100% Company-paid Benefits

- Basic Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance
- Basic Dependent Life Insurance
- Short Term Disability
- Long Term Disability
- Employee Assistance Program (EAP)
- Business Travel Accident Insurance
- Health Advocate

Your XYZ Benefits Continued.

Voluntary Benefit Options

- Medical
- Dental
- Vision
- Supplemental Employee Life Insurance
- Supplemental Dependent Life Insurance
- Supplemental AD&D Insurance
- Health Savings Account (HSA)
- Flexible Spending Accounts (FSA)
  - Health Care FSA
  - Dependent Care FSA
- Tax-free Transportation Programs
  - Parking
  - Mass Transit
- Long-term Care Insurance
- Accident Insurance
- Critical Illness Insurance
- Hospitalization Insurance Plan
- Identity Theft
- Life Events Legal Plan

Who Is Eligible?

If you are a regular, full-time employee scheduled to work at least 30 hours per week, you are eligible for benefits on the first day of the month following your date of hire. This includes you, your legally dependent children, spouse and /or domestic partner.

Eligible Dependents

Dependents you can cover include:

Your legal spouse

Your child(ren)*

- For medical, dental, vision and life insurance coverage only: Children up to age 26, regardless of whether they quality as your tax dependent, marital or student status
- Age 26 or older if they are primarily supported by you and are physically or mentally incapable of self- support

*Eligible children include your own children, stepchildren who live with you at least six months of the year, legally adopted children and children for whom you have legal guardianship.

Employees have the ability to enroll their domestic partners and children of domestic partners in the XYZ benefit plans. The tax implications, however, for domestic partners and dependents of domestic partners are different from those of legally married spouses and dependent children.

When an employer provides health care benefits for the spouse or dependents of an employee, the IRS allows the money paid by the employer for these benefits to be excluded from the employee's gross income. No such exclusion exists, however, for benefits of an employee's domestic partner or dependents of a domestic partner. The money paid by an employer for the health care benefits for an employee's domestic partner and dependents of a domestic partner is taxable income.

Neither a domestic partner, nor the children of a domestic partner (who are not dependents of the employee), are eligible to receive tax-favored benefits through a cafeteria plan.

Your XYZ Benefits Continued

Changing Benefits

You may make changes to your benefit elections outside of the Annual Enrollment period only when you have a qualified change in status. Qualified changes in status are life events as shown below:

- Marriage, legal separation or divorce
- Death of your spouse or dependent
- Birth or adoption of a child
- Termination of employment by your spouse or his/her obtainment of new employment, when either results in a loss or gain of benefits
- A change in employment status from full-time to part-time (or vice versa) by you or your spouse, when either results in a loss or gain of benefits
- Disqualification of a child as an eligible dependent due to age
- A change in residence that affects eligibility

Only benefit changes that are consistent with the qualified change in status are permitted, and these changes must be made within 31 days.* Benefits will be effective the first of the month following the date of the qualified event (with the exception of birth, adoption and legal guardianship of a dependent; these events will have benefits effective on the date of birth, placement of the child or the date legal guardianship is obtained). You are responsible for notifying the corporate Benefits Department of any changes, and you must provide the necessary paperwork within 31 days. Visit www.fisandme.com for more information.

**Employees or dependents covered under Medicaid or a Children's Health Insurance Program (CHIP) plan have 60 days after loss of benefits under such plan to submit the necessary paperwork to request coverage. Also, employees or dependents have 60 days after the eligibility determination date to submit the necessary paperwork to cease their employer benefits once they become eligible for Medicaid or CHIP assistance.*

UNDERSTANDING
YOUR MEDICAL PLAN

The following medical plans provide the framework for your good health and wellbeing. XYZ medical benefits are provided by United HealthCare. Employees may select either the HDHP with HSA plan, the Base Plan, the Buy Up Plan, or waive coverage altogether.

Qualified High Deductible Health Plan with HSA

Our High Deductible Health Plan (HDHP) is administered by United Health Care (UHC). This plan allows you to receive care from any medical provider, but pays higher benefits when you use UHC's PPO providers. With PPO providers, you pay an annual deductible and then the plan pays 100% of the cost of eligible services. If you do not use a PPO provider, you pay a higher deductible and then the plan pays 80% of the cost of eligible services. You pay the remaining cost until your deductible and coinsurance payments reach an annual payment limit. Once you reach this limit, the plan pays 100% of your eligible expenses for the rest of the year (excluding charges that are not otherwise covered by the plan).

If you choose to receive care from a non-PPO provider, you are also responsible for obtaining precertification for hospital, treatment facility and convalescent facility admissions; home health care; hospice care and private duty nursing.

Base Plan

XYZ's Base Plan option is an Exclusive Provider Organization (EPO). The Base Plan is a managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency). If you use a doctor or facility that isn't in the network, you may have to pay the full cost of the services provided.

Buy Up Plan

XYZ's National Buy Up Plan is a Preferred Provider Organization Plan (PPO). The Buy Up Plan gives you the option to use network providers and receive the highest level of coverage, or non-network providers and pay more for services.

C PLAN COMPARISON 2017

	QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (HDHP with HSA)		CHOICE PLUS BASE PLAN	CHOICE PLUS BUY UP PLAN	
BENEFIT	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible					
Individual	$1,500	$3,000	None	None	$1,000
*Family**	$3,000	$6,000			$2,000
Annual Out-of-Pocket Maximum *(Includes Deductible and all co-pays)*					
Individual	$4,000	$6,000	$1,250	$1,250	$4,000
*Family**	$8,000	$12,000	$3,750	$3,750	$8,000
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Office Visits	100% after deductible	80% after deductible	$20 co-pay per visit	$20 co-pay per visit	Plan pays 80% after Deductible
Specialist Office Visits	100% after deductible	80% after deductible	$40 co-pay per visit	$40 co-pay per visit	Plan pays 80% after Deductible
Urgent Care	100% after deductible	80% after deductible	$50 co-pay per visit	$50 co-pay per visit	Plan pays 80% after Deductible
Emergency Room	100% after deductible	100% after deductible	$100 co-pay (Waived if admitted)	$100 co-pay (Waived if admitted)	$100 co-pay (Waived if admitted)
Maternity Physician Services	100% after deductible	80% after deductible	$20 co-pay (First office visit only)	$20 co-pay (First office visit only)	Plan pays 80% after Deductible
Hospital Inpatient Expenses	100% after deductible	80% after deductible	$500 co-pay per inpatient stay	$500 co-pay per inpatient stay	Plan pays 80% after Deductible
Hospital Outpatient Expenses	100% after deductible	80% after deductible	Plan pays 100%	Plan pays 100%	Plan pays 80% after Deductible
Outpatient Therapies *(ex: physical, speech and occupational) 20 visits maximum per calendar year*	100% after deductible	80% after deductible	$20 co-pay	$20 co-pay per visit	Plan pays 80% after Deductible
Chiropractic Care	100% after deductible	80% after deductible	$20 co-pay	$20 co-pay per visit	Plan pays 80% after Deductible
Mental Health/Behavioral Treatment Services	100% after deductible	80% after deductible	Inpatient: $500 co-pay per inpatient stay Outpatient Services: $20 co-pay per visit	Inpatient: $500 co-pay per stay Outpatient: $20 co-pay per visit	Plan pays 80% after Deductible
Durable Medical Equipment *Limited to 1 type of DME (including repair/replacement) every 3 years*	100% after deductible	80% after deductible *(Pre-authorization required for charges over $1,000)*	Plan pays 100%	Plan pays 100%	Plan pays 80% after Deductible *(Pre-authorization required for charges over $1,000)*
Prescription Drugs *Please note that you must first meet your medical deductible before any Rx co-pays will be applied.**					
Retail Pharmacy *(31 day supply)*	$10 for Tier 1 drugs $35 for Tier 2 drugs $60 for Tier 3 drugs	$10 for Tier 1 drugs $35 for Tier 2 drugs $60 for Tier 3 drugs	$10 for Tier 1 drugs $30 for Tier 2 drugs $50 for Tier 3 drugs	$10 for Tier 1 drugs $30 for Tier 2 drugs $50 for Tier 3 drugs	$10 for Tier 1 drugs $30 for Tier 2 drugs $50 for Tier 3 drugs
Mail Order Maintenance Drug *(90 day supply)*	$25 for Tier 1 drugs $87.50 for Tier 2 drugs $150 for Tier 3 drugs	Not covered	$25 for Tier 1 drugs $75 for Tier 2 drugs $125 for Tier 3 drugs	$25 for Tier 1 drugs $75 for Tier 2 drugs $125 for Tier 3 drugs	Not Covered
	*In addition to the post tax contributions, a portion of the premium for DP and dependents of DP will be taxable income to the employee. These amounts are $198.50 for DP coverage only and $431.69 for DP and dependent coverage (per semi monthly pay period).		*In addition to the post tax contributions, a portion of the premium for DP and dependents of DP will be taxable income to the employee. These amounts are $277.26 for DP coverage only and $494.24 for DP and dependent coverage (per semi monthly pay period).	*In addition to the post tax contributions, a portion of the premium for DP and dependents of DP will be taxable income to the employee. These amounts are $217.87 for DP coverage only and $473.88 for DP and dependent coverage (per semi monthly pay period).	

*The Family Deductible and Family Out-of-Pocket Maximum are now embedded. No one family member enrolled in the HDHP plan will be responsible for more than the individual deductible or individual out-of-pocket maximum.

2017 MEDICAL CONTRIBUTIONS

	Semi - Monthly Contributions	Pre Tax	Post Tax
QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (HDHP with HSA)	*Employee*	$57.61	N/A
	Employee + 1	$110.95	N/A
	Family	$173.61	N/A
	*Domestic Partner (DP)**	N/A	$53.34
	*DP & DP Child(ren)**	N/A	$116.00
	Semi - Monthly Contributions	**Pre Tax**	**Post Tax**
CHOICE PLUS BASE PLAN	*Employee*	$64.73	N/A
	Employee + 1	$124.65	N/A
	Family	$195.05	N/A
	*Domestic Partner (DP)**	N/A	$59.92
	*DP & DP Child(ren)**	N/A	$130.32
	Semi - Monthly Contributions	**Pre Tax**	**Post Tax**
CHOICE PLUS BUY UP PLAN	*Employee*	$96.28	N/A
	Employee + 1	$185.44	N/A
	Family	$290.12	N/A
	*Domestic Partner (DP)**	N/A	$89.16
	*DP & DP Child(ren)**	N/A	$193.84

UNDERSTANDING
YOUR HSA

If you enroll in the QHDHP plan, you are eligible to set-up an individual Health Savings Account (HSA) at the bank or investment company of your choice. You can deposit money into your HSA and lower your taxable income at time of filing.

An HSA is an employee-owned account that allows you to set aside money for eligible medical expenses (including vision and dental expenses) incurred this year or in future years. Your contributions to the account are tax-exempt, so you can save on taxes when you participate. Unlike a Flexible Spending Account, any unused balance in your HSA rolls over from year to year—there is no "use it or lose it" rule. *We recommend that you see your tax advisor for additional information on the tax advantages this account may offer you.*

You must be enrolled in the Qualified High Deductible Health Plan in order to contribute to an HSA. In future years, if you decide to dis-enroll from the QHDHP, you can continue to use any money in your HSA for qualified medical expenses, but you are ineligible to contribute any additional funds to the account.

If you ever withdraw funds from the account for non-medical expenses, you will be subject to a penalty. At age 65, however, any unused funds in your HSA can be withdrawn without penalty for non-medical purposes. If you withdraw the funds from your HSA after age 65, you would be subject to normal income tax on the money in the account, but you would not be limited to using the money for just medical expenses.

There are limits to how much you can contribute to your HSA each calendar year. For 2017, the contribution limits are:

	Under Age 55	Age 55+ ($1,000 Catch Up)
Individual	$3,400	$4,400
Family	$6,750	$7,750

If you enroll in the QHDHP and open an HSA, you will not be eligible to enroll in the medical portion of the Flexible Savings Account (FSA). **You will be able to participate in other portions of the plan such as parking and transit and dependent care reimbursement.**

Your HSA

Please use the list on the next page as a guide to help you determine whether a medical expense is qualified or not for an HSA distribution.

UNDERSTANDING
YOUR DENTAL PLAN

Aetna Dental®

Smiles happen when XYZ employees enroll in a dental plan from Aetna Dental. XYZ dental benefits are provided by Aetna. You may select either the DMO Plan, which provides in-network coverage only and utilizes a smaller network of providers, or the PPO Plan which provides both in-network and out-of-network coverage.

The Passive PPO dental plans give you the freedom to choose either a participating network dentist or an out-of-network dentist. Typically you benefit from considerable cost savings when using a dentist who is in the network.

**Employees may change between dental plans at any point during the plan year. Any change will take effect on the first day of the month following the request for change.*

Type of Plan	DMO PLAN	PASSIVE PPO PLAN	
	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK
Deductible			
Individual	None	$50	$50
Family	None	$150	$150
Annual Maximum Benefit	None	$1,500	
Preventive Services *(oral exam, cleaning, x-rays)*	100%	100%	
Basic Services *(fillings, root canal, oral surgery)*	100%	Plan pays 80% after Deductible	Plan pays 80% after Deductible
Major Services *(crowns, dentures, endo, periodontal)*	Plan pays 60%	Plan pays 50% after Deductible	Plan pays 50% after Deductible
Orthodontia *(Adult and child coverage)*	$2,000 copay	$50 deductible, Plan pays 50% up to $1,000 annual maximum	
Semi-Monthly Contributions	**Pre Tax**		**Post Tax**
Employee	$9.10		N/A
Employee + 1	$17.16		N/A
Family	$23.92		N/A
Domestic Partner (DP)*	N/A		$8.06
DP & DP Child(ren)*	N/A		$14.82

UNDERSTANDING
YOUR VISION PLAN

XYZ is pleased to offer vision benefits through EyeMed Vision Care. With EyeMed, you have the freedom to choose from an extensive network of private practice optometrists, ophthalmologists, opticians or from leading optical retailers.

Please note that EyeMed does not issue Identification Cards. Your provider can contact EyeMed directly to verify benefits.

XYZ utilizes the EyeMed Select vision network.

	IN-NETWORK	OUT-OF-NETWORK
Eye Exam	*1 every 12 months*	
	$10 co-pay	Up to $30 allowance
Prescription Lenses	*1 pair every 12 months*	
Single	$10 co-pay	Up to $25 allowance
Bifocal	$10 co-pay	Up to $40 allowance
Trifocal	$10 co-pay	Up to $60 allowance
Progressive	*Premium*: $75 co-pay plus 80% of charge (less $120 allowance) *Standard*: $75 co-pay	Up to $40 allowance
Frames	*1 every 12 months*	
	Up to $140 allowance plus 20% off any amount over allowance	Up to $70 allowance
Contact Lens	*1 every 12 months in lieu of lenses and frames*	
Elective	*Conventional*: Up to $130 allowance plus 15% off any amount over allowance *Disposable*: Up to $130 allowance	Up to $104 allowance
Fit and Follow up Exam *(Comprehensive eye exam must be completed first)*	*Standard*: Up to $40 allowance *Premium*: 10% off retail price	Up to $104 allowance
Network Providers	Cohen Fashion	Eye to Eye
	Lenscrafters	Pearl Vision
	Sears Vision	JC Penny Optical
Semi-Monthly Contributions	Pre Tax	Post Tax
Employee	$2.10	N/A
Employee + 1	$2.89	N/A
Family	$4.99	N/A
*Domestic Partner (DP)**	N/A	$0.79
*DP & DP Child(ren)**	N/A	$2.89

*In addition to the post tax contributions, a portion of the premium for DP and dependents of DP will be taxable income to the employee. These amounts are $2.97 for DP coverage only and $4.58 for DP and dependent coverage (per semi monthly pay period).

The Vision Care Plan through EyeMed will help you keep your life in focus.

UNDERSTANDING
YOUR FLEXIBLE SPENDING ACCOUNTS

Save money when you use a Flexible Spending Account (FSA) to pay for certain health care and dependent care expenses, with favorable pre-tax dollars.

Health Care Spending Account

You can deposit as much as $2,600 a year on a pre-tax basis to the Health Care Spending Account. You reimburse yourself with these tax-free dollars for things such as medical and dental plan deductibles, coinsurance and copayments. Examples of eligible expenses are those not covered by insurance. They include the cost of routine physical exams, extra dental cleanings, childbirth classes, routine hearing exams, hearing aids and repairs, eye exams and prescription eyewear, chiropractic services, infertility services, diabetic supplies and much more.

Over-the-counter Drugs and Medicines

As a result of the Patient Protection and Affordable Care Act, out-of-pocket expenses for over-the-counter drugs and medicines must be accompanied by a doctor's prescription in order to qualify for reimbursement from a Flexible Spending Account (FSA) or Health Savings Account (HSA).

For example, cold medicines, allergy medicines, cough syrups, etc., are not reimbursable under the Health Care Spending Account or HSA; only medical supplies, equipment and contact lens solution will remain eligible without a prescription.

Transit/Parking

Mass Transit	Maximum contribution is $130 per month	Maximum monthly Contribution Balances not used in your Transit and Parking Account will roll from one Plan year to the next. This is not a use it or lose it plan.	Save 20% - 40% on your transit/parking expenses. Reduces your taxable income.
Parking	Maximum contribution is $250 per month		

Dependent Day Care Spending Account

Pre-tax money that you deposit into the Dependent Day Care Spending Account pays for care expenses for a dependent child up to age 13, or a dependent adult. Care expenses are reimbursable if the services enable you and your spouse to work. Expenses are also reimbursable if your spouse is disabled or attends school full-time at least five months of the year. You can deposit as much as $5,000 a year ($2,500 if married, filing separately). Then you can reimburse yourself using these tax-free dollars for such things as nursery school tuition, day care, summer day camp and dependent-adult day care center expenses. Care can be provided inside or outside your home. All reimbursement claims are filed manually.

FSA Debit Card

The FSA Debit Card offers the convenience of a pre-funded credit card, with no annual fee. Use your FSA Debit Card to pay for eligible FSA expenses at the point of service, such as doctor and dentist offices, pharmacies and vision service offices.

Using your FSA Debit Card saves you the hassle of paying cash for services (in addition to your payroll deduction), filling out and submitting a claim form and waiting for a reimbursement check. A debit card is only available with the Health Care FSA. Dependent Day Care FSA reimbursements are filed manually.

Rules for the FSAs

If a balance is remaining in an FSA on December 31, participants have until March 15 of the following plan year to incur eligible expenses to be applied against the remaining plan year balance.

According to the IRS, after the deadline, any money left in an FSA is forfeited. This is known as the "use it or lose it" rule. Thus, claims incurred for the current plan year MUST be submitted for reimbursement by March 31 of the following plan year or the money is forfeited.

Changes in elections can be made only during annual enrollment or if you have a qualified change in status. The change in status must be consistent with the requested change.

Keep all receipts and backup documentation regarding your FSA expenses – you may be required to provide proof of eligible expenses to WageWorks, the FSA vendor. An Explanation of Benefits (EOB) is the best type of documentation as it includes everything the IRS requires for backup substantiation.

UNDERSTANDING
YOUR LIFE & DISABILITY BENEFITS

XYZ's ancillary benefits are offered through Unum. Unum has worked hard to earn a reputation for high quality insurance products.

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (AD&D)

Basic Life and AD&D insurance coverage are important parts of your financial well-being and XYZ provides these benefits at no cost to you.

All regular, full-time employees scheduled to work at least 30 hours per week, are eligible for Basic Life insurance. Basic Life insurance is equal to 1.5 times basic annual earnings to a maximum benefit of $750,000. Benefits are reduced by 65% at the age of 70 and an additional 50% at the age of 75. XYZ also offers Basic Dependent Life insurance. This benefit is $10,000 for your spouse and $2,500 for each of your eligible dependent children.

AD&D insurance provides benefits to you and your beneficiary should you suffer loss of life or limb due to an accident. All regular, full-time employees scheduled to work at least 30 hours per week, are eligible for AD&D. AD&D insurance is equal to 1.5 times basic annual earnings up to a maximum of $750,000.

*Please note that annual salaries in excess of $50,000 require imputed income and you will notice social security and Medicare taxes on your paycheck.

SUPPLEMENTAL LIFE AND AD&D

You have the option to purchase additional Life and AD&D insurance for yourself, your spouse and your eligible dependent children. Employees may elect up to 5 times base annual earnings (in $10,000 increments) up to $750,000. Election amounts over $250,000 will require evidence of insurability form to be completed and returned to UNUM. Employees may also elect additional coverage for spouses and/or eligible dependent children:

Spouse: Amounts in $5,000 increments equal to the lesser of 100% of the employee election amount or $500,000. Amounts over $25,000 will require evidence of insurability and approval from UNUM

Eligible Dependent Children: Up to $10,000 (in $2,000 increments)

You pay 100% of the cost of coverage, and the premium will be deducted from your paycheck on a post-tax basis. Any coverage elected over the Guarantee Issue Amount must be approved by Unum.

SHORT-TERM DISABILITY (STD)

XYZ provides a Short-Term Disability plan at no cost to you. Short-Term Disability (STD) replaces a portion of your income if you become disabled due to an accident, injury, or illness.

All active regular, full-time employees scheduled to work at least 30 hours per week, are eligible to receive the STD benefit. If you cannot work due to injury or sickness, your STD benefit will begin after a 7-day waiting period (calendar days) and can last up to 13 weeks. You may use standard sick days as income replacement during your 7-day waiting period.

The STD benefit replaces 66.67% of your base annual earnings up to a $1,500 weekly maximum.

LONG-TERM DISABILITY (LTD)

XYZ provides a Long-Term Disability plan at no cost to you. Long-Term Disability (LTD) replaces a portion of your income if you become disabled due to an accident, injury, or illness.

All active regular, full-time employees scheduled to work at least 30 hours per week, are eligible to receive the LTD benefit. The LTD benefit begins on the 91st day of disability (calendar days) and replaces up to 60% of your gross monthly base earnings to a maximum monthly benefit of $15,000. The LTD benefit may be reduced by other sources of income.

YOUR LIFE & DISABILITY BENEFITS OVERVIEW

Basic Life & AD&D - Employer Paid		
Employee Basic Life & AD&D	1.5 times Base Annual Earning (BAE) up to a maximum $750,000	
Benefit Reduction	35% at age 70; 50% at age 75	
Short-Term Disability (STD) - Employer Paid		
Amount of Benefit	66.67% of Base Salary up to a Maximum of $1,500 per week	
When Benefits Begin	After 7 day waiting period	
Maximum Benefit Period	12 weeks	
Long-Term Disability (LTD) - Employer Paid		
Amount of Benefit	60% of Gross Monthly Base Salary up to a Maximum of $15,000 per month	
When Benefits Begin	After 90 days of disability	
Maximum Benefit Period	To SSNRA	

State Disability

Employees who are absent because of their own disability may be eligible for State Disability Insurance (SDI) benefits depending on the state in which they are employed. SDI benefits may be payable when you cannot work because of illness or injury, including pregnancy and childbirth, not caused by employment at the Company.

Note: Please note that SDI is administered by the applicable state and does not provide for any leave or pay rights from the Company. For more information regarding State Disability Insurance please contact Human Capital at USHumanCapitalOperations@XYZ .com.

Supplemental Life - Voluntary		
Employee	1x, 2x, 3x, 4x or 5x salary up to a $750,000 maximum. Amounts over $250,000 are subject to Evidence of Insurability (EOI).	
Spouse / Domestic Partner	Amounts in $5,000 increments equal to the lesser of 100% of the employee election amount or $500,000. Amounts over $25,000 subject to Evidence of Insurability (EOI).	
Employee and Spouse/Domestic Partner *Monthly Contributions based on age and coverage amounts elected*	Age	Employee / Spouse Rates Per $1,000
		Spouse/Domestic Partner Cost per $1,000
	<25	$0.060
	25-29	$0.060
	30-34	$0.080
	35-39	$0.095
	40-44	$0.159
	45-49	$0.243
	50-54	$0.451
	55-59	$0.697
	60-64	$0.935
	65+	$2.173
Employee Voluntary AD&D	Voluntary AD&D Benefit will match your Supplemental Life election amount. Cost for AD&D is $0.022 per $1,000 of benefit.	
Eligible Children	Increments of $2,000 up to a $10,000 maximum. Benefit to age 19 or 26 if full time student	
	$.053 per $2,000	

BUSINESS TRAVEL ACCIDENT
PROGRAM

XYZ, Inc. is offering travel benefits to employees, guests and their eligible dependents traveling on behalf of the company for business purposes*. Below is a brief overview of the benefits being offered and contact information in the event of illness or injury. Should you have any questions, please contact your Benefits Administrator or Local HR representative.

WHILE YOU ARE TRAVELING ANYWHERE IN THE WORLD

Accidental Death & Dismemberment Benefits

If, within 365 days of a covered accident, injury results in anyone of the losses shown, the benefit amount shown opposite the loss will be paid. If multiple losses occur, only one benefit amount the largest will be paid for all losses due to the same accident.

Additional Benefits:

- Coma, Disability (PTD), Home Alteration and Vehicle Modification, Rehabilitation, Seatbelt and Airbag

WHILE YOU ARE TRAVELING OUTSIDE YOUR HOME COUNTRY OR COUNTRY OF PERMANENT ASSIGNMENT

Medical Expense Benefits:

We will pay up to $500,000 for medically necessary expenses incurred for hospital and medical care, treatment or services within 30 days of a covered accident or sickness.

Additional Benefits:

- Baggage Delay, Family Reunion, Lost Baggage, Personal Property and Financial Instrument Reimbursement, Trip Cancellation, Trip Interruption

ISOS will provide "Assistance Services Only" for these benefits during your business trip. Contact your local Benefits Administrator or Local HR representative for a claim form for payment of these benefits

EMERGENCY RESPONSE BENEFITS APPLICABLE TO ALL PLANS

If you are traveling more than 100 miles from your permanent residence or you are outside your home country on company business, we will pay the following emergency response benefits:

- Emergency Medical Evacuation, Guarantee of Payment for Hospital Admission, Repatriation of Remains, Security Evacuation Expense, including Natural Disaster (applies only if traveling outside home country), War Risk (applies only if traveling outside your home country, country of permanent assignment, the United States, Afghanistan, Iran or Iraq)

Covered Loss	Benefit Amount
Life, Two or more Members, Quadriplegia	100% of Principal Sum
Paraplegia	75% of Principal Sum
Hemiplegia, One Member	50% of Principal Sum
Thumb Index Finger of the Same Hand, Uniplegia	25% of Principal Sum

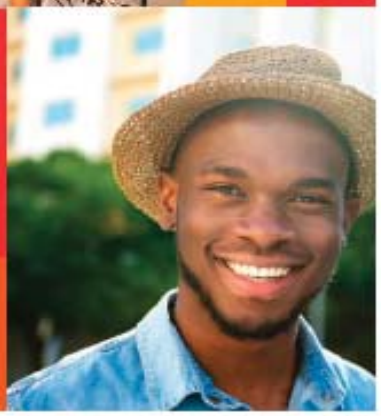
If you need medical or security advice or assistance, call International SOS 24 hours a day, 7 days a week (call collect where available):
Philadelphia +1.215.942.8226
Singapore +65.6338.7800
London +44.20.8762.8008
Sydney +61.2.9372.2468
www.internationalsos.com
Please call when:

- You require a referral to a hospital or doctor
- You are hospitalized
- You need to be evacuated or repatriated
- You need to guarantee payment for medical expenses
- You experience local communication problems

ADDITIONAL BENEFIT PROGRAMS

We're here to help when you need it most.

Here's how.



Find the right doctors

We can also find the right hospitals, specialists and other leading providers, anywhere in the country.

Schedule appointments

Our experts can expedite appointments, arrange second opinions and transfer medical records.

Assist in the transfer of medical records

We'll also handle the details of transferring X-rays and lab results.

Work with insurance companies

Our team works on your behalf to obtain appropriate approvals for needed services.

Resolve benefits issues

We'll do the legwork to resolve insurance claims and billing issues, untangle medical bills and coordinate benefits.

Help with eldercare

We can help address senior issues including finding eldercare services, adult day care and more.

Get your questions answered

We help you become informed about test results, treatments and medications.

Help to make informed decisions

We will research conditions and treatment options, and facilitate second opinions.

Your Health Advocate benefit is being offered by your employer at no additional cost for you and covers eligible employees, their spouses, dependent children, parents and parents-in-law.*

* Restrictions apply
Health Advocate is not affiliated with any insurance company or third party provider, and does not provide medical care or recommend treatment.

24/7 support

866.695.8622

Visit us online at:
HealthAdvocate.com/members

HealthAdvocate
Always at your side

ADDITIONAL BENEFIT PROGRAMS

401(K) PLAN

Under the XYZ 401(k) plan through Investments; all eligible employees may withhold a maximum of up to 60% of pay on a pre-tax basis to the IRS maximum for 2017. XYZ matches 50% of the employee's contribution; the match cannot exceed 6% of eligible compensation. There is a three-year progressive vesting schedule, less than one year 0%, one year, but less than two years 34%, two years, but less than three 67% and three or more years, you are 100% vested on all Company contributions. You are always 100% vested on all employee contributions and rollover amounts.

VOLUNTARY BENEFITS

XYZ offers voluntary products! There are several plans that are available to employees--plans are portable and employees may choose to elect more than one line of coverage.

Aflac Supplemental Hospital Indemnity	Provides benefits for inpatient and outpatient service as a result of covered accidents and sickness. Benefits also available for spouse and dependent children.
Aflac Critical Illness	Provides a lump sum benefit upon the diagnosis of each covered illness, which include: heart attack, stroke, major organ transplant, kidney failure (end stage), cancer, carcinoma in situ and coronary.
Aflac Accident	Provides benefit for the treatment of injuries suffered as the result of a covered accident. Provides 24 hour protection and does not limit number of claims.
UNUM Long Term Care (LTC)	Helps provide for the cost of long-term care beyond a pre-determined period. Long-term care insurance covers care generally not covered by health insurance, Medicare or Medicaid.
Identity Theft	Covers any type of identity theft- not just financial or credit. Licensed investigators will restore your identity without any caps or limits on their services.
Life Events Legal Plan	Offers the ability to speak with an attorney on any type of legal issue.

WELLNESS REIMBURSEMENT PROGRAM

XYZ encourages a healthy workforce and has put in practices that support a healthy culture!

Employee may select one of the two wellness options below (not both):

Option 1	Employee may sign up for a gym membership via XYZ's corporate discount program (gyms listed below). XYZ will pay the full amount of the membership up front and Employee will reimburse XYZ through semi-monthly payroll deductions. XYZ subsidizes $50 monthly for the membership dues. Up to $39 of the one-time processing fee is reimbursable via T&E for employee only (use project code 1200295). Corporate discount is extended to spouses/domestic partners. Note: Spouses/domestic partners and family members of XYZ employees are not eligible for the monthly employer subsidy. Please contact HC Ops for more details. • New York Sports Club • New York Health & Racquet Club • Equinox • Crunch • Sport & Health • RDV Athletic Club • Complete Body
Option 2	Employee may request reimbursement for up to $50 monthly on ***any physical activity expense or massage therapy service*** (gym membership of choice, fitness class or massage therapy) by sending supporting documentation (receipt of payment and proof of enrollment) to Human.Capital.Americas@XYZ.com. Please note that this option is a taxable benefit processed via payroll. Applicable taxes will be withheld from the $50 reimbursement. Up to $39 of the one-time processing fee is reimbursable via T&E for employee only (use project code 5022927). This provides you of the freedom to self-select your fitness venue or enjoy a relaxing massage for: • Traveling employees who may not want to get "locked in" to a specific gym • More variety of gyms and fitness venues for mobile and dispersed workforce • Employees who wish to enjoy the benefits of massage therapy

WORKING ADVANTAGE

XYZ has a membership with Working Advantage and employees have access to discounts for movie theatres, movie rental, theme parks, ski tickets, Broadway theatre tickets, special family events, online shopping and much more.

Registering is easy. Simply go to the Working Advantage website at www.workingadvantage.com and click on "Register". Using the Member ID (9469170071), you may complete your one-time registration for free and create your own personal account with a password of your choice. You can order either online or by phone at 1-800-565-3712 Monday through Friday 8:00 a.m. to 6:30 p.m. and Saturday 9:00 a.m. to 5:00 p.m. ET.

ADDITIONAL BENEFIT PROGRAMS

Introducing …

MARKETPLACE

GET THE ABSOLUTE BEST PRICING ON:

- Apparel
- Auto
- Cell phones
- Computer/software
- Dining
- Electronics
- Entertainment
- Financial services
- Flowers/gifts
- Health/wellness
- Home
- Personal Vacations
- Tickets
- Travel

Don't pay retail ever again! Marketplace is a new, employee perks program designed to be a one-stop shop for employees. Save money on large purchases, as well as your everyday purchases. And, earn points for every dollar you spend, and get even more stuff for free. Once you activate your account, you will have access to exclusive offers and deep discounts from top popular merchants at the places you already shop. In addition, your employee access comes with five friends and family accounts.

START SAVING TODAY!

1. Visit
   > *via* Employee Matters > HR and Benefits
2. Login/register
3. Shop

*This program is currently only available to U.S. employees. Other locations will be rolled out in the future.

ADDITIONAL BENEFIT PROGRAMS

Maternity/Paternity Leave Policy

Maternity leave will be paid at 100% of base salary up to a maximum of eighteen (18) weeks in the event of the birth of a child, or placement of a child due to adoption or foster care for the primary caregiver. Paternity leave is covered at 100% of base salary up to a maximum of four (4) weeks.

To assist with managing your parental leave under this policy, please note the following guidelines and support:

- Paternity leave must be taken within the first three (3) months of the baby being born. New parent will need to provide documentation, such as hospital discharge paperwork or birth certificate.
- Maternity leave will be covered for two (2) weeks full pay prior to delivery date, and sixteen (16) weeks thereafter, for a total of eighteen (18) weeks of paid leave.
- In the event of placement of a child due to adoption or foster care, the primary caregiver will be entitled to a maximum of eighteen (18) weeks of paid leave.

Newborn Gift

XYZ is proud to present our new parents with a $750 gift (per baby) as a way to welcome our newborns and newly adopted family members.

Adoption Assistance Program

Recognizing adoption as a meaningful and viable way to build a family, XYZ provides an Adoption Assistance Program to assist employees with their adoption expenses. XYZ provides up to $10,000 in adoption assistance to all employees who are eligible for benefits and have a minimum of one (1) year of service. Active employees who opt out or waive health, dental, and vision coverage remain eligible for the Adoption Assistance Program. The adoption must be final before expenses are eligible for reimbursement.

The coverage applies to public and private agency adoptions, independent adoptions, and international adoptions. The adopted child must be under the age of 18.

Eligible Expenses

The following adoption charges are eligible for reimbursement:

- Legal/Court fees
- Agency fees
- Required medical exams/immunizations for child
- Transportation costs to bring the child home to the adopting parents

Ineligible Expenses

The following charges are not eligible for reimbursement:

- Expenses for adopting stepchildren or children related to either parent, such as nephews, nieces, cousins
- Transportation for adopting parents
- Medical examination fees for adopting parents
- Cost of personal items for parents or children during or after the adoption

Please contact Human Capital for additional information, USHumanCapitalOperations@XYZ.com

ADDITIONAL BENEFIT PROGRAMS

Family Care. SOLVED.

Start Making Your Life Easier.

REGISTER AT NO COST:

OR CALL: 877-BH-CARES (242-2737)

Bright Horizons Care Advantage™

A Bright Horizons Solution at Work

Your Many *Bright Horizons Care Advantage®* Benefits Include:

BACK-UP CHILD AND ADULT/ELDER CARE:
High-quality, low-copay replacement care for your child in your home or in a center; in-home care for adult/elder loved ones throughout the U.S. any time you need an extra hand.

NEW COPAYS IN 2016 FOR BACK-UP CARE:
Employees can access up to 10 annual days of family care when regular arrangements fall through. Get immediate access to care supports at subsidized rates; center-based care is $10/child or $15/family; all in-home care is $4/hour.

NANNIES, ELDER CARE, PET CARE, AND MORE:
Do-it-yourself access to a comprehensive database of self-pay services including nannies and sitters for evening and weekend care, plus elder care resources, pet sitters, homework help, and more.

Life Balance - Employee Assistance Program

When you have questions, concerns or emotional issues surrounding your personal or work life, you can count on us to offer help. Unum's EAP offers unlimited access to master's level consultants by telephone, resources and tools online, and up to three face-to-face visits with a consultant for help with a short-term problem.

Help for personal challenges, big and small

Keeping your work and personal life in balance can sometimes be tricky. Stressful situations can affect your health, well-being and ability to focus on what's important.

That's when you can pick up the phone and speak confidentially to a master's level consultant who can help you or a family member to:

- Locate childcare and eldercare services and obtain matches to the appropriate provider based on your or your family's preferences and criteria. The consultant will even confirm space availability.
- Speak with financial experts by phone regarding issues such as budgeting, controlling debt, teaching children to manage money, investing for college, and preparing for retirement.
- Work through complex sensitive issues such as personal or work relationships, depression, or substance abuse.
- Get a referral to a local attorney for a free, 30-minute in-person or telephonic legal consultation.

You'll have access to an attorney for state specific legal information and services. If you decide to retain the attorney, you may be eligible to receive a 25% discount on additional services.

You also have unlimited access at www.lifebalance.net where you can:

- Read booklets, life articles and guides
- View videos and online seminars, as well as listen to podcasts
- Subscribe to email newsletters
- Find information on parenting, retirement, finances, education and more
- Use health management online calculators and other tools to help you with topics such as losing weight or starting a new exercise program
- Access links to other informative websites
- Use school, camp, eldercare and childcare locators
- Use financial calculators, retirement planners, worksheets and more

Guidance for work-related conflicts

If you're a manager dealing with staff issues such as an employee who's feeling overwhelmed, you have unlimited access to guidance from a team of consultation experts. Call the toll-free work-life balance EAP to:

- Have a confidential sounding board and objective view
- Work on communication and problem-solving skills
- Learn how to motivate your employees

A wallet card is available with telephone number and online contact information. Please see your human resources manager to request one.

Your work-life balance employee assistance program can help you find solutions to the everyday challenges of work and home as well as for more serious issues involving emotional and physical well-being.

- Childcare and/or eldercare referrals
- Personal relationship information
- Health information and online tools
- Legal consultations with licensed attorneys
- Financial planning assistance
- Stress management
- Career development

Help is easy to access:

- Telephonic consultations: Speak confidentially with a master's level consultant to clarify your need, evaluate options and create an action plan.
- Face-to-face meeting: Meet with a local consultant up to three times per issue for short-term problem resolution.
- Educational materials: Receive information through our online library of downloadable materials and interactive tools.

To learn more, please visit www.lifebalance.net; user ID and password: lifebalance

ADDITIONAL BENEFIT PROGRAMS

Petplan pet insurance

Claim your 15% discount when you enroll online

Call **1.800.809.9200** or Visit **PetplanBenefits.com**

15% EMPLOYEE DISCOUNT VOUCHER

Visit PetplanBenefits.com and type in _____ to receive a 15% discount.

Policy Benefits	Petplan Bronze Policy	Petplan Silver Policy	Petplan Gold Policy
Annual Coverage Limits	$10,000	$14,000	$22,000
Deductible	Choice of $50, $100, or $200 deductible		
Reimbursement	Choice of 100%, 90% or 80% reimbursement direct to you		
Policy Coverage	Accidents • Illnesses • Hereditary, congenital + chronic conditions Prescription medications • Surgery • Specialist treatment Cancer treatment • Alternative + holistic therapies Non-experimental stem cell therapies • Diagnostic testing MRI + CAT scan imaging • Non-routine dental treatment		
Additional Coverage	N/A	Boarding + kennel fees Advertising + reward Loss due to theft/straying	Boarding + kennel fees Advertising + reward Loss due to theft/straying Death from illness or injury Vacation cancellation
Additional Info	Covered for Life™ with annual renewal		

Terms and conditions apply. Policy becomes effective at 12:01am the day after adoption. A 24-hr waiting period for accidents, a 14-day waiting period for illnesses and a 6-month exclusion for cruciate ligaments and patellas applies. Lifetime coverage is contingent on the policy being renewed each year without any break in coverage. Subject to annual policy limits of $10,000, $14,000 or $22,000. Limits are replenished in full on renewal. Pre-existing conditions, including those where clinical signs are present prior to the effective date of the policy or during the policy waiting period, are excluded from coverage.

Coverage under any pet insurance policy is expressly subject to the conditions, restrictions, limitations, exclusions and terms of the policy documentation issued by the insurer. Availability of this program is subject to each state's approval and coverage may vary by state. Pet insurance policies are issued by AGCS Marine Insurance Company and administered by Fetch Insurance Services, LLC (Fetch Insurance Agency, LLC in Michigan), d/b/a Petplan (Petplan Insurance Agency, LLC in California). AGCS Marine Insurance Company, a member of the Allianz Group, is rated A+ by A.M. Best (2012).

Visit **PetplanBenefits.com** and type in _____ to receive 15% discount.

2017 Health Plan Notices

* Women's Health and Cancer Rights Act of 1998

Your medical plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy - related services, including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedema).

Please call your plan administrator for more information. These benefits may be subject to annual deductibles, co-insurance provisions or copays that are appropriate and consistent with other benefits under your plan.

* The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is a federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health. The law prevents discrimination from health insurers and employers.

Who needs protection from genetic discrimination?

Everyone should care about the potential for genetic discrimination. Every person has dozens of DNA differences that could increase or decrease his or her chance of getting a disease such as diabetes, heart disease, cancer or Alzheimer's. It's important to remember that these DNA differences don't always mean someone will develop a disease, just that the risk to get the disease may be greater.

More and more tests are being developed to find DNA differences that affect our health. These tests (called genetic tests) will become a routine part of health care in the future. Health care providers will use information about each person's DNA to develop more individualized ways of detecting, treating and preventing disease. But unless this DNA information is protected, it could be used to discriminate against people.

Why was the law needed?

The law was needed to help ease concerns about discrimination that might keep some people from getting genetic tests that could benefit their health. The law also enables people to take part in research studies without fear that their DNA information might be used against them in health insurance or the workplace.

* Notice of Special Enrollment Rights

If you are an active employee declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends and you fulfill other special enrollment requirements. (These requirements are set out in your Certificate of Coverage)

In addition, if active employees have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

There is an additional enrollment period if an active employee or dependent loses eligibility for Children's Health Insurance Program (CHIP), Medicaid or becomes eligible for CHIP for Medicaid premium assistance. The special enrollment allows children or their parents to have 60 days, rather than 30, to request enrollment.

Also, your health plan may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on a health status-related factor.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462

NEVADA – Medicaid	RHODE ISLAND – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor U.S. Department of Health and Human Services Employee Benefits Security Administration Centers for Medicare & Medicaid Services

www.dol.gov/ebsa www.cms.hhs.gov

1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2017)

Important Notice from XYZ 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 XYZ 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. XYZ has determined that the prescription drug coverage offered by United Healthcare 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 through 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 XYZ coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current XYZ coverage, be aware that you and your dependents may 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 XYZ 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 November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You will 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 changes through XYZ. 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 will 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).

Name of Entity/Sender: XYZ Company
Contact--Position/Office:
Address:

Phone Number:

CONTACT INFORMATION

Find policy numbers, customer service phone numbers, and websites for benefit carriers below.			
BENEFIT PROVIDER	**POLICY NUMBER**	**PHONE NUMBER**	**WEBSITE and ADDITIONAL INFORMATION**
United Healthcare **Medical**	GA-700855	1.888.444.6222	www.myuhc.com
United Healthcare/Optum Rx **Retail and Mail-order Prescription Drug Service**	GA-700855	1.800.562.6223 *Doctors may call 1-800-791-7658*	www.myuhc.com Fax forms to 1.800.491.7992 Fax request form can be found on the EMS portal
Aetna/US Healthcare **Dental**	723707	1.877.238.6200	www.aetna.com
EyeMed **Vision**	9833823	1.866.9EYEMED	www.eyemedvisioncare.com
Unum **Life/AD&D** **STD – NY Employees** **STD – All Employees** **LTD**	Basic Life and AD&D, STD, LTD: 951554 STD - NY: 951556 Supplemental Life: 951555	1.866.679.3054	www.unum.com
Employee Assistance Program (Unum) **Life Balance**		1.800.854.1446	www.lifebalance.net User ID and Password: lifebalance
CBIZ **Flexible Spending Accounts**		1.800.815.3023 Option 4	https:\\myplans.cbiz.com
Investments **401(k)**	Plan 45459	1.800.581.5800	www.401k.com
Health Advocate		1.800.581.5800	healthadvocate.com/members

NOTES

LOGO GOES
HERE

Disclaimer: This Benefit Guide provides a brief summary of the benefits available under XYZ's Benefit Program. In the event of any discrepancy(ies) between this summary and any Document, Insurance Contract or Certificate, the Insurance Document(s) will prevail. XYZ retains the right to modify or eliminate these benefits at any time and for any reason.

25. **Describe services you offer to support employee surveys and/or focus groups.**

    CBIZ will design employee surveys targeting areas of concern evidenced directly by employees or designated by PIKE. Survey results can be displayed/summarized by occupational specialty, age, location or any other indicated demographics.

    Likewise, CBIZ HR specialists can assist with organizing and conducting focus groups in a similar manner as with surveys.

26. **Describe services you provide to assist with benefits benchmarking.**

    CBIZ will perform benchmarking comparisons for Pike by industry, employer size and region (see attached).

BENCHMARKING

COST

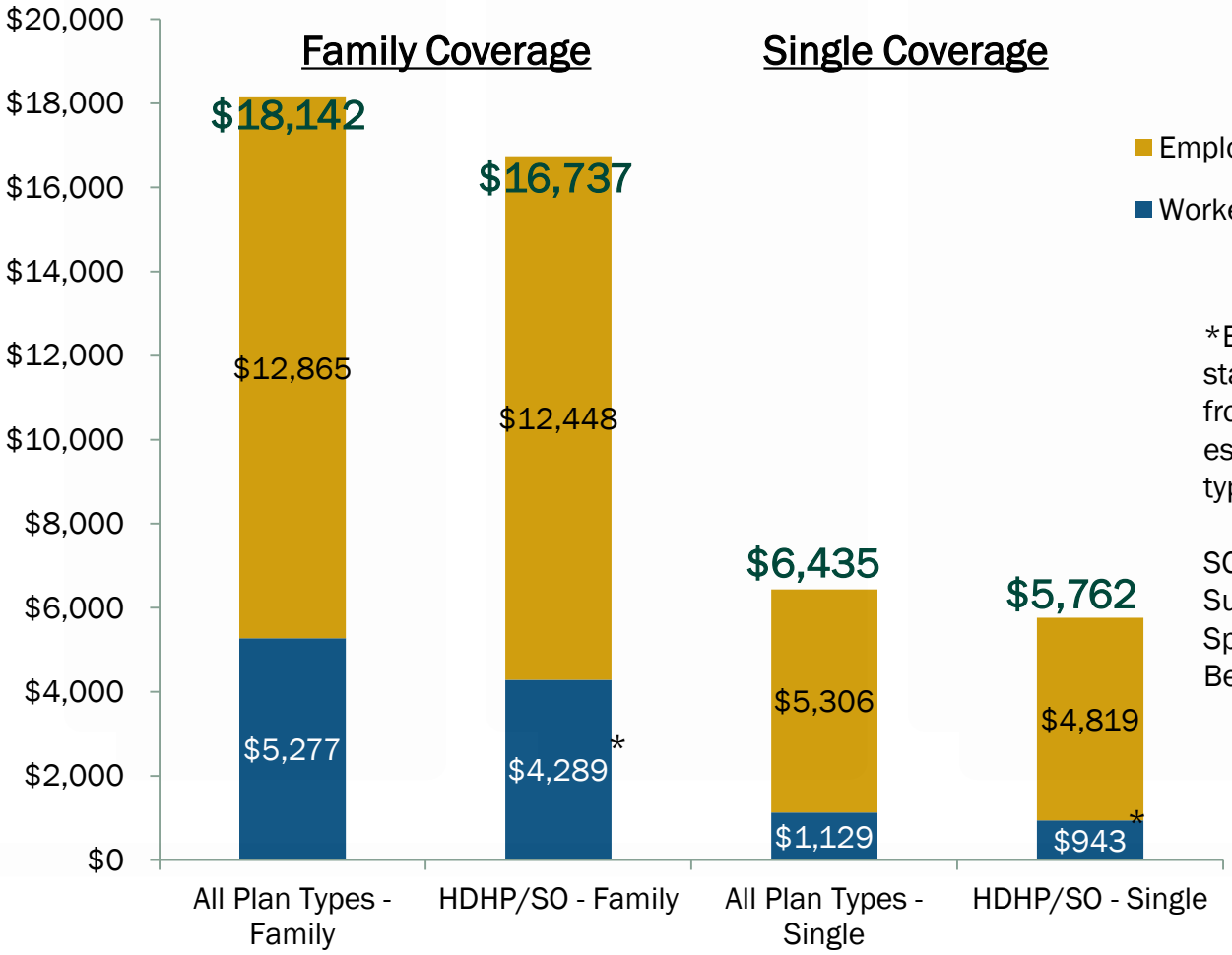
Benchmarking | Cost

Employee Contributions

Contribution as a % of Total	Single Coverage	Dependent Coverage
< 10%	8%	4%
10% - 14%	12%	8%
15% - 19%	13%	8%
20% - 24%	29%	26%
25% - 29%	18%	20%
30% - 39%	13%	18%
40% +	7%	16%
	100%	100%

Source: Health and Well-Being Touchstone Survey Results PwC 2016

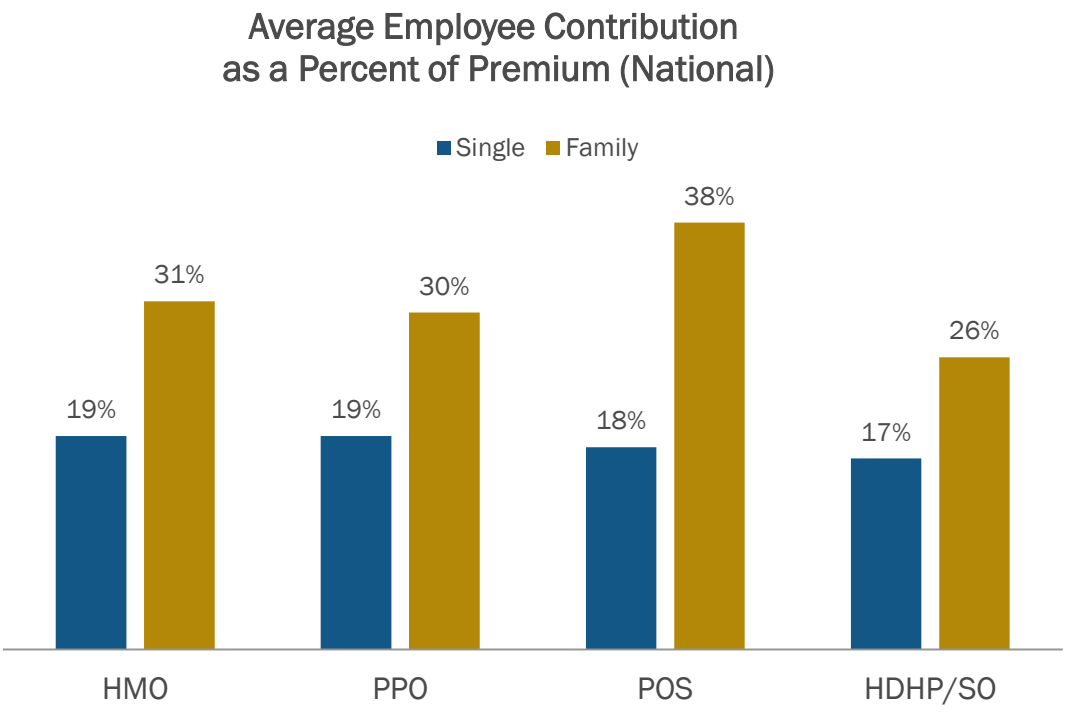
Average Annual Firm and Worker Premium Contributions and Total Premiums for Covered Workers for Single and Family Coverage, by Plan Type, 2016



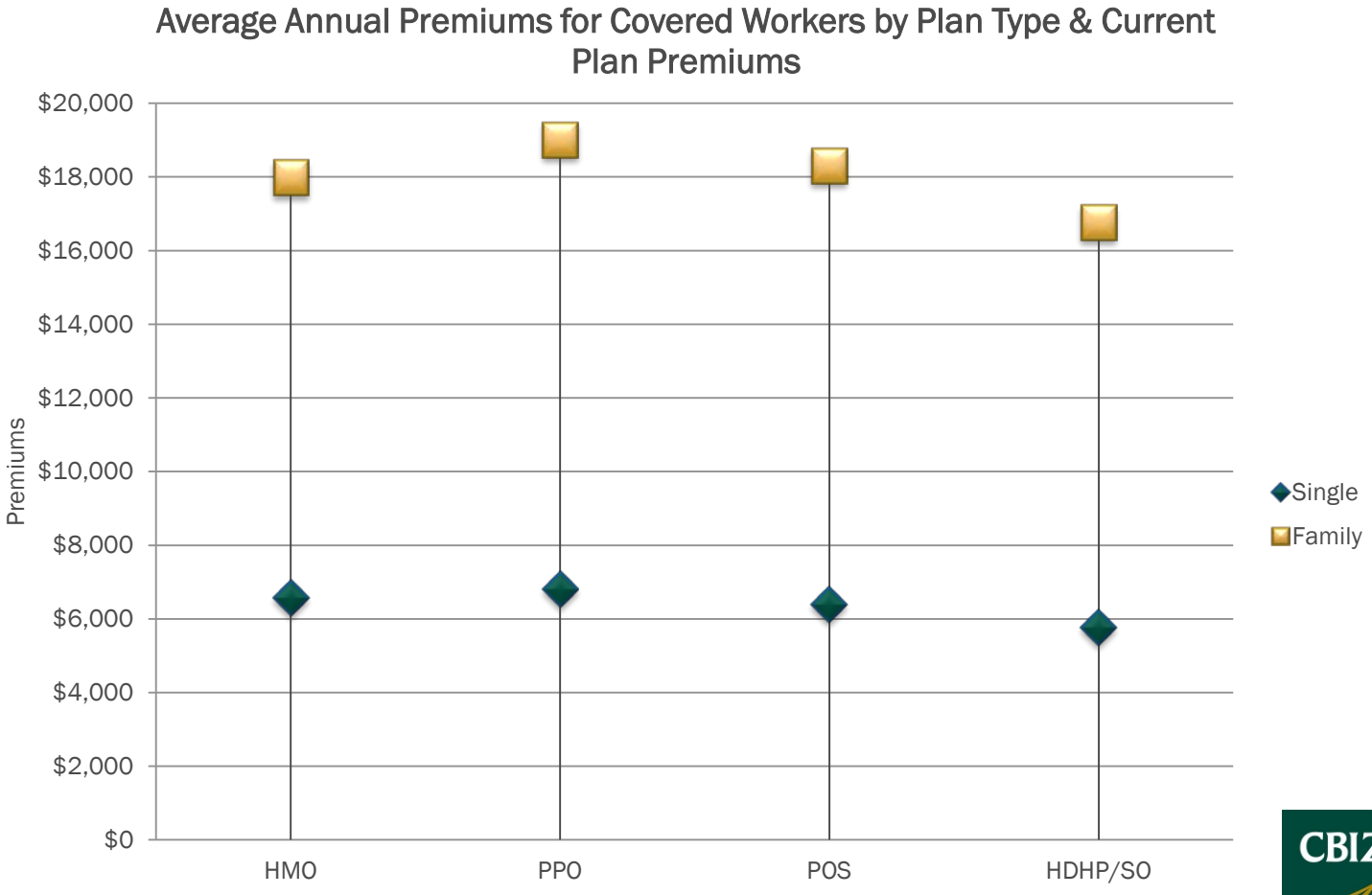
*Estimate is statistically different from All Plans estimate by coverage type ($p < .05$).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2016.

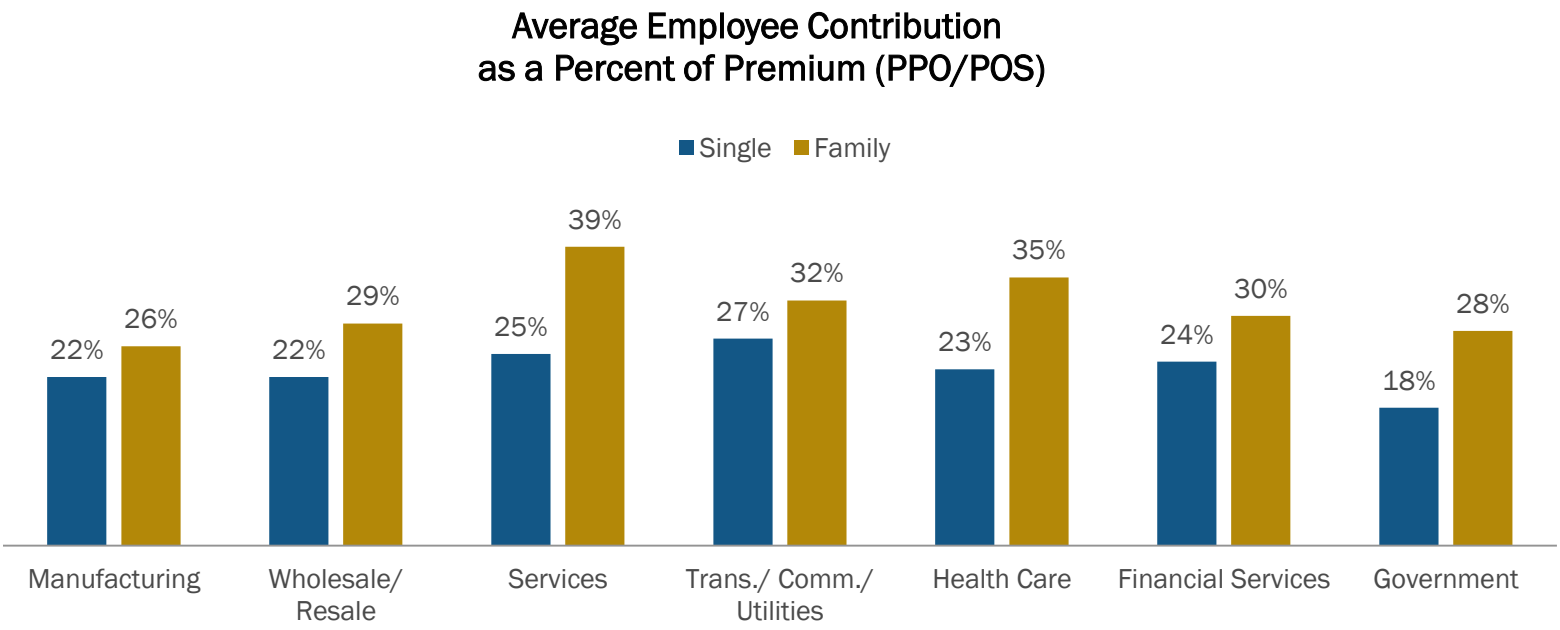
Benchmarking | Cost

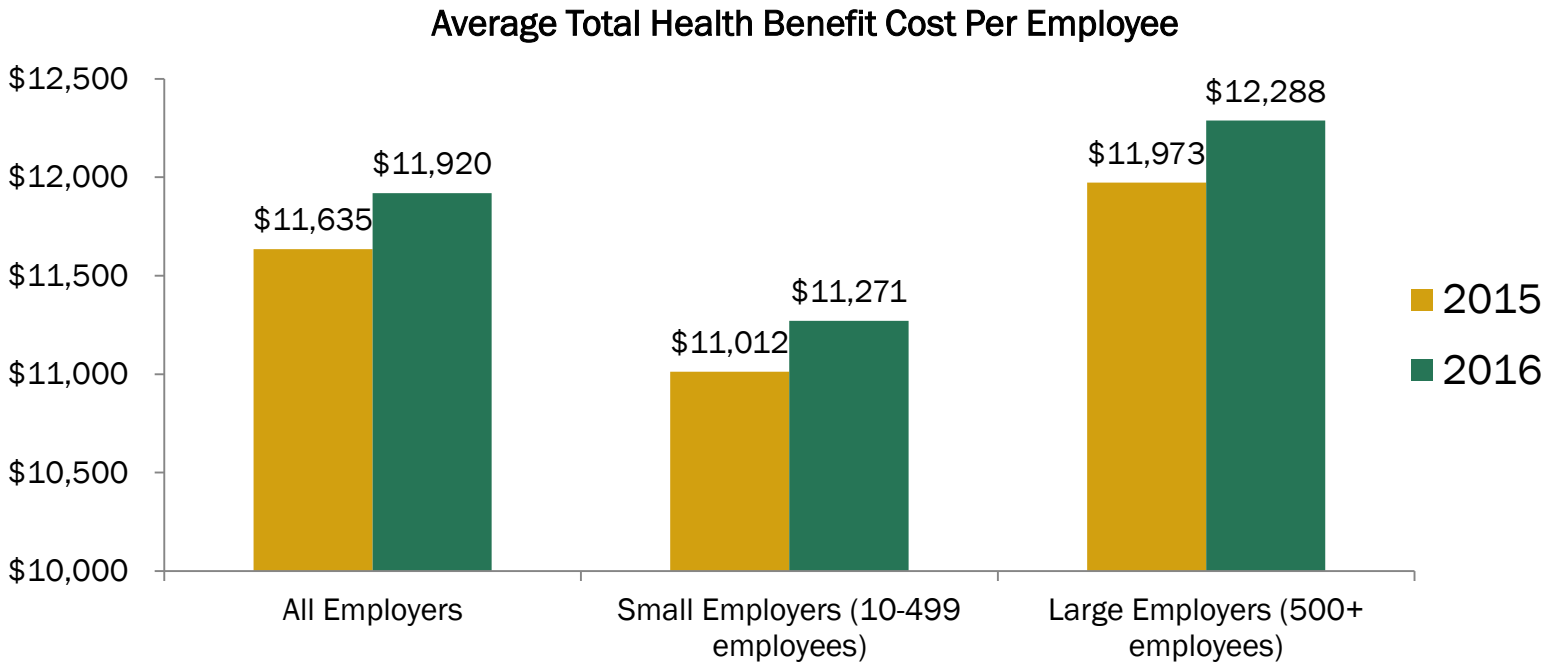


Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2016



Benchmarking | Cost





Source: Mercer National Survey of Employer-Sponsored Health Plans, 2015 (released in 2016)

Benchmarking | Cost

Average Employee Contributions – PPO v. CDHP
Large Employers

	Average Monthly Dollar Amount	Average Contributions as a % of Premiums
HSA – eligible CDHP		
Employee – only	$84	19%
Family	$321	25%
PPO		
Employee – only	$132	24%
Family	$467	33%

Source: Mercer National Survey of Employer-Sponsored Health Plans, 2015 (released in 2016)

BENCHMARKING

PLAN DESIGN

Benchmarking | Plan Design

Single In-Network Deductible

$0	10%
$1 - $499	18%
$500 - $999	23%
$1000 - $1999	29%
$2,000 +	20%

Single Out-of-Pocket Max (Includes Deductible)

< $2,000	15%
$2,000 - $2,999	25%
$3,000 - $4,999	40%
$5,000 +	20%
Unlimited	0%

Primary Care Office Visit

<$19 Copay	8%
$20 - $24 Copay	17%
$25 - $29 Copay	19%
$30 - $34 Copay	12%
$35 +	7%
Coinsurance	37%

Employee Coinsurance (for most services)

0%	17%
1% - 19%	28%
20% - 29%	49%
30% +	6%

Specialist Office Visit

< $30 Copay	11%
$30 - $39 Copay	15%
$40 - $49 Copay	18%
$50 +	17%
Coinsurance	39%

Average Retail Prescription Drug Copays (30 day Supply)

Preferred Generic	$11
Non-Pref. Generic	$16
Brand (Formulary)	$35
Brand (Non-Form.)	$48
Preferred Specialty	$58
Non-Pref. Specialty	$64

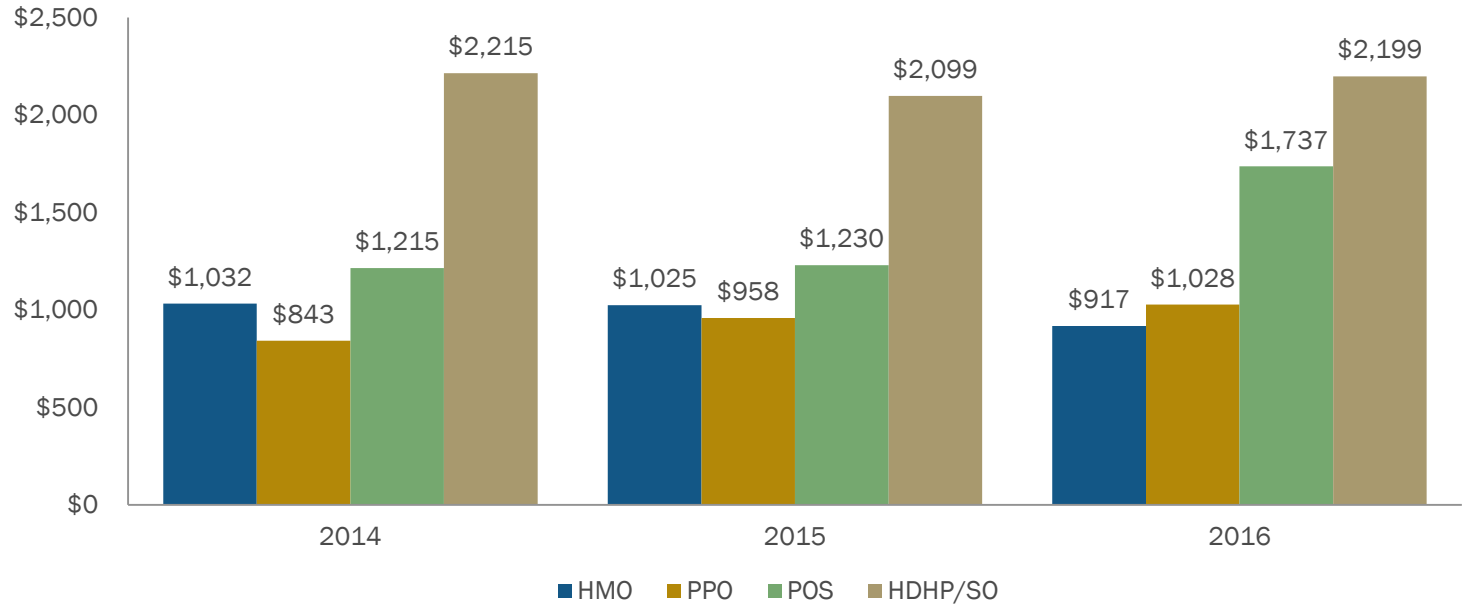
Source: Health and Well-Being Touchstone Survey Results PwC (PricewaterhouseCoopers) 2016

Average Mail Order Prescription Drug Copays (90 day Supply)

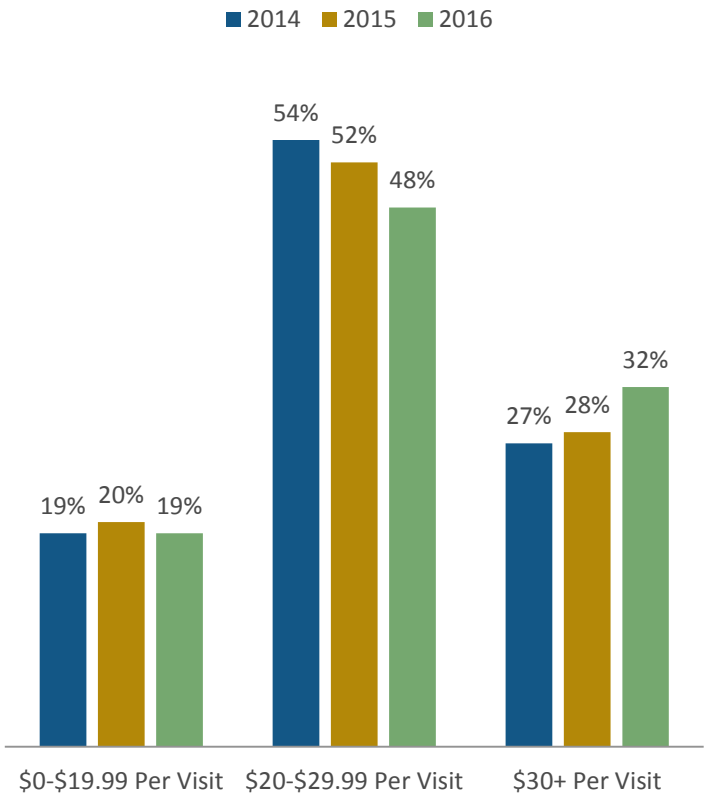
Preferred Generic	$21
Non-Pref. Generic	$29
Brand (Formulary)	$63
Brand (Non-Form.)	$98
Preferred Specialty	$93
Non-Pref. Specialty	$113

Benchmarking | Plan Design

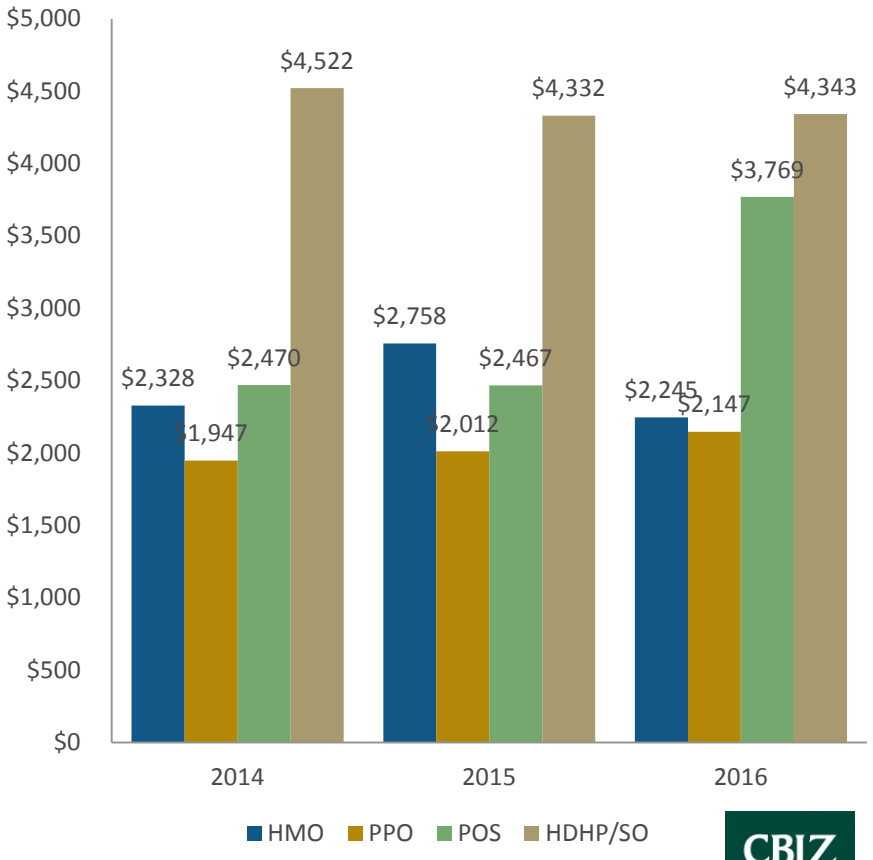
Average Single Deductible



Distribution of Co-Payments for Plans with a Primary Care Office Visit Co-Pay

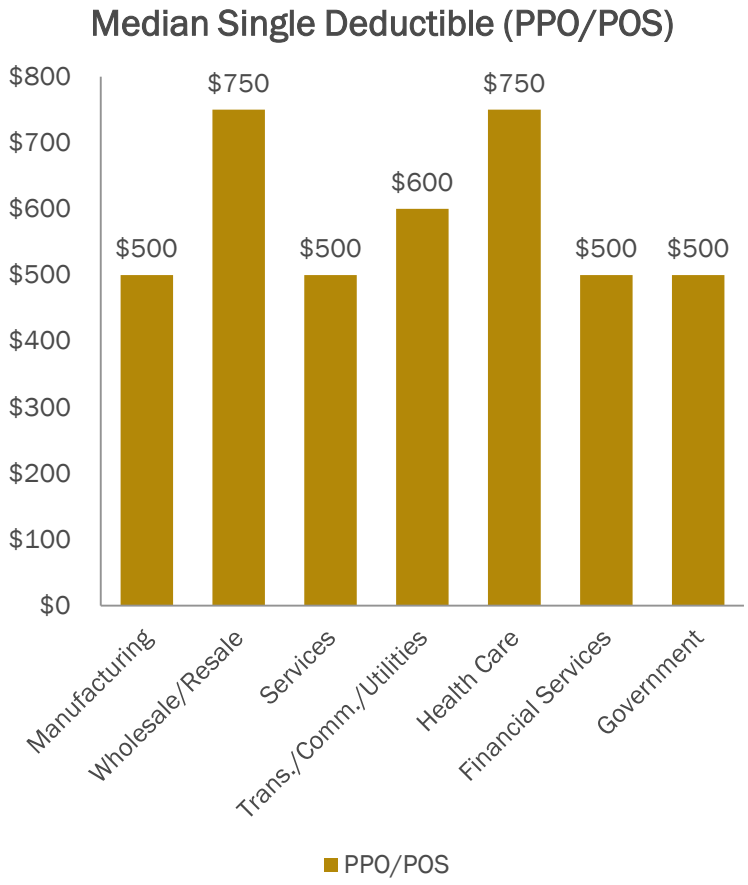


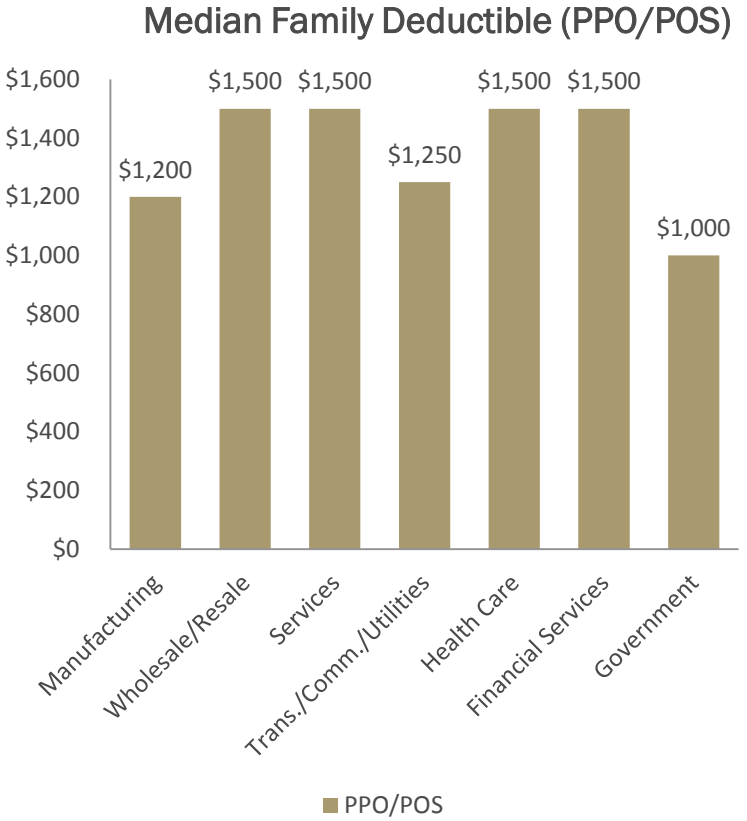
Average Family Deductible



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2016

Benchmarking | Plan Design

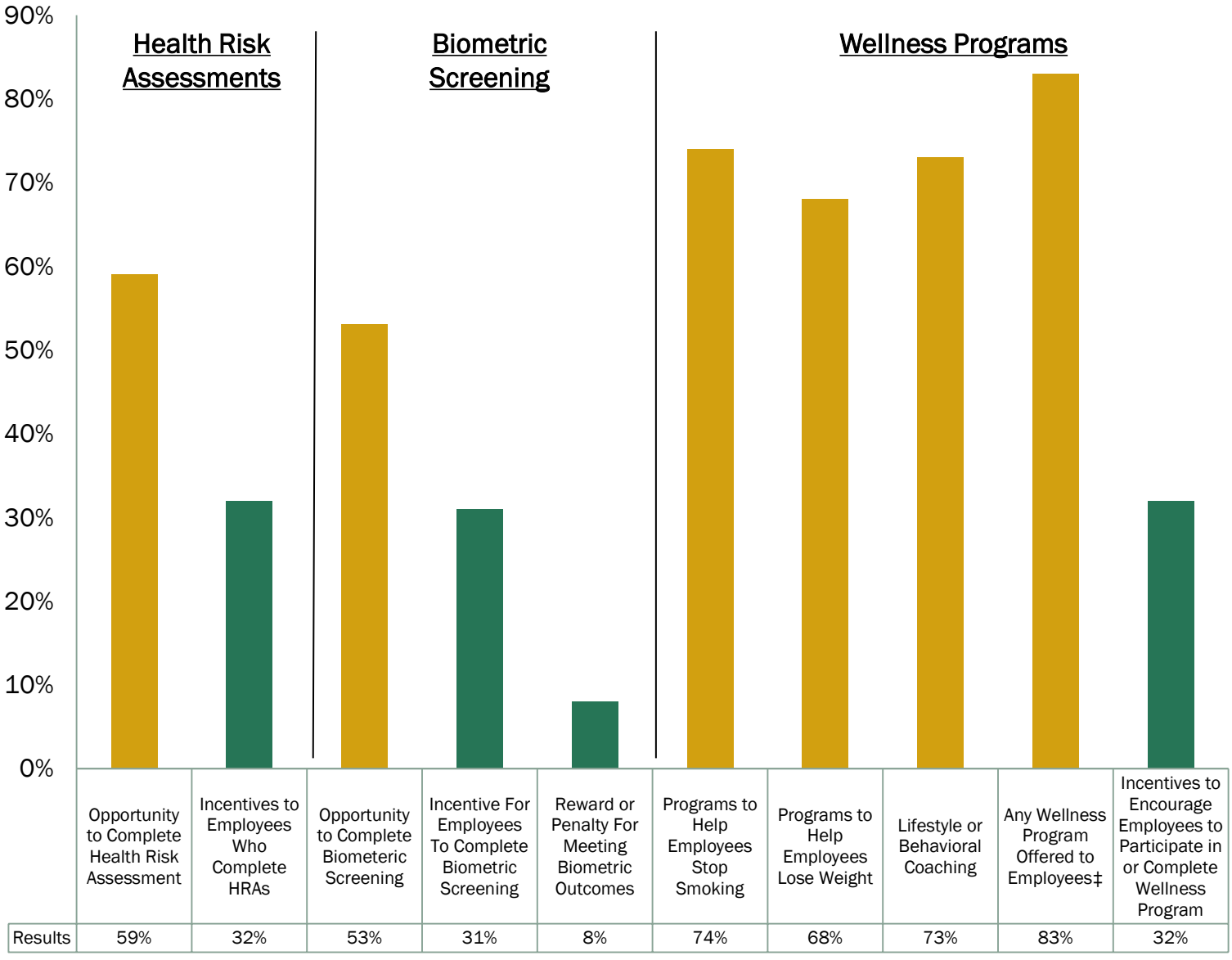




Source: Mercer National Survey of Employer-Sponsored Health Plans, 2015 (released in 2016)

Benchmarking | Plan Design

Among Large Firms Offering Health Benefits, Percentage of Firms Offering Incentives for Various Wellness and Health Promotion Activities, 2016



	Opportunity to Complete Health Risk Assessment	Incentives to Employees Who Complete HRAs	Opportunity to Complete Biometeric Screening	Incentive For Employees To Complete Biometric Screening	Reward or Penalty For Meeting Biometric Outcomes	Programs to Help Employees Stop Smoking	Programs to Help Employees Lose Weight	Lifestyle or Behavioral Coaching	Any Wellness Program Offered to Employees‡	Incentives to Encourage Employees to Participate in or Complete Wellness Program
Results	59%	32%	53%	31%	8%	74%	68%	73%	83%	32%

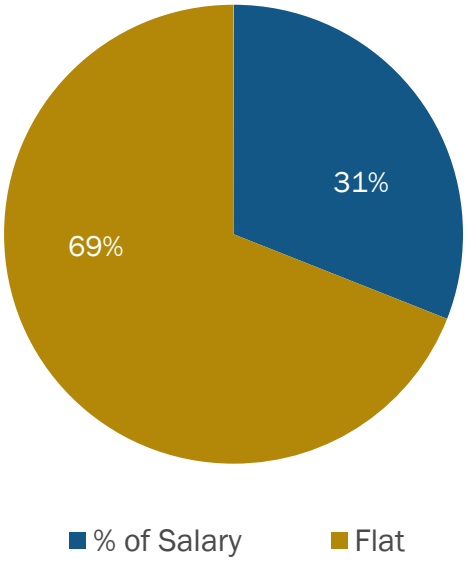
NOTE: Among large firms that offer a health risk assessment, 54% had incentives or penalties to encourage employees to complete it. Among large firms that offer biometric screening, 59% had incentives or penalties to encourage employees to complete it and 14% had incentives or penalties for employees to meet a biometric outcome. Among large firms that offer a wellness program, 42% had incentives or penalties to encourage employees to complete it.
‡Firms that offer either "Programs to Help Employees Stop Smoking","Programs to Help Employees Lose Weight", or "Other Lifestyle or Behavioral Coaching".

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2016.

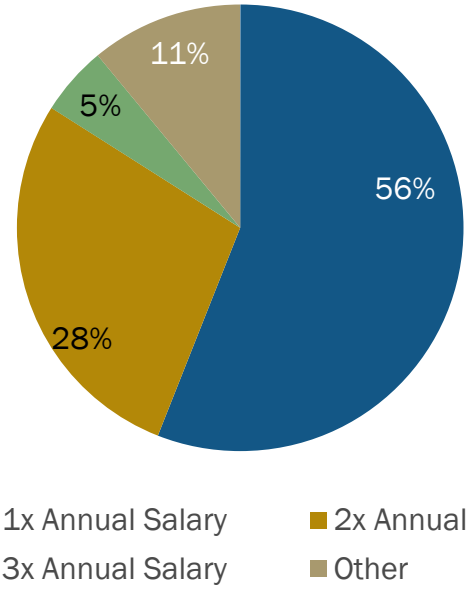
CBIZ

Benchmarking | Basic Life Plan Design

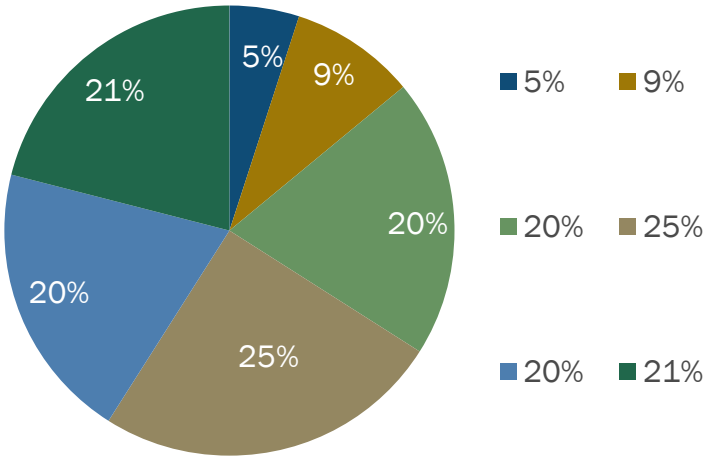
Plan Design



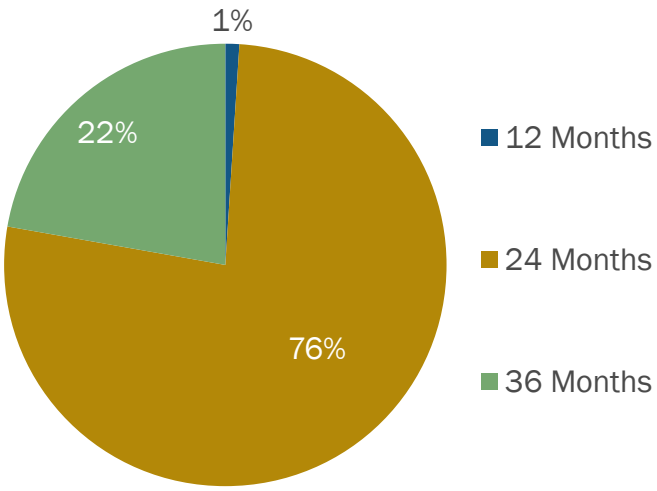
% of Salary



Maximum Issue Limit



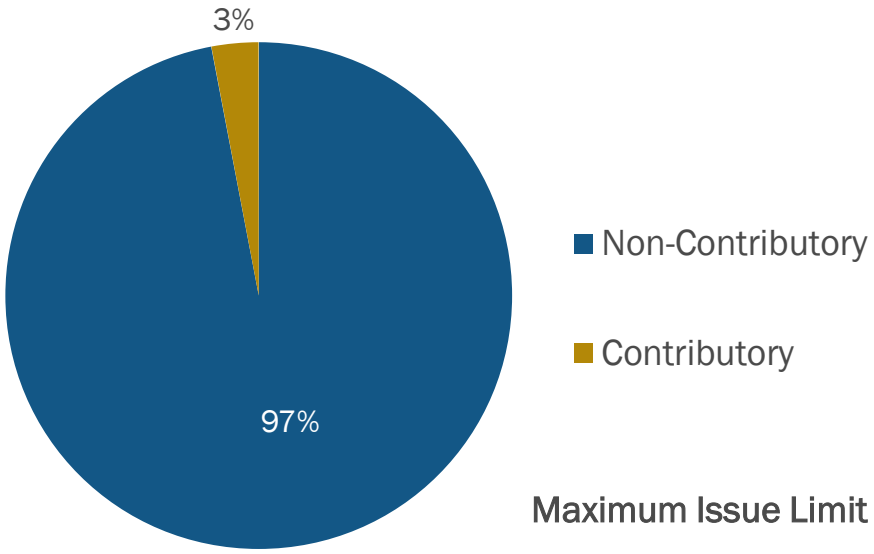
Rate Guarantee Period



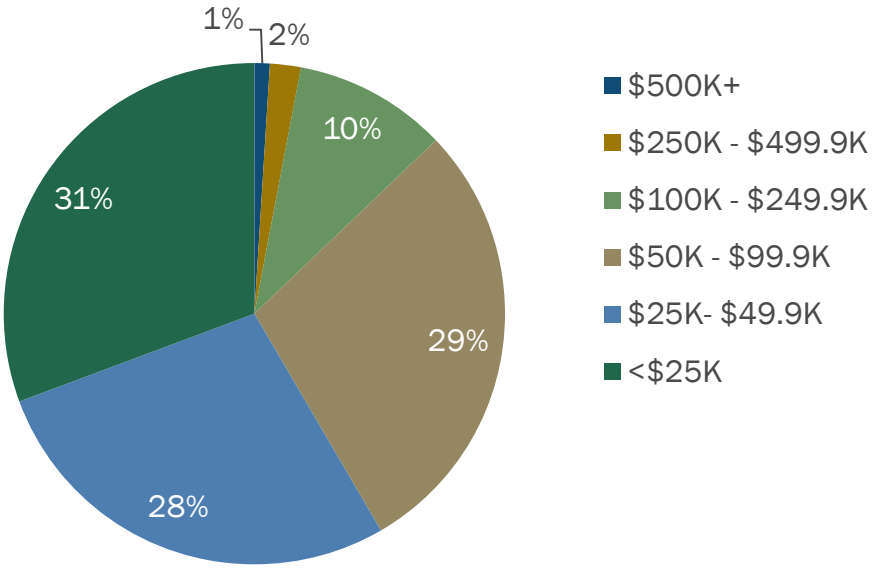
Source: Group Marketshare, LLC,
**Based on 31,418 cases (Industry Data including Guardian)*

Benchmarking | Basic Life Plan Design

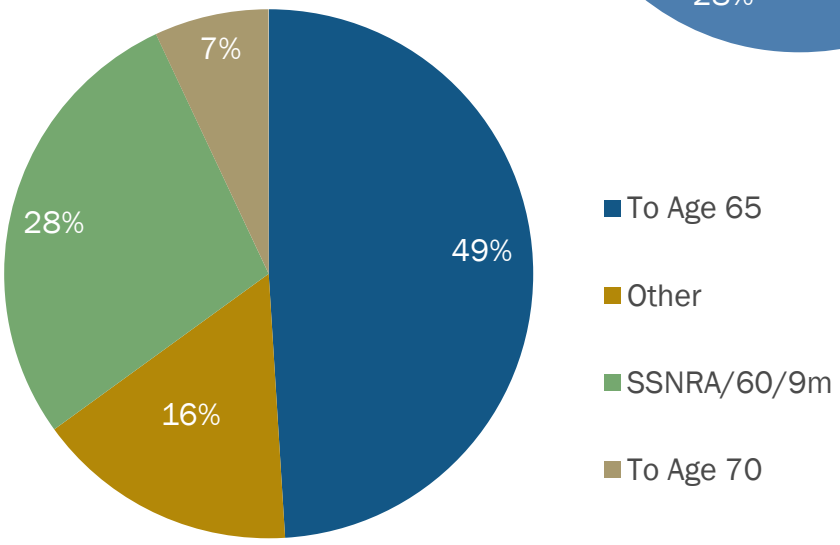
Contributory Basis



Maximum Issue Limit (Flat Benefit)



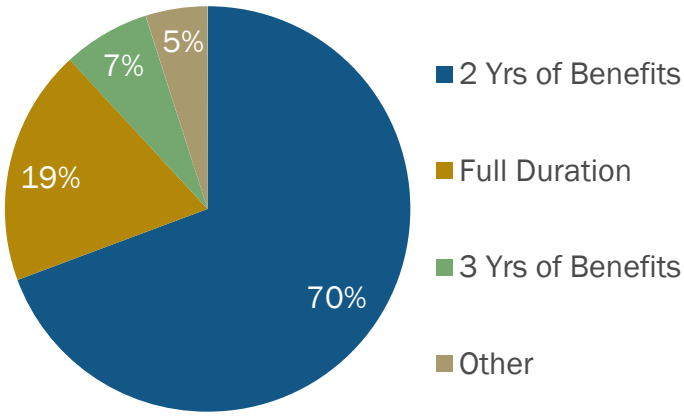
Waiver of Premium



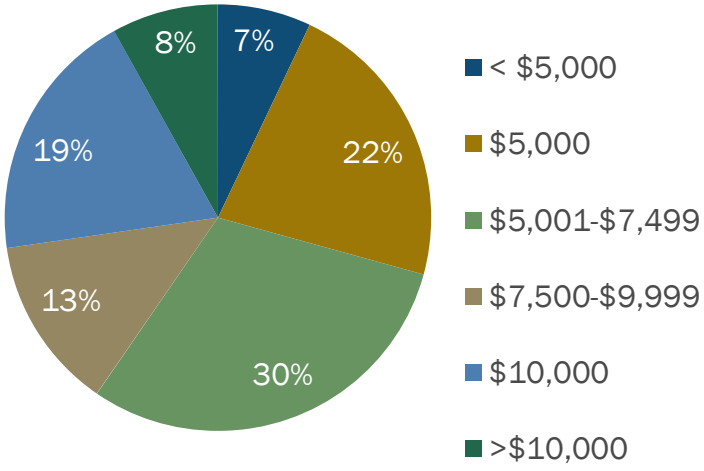
Source: Group Marketshare, LLC,
**Based on 31,418 cases (Industry Data including Guardian)*

Benchmarking | Long Term Disability Plan Design

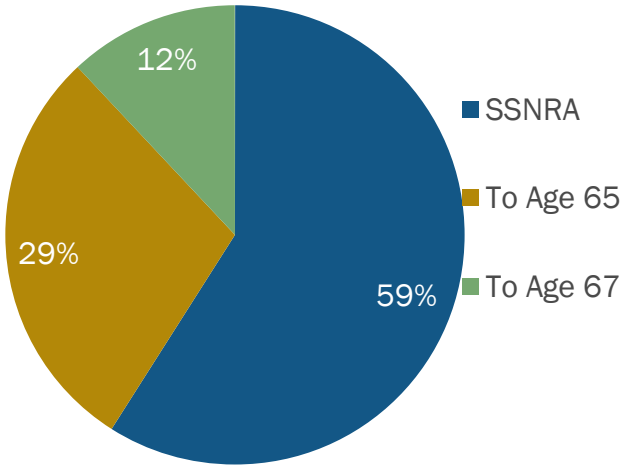
Own Occupation Period



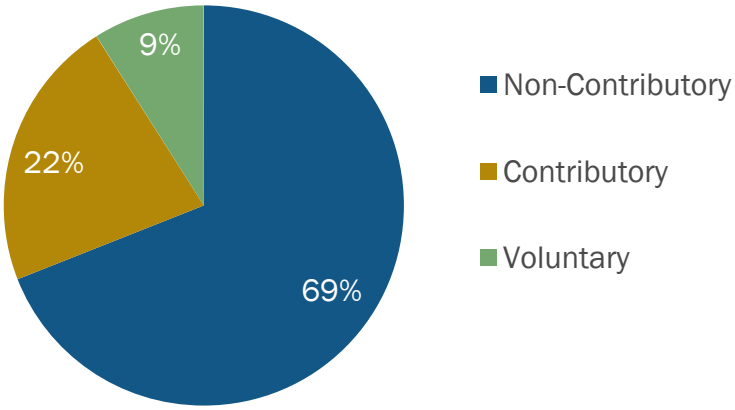
Maximum Benefit Amount



Maximum Benefit Period



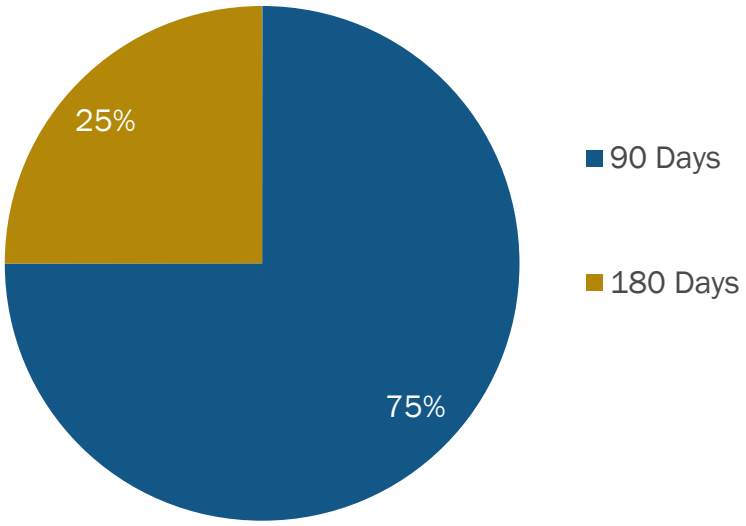
Contributory Basis



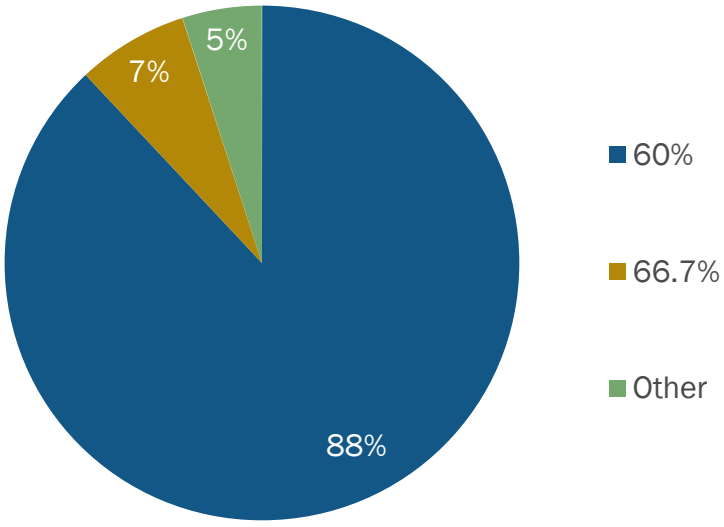
Source: Group Marketshare, LLC,
**Based on 31,418 cases (Industry Data including Guardian)*

Benchmarking | Long Term Disability Plan Design

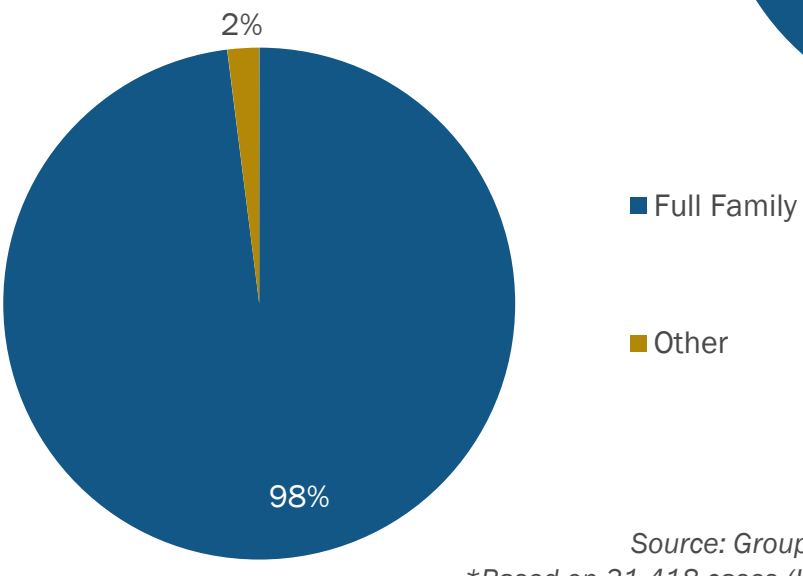
Elimination Period



Maximum Benefit Percentage



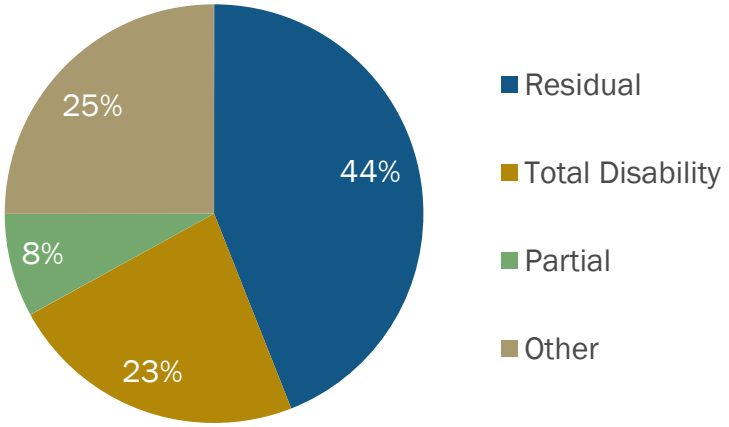
Social Security Integration



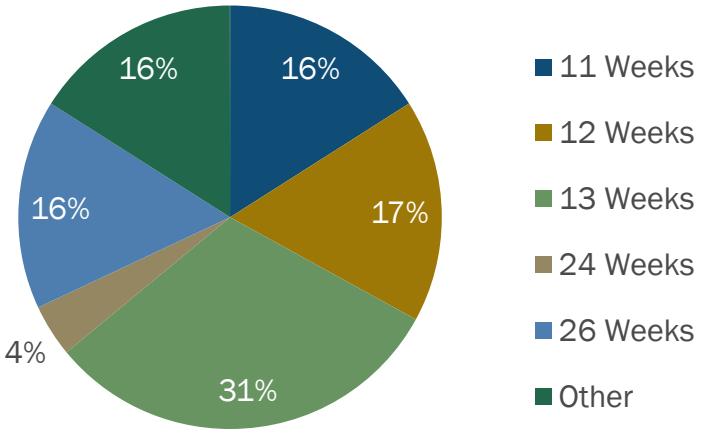
Source: Group Marketshare, LLC,
**Based on 31,418 cases (Industry Data including Guardian)*

Benchmarking | Short Term Disability Plan Design

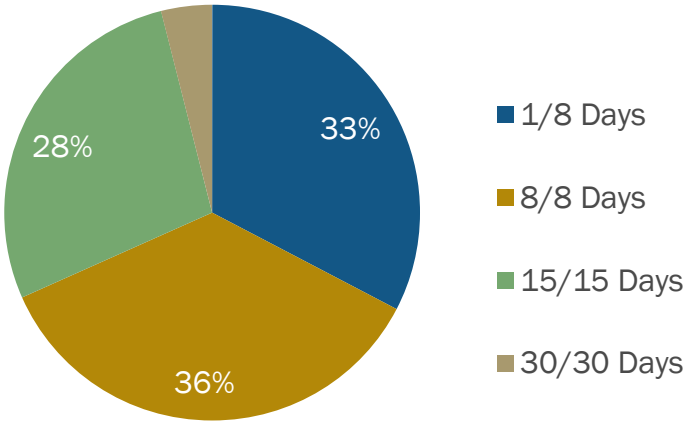
Definition of Disability



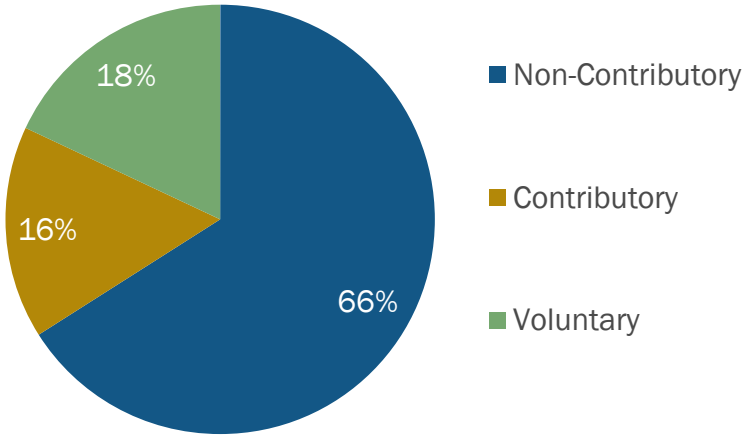
Maximum Benefit Period



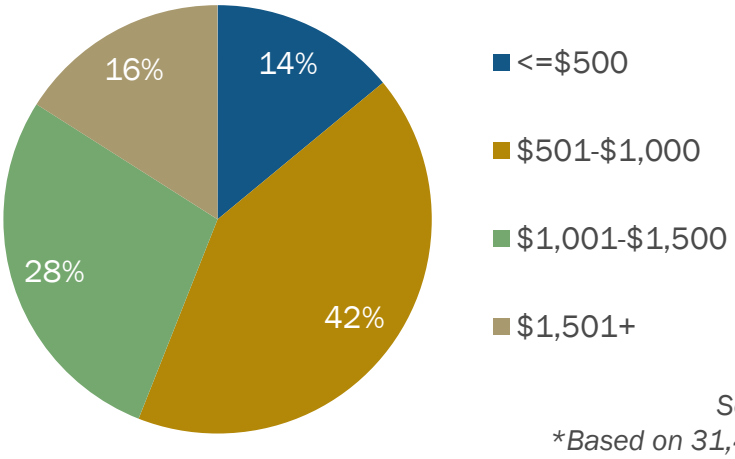
Elimination Period



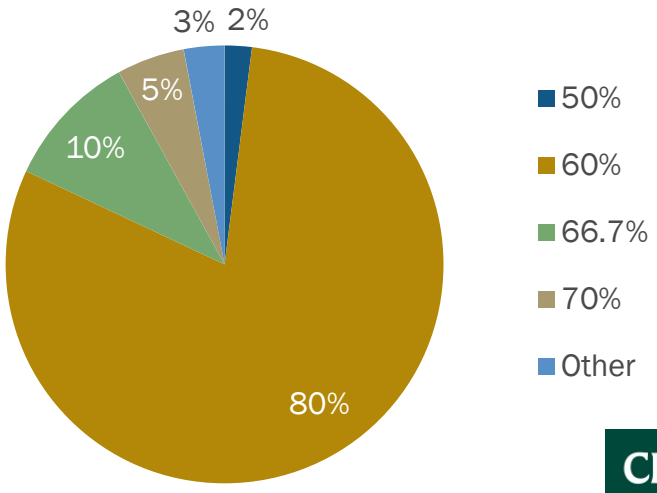
Contributory Basis



Maximum Weekly Benefit Amount



Maximum Benefit Percentage

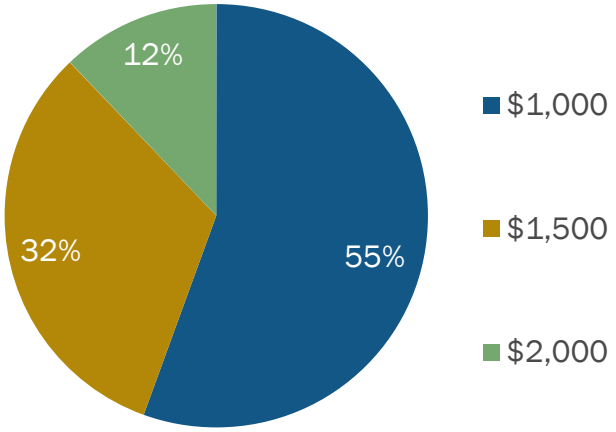


Source: Group Marketshare, LLC,
**Based on 31,418 cases (Industry Data including Guardian)*

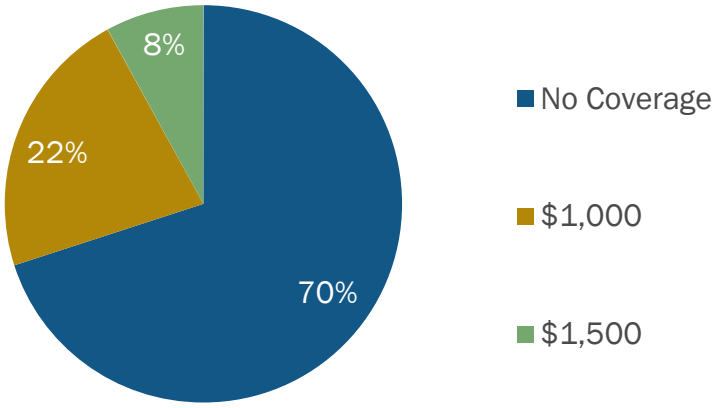
CBIZ

Benchmarking | Dental Plan Design

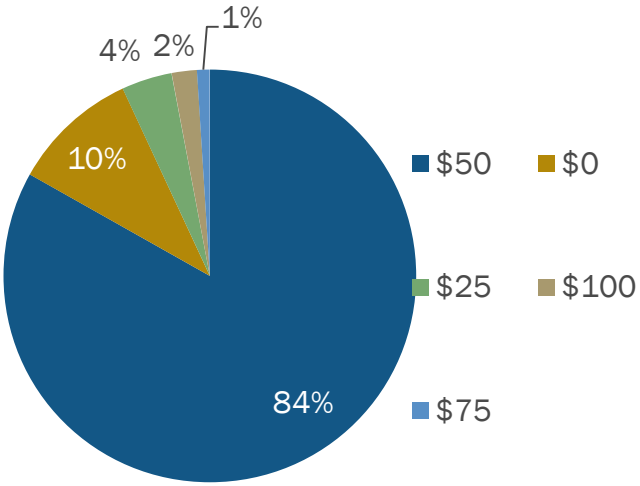
Dental Maximum



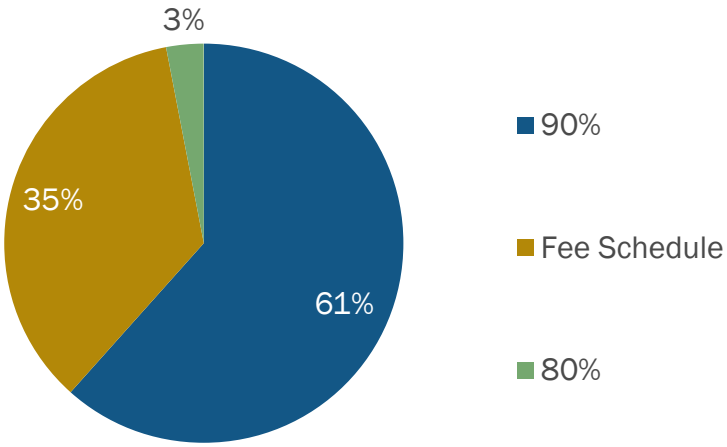
Ortho Maximum



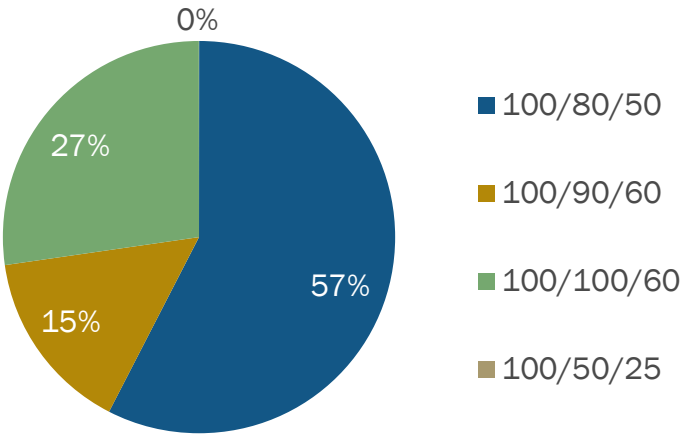
Deductible



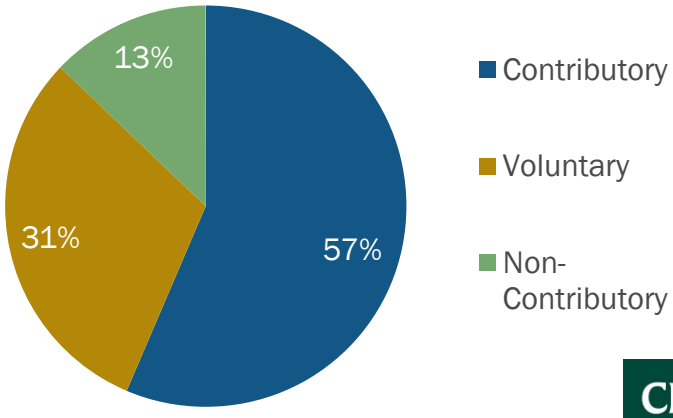
UCR



Coinsurance Combinations



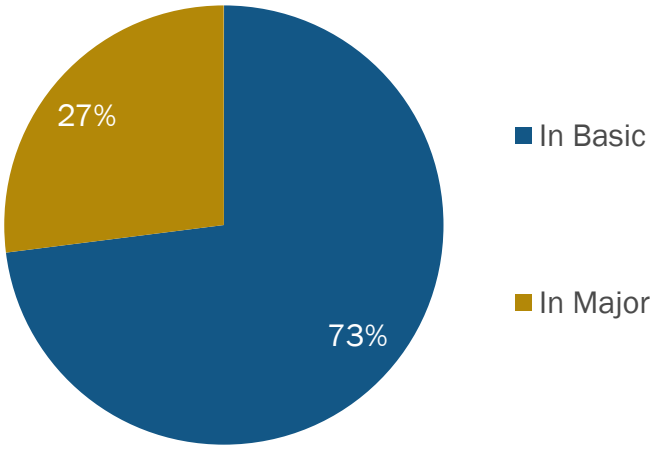
Contributory Basis



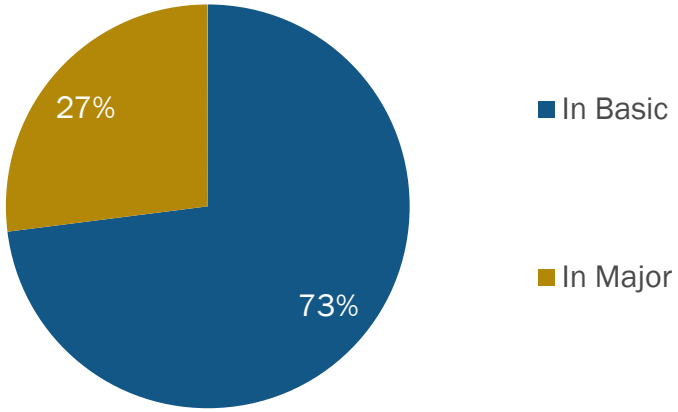
Source: June 2016 Dental GAGE Extract (Guardian Only)

Benchmarking | Dental Plan Design

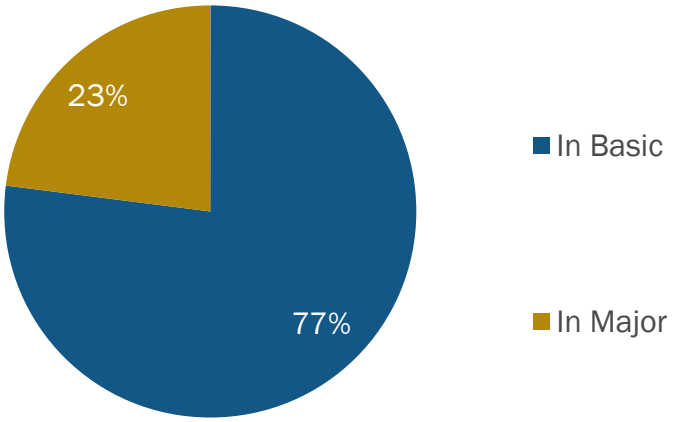
Periodontic Surgery



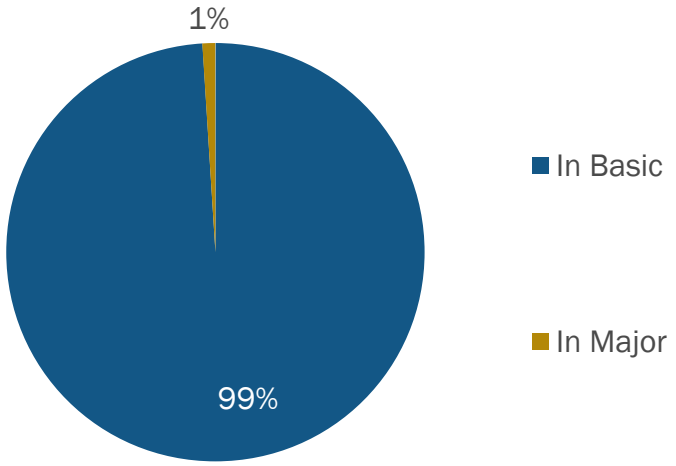
Complex Oral Surgery (Surgical Extractions and Other Oral Surgery)



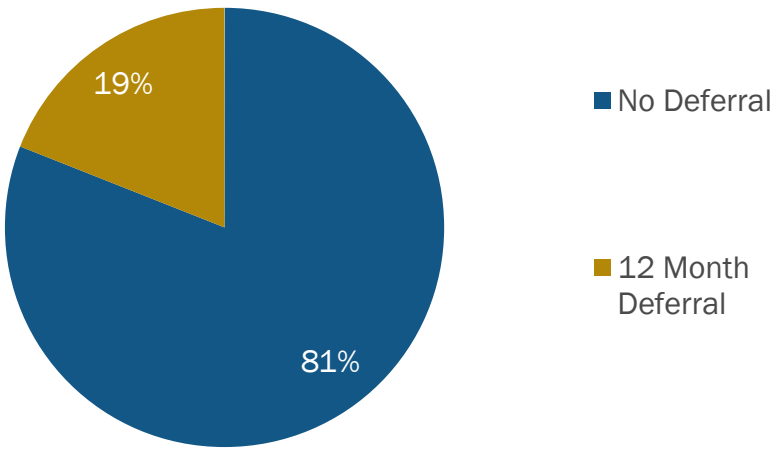
Endodontics: Molar Root Canals



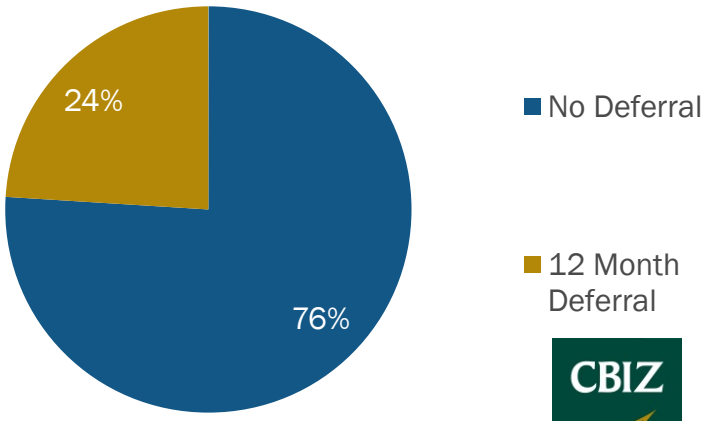
Endodontics: Non-Molar Root Canals



Deferred Perio Services



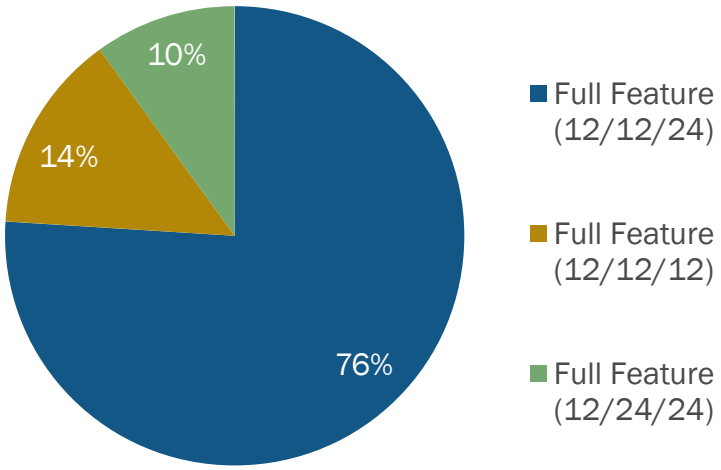
Deferred Major Services



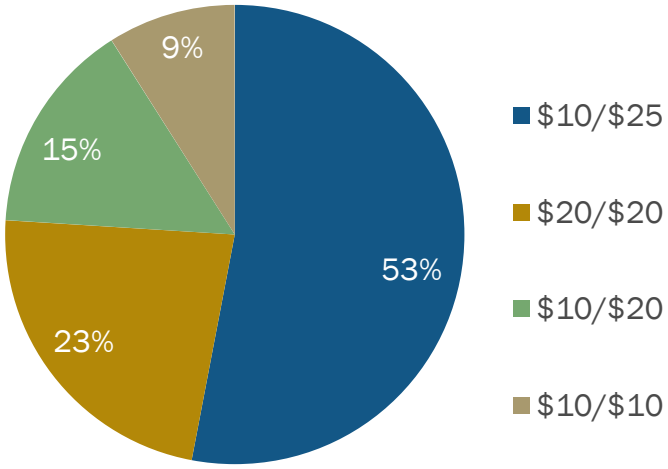
Source: June 2016 Dental GAGE Extract (Guardian Only)

Benchmarking | Vision Plan Design

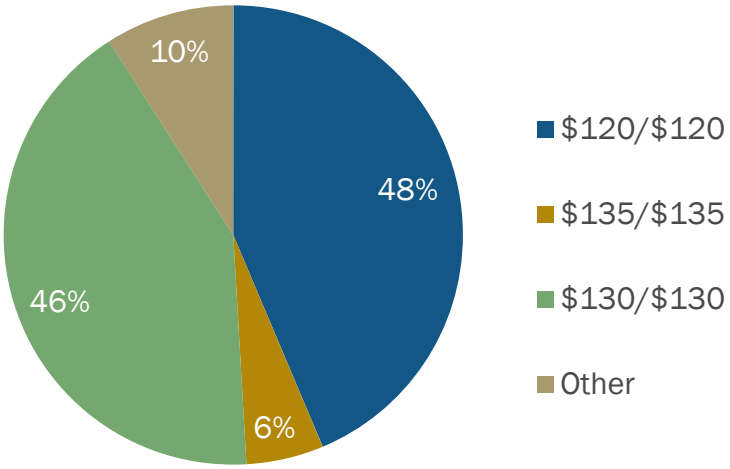
Plan Design



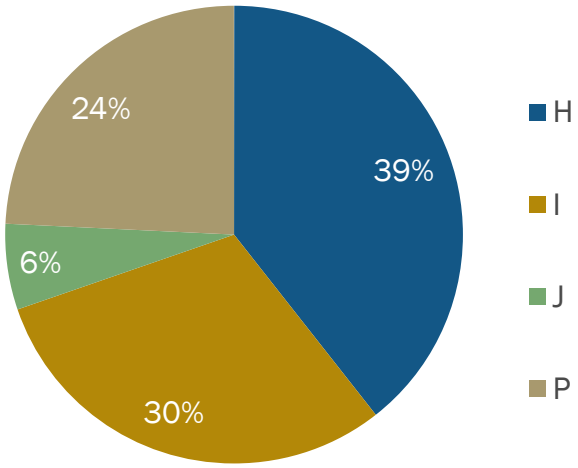
Split Copays



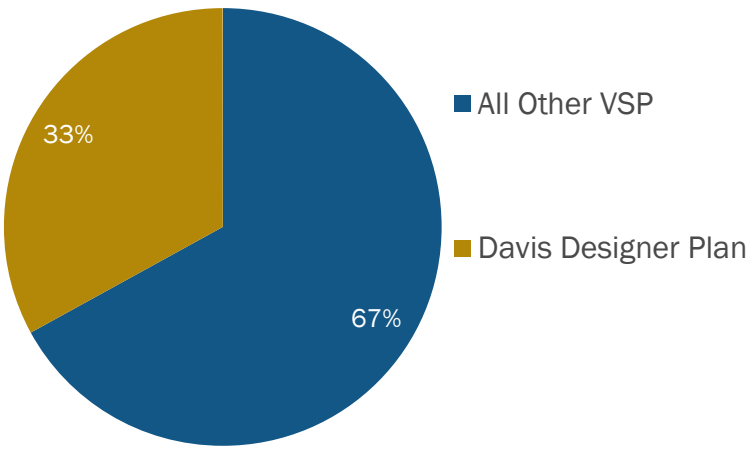
Contacts/Frame Allowances



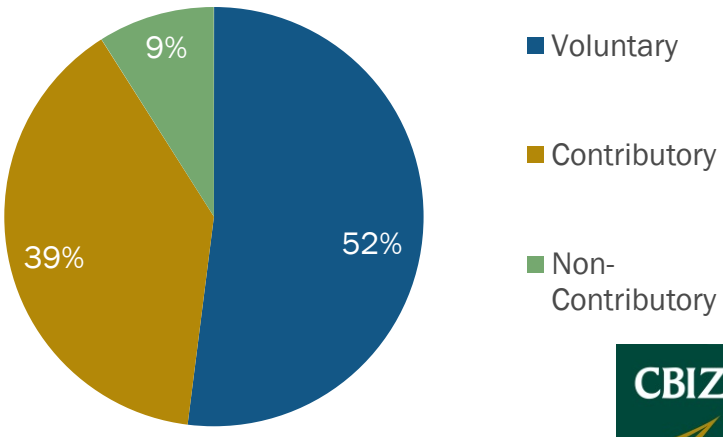
OON Schedule



VSP or Davis



Contributory Basis



Source: June 2016 Vision GAGE Extract (Guardian Only)

27. **Describe how you support the ongoing professional development of your clients.**

CBIZ provides the following programs for client's staff professional development:

- CBIZ publishes numerous periodic reports. See attached.
- CBIZ sponsors monthly webinars for our clients. See attached for a list of topics this year
- CBIZ University is available to our clients and their staff. See attached.
- CBIZ Atlanta staff conducts onsite training for HR and benefit staff on numerous topics ranging from Group Insurance 101 to HIPAA

28. **Does your firm provide assistance with executive benefits review and design?**

CBIZ has in house experts in executive benefits and design providing compensation consulting, benchmarking and design, as well as estate planning, differed compensation and wealth management. Three divisions within CBIZ handle this area of expertise headed by:

Compensation Planning	–	Ed Rataj
Life and Estate Planning	–	Steve Sublett
Wealth Management	–	Brian Dean

29. **Describe any additional services offered by your company that may be of interest to Pike.**

CBIZ full suite of services includes:
(Please see Scope of Services included after question 1)

- Property and Casualty Consulting / Brokerage
- Retirement Plan Service
- Human Resource Outsourcing – Full or Task Specific (see attached)
- FSA and COBRA Administration
- Executive Recruiting
- Executive Estate Planning and Business Continuation Planning
- Clinical Site and Practice Analysis e.g. onsite clinics, Accountable Care Organizations
- Cyber Security
- Accounting, Tax and Valuation Services
- Profit Recovery and Enhancement Practices

30. **Provide examples of value-added with employers and how this was executed.**

The following examples of Value Added for our client employers are:

- Employee Purchasing Programs
- Wellness Fairs, Incentives, and Giveaways
- Manual Data Conversion to Electronic Files and Manipulations
- Annual Compliance Guide by State
- Cyber Security Audit
- Foreign Language Assistance
- CBIZ University – Staff Training
- Pharm D review of Rx Utilization and Cost Mitigation Analysis
  (See all attachments on the following pages)

In This Edition:

CBIZ Benefits & Insurance Services

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WELLNESS RULES UNDER SCRUTINY

Two recent developments in the wellness program arena bear monitoring.

Challenging EEOC's Voluntary Standards. In response to the wellness program final regulations issued by the Equal Employment Opportunity Commission on May 17, 2016, the American Association of Retired Persons (AARP) brought a lawsuit against the EEOC, challenging the voluntary standards of the 30 percent requirement.

As background, the EEOC's regulations relating to the Americans with Disabilities Act (ADA) wellness standards prohibit the collection of medical information except to the extent that the request is voluntary (see *Wellness and the ADA – More Guidance Issued, Benefit Beat,* 7/7/16 and our Special Edition of *At Issue*, dated May 25, 2016, for a summary of the EEOC rules). Accordingly, the use of incentives (financial or in-kind such as time-off awards, prizes, or other items of value) in a wellness program, whether in the form of a reward or penalty, is permissible. If the wellness program is a participatory program or a health-contingent program, or some combination of the two, the maximum allowable incentive available under the program is 30 percent. The AARP challenged the 30 percent standard alleging that the 30 percent threshold is too high to constitute a voluntary standard.

In its review, the Court determined that the EEOC did not provide adequate substantiation for the 30 percent standard; therefore, the matter is returned to the EEOC for further consideration and validation of the 30 percent standard. The Court did say, though, that the May 2016 regulations will remain in effect until further analysis is provided by the EEOC. The Court's position is that plans have been implemented based on these regulations and to suspend them at this time would be too disruptive.

Continued from Page 1

Employers sponsoring wellness programs should stay tuned for future developments. It is unclear when the EEOC will have an opportunity to review these regulations since many of the EEOC's administrative and enforcement team positions remain unfilled.

Failure to provide reasonable alternatives to achieve wellness goals. The Department of Labor (DOL) is challenging Macy's benefit package, specifically relating to its smoking cessation component of its wellness program in a civil action complaint filed on August 16, 2017 in the U. S. District Court for the Southern District of Ohio (*Acosta v. Macy's Inc.* , S.D. Ohio, No. 1:17-cv-00541). The challenge alleges that Macy's failed to provide a reasonable alternative to participants which would have enabled them to avoid a tobacco surcharge, ranging from $35 to $45, for those who failed to meet the standards of Macy's tobacco cessation program.

As background, a contingent wellness program, whether activity or outcome-based, must provide a reasonable alternative to individuals under certain circumstances. Generally, a smoking cessation program can qualify as a reasonable alternative. The DOL alleges that Macy's continued to charge the smokers the higher rate without giving them an opportunity to achieve the reward.

Employers should review their wellness program to ensure that reasonable alternatives are provided and full rewards are granted to individuals who accomplish the reasonable alternative.

Procedures Important, Even in Denial

ERISA sets forth specific claims and appeal rules to be followed by health and welfare benefit plans, as well as retirement plans. Accordingly, plans are required to provide written notice of claim denials to participants and beneficiaries, in clear, easily understood language, setting forth the specific reasons for the denial, together with information about how the individual could seek a full and fair review of the denied claim. The plan's specific procedures, together with the relevant timeframes for processing claims and appeals, must be set forth in the plan document, as well as the summary plan description (SPD).

A recent case highlights the importance of providing adequate information to enable beneficiaries to exercise their rights under claims and appeals procedures. In *Turner v. Volkswagen Grp. of Am., Inc.*, 2017 WL 3037803 (S.D. W. Va. 2017), an employee was covered under a group plan that included health, life and disability benefits. Following the covered employee/participant's death, his surviving spouse sought the proceeds from the life insurance and long term disability benefits under the plan. While the employee/participant had received confirmation of coverage prior to his death, the insurer denied both the life and LTD benefits. Upon the spouse's inquiry relating to denial of the group life benefit, she subsequently received a letter from the employer/plan sponsor stating that an appeal of the denial must be accomplished within 60 days of the denial, together with the plan's SPD. The Court determined that the denial letter failed to reference the specific plan's internal review procedures in the body of the denial letter and merely enclosing the SPD was insufficient notification to enable the spouse to timely file an appeal.

Harvey Aftermath: Benefit Plan Assistance

Several government agencies including the Internal Revenue Service (IRS) and Department of Labor (DOL) are providing assistance and guidance to assist individuals and businesses affected by Hurricane Harvey. Following are highlights of guidance issued thus far.

- **Retirement plans**. Certain restrictions on plan loans and hardship distributions from retirement plans are eased for participants impacted by the hurricane, according to IRS Announcement 2017-11.
- Plan sponsors of **group health plans** are encouraged to provide reasonable accommodations to prevent loss of benefits by plan participants and beneficiaries who may be unable to meet certain deadlines for filing benefit claims or COBRA elections. See the DOL Compliance Guidance and FAQs for Participants and Beneficiaries for additional information.
- **Leave-based donation programs.** In Notice 2017-48, the IRS provides for certain tax relief for leave-based donation programs set up by employers to aid Hurricane Harvey victims. Under these programs, employees can elect to forgo vacation, sick, or personal leave in exchange for cash payments that the employer makes to charitable organizations. For income and employment tax purposes, leave donations would not be considered wages and thus, are tax free, as long as the employer provides these amounts to charitable organizations (as defined in Code Section 170(c)) before January 1, 2019.
- **Tax Filings**. Relief is available for certain tax filings and payments (see IRS' Tax Relief for Victims of Hurricane Harvey in Texas). Specifically, an extension is available for filing the Form 5500 series. This relief is not extended, however, for the Form W-2 nor the Forms 1094 and 1095.

Additional information relating to tax relief can be found on the IRS's dedicated webpage, Hurricane Harvey Information Center.

Looking ahead as other hurricanes are currently brewing, employers and plan sponsors are encouraged to monitor the IRS and DOL websites should the need for disaster assistance and guidance arise.

Another Delay in Fiduciary Rule Implementation

As has been anticipated for some time, the Department of Labor (DOL) is proposing delaying the January 1, 2018 effective date for certain aspects of fiduciary rules. On August 31, 2017, the DOL's Employee Benefits Security Administration (EBSA) published proposed regulations which would delay, until July 1, 2019, full implementation of the fiduciary rule's Best Interest Contract (BIC) exemption, the Principal Transactions Exemption, and certain amendments to a Prohibited Transaction Exemption. In addition, EBSA issued a Field Assistance Bulletin which sets forth an enforcement policy relating to an arbitration provision in the BIC Exemption and Principal Transaction Exemption.

For background information relating to the investment advice rules, see the May and December 2016 editions of our *At Issue* newsletters, and our *Benefit Beat* implementation coverage this year from the June 13th, April 10th , March 3rd, and February 15th editions.

As is currently the standard, investment advisers must comply with the impartiality standards contained in the fiduciary advice rules that require:

1. Any advisement rendered by a fiduciary must be in the best interest of the investor,
2. The fiduciary must take no more than reasonable compensation for such advice, and
3. The fiduciary must avoid making materially misleading statements.

Comments on these regulations are due by September 15, 2017. In the meantime, compliance with the impartiality standards as described above must continue to be maintained.

Possible Delay or Amendments to Enhanced Disability Claim Rules

The Department of Labor's Employee Benefits Security Administration (EBSA) released final rules on December 19, 2016 providing for enhanced standards for plans that make disability determinations (see *Disability Determinations: New Enhanced Rules Are Coming* (*Benefit Beat*, 1/5/17). These enhanced rules become applicable to all claims for disability benefits filed on or after January 1, 2018, and apply to any ERISA plan that makes a disability determination, including short and long term disability plans and retirement plans if such plan makes a disability determination.

On July 20, 2017, the DOL and EBSA submitted notice to the Office of Management and Budget indicating its intent to delay or amend these final rules due to questions of law and policy. The rationale for the delay or amendment is not publicly available at this time. In this interim, unless and until any amendment or delay is formally announced or put in place, plan sponsors are encouraged to review their current claims and appeal procedures to ensure compliance with the expanded rules.

Overtime Rules Thrown Out for Now

Many will recall that modification to the Department of Labor's (DOL) Wage and Hour Division overtime rules were to take effect on December 1, 2016. In large part, these rules would have changed the salary basis on which overtime is determined, raising it from an equivalent of $23,660 per year to a new level equivalent of $47,476 per year, and tying it to a regular inflationary increase.

On the eve of its effective date, the U.S. District Court of Eastern District of Texas granted a preliminary injunction preventing the DOL from implementing and enforcing the rules. Then, on December 1, 2016, the Department of Justice (DOJ), on behalf of the DOL, filed for an appeal of the District Court's preliminary injunction ruling, and subsequently filed a request for expedited briefing and oral arguments in the Fifth Circuit Court of Appeals on the following day. This was followed by a reply brief filed by the DOJ with the Court on June 30, 2017. Then, just a few days ago, on August 31, 2017, that same District Court has thrown out the overtime rules altogether. It is possible that an appeal could be filed, but for the moment, the overtime rules will not take effect.

Revised Medicaid/CHIP Premium Assistance Notice

Employers sponsoring health plans are obligated to annually provide a premium assistance notice to their workforce. This notification can be accomplished by using a model notice provided by the DOL's Employee Benefit Security Administration (EBSA). The model Medicaid/CHIP notice has been revised and is current as of August 10, 2017. Following are the changes to the revised notice, as compared to the January 31, 2017 version:

- In Massachusetts and Rhode Island, the phone numbers for the relevant agencies have changed;

- Both the website address and phone number for the Medicaid agency in Nebraska have changed; and
- The Medicaid website address has changed in West Virginia.

And finally, EBSA's website address that appears at the end of the model notice has been updated.

The notice explaining the right to premium assistance must be provided to employees residing in the below-listed states at least once annually, without regard to where the employer is located, or where the health plan is situsued:

States with Premium Assistance		
Alabama	Minnesota	Pennsylvania
Alaska	Missouri	Rhode Island
Arkansas	Montana	South Carolina
Colorado	Nebraska	South Dakota
Florida	Nevada	Texas
Georgia	New Hampshire	Utah
Indiana	New Jersey	Vermont
Iowa	New York	Virginia
Kansas	North Carolina	Washington
Kentucky	North Dakota	West Virginia
Louisiana	Oklahoma	Wisconsin
Maine	Oregon	Wyoming
Massachusetts		

The revised Medicaid/CHIP notice is available for viewing and/or downloading from the DOL's website, in both English (pdf or word) and Spanish (pdf or word).

Reminder: Distribute Medicare Part D Notices by October 15th

Plan sponsors have an annual obligation to provide the Medicare Part D creditable notices to Medicare-eligible individuals. The annual Medicare Part D open enrollment period for the 2018 year begins October 15, 2017 and runs through December 7, 2017.

The Medicare Part D Notice of Creditable or Non-creditable Coverage must be provided to Medicare-eligible individuals at least annually, prior to the Medicare Part D open enrollment period. This means that all Medicare Part D notices of creditable or non-creditable coverage must be provided within the 12-month period ending on October 15, 2017.

The Centers for Medicare and Medicaid Services (CMS) provide model language that can be tailored by plan sponsors to satisfy their notice obligation:

- Model Individual Creditable Coverage Disclosure Notice Language (English or Spanish)
- Model Individual Non-Creditable Coverage Disclosure Notice Language (English or Spanish)

New York Paid Family Leave Law Updates

As follow-up to last month's *Benefit Beat* article discussion of the New York Paid Family leave (PFL) law, this article discusses some recently released guidance relating to reporting of employee contributions, as well as some additional compliance tips for employers.

Reporting Contributions on Form W-2. The New York Department of Taxation and Finance released guidance relating to the tax consequences of this law. Under the PFL law, an employee can be required to pay the full cost of the benefit. The tax guidance indicates that the premium is to be paid on an after-tax basis and reported on the employee's Form W-2, using Box 14 (state disability insurance taxes withheld). PFL benefits are taxable non-wage income that must be included in federal gross income. Generally, withholding is not automatic, though, the individual beneficiary can request withholding. The benefits paid are reported by the payer (generally, the insurer) on a Form 1099-MISC.

Next Steps for Employers. In light of the final regulations adopted by New York Workers' Compensation Board and Department of Financial Services, following are some steps for employers to consider in an effort to ensure compliance with the law when it takes effect on January 1, 2018.

1. Contact your state temporary disability insurer to begin the process of obtaining a PFL policy.
2. Determine, in conjunction with your insurer, what, if any, payroll deduction will be collected from your employees.
3. Develop an internal PFL policy. Points to include:
   - *Eligibility*. Generally, employees who regularly work a minimum of 20 hours per week are eligible for PFL benefits after 26 consecutive weeks of employment; those working fewer than 20 hours a week are eligible after 175 work days.
   - *Funding sources* addressing whether contributions will be derived solely by the employee contributions through a payroll deduction process, or, whether the employer fully funds the benefit, or perhaps a combination of both employee/employer contributions;
   - *A description of how leave can be used*. Under the PFL law, instances giving rise for the need for leave include baby bonding, to provide physical or psychological care to a family member with a serious health condition; or to relieve family pressures when the employee's spouse, domestic partner, child, or parent is on active military duty.

Leave taken to attend to the employee's own serious health condition would be handled through the state temporary disability program.

- *Definition of family member*. Keep in mind that the law defines family member as a biological, adopted or foster child, a parent, grandparent, grandchild, spouse, or domestic partner.
- *Amount of leave available*. The law requires that PFL benefits must be available to an eligible employee for the first full day when family leave is required and thereafter during the continuance of the need for family leave, subject to limitations below:

Effective Date	Weekly amount of PFL per any 52-week period	Amount of Benefit	Benefit Cap
January 1, 2018	8 weeks	50% of employee's average weekly wage	50% of the state average weekly wage
January 1, 2019	10 weeks	55% of employee's average weekly wage	55% of the state average weekly wage
January 1, 2020	10 weeks	60% of employee's average weekly wage	60% of the state average weekly wage
January 1, 2021	12 weeks	67% of employee's average weekly wage	67% of the state average weekly wage

- *Coordination with other types of leave*, including but not limited to the New York City Earned Sick leave law, the federal Family and Medical Leave law (FMLA), and any existing internal leave policies and applicable federal, state and local leave laws;
- *A description of the employee notification obligations* addressing both foreseen and unforeseen instances that would give rise for the need for leave and the process for requesting leave. Include the insurer contact information, where applicable. Under the PFL law, employees making a claim for PFL leave are required to complete a designated PFL request form provided by the insurer, or by an employer who is self-funding the benefit. Generally, the employer would be required to complete its portion of the form and return it to the employee within three business days. In addition, consider including an explanation of the process of how employees can provide proper substantiation for the need for leave, for example, medical certification from a healthcare provider, active duty orders or other military documentation, a birth certificate or other documentation of the need for family leave.
- *A description of continuation of benefits during the leave* including how and when health premium or other benefit premiums must be paid, as well as address the manner and methodology of benefit accruals during the leave; and
- *A description of reinstatement rights*. Under the PFL law, an individual is entitled to be returned to his/her same or equivalent position once the individual returns from leave.

And finally, be aware of the workplace posting requirement. Check with the insurer to determine whether a model workplace posting is available.

Additional information and any available updates about the New York PFL program can accessed on the state's dedicated website.

About the Author:

Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.

Subject: 1) IRS Releases Finalized 2017 Forms and Instructions for the 1094/1095 Series; 2) Fee Reminders: Health Insurer Provider Fee and Transitional Reinsurance Fee
Date: October 4, 2017

2017 ACA Reporting Forms 1094 and 1095 Series

The 2017 Affordable Care Act reporting is upon us. The forms to be used, and the instructions for those forms, have just been released by the Internal Revenue Service. As a reminder, there are two annual reporting obligations imposed by IRC Section 6055 minimum essential coverage reporting, and by IRC Section 6056, employer shared responsibility reporting.

- The minimum essential coverage (MEC) reporting obligation is accomplished on the Form 1094-B transmittal and Form 1095-B statement to individuals. Generally, this reporting is accomplished by the insurer if the plan is insured. If the plan is self-funded, the employer is obligated to complete the MEC reporting and disclosure.
- Employers subject to employer shared responsibility (those employing 50 or more employees as of December 31, 2016 for the 2017 reporting year), can accomplish the MEC obligation by completing Part III of the Form 1095-C. Employers not subject to employer shared responsibility reporting accomplish the MEC reporting obligation by reporting the B series described above. The employer shared responsibility reporting obligation is accomplished on the Form 1094-C transmittal and the Form 1095-C statement to individuals.

Following are links to the particular forms and instructions:

Health Insurance Coverage Reporting by Insurers and Sponsors of Self-funded Plans (IRC § 6055)

- Instructions for 2017 Forms 1094-B and 1095-B (PDF)
- Form 1094-B, *Transmittal of Health Coverage Information Returns*
- Form 1095-B, *Health Coverage*

Employer Health Insurance Reporting Requirement (IRC § 6056)

- Instructions for 2017 Forms 1094-C and 1095-C (PDF)
- Form 1094-C, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*
- Form 1095-C, *Employer-Provided Health Insurance Offer and Coverage*

Deadlines for Filing and Distributing Forms 1094 and 1095

- ✓ Statements to individuals for both the B and C series must be furnished by January 31, 2018. Entities can request an extension for furnishing the statements by sending a letter to the IRS (see the instructions for the required content of the letter to request the extension and mailing address).

- ✓ Electronic filing of the forms must be accomplished by April 2, 2018; or, February 28, 2018 if filing by paper. At this point, no delay has been granted for filing these forms. An automatic 30-day extension is available by filing a Form 8809.

Changes to the Forms and Instructions. Generally, the 2017 forms are similar to the 2016 forms. Narrowing our focus on the C series of the forms, following are a couple clarifications and modifications:

- Several forms of transitional relief were available in 2015. To the extent the relief is no longer available, references to such relief have been removed.
- The instructions clarify that for purposes of the 9.5% affordability safe harbors and qualifying offer method references, the adjusted indexed percentage is 9.66 percent for plan years beginning in 2016, and 9.69 percent for plan years beginning in 2017. For 2018, the percentage decreases to 9.56 percent
- With regard to making corrections to filed forms, the instructions indicate that a Form 1095-C filed with incorrect dollar amounts on line 15, Employee Required Contribution, may fall under a safe harbor for certain *de minimis* errors. The safe harbor generally applies if no single amount in error differs from the correct amount by more than $100. If the safe harbor applies, then the reporting entity would not be required to correct the Form 1095-C to avoid penalties. However, if the recipient elects for this safe harbor not to apply, then the reporting entity may have to issue a corrected Form 1095-C to avoid penalties.
- Part II of the Form 1095-C contains a box to indicate a 2-digit number designating the start month of the plan. The obligation to complete this box remains optional for 2017 reporting purposes.
- Certain multiemployer transition relief is still available.

Information reporting penalties. The penalties for failure to provide the information return or provide correct payee statement remain essentially the same.

- The penalty for failure to file a correct information return is $260 for each return for which the failure occurs, with the total penalty for a calendar year not to exceed $3,218,500.
- The penalty for failure to provide a correct payee statement is $260 for each statement for which the failure occurs, with the total penalty for a calendar year not to exceed $3,218,500.
- Special rules apply that increase the per-statement and total penalties if there is intentional disregard of the requirement to file the returns and furnish the required statements.

Additional information relating to ALE obligations including the ACA Information Returns (AIR) system, can be found on the IRS's dedicated webpage, *ACA Information Center for Applicable Large Employers (ALEs)*. Also see:

- *Questions and Answers about Information Reporting by Employers on Form 1094-C and Form 1095-C*
- *Questions and Answers on Information Reporting by Health Coverage Providers* (Section 6055)

Fee Reminders: Health Insurer Provider Fee and Transitional Reinsurance Fee

- ❑ **Return of the Annual Health Insurer Provider Fee.** As mentioned this summer, covered entities and insurers will become subject to the ACA's health insurer provider fee again, beginning January 1, 2018. These entities were given a one-year moratorium for 2017. Although employers are not subject to these fees, the covered entity/insurer may pass along some of these costs to employer/policyholders; thus, employers with insured plans may begin seeing this fee reflected in their renewals.

- **Transitional Reinsurance Fee Reminder.** The transitional reinsurance fee and related reporting obligation was imposed over a three-year period from 2014 to 2016. For the last year of the program, insurers and plan sponsors of self-funded plans were obligated to submit their 2016 form reflecting the annual enrollment count of covered lives by November 15, 2016. The full fee was due by January 17, 2017. However, for reporting entities who opted to make two payments, the deadline for submitted the Form remains November 15, 2016, with the first part of two payments due by January 17, 2017; the second payment is due by November 15, 2017.

About the Author: Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.

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CBIZ ESO™

Wellbeing Insights

Living a Better, More Vibrant Life

Brain Power Boosters

Our intelligence is not purely a fixed quality. In fact, there are several things we can do to boost our brain power to not only learn new things but also retain the information we learn.

1. **Be curious**. Einstein once said, "I have no special talent. I am only passionately curious." By nature, some of us are more curious than others; however, we can all act on our curiosities more often. Try to become more aware of the things that spark your interest and seek to understand them better. As adults it's easy to take on our past interests as 'who we are,' but the truth is that you probably have new interests and curiosities popping up all the time; take the time to learn.

2. **Be wise with your time online.** It's hard to avoid the mindless black hole of social media, so we must bring some awareness to how we are spending our time online. Set a timer if you must to limit your time scrolling through biased or unimportant content. Make sure you are not only researching new things that challenge you but also seeking out reputable sources and multiple perspectives when it comes to matters of opinion.

Continued on page 2

In This Issue

September: Prostate & Ovarian Cancer Awareness Month; Family Health & Fitness Day

Brain Power Boosters Continued from page 1

3. **Write it down.** This is a tried and true method to help retain new information. Even if you learn something that you think is so interesting you would never forget it, chances are you probably will. You may even wish to carry a notebook and make it a point to write what you've learned each day. Then, make a habit of reading it each week.

4. **Keep wise company.** You become more like the people you surround yourself with, so make time for friends who challenge you mentally. Don't let fear of sounding stupid get in your way; ask probing questions, be a good listener and ask openly for opinions on your views.

5. **Teach.** "If you can't explain it simply, you don't understand it well enough." Another gem from our friend Einstein. Teaching something to someone else is a great way to gauge just how well you actually understand it. If you can teach it easily, that means you're also committing it to memory.

6. **Try new things.** You never know what is useful until it is. If the opportunity to learn a new skill or understand an unfamiliar phenomenon arises, take it. Even if it seems irrelevant or useless to you, we incorporate new skills in abstract ways, so it may be more useful than it appears.

7. **Reflect.** Take some downtime each week or even daily to reflect. Taking this time to process and synthesize information may help you come to new realizations about your experiences or a better understanding of things you've learned.

Mindful Minute

When it comes to self-care there is no shortage of things we know we should do: I should drink a glass of water, I should take a break from my computer, I should choose a healthier lunch option, I should mediate, I should read, I should take time for myself, etc.

Perhaps the one thing we really should do is let go of thinking we should do so much. It's quite the paradox really – viewing acts of self-love, which are self-serving by nature, as a chore. Instead, what if we could shift our thinking so that we let go of what we should do and simply focus on what we would like to do? Here's how to **let go of what you should do** in a healthy way.

The next time you find yourself feeling obligated to an act of self-care (exercising, going to bed early or attempting to be a more positive thinker or organized person) take pause. Ask yourself, what do I want to do right now that would support me in the contribution I hope to make today/in this moment?

True self-care cannot occur in a judgmental context (e.g., If I don't do this, I'm failing or not good enough.). So tend to your needs by asking more thoughtful questions around self-care that lead to better actions. Remember to give yourself a break as you experiment with this. If you listen to yourself and do end up in self-sabotage or feeling guilty, just take note. Simply bringing in awareness will help you find better ways to care for yourself and find what feels right for you.

"When you recover or discover something that nourishes your soul and brings joy, care enough about yourself to make room for it in your life."

JEAN SHINODA BOLEN

All About Artichokes

Artichokes are an interesting vegetable with a long history and a reputation for having myriad health benefits. Artichokes first appeared in the Mediterranean and were enjoyed by ancient Greeks and Romans. They are reportedly one of the oldest foods known to humans. In fact, during the 16th century, eating an artichoke was reserved only for men because they were considered a strong aphrodisiac and not suitable for women.

Cultivation of the vegetable spread throughout the western hemisphere and eventually reached the United States through California. Today, California remains the main producer of globe artichokes in the U.S.

Artichokes have been sought after for centuries for their proposed medicinal properties. Today, we know that they do contain high nutritional value. Studies have shown that artichokes can provide many health benefits, including:

- high levels of dietary fiber, which can help control constipation and decrease “bad” cholesterol
- chemical compounds cynarin and sesquiterpene-lactones, which are known to maintain healthy blood cholesterol levels
- large amount of vitamin C, which helps the human body develop resistance against infections and free radicals in the body
- a great source of vitamin K, which plays a vital role in bone and brain health
- a rich source of B-complex vitamins, which are essential for optimal cell function
- an excellent source of folic acid, which is especially important during early pregnancy in helping to prevent neural tube defects in newborn babies

Keep It Fresh

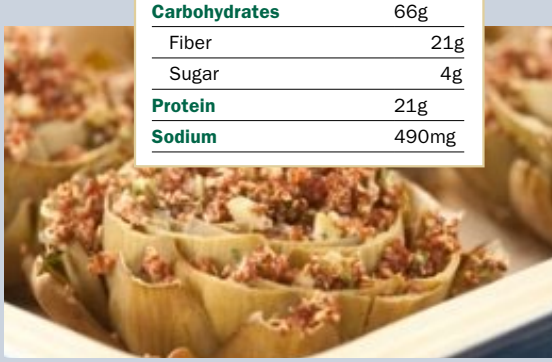
Artichokes are a popular Fall/Winter season vegetable but can be found in grocery stores year round. Choose fresh artichokes that feel heavy and don’t exhibit any cuts or bruises. The leaves of the artichoke should be compact and dark green. They are best used while fresh but will keep well in the refrigerator in a sealed plastic bag up to one week.

Quinoa-Stuffed Artichokes

Nutrition Info

Per Serving (1 artichoke)

Calories	370
Carbohydrates	66g
Fiber	21g
Sugar	4g
Protein	21g
Sodium	490mg



Ingredients:

- ☐ 4 large artichokes
- ☐ 1 lemon
- ☐ 1 cup red quinoa (or preferred variety)
- ☐ ½ cup grated Parmesan cheese
- ☐ 2 Tbsp. freshly chopped mint
- ☐ 2 Tbsp. freshly chopped parsley

Directions:

Fill a large bowl with water and juice of the lemon and stir well. Cut stems of the artichokes so they sit flat and peel stems with a paring knife. Cut off the top third portion of the artichoke and use scissors to clip off the sharp leaf points. Put artichokes in bowl with lemon and water. Bring a large pot of water to boil (water depth of 1 - 2 inches). Once boiling, arrange trimmed artichokes, bottoms up, in a single layer. Cover pot, reduce heat to medium low and steam until tender, about 20 - 40 minutes. Artichokes will be ready when the leaves pull out easily and the base can be pierced with a knife. Drain well.

Meanwhile, rinse quinoa under cold running water and drain. Combine quinoa and 2 cups water in a medium pot and bring to a boil. Reduce to a simmer and cook until tender, about 15 - 20 minutes. Fluff with a fork and set aside to cool. Stir in Parmesan, mint and parsley.

Preheat oven to 400°F. Remove the center leaves from each artichoke and scoop out and discard the fuzzy center. Place artichokes stem side down in a baking pan and stuff with quinoa mixture. Bake 20 minutes or until heated through.

Adapted from wholefoodsmarket.com

Prostate Cancer At-a-Glance

The prostate produces fluid that nourishes the sperm in semen. This walnut-shaped gland surrounds the urethra just below the bladder. Prostate cancer is the second most common cancer in American men with over 230,000 cases diagnosed each year, more than 29,000 of which result in death.

Risk Factors:

- increasing age
- a family history of prostate cancer
- being African American

Signs/Symptoms: Early-stage prostate cancer typically has no symptoms. At more advanced stages, prostate cancer may cause any of the following:

- difficulty starting urination and emptying the bladder
- decreased force in urine stream
- blood in the urine or semen
- pain or burning during urination
- difficulty ejaculating or erectile dysfunction
- bone pain or discomfort in the pelvis

Prevention/Detection:

- Digital Rectal Exam: A doctor or nurse inserts a gloved, lubricated finger into the rectum to check the prostate for abnormalities.
- Prostate-Specific Antigen (PSA) Test: A blood test that measures the level of PSA in the blood. Higher PSA levels are one indication of prostate inflammation, infection, enlargement or cancer.

The use of these two tests combined can help identify prostate cancer in its earliest stages. However, there is a debate on the risks and benefits of screening, and medical organizations differ in their recommendations.

Speak with your doctor about screening to determine what's right for you.

BEAT Ovarian Cancer

The ovaries produce a woman's eggs and are the main source of the female hormones estrogen and progesterone Women have two ovaries, each about the size of an almond, on either side of the uterus. Ovarian cancer ranks fifth among leading causes of cancer death in American women with over 21,000 cases diagnosed each year, more than 14,000 of which result in death.

Risk Factors:

- increasing age (particularly post-menopausal)
- family or personal history of ovarian, breast, uterine or colon cancer
- never giving birth
- trouble getting pregnant
- being of Eastern European decent

Signs/Symptoms:

- persistent bloating/increased size of abdomen
- pelvic or abdominal pain
- trouble eating or feeling full quickly
- increased urinary urgency or frequency

Prevention/Detection:

Protective factors for ovarian cancer include pregnancy, breastfeeding, the use of birth control pills, having your 'tubes tied' and having a hysterectomy.

Unfortunately, there are no formally recommended screening tests for ovarian cancer. Contrary to popular belief, a PAP test does not detect ovarian cancer. If you believe you are at increased risk and/or experience unexplained signs or symptoms of ovarian cancer, speak with your doctor about screening options. These may include a rectrovaginal pelvic exam, a transvaginal ultrasound, a CT or PET scan, or various blood tests.

BEAT stands for:

Bloating. It's persistent and doesn't come and go.

Eating. Difficulty eating and feeling full more quickly.

Abdomen. And pelvic pain you feel most days.

Talking. Tell your doctor.

Exercise Myth Busters

Myth: Your routine isn't working if you aren't losing weight.

Fact: Exercise is beneficial regardless of weight loss. It's true that it's better to be overweight and fit than skinny and sedentary. Exercise can also change the way your body functions and your muscle-to-fat ratio in the absence of weight loss. It's more beneficial to focus on the rewards of your exercise, such as increased energy and stamina and improved focus, flexibility, mood, sleep and functionality than the number on the scale.

Myth: As long as you get regular exercise it's ok to be a couch potato the rest of the time.

Fact: Research has found that reaching the recommended 150 minutes of exercise each week is not enough to combat the negative effects of prolonged sitting. You don't need to exercise during the day, but it is imperative that you regularly stand up and move around a bit. Shoot for five minutes of every hour to stand and stretch at your desk, climb a few flights of stairs or take a short walk.

Myth: You can lose fat from specific parts of your body.

Fact: Spot reduction is an elusive concept. The calories you expend during exercise help burn fat from your entire body. While exercises that target specific areas certainly help tone specific muscles, that does not necessarily mean they are burning fat from that place. Performing exercises only on targeted areas can actually be detrimental to overall functionality, so take a full-body approach.

Myth: You should do extensive stretching before your workout to avoid injury.

Fact: Stretching is exceedingly important post-workout. Performing static stretches on cold muscles can increase your chance of injury. To warm up, stick to dynamic stretches, that is, ones where you are moving the entire time and warming up the muscles, not stretching them and holding the position.

Myth: Sports drinks are superior to water during exercise.

Fact: Sports drinks are only necessary when you've lost significant sodium or electrolytes due to a very long workout (longer than 90 minutes) or a very high intensity workout where you sweat substantially. Many sports drinks are full of sugar and/or artificial sweeteners that can do more harm than the electrolytes you are trying to replenish. Water is the ideal hydration for the average person, exercising at moderate intensity for up to an hour.

App in a Snap

Name: Geocaching
Price: Free
Focus: Physical Wellbeing

Geocaching is the world's largest treasure hunting game! This app allows participants to hide and seek containers, called "geocaches" or "caches," at specific locations marked by coordinates all over the world. Geocaches are real objects full of treasures. You can even swap out something someone else left and leave your keepsake for the next geocacher to discover. Connect with others in your community who share an interest in treasure hunting or enjoy an exciting way to get the kids active with you.

Gabriel Ross, CBIZ Wellbeing Account Manager, says, "Whether it's finding an activity to entertain the children on Saturday afternoon or getting some extra Vitamin D in the summer sun, geocaching is a fun way for me to socially connect and explore my community."

Encouraging Active Kids

Parenting is a constant balancing act between work, daily life routines and finding time to instill habits that will help your child develop as they mature. Parents today have the benefit of technology to help them teach and instill habits during child development. However, recently there has been a lot of focus on the negative impact technology has, along with other factors, on the physical inactivity of adolescents.

The American Heart Association recommends that children and adolescents participate in at least 60 minutes of moderate physical activity every day. The following are a few suggestions to help parents teach their children the importance of exercise and maintaining a physical activity regiment throughout all stages of life, especially childhood.

1. **Lead the way.** Observational learning is the most basic and natural form of education for children. Thus, it is important as parents that we exhibit habits of regular physical activity to our children, especially during their early developmental years when their actions are a direct response to and mimic their observations.

2. **Make the best use of time.** Use the smallest breaks in your schedule as an opportunity for family exercise. Take a family walk after dinner and use that time to talk about your days. Is the weather outside too bad to walk today? Use commercial breaks during your favorite television shows to practice stretching. Stretching is a low-impact activity, requires no equipment and can be practiced in any environment. All ages and demographics can benefit from the benefits of stretching, such as increased flexibility and mobility and reduced risk of injury.

3. **Use technology to your advantage.** Of course we need to limit the amount of time our children watch television and play on their electronic devices. However, gamification through technology is a resource parents should embrace to help instill engagement and good habits of physical activity in their children. Geocaching is a free app that my family plays to stay connected and engaged in physical activity. Through this socially engaging treasure hunt game we have the opportunity to explore the community in which we live, while trying to achieve our goal of walking at least 7,000 steps daily.

Family Health & Fitness Day is September 30

Find events and activities near you at fitnessday.com to join in the celebration! Or, forge your own path and get creative with some active family fun.

The *Wellbeing Insights* Newsletter is prepared for you by CBIZ ESO. The contributions included in this newsletter do not specifically reflect your employer's opinions. Consult your health care provider before making any lifestyle changes.

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Visit the CBIZ Wellbeing website at www.cbiz.com/wellbeing

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ESO: Benefits & HR Technology • Compliance • Wellbeing Solutions
Talent & Compensation Solutions • Property & Casualty • Retirement Plan Services

B&I Webinar Series 2017

FEBRUARY

HOW TO IMPROVE COMMUNICATION AND DEVELOP A COACHING CULTURE

Tues., Feb. 21 - 1 to 2 p.m. Central Time

Learn how to have more effective, productive conversations with your employees using the Socratic method, a time-honored coaching technique.

PRESENTER: Leslie Anderson, Managing Consultant, Executive Coaching and Leadership Development, CBIZ Talent and Compensation Solutions, EFL Associates

FOR: HR personnel, managers, executives and anyone else interested in improving communication with subordinates. All employer sizes are welcome.

CREDIT: Approved for 1 HR (General) recertification credit hour through the HR Certification Institute.

MARCH

THE ACA: WHAT YOU MUST BE DOING TODAY!

Tues., March 21
1 to 2 p.m. Central Time

This webinar will focus on current requirements of the Affordable Care Act. If there is any indication about where the current administration might be taking health care reform, a glimpse of future rule making will also be discussed.

PRESENTER: Karen McLeese, Vice President of Regulatory Affairs, CBIZ Benefits & Insurance Services, Inc.

FOR: Human resources executives or anyone else responsible for HR compliance, chief operating officers and chief executive officers. Employers of all sizes are welcome.

CREDIT: Approved for 1 HR (General) recertification credit hour through the HR Certification Institute.

APRIL

CAPTIVES: ALTERNATIVE INSURANCE SOLUTIONS FOR YOUR ORGANIZATION

Tues., April 18 – 1 to 2 p.m. Central Time

Take control of your property and casualty risk management and insurance program through captive insurance solutions. Design coverages tailored to your organization's specific needs.

PRESENTERS: Tony Consoli, President, Mid-Atlantic Region, CBIZ Insurance Services, Inc.; Mark D. Stoltz, Director of Business Development, Southwest Region, CBIZ Insurance Services, Inc.

FOR: CFOs, CEOs, business owners and anyone else responsible for the company's risk management and insurance program.

CREDIT: Approved for 1 HR (General) recertification credit hour through the HR Certification Institute.

MAY

THE BUSINESS CASE FOR UNDERSTANDING BENEFITS AND HR TRENDS

Tues., May 16 – 1 to 2 p.m. Central Time

Use historical, current, and future trends in employee benefits and human capital management to overcome roadblocks to successful benefits/HR programs and administration. See how this can fit within your company's business and growth strategy.

PRESENTERS: Wendra Johnson, SPHR, Chief Business Development Officer, CBIZ Employee Services Organization; Zack Pace, Senior Vice President, Employee Benefits, CBIZ Employee Services Organization. Zack is a contributing writer for Employee Benefit News.

FOR: HR professionals and C-suite executives. For companies with 50 to 1,000 employees.

CREDIT: Approved for 1 Business recertification credit hour through the HR Certification Institute.

JUNE

HEALTH COVERAGE CONTINUATION: COBRA, LEAVES OF ABSENCE AND THE LIKE

Tues., June 6 – 1 to 2 p.m. Central Time

We'll review the requirements of COBRA law, as well as address issues that arise when individuals take a leave of absence, the impact of alternative coverage on an individual's right to COBRA, and the impact of Medicare entitlement on the right to continue health coverage.

PRESENTER: Karen McLeese, Vice President of Regulatory Affairs, CBIZ Benefits & Insurance Services, Inc.

FOR: HR executives or anyone else responsible for HR compliance, COOs and CEOs. Employers of all sizes are welcome.

CREDIT: Approved for 1 HR (General) recertification credit hour through the HR Certification Institute.

WELLBEING BENEFITS: WHAT'S OUT, WHAT'S IN AND WHAT'S ON THE HORIZON

Tues., June 27 – 1 to 2 p.m. Central Time

Find out which wellbeing programs employers are conducting less often, which programs they are replacing them with and why. Learn about emerging wellbeing programs and practices that show promise.

PRESENTERS: Emily Noll, National Director of CBIZ Wellbeing Solutions; Angie Schmidt, Senior CBIZ Wellbeing Consultant

FOR: Human resources executives and anyone responsible for managing employee health and wellbeing programs, CFOs and CEOs. Employers of all sizes are welcome.

CREDIT: Approved for 1 HR (General) recertification credit hour through the HR Certification Institute.

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HRCI-APPROVED PROGRAMS

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B&I Webinar Series 2017

(continued from front page)

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FOR MORE INFORMATION send an email to juditha@cbiz.com.

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JULY

THE EVOLUTION OF SELF-FUNDED BENEFITS STRATEGIES: A FIT FOR YOUR ORGANIZATION?

Tues., July 25 – 1 to 2 p.m. Central Time

This webinar covers creative employee benefits plans available to you now and in the future, including a look at pharmaceutical options – and can help you evaluate if self-funding is right for your organization.

PRESENTERS: Jim O'Connor, Executive Vice President, of Employee Benefits, CBIZ Employee Services Organization; Mike Zucarelli, National Director, Managed Pharmacy Practice, CBIZ Employee Services Organization

FOR: Human resources professionals and C-suite executives. Recommended for organizations with 50 to 1,000 employees.

CREDIT: Approved for 1 HR (General) recertification credit hour through the HR Certification Institute.

AUGUST

NEXT PRACTICES IN WORKPLACE WELLBEING: HONORING THE EDINGTON CBIZ AWARD WINNERS

Tues., Aug. 22
1 to 2:30 p.m. Central Time

Hear both the wellbeing-strategy successes and challenges faced by some of today's most forward-thinking employers who have earned the prestigious Edington CBIZ Next Practice Award.

PRESENTERS: Dr. Dee Edington, Author and Founder of Edington Associates, LLC; Jack Bastable, CBIZ Executive Wellbeing Consultant

FOR: Human resources executives and anyone responsible for managing employee health and wellbeing programs, CFOs and CEOs. Employers of all sizes are welcome.

CREDIT: Approved for 1.5 HR (General) recertification credit hours through the HR Certification Institute.

SEPTEMBER

EMPLOYEE BENEFITS PLAN ADMINISTRATION: FROM SOUP TO NUTS

Tues., Sept. 19 – 1 to 2 p.m. Central Time

This webinar will review employee benefits plan documentation, plan reporting and disclosure requirements, plan administration requirements, and record-retention requirements.

PRESENTER: Karen McLeese, Vice President of Regulatory Affairs, CBIZ Benefits & Insurance Services, Inc.

FOR: Human resources executives or anyone else responsible for HR compliance, chief operating officers and chief executive officers. Employers of all sizes are welcome.

CREDIT: Approved for 1 HR (General) recertification credit hour through the HR Certification Institute.

OCTOBER

EMERGING RETIREMENT PLAN SOLUTIONS FOR THE SMALL-BUSINESS OWNER

Tues., Oct. 17 – 1 to 2 p.m. Central Time

Learn about a quality retirement plan that can help you attract and retain good employees; save you time and resources; and allow you to share the administrative risk with an outside vendor, enjoy a state-of-the-art recordkeeping platform and completely integrate your program with payroll.

PRESENTER: Robert Auster, J.D., Executive Vice President, CBIZ Retirement Plan Services

FOR: Small-business owners with fewer than 100 employees and any professional groups, such as accountants and attorneys, who assist these small-business owners.

CREDIT: Approved for 1 HR (General) recertification credit hour through the HR Certification Institute.

NOVEMBER

LEGISLATIVE UPDATE: THE YEAR IN REVIEW

Tues., Nov. 14 – 1 to 2 p.m. Central Time

Join us for our annual review of benefits and other employer-employee related laws that affect your business, including any additional new and relevant legislation on the books.

PRESENTER: Karen McLeese, Vice President of Regulatory Affairs, CBIZ Benefits & Insurance Services, Inc.

FOR: Human resources executives or anyone else responsible for HR compliance, chief operating officers and chief executive officers. Employers of all sizes are welcome to participate.

CREDIT: Approved for 1 HR (General) recertification credit hour through the HR Certification Institute.

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7/17 rev. 3

CBIZ University

Are you looking for a cost-effective way to deliver consistent employee training? How about a way to deliver training to multiple locations and avoid the scheduling conflicts when trying to bring several employees together?

If so, CBIZ University is the tool for your organization!

CBIZ University is an online learning management system (LMS), which gives you the flexibility to offer training courses to your entire workforce quickly and efficiently.

CBIZ University Courses

CBIZ University is comprised of more than 450 e-learning modules developed by legal counsel, subject matter experts and licensed professionals. Most CBIZ University courses have integrated quizzes throughout the course to test the individual's understanding of the material. Course subject matter includes but is not limited to:

- HR Compliance
- Communicating Effectively at Work
- Leadership
- Customer Service
- Hospitality
- Sales Training
- Wellness
- Environmental Compliance and Regulatory Analysis
- Workplace Safety for multiple industries

Many courses include employee and manager level training.

Custom Courses

CBIZ can also load and/or design customized course content based on your specific training and development goals, such as New Employee Orientation. Our consultants will work with you to develop materials that effectively deliver superior adult learning opportunities and ensure a clear communication of your companies' policies and procedures.

Our comprehensive learning management system also provides employees and managers with:

- Automatic e-mail notification informing employees of the need to take a course by a specified date
- Reminder emails regarding training status
- Full reporting capabilities

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CBIZ HRSOLUTIONS

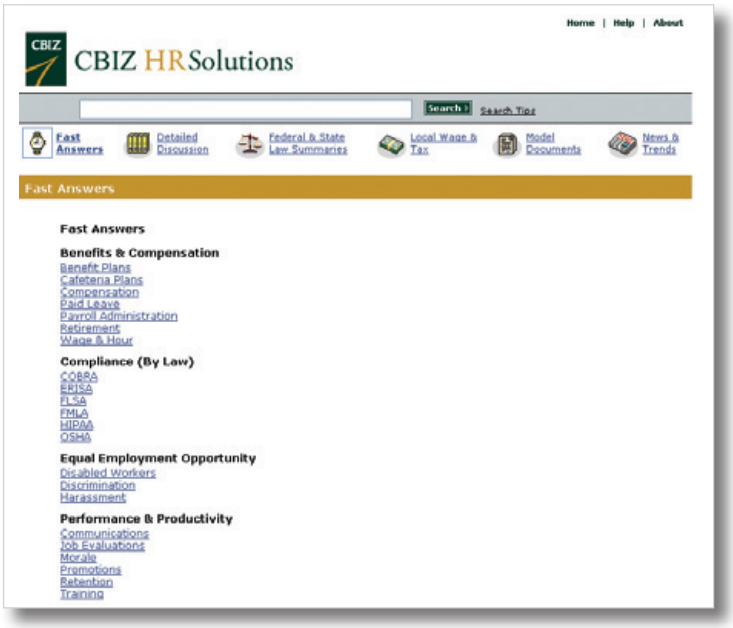
CBIZ HRSOLUTIONS

CBIZ HRSolutions is a comprehensive online HR Information Portal and Live Hotline, providing you with quick access to the resources, information, and answers you need...when you need them. CBIZ HRSolutions is your HR Lifeline that helps you manage day-to-day human resources issues, thereby freeing up your valuable time.

FEATURES

LIVE HOTLINE that gives you the support of a full team of Human Resources specialists who are prepared to provide you with the answers and practical advice you need. Every month you have access to four (4) hours of HR assistance – via phone or email – so that you can:

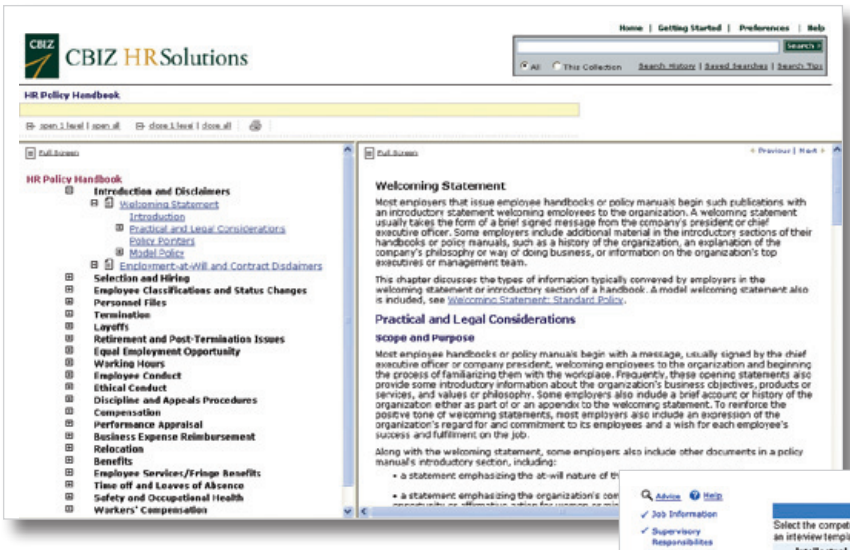
- Submit questions and receive thorough answers
- Address HR issues while they are small and manageable
- Have a safety net and extra support when needed
- Save time!



INFORMATION on crucial HR topics, including:

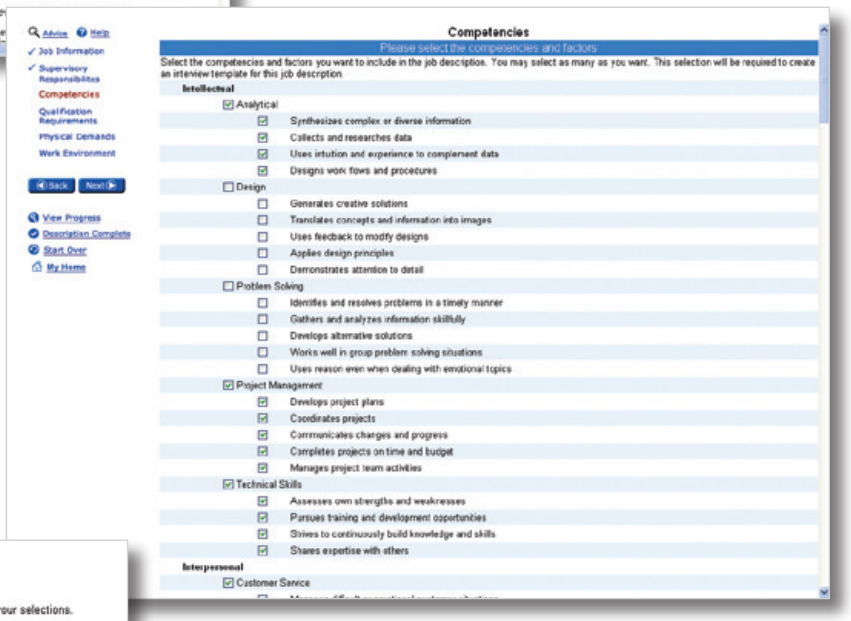
- Benefits & Compensation
- Compliance
- Leaves of Absence
- Performance & Productivity
- Equal Employment Opportunity
- Risk Management & Safety
- Recruiting, Selection & Staffing

The CBIZ HRSolutions team provides practical human resources consulting advice based upon our research and experience in the industry and with our clients. We do not provide legal or tax advice and encourage you to consult with your labor attorney or tax accountant.



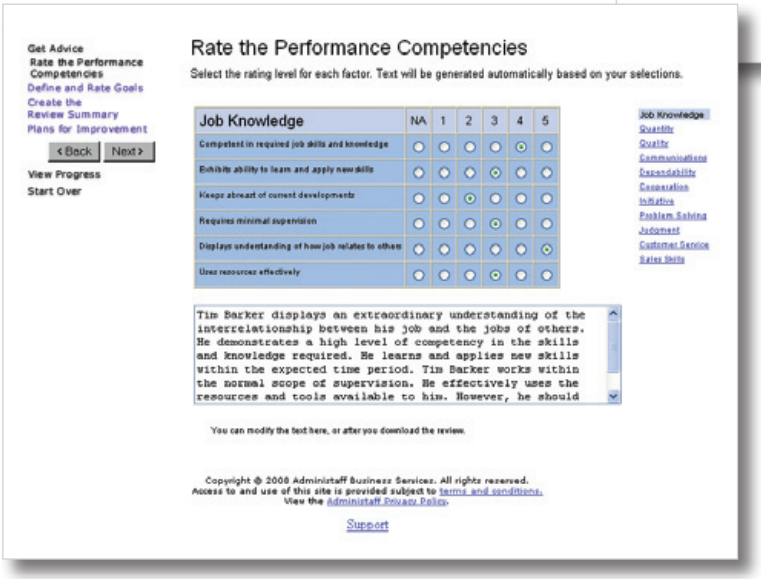
RESOURCES, MODEL DOCUMENTS AND FORMS that can be downloaded and used as a foundation from which to build custom documents for your organization, such as:

- HR Policy Handbook
- COBRA Forms
- Personnel Forms
- Promotion & Transfer Policies
- Handbook Receipt Form
- Health & Safety Policy
- Leave Policies & Forms



PRODUCTIVITY TOOLS, including:

- Custom Job Descriptions: a library of thousands of job descriptions and a tool to create your own custom descriptions within minutes
- Performance Now: a tool that facilitates preparation of employee reviews



NEWS AND ARTICLES on current trends, timely subjects, best practices, and more.

VISIT US at www.cbiz.com/hrsolutions to view a brief demo.

MULTIPLE SERVICES WITH A SINGLE FOCUS: YOUR SUCCESS

Growth and Success. Efficiency and Profitability. It's likely these goals are top priorities for your business. It's also likely that the daily distractions of financial and employee issues diminish your ability to focus on those goals.

CBIZ enables you to dedicate your time to critical business matters by providing custom solutions that help you manage your finances and employees.

We offer clients exceptional quality and diverse capabilities with the personal attention your business needs and deserves, all with a single focus: your success.

For more information, contact your local CBIZ Advisor or call our toll-free help line, **1-800-ASK-CBIZ** (1-800-275-2249).

Employee Services

- ☐ EMPLOYEE BENEFITS
- ☐ RETIREMENT SERVICES
- ☐ PAYROLL / FLEX / COBRA
- ☐ PROPERTY & CASUALTY INSURANCE
- ☐ RISK MANAGEMENT
- ☐ LIFE INSURANCE
- ☐ EXECUTIVE SEARCH
- ☐ COMPENSATION CONSULTING
- ☐ HUMAN CAPITAL SERVICES

Financial Services

- ☐ ACCOUNTING & TAX
- ☐ LITIGATION SUPPORT
- ☐ VALUATION
- ☐ INTERNAL AUDIT
- ☐ MERGERS & ACQUISITIONS
- ☐ FINANCIAL ADVISORY
- ☐ RISK & ADVISORY SERVICES
- ☐ CORPORATE RECOVERY
- ☐ FAMILY OFFICE SERVICES

CBIZ also provides specialized services, including Real Estate Services and Health Care Services

CBIZ®

our business is growing yours

www.cbiz.com

Corporate Wellness

31. **Does your company provide and/or support corporate wellness initiatives?**

    CBIZ has a robust internal Wellness staff with a Wellbeing Account Executive in Atlanta. LaTonia McGinnis' bio sketch is show in question #6.

    LaTonia in concert with our home office resources help our clients design, implement, monitor and update Wellbeing programs that are custom design to meet our client's culture and objectives. The attached pages outline our approach.

32. **Describe any programs that you provide to your clients that foster employee wellness.**

    Please see page 9 of the attached.

CBIZ Wellbeing Solutions Overview

Our Process

Health & Welfare Benefits Review

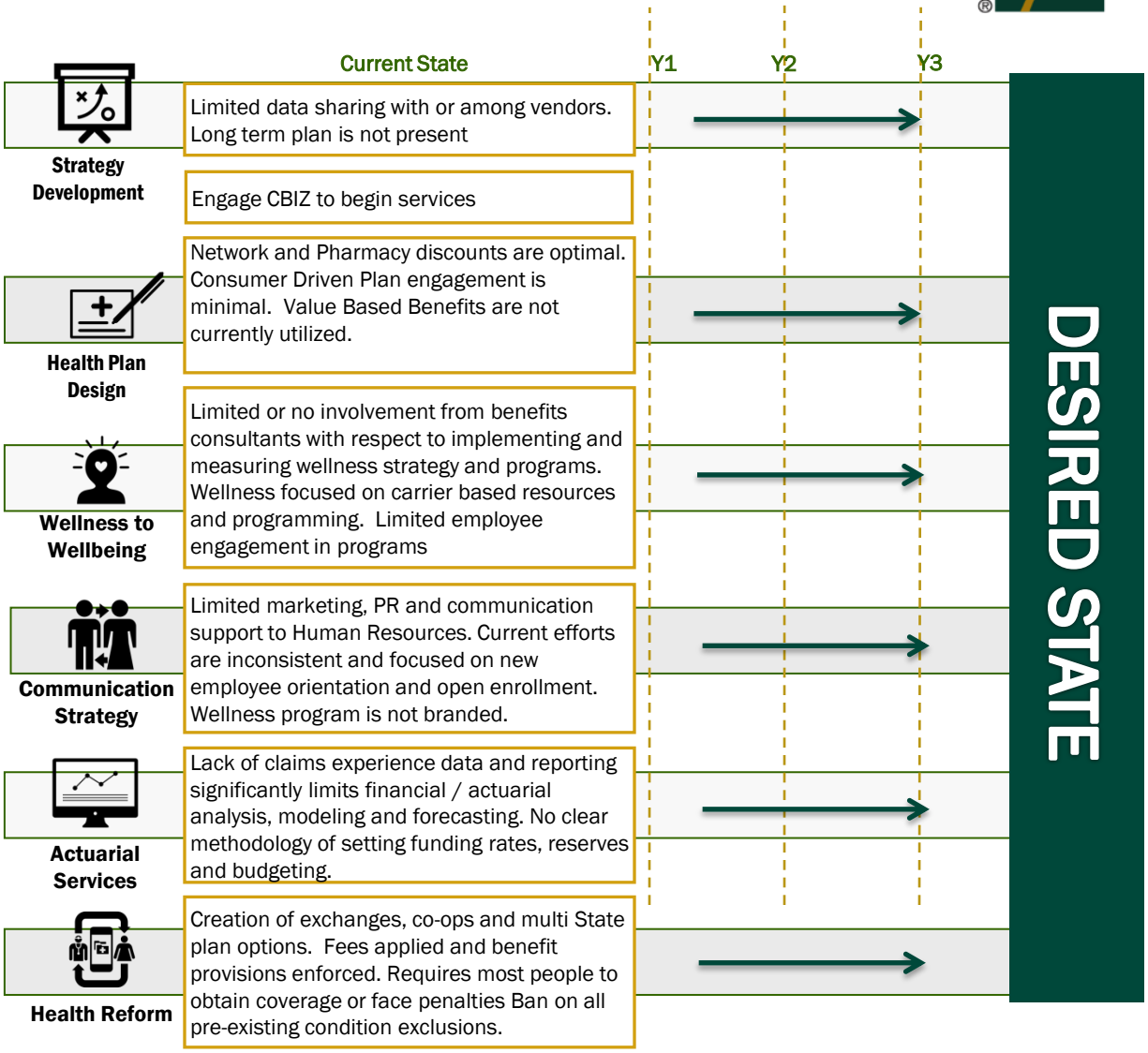
Interview Key Human Resources Staff

Benchmark Plans

Develop 3-5 Year Benefit Plan Strategy

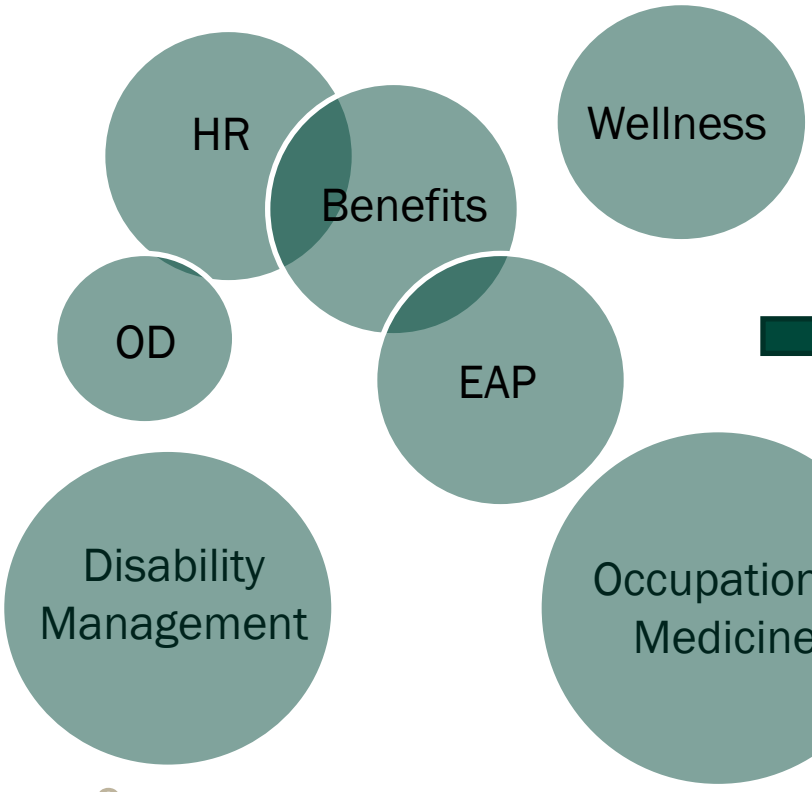
Review Claims, History, Disease States, & Key Cost Drivers

Provide Recommendations for Improvements



Wellbeing Solutions

Moving from program silos…



…to integrated work performance, total health management, well being, and thriving

CBIZ Wellbeing Program Approach

Addressing the Needs of the Whole Person

Wellbeing Program Approach

Wellbeing Program Approach

Organizational Commitment

Wellbeing is integral to business strategy. Commitment to a culture of wellbeing is evident and shared by leaders and managers across the organization.

Sustainable Culture

The built environment, physical work spaces, procedures, policies and engaged-employee champions support a culture of wellbeing and encourage healthy choices.

Communication & Engagement Methods

Communications have a recognizable wellbeing brand. Marketing methods reach all segments of the population and engage employees and their families in meaningful ways.

Actionable Data

Data is gathered and analyzed to identify wellbeing risks, needs and resources. Data is used to make environmental changes, introduce new benefits and increase engagement.

Wellbeing Programs, Benefits & Networks

Selection, design and delivery of programs and benefits address various aspects of wellbeing. Emphasis is on vendor/ provider and employer collaboration, quality assurance and shared results.

Outcomes & Value of Investment

Analytical tools and benchmarks are used to evaluate the reach and impact of programs and practices and demonstrate the value of investing in wellbeing benefits.

Approaches to Wellbeing

Activity / Opportunity Based

Focus:
Employees (general)
Fun activities
Annual Health Fair
High level info/tips
Newsletter
Promote benefits & tools

Anticipated Results:
Awareness of programs
Moderate utilization, mostly of "worried well"

0 – 1% ROI

Engagement Based

Focus:
Employees (including hard to reach segments)
Health risk assessment
Biometric screenings
Individual incentives
Tracking participation and aggregate results
Wellbeing Committee

Anticipated Results:
Moderate peer-to-peer socialization of programs
Greater participation of moderate risk group
Enhanced risk stratification
Data to inform programming
Higher Ee engagement scores

1 – 2% ROI

Population Health Management

Focus:
Employees, Spouses & Families, Community
Targeted, member-centric interventions (Coaching, disease mgmt., EAP)
Meaningful individual and team incentives (outcomes based)
Provider/partner collaboration
Plan design and network
Management commitment
Environment and policy change
Three-year strategy and scorecard

Anticipated Results:
Leader-led wellbeing culture
Population engagement
Physician engagement
Risk reduction, including high risk
Best place to work recognition

3 – 4% ROI

Consulting Activities (examples)

Wellbeing consulting includes activities, such as, the following:

- Identify and document wellbeing program goals
- Assess health risks, priorities, interests
- Review environment and policies
- Inventory benefits and resources, identify gaps
- Develop business case/value for wellness programs
- Garner leader input and support
- Recommend wellbeing budget aligned with goals
- Create a three-year wellbeing strategy
- Help to develop wellbeing mission and brand

Consulting Activities (examples)

Wellbeing consulting activities, continued:

- Create employee wellbeing champions and provide resources for the wellbeing committee
- Co-develop an annual Calendar of Activities
- Recommend meaningful, compliant incentives
- Administer wellbeing services RFP, as needed
- Facilitate partner collaboration and integration
- Identify meaningful metrics for annual Scorecard
- Place and support on-site wellbeing coordinator (training, coaching, benchmarks)
- Develop ‘best practice’ case study and consult on employer recognition award opportunities

CBIZ Wellbeing Solutions (CWS)

CWS Team

- National Wellness Director
- Wellness Consultants/ Specialists
  - Atlanta
  - Arizona
  - Kansas/Mo.
  - Maryland
  - Minneapolis
  - Tennessee
- On-site Wellness Coordinators

Internal Partners

- Wellbeing Advisory Group
- CBIZ Business Units
- On-site Clinic Consulting
- Pharmacy Consulting
- Regulatory Affairs/ERISA
- Actuary
- Marketing…

External Partners

- Wellness Research Institute
- Preferred Wellness Vendor Network
- NBGH, WELCOA, HERO, and others
- Edington Next Practice Awards, Healthiest Employer
- Internship Program…

Wellbeing Partners (Examples)

CBIZ

Health Enhancement Systems

BRAVO WELLNESS

ZYWAVE

American Institute for Preventive Medicine

MOM Mobile On-site Mammography

the YMCA

PUREWellness Wellness Made Easy

LA FITNESS

movable

Virgin Pulse

POP PROSTATE ON-SITE PROJECT

BioSignia™ TECHNOLOGY FOR LIFE

Weight Watchers® @work program

WebMD℠

Wellworks For You

VIVERAE®

Legislative / Compliance

33. **How do you support your clients in ensuring their employee benefits programs remain compliant with all federal/state laws, and all deadlines are met?**

Upon hire CBIZ will perform a complete Compliance Audit for PIKE. This audit is composed of the following:

- Creation of Compliance Calendars
- Annual Compliance Checklist and Audit
- Annual Compliance Guide by State
- Annual HIPAA Privacy and Security Training to meet Employers Regulatory Requirements
- Monthly Regulatory and Trending Issues Publication and Webinars
- Filing Assistance
    - Obtain Form 5500 Schedule A's and or C's
    - Prepare Form 5500 for review, execution and filing
- Complete Summary Annual Reports for Distribution
- Assistance with ACA Reporting
- Preparation of Summary of Material Modification and Reduction documents when needed
- Review and update of 125,105 and 105L wrap documents
- Vendor selection for nondiscrimination testing
- Auditing of Summary Plan Descriptions for Content and Compliance

Post audit, CBIZ provides HIPAA and compliance training utilizing periodic reports, webinars, CBIZ University and onsite classes.

CBIZ assists employers with regulatory filings for Form 5500, ACA, Discrimination Testing.

34. **How does your firm assist clients with HIPAA compliance?**

In addition to CBIZ's compliance audit, (see question 33), we evaluate the following:

- Provide required annual training
- Assist with drafting HIPAA Compliance Manual
- Review required notices for compliance and schedule distribution
- Provide HIPAA regulatory changes and compliance update webinars

35. **Do you have in-house legal advisors or outside counsel who provides guidance to you and your clients?**

CBIZ has both in house legal and outside legal counsel that provide guidance to our clients. Karen McLeese Esq. heads our in house compliance. Her bio sketch has been included in question #6.

Ann Murray, partner at Nelson Mullins, leads our outside counsel team. Please see her detailed information attached.

Ann E. Murray

Partner

Atlantic Station
201 17th Street NW
Suite 1700
Atlanta, GA 30363

T 404.322.6603

ann.murray@nelsonmullins.com

Ann Murray is a partner in Nelson Mullins Riley & Scarborough LLP's Atlanta office where she practices in the areas of employee benefits and executive compensation. She previously served as in-house benefits counsel for a publicly-traded company, so she is able to provide clients with a business-oriented and practical approach to help them stay in compliance with the ever-changing rules.

Ms. Murray's clients include private and public employers, brokers and individuals. She assists her clients with all types of HR and benefits-related matters, including those relating to:

- qualified retirement plans (401(k), 403(b), ESOP, pension), including fiduciary obligations with respect to plan investments;
- health, life, disability, and other welfare benefits, including ERISA, ACA and HIPAA compliance;
- stock options, restricted stock and other equity incentive programs;
- deferred compensation rules;
- employment, change-in-control, bonus and other executive compensation arrangements;
- short and long-term incentives; and
- HR-compliance matters, such as payroll taxes, worker classification and data protection.

Ms. Murray also advises buyers and sellers regarding the HR and benefits risks and concerns involved in the purchase or sale of a business. She is involved with our venture capital and lending practices in assessing the potential impact of ERISA and Internal Revenue Code requirements on offerings and loans. She is a regular speaker on various topics, with recent presentations on the ACA, HIPAA & Data Breaches,

Education

University of San Diego School of Law, JD

University of San Diego, LLM, Tax

Menlo College, BA

Admissions

Georgia

Florida

California

Practice Areas

Cybersecurity & Data Breach Response

Employment & Labor

Executive Compensation, ERISA, Employee Benefits

Mergers & Acquisitions

Non-Profit Organizations

Outsourcing

Private Equity

Public Company Compliance & Counseling

Fiduciary Compliance of Investment Committees, and On-Site Clinics.

Recognitions

The bar rules of some states require that the standards for an attorney's inclusion in certain public accolades or recognitions be provided. When such accolades or recognitions are listed, a hyperlink is provided that leads to a description of the respective selection methodology.

- The Legal 500
- Georgia's Legal Elite, Georgia Trend magazine
- AV® Preeminent™ by Martindale-Hubbell®

Articles & Speeches

Insights

Stop and Consider Before Cutting Back to Save on Affordable Care Act Costs, *FSR Magazine* (June 2016)

4 Things You Don't Know About the ACA (But Should), *QSR Web* (April 6, 2016)

On-Site Health Clinics --Privacy Issues - Coauthor (March 25, 2014)

Employers Should Carefully Consider Their ACA Strategies, *Daily Journal* (November 27, 2013)

Health Plan Changes Proposed, *Daily Journal* (December 5, 2012)

TalkingPoint: Boardroom Challenges – Executive Compensation And Say On Pay, *Financier Worldwide* (May 2012)

How Health Care Reform Could Impact Your Employment and Severance Agreements, *Pension & Benefits Daily* - Coauthor (November 10, 2010)

Cost-Savings and Risk-Reducing Ideas for Severance Programs, *Bloomberg Law Reports* (July 30, 2010)

Update on the Federal COBRA Subsidy: Traps for the Unwary and a Possible Savings Opportunity, *Bloomberg Law Reports* (March 29, 2010)

Offering Company Stock as an Investment Option in Retirement Plans, *Employee Benefit Plan Review* (June, 2009)

Could Your Officers or Board Face Personal Liability for Your 401(k) Plan Investment Losses?, *Journal of Compensation and Benefits* (May/June 2009)

Focus on Executive Compensation After the Election, *Fulton County Daily Report* (November 17, 2008)

The Best Laid Plans – Unique Tax and Benefits Issues in US Acquisitions, *Financier Worldwide* (October, 2008)

Health Saving Account Update, *Employee Benefit Plan Review* (October, 2008)

Employer-sponsored Personal Health Records, *Thompson's Human Resources 2009: Answers to the Top HR Questions in 2009* (October, 2008)

Events/Speaking Engagements

Dealing with the Changing HR & Benefits Landscape in 2017, *Georgia Independent College Association's Annual CFO Meeting* (March 10, 2017)

Legal and Tax Issues Impacting On-Site Health Clinics, *presented at The Value of Onsite and Near-Site Clinics Conference sponsored by the National Association of Worksite Health Centers in Memphis, Tenn.* (March 17, 2016)

Business Considerations Regarding the Affordable Care Act Requirements, *Midtown Business Radio* (March 10, 2016)

Healthcare Reform: Updates for 2016 and Beyond, *presented to Atlanta WEB* (February 18, 2016)

Affordable Care Act and Employers: Final Countdown to Compliance, *NextGeneration Manufacturing* (December 2, 2015)

Affordable Care Act Update for Small Employers and Affordable Care Update for Large Employers, *Cobb County Chamber of Commerce* (June 25, 2014)

Affordable Care Act: The Clock is Ticking for Government Contractors, *National Contract Management Association (NCMA) Webinars* (June 12, 2014)

Affordable Care Act: What Government Contractors Need to Focus on Now, *NCMA Webinars* (February 6, 2014)

California's Valued Trust, *IFEBP Health & Welfare Training for California's Valued Trust, Monterey, California* (September 12-13, 2013)

Clarifying Recent Guidance under PPACA in Anticipation of 1/1/14: Weighing the Employee-Benefit Options, *ACI 2nd National Advanced Compliance and Benchmarking Forum, New York* (May 31, 2013)

Retirement Plans – Current Legal Issues in Fiduciary Risk, CITs and Cash Balance, *Benefits Coalition Conference* (May 15-16, 2013)

Plan Sponsor Compliance with Final HIPAA/HITECH Act Regulations (May, 2013)

2013 Benefit Legal Update, *2013 Intercare Roundtable, Orange County and San Diego* (January 30, 2013)

Employee Benefits Issues in M&A, *ACI Benefits Conference* (May 24-25, 2010)

Department of Labor Correction Programs, *Worldwide Employee Benefits Network* (September 17, 2009)

Do You Have Arrangements That Might Be Affected By 409A? (January 2008)

ERISA Checklist for Group Insurance, *CSRA-Association of Health Underwriters, Augusta Chapter* (January 10, 2007)

Code §409A: Your Employees Will Pay the Price If Your Comp Plans Don't Comply (April 2006)

36. **Describe methods you employ to disseminate information about current trends and legislation. Please provide examples.**

CBIZ provides constant real-time updates as well as scheduled monthly updates. CBIZ also provides a complete state by state annual compliance manual.
(See documents provided in response to questions 27 and 29)

37. **Do you assist clients in the preparation of their Form 5500s and Summary Annual Reports? Is there a cost for these services?**

    We do assist our clients with the presentation of Form 5500 and Summary Annual Reports as well as other federal and state requirements. There is no charge for this service.

Compensation

38. **How is your firm compensated for your services?**

    Our firm can be compensated in one of three ways:

    - Commission only
    - Fee only
    - Combination of commission and fees

39. **Has your firm been subject to any lawsuits or settlements specific to compensation disclosure or practices within the last five years?**

    No

40. **Does your firm have any reservations in making available documentation of the commissions received from insurers?**

    All commissions and or fees will be fully disclosed by both CBIZ directly and by Schedule A to Form 5500.

41. **What is your company's philosophy on accepting contingency/override compensation from insurers relative to the placement of insurance programs?**

    CBIZ will accept no contingency/override compensation from insurers relative to the placement of insurance programs at Pike.

42. **Describe our right to terminate a contract with you. Is there a minimum contract period?**

    If elected to provide service to PIKE, CBIZ would require a Broker of Record (BOR) letter executed by PIKE appointing CBIZ as your broker/consultant (see attached).

    This appointment can be terminated at any time by PIKE.

Date

Carrier
Contact Person
Address
City, ST Zip Code

Re: Client

Dear:

Effective immediately we have appointed CBIZ Benefits & Insurance Services, Inc. ("CBIZ") as our exclusive insurance broker. The appointment of CBIZ Benefits & Insurance Services, Inc., tax identification number 31-1582098, rescinds all previous appointments and the authority contained herein shall remain in full force until canceled in writing.

This letter constitutes your authority to furnish the representatives of CBIZ all information they may request as it pertains to our insurance contracts, rates, rating schedules, surveys, reserves, retention and all other financial data they may wish to obtain for their study of our present and future requirements in connection with the insurance programs to which this letter applies. CBIZ is hereby authorized to negotiate directly with any interested company, with respect to changes in existing insurance policies and in closing, changing, increasing or canceling insurance carried under temporary binders or cover notes. We understand, however, that CBIZ will not share the responsibility for any deficiencies in the insurance programs to which this letter applies until they have had a reasonable opportunity to make a review and to provide us with their recommendations.

It is understood and CBIZ has disclosed to us that CBIZ may from time to time receive from you or your insurance company affiliates standard commissions and other compensation and consideration pursuant to this broker appointment for performing advisory and consultative services regarding the insurance coverages in force for our group account.

Sincerely,

43. **Based on the information provided and the services requested, what is your proposed annual fee? Please make certain to identify any services mentioned in your proposal that are not included in your proposed fee (services that would be an additional expense- please include relevant rate card)**

CBIZ proposes the following two compensation structures:

a) If PIKE decides to utilize the Oracle self-service enrollment platform:

- $3.30 per eligible employee per month. No commission will be paid on any of the core benefit programs insuring the lowest net cost to Pike.

b. If PIKE elects to utilize the Hodges Mace SmartBen communications, call center and enrollment platform:

- To CBIZ - $3.30 per eligible employee per month
- To Hodges Mace
  - i. If Hodges Mace SmartBen conducts a new voluntary benefit offering as part of the annual enrollment and receives commission and overrides for same, their fee is $1.90 per eligible employee per month
  - ii. If there are no voluntary commissions and or overrides paid, their fees are shown on the attached proposal

c. Dependent Eligibility Audit (DEA) Significant savings and a compelling ROI are projected for PIKE if a Dependent Eligibility Audit is approved and conducted. Assuming 6000 dependents (spouses and children) the cost of the audit would be $54,000 ($9 per dependent). Assuming a 5% ineligible find, projected savings would be $1,047,000 or a claim reduction of $3,490 per dropped dependent. This produces a ROI of 19 to 1. If a DEA has never been conducted in the past the ROI would move to 38 to 1 at a $54,000 cost assuming a 10% find (see attached).

This would be an additional cost as we would use Hodges Mace to conduct the DEA.

hodges mace

SMARTER BENEFITS

Engagement Outline and Proposal

for Pike Enterprises, LLC

Presented by Alex Ward
September 29, 2017

Our mission is to simplify benefits for all stakeholders with a smarter approach to delivery, management and support.

Commit to a smarter benefit experience.

Table of Contents

Benefit Administration Technology

Recommended Technology Solution – **SmartBen™**

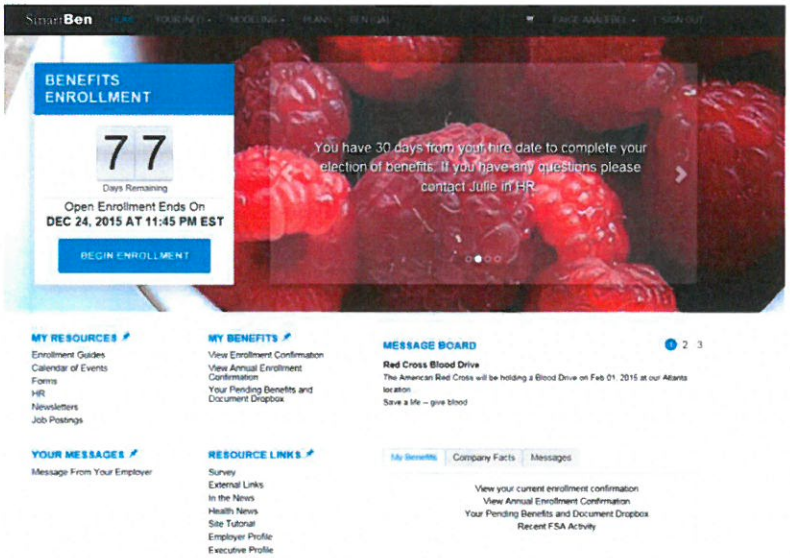
SmartBen™ is a web-based system that modernizes benefit administration and employee self-service by delivering a "smart" information platform that empowers HR and employees to be true consumers of benefits. The **SmartBen™ proprietary platform is used by more than 1,500 companies, and we are confident that the** application is well-suited for **Pike Enterprises, LLC.**

SmartBen Essentials ™ ***Communication*** *- Enrollment - Administration*

Communication – *within a few clicks of your mouse…*

The SmartBen site-builder allows the employer to customize a comprehensive HR communication portal. Common postings include:

- Employee Manuals, SPDs, Claims Forms and Provider Links
- News Bulletins, Newsletters, Event Calendars and Announcements
- HR Manuals, Department Directories, HR Contacts, Carrier Contacts and Job Postings
- Employee Surveys – specific to Job Class, Division or Location



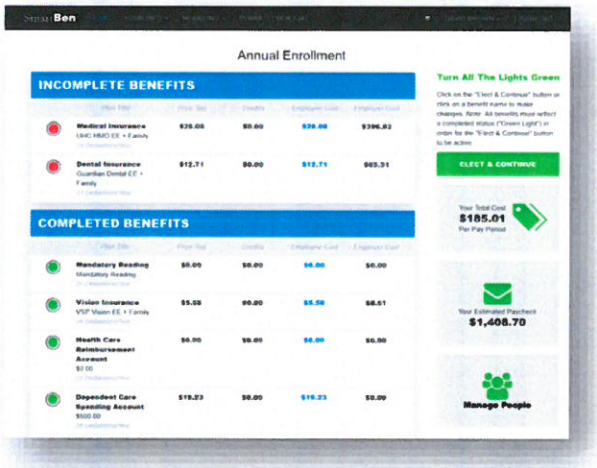
SmartBen Essentials™ can be customized to include the client's logo and to host any number of important corporate communication pieces.

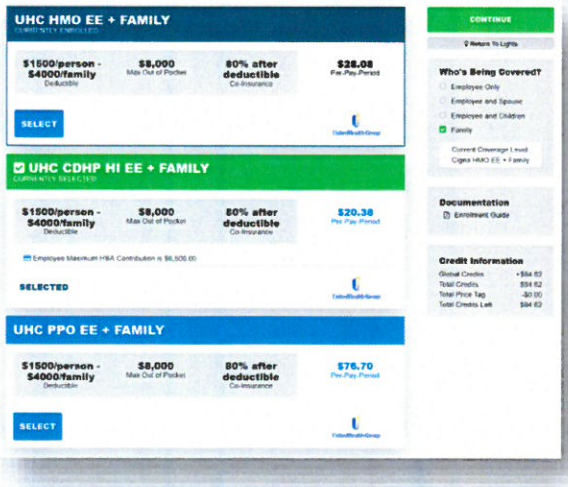
SmartBen Essentials™ (Cont.) *Communication - **Enrollment** - Administration*

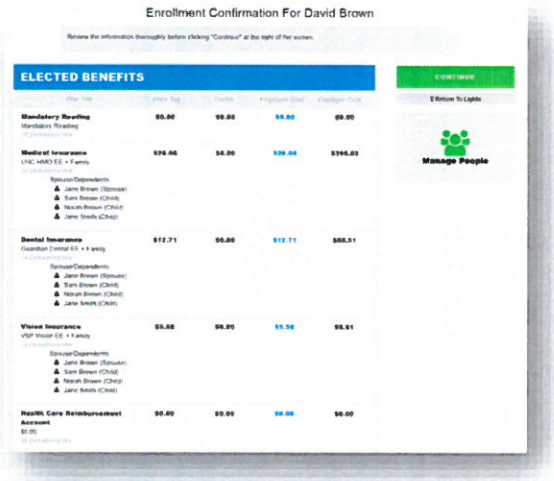
Enrollment – *made easy for employees during active or passive enrollments*

SmartBen's Enroller module supports all annual and ongoing enrollment events, including open enrollment, new hire enrollment and qualified life events. Features include:

- Self-service enrollment
- Employee-specific login
- Summary of current elections
- Visual enrollment indicator status button per benefit
- SmartEnroll feature for passive enrollments
- Benefit plan descriptions
- Animated storyboards
- Animated tutorial help sections
- Plan shopping / comparison tool
- Paycheck illustration and modeling (based on employee-specific tax withholdings)
- Confirmation statements for online viewing or print





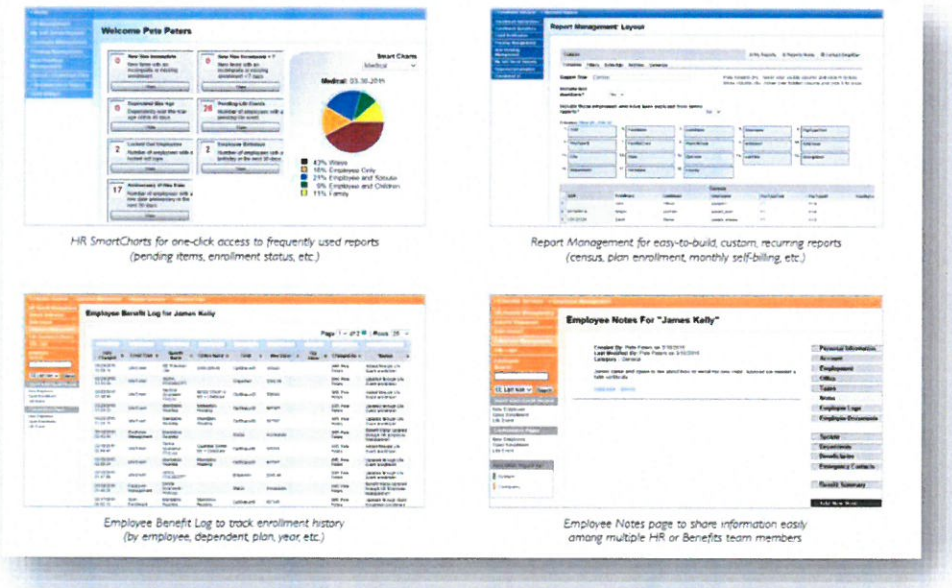


SmartBen Essentials (Cont.) *Communication - Enrollment - **Administration***

Administration – *simplified for corporate Human Resources and Benefit teams*

SmartBen does the heavy lifting by customizing the site with your plans, rates and eligibility rules, allowing the HR and Benefits teams to focus on strategy and planning and employee interaction. SmartBen administrative features and services include:

- Electronic data upload of employee data into SmartBen – no manual key entry!
- Custom data exports to carriers and vendors
- Complete data collection and tracking for employee, spouse, dependent and beneficiary
- Comprehensive enrollment history tracking
- HR SmartCharts for one-click access to frequently used reports (e.g., Pending Items, Enrollment Status, etc.)
- Customized and scheduled reports (census, plan enrollment, monthly self-billing, etc.)
- Ad hoc reports and HR report writer
- Email notifications on all pending events



HR SmartCharts for one-click access to frequently used reports (pending items, enrollment status, etc.)

Report Management for easy-to-build, custom, recurring reports (census, plan enrollment, monthly self-billing, etc.)

Employee Benefit Log to track enrollment history (by employee, dependent, plan, year, etc.)

Employee Notes page to share information easily among multiple HR or Benefits team members

SSAE 16 Security Audit

SmartBen has successfully completed its (SSAE) No. 16 Type II, Reporting on Controls at a Service Organization. The audit was performed by an independent auditing firm. SSAE 16, developed by the Auditing Standards Board ("ASB") of the American Institute of Certified Public Accountants ("AICPA"), replaces the Statement on Auditing Standards No. 70 ("SAS 70"), which was the standard used for reviewing the control processes of service organizations for nearly two decades.

Optional SmartBen Products and Services

SmartBen Assist™

SmartBen Assist *Year-Round Customer Support*

SmartBen Assist is a year-round employee call center that provides professional support for all benefit inquires and enrollment activities (annual, new hire and life events) that employees may have during the year at **Pike Enterprises, LLC**. SmartBen Assist is easily accessible to all benefit-eligible employees via a dedicated, toll-free number, weekday live answering services, and voice recording of all calls.

- **Technical Support**: Password resets, navigational assistance, screen-sharing option
- **Benefits Q&A**: Eligibility and coverage review, reprint of confirmation statements, warm transfers to core carriers for service, claim forms, etc., and employee lookups
- **Enrollment Assistance**: Dependent demographic updates, beneficiary assignment changes, enrollment assistance during new hire, life events and self-service annual enrollments

Think you'll need additional support like QLE Management or Dependent Verification? Consider upgrading to HR Support Pack.

SmartBen HR Support Pack™

SmartBen HR Support Pack *Optional HR Support*

With SmartBen Assist plus HR Support Pack you receive all of the great benefits of our SmartBen Assist service PLUS additional support for some of your most important administrative functions, including management of Qualifying Life Events (QLEs), Evidence of Insurability (EOI), Dependent Verification and Overage Dependents.

- **QLE Management:** Administration of IRS-recognized life event processes (includes document requests, collection, adjudication and storage), completion of pended QLE elections as documents are received/approved
- **EOI Management:** Finalization of all life insurance benefits in SmartBen, processing of pended elections based on underwriting decisions
- **Dependent Verification:** Verification of dependents added during Annual, New Hire and QLE enrollments, removal of ineligible dependents in SmartBen with notification to payroll and carriers, includes document requests, collection, adjudication and storage
- **Management of Overage Dependents:** Confirmation of overage dependent eligibility by individual, removal of applicable overage dependents from SmartBen, includes notification to payroll and applicable carriers

SmartBen Sentry™

Eligibility Verification – *Healthcare Cost Containment and Compliance Solution*

Ensuring the eligibility of all dependents enrolled in your employer-sponsored health plan is crucial to reducing financial, legal and employee risk within **Pike Enterprises, LLC**. As part of our desire to reduce employer healthcare costs, Hodges-Mace offers an Eligibility Verification Service designed to accomplish maximum compliance with minimal operational disruption.

Why Eligibility Verification?

Eligibility Verification processes identify and remove on average between 5% - 12% of dependents that should not be enrolled in your plan without decreasing benefits for eligible employees or disrupting business operations.

As part of our discovery and implementation process with **Pike Enterprises, LLC**, we will explore opportunities to improve cost-efficient practices with maximum results by focusing on three critical areas:

1. Educating and assisting employees
2. Scalable, flexible and secure technology (employee and employer portal)
3. Customizable communications campaign
    - Dedicated toll-free number, email, fax and customized website

Timeline

- Planning – 4 weeks
- Announcements
- Verification Phase – 6 weeks
- Appeal Phase – 4 weeks

H-M's verification process should reduce healthcare expenses by 3-5% on average. And it all happens in a 14-week timeframe.

Post-Verification Support (Optional)

- **Soft Landing** – Confidential counseling and placement assistance is provided to ineligible dependents to obtain best affordable non-group health insurance coverage.
- **Ongoing Maintenance** – After the Eligibility Verification is complete, Hodges-Mace offers ongoing maintenance focusing on new hires and life changes to keep employees in compliance.

Specialized Services

Recommended Education/ Enrollment Strategy with SmartBen Essentials – **for Benefit-Eligible Employees**

Formal New Hire Orientation

A *single-source* enrollment strategy is recommended for new hires to ensure that all newly eligible employees receive the same level of service related to their benefits orientation. Rather than offer employees multiple options to enroll, clients have found that our simple telephonic process is equally accessible to all members of the team and ensures that messaging and decision-support are delivered consistently. The process also ensures that benefits are enrolled accurately and confirmation statements are delivered on a timely basis after enrollment.

Benefit Orientation Services Include:

Enrollment Status Reports and Reminders

- Automated *email* reminders to Corporate HR and/or Local HR contacts
- Automated phone *call* reminders to employees during enrollment window

Pre-Enrollment Welcome and Instructions

- Simplified one-page customized flyer with welcome and enrollment instructions

Personalized Enrollment for Each Employee

- Dedicated toll-free number with customized greeting
- Dedicated scheduling website – with email and call reminders prior to appointment
- Full-time Benefit Orientation Specialists provide:
    - Education on *all* core and supplemental benefits and promotion of HR initiatives
    - Electronic enrollment of core benefits directly into *SmartBen Essentials*

Voice Recording Software

- Voice recording of all calls in their entirety; voice file storage and retrieval
- Voice signature capture to confirm all benefit elections

Post-Enrollment Communications

- Confirmation statements sent electronically (or via home mailing, if desired)
- **"What To Expect Next"** customized reminder communication

Post-Enrollment Survey

- Automated survey presented at the conclusion of each enrollment session
- Questions tailored for **Pike Enterprises, LLC** to solicit feedback on plans, processes, etc.

Monthly and Quarterly Reports of enrollment/survey results and call activity

Summary and Pricing – Benefits Administration Solution

Per employee per month (PEPM) fees calculated based on **5,500** active employees on the software.

SmartBen Core Functionality	*Standard Fee*	*With Offsets[1]*
SmartBen Software Setup • Dedicated Project Coordinator and EDI specialist • Configuration of all benefit plans, rates, rules, etc. • System testing ***SmartBen*** Payroll and Carrier Feed Setup • One (1) custom payroll feed to payroll system • Up to eight (8) custom carrier feeds • Additional carrier feeds priced at $1,000 per feed	$10,500 **3-Year Agreement: 50% discount or option to have $250 Monthly Service Fee*	**Fees Waived based on offering Voluntary Benefits**
SmartBen Essentials • Ongoing payroll and carrier feeds • Annual reconfiguration of plans, rates, etc. • Perpetual storage of terminated employee data • 200MB document storage space. ***SmartBen Assist – Year-Round Call Center Support*** • SmartBen technical support • Answers to general benefit questions • Enrollment assistance for annual, new hire & life events	$3.90 PEPM **Assumes ≤ 25% enrollment utilization during AE*	**$1.90 PEPM** **Assumes agreed upon offset strategy**
OPTIONAL - Ongoing SmartBen Products and Services	***Standard Fee***	
SmartBen HR Support Pack – Year-Round Employer Assistance • SmartBen technical support • Answers to general benefit questions • Enrollment assistance for annual, new hire & life events • QLE Management • EOI Management • Dependent Verification • Management of Overage Dependents	$1.05 PEPM + $8,500 setup **Assumes ≤ 25% enrollment utilization during AE*	**N/A**
Sentry - Initial and Ongoing Review • Verification of dependents added during the plan year • New hires, life events, annual enrollment	$9 per dependent	**N/A**
New Hire Benefit Orientation • Formal scripting and messaging • Electronic enrollment of all benefits • Assume core enrollment into SmartBen Essentials • Status reminders to managers and employees • Voice recording software/ storage/ retrieval • Post-enrollment survey and post-enrollment fulfillment	$1.52 PEPM *Minimum 500 new hires per year	**Fees Waived based on offering Voluntary Benefits**

Fee Offset Assumptions and Disclaimers

[1]The above proposal showing fee offsets assumes that:

GENERAL

90-Day Disclaimer

The information (data) contained in this proposal constitutes a trade secret and/or information that is commercial or financial and confidential or privileged. It is furnished to **Pike Enterprises, LLC** in confidence with the understanding that it will not, without permission of Hodges-Mace, be used or disclosed other than for evaluation purposes; provided, however, that in the event a contract (or other agreement) is awarded on the basis of this proposal the prospect shall have the right to use and disclose this information (data) to the extent provided in the contract (or other agreement). This restriction does not limit **the prospect's right to use or disclose this information (data) if obtained from another** source without restriction.

This quote is valid for 90 days from the date of this proposal.

Supplemental Benefits

Pike Enterprises, LLC elects to offer the following supplemental benefits to its eligible employees:

- Vision
- Dental
- Disability Insurance
- Life Insurance
- Accident Insurance
- Critical Illness
- Whole Life Insurance

Payroll Deductions

Client will maintain payroll deductions for the products outlined above for the duration of the Agreement *and for a minimum period of 12 months following the latest effective date of such products enrolled by H-M.* This provision does not prevent employees from canceling their supplemental benefits at any time.

Eligibility

All employees included in this enrollment will be eligible for supplemental benefits and will be required to enroll through H-M as outlined in the proposal. *Additional fees will apply* for enrollment of employees not eligible for supplemental benefits (e.g., COBRA, LOAs, etc.).

Offset Guarantee

Hodges-Mace will guarantee its fee-offset proposal regardless of the level of supplemental benefit participation by employees.

ONGOING ENROLLMENT

Single-Source Enrollment Method

New benefit-eligible employees, except officers and executives, will enroll through H-M's dedicated employee benefit resource center vs. enrolling in paper, self-service or other methods.

Data File Requirements

If the client is unable to provide change files and requires H-M to extrapolate changes from full census files, H-M can provide this service at $250/file.

CHANGE ORDERS

The client will assume responsibility for costs associated with changes to items and/or services not included in the proposal. Change Orders should be sent to H-M and are subject to approval by H-M, based on timeline requirement.

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Dependent Verification Project

CASE STUDY

Project Background

ABC Company (ABC) is a leading provider of well completion services. With constant expansion and the increasing number of employees who are offered medical benefits, ABC wanted to complete a Dependent Verification Audit in an effort to help reduce healthcare costs, ensure accuracy in their records and eliminate ineligible dependents from their plan.

Hodges-Mace was cognizant that ABC did not want this process to negatively impact employees' viewpoint on benefits. We didn't want employees that were abiding by the eligibility rules to feel as though they had to go through a painstaking process. We made the process as easy as possible for everyone through detailed communications, and we were able to meet ABC's goals and identify ineligible dependents.

Hodges-Mace Approach

- Communications. A limited number of ABC's workforce has access to email. It was important to build a multiple-touch print communications campaign to deliver the message about the verification process to employees. A customized announcement packet was sent to 1,798 employees, with two additional reminder notices sent during the verification period. ABC also elected to allow an appeal process, which created an additional letter and mailing to those who had not responded.
- Verification Process. ABC's employees had access to a toll-free call center, toll-free fax line, email support box and a 24/7 Web portal for verifying their dependents. A dedicated customer service staff was also available to answer questions and guide employees on how to obtain and submit proper documentation. In total, the customer service line received 3,090 calls during the course of the project.
- Real-Time Reporting. Throughout the verification process, ABC had 24/7 access to our customized employer portal. The portal provided them with critical information about the audit, including employee status updates and real-time statistics about the audit process and performance.
- Ineligible Dependents. The verification process discovered 626 dependents who were ineligible for ABC's benefits. Our confidential concierge service provided placement assistance for all impacted employees in order to help them obtain affordable non-group health insurance coverage.

"I found that the dependent verification audit was a very smooth process. This was our first dependent audit, and we knew this would be a very sensitive topic for our employees. The Hodges-Mace team was extremely professional when our employees called, and every employee was handled in the same professional manner. The interaction between ABC and H-M was a very pleasant experience, and I would highly recommend this process. We were very pleased with the outcome and look forward to working with H-M in the future."

- Melissa Merrifield
HR Manager, ABC Company

Strong Results

At the conclusion of the process, Hodges-Mace had identified 626 ineligible dependents, representing 15% of covered dependents. With ABC spending $3,204 per dependent per year, the process generated an estimated savings of $2,015,316 for the first year.

NUMBER OF EMPLOYEES WITH DEPENDENTS	NUMBER OF DEPENDENTS ON PLAN	NUMBER OF DOCUMENTS RECEIVED	IDENTIFIED INELIGIBLE DEPENDENTS	ANNUAL SAVINGS
1,798	4,500	9,310	626 (15%)	$2,015,316

Continued Savings – and Partnership

ABC has utilized our Annual Enrollment services for many years. Hodges-Mace continually provides comprehensive annual enrollment services that include customized enrollment communications, one-to-one Benefits Counselor sessions and enrollment of both core and voluntary benefits.

With the success of the initial Dependent Audit, ABC will continue to perform a monthly audit of all new dependents added during new hire enrollments and qualifying life events.

About Hodges-Mace

Hodges-Mace, LLC, headquartered in Atlanta, Georgia, is a leading provider of employee benefits communication and enrollment services to large U.S. employers.

Founded in 2004, the company's strategy remains the same as it did then: work with fewer, larger clients than our competitors, so that we can dedicate the best resources to each client. Ultimately, our high-touch service philosophy and thorough approach to solving our client's challenges translate to an exceptional customer service experience.