CITY OF HOLLYWOOD
FLORIDA

BENEFITS CONSULTANT
SOLICITATION #RFP-4513-16-RD

DUE DATE:
THURSDAY, JUNE 16, 2016 @ 3:00 P.M.

Proposal Contact:	**Cindy Thompson, V.P. of Operations**
Tel:	**(800) 244-3696 or (561) 626-6797**
Email:	**cindy.thompson@gehringgroup.com**

SUBMITTED BY:

GEHRING GROUP
INSURANCE BROKERS & CONSULTANTS

11505 Fairchild Gardens Avenue, Suite 202
Palm Beach Gardens, Florida 33410
(561) 626-6797 / (800) 244-3696
(561) 626-6970 – Fax
www.gehringgroup.com

GEHRING GROUP
INSURANCE BROKERS & CONSULTANTS

June 10, 2016

City Clerk's Office
City of Hollywood, Florida
2600 Hollywood Boulevard, Room 221
Hollywood, Florida 33020

Re: Benefits Consultant, Solicitation #RFP-4513-16-RD

Dear Evaluation Committee Member:

Gehring Group is pleased to provide this proposal in response to the City of Hollywood's RFP for Benefits Consultant. Through our extensive experience over the past 23 years serving as Benefits Consultant/Broker for over 80 Florida public sector entities, we are confident that our firm will offer efficiencies, value added services, in-depth public sector experience, and an unparalleled service standard with the goal of not merely meeting the City's needs, but exceeding expectations.

Gehring Group's core services have been designed to meet and exceed those requested in the Scope of Services outlined in the RFP. We anticipate these services will include, but are not limited to: servicing all lines of City's employee benefits insurance coverages, benefits analysis and research, procurement of insurance, developing communication strategies, monitoring regulatory and compliance issues, providing benchmark data, continuous examination and review of claims and benefit data, and overall benefits administration support. And, as Health Care Reform deadlines approach, Gehring Group also assists our clients for the requirements that are specific to their size of group, funding arrangement and reporting requirements.

We provide sophisticated solutions to complex problems and utilize technology and administrative capabilities to assist our clients in gaining efficiencies and developing long range strategies to conform to the entity's overall financial goals. We remain in contact with our clients continuously throughout the plan year, preparing renewal projections and monitoring available claims experience as well as assisting employees with claims issues and enrollments.

At Gehring Group, we're two decades invested in believing that insurance is about advisory services, not just the placement and sale of a product. We employ an atmosphere of collaboration, a culture of teamwork, provide value added resources, and design and implement innovative and progressive solutions. With our extensive experience servicing numerous large group public sector clients throughout the state, this level of sophistication has encouraged innovation, a national outreach and perspective; attracted and developed outstanding professionals, resources, and partner access; and given us top tier recognition with insurance carriers.

Gehring Group has specialized in serving the public sector since 1992 and currently places over $600 million in insurance premium annually, for each of more than 80 Florida public sector organizations. We employ the highest caliber industry staff and remain committed to ongoing training for both our staff and our clients as the insurance marketplace transforms through the implementation of the Health Care Reform Acts. In addition, our extensive public sector experience and expertise affords us the ability and experience to provide benchmarking studies, and related case study comparatives for consideration. With

a centralized, rather than decentralized analytics team, we are able to collaborate and negotiate in an informed and experienced concurrent manner in order to achieve the most cost savings and greatest results for our clients. One example is the savings our team has already achieved for the City during the RFP and negotiation process for its group life and AD&D coverage. Gehring Group was able to negotiate a three-year contract, saving the City $25,000 annually for a total contract savings of $75,000.

As one of the top brokers/consultants for public sector entities throughout the state, our firm also has the distinct honor of participating in the advisory councils of some of the top carriers in the state including Florida Blue and CIGNA HealthCare. This provides us with considerable leverage during client negotiations. We have also received additional acknowledgments, having achieved Florida Blue BlueDiamond recognition, CIGNA HealthCare Platinum recognition, Aetna Preferred Broker, United Healthcare Advantage Gold membership and Local Regional Partner status with The Standard. We represent our clients to all carriers and hold no interest or ownership in any insurer, TPA or trust; therefore, emphasizing our independent status.

Inherent in our response to the RFP, Gehring Group confirms the ability to perform all services as outlined within the scope of work. Our proposal also includes various relevant exhibits to illustrate sample work product, reports, communication materials and letters of recommendation. In addition, Gehring Group meets all qualification requirements including licensing, insurance and years of experience. This proposal is made without collusion with any other person or entity submitting a proposal pursuant to this RFP.

The primary contacts for purposes of this solicitation are:

Name	Tel:	Email:
Anna Maria Studley, Senior Benefits Consultant	(954) 488-8543	annamaria.studley@gehringgroup.com
Cindy Thompson, VP – Operations	(800) 244-3696	cindy.thompson@gehringgroup.com
Kate Grangard, CPA, CFO	(800) 244-3696	kate.grangard@gehringgroup.com

In summary, Gehring Group meets and exceeds the minimum requirements of the City's RFP; and we are confident that we can provide the City with additional value and exceptional services. Our approach to the business as detailed in this proposal, coupled with our industry experience, familiarity with applicable regulations, market relationships and enthusiasm, make us a broker of choice for many public entities. We thank the members of the selection committee in advance for taking the time to review our comprehensive response, and stand ready to provide any additional required clarification upon review this proposal's contents.

Sincerely,

Kurt Gehring, CEO

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TAB A: SUBMITTAL REQUIREMENTS

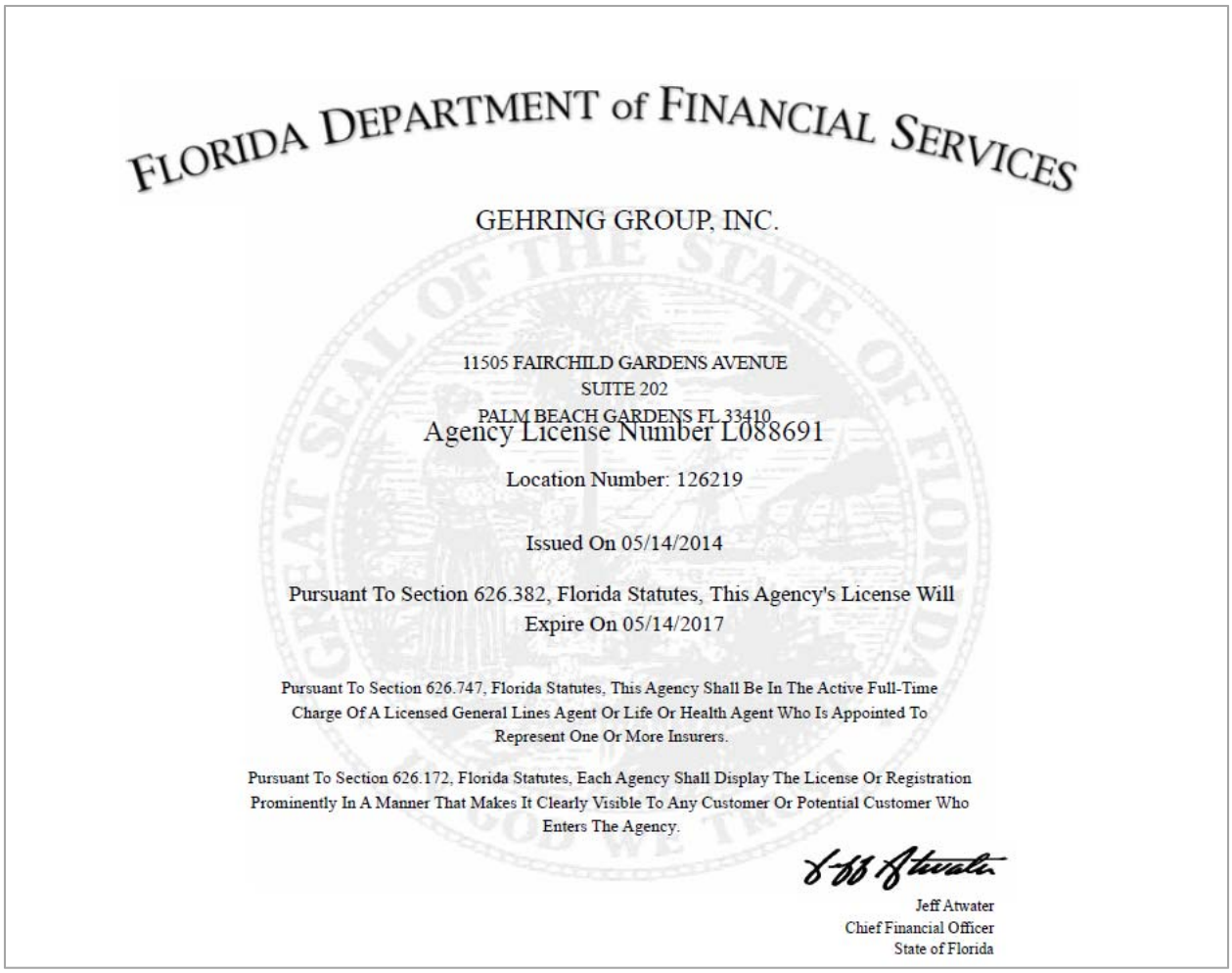
The Minimum Eligibility Requirements for this solicitation are listed below. Proposer shall submit detailed verifiable information affirmatively documenting compliance with each minimum requirement. Proposers that fail to comply with minimum requirements will be deemed non-responsive and will not be considered.

Submittal Requirements:

Proposers must be licensed in the State of Florida and provide a copy of Proposer's current license.

Gehring Group will perform all requested Benefits Consultant services in full compliance with all federal and state regulations. In addition, Gehring Group and all assigned key professional staff are properly registered and licensed by the State of Florida as documented by the following "Agency Registration" and "Proof of Florida Agent Insurance Licensing". We consistently monitor state compliance requirements via our corporate profile as a registered agency with the Florida Department of Financial Services and ensure that all of our licensed agents remain in compliance with all continuing education requirements.

Agency Registration



FLORIDA DEPARTMENT of FINANCIAL SERVICES

GEHRING GROUP, INC.

11505 FAIRCHILD GARDENS AVENUE
SUITE 202
PALM BEACH GARDENS FL 33410

Agency License Number L088691

Location Number: 126219

Issued On 05/14/2014

Pursuant To Section 626.382, Florida Statutes, This Agency's License Will Expire On 05/14/2017

Pursuant To Section 626.747, Florida Statutes, This Agency Shall Be In The Active Full-Time Charge Of A Licensed General Lines Agent Or Life Or Health Agent Who Is Appointed To Represent One Or More Insurers.

Pursuant To Section 626.172, Florida Statutes, Each Agency Shall Display The License Or Registration Prominently In A Manner That Makes It Clearly Visible To Any Customer Or Potential Customer Who Enters The Agency.

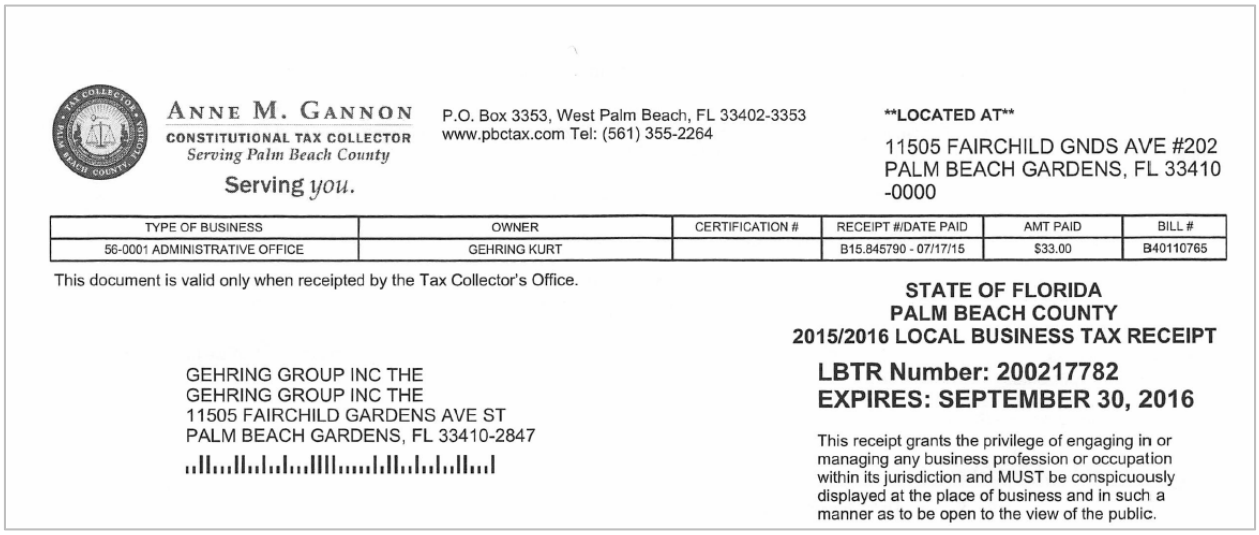
Jeff Atwater
Chief Financial Officer
State of Florida

Proof of Florida Agent Insurance Licensing

Gehring Group Service Team Member	Florida Insurance License #
Kurt Gehring, CEO	A094973
Anna Maria Studley, Senior Benefits Consultant	A097068
Athena Erchard, Benefits Consultant	A078425
Marc Rodriguez, Senior Analyst	W252093
Ed Aguiar, Senior Account Manager	A002137

Florida Insurance licensing credentials can be verified at http://www.myfloridacfo.com/data/aar_alis1/index.htm.

Proof of Business Licensing



ANNE M. GANNON
CONSTITUTIONAL TAX COLLECTOR
Serving Palm Beach County
Serving *you.*

P.O. Box 3353, West Palm Beach, FL 33402-3353
www.pbctax.com Tel: (561) 355-2264

****LOCATED AT****
11505 FAIRCHILD GNDS AVE #202
PALM BEACH GARDENS, FL 33410
-0000

TYPE OF BUSINESS	OWNER	CERTIFICATION #	RECEIPT #/DATE PAID	AMT PAID	BILL #
56-0001 ADMINISTRATIVE OFFICE	GEHRING KURT		B15.845790 - 07/17/15	$33.00	B40110765

This document is valid only when receipted by the Tax Collector's Office.

STATE OF FLORIDA
PALM BEACH COUNTY
2015/2016 LOCAL BUSINESS TAX RECEIPT

GEHRING GROUP INC THE
GEHRING GROUP INC THE
11505 FAIRCHILD GARDENS AVE ST
PALM BEACH GARDENS, FL 33410-2847

LBTR Number: 200217782
EXPIRES: SEPTEMBER 30, 2016

This receipt grants the privilege of engaging in or managing any business profession or occupation within its jurisdiction and MUST be conspicuously displayed at the place of business and in such a manner as to be open to the view of the public.

CITY OF PALM BEACH GARDENS
BUSINESS TAX RECEIPT
10500 N. MILITARY TRL, PALM BCH GARDENS, FL 33410
EXPIRES SEPTEMBER 30,2016

No: 004464

DBA: GEHRING GROUP INC THE
Address: 11505 FAIRCHILD GARDENS AVE, 202
PALM BEACH GARDENS, FL 33410
Activity: INSURANCE

Insurance Adjustor/Agent/Off
Issued to: GEHRING GROUP INC THE
11505 FAIRCHILD GARDENS AVE
202
PALM BEACH GARDENS, FL 33410

2015 / 2016

MUST BE POSTED CONSPICUOUSLY AT YOUR PLACE OF BUSINESS
Per City Code Sec. 66-44

Elizabeth Williams
ELIZABETH WILLIAMS
CERTIFIED BUSINESS TAX OFFICIAL

Proof of Corporation in Good Standing

State of Florida
Department of State

I certify from the records of this office that THE GEHRING GROUP, INC. is a corporation organized under the laws of the State of Florida, filed on October 6, 1992.

The document number of this corporation is V68833.

I further certify that said corporation has paid all fees due this office through December 31, 2016, that its most recent annual report/uniform business report was filed on February 4, 2016, and that its status is active.

I further certify that said corporation has not filed Articles of Dissolution.

Given under my hand and the Great Seal of the State of Florida at Tallahassee, the Capital, this the Twenty-seventh day of May, 2016

Ken Detzner

Secretary of State

Tracking Number: CU0826890693

To authenticate this certificate,visit the following site,enter this number, and then follow the instructions displayed.

https://services.sunbiz.org/Filings/CertificateOfStatus/CertificateAuthentication

Proof of Insurance – Professional Liability

Arch Insurance Group®

ARCH SPECIALTY INSURANCE COMPANY
(A Missouri Corporation)

Home Office Address:
2345 Grand Blvd., Suite 900
Kansas City, MO 64108

Administrative Address:
One Liberty Plaza, 53rd Floor
New York, NY 10006
Tel: (800) 817-3252

MISCELLANEOUS PROFESSIONAL LIABILITY
NETWORK SECURITY AND PRIVACY COVERAGE POLICY
DECLARATIONS

Policy Number: SPL0055072-03 **Renewal of:** SPL0055072-02

THIS IS A CLAIMS-MADE AND REPORTED POLICY. SUBJECT TO ITS PROVISIONS, THIS POLICY PROVIDES COVERAGE FOR CLAIMS FIRST MADE AGAINST THE INSURED AND REPORTED TO THE INSURER DURING THE POLICY PERIOD, UNLESS AN EXTENDED REPORTING PERIOD APPLIES. PLEASE READ THE ENTIRE POLICY CAREFULLY.

Item 1. Named Insured: **Mailing Address**	GEHRING GROUP, INC. 11505 FAIRCHILD GARDENS AVENUE SUITE 102, 202 PALM BEACH GARDENS, FL 33410	
Item 2. Producer Name: **Mailing Address:**	AMWINS BROKERAGE OF GEORGIA 3630 PEACHTREE RD. NE SUITE 1700 ATLANTA, GA 30326	
Item 3. Policy Period:	**Inception Date:** 5/22/2016	**Expiration Date:** 5/22/2017
	(12:01 A.M. Standard time at the address shown above)	
Item 4. Retroactive Date:		
A. Miscellaneous Professional & Media Liability Coverage	• Full Prior Acts applies to $3,000,000 Limit of Liability for Gehring Group, Inc. • May 22, 2013 applies to $2,000,000 excess of $3,000,000 Limit of Liability for Gehring Group, Inc. • March 12, 2010 applies to $1,000,000 excess $1,000,000 for BenTek, Inc • May 22, 2013 applies to $1,000,000 excess $1,000,000 for BenTek, Inc.	
B. Network Security Liability Coverage	May 22, 2013	
C. Privacy Violation Liability Coverage	May 22, 2013	
Item 5. Aggregate Limit of Liability -- Each "Policy Period":	$5,000,000	
Item 6. Sublimits and Deductibles	**Sublimit (A)**	**Deductible (B)**
A. Miscellaneous Professional	$5,000,000	$15,000

06 NPL0002 00 10 08 Page 1 of 2

GEHRING GROUP INSURANCE BROKERS & CONSULTANTS

Item 6. Sublimits and Deductibles	Sublimit (A)	Deductible (B)
Coverage		
B. Network Security Liability Coverage	$5,000,000	$15,000
C. Privacy Violation Liability Coverage	$5,000,000	$15,000

D. Computer Network Business Interruption Coverage	BI Sublimit: Hourly Sublimit: Service Provider BI Loss Sublimit: FORENSIC EXPENSE Sublimit: Waiting Period:	No Coverage $ No Coverage $ No Coverage $ No Coverage N/A hours	N/A
E. Data Loss Coverage	$500,000		$15,000
F. Cyber Extortion Coverage	$5,000,000		$15,000
G. Security Breach Notice Coverage	$2,000,000		$15,000
H. Crisis Management Coverage	$2,000,000		$15,000
I. Regulatory Action Sublimit	$2,000,000		

Item 7.	Premium:	$30,800.00
	State Tax:	$ BY BROKER
	Stamping Fee:	$ BY BROKER
Item 8.	Endorsement(s) Effective At Inception: See attached Schedule of Forms and Endorsements	
Item 9.	Notice Address:	

Arch Specialty Insurance Company
Attention: Professional Liability Claims
1299 Farnam Street, Suite 500
Omaha, NE 68102
P.O. Box 542033
Omaha, NE 68154
Phone: 877 688-ARCH (2724)
Fax: 866 266-3630
E-mail: Claims@ArchInsurance.com

Arch Specialty Insurance Company is licensed in the state of Missouri only.

Surplus Lines Agent's Name: Michael Orren Christian
Surplus Lines Agent's Address: 3630 Peachtree Road NE St. 1700
Atlanta, GA 30326
Surplus Lines Agent's License #: A046973
Producing Agent's Name: _____
Producing Agent's Address: _____

This insurance is issued pursuant to the Florida Surplus Lines Law. Persons insured by surplus lines carriers do not have the protection of the Florida Insurance Guaranty Act to the extent of any right of recovery for the obligation of an insolvent unlicensed insurer.

Premium: _____ Tax: _____ Service Fee: _____
Citizen's Assessment: _____ EMPA Surcharge: _____ Broker Fee: _____
Inspection Fee: _____ Policy Fee: _____

Surplus Lines Agent's Countersignature: _____

Proof of Insurance – All Other

GEHRGRO-01 STRANEC

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 5/2/2016

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Insurance Office of America, Inc.
Abacoa Town Center
1200 University Blvd, Suite 200
Jupiter, FL 33458

CONTACT NAME: Annie Uribe
PHONE (A/C, No, Ext): (561) 776-0660 FAX (A/C, No): (561) 776-0670
E-MAIL ADDRESS: Annie.Uribe@ioausa.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Depositors Insurance Company	42587
INSURER B : Nationwide Insurance Company of America	25453
INSURER C : Twin City Fire Insurance Company	29459
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Gehring Group, Inc.
11505 Fairchild Gardens Ave
Suite 202, Viridian Off Ctr.
Palm Beach Gardens, FL 33410

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY [ ] PRO-JECT [ ] LOC OTHER:			ACP GLDO 5954904781	03/12/2016	03/12/2017	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 100,000 $ 5,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS [ ] SCHEDULED AUTOS HIRED AUTOS [ ] NON-OWNED AUTOS			ACP BAPD5954904781	03/12/2016	03/12/2017	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
B	X UMBRELLA LIAB [X] OCCUR EXCESS LIAB [ ] CLAIMS-MADE DED [ ] RETENTION $			ACP CAP 5954904781	03/12/2016	03/12/2017	EACH OCCURRENCE AGGREGATE	$ 5,000,000 $ 5,000,000
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N [ ] N / A (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below			21WECPO1562	03/12/2016	03/12/2017	X PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
RE: RFP #15-0-2015/SB

CERTIFICATE HOLDER

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
C. Ray Doorey III

ACORD 25 (2014/01) The ACORD name and logo are registered marks of ACORD

GEHRING GROUP INSURANCE BROKERS & CONSULTANTS

Proposed Subcontractor

Actuarial Services

It is by design that we incorporate third party actuarial oversight, a feature our clients and their auditors value more than a broker/consultant having an actuary on staff. In response to requests from our clients, we've made the strategic decision not to have any actuaries on staff to avoid any conflict of interest. The reasoning behind this strategy is that during the audit process clients have confirmed that this structure helps them to best meet their goals of an independent analysis of the facts.

Gehring Group proposes to provide actuarial services through the subcontracted services of Wakely Consulting Group inclusive within our proposed flat fee. Wakely Consulting Group Inc. is an actuarial consulting firm with a focus on the health care industry. All of their professionals are members of the American Academy of Actuaries (www.actuary.org) as well as being recognized as Associates or Fellows of the Society of Actuaries (www.soa.org) and many have gone on to work on or complete their Master's Degree in Actuarial Science or Statistics. Wakely's mission is to provide each client with personal value-added service at a very reasonable cost. Once assigned to your project, their actuaries quickly focus on your timetable and the tasks at hand. Unlike other firms that hire nurses, doctors, lobbyists, and attorneys; Wakely focuses on what they do best — providing actuarial services to the health care sector.

Resume of Proposed Actuary:

ALISON POOL
Senior Consulting Actuary
ASA, MAAA

Experience

Since entering the actuarial profession in 1983, Alison was employed with a Blue Cross/Blue Shield company, and the nation's largest independent third party administrator (TPA) of health insurance plans for small employers. Prior to joining Wakely Consulting Group as a consulting actuary, she was employed at a large Florida-based actuarial consulting firm. Her 17 years at Wakely includes experience working with numerous Florida public sector clients, providing services such as Medicare D attestation, Florida Statute 112.08 annual filing of actuarial soundness, rate setting, IBNR calculations, and more. Current clients include the City of Clearwater, Martin County Board of County Commissioners, Charlotte County Board of County Commissioners.

Professional Credentials

- Associate, Society of Actuaries (A.S.A.)
- Member, American Academy of Actuaries (M.A.A.A.)

Areas of Specialization

Third-party plan administration
State rate filings and actuarial certifications
Claim liability and rate adequacy analysis
Effectiveness and pricing of managed care products

Education

- M.S. studies, Statistics, University of South Florida
- B.S. Mathematics, Birmingham-Southern College

TAB B: REQUIRED FORMS

This section includes the following required forms:

- Acknowledgement & Signature Page
- Hold Harmless and Indemnity Clause
- Non-Collusion Affidavit
- Public Entity Crimes
- Certifications Regarding Debarment
- Drug-Free Workplace Program
- Gifts Policy

ACKNOWLEDGMENT AND SIGNATURE PAGE

This form must be completed and submitted by the date and the time of bid opening.

Legal Company Name (include d/b/a if applicable): The Gehring Group, Inc. Federal Tax Identification Number: 65-0361295

If Corporation - Date Incorporated/Organized: 10/6/1992

State Incorporated/Organized: Florida

Company Operating Address: 11505 Fairchild Gardens Avenue, #202

City Palm Beach Gardens State FL Zip Code 33410

Remittance Address (if different from ordering address): 11505 Fairchild Gardens Avenue, #202

City Palm Beach Gardens State FL Zip Code 33410

Company Contact Person: Cindy A. Thompson Email Address: cindy.thompson@gehringgroup.com

Phone Number (include area code): 561-626-6797 Fax Number (include area code): 561-626-6790

Company's Internet Web Address: www.gehringgroup.com

IT IS HEREBY CERTIFIED AND AFFIRMED THAT THE BIDDER/PROPOSER CERTIFIES ACCEPTANCE OF THE TERMS, CONDITIONS, SPECIFICATIONS, ATTACHMENTS AND ANY ADDENDA. THE BIDDER/PROPOSER SHALL ACCEPT ANY AWARDS MADE AS A RESULT OF THIS SOLICITATION. BIDDER/PROPOSER FURTHER AGREES THAT PRICES QUOTED WILL REMAIN FIXED FOR THE PERIOD OF TIME STATED IN THE SOLICITATION.

Bidder/Proposer's Authorized Representative's Signature: June 10, 2016 Date

Type or Print Name: Kurt N. Gehring

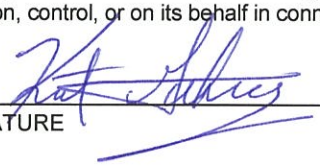
THE EXECUTION OF THIS FORM CONSTITUTES THE UNEQUIVOCAL OFFER OF BIDDER/PROPOSER TO BE BOUND BY THE TERMS OF ITS PROPOSAL. FAILURE TO SIGN THIS SOLICITATION WHERE INDICATED BY AN AUTHORIZED REPRESENTATIVE SHALL RENDER THE BID/PROPOSAL NON-RESPONSIVE. THE CITY MAY, HOWEVER, IN ITS SOLE DISCRETION, ACCEPT ANY BID/PROPOSAL THAT INCLUDES AN EXECUTED DOCUMENT WHICH UNEQUIVOCALLY BINDS THE BIDDER/PROPOSER TO THE TERMS OF ITS OFFER.

ANY EXCEPTION, CHANGES OR ALTERATIONS TO THE GENERAL TERMS AND CONDITIONS, HOLDHARMLESS/INDEMNITY DOCUMENT OR OTHER REQUIRED FORMS MAY RESULT IN THE BID/PROPOSAL BE DEEMED NON-RESPONSIVE AND DISQUALIFIED FORM THE AWARD PROCESS.

HOLD HARMLESS AND INDEMNITY CLAUSE

(Company Name and Authorized Representative's Name)

, the contractor, shall indemnify, defend and hold harmless the City of Hollywood, its elected and appointed officials, employees and agents for any and all suits, actions, legal or administrative proceedings, claims, damage, liabilities, interest, attorney's fees, costs of any kind whether arising prior to the start of activities or following the completion or acceptance and in any manner directly or indirectly caused, occasioned or contributed to in whole or in part by reason of any act, error or omission, fault or negligence whether active or passive by the contractor, or anyone acting under its direction, control, or on its behalf in connection with or incident to its performance of the contract.



SIGNATURE

Kurt N. Gehring
PRINTED NAME

The Gehring Group, Inc.
COMPANY OF NAME

June 10, 2016
DATE

Failure to sign or changes to this page shall render your bid non-responsive.

NONCOLLUSION AFFIDAVIT

STATE OF: Florida

COUNTY OF: Palm Beach, being first duly sworn, deposes and says that:

(1) He/she is President and CEO of The Gehring Group, Inc., the Bidder that has submitted the attached Bid.

(2) He/she has been fully informed regarding the preparation and contents of the attached Bid and of all pertinent circumstances regarding such Bid;

(3) Such Bid is genuine and is not a collusion or sham Bid;

(4) Neither the said Bidder nor any of its officers, partners, owners, agents, representatives, employees or parties in interest, including this affiant has in any way colluded, conspired, connived or agreed, directly or indirectly with any other Bidder, firm or person to submit a collusive or sham Bid in connection with the contractor for which the attached Bid has been submitted or to refrain from bidding in connection with such contract, or has in any manner, directly or indirectly, sought by agreement or collusion or communication or conference with any other Bidder, firm or person to fix the price or prices, profit or cost element of the Bid price or the Bid price of any other Bidder, or to secure an advantage against the City of Hollywood or any person interested in the proposed Contract; and

(5) The price or prices quoted in the attached Bid are fair and proper and are not tainted by any collusion, conspiracy, connivance or unlawful agreement on the part of the Bidder or any of its agents, representatives, owners, employees, or parties in interest, including this affiant.

(SIGNED) _____

Kurt N. Gehring **Title** President and CEO

Failure to sign or changes to this page shall render your bid non-responsive.

SWORN STATEMENT PURSUANT TO SECTION 287.133 (3) (a) FLORIDA STATUTES ON PUBLIC ENTITY CRIMES

THIS FORM MUST BE SIGNED AND SWORN TO IN THE PRESENCE OF A NOTARY PUBLIC OR OTHER OFFICIAL AUTHORIZED TO ADMINISTER OATHS

1. This form statement is submitted to City of Hollywood
by Kurt N. Gehring, CEO and President for The Gehring Group, Inc.
(Print individual's name and title) (Print name of entity submitting sworn statement)
whose business address is 11505 Fairchild Gardens Avenue, #202, Palm Beach Gardens, FL 33410
and if applicable its Federal Employer Identification Number (FEIN) is 65-0361295 If the entity has no FEIN, include the Social Security Number of the individual signing this sworn statement.

2. I understand that "public entity crime," as defined in paragraph 287.133(1)(g), Florida Statues, means a violation of any state or federal law by a person with respect to and directly related to the transaction of business with any public entity or with an agency or political subdivision of any other state or with the United States, including, but not limited to, any bid, proposal, reply, or contract for goods or services, any lease for real property, or any contract for the construction or repair of a public building or public work, involving antitrust, fraud, theft, bribery, collusion, racketeering, conspiracy, or material misinterpretation.

3. I understand that "convicted" or "conviction" as defined in Paragraph 287.133(1)(b), Florida Statutes, means a finding of guilt or a conviction of a public entity crime, with or without an adjudication of guilt, in an federal or state trial court of record relating to charges brought by indictment or information after July 1, 1989, as a result of a jury verdict, nonjury trial, or entry of a plea of guilty or nolo contendere.

4. I understand that "Affiliate," as defined in paragraph 287.133(1)(a), Florida Statutes, means:

1. A predecessor or successor of a person convicted of a public entity crime, or
2. An entity under the control of any natural person who is active in the management of the entity and who has been convicted of a public entity crime. The term "affiliate" includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in the management of an affiliate. The ownership by one person of shares constituting a controlling interest in another person, or a pooling of equipment or income among persons when not for fair market value under an arm's length agreement, shall be a prima facie case that one person controls another person. A person who knowingly enters into a joint venture with a person who has been convicted of a public entity crime in Florida during the preceding 36 months shall be considered an affiliate.

5 I understand that "person," as defined in Paragraph 287.133(1)(e), Florida Statues, means any natural person or any entity organized under the laws of any state or of the United States with the legal power to enter into a binding contract and which bids or applies to bid on contracts let by a public entity, or which otherwise transacts or applies to transact business with a public entity. The term "person" includes those officers, executives, partners, shareholders, employees, members, and agents who are active in management of an entity.

6. Based on information and belief, the statement which I have marked below is true in relation to the entity submitting this sworn statement. (Please indicate which statement applies.)

__✓__ Neither the entity submitting sworn statement, nor any of its officers, director, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, nor any affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989.

_____ The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, or an affiliate of the entity, or an affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989.

_____ The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, or an affiliate of the entity has been charged with and convicted of a public entity crime, but the Final Order entered by the Hearing Officer in a subsequent proceeding before a Hearing Officer of the State of the State of Florida, Division of Administrative Hearings, determined that it was not in the public interest to place the entity submitting this sworn statement on the convicted vendor list. (attach a copy of the Final Order).

I UNDERSTAND THAT THE SUBMISSION OF THIS FORM TO THE CONTRACTING OFFICER FOR THE PUBLIC ENTITY IDENTIFIED IN PARAGRAPH 1 (ONE) ABOVE IS FOR THAT PUBLIC ENTITY ONLY AND THAT THIS FORM IS VALID THROUGH DECEMBER 31 OF THE CALENDAR YEAR IN WHICH IT IS FILED. I ALSO UNDERSTAND THAT I AM REQUIRED TO INFORM THAT PUBLIC ENTITY PRIOR TO ENTERING INTO A CONTRACT IN EXCESS OF THE THRESHOLD AMOUNT PROVIDED IN SECTION 287.017 FLORIDA STATUTES FOR A CATEGORY TWO OF ANY CHANGE IN THE INFORMATION CONTAINED IN THIS FORM.

_____
(Signature)

Sworn to and subscribed before me this 15TH day of June, 2016.

Personally known ✓ Kurt N. Gehring personally known to me

Or produced identification _____ Notary Public-State of Florida

_____ my commission expires 3/21/2017
(Type of identification)

Valerie Jean Ensinger
(Printed, typed or stamped commissioned name of notary public)
Valerie Jean Ensinger

VALERIE JEAN ENSINGER
MY COMMISSION # EE 881098
EXPIRES: March 21, 2017
Bonded Thru Notary Public Underwriters

Failure to sign or changes to this page shall render your bid non-responsive.

CERTIFICATIONS REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The applicant certifies that it and its principals:

(a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, sentenced to a denial of Federal benefits by a State or Federal court, or voluntarily excluded from covered transactions by any Federal department or agency;

(b) Have not within a three-year period preceding this application been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction, violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) Have not within a three-year period preceding this application had one or more public transactions (Federal, State, or local) terminated for cause or default.

Applicant Name and Address:

The Gehring Group, Inc.

11505 Fairchild Gardens Avenue, #202

Palm Beach Gardens, Florida 33410

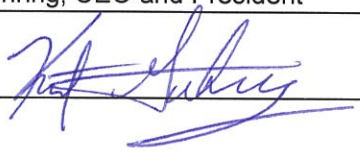
Application Number and/or Project Name:

Benefits Consultant Solicitation #RFP-4513-16-RD

Applicant IRS/Vendor Number: 65-0361295

Type/Print Name and Title of Authorized Representative:

Kurt N. Gehring, CEO and President

Signature:  Date: June 10, 2016

Failure to sign or changes to this page shall render your bid non-responsive.

DRUG-FREE WORKPLACE PROGRAM

IDENTICAL TIE BIDS - Preference shall be given to businesses with drug-free workplace programs. Whenever two or more bids which are equal with respect to price, quality, and service are received by the State or by any political subdivision for the procurement of commodities or contractual services, a bid received from a business that certifies that it has implemented a drug-free workplace program shall be given preference in the award process. Established procedures for processing tie bids will be followed if none of the tied vendors have a drug-free workplace program. In order to have a drug-free workplace program, a business shall:

1. Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.
2. Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.
3. Give each employee engaged in providing the commodities or contractual services that are under bid a copy of the statement specified in subsection (1).
4. In the statement specified in subsection (1), notify the employee that, as a condition of working on the commodities or contractual services that are under bid, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of chapter 893 or of any controlled substance law of the United States or any state, for a violation occurring in the workplace no later than five (5) days after such conviction.
5. Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program (if such is available in the employee's community) by, any employee who is so convicted.
6. Make a good faith effort to continue to maintain a drug-free workplace through implementation of these requirements.

As the person authorized to sign the statement, I certify that this firm complies fully with the above requirements.

Kurt N. Gehring

VENDOR'S SIGNATURE — PRINTED NAME

The Gehring Group, Inc.

NAME OF COMPANY

SOLICITATION, GIVING, AND ACCEPTANCE OF GIFTS POLICY

Florida Statute 112.313 prohibits the solicitation or acceptance of Gifts. - "No Public officer, employee of an agency, local government attorney, or candidate for nomination or election shall solicit or accept anything of value to the recipient, including a gift, loan, reward, promise of future employment, favor, or service, based upon any understanding that the vote, official action, or judgment of the public officer, employee, local government attorney, or candidate would be influenced thereby.". The term "public officer" includes "any person elected or appointed to hold office in any agency, including any person serving on an advisory body."

The City of Hollywood policy prohibits all public officers, elected or appointed, all employees, and their families from accepting any gifts of any value, either directly or indirectly, from any contractor, vendor, consultant, or business with whom the City does business.

The State of Florida definition of "gifts" includes the following:

Real property or its use,
Tangible or intangible personal property, or its use,
A preferential rate or terms on a debt, loan, goods, or services,
Forgiveness of indebtedness,
Transportation, lodging, or parking,
Food or beverage,
Membership dues,
Entrance fees, admission fees, or tickets to events, performances, or facilities,
Plants, flowers or floral arrangements
Services provided by persons pursuant to a professional license or certificate.
Other personal services for which a fee is normally charged by the person providing the services.
Any other similar service or thing having an attributable value not already provided for in this section.

Any contractor, vendor, consultant, or business found to have given a gift to a public officer or employee, or his/her family, will be subject to dismissal or revocation of contract.

As the person authorized to sign the statement, I certify that this firm will comply fully with this policy.

SIGNATURE	Kurt N. Gehring PRINTED NAME
The Gehring Group, Inc. NAME OF COMPANY	President and CEO TITLE

Failure to sign this page shall render your bid non-responsive.

TAB C: KEY PERSONNEL

Offerors must provide a resume and preferably the past two year's performance evaluation of the Key Personnel. Resume must include all certifications, awards, education, number of years performing Consulting work for the private and public sector similar to the Scope outlined in this RFP.

Gehring Group holds a strong commitment to hiring talented high caliber professionals for our team and remaining on the cutting edge of industry innovation. Such strategic hires include former risk management personnel with public sector experience as well as former insurance carrier personnel with significant client service and underwriting experience. We also have former insurance carrier underwriters, who bring their significant experience and expertise into the negotiation of carrier renewals and rates, to the direct benefit of our clients.

At Gehring Group, we rely on our clients to be our references, and insomuch we work toward not only being excellent technicians but also excellent communicators and a valued resource for all their benefits needs. Our staff understands the value of our reputation and the importance of meeting our clients' expectations. We are always communicating not only with our clients, but also internally to ensure that we are on track with meeting client expectations and delivering quality service and expertise to each and every client.

Gehring Group meets all minimum requirements as outlined in the RFP. Our staff members have the required experience in all areas outlined. Engaged, personalized account leadership is paramount to effective long-term client relationships. You will see that our passion for service shines through daily.

PROPOSED SERVICE TEAM

Role	Name	License #	Years of Industry Experience
Executive Staff	Kurt Gehring, CEO	A094973	28 years
Senior Benefit Consultant	Anna Maria Studley	A097068	35 years
Benefits Consultant/Senior Analyst	Athena Erchard	A078425	20 years
Employee Benefits Analyst	Marc Rodriguez	W252093	3 years
Account Manager	Ed Aguiar, PAHM	A002137	25 years

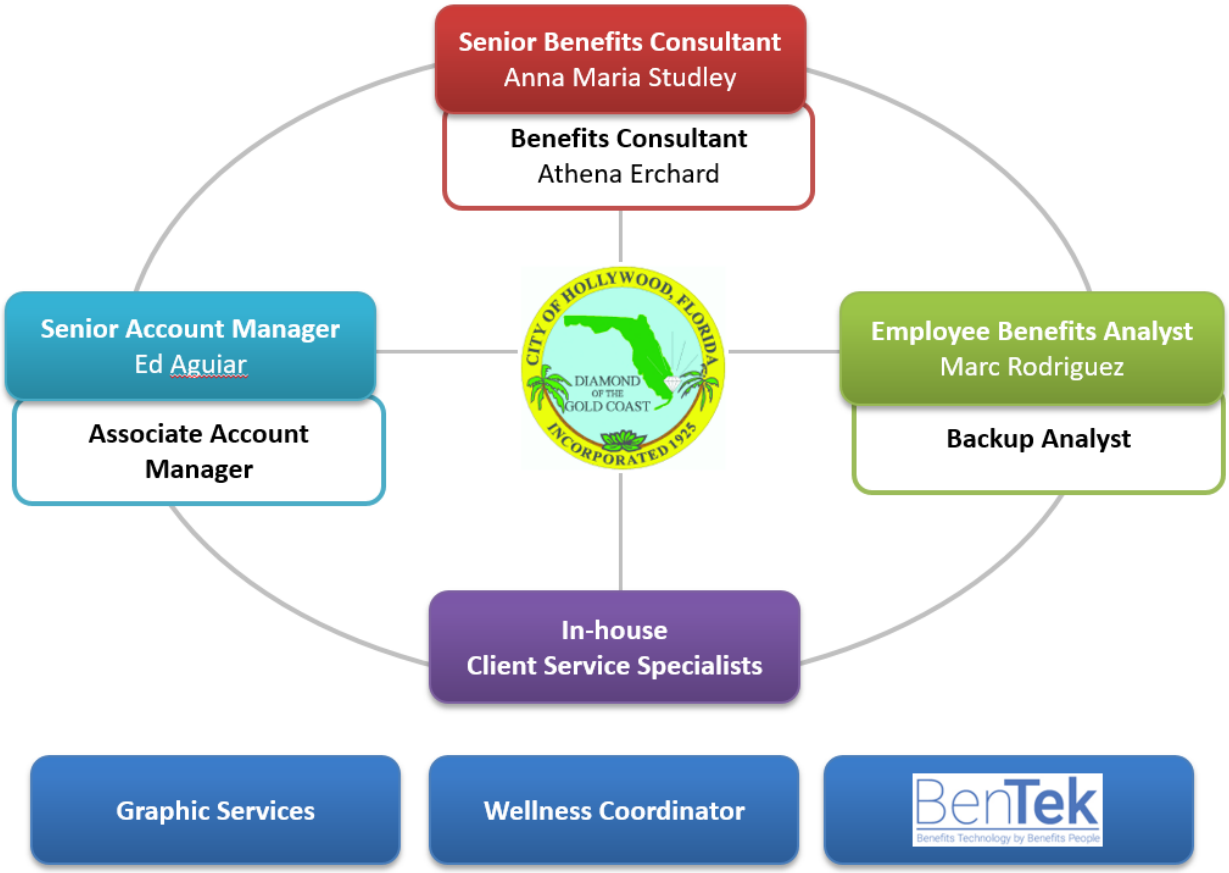
Licensing can be verified at http://www.myfloridacfo.com/data/aar_alis1/.

Resumes for the above team members are included on following pages.

In addition to the above service team, the City will also have direct access to additional staff resources with varying specialties including:

- Kate Grangard, CPA, CGMA, CFO – *Certified Healthcare Reform Specialist*
- Shawn Fleming, CSFS, Senior Benefits Consultant – *Certified Self-Funding Specialist*
- Christian Bergstrom, CHRS, Senior Benefits Consultant – *Certified Healthcare Reform Specialist*
- Sarah Burt, CWWS, CCWS – Wellness Coordinator
- Kimberly Hall, Analytical Services Supervisor

Our service team model for the City is represented as follows:



EMPLOYEE BENEFITS CLIENT SERVICE TEAM

Senior Benefit Consultant: Anna Maria Studley
Professional Licenses: Life, Health & Variable Annuity
Education: Suffolk Community College
Degree: Associates – Accounting and Business Administration
An eight-year veteran of serving the public sector here at Gehring Group, Anna Maria Studley is a seasoned professional with 35 years of experience in the insurance industry and has obtained vast experience undertaking many roles in the insurance sector. Her work history includes time as a General Agent and a Consultant, experience with two national insurance carriers, owning and operating a third party administration company, and experience as Director of Account Management with a national brokerage firm. Her responsibilities have included: providing analysis of benefit plans and claims utilization, oversight of the RFP and evaluation process, management of various funding arrangements, coordination of open enrollments and health fairs, and the handling of escalated member issues and billing reconciliation. Licensed in 26 states, she has also serviced such large employers as IBM and FPL where she managed several multi-state employee benefit programs, performed health insurance claim audits and assisted with the completion of required Form 5500's. Her expertise in compliance issues, state and federal regulations also make her a valuable asset the Gehring Group team and the clients she serves.

In addition, Anna Maria brings invaluable insight and experience from her employment experience with two national health insurance carriers. Her years at these carriers enabled her to gain special expertise regarding the inner workings of an insurance carrier and provided the opportunity for the establishment of significant industry relationships. As Senior Benefits Consultant and the lead of your Gehring Group

service team, Anna Maria is responsible for overseeing all aspects of client service and technical analysis to ensure delivery of the highest level of service with the ultimate goal of achieving both client and member satisfaction. She is supported by several other Gehring Group staff members including account managers, benefits specialists and analytical staff.

Anna Maria's experience at Gehring Group includes servicing clients from 50 to 3,500 employees to whom she brings the experience and knowledge to lead each client in its effort of maintaining a cost effective program. Some of these clients include the Martin County School District (3,000+ employees), Martin County Sheriff's office (600+ employees), St. Lucie County Sheriff's Office (550+ employees), City of Cape Coral (1,600 + employees) and the Citrus County BOCC (800+ employees), to name a few.

Athena Erchard, Benefits Consultant
Professional Licenses: Life, Health & Variable Annuity
Education: Palm Beach Atlantic University
Degree: B.A., Marketing & Psychology
Athena Erchard is an experienced employee benefits professional with 20 years of experience in the industry including working for an international brokerage and consulting firm. During the course of her career, she has worked in multiple roles allowing her the unique opportunity to gain an understanding of the client perspective from different vantage points. Athena has spent over 10 years working specifically in the public sector large group space analyzing benefit plans, funding arrangements and insurance carrier data, researching and developing employer tools for comparing programs and managing open enrollments, benefit fairs and wellness programs.

Her work history is rich, working with all major carriers and large group employers, assisting through the navigation of healthcare reform and the options afforded in this cycle of the benefits arena. Athena has worked as a Senior Marketing Analyst, Account Executive and as an Employee Benefits division manager which provides her clients with an in-depth understanding through organizing and analyzing data to best fit the needs of employer group.

Her communication skills and industry knowledge fosters a dynamic relationship with both clients and carriers. Her collaborative spirit helps maintain interpersonal relationships between brokers, clients and employees. She has been instrumental in developing strategies that include various funding arrangements based on client objectives with consideration of the insurance marketplace, budget objectives, benchmarking and legislative compliance.

Athena is a member of the National Association of Health Underwriters, Florida Association of Health Underwriters and Tampa Bay Underwriters organizations.

Account Manager: Ed Aguiar, PAHM
Professional Licenses: Life, Health & Variable Annuity; *Professional, Academy for Healthcare Mgmt.*
Education: Electronic Computer Institute, NJ
Degree: AS – Computer Science
Ed Aguiar is an expert in the employee benefits arena with 25 years' experience in the area of employee benefit programs. Throughout his tenure in the industry, Ed has spent time at several major insurers as well as with employee benefits insurance agencies, where he was a leader in the service, support, and strategy of plan management for public sector entities and retiree coverage.

During the past ten years, Ed's focus has primarily been in serving public sector clients. Working as head of the Florida public sector division for a national agency, and for a regional agency in the Florida marketplace, as well as through Ed's 4 years at Florida Healthcare Plans, Ed accumulated a deep knowledge of the Florida insurance products and marketplace. Servicing counties, municipalities, and special taxing districts, Ed has amassed experience with all major insurance providers, and gained a thorough knowledge of all health plan funding arrangements. His extensive experience in this market has afforded him a comprehensive understanding of the requirements and unique issues faced by government entities.

Ed is a very tenured and seasoned insurance professional, having also held roles with various insurance carriers including Director of Account Management for Humana; Executive Director for AvMed Health Plans; and Manager of Broker Relations for Florida Health Care Plans/BCBSF. In addition to his professional experience in the insurance industry, Ed holds the professional designation of "Professional, Academy for Healthcare Management" (PAHM) through the Academy for Healthcare Management/AHIP, Washington, D.C.

Employee Benefits Analyst: Marc Rodriguez
Professional Licenses: Life, Health & Variable Annuity
Education: Syracuse University – BA, Psychology
Degree: MSW – Fordham University

Under the direction of your Senior Benefit Consultant, Marc Rodriguez will be responsible for all aspects of the analytical services functions including the RFP and evaluation process as well as renewal negotiations. In addition, he will monitor available claims utilization on a monthly basis in order to better anticipate future cost increases and make recommendations regarding utilization patterns as well as providing budget and renewal projections.

Marc is a graduate of Syracuse University where he earned a bachelor's degree, and a graduate of Fordham University, where he earned the advanced degree – Masters of Social Work. A tenured professional with more than 10 years of experience in both the private and public sector, Marc brings a vast array of analytics experience to the Gehring Group. Prior to joining the Gehring Group, Marc served as the Assistant Director of Data Management at a national healthcare assessment organization where he developed and maintained data management policies and procedures. He also served as Business Analyst for a Florida not-for-profit agency where he provided expert analysis of patterns and trends in data relevant to the organization's mission.

Marc is a critical member of Gehring Group's Analytic Services Team and has served as Employee Benefits Analyst for two years. With his strong background in analytics, Marc provides his clients with reliable and relevant budget planning information, and makes informed recommendations on various employee benefit plans and funding options. His public sector experience includes serving groups such as the City of Stuart, City of Sebastian and Southern Manatee Fire Rescue District. In this role, Marc plays a pivotal role in the strategic reporting and analysis of pertinent information for our employer clientele so that they are equipped with the data and knowledge they need to establish the most effective approach to providing their employees with comprehensive, cost-effective employee benefits.

ADDITIONAL STAFF RESOURCES

Kurt Gehring, CEO
Professional Licenses: Life, Health & Variable Annuity, General Lines Property & Casualty, Surplus Lines
Education: Florida State University
Degree: BA - Marketing
Kurt Gehring is an alumnus of Florida State University and currently serves on FSU's College of Business Board of Governors. An insurance industry veteran with over 25 years' experience, Kurt is an insurance expert licensed in Health, Life, and Variable Annuities, Property and Casualty Insurance, and Surplus Lines License. Kurt has successfully recommended, implemented, and serviced various types of employee benefit, workers' compensation and property and casualty insurance programs, while specializing in the large group market. Recognized for his extensive knowledge, expertise as well as his excellent communication skills, Kurt has been a featured speaker at various conferences on a variety of insurance topics.

Kurt founded the Gehring Group with the mission of providing clients the highest level of service, exceeding not only industry standards, but also client expectations. Recognizing the inherent challenges in servicing organizations with a large number of employees, various contracting parties, and various insurance obligations, the Gehring Group utilizes a unique, team-based approach customized to meet the specific needs of each client. Each Gehring Group employee makes an unprecedented effort to address each situation both promptly and effectively. The success of the Gehring Group is a direct result of this promised and delivered, unparalleled service standard.

Under the guidance and visionary leadership of Kurt Gehring, Gehring Group clients have successfully implemented leading edge concepts such as Consumer Directed Health Plans, Onsite Clinics and Innovative Wellness Programs. In addition, the Gehring Group developed BenTek®, an internet based employee benefits administration system in order to meet the growing benefit administration needs of its clients. This system allows clients to conduct internet enrollments, transmit electronic eligibility to insurance carriers, and provides employees with access to an "Employee Benefits Center" help site. The Gehring Group's growth and success in maintaining long lasting client relationships is a result of its strong commitment to personalized service to its clients as an independent resource, facilitator, advocate, and advisor.

Name: Kate Grangard, CPA, Chief Financial Officer
Professional Licenses: Certified Public Accountant, Certified Health Care Reform Specialist
Education: Fordham University
Degree: BS – Business Administration, Public Accounting
Kate Grangard graduated with honors from Fordham University in 1987 with a B.S. degree in Business Administration with a concentration in Public Accounting. She is a licensed Certified Public Accountant in Florida, and has also held licensure in New York. Kate is a member of the American Institute of Certified Public Accountants, the Florida Institute of Certified Public Accountants, and an associate member of the Association of Certified Fraud Examiners.

Kate started her career in public accounting with the Metropolitan Services Group of Price Waterhouse in Manhattan. As an auditor, she worked on a variety of industry clients including financial institutions, insurance companies, and pension funds. After moving to Florida, she continued her Price Waterhouse career in the West Palm Beach office.

Mrs. Grangard also spent eleven years as Vice President of Finance for a Florida based regional restaurant chain. In her position, she developed and managed the accounting, risk management, employee benefits, and information technology departments. In this executive position, she designed and implemented highly successful internal control and risk management programs and formulated and implemented company policies and procedures. In addition, in the finance arena, she successfully obtained senior debt facility commitments and maintained the commercial bank and financing partner relationships. Notably, Kate's achievements in the risk management area while in this position resulted in substantial savings to the company. In managing this department, she gained experience in the property and casualty, general liability, workers compensation, employee benefits, and umbrella insurance sectors. Her ability to first recognize contributing factors to trends and negative experience, and subsequently effectively negotiate and redesign program parameters resulted in substantial savings to her employer.

Kate brings her extensive management, finance, audit and analytical experience, and customer service commitment to her leadership role with the Gehring Group. Kate is a legislative compliance lead on the Health Care Reform Acts for our clients, and is respected as a highly regarded speaker on health care reform updates for various conferences and groups. Additionally, as CFO of Gehring Group for over nine years, Kate is responsible for overseeing the growth and development of the Company's finances, infrastructure, and staff so that Gehring Group is able to meet its commitment to provide the highest level of customer service to its clients.

Kate is also a frequent speaker at various organizations, and authors and presents webinars and seminars throughout the year believing her role to be an educator with regard to this landmark legislation. In addition to appearing as a recurring guest expert on the Affordable Care Act on The South Florida Business Report on WPEC, Kate also serves as Vice Chair on the Executive Board of The Lord's Place, an organization in Palm Beach County dedicated to breaking the cycle of homelessness. Kate is a 20+ year member of the Jupiter-Tequesta Kiwanis Club, and maintains various professional affiliations including membership in the AICPA, FICPA, FGFOA, and NAHU. Kate serves on 2 committees each for both FGFOA and FICPA for the 2015-2016 year, including the FICPA Employee Benefits Conference Committee.

Senior Benefit Consultant: Christian Bergstrom, CHRS, Senior Benefits Consultant
Professional Licenses: Life, Health & Variable Annuity, General Lines Property & Casualty, Certified Healthcare Reform Specialist
Education: University of Texas
Degree: B.S., Public Administration

In Christian Bergstrom's role as Senior Benefits Consultant, he will assist in strategic and budget planning as it relates to the entity's employee benefits program, making recommendations as necessary and providing guidance with regard to compliance with health care reform. He will be available as needed for meetings with decision makers and is available to make presentations to executive staff and boards as required.

For the past fourteen years, twelve of which spent at Gehring Group, Christian has worked in the insurance arena, focusing on large group public sector clients. Familiar with all lines of insurance coverage and funding arrangements, Christian is licensed to transact life, health, variable annuity, and property and casualty classes of insurance in the State of Florida. Christian Bergstrom earned a Bachelor of Science Degree in Public Administration, Cum Laude from the University of Texas. He was a Fast Track student in Public Affairs and is an alumnus of Pi Sigma Alpha, the national political science honor society. Christian has also earned his CHRS (Certified Healthcare Reform Specialist) designation through the Employer Healthcare & Benefits Congress.

Christian joined Gehring Group as a Senior Analyst in 2003. Currently in his role as Senior Benefits Consultant, he is responsible for overseeing all aspects of client service and technical analysis of his large group clients' employee benefits program needs. These include: spearheading RFP development, bidding and compliance during the RFP process, and providing detailed analysis of the bid's analytical data in order for an appropriate recommendation to be made. During the bid and negotiation process, Christian acts as the key liaison between the client and the insurance carrier/TPA. Christian currently serves as the Senior Benefits Consultant for such large employers as the Palm Beach County Sheriff's Office, the City of West Palm Beach, City of Margate, Town of Jupiter, and City of Naples and is therefore, well-versed in the services required in the public sector market.

Christian's reputation in the industry has earned him the invitation to sit on the "agent advisory councils" of two of the largest group insurance carriers in the State of Florida; Florida Blue and Cigna Healthcare. His insurance expertise and real-life experience in advising his clients allow him to provide real time, relevant feedback to these carriers regarding specific programs and plan models. He also maintains close working relationships with other vendors and upholds an unbiased allegiance to making recommendations that best meet the needs and goals of his clients.

Senior Benefits Consultant: Shawn Fleming, CLTC, CSFS
Professional Licenses: Life, Health & Variable Annuity, *Certified Self-Funding Specialist*
Education: University of Missouri
Degree: B.S., Business Administration
Shawn began his insurance career in 2002 pursuant to earning his Bachelors of Science Degree in Business Administration from the University of Missouri. As a Financial Representative for Northwestern Mutual, his responsibilities focused on advising clients in the purchasing of Life, Health, Disability Insurance, as well as small business insurance planning. He is licensed to transact Life, Health, and Variable Annuity Insurance and also holds a Series 6 and 63 Investment License in the State of Florida. In addition, he is recognized for having the "Certified in Long Term Care" (CLTC) and "Certified Self-Funding Specialist" (CSFS) professional designations.

Immediately prior to joining Gehring Group in 2007, Shawn worked with a brokerage firm that represented large partnerships, including many Top 25 AMLAW law firms and large advertising partnerships. Shawn's responsibilities included analyzing current benefit plans for partners and employees, developing RFP's, and providing plan analysis to clients. While there, Shawn earned a reputation for using his detailed contract, demographic, and product analysis to ensure proper plan design and selection. Shawn has brought his extensive analytical and presentation skills to his position as Senior Analyst for the Gehring Group.

During his nine years at Gehring Group, Shawn has not only increased his level of expertise in all types of insurance programs and funding arrangements, he has also pioneered Gehring Group's efforts with regards to onsite clinic consultation, a role in which he spearheaded the process for over a dozen Gehring Group clients throughout the state in the successful implementation of an onsite clinic, with additional clients currently in the evaluation and/or implementation process.

Shawn is also well respected as an insurance expert among the vendors with whom Gehring Group maintains a relationship. He is a current member of Cigna's Agent Advisory Committee for the Florida Region which provides him with advance notice of new product offerings as well as the opportunity to

share feedback regarding carrier service issues and make recommendations to improve products and services.

Cindy Thompson, Vice President – Operations
Professional Licenses: Life, Health & Variable Annuity
Education: Palm Beach Atlantic University
Degree: B.S., Finance & Banking

As Vice President of Operations for Gehring Group, Cindy is responsible for providing senior level leadership and operations guidance to the organization and its team members. A 20-year veteran of Gehring Group, holding her Health, Life, and Variable Annuity Insurance License, Cindy brings a full array of talents and experience to her position, and serves as a valuable resource in various benefit related areas including employee benefits best practices, compliance and legislative issues, and technical and analytical tools. Her quest for in depth, rather than cursory understanding of the complexities of employee benefits laws complement her experience in servicing all aspects of an employee benefits program including analytical services, account management and wellness. Her responsibilities have included developing Requests for Proposals, preparing bid evaluations from responses received from the insurance market, and negotiating with carriers on behalf of many large employers throughout the State of Florida. Her expertise also extends to the various insurance plan funding arrangements including fully insured, self-insured and minimum premium arrangements, implementation of new programs and/or new carriers, enrollment and communication of group insurance benefits, as well as the day to day service requirements associated with administering a cost effective and administratively efficient employee benefits program.

Cindy's participation in coordinating and designing innovative program solutions to clients ranging from 50 employees to 5,000 employees that are fully insured, self-insured or under other types of funding arrangements brings value to every discussion as she offers history and experience, together with a methodical implementation and troubleshooting perspective, while considering and recommending forward thinking solutions. A valued member of the executive team, Cindy works with management to ensure overall client satisfaction and quality expectations. Cindy holds a Bachelor's degree from Palm Beach Atlantic University, where she majored in Finance, Banking, and Business Administration.

Kimberly Hall, Analytics Team Supervisor
Professional Licenses: Life, Health & Variable Annuity
Education: Immaculata College
Degree: B.S., Mathematics/Computer Science/Physics

In her role as the Analytics Team Supervisor, Kim Hall will be responsible for overseeing the team performing the financial and analytical aspects relating to the account. She will also be an additional contact regarding all financial aspects of its benefits program.

Kimberly is a tenured professional with extensive experience in the Underwriting and Actuarial Services arena. Prior to joining the Gehring Group, Kimberly spent 28 years in the underwriting department of Blue Cross Blue Shield of Delaware where served as an Underwriting Senior Consultant and then promoted to Tactical Manager where she provided operational management to the entire underwriting department. In this role, she was responsible for developing, evaluating and recommending underwriting strategies designed to increase market share by providing cost effective solutions for clients. She was also involved in conducting analysis of client data and financials, monitoring performance, rate setting strategy, coaching and account level guidance and collaborating between sales, account management and other key internals. As Tactical Manager for over 10 years, Kimberly served as a company-wide resource on

matters pertaining to rating and was responsible for reviewing and approving the work output of the entire unit, as well as delivering top-notch consulting work on the most "premier accounts".

Kimberly Hall earned her Bachelor of Science Degree in Mathematics/Computer Science/Physics graduating Sigma Zeta Math/Science Honor Society from Immaculata College, Pennsylvania. Upon her move to Florida, Kim joined the Gehring Group team in early 2015. Having worked with Local and National governmental accounts, her level of expertise has proven and invaluable resource to our team.

Sarah Burt, Wellness Coordinator
Professional Designations: CWWS, CCWS, ACSM CPT
Education: University of West Florida
Degree: B.S., Exercise Science
A skilled professional with focus in fitness and corporate wellness program implementation, Sarah has valuable experience in designing and implementing wellness, fitness, and health improvement programs and promotions for one of the nation's leading models for worksite wellness. Sarah's experience involves working with both large and small employee populations and she is focused on long-term participation and results.

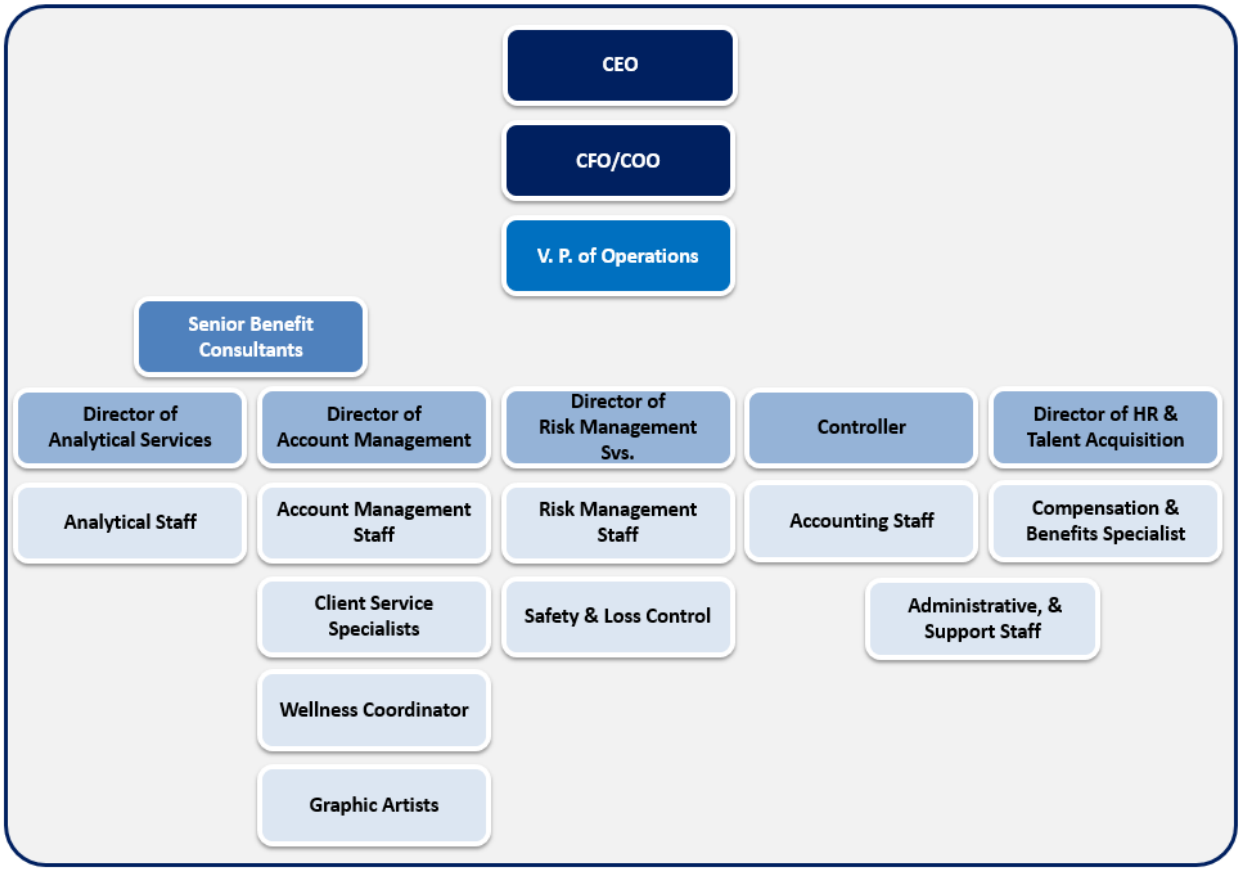
As Wellness Coordinator at Gehring Group, Sarah employs a combination of experience, knowledge, enthusiasm, coordination and empathy to deliver cost saving, achievable, proven, and innovative programs to our clients.

During her years working in this specialized field, Sarah has worked in both the private and public sectors and has achieved a reputable resume which includes the supervision of all health promotion functions for a population of over 400 employees and coordination and implementation of wellness programs for a population of nearly 5000 employees.

In addition to these accomplishments, Sarah, who holds a bachelor's degree in Exercise Science from the University of West Florida, has also achieved the following education and health and wellness related credentials:

- Certified Worksite Wellness Specialist
- Certified Corporate Wellness Specialist
- Member of the American College of Sports Medicine
- American College of Sports Medicine Certified Personal Trainer
- Aerobic and Fitness Association of America Certified Group Exercise Instructor
- Trained in Motivational Interviewing Behavior Modification Technique
- Trained in Office Ergonomic Assessments

Organizational Structure of the Company



TAB D: CORPORATE EXPERIENCE, APPROACH & METHODOLOGY

Offerors must describe their company qualifications as it pertains to the scope of work, describe how their staff has the resources/understanding of the services for this scope.

Firm History & Experience

Incorporated in 1992, Gehring group has been providing expert employee benefits consulting services to Florida public sector clients for 23 years and has grown to become one of the most respected insurance and risk management consulting agencies in the state. Since incorporation in 1992, Gehring Group has experienced consistent growth year over year in staff and number of clients. Under the guidance and visionary leadership of Kurt Gehring, CEO, Gehring Group clients have successfully implemented leading edge concepts such as Consumer Directed Health Plans, Onsite Clinics and Innovative Wellness Programs. In addition, Gehring Group developed BenTek, an internet based employee benefits administration system in order to meet the growing benefit administration needs of its clients. Gehring Group currently employs 55 full-time staff members and specializes in serving the public sector. We are also known for the value-added services that we provide to our clients including:

- Expert Benefits Consulting Services
- Online Enrollment & Benefits Administration (BenTek®)
- Health Care Reform Consulting
- Custom Graphics Division
- Actuarial Services
- Wellness Coordinator
- HR and Compliance Resources

Kurt Gehring remains 100% owner of the firm; therefore, decisions can be made quickly without the layers and red tape inherent in other firms. Gehring Group's philosophy is to provide a full range of superior brokerage and consulting services to each of our clients. We take an innovative, proactive approach to continuously enhance the quality of our performance level beyond industry standards by providing an unparalleled service philosophy and a dedication to protecting the financial assets of our clients. Gehring Group's team of experts strives to become informed of each client's desired goal and work diligently to produce positive results. Our goal is for our clients to realize real dollar savings, while experiencing greater employee satisfaction through increased communication and availability of benefits information.

Gehring Group operates under a unified service approach under a team environment, whereby all staff is responsible for the successful servicing of all clients. Each staff member is considered an important part of the team, representing us at seminars, attending prospective client visits to overview their roles, and contribute to the competitive bid process. Most of all, our employees understand the greatest influence on sales is reaped by providing excellent service to all current clients, to form an unparalleled reference base. We hire highly qualified, professional, productive individuals who bring the skills and capabilities to meet our stringent expectations. Our account managers meet on a regular basis to overview client concerns, and our evaluators meet on a daily basis. All present members of our Company meet each week to endorse the team approach and corporate culture based on teamwork. As a Company, we provide our employees the technology and tools to perform their duties and responsibilities as required, including the use of a web based task management system to track items needing resolution.

Gehring Group employs a team/back up approach. Each team include a Senior Benefits Consultant, a Benefits Consultant, three account managers, two employee benefits analysts and various support staff. Your dedicated Account Manager is available for all on-site meetings and takes an active role in the servicing of all aspects of your group. In addition to your Account Manager, our clients are also assigned an Internal Client Service Specialist as an additional resource for questions and claim issues. Your Account Manager and other back up Gehring Group staff are available for all meetings as requested. These professionals, along with an easily accessed upper management staff and our corporate philosophy regarding our team approach, provides assurance that our clients have access to experienced professionals who are aware of, or can easily access their files, to provide resolution and answers at all times.

Gehring Group standard is to return a call promptly, generally within the same day; however, our clients enjoy the ability to always get a message to their account managers who are out of the office either through their cell phones or our administrative assistant. The accessibility and attendance of our management and executive team at various conferences and client functions not only builds our relationship with our clients, but also supports our position that we are available and accessible in the event of a client issue or concern. All managers and executives employ a hands-on approach with regards to their positions, offering another integral level of expertise to our clients.

Negotiating Clout

As one of the top producing brokers/consultants for public sector entities throughout the state, our firm has earned the distinct honor of participating in the agent advisory councils of three of the top carriers in the state: Florida Blue, CIGNA HealthCare, and Humana. This provides us with considerable leverage during client negotiations. We have also received additional recognitions and have been named an AETNA Preferred Producer, Florida Blue BlueDiamond Producer, CIGNA HealthCare Platinum Broker, and United Healthcare Advantage Gold membership. In addition, we are recognized as a "Local Regional Partner" by The Standard, a status that provides our firm with a dedicated service representative who can advance claim issues through processing for faster resolution. We represent all carriers and hold no interest or ownership in any insurer, trust or TPA, therefore, emphasizing our independent status.

In addition, Gehring Group has extensive experience in dealing with all types of funding arrangements, from fully insured to self-funded to minimum premium programs, as well as numerous insurance carriers, third party administrators and stop loss providers. We offer impartial and independent expertise, currently placing over $600 million in insurance premium annually. This clout in the marketplace affords our firm the credibility to negotiate with carriers effectively. Gehring Group is also known for the high quality of analysis provided in our evaluation and recommendation proposals, and our ability to present and communicate this information in a clear and concise manner.

Industry Knowledge & Trends

Gehring Group maintains a strong commitment to remain at the forefront of industry trends, new legislation, cutting edge benefits technology tools, and new types of insurance programs offered by insurance companies and third-party administrators. We consistently attend conferences, continuing education and industry seminars in order to remain ahead of the curve. In addition, members of our qualified team are featured speakers at various HR, public sector and benefits associations meetings and conferences.

Our staff has extensive experience with reviewing, implementing and servicing all types of programs that include fully and self-insured programs, Health Savings Accounts (HSA), Health Reimbursement Accounts (HRA), Consumer Driven Health Plans (CDHP), and Cafeteria Plans. Through our knowledge and expertise,

Gehring Group is able to aid clients in determining which plans represent viable options in order to assist management in making informed decisions regarding new concepts and ascertaining the best interest of their organization. During Gehring Group's tenured experience, we have assisted our clients through a variety of plan and funding changes. We have assisted our clients through transition in many ways such as: changing from fully insured to self-insured, switching insurance carriers, and implementing health savings vehicles such as HSA's and HRA's.

Gehring Group is well respected as a forward thinking consultant. We were on the forefront of evaluating the concept of the employer onsite clinic and determining the potential cost savings available under such an arrangement. Inherent in our onsite clinic experience, we have independently advised on, and implemented a number of onsite/near-site health center models with various clinic service vendors. We have also assisted numerous public sector clients in evaluating various benefits technology tools such as online open enrollment and benefits eligibility and administration systems.

In recent years, our focus has turned to ensuring that our clients are fully educated on and remain compliant with all the requirements mandated under the 2010 Health Care Reform legislation. Spearheaded by our CFO, Kate Grangard, CPA, who has achieved her ***Certified Health Care Reform Specialist*** designation, we take our role as advisor in guiding our clients through the requirements of health care reform very seriously. We have assisted, and continue to assist our clients through the compliance steps mandated by the Acts such as; assisting in the calculation and distribution of MLR rebates, providing guidance relating to the reporting of employer sponsored health benefits on employee W-2's, evaluating the penalty exposure relating to part-time and variable hour employees, providing guidance relating to 1094/1095 applicable large employer (ALE) reporting, and planning for the future. We routinely guide our clients with compliance and preparing financially in anticipation of legislative regulations.

In addition, our Experts are frequent guest speakers at strategic business leadership events customized for CEOs, CFOs and HR and Benefits practice leaders, explaining the nuances and impact of the Affordable Care Act as it continually evolves and drives both near-term and long-term business decisions. Some of these considerations include:

- Technical aspects of calculating, reporting, and paying the new PCORI, Health Industry Fee and Transitional Reinsurance Fee;
- Impact of having an employer sponsored group medical plan that is both "affordable" and meets "minimum value" requirements on both employers and employees;
- Employer alternatives, including a health insurance exchange; and
- Effect of subsidies, penalties, and taxes.

In summary, Gehring Group has proven to be invaluable in assisting clients to control spiraling benefit costs. We continually ensure clients are up to date and informed on the latest market trends. We recommend that our clients make employee benefits management a strategic initiative by defining objectives and developing an action plan based on meeting those objectives and ensuring an organized, complete approach to fulfilling our clients' benefits needs.

Additional Special Expertise & Competitive Advantages

Based on our tenure in the benefits marketplace and concentration in the public sector, Gehring Group has significant expertise in providing employee benefits and insurance services to clients with needs similar to those of the City.

- **Public Sector Focus & Experience**

  Since the majority of the Gehring Group's client base consists of public entities our firm is uniquely qualified in its understanding of public entity issues. We understand the bid process and public record laws while maintaining familiarity with the constantly changing and complex Statutes that apply to governmental organizations. This specialized knowledge is especially vital when negotiating renewals and program changes with insurance carriers and health insurance consortiums. The experience we offer guarantees that no piece of the puzzle will be missing when a benefit change is implemented.

  Gehring Group's successful experience with public sector entities is further evidenced by the list of current public sector clients provided below. We also invite you to review our Letters of Reference included in **Exhibit 7.**

Public Sector Clients	Client Since
Boynton Beach, City of	1/1/2013
Brooksville, City of	10/1/2007
Cape Coral, City of	10/3/2011
Cape Coral Professional Firefighters Health Insurance Trust	11/10/2015
Career Source Palm Beach County	10/1/2007
Charlotte County BOCC	9/26/2000
Children's Services Council of Palm Beach County	4/6/2005
Citrus County BOCC	3/24/2009
Clearwater, City of	5/1/2001
Clerk & Comptroller, Palm Beach County	10/1/2002
Cocoa, City of	10/1/2012
Coconut Creek, City of	6/1/2010
Dania Beach, City of	5/30/2013
Dunedin, City of	4/1/2004
Delray Beach, City of	3/10/2015
Fellsmere, City of	3/13/1997
Florida Keys Aqueduct Authority	4/28/2006
Hernando County BOCC	4/13/2011
Indian River County BOCC	7/1/2010
Islamorada, Village of Islands	10/1/2012
Juno Beach, Town of	8/18/2003
Jupiter Island, Town of	6/6/2009
Jupiter, Town of	1/1/2009
Key West Housing Authority	7/16/2009
Key West, City of	6/21/2001
Keys Energy Services	8/30/2010
Lake Park Community Redevelopment Agency	5/10/1994
Lake Park, Town of	5/10/1994
Lighthouse Point, City of	5/11/2011
Loxahatchee River District	8/1/2009

Public Sector Clients	Client Since
Manalapan, Town of	9/27/2006
Mangonia Park, Town of	2/1/2003
Marco Island, City of	7/5/2011
Margate, City of	9/19/2012
Martin County BOCC	2/21/2001
Martin County School District	8/16/2004
Martin County Sheriff's Office	10/1/2008
Miramar, City of	4/4/2012
Naples, City of	5/5/2010
North Palm Beach, Village of	6/8/2006
Oakland Park, City of	7/7/2011
Oldsmar, City of	8/1/2008
Osceola County Sheriff's Office	5/17/2011
Oviedo, City of	4/1/2012
Palm Harbor Fire Rescue District	4/26/2016
Palm Bay, City of	5/1/2015
Palm Beach County Sheriff's Office	11/1/1992
Palm Springs, Village of	11/5/2014
Parkland, City of	5/1/2012
Pinellas Suncoast Fire and Rescue	11/22/2011
Pinellas Suncoast Transit Authority	5/1/2013
Port Richey, City of	1/20/2010
Port St. Lucie, City of	7/12/2011
Rockledge, City of	9/4/2012
Royal Palm Beach, Village of	11/11/1993
Sanibel, City of	2/1/2003
Sarasota County Sheriff's Office	3/2/2010
Sarasota, City of	6/26/2009
Satellite Beach, City of	7/22/2013
Seacoast Utility Authority	1/1/1993
Sebastian, City of	5/25/1999
Solid Waste Authority of Palm Beach County	5/8/1995
Southern Manatee Fire Rescue District	2/16/2016
Southwest Florida Water Management District	7/11/2014
St. Lucie County Sheriff's Office	3/25/2013
Stuart, City of	7/1/2003
Tax Collector, Palm Beach County	8/15/2007
Tequesta, Village of	5/1/2009
Wellington, Village of	3/23/2000
West Palm Beach Housing Authority	4/28/1998
West Palm Beach Police Benevolent Association	5/8/2000
West Palm Beach, City of	4/28/1998

- **No Commissioned Employees**
  In addition to our public sector focus, Gehring Group is not organized like a traditional insurance agency. Traditionally, agencies grow by employing a number of producers who sell and manage a "silo" of accounts. Free of this business model, Gehring Group is able to maintain a supportive team

environment and culture whereby all employees feel an allegiance and commitment to all of our clients as a whole. What this means to you is that all decisions are made based on what is in the best interest of the client.

- **Experience with Employee and Departmental Committees**
  We also believe it is especially important as your insurance professional to develop credibility and a strong communication base with the Risk Management, Human Resource, Finance and Administrative Departments as well as other overseeing committees in order to ascertain an impartial and thorough analysis of all proposed options. The participation of all parties involved in these meetings and the feeling that an objective, experienced insurance professional has assisted in the coordination of the process, will serve to make any transition as smooth as possible. These meetings will also ensure that any changes or recommendations are communicated back to the employee base in a positive and effective manner. Gehring Group staff members are active participants in many clients' employee benefits and wellness committees.

- **Clinic Experience**
  Gehring Group has assisted several of our clients in the decision of whether to open an onsite health clinic. This process includes conducting an analysis to determine if our clients can take advantage of the potential cost saving benefits of opening an onsite or near-site clinic. By shifting costs from the medical plan to the clinics, many groups have been better able to manage specific areas of claims costs, while providing additional access to medical care to their employees. Gehring Group has experience in conducting the bid process to determine which clinic model and provider would best meet the needs of our clients, and in addition, is available to oversee the implementation process once a decision has been made. Our staff coordinated and conducted the entire bid and implementation process for the Charlotte County Board of County Commissioners, the Palm Beach County Sheriff's Office, Martin County BOCC, City of Clearwater, City of Sarasota as well as the City of West Palm Beach who have each opened an onsite clinic. Gehring Group currently has over 20 clients operating or participating (through interlocal agreements) in a clinic arrangement.

- **Human Resources Experience**
  In addition to the high level of insurance expertise of our staff, Gehring Group also employs several staff members with significant human resources experience. Having achieved their PHR or SPHR designation, these employees often serve as an additional resource to our clients facing general HR questions as they relate to employee benefits.

- **Professional Memberships**
  Additionally, Gehring Group's expertise is well-known throughout the state as evidenced by the repeated number of requests for our staff members to be featured speakers at various Florida public sector associations and other organizations including:

  - FAC – Florida Association of Counties
  - FASD – Florida Association of Special Districts
  - FERMA – Florida Educational Risk Management Association
  - FGFOA – Florida Government Finance Officers Association
  - Florida League of Cities
  - FPELRA – Florida Public Employer Labor Relations Association
  - FPPA – Florida Public Personnel Association
  - FSA – Florida Sheriff's Association
  - Florida Institute of Certified Public Accounting Chapter Meetings

- PRIMA – Public Risk Management Association
- RIMS – Risk & Insurance Management Society
- SHRM – Society for Human Resource Management

Gehring Group is also a member of each of the above listed associations through which we are able to stay abreast of all issues public sector entities are facing today.

Submit detailed information on how Proposer plans to accomplish the required scope of services, including detailed information, as applicable, which addresses, but need not be limited to: review and evaluate existing City benefit related agreements to provide recommendations; assist in preparation of City's request for proposals for its medical, dental, life, disability and voluntary benefit plans; provide plan design and contribution design modeling, manage negotiations of premium rates, etc.

Requested Scope of Services

It is apparent that the City's goal is to maintain a competitive, yet cost effective employee benefits program and is seeking the aid of an experienced insurance professional in order to accomplish this goal. Based on Gehring Group's level of industry expertise and leverage in the marketplace, we are confident that our firm would offer the City efficiencies, services and a service standard that would not only meet your needs, but exceed your expectations as well as produce savings. Our services would include expert knowledge of the insurance industry and all available programs and funding options, consistent monitoring of the program claims experience and contract language, and the provision of budgetary projections and funding recommendations for the City's life, medical, dental, disability, vision and supplemental insurance programs.

Per the City of Hollywood's RFP#4513-16-RD, Gehring Group understands the work objective to include, but not be limited to the following:

- Review, analyze, and provide recommendations of current and future employee benefit plans, including critical plan components, appropriate funding, and propose plan changes supported by fact driven analysis and best practices;

- Assist in the development of formal solicitations for employee benefit plans including the preparation of the scopes of services and evaluation criteria, analysis of proposals received and preparation of response comparison, network review, present to and serve as a technical advisor (non-voting) to the Evaluation Committee, fee and contract negotiations, and be prepared to explain recommendations;

- Assist in the implementation and oversight of self-funded health and dental plan, vision, life, accidental death & dismemberment, long term disability, and, flex, stop loss, COBRA and other voluntary fully-insured benefits;

- Review all plan documents and proposed amendments for accuracy, completeness, and compliance with appropriate laws and regulations;

- Review agreements and policies purchased by the City to assure their accuracy and appropriateness;

- Review and evaluate existing City benefit related agreements including but not limited to administrative service agreements with insurance carriers, business associate agreements, new case documents and service agreements to provide recommendations for possible improvement in price, terms and conditions.

- Review vendor summary plan descriptions for accuracy in benefits provided and ensure compliance with all governmental regulations;

- Assist in the development and review of communication materials written by benefits vendors and administrators for content, appearance, compliance, and accuracy;

- Provide independent annual review of group health programs including funding, reserves, service, benefit plan provisions, premium history, contractual provisions and competitiveness.

- Analyze the feasibility of alternative employee benefit program designs and cost containment methods by modeling and providing recommendations and assisting in the development and implementation of such programs;

- Provide annual recommendations for changes in plan premiums, plan design, and plan employer subsidy for the upcoming fiscal year;

- Evaluate stop loss coverage and make related recommendations to ensure the City's self-insurance benefits are protected from catastrophic losses;

- Manage negotiations of reimbursement rates;

- Provide unlimited actuarial services by a professional actuary who is either a staff member or sub-contractor of the successful proposer to analyze all benefit programs including plan design, claims, utilization trends, and contribution rates for the self-insured plans prior to open enrollment each year;

- Provide guidance on annual budgets, recommended reserves, payroll deduction allocations, and plan costs;

- Conduct periodic audits of health plan administrator/provider, analyze results and prepare reports, when requested (a la carte);

- Assist in gathering information necessary to prepare full bi-annual Governmental Accounting Standards Board (GASB) 75 evaluation and reporting;

- Prepare reports informing the City's Administration of benefit market conditions (Market Analysis) that may affect the City's policies and risk exposures prior to policy renewals;

- Assist in the preparation of data required for annual financial reporting in accordance with governmental standards, Accounting and Financial Reporting by Employer for post-employment Benefits other than Pensions, and other accounting standards promulgated by governmental standard setting bodies;

- Assist in gathering information necessary to prepare an annual report of the City's OPEB liability as of September 30 each year by October 15 of the same year;

- Provide guidance on Medicare Part B Retiree Drug Subsidy and submit actuarial attestation upon request;

- Provide the City with guidance on its Obligations for other post-employment benefits;

- Conduct the City's Healthcare Reform Forecasting Analysis;

- Provide general and technical guidance on employee benefit issues to include healthcare utilization patterns, market analysis, contract trends, federal regulation, and statute interpretation;

- Assist with the development of policies and procedures regarding eligibility, retirement, Health Insurance Portability and Accountability Act (HIPAA), and other related topics;

- Provide ongoing training for City Staff to ensure appropriate controls, plan provision compliance, and statutory compliance (e.g. HIPAA training);

- Assist in the implementation and evaluation of the effectiveness of wellness initiatives and disease management programs;

- Assist in the coordination, material preparation, presentation and other tasks for the City's annual enrollment period;

- Attend and present at City Commission meetings, employee meetings, open enrollment meetings, health insurance committee meetings and other meetings as requested;

- Advise and provide interpretations on new healthcare and benefit plan models, delivery systems, and other topics as necessary;

- Provide updates on law, regulatory, legislative changes, and related compliance issues such as the Patient Protection and Affordable Care Act, including administrative and financial impacts, timelines and requirements. Provide guidance on Transitional Reinsurance program and calculate Transitional Reinsurance Fee;

- Assist with all compliance issues including the Patient Protection and Affordable Care Act, Health Insurance Portability and Accountability Act (HIPAA), Medicare Part D, Consolidated Omnibus Budget Reconciliation Act (COBRA) and Governmental Accounting Standards (GASB) and any legislation that has an impact on employee benefits;

- Develop and recommend performance standards and guarantees for service providers to measure levels of service as applicable;

- Assist the City and plan members in resolving claims or other disputes related to vendors, carriers and/or providers;

- In the event that the City is involved in litigation arising from the solicitation process, the agreement, or employee grievances, the Consultant may be required by the City to prepare the necessary materials and to testify;

- Designate a Project Manager for the Agreement at no additional cost to the City;

- Conduct quarterly meetings with the City's Human Resources, Finance and Budget staff to provide claims experience, plan costs and projections of claims and revenues; and

- Provide additional health and benefits plan consulting services as deemed necessary.

Additional Recommended and Value-Added Services

The following includes information regarding the BenTek® Online Enrollment and Administration Solution as an option to provide benefits enrollment and administration services for the City in addition to several value added services as outlined below:

- ***BenTek® Online Enrollment and Administration System****
  (Cost outlined in Tab F: Price)
  For those clients seeking a more comprehensive solution providing YEAR ROUND benefits administration services and capabilities, Gehring Group proposes the **BenTek® Online Enrollment and Administration Solution**. BenTek® is an easy and convenient, online benefits enrollment and administration system that streamlines benefit enrollment by delivering a 100% paperless enrollment solution. Employees can easily and securely access the *Employee Benefits Center* and enroll from anywhere. **BenTek may be a viable option for the City to provide a paperless enrollment option and reduce the number of redundant entries into the various carrier websites by housing all benefits data for all constitutionals in one place.**

  The online enrollment experience, "Enrollment in 7 Steps", is designed to guide employees through the enrollment process in seven progressive steps, each tracked within the Enrollment Progress Bar. During any enrollment process (Open Enrollment, New Hire, Qualifying Event), employees can view both current and future enrollment and deduction information for all benefit options on one page. Each enrollment module provides a detailed confirmation statement of all elected benefits and deductions that can be saved, printed, and viewed in future sessions. Employees can access detailed plan information such as Summaries of Benefits and Coverage (SBC's), plan summaries, plan comparisons as well as acknowledge compliance notifications, disclaimers, and more.

  The **Employee Benefits Center** also provides easy access to benefit information and resources, self-service tools and online enrollment 24/7/365. Employees can perform many benefit related functions including reporting qualifying life events, manage life insurance beneficiary designations, access provider sites, claim forms, and more.

  BenTek® Open Enrollment Key Advantages:

  - Rules based enrollment provides a customized user experience built with benefit logic, alerts, and informational notifications based on the unique needs of each Client's employee population.
  - Improved employee communication with access to current enrollment, cost, and provider information to assist with enrollment decisions.
  - Customized content including open enrollment news, embedded links, access to videos and presentations to create a system that is filled with benefit resources for employees.
  - Powerful self-service tool providing employees with 24/7/365 access from the comfort of their homes to view real time comprehensive benefit summary, review and compare plans,

report qualifying life events, view dependents, manage beneficiaries for life insurance and retirement plans, and more.

BenTek®'s Open Enrollment module features include:

- SSL Based login
- Easy access to Benefit Statements
- Access to current, historical, and future elections
- Session Time Security
- Enrollment Progress Bar
- Open Enrollment Introduction Page
- Web Single Sign-On
- Dependent Information Screen
- Benefit Highlights & Resources
- Single Screen for all Benefit Election
- Beneficiary Designation
- Summary of Elections
- Elections Submitted "Electronic Signature"
- Employee Demographics Verification

Within the **Administration Module**, Benefit Administrators can manage employee demographics, personnel data, coverage eligibility, and dependent records in one system, and automatically transmit electronic eligibility to insurance providers. They can also approve qualifying life event submissions and generate customized approval, pending, and denial letters. In addition, Benefit Administrators can utilize ongoing Personnel and Payroll audit features to maintain the integrity of data between the Payroll system, HRIS system, and BenTek®.

Additional information regarding the BenTek Online Enrollment and Administration System is included in **Exhibit 1** for your review. We would be pleased to demonstrate BenTek's functionality via a webcast or provide an onsite demonstration at your earliest convenience. We would like to emphasize that BenTek's slogan is Benefits Technology by Benefits People. What this means for you is a seamless implementation by an experienced team of programmers, along with a benefits expert guiding the implementation process. Together with professionally produced communication collateral, we feel confident that BenTek® will prove itself a true extension of your benefits team, resulting in measureable savings of invaluable resources.

- **Online Human Resources Research Tool: *ThinkHR*** *(included for all clients at no cost)*
  Gehring Group provides *Think HR* to all clients at no additional charge. *Think HR* offers a one-stop resource for quick answers to thousands of human resources and employee benefits questions covering such issues as record-keeping, employment law, wages and withholding, workers' compensation, harassment, ERISA, COBRA and FMLA. *Think HR* provides you with easy and immediate access to expert HR advisors who will provide information and answers in a timely manner to minimize the exposure and risk associated with legal and regulatory matters. These answers are provided via phone, web or email, followed up with a written response to summarize the issue and result.

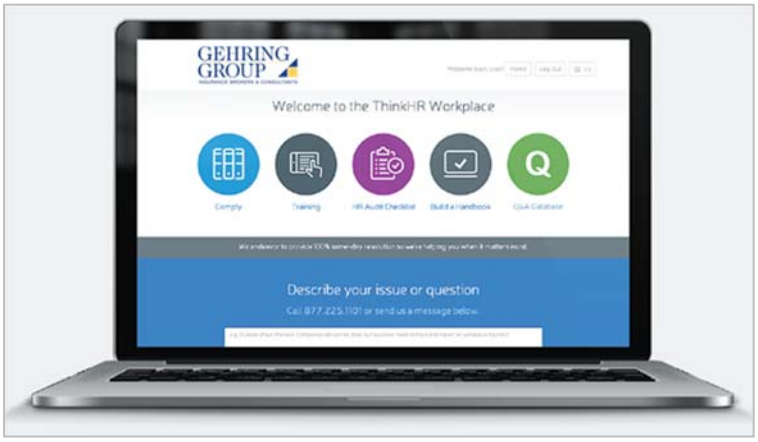
  ThinkHR Live includes:

  HR Hotline – Immediate, unlimited help from PHR and SPHR Advisors via phone or email.
  - Phone access to HR advisers anytime Mon-Fri, 9am-8pm EST

- Written/email follow-up on complex issues or researched matters
- National and regional expertise

HR Library – Immediate access to HR resources to solve your HR concerns.

- Thousands of forms, documents, tools and checklists for every HR department
- Job description builder and salary benchmarking tools



- **<u>Gehring Group's Client Portal</u>** *(included for all clients at no cost)*
  Gehring Group hosts a client portal to communicate with and serve as an informational resource to its clients. This site allows us to post documents for clients to review, so that as the landscape of health care reform evolves, we can ascertain that they have timely access to relevant documents and analysis to help them navigate through this period of change. We also use the portal to communicate with them about upcoming seminars and workshops we will host; as well as conferences at which we will be in attendance; and upcoming speaking engagements. Subscribers to our portal additionally receive daily updates from CCH on national regulatory changes.

- **<u>Graphic Services – Employee Benefits Handbook & Employee Communications</u>** *(included for all clients at no cost)*
  Gehring Group employs an in-house Graphics Department. This enables us to assist our clients with the development of creative and educational employee communication materials. As part of our services, we draft and produce employee communication pieces such as payroll stuffers, department posters, mass employee mailings, etc. This allows our clients to better communicate its employee benefit offerings and keep their employees well educated with regard to their employee benefit options and responsibilities. All of the work products and samples included in the **Exhibits** section were created and produced in house.

  In addition, at the beginning of each new plan year we gather and compile all of the information regarding your insurance coverages and summarize it in an employee friendly benefit highlights booklet. This booklet has proven to be a valuable resource to our client's employees and has reduced the number of inquiries received by our client's HR and Benefits staff. This service is offered at no additional cost. We will provide you with enough copies for open enrollment and as needed for new-hire orientations throughout the plan year. (Examples of the above are included in **Exhibit 2.**)

Gehring Group Technical Approach

Gehring Group understands the City's desire to offer its employees a competitive benefit package to attract and retain valued employees. Gehring Group will partner with the City to provide innovative ideas and solutions pursuant to the City's benefit plan offerings. Gehring Group will provide professional, timely advice and consulting services. Upon selection as Benefits Consultant/Agent of Record, Gehring Group's first priority would be to meet with City staff to determine what they deem to be the positive aspects of their program as well as any areas of particular concern. We would review all lines of coverage and benefits included in the City's total employee benefits program package. Gehring Group's traditional marketing process includes a comprehensive analysis of the current programs, past programs, claims history, in addition to numerous other factors including demographics and the local market. In addition to reviewing the incumbent carriers' renewal quotes, we would review a list of prospective carriers, coalitions & trusts with HR staff in discussing whether to release any RFP's for the various lines of coverage. As an independent consultant, our goal is to ascertain that all available products and insurers are considered to ensure that the City finds the best match for its needs. Our marketing process typically includes the following steps:

- Step One: Information Gathering Process
- Step Two: Presentation of Initial Findings
- Step Three: Presentation to the Market
- Step Four: Proposal Analysis & Recommendation
- Step Five: Program Implementation
- Step Six: Year-Round Service

Step One: Information Gathering Process

The first step in the procurement process is the gathering of all information pertinent to your current programs. This includes interviewing staff regarding what they deem to be the positive aspects of their program as well as any areas of particular concern. Discussion of future goals will be analyzed. We would also collect all relevant plan documents and benefit summaries in order to become familiar with the details of each policy. In addition, a review of your available claims information, premium rates and all other information would take place in order to evaluate your current in force program. At that time, we will determine a tentative schedule for monthly or quarterly meetings, setting a timetable for the release of any RFP's that may be necessary.

Step Two: Presentation of Initial Findings

Upon our review of the current program, the Gehring Group will produce a concise analysis of each line of insurance to include any compliance concerns. Due to our specialization in the public entity market, we maintain access to comparative data from numerous other public sector entities that is often used to determine how your benefits program equates to those of other like entities. With this information, we can offer insight regarding the implementation of additional programs, such as consumer driven healthcare options and onsite clinics, and make recommendations regarding potential changes to your current program. It is our job to educate the City on any new product in the industry that may reduce administrative burden or aid in the reduction of costs.

Step Three: Presentation to the Market

Gehring Group would assist in conducting all phases of the procurement process for those lines of insurance deemed suitable for bidding. Our involvement in this process can be as comprehensive as you wish. Once we have reviewed all necessary background information, we will work with staff to compile all RFP's for submission to the insurance market. This includes negotiating renewal rates, working with

the procurement division to maintain integrity with the bid process as well as issuing bid specifications directly to the market. Gehring Group has vast experience in the solicitation of all types of insurance and we are confident that acquisition of various competitive options will be accomplished.

To effectively market an employee benefits plan, we at Gehring Group consider many factors. We must present and negotiate a plan that is in line with our clients' goals, contribution structure, plan design, network availability and entity structure. In addition to the required information such as census data, plan design and claims experience, we also consider the various other aspects involved in the decision making process. One of these aspects is the current employer/employee contribution structure and the entity's ability to maintain current levels based on fiscal limitations or budgetary constraints. Another consideration is the 9.5% affordability rule as it relates to the Pay or Play penalty under PPACA. Yet another consideration is the level of benefits included in the plan design and the Affordable Care Act requirement that the plan be "Affordable" and provide a level of coverage that is of "Minimum Value". Health insurance and employee benefit plans are often considered significant recruiting tools for public sector employers; therefore, some employers place a high priority on offering the most competitive benefits program they can afford. Another important consideration is the physical location of the entity. Location with the state may have an impact on how robust each provider network is as well as the level of provider discounts.

Generally, Gehring Group staff initially evaluates a proposal based on broad parameters. The obvious factors include overall cost, plan design, network of providers and compliance with the RFP. Preparation is the key to a successful outcome.

Step Four: Proposal Analysis

Upon receipt of all proposals submitted in response to the RFP process, Gehring Group will perform a detailed analysis of each program offered. We will compare all proposals to the in force program and illustrate the program differences to include the advantages and disadvantages of each. This will include a detailed cost comparison which outlines the total cost of the program in addition to breaking down the costs related to employer and employee contributions. At this time, we will also compare provider networks to determine which proposers may be considered viable options for the City in addition to performing a network discount analysis. During this stage in the procurement process, Gehring Group will schedule a meeting with Staff to review our initial findings. Once our analysis has determined that particular vendors are viable, we then attempt to clear up any details that must be established prior to any changes being made. This process is a second level request for clarification and is developed following the review of submitted proposals. The first draft review process always produces questions that may not be anticipated and, as insurance is one of the few areas in public entity purchasing regulations where simultaneous negotiations can take place, it is always important for the RFP process to include best and final responses within the RFP timeline.

Due to our unique process, providers with whom we work will spend time compiling their best numbers to bring to the table. Due to the cost associated with the preparation of each carrier proposal, we have found that competitive vendors appreciate the Gehring Group's approach to this process and, as a result, we tend to be extremely successful in obtaining the maximum number of truly competitive quotations from an extensive array of carriers.

After such finalist negotiations and continuous communication with staff, we will provide our formal evaluation and recommendation. The City can be confident that all recommendations will be based on the needs of the entity.

Step Five: Program Implementation

After the RFP and evaluation process, Gehring Group staff remain involved to assist with program implementation. Again, we can be as involved as you would like. The services we provide include but are not limited to the following:

- Coordinate implementation process with all selected carriers.
- Assist in coordinating and attending employee informational and enrollment meetings at all sites as determined by the client.
- Develop education materials and employee benefit booklets based on new programs and updates in current plans.
- Aid in cancellation or renewal of current insurer upon written acceptance.
- Review all programs implemented and continue project along same format.

Step Six: Year-Round Service

As part of our continuous service, Gehring Group staff also conducts detailed reviews, analysis and projection sessions with decision makers at key points throughout the year. We consistently track the available claims utilization data of your program throughout the plan year in order to more effectively prepare for the renewal process and develop strategies for ensuring that your group gets the most value for its health care dollar. We review available claims utilization reports to determine whether your programs are running favorably and utilize this claims data to forecast renewal projections and negotiate with vendors. With this information and by conducting a local entity survey, we can partner with you to develop an action plan to accomplish the goals of the City.

Additional services provided during our year-round presence at our clients include health care reform consulting, assistance with claims and billing issues, assistance with coordinating health and wellness fairs and implementing/maintaining wellness programs and initiatives, hosting seminars and webinars for our clients throughout the year regarding numerous legislative compliance issues, various technology services as well as onsite clinic consulting (if applicable).

A typical timetable of activities is included below for your review. This schedule can be customized to accommodate any specific needs or additional services requested by City.

Standard Schedule of Activities	
Date	**Action**
7 months prior to renewal	• Gehring Group review of current employee benefits program including claims experience (if available) • Pre-Renewal Meeting with employee benefits Staff to discuss satisfaction and strategy • Gehring Group to request coverage renewals • Release RFP to carriers for all applicable lines of coverage (if deemed necessary)
6 months prior to renewal	• Renewals Due at Gehring Group • Utilize competitive data to negotiate with incumbent carriers • Gehring Group receives proposal responses from Purchasing • Gehring Group review and analysis of proposals • Draft of initial review presented to Staff • Interview finalists (if deemed necessary)

Standard Schedule of Activities	
Date	**Action**
	• Best and Final offers due • Gehring Group recommendation/Gehring Group available to make presentations to committees and/or Staff • Staff makes selection
5 months prior to renewal	• Preparation of Open Enrollment Materials including Employee Benefit Highlights booklet and communication posters, payroll stuffers, universal enrollment form, etc. • Discuss and finalize employer contribution strategies • Plan Implementation
4 months prior to renewal	• Preparation of OE Materials including Employee Benefit Guide, communication posters, payroll stuffers, etc. • Discuss and finalize employer contribution strategies • Completion of implementation paperwork with carriers • Implementation meetings with all applicable carriers in the event of a carrier change
October/November	• Open Enrollment Meetings
November/December	• Finalize all details regarding new plan year
January 1st	• Plan Year Begins
January - March	• Conduct New Hire Orientations as necessary • Additional meetings with Staff and/or employees as needed
April	• Review Quarterly claims experience (if available) & meet with Staff
April - June	• Conduct New Hire Orientations as necessary • Additional meetings with Staff and/or employees as needed

Due to Gehring Group's industry experience, we are confident that we can meet and exceed your service expectations. Gehring Group's advisory services also include, but are not limited to the following:

- **Health Care Reform Compliance Advisory Services**
  Gehring Group is proactively addressing each of the requirements on behalf of all of our clients to ensure that all policy renewals subject to the mandates are in compliance with the Health Care Reform legislation. We proactively host informational seminars and webinars on the new laws for our clients so that they have all the information needed to be adequately prepared for the mandates. Topics have included MLR Rebate Distribution, W-2 Reporting of Employer Sponsored Health Coverage, Determining Seasonal and Variable Employees and the Employer Shared Responsibility Penalty (a.k.a. Pay or Play), Reporting Requirements under Sections 6055/6056 of Minimum Essential Coverage and

Applicable Large Employer, Mastering the 1094-C, etc. As many Health Care Reform deadlines are already here, Gehring Group diligently reviews all newly available product offerings to ensure that our clients are always presented with the best available options while complying with all mandates and reporting requirements of the health care reform legislation.

- **Clinic Consulting**
  Gehring Group also assists our clients in the decision of whether to open an on-site health clinic. If requested, Gehring Group is able to conduct a feasibility analysis to determine if our clients can take advantage of the potential cost saving benefits of opening an on-site or near-site clinic. By shifting costs from the medical plan to the clinics, many groups have been better able to manage specific areas of claims costs, while providing additional access to medical care to their employees. Gehring Group has experience in conducting the bid process to determine which clinic provider and clinic model would best meet the needs of our clients, and in addition, is available to oversee the implementation process once a decision has been made.

- **Continuous Plan Analysis**
  As part of our continuous service, Gehring Group staff conducts detailed reviews, analysis and projection sessions with decision makers at key points throughout the year. We consistently track the available claims utilization data of your program throughout the plan year in order to more effectively prepare for the renewal process. We review available claims utilization reports to determine whether your programs are running favorably, and utilize this claims data to forecast renewal projections and negotiate with vendors.

- **Plan & Proposal Evaluation**
  Gehring Group will consistently provide thorough examination of all proposals received during a bid process. We will compare all proposals to the in-force program and illustrate the program differences to include the advantages and disadvantages of each. This will include a detailed cost comparison which outlines the total cost of the program in addition to breaking down the costs related to employer and employee contributions. During this process, we will also compare provider networks to determine which proposers may be considered viable options.

- **Plan Renewals & Effective Negotiations**
  In addition to bidding your employee benefits program, Gehring Group will also negotiate renewals with your current carriers. As previously stated, our block of business provides us with the credibility to negotiate with insurance carriers more effectively. We get results. Our highly trained staff is able to negotiate more effectively due to the high quality of our own analysis.

- **Program Implementation**
  Gehring Group provides extensive assistance during program implementation and the open enrollment process. After the RFP and evaluation process, Gehring Group staff remains involved in:

  - Coordinating implementation process with all selected carriers.
  - Assisting with employee meetings at all sites as determined by client.
  - Developing education materials and employee benefit booklets based on new programs and updates in current plans.
  - Aiding in cancellation or renewal of current insurer upon written acceptance from the client.

- **Ongoing/On-site Service**
  In addition to the processes above, your Gehring Group service team will maintain continuous communication throughout the plan year to provide support to staff with administrative, legislative, enrollment and billing questions. Gehring Group is available to assist our clients' staff with the resolution of claim problems and other issues such as policy interpretation. In addition, Gehring Group staff is always available to provide on-site assistance with new-hire orientations and employee benefits fairs.

- **Employee Surveys**
  One of the most effective ways to acquire employee feedback regarding their benefits program, or any other topic of interest, is through an employee survey. Gehring Group has the ability to accomplish this via paper survey form, or electronically, via the internet. These surveys have proven to generate effective results that aid in future decision making.

- **Employee Benefits Handbook**
  At the beginning of each new plan year we compile all of the information regarding your insurance coverages and summarize it in an employee friendly benefit booklet. This booklet has proven to be a valuable resource to our client's employees and has reduced the number of inquiries received by our client's HR and Benefits staff. This service is offered at no additional cost. We will provide you with enough copies for open enrollment and as needed for new-hire orientations throughout the plan year. (Example included in **Exhibit 2**.)

- **Professional Employee Communications**
  Gehring Group employs an in-house Graphics Department. This enables us to assist our clients with employee communication materials. As part of our services, we draft and produce employee communication pieces such as payroll stuffers, department posters, mass employee mailings, etc. (**Exhibits 2 & 3**). This allows our clients to better communicate its employee benefit offerings and keep their employees well educated with regard to their employee benefit options and responsibilities. All of the work products and samples included in the **Exhibits** section were created and produced in house.

- **Legislative Compliance & Updates**
  Gehring Group provides its clients with regular updates client alert emails, compliance publications and newsletters regarding any changes in applicable laws and how they might affect your benefits program. **Exhibit 6: Sample Employee Benefit Newsletters** include several examples of such notifications on legislative issues. We are proactive on follow-up and will contact you directly in the event of any legislative changes that may affect your group or your coverage.

- **Client Seminars & Webinars**
  During this time of legislative change, Gehring Group has taken on the role of becoming an educational resource for our clients by hosting several informative seminars on relevant topics. Each year, we hosted several client seminars on the topic of health care reform at various locations throughout the state, in order to ensure that our clients have all the information needed to be adequately prepared for the upcoming mandates and are comfortable in their understanding of the new requirements. In addition, as more guidance continues to be released, Gehring Group hosts topic specific webinars on a regular basis which are recorded and posted on the client portal for future reference. (Sample included in **Exhibit 5**.)

TAB E: REFERENCES

Offerors must provide contact information for three references on similar projects as outlined in the scope. Provide Point of Contact; phone number & email address, total value of contract, and any letters/emails of praises for work performed.

The following pages include the *Reference Questionnaires* from the following clients:

1. City of Clearwater
2. Charlotte County Board of County Commissioners
3. Martin County Board of County Commissioners

Please also refer to **Exhibit 7** to review several letters of recommendation.

REFERENCE QUESTIONNAIRE

It is the responsibility of the contractor/vendor to provide a minimum of three (3) similar type references using this form and to provide this information with your submission. Failure to do so may result in the rejection of your submission.

Giving reference for: The Gehring Group, Inc.

Firm giving Reference: City of Clearwater

Address: 100 South Myrtle Avenue, Clearwater, Florida 33756

Phone: (727)562-~~4879~~ 4886

Fax: (727)562-4877

Email: joseph.roseto@myclearwater.com

1. **Q:** What was the dollar value of the contract?
   A: Paid by the Health provider.
2. Have there been any change orders, and if so, how many?
   A: Contract services have been consistent. They have added additional services with no increase in cost.
3. **Q:** Did they perform on a timely basis as required by the agreement?
   A: Consistently excellent. Always timely.
4. **Q:** Was the project manager easy to get in contact with?
   A: yes. They are always available
5. **Q:** Would you use them again?
   A: Our Agent of record for the last 15 years. Yes, I would hire them again without hesitation.
6. **Q:** Overall, what would you rate their performance? (Scale from 1-5)

   A: ☒5 *Excellent* ☐4 *Good* ☐3 *Fair* ☐2 *Poor* ☐1 *Unacceptable*

7. **Q:** Is there anything else we should know, that we have not asked?
   A: They are like A part of our staff. The services they provide could not be performed by staff.

The undersigned does hereby certify that the foregoing and subsequent statements are true and correct and are made independently, free from vendor interference/collusion.

Name: Joseph Roseto Title Human Resource Director

Signature: _____ Date: June 8, 2016

REFERENCE QUESTIONNAIRE

It is the responsibility of the contractor/vendor to provide a minimum of three (3) similar type references using this form and to provide this information with your submission. Failure to do so may result in the rejection of your submission.

Giving reference for: The Gehring Group, Inc.

Firm giving Reference: Charlotte County Board of County Commissioners

Address: 18500 Murdock Circle, Room B-201, Port Charlotte, Florida 33948

Phone: (941)743-1244

Fax: (941)743-1989

Email: janine.hewitt@charlottecountyfl.gov

1. **Q:** What was the dollar value of the contract?
   A: $27,000,000 in health benefits costs

2. Have there been any change orders, and if so, how many?
   A: Not during a plan year. However, if changes are being made from one year to the next, they work with us and the carriers so it is an easy process.

3. **Q:** Did they perform on a timely basis as required by the agreement?
   A: Yes, they are very timely.

4. **Q:** Was the project manager easy to get in contact with?
   A: Yes, staff is very easy to get in contact with and understands our specific needs

5. **Q:** Would you use them again?
   A: Yes, we have them used them for years and are very satisfied

6. **Q:** Overall, what would you rate their performance? (Scale from 1-5)

   A: ☒ **5** *Excellent* ☐ **4** *Good* ☐ **3** *Fair* ☐ **2** *Poor* ☐ **1** *Unacceptable*

7. **Q:** Is there anything else we should know, that we have not asked?
   A: I would highly recommend the Gehring Group. They are leaders in the industry and we are very confident in them.

The undersigned does hereby certify that the foregoing and subsequent statements are true and correct and are made independently, free from vendor interference/collusion.

Name: Janine Hewitt Title Risk/Benefits Coordinator

Signature: Janine Hewitt Date: June 8, 2016

REFERENCE QUESTIONNAIRE

It is the responsibility of the contractor/vendor to provide a minimum of three (3) similar type references using this form and to provide this information with your submission. Failure to do so may result in the rejection of your submission.

Giving reference for: The Gehring Group, Inc.

Firm giving Reference: Martin County Board of County Commissioners

Address: 2401 S.E. Monterey Road, Stuart, Florida 34996

Phone: (772)221-1320

Fax: (772)223-4812

Email: ggierlic@martin.fl.us

1. **Q:** What was the dollar value of the contract?
   A: Our insurance program (Health) is approximately $14MM annual.
2. Have there been any change orders, and if so, how many?
   A: No
3. **Q:** Did they perform on a timely basis as required by the agreement?
   A: YES
4. **Q:** Was the project manager easy to get in contact with?
   A: YES
5. **Q:** Would you use them again?
   A: YES
6. **Q:** Overall, what would you rate their performance? (Scale from 1-5)
   A: ☒ **5** *Excellent* ☐ **4** *Good* ☐ **3** *Fair* ☐ **2** *Poor* ☐ **1** *Unacceptable*
7. **Q:** Is there anything else we should know, that we have not asked?
   A: Gehring group was instrumental in the implementation of our Employee Wellness Center which is extremely successful. They guided us from RFP to implementation.

The undersigned does hereby certify that the foregoing and subsequent statements are true and correct and are made independently, free from vendor interference/collusion.

Name: Gary Gierlic2 Title Human Resources Administrator

Signature: Date: June 8, 2016

TAB F: PRICE

Proposers must submit pricing for this Effort. Pricing is to be a Monthly Fixed Amount: Proposers will fill out the pricing, highlighted, on the below tables.

1st year of the Initial Term:

Services	Amount	Frequency; Monthly	Total Monthly Amount	Total Annual Amount
Benefit Administration Services	**$12,500.00**	12	**$12,500.00**	**$150,000.00****
Optional Service: BenTek Online Enrollment & Admin System	**$1,666.00**		**$1,666.00**	**$20,000.00**
*Other Direct Cost	**N/A**	LOT	N/A	**N/A**
			Total Cost 1st Year	**$150,000** ***(without BenTek)*** **$170,000** ***(with BenTek)***

*ODC Cost is associated with this effort that may be paid if approved by the HR Director. Examples of ODC cost-special travel, supplies for a presentation, binding of documents, overlays, etc.

***Proposed price assumes Gehring Group retains current commission as Agent of Record on the City's group life and AD&D coverage.*

2nd year of the Initial Term:

Services	Amount	Frequency; Monthly	Total Monthly Amount	Total Annual Amount
Benefit Administration Services	**$12,500.00**	12	**$12,500.00**	**$150,000.00****
Optional Service: BenTek Online Enrollment & Admin System	**$1,666.00**		**$1,666.00**	**$20,000.00**
*Other Direct Cost	**N/A**	LOT	N/A	**N/A**
			Total Cost 2nd Year	**$150,000** ***(without BenTek)*** **$170,000** ***(with BenTek)***

***Proposed price assumes Gehring Group retains current commission as Agent of Record on the City's group life and AD&D coverage.*

Total Cost for Initial 2 years: $ $300,000 (without BenTek) / $340,000 (with BenTek)

It is important to note that Gehring Group does not participate in any provider relationships that would prevent us from acting independently and providing objective advice and guidance. We do not accept indirect compensation such as gifts or trips and we practice full disclosure relating to all direct and indirect compensation. Gehring Group is an independent agency, not affiliated with any particular insurance

companies, third party administrators or provider networks. We do not have a fund or trust that we or a related entity holds, and we do not sell related third party insurance products. The relationships and recognitions Gehring Group does have with carriers are based on premium volume providing us with significant negotiating clout. As one of the top producing brokers/consultants for public sector entities throughout the state, our philosophy has always been to offer complete revenue disclosure upon request which we will continue to practice with the City.

Please note that there be will no additional charges to the City as this arrangement includes:

- All travel costs
- Health Care Reform Advisory Services
- Onsite attendance at annual Open Enrollment meetings as needed
- Development, production and printing of annual employee benefit booklet (1,500 copies for open enrollment and additional copies as needed throughout the year) and other employee communications (Samples included in **Exhibit 2)**
- Access to Gehring Group Client Portal
- Access to *HR Answers Now* online H.R. research tool
- All other services as outlined in herein

Gehring Group is open to discussion regarding alternative service and compensation options under consideration by the City.

TAB G: EXHIBITS

EXHIBIT 1
BenTek® Online Enrollment and Administration System

BenTek®

Benefits Technology by Benefits People

Paperless Benefits Administration and Enrollment for the Public Sector

BenTek®, Benefits Administration without compromise

Enroll, anytime, anywhere

Benefits Administration

Control at your fingertips...

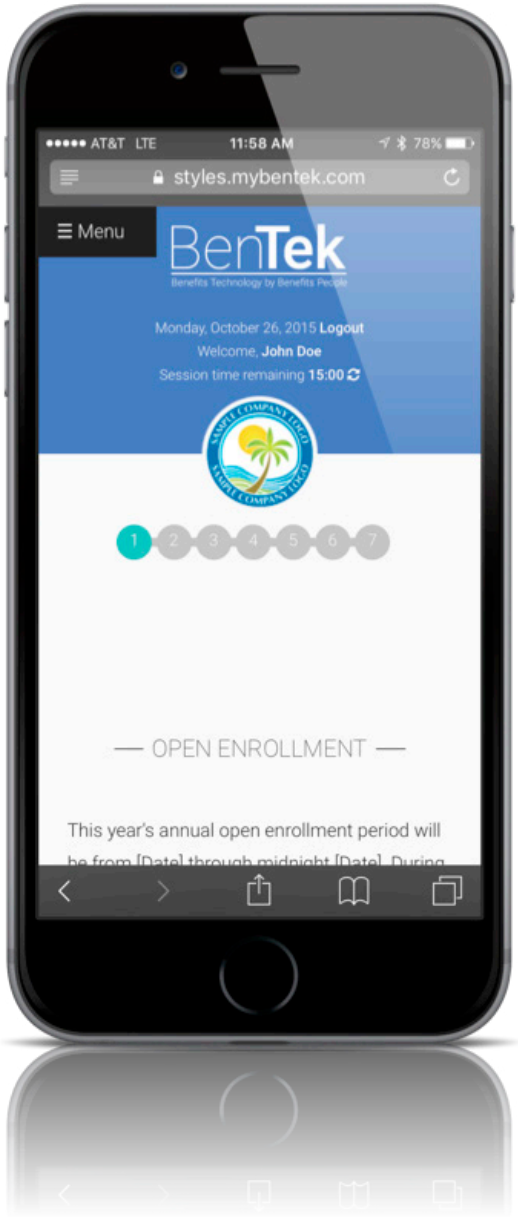
BenTek® is an easy and convenient, online benefits and administration system that streamlines benefits enrollment by delivering a paperless solution.

- Manage employee demographics, personnel data, coverage eligibility, and dependent records within the Administration module
- Automatic transmission of electronic eligibility to insurance providers
- Approve qualifying life event submissions and generate customized approval, pending, and denial employee letters
- Ongoing Personnel and Payroll audit features to maintain the integrity of data between your payroll system, HRIS system, and BenTek®
- Custom benefits deduction file generated and transmitted from BenTek® to Payroll on a per pay period basis
- Integrated billing allowing Benefit Administrators to generate and transmit monthly vendor invoices with detailed back-up information including the ability to record and report adjustments per employee
- 40+ standard reports, giving Benefit Administrators quick access to their data for auditing and evaluation purposes within the system

Paperless Enrollment

Enrollment in 7 Easy Steps
24x7 Online Mobile Access

The online enrollment experience is designed to guide employees through the enrollment process in seven progressive steps, each tracked within the Enrollment Progress Bar. Employees can view both current and future enrollment and deduction information for all benefit options on one page.



Each enrollment module provides a detailed confirmation statement of all elected benefits and deductions that can be saved, printed, and viewed in future sessions. Employees can access detailed plan information such as SBCs, plan summaries, and plan comparisons in addition to compliance notifications, disclaimers, and much more.

The Employee Benefits Center also provides easy access to benefit information and resources, self-service tools, and online enrollment 24x7.

10 YEARS GROWING

Contact us to schedule a demonstration of the BenTek® system:

Phone:
1-888-5-BENTEK

Email:
Sales@mybentek.com

www.mybentek.com

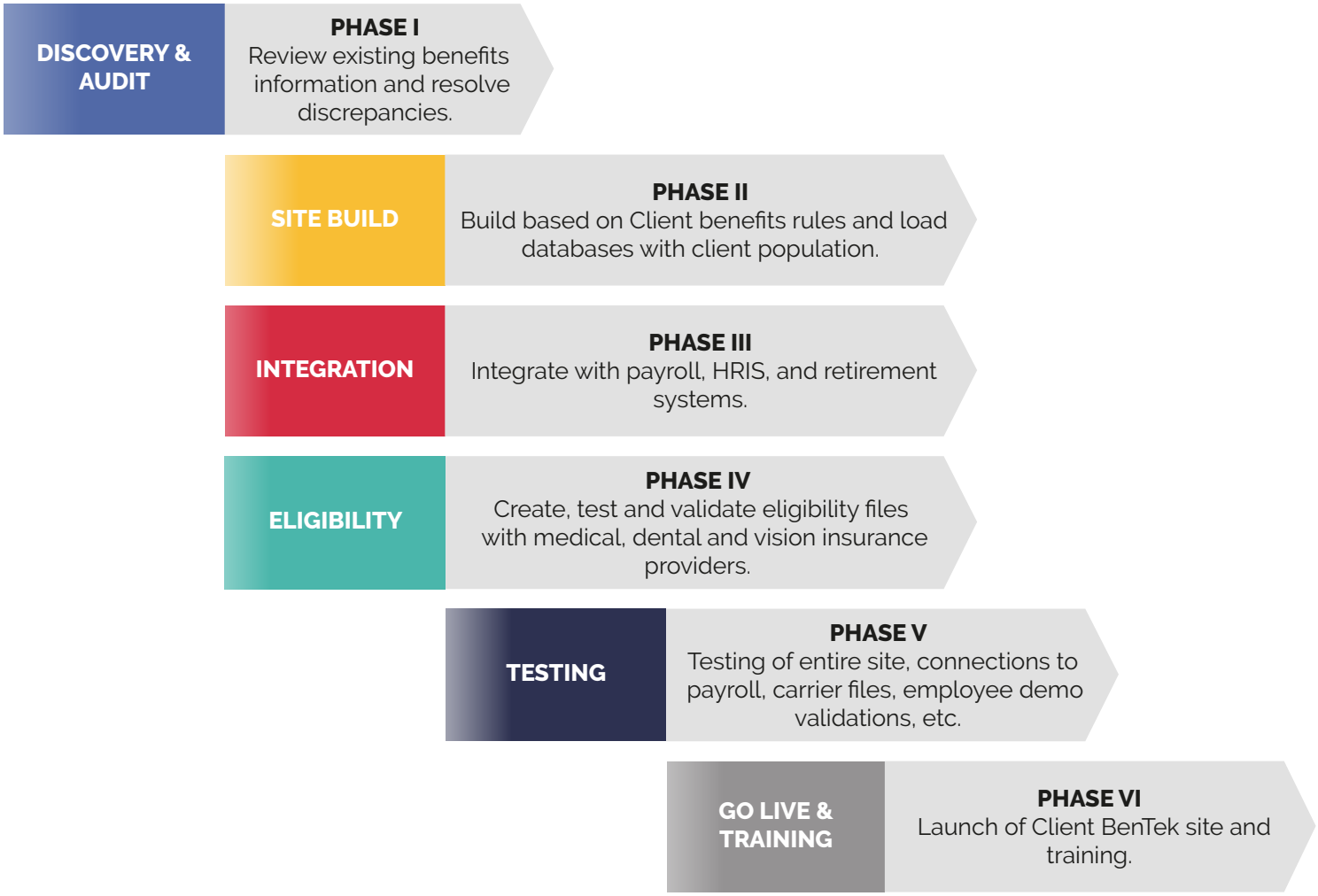
- ✓ Open Enrollment
- ✓ New Hires
- ✓ Qualifying Events
- ✓ Life Insurance Beneficiaries

Implementation & Service

100% referenceability shows that we care more about your success than anything else

BenTek®
Benefits Technology by Benefits People

Our Clients can expect a team approach while working with our BenTek® team. All Clients are assigned an Implementation Team including a Primary and Back-up Account Manager.



Our Account Manager teams are product experts and benefits analysts. The Account Managers provide insight and suggestions to guide Clients on the best set-up and design of their customized BenTek® site while keeping the employee population in mind every step of the way.

An Implementation Engineer is assigned to each implementation and works closely with the Account Management Team to create each BenTek® site according to each Client's unique configuration.

At BenTek®, security is our number one goal

We implement the latest in security technologies to provide the maximum protection for our Customers' employee information.

The HIPAA Privacy Rule provides federal protections for personal health information (PHI) held by covered entities and gives patients an array of rights with respect to that information. BenTek® maintains full compliance with all Federal regulations regarding PHI. Users' session information is encrypted via SSL using a 256-bit Thawte security certificate with 128-bit step down. BenTek® logs and monitors all transactions in the event of accidental, malicious, or criminal activity.

Security & Compliance

Protecting your data, protecting your employees

Secure Business Communication Portal

BenTek®'s Client Information Portal is a secure SaaS -based community for BenTek® Clients. This state of the art secure communications solution provides a multi-way collaboration channel between BenTek®, Clients, Brokers, and Vendors.

Clients can exchange files, post questions, review project plans and obtain information guides on BenTek® software and technical specifications. The Client Information Portal is a web enabled secure environment using modern encryption technology.

Vendor Certification for Secure Integration

BenTek® manages a Vendor Certification program, which certifies carriers, vendors, and Third Party Administrators with whom BenTek® has achieved file transmission success, whether via electronic or manual transmission.

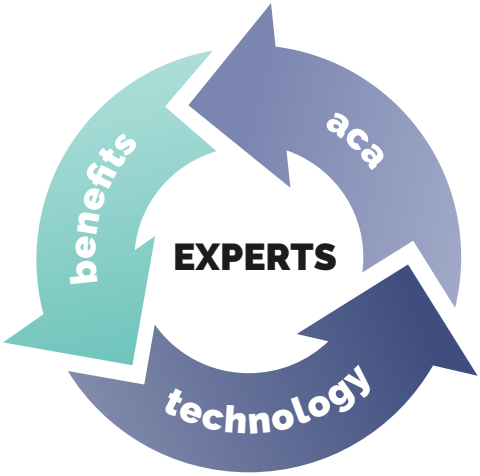
BenTek® has the ability to create custom files according to vendor specifications, and provides our own established file specification documents in many formats including CSV, comma/pipe delimited text files, Excel, and more to equip the vendor with the data necessary to process eligibility and enrollment updates in a timely manner.

Affordable Care Act (ACA)

BenTek® uses technology to tackle the complexities of ACA.

- ✓ PCORI Fee
- ✓ Transitional Re-insurance Fee
- ✓ W-2 Report of Employer Sponsored Coverage
- ✓ 1094/1095 B & C Form Production

Our people are:



KEY ADVANTAGES OF BENTEK:

- One system of record for benefits administration
- Post all benefits related materials, forms, etc. Benefit/Deduction Reconciliation
- Reduce vendor billing adjustments
- Verification of processed payroll deductions Electronic Eligibility
- Manage your own eligibility
- Expedited ID Card processing for new hires and annual enrollment
- Reduction of Data Entry/Human Error
- Efficiencies in processing new hires/ terminations
- Employee Year Round Self-Service
- Reduction in employee calls/walk-ins
- Integrated ACA Reporting

"It's been such a pleasure working with BenTek® and I appreciate all the patience and help provided when BenTek was implemented for our account 4 years ago. It was crazy time with crazy time lines, but we did it and having BenTek has been a lifesaver!"

"We are exceptionally satisfied by the excellent and responsive service from BenTek® administrative staff. Every phone call was answered timely."

"Our best recommendations came from our employees who were so complimentary of the process and felt this was the best Open Enrollment we ever had... this validated everything we had hoped for with this new process."

"BenTek® immediately solved a variety of enrollment challenges... most important, the ease in which our employees were able to navigate the system eased their apprehensions and allowed them to focus on their benefit options and elections."

For more information visit our website:
www.mybentek.com

11505 Fairchild Gardens Ave Suite 102
Palm Beach Gardens, FL 33410

BenTek®
Benefits Technology by Benefits People

Contact us to schedule a demonstration of the BenTek® system:

Phone:
1-888-5-BENTEK

Email:
Sales@mybentek.com

www.mybentek.com

SAS 70 Type II

HIPAA COMPLIANCE

amazon web services™

BenTek®

Benefits Technology by Benefits People

11505 Fairchild Gardens Ave, Suite 102
Palm Beach Gardens, FL 33410

Sales@mybentek.com
Toll free: 1-888-5-BENTEK

EXHIBIT 2
Sample Employee Benefit Guide

Employee and Family Health Center
464 Fern Street, West Palm Beach, FL 33401
(561) 822-2000

7/1/2015-6/30/2016

Employee Benefit Highlights

GENERAL EMPLOYEES

City of West Palm Beach

Employee Health Center

West Palm Beach Employee Health Center

464 Fern Street,
West Palm Beach,
FL 33401

Tel: (561) 822-2000
Fax: (561) 822-1588
www.cityfitmd.com

Monday - Thursday • 7:00 am - 6:00 pm,
Friday • 7:00 am - 4:00 pm,
Saturday • 8:00 am - Noon, Sunday • Closed
**(Hours subject to change)*

Stuart Urgent Care

3405 NW Federal Hwy,
Jensen Beach,
FL 34957

(772) 692-8082
www.stuarturgentcare.com

Mon.- Fri. • 8:30 am - 7:00 pm
Sat. • 8:30 am - 3:00 pm
Sun. • Closed
**(Hours subject to change)*

PLEASE NOTE - The above Employee Center telephone numbers are also an On-Call Medical Answering Hotline. This is available to members and their dependents 24 hours a day, 7 days a week in addition to the regularly scheduled hours.

CLOSED THE FOLLOWING HOLIDAYS (otherwise open regular hours):

- *New Year's Day*
- *Memorial Day*
- *Independence Day*
- *Labor Day*
- *Thanksgiving Day*
- *Christmas Day*

✓ **Services are 100% FREE**
✓ **24-Hour Medical On-Call Answering Service**
✓ **Primary Care and Urgent Care Services**
✓ **Wellness and Health Maintenance**
✓ **Chronic Disease Management**
✓ **Physicals**
- Wellness
- Well Woman
- DOT
- Preoperative
- School / Sports / Camp

✓ **On-Site Services**
- X-Ray
- Laboratory Draws*
- 12-Lead EKG
- IV Fluids

✓ **Medications Dispensed On Site****

* There may be specialty lab draws that must be drawn at an actual lab-draw station. Outside orders with uncommon lab requests must be provided to the health center so as to determine the capability of drawing such specimens.

** Providers may request lab studies and/or a provider/patient visit prior to the dispensing of any medications.

Rx Refill Line
Phone: 561.822.1585. *Available for established patients.*
***Remember:** upon visiting the Health Center, employees MUST provide a valid City ID Badge and show a current Cigna medical insurance ID card.*

In ALL Emergency Situations,
Please Call 9-1-1.

City of West Palm Beach Employee & Family Health Center

IMPORTANT CONTACT INFORMATION

City of West Palm Beach	Contact Name	Contact Information
Human Resources/Benefits Department	General Benefit Questions	Phone: (561) 494-1000
Health Center	Employee and Family Health Center	464 Fern Street West Palm Beach, FL 33401 Phone: (561) 822-2000 www.cityfitmd.com
	Prescription Refill Line	Phone: (561) 822-1582
Service	**Provider**	**Contact Information**
BenTek Online Enrollment	BenTek Technical Support	Email: support@mybentek.com Phone: (888) 5-BenTek (523-6835) www.mybentek.com/wpb
Medical Insurance	Cigna	Customer Service: (800) 244-6224 www.mycigna.com On-Site Cigna Representative: (561) 494-1032
Prescription Drug Coverage & Mail-Order Program	Cigna Home Delivery	Customer Service: (800) 835-3784 www.mycigna.com
Health Reimbursement Account	Cigna	Customer Service: (800) 244-6224 www.cigna.com
Dental Insurance	Humana	Customer Service: (800) 233-4013 www.compbenefits.com
Vision Insurance	Humana	Customer Service: (866) 537-0229 www.compbenefits.com
Flexible Spending Account (FSA)	WageWorks	Customer Service: (800) 950-0105 Mon. – Fri. 8:00am – 7:00pm CST www.takecarewageworks.com www.fsaworksforme.com/takecare
Basic & Voluntary Life and AD&D Insurance	The Hartford	Customer Service: (888) 563-1124 www.thehartfordatwork.com
Employee Assistance Program (EAP)	Aetna Resources for Living	24-Hour Crisis Line: (800) 272-7252 www.mylifevalues.com Login ID: CWPB Password: CWPB
Supplemental Insurance	Aflac	Customer Service: (800) 992-3522 www.aflac.com Local City Aflac Representative: Linda Carcich (561) 784-5256 aflac@wpb.org (Lotus Note)
Preferred Legal Plan	Preferred Legal Plan	Customer Service: (888) 577-3476 www.preferredlegal.com Brian Samuels Email: info@preferredlegal.com
Defined Contribution and Deferred Compensation Programs	Empower Retirement (Great-West Retirement Services)	Customer Service: (800) 701-8255 www.gwrs.com On-Site Empower Retirement Representative: Helena Novakova Cell: (786) 877-9572 or On-Site HR (561) 494-1000 Email: Helena.novakova@empower-retirement.com

Table of Contents

Introduction

The City of West Palm Beach provides a comprehensive compensation package including group insurance benefits. The Employee Benefit Highlights Booklet provides a general summary of these benefit options as a convenient reference. Please refer to the City's Personnel Policies, applicable Contracts and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If you require further explanation or need assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact the Human Resources/Benefits Department using the contact information provided.

Notices

COBRA Continuation of Medical Coverage Benefits

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), employees and/or dependents may be able to continue their enrollment in certain health plans such as medical and dental, if such coverage is terminated or changed due to a qualifying event.

Medicare Part D Creditable Coverage

The City of West Palm Beach prescription drug coverage is considered Creditable Coverage under Medicare Part D. If you or your dependents are or will be eligible for Medicare, you may obtain more information by requesting a Medicare Part D Disclosure of Creditable Coverage Notice.

Online Benefit Enrollment

BenTek
Technical Support - Email: support@mybentek.com
Technical Support - Phone: (888) 5-BenTek (523-6835)

Online enrollment with BenTek!

The City of West Palm Beach provides electronic enrollment through BenTek's Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to make group insurance benefit elections and changes online during the annual open enrollment, new hire orientation and qualifying events module.

To access the Employee Benefits Center during open enrollment:

- Log on to **https://www.mybentek.com/wpb**
- If you forget your username and/or password, click on the link "Forgot Username" or "Forgot Password" and follow the instructions.
- Enter BenTek to review current elections, learn about your benefit options, and make any elections or changes.
- You may also submit and update your life insurance beneficiary designation(s).

You have the option to print out your enrollment confirmation statement containing all your benefit elections for you and your family, including your life insurance beneficiary designations.

Accessible 24 hours a day during the open enrollment process, information about all of your employee benefits election options, including premiums and carrier contact information, is also available to help you make informed decisions. You can also log on to the EBC at any time to review your benefits, access carrier links, update life insurance beneficiaries and report qualifying events.

If any technical questions arise while visiting the EBC, please email BenTek Support at **support@mybentek.com** or call **(888) 5-BenTek (523-6835)**, Monday through Friday, during regular business hours.

To access your group insurance benefits online, log on to https://www.mybentek.com/wpb

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for the Medical Plan is **inserted here or provided as a supplement** to this booklet which is being distributed to New Hires and Existing Employees during open enrollment. The summary is an important item in understanding your benefit options. A copy of the SBC document is also available as follows:

From:	Human Resources/Benefits Department
Address:	401 Clematis Street, 3rd Floor
	West Palm Beach, FL 33401
Phone:	(561) 494-1000

Through the enrollment software – BenTek: www.mybentek.com/wpb

The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the actual group certificate of coverage can be reviewed and obtained by contacting the Human Resources/Benefits Department or at the following web address: www.mybentek.com/wpb.

If you have any questions about the plan offerings or coverage options, please contact the Human Resources/Benefits Department at (561) 494-1000.

Group Insurance Eligibility

The City's group insurance plan year is **July 1, 2015 through June 30, 2016.**

Employee Eligibility

Employees are eligible to participate in the City's insurance plans if they are full-time employees working a minimum of 30 hours per week. Coverage will be effective the **1st of the month following 30 days of employment**. For example: If you are hired on April 11th, your coverage will be effective on June 1st.

Termination

If you separate employment from the City, medical, dental and vision insurance will continue through the end of the month in which the separation occurred. COBRA continuation of coverage may be available as applicable by law.

Dependent Eligibility

A dependent is defined as the legal spouse/domestic partner and/or dependent child(ren) of the participant or the spouse/domestic partner. Dependent children may be covered through the end of the calendar year in which the child reaches age 26 for medical, dental and vision. The term "child" includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A foster child
- A newborn (up to age 18 months) of a covered dependent (Florida)
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse

Dependent Eligibility Age Requirements

Eligibility requirements for eligible Over-age Dependents have been eliminated for group medical, dental, and vision insurance. Dependents may be covered by the medical, dental and vision plans through the end of the calendar year in which the child turns age 26.

Medical coverage may continue to the end of the calendar year in which the dependent reaches the age of 30, if the dependent is:

- Unmarried with no dependents; AND
- A Florida resident, or full-time or part-time student; AND
- Otherwise uninsured; AND
- Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is handicapped.

Disabled Dependents

Coverage for an unmarried dependent child may be continued beyond age 26 if:

1. The dependent is physically or mentally disabled and incapable of self-sustaining employment; AND
2. The dependent is otherwise eligible for coverage under the group medical plan; AND
3. The dependent has been continuously insured; AND
4. Coverage began prior to the age of 19.

Proof of disability will be required upon request. Please contact the Human Resources/Benefits Department if further clarification is required.

Taxable Dependents

IRS guidelines state that an employee may not receive a tax advantage on any portion of premium paid related to non-qualified dependents; therefore, employees covering adult children under their health insurance plan may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which the child reaches age 26. **Beginning January 1st of the calendar year in which the child reaches age 27 through the end of the calendar year in which the child reaches age 30, employees will be charged an additional premium on a post-tax basis to continue coverage for such dependents.** Please refer to page 6 for the Over-age Dependent rate. Contact the Human Resources/Benefits Department for further details if you are covering an adult child who will turn 27 any time during the upcoming calendar year or for more information.

Group Insurance Eligibility *(Continued)*

Domestic Partner Coverage

The City offers domestic partner benefits to a person whom the employee shares a mutual residence within the context of a committed relationship and who has registered with the City pursuant to Section 42/48 Code of Ordinances 3838-05, found at http://wpb.org/clerk/domestic-partnership and has completed a HR/Affidavit of Domestic Partnership form. Both a Certificate of Domestic Partnership and completed HR/Affidavit of Domestic Partnership must be turned in to the Human Resources/Benefits Department along with supporting documentation required on Affidavit for review and approval to be eligible for domestic partner insurance benefits.

Per IRS rules, an employee may not receive a tax advantage on any portion of premium attributable to a domestic partnership; therefore, imputed income for the value of the applicable domestic partner coverage for the period of coverage, including the value of the coverage for a domestic partner's child(ren), must be reported on the employee's W-2 and taxed accordingly. Imputed income is the dollar value of insurance coverage attributable to covering the domestic partner (and the domestic partner's child(ren). However, the City of West Palm Beach has established a policy of tax equity for domestic partnership with regards to health insurance benefits pursuant to Section 62-66 Code of Ordinances 4469-13, which states that an employee who insures a domestic partner shall be entitled to a tax reimbursement stipend equal to the gross up amount of income tax imputed to the employee for the value of the health insurance premium paid on behalf of the domestic partner. The effect of that tax reimbursement stipend is to attempt to leave the employee in the same after tax position as an employee who is not subject to taxation on their health insurance premium.

Domestic Partners Who Become Married: Opposite or Same Sex Domestic Partners (IRS Revenue Ruling 2013-17) who become legally married need to notify the Human Resources/Benefits Department during Open Enrollment or within 30 days of marriage.

PLEASE CONTACT THE HUMAN RESOURCES/BENEFITS DEPARTMENT IF YOU ARE COVERING AN OVERAGE DEPENDENT OR A DOMESTIC PARTNER FOR FURTHER DETAILS.

Qualifying Events and IRS Code Section 125

IRS Code Section 125

Premiums for medical, dental, vision insurance, and/or certain Aflac policies and contributions to FSA accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-tax to the extent permitted. Under Section 125, changes to your pre-tax benefits can be made ONLY during the Open Enrollment period unless you or your qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event.

Under certain circumstances, you may be allowed to make changes to your benefits elections during the plan year, if the event affects your own, your spouse's, or your dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125.

Examples of qualifying events include the following:

- You get married or divorced
- Birth of a child (60 day notification period)
- You gain legal custody or adopt a child
- Your spouse and/or other dependent(s) die(s)
- You, your spouse, or eligible dependent(s) terminate or start employment
- An increase in your work hours causes eligibility
- A decrease in your work hours causes ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with an ex-spouse
- Gain or loss of Medicare coverage
- Losing eligibility for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)
- Becoming eligible for State premium assistance under Medicaid or CHIP (60 day notification period)

Please Note the Following:

- *Purchasing or dropping an individual policy for a covered dependent IS NOT a qualifying event and does not permit adding or dropping a dependent from the group health plan outside of Open Enrollment.*
- *Qualifying events allow you to only make changes to your existing coverage, it does not allow you to change your current insurance plan(s).*

IMPORTANT

If you experience a qualifying event, you must contact the Human Resources/Benefits Department within 30 days (30 to 60 days for newborns) of the event to make the appropriate changes to your coverage. Beyond the qualifying event deadline date, the request for change will be denied and you may be responsible both legally and financially for any claim and/or expense incurred as a result of you or a dependent who continued to be enrolled but not longer met the eligibility requirements.

(Furnishing Valid documentation supporting the qualifying event is required)

NEWBORNS: If the qualifying event is a birth of a child, the newborn will be covered for the first 31 days of life even if you fail to enroll the child. The employee contacting the Human Resources/Benefits Department within 30 days of the birth allows for the first month employee contributions of premium to be waived. If the newborn is enrolled after the first 31 days but the employee meets the deadline to enroll by the 60th day after the birth, coverage will be offered at an additional premium (employee contributions back to date of birth).

Medical Insurance Premiums

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your Cigna medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan please contact Cigna's Customer Service at (800) 244-6224.

The City offers medical insurance through Cigna to benefit eligible employees. The cost of coverage per month is listed in the premium tables below. **For information about your medical plan please refer to the Summary of Benefits and Coverage (SBC) provided.**

Medical Insurance – Base OAPIN High Deductible Health Plan (HDHP)
Monthly Premium Deductions

Tier of Coverage	Employee Pays	City Pays	Total Premium
Employee Only	$24.65	$468.37	$493.02
Employee + 1 Dependent	$260.12	$780.35	$1,040.46
Employee + Family	$361.93	$1,085.79	$1,447.72
Over-Age Dependent [1, 2]	$247.56	$0.00	$247.56

1) For the entire 2015-2016 Benefits year, an over-age dependent is defined as: "a dependent who will reach age 27, 28, 29, or 30 during 2015-2016".

2) Additional post tax payroll deduction.

Medical Insurance – Buy-Up OAPIN High Deductible Health Plan (HDHP)
Monthly Premium Deductions

Tier of Coverage	Employee Pays	City Pays	Total Premium
Employee Only	$31.14	$461.88	$493.02
Employee + 1 Dependent	$328.18	$712.28	$1,040.46
Employee + Family	$456.54	$991.18	$1,447.72
Over-Age Dependent [1, 2]	$247.56	$0.00	$247.56

Medical Insurance – Base & Buy-Up OAPIN High Deductible Health Plan (HDHP) – Domestic Partner
Monthly Reported Imputed Income Value

Tier of Coverage	Reported Income Value
Employee + Domestic Partner Value [1]	$547.44
Employee + Domestic Partner + Employee Child(ren) Value [1]	$547.44
Employee + Domestic Partner + Domestic Partner Child(ren) Value [1]	$954.70

1) Imputed income amount reportable on employee W-2 Form for value of insurance.

Please Note: *If employee is covering his/her own children AND a child(ren) of a Domestic Partner, please contact the Human Resources/Benefits Department for a customized calculation of the specific scenario.*

Medical Insurance: OAPIN High Deductible Health Plan (HDHP) At-A-Glance

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your Cigna medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan please contact Cigna's Customer Service at (800) 244-6224.

Network	Open Access Plus
HRA Funding (City Contribution)	**In Network**
Employee	Please refer to page 9 for Base & Buy-Up HRA Funding Options.
Employee + 1	
Employee + Family	
Plan Year Deductible (PYD)	**In Network**
Employee	$1,500
Employee + 1	$2,250
Employee + Family	$3,000
Coinsurance	**In Network**
Member Responsibility	20%
Plan Year Out-of-Pocket Limit	**In Network**
Employee	$3,000
Employee + 1	$4,500
Employee + Family	$6,000
What Applies to the Out-of-Pocket Limit?	Deductibles and Coinsurance (Includes Rx)
Physician Services	**In Network**
Primary Care Physician (PCP) thru Employee Health Center	**No Charge at Health Center Only**
Physician and/or Specialist Office Visit	20% After PYD
Diagnostic Services	**In Network**
Lab (Blood Work) thru Employee Health Center	**No Charge at Health Center Only**
Clinical Lab (Blood Work) at Independent Facility	20% After PYD
X-rays thru Employee Health Center	**No Charge at Health Center Only**
X-rays at Independent Facility	20% After PYD
Advanced Imaging (MRI, PET, CT)	
Hospital Services	**In Network**
Inpatient and/or Outpatient	20% After PYD
Physician Services at Hospital	
Emergency Room	
Urgent Care Facility	
Mental Health / Alcohol & Substance Abuse	**In Network**
Inpatient and/or Outpatient	20% After PYD
Prescription Drugs (Rx)	**In Network**
Generic thru Employee Health Center	**No Charge thru Health Center Only**
Generic	20% After PYD
Preferred Brand Name	30% After PYD
Non-Preferred Brand Name	40% After PYD
Mail Order Drug (90 Day Supply)	Included

Group Plan Number: 3332277

Health Reimbursement Account

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your Cigna medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan or your Health Reimbursement Account, please contact Cigna's Customer Service at (800) 244-6224.

Cigna
Customer Service: (800) 244-6224
www.cigna.com

The City is providing employees who participate in the **Cigna High Deductible Health Plan** with a Health Reimbursement Account (HRA). The City utilizes Cigna for the administration of the Health Reimbursement Account (HRA). HRA monies are not taxable and funded by the City and can be used for any qualified medical expenses such as **deductibles and coinsurance** for physician services, hospital services, prescription drugs, etc. The HRA monies provide tax-free funds to cover those expenses incurred under the medical plan.

All employees will be defaulted into the Base HRA plan. All employees have the option of enrolling in the Buy-Up HRA plan.

HRA Funding Allotment for BASE High Deductible Health Plan

	Health Reimbursement Account (HRA) Funded by City Upon Employee Enrollment		Optional City Funded HRA Funding Upon Employee's Completion of Health Assessment (HA)*		Employee Responsibility of Deductible for Plan Year		Total Cost of Plan Year Deductible
	(1)		(2)		(3)		(4)
Employee Only	$1,000	+	$400	+	$100	=	$1,500
Employee + 1 Dependent	$1,500	+	$400 + $200 (Spouse / DP)*	+	$150	=	$2,250
Employee + Family	$2,000	+	$400 + $400 (Spouse / DP)*	+	$200	=	$3,000

** If a spouse / domestic partner is covered, they will have to complete a Health Assessment (HA) in order to receive the full HRA amount. Dependent children covered on the medical plan are not required to complete a Health Assessment for the plan year.*

HRA Funding Allotment for BUY-UP High Deductible Health Plan

	Health Reimbursement Account (HRA) Funded by City Upon Employee Enrollment		Optional City Funded HRA Funding Upon Employee's Completion of Health Assessment (HA)*		Total HRA Funding (Funded by City)	Total Cost of Plan Year Deductible		HRA Funding Bonus
	(1)		(2)		(3)	(4)		(5)
Employee Only	$1,350	+	$400	=	$1,750	-$1,500	=	$250
Employee + 1 Dependent	$2,300	+	$400 + $200 (Spouse / DP)*	=	$2,900	-$2,250	=	$650
Employee + Family	$3,200	+	$400 + $400 (Spouse / DP)*	=	$4,000	-$3,000	=	$1,000

** If a spouse / domestic partner is covered, they will have to complete a Health Assessment (HA) in order to receive the full HRA amount. Dependent children covered on the medical plan are not required to complete a Health Assessment for the plan year.*

Optional HRA Funding:

- You have the opportunity to rollover any unused funds year to year, up to a maximum of:
  Employee Only $7,500; Employee + 1 Dependent $11,250; Employee + Family $15,000
- To receive optional City HRA funding you must complete the following steps:
  1. Employee (and or spouse if applicable) must complete lab testing (blood work) with the City's Health Center.
  2. Upon Completion of the Lab testing the employee (and or spouse if applicable) must also meet with a Health Center provider. Once results are reviewed please complete Cigna's online Health Assessment (HA) questionnaire.
  3. The Health Assessment must be completed between **July 1, 2015 through December 31, 2015**.
- Any unused will funds, up to the funding maximum, will remain in your account when the new HRA plan year begins. **Therefore, as of July 1, 2015 any unused funds from the previous year will be available to use.**

Health Reimbursement Account *(Continued)*

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your Cigna medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan or your Health Reimbursement Account, please contact Cigna's Customer Service at (800) 244-6224.

Cigna
Customer Service: (800) 244-6224
www.cigna.com

HRA IRS Guidelines

HRA's must be funded solely by an employer. The contribution cannot be paid through a voluntary salary reduction agreement on the part of an employee. Employees are reimbursed tax free for qualified medical expenses up to a maximum dollar amount for a coverage period. An HRA may be offered with other health plans, including Flexible Spending Accounts.

What are the benefits of an HRA?

- Contributions made by your employer can be excluded from your gross income.
- Reimbursements may be tax free if you pay qualified medical expenses.
- Any unused amounts in the HRA can be carried forward for reimbursements in later years.

What is the difference between an HRA and an FSA?

Health Reimbursement Account (HRA)

- **Employer** Funded Account
- Enrollment is automatic if enrolled in medical plan
- Funds used for eligible medical expenses for you and your dependents who are enrolled in medical plan
- Unused funds accumulate and roll over year to year

Flexible Spending Accounts (FSA)

- **Employee** Funded Accounts
- You must enroll annually
- Funds used for eligible medical, dental, vision & dependent care for you and your qualified dependents
- Unused funds will be forfeited at the end of the plan year (once the filing deadlines have expired).

Please Note: *If you voluntarily contribute to a Flexible Spending Account, your HRA pays first, then your FSA. You may voluntarily choose to utilize FSA Funds prior to utilizing HRA Funds. To change your HRA utilization settings please log on to www.mycigna.com or contact the Cigna On Site Representative at (561) 494-1032. Select "Review My Coverage," then click on "Health Reimbursement Account" and choose "Autopay/Change." Please contact the Human Resources/Benefits Department for more information.*

Do I still need to keep my receipts?

Yes. During the year, you should keep all receipts and documentation for all eligible expenses for all transactions so that you have them if needed to verify a claim for Cigna or for IRS taxes. If asked to produce documentation, a valid Explanation of Benefits (EOB) and receipt of payment for the services rendered will be sufficient.

How can I find my available HRA balance?

You can check your available balance, activity and account history anytime online at www.cigna.com or you can call (800) 244-6224.

Please Note: *The Plan Year Deductibles exceed the HRA funding amounts. Members will be responsible for any amount over the HRA funding until the Plan Year Deductible and Out-of-Pocket Limit have been met for the plan year.*

At Retirement

Upon age 55+ or 25 years of service **and** retiring from the City, employees can transfer all remaining unused City HRA funds (up to maximum shown on page 9) to an employer sponsor Retirement Health Savings plan (RHS).

**For information on these methods, see Revenue Ruling 2003-43 on page 935 of Internal Revenue Bulletin (IRB) 2003-21 at www.irs.gov/pub/irs-irbs/irb03-21.pdf, Notice 2006-69, 2006-31 I.R.B. 107 available at www.irs.gov/irb/2006-31_IRB/ar10.html, and Notice 2007-2, 2007-2 I.R.B. 254 available at www.irs.gov/irb/2007-2_IRB/ar09.html.*

Other Available Plan Resources

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your Cigna medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan please contact Cigna's Customer Service at (800) 244-6224.

Cigna offers to all enrolled members and dependents additional services and discounts through value added programs. **For more details regarding other available plan resources, please refer to your Summary of Benefits and Coverage (SBC).**

Healthy Rewards

Cigna's Healthy Rewards is provided to you automatically at no additional cost and offers access to discounted health and wellness programs at participating providers. Members can log on to www.mycigna.com, click on "Review My Coverage"; then select "Discount Programs - Healthy Rewards" to learn more about these programs or call 1-800-870-3470.

- Weight Management and Nutrition
- Fitness and Mind/Body
- Vision, Hearing and Dental Care
- Tobacco Cessation
- Alternative Medicine
- Wellness and Healthy Products

24 Hour Help Information Hotline (800) CIGNA-24

The Cigna 24-Hour Health Information Line provides you access to helpful, reliable information and assistance from qualified health information nurses on a wide range of health topics 24 hours a day, any day of the year. Not sure what to do when your child has a fever in the middle of the night? Have you injured yourself and are not sure if you should seek treatment or go see a doctor? There are over 1,000 topics in the Health Information Library that include FREE audio, video and printed information on aging, women's health, nutrition, surgery and specific medical conditions to help you weigh the risks and advantages of treatment options. The call is FREE and is strictly confidential.

The myCigna Mobile App

The myCigna Mobile App gives you an easy way to organize and access your important health information. Anytime. Anywhere. Download it today from the App Store℠ or Google Play™. With the myCigna Mobile App you can:

- Find a doctor, dentist or health care facility
- Access maps for instant driving directions
- View ID cards for the entire family
- Review deductibles, account balances and claims
- Compare prescription drug costs
- Speed-dial Cigna Home Delivery Pharmacy™
- Store and organize all important contact info for doctors, hospitals, and pharmacies
- Add health care professionals to contact list right from a claim or directory search
- And, much more!

How to Locate A Provider

To search for a participating provider, contact Customer Service or visit www.cigna.com. You may either log into mycigna.com and search for a participating provider, or click the "Find a Doctor" tab. Then under Choose a Directory, select "If your insurance plan is offered through work or school... Find a doctor or dentist using this directory" box. Under Select a Plan, click "Pick." Select the "**Open Access Plus, OA Plus, Choice Fund OA Plus**" medical plan option, then click "Choose." Complete the additional search criteria, then "Search."

Dental Insurance: CompBenefits DHMO CS150 Plan

Humana/CompBenefits
Customer Service: (800) 233-4013
www.mycompbenefits.com

The City provides dental insurance through Humana. A brief description of the CompBenefits DHMO CS150 Plan is provided below, and the employee costs are shown on the premium table to the right, with a summary of the plan's schedule of benefits on the following pages. For detailed coverages, exclusions and stipulations please refer to the carrier's benefit summary or contact Humana.

Group ID Numbers			
PMSA	CP 1851	FF & PBA (Grandfathered)	CP 1850
SEIU	CP 1853	COBRA	CP 1849
Unclass / None / Conf	CP 1854	Retiree's	CP 1852

In-Network Benefits

The DHMO plan is an "in-network" only plan that **requires** you to select and receive services from a Primary Dental Provider. In order to receive services, you can select any participating dentist in the network. The network of participating providers who this dental plan utilizes is the "**DHMO Network**."

The DHMO plan's schedule of benefits is set forth by the Patient Charge Schedule (fee schedule) which is highlighted on the following pages. Please refer to your plan's certificate of coverage for a detailed listing of charges and what is covered.

How to Locate a Provider

To search for a participating provider, contact Customer Service or visit www.compbenefits.com and under the "Providers/Search" tab click on "Find Dental Providers." Under Plan Type Options, choose "**DHMO Plans**," complete your search criteria, then click "Submit."

Dental Insurance – CompBenefits DHMO CS150 Plan
Monthly Premium Deductions

Tier of Coverage	Employee Pays	City Pays	Total Premium
Employee Only	$0	$11.94	$11.94
Employee + 1 Dependent	$6.20	$14.32	$20.52
Employee + Family	$17.60	$12.80	$30.40

Dental Insurance – CompBenefits DHMO CS150 Plan – Domestic Partner
Monthly Reported Imputed Income Value

Tier of Coverage	Reported Income Value
Employee + Domestic Partner Value [1]	$8.58
Employee + Domestic Partner + Employee Child(ren) Value [1]	$8.58
Employee + Domestic Partner + Domestic Partner Child(ren) Value [1]	$18.46

1) Imputed income amount reportable on employee W-2 Form for value of insurance.

Please Note: *If employee is covering his/her own children AND a child(ren) of a Domestic Partner, please contact the Human Resources/Benefits Department for a customized calculation of the specific scenario.*

Out-of-Network Benefits

This plan does not provide any coverage for services received out of network. If you use an out-of-network dental provider you will pay out of pocket and will not be reimbursed.

Plan Year Deductible

There is no deductible that needs to be met on this plan.

Plan Year Benefit Maximum

This plan is not subject to any benefit maximums.

Please Note the Following:

- *Each covered family member may receive up to 2 FREE cleanings per year (must be 6 months apart) covered under the preventative benefit. Members can also receive 2 additional cleanings at the charge of a copay.*
- *No referrals are necessary for specialty dentists in the network.*
- *Unlisted covered dental care services may be available at the participating dentist's usual fee less 25%. Not all dentists perform all services.*
- *Service frequencies and age limitations may apply for some services.*

Dental Insurance: CompBenefits Advantage Plan AVN4S

Humana/CompBenefits
Customer Service: (800) 233-4013
www.mycompbenefits.com

The City offers dental insurance through Humana. A brief description of the CompBenefits Advantage AVN4S Plan is provided below, and the employee costs are shown on the premium table to the right, with a summary of the plan's schedule of benefits on the following pages. For detailed coverages, exclusions and stipulations please refer to the carrier's benefit summary or contact Humana.

Group ID Numbers			
PMSA	CP 4151	FF & PBA (Grandfathered)	CP 4150
SEIU	CP 4153	COBRA	CP 4149
Unclass / None / Conf	CP 4154	Retiree's	CP 4152

In-Network Benefits

The Advantage plan is an "in-network" only plan that allows you to receive services from any dental provider without first selecting or coordinating your care through a Primary Dental Provider. The network of participating providers who this plan utilizes is the **"Advantage" Network**.

The Advantage plan's schedule of benefits is set forth by the Patient Charge Schedule (fee schedule) which is highlighted on the following pages. Please refer to your plan's certificate of coverage for a detailed listing of charges and what is covered.

How to Locate a Provider

To search for a participating provider, contact Customer Service or visit www.compbenefits.com and under the "Providers/Search" tab click on "Find Dental Providers." Under Plan Type options, choose "**AdvantagePlus Plans**", complete your search criteria, then click "Submit."

Out-of-Network Benefits

This plan does not provide any coverage for services received out of network. If you use an out-of-network dental provider you will pay out of pocket and will not be reimbursed.

Dental Insurance – CompBenefits Advantage Plan AVN4S Monthly Premium Deductions

Tier of Coverage	Employee Pays	City Pays	Total Premium
Employee Only	$11.28	$11.94	$23.22
Employee + 1 Dependent	$25.62	$14.32	$39.94
Employee + Family	$46.36	$12.80	$59.16

Dental Insurance – CompBenefits Advantage Plan AVN4S Domestic Partner – Monthly Reported Imputed Income Value

Tier of Coverage	Reported Income Value
Employee + Domestic Partner Value [1]	$16.72
Employee + Domestic Partner + Employee Child(ren) Value [1]	$16.72
Employee + Domestic Partner + Domestic Partner Child(ren) Value [1]	$35.94

1) Imputed income amount reportable on employee W-2 Form for value of insurance.

Please Note: *If employee is covering his/her own children AND a child(ren) of a Domestic Partner, please contact the Human Resources/Benefits Department for a customized calculation of the specific scenario.*

Plan Year Deductible

There is no deductible that needs to be met on this plan.

Plan Year Benefit Maximum

This plan is not subject to any benefit maximums.

Please Note the Following:

- *Each covered family member may receive up to 2 FREE cleanings per year (must be 6 months apart) covered under the preventative benefit.*
- *No referrals are necessary for specialty dentists in the network.*
- *Unlisted covered dental care services may be available at the participating dentist's usual fee less 20%. Not all dentists perform all services.*

Dental Insurance: CompBenefits DHMO & Advantage Plan Side by Side At-A-Glance

Class I Services: Diagnostic & Preventative	Code	CS150	Advantage
Office Visit	9430	$5 Copay	N/A*
Emergency Care to Relieve Pain (During Regular Hours)	9999	$20 Copay	N/A
Routine Oral Exam (1 Every 6 Months)	0120	No Charge	No Charge
Routine Cleanings (1 Every 6 Months)	1110/20	No Charge	No Charge
Additional Routine Cleanings	1110/20	$20 Copay	20% Discount
Bitewing X-rays (4 Films; 1 Every 6 Months)	0274	No Charge	No Charge
Panoramic X-rays (1 Set Every 3 Years)	0330	No Charge	No Charge
Sealants - Per Tooth (Children Under Age 14)	1351	$10 Copay	No Charge
Fluoride Treatments (Children Under Age 16; Every 6 Months)	1203	No Charge	No Charge
Space Maintainer (Children Under Age 14)	1510/15	$45 Copay + Lab	No Charge
Class II Services: Basic Restorative	**Code**	**In Network**	**In Network**
Fillings (Amalgam; 3 Surfaces)	2160	No Charge	No Charge
Fillings (Composite; 3 Surfaces, Anterior)	2332	$50 Copay	No Charge
Fillings (Composite; 3 Surfaces, Posterior)	2393	$100 Copay	No Charge
Extractions (Erupted Tooth or Exposed Root)	7140	No Charge	No Charge
Root Canal Therapy (Molar)	3330	$250 Copay**	No Charge
Surgical Removal of Tooth (Erupted/Impacted)	7210/7240	$40 Copay/$85 Copay	No Charge
Full Mouth Debridement (Deep Cleaning; 1 Every 5 Years)	4355	$45 Copay	No Charge
Periodontal Maintenace	4910	$50 Copay	No Charge
Class III Services: Major Restorative	**Code**	**In Network**	**In Network**
Bridges (Porcelain Fused to High Noble Metal)	6240	$280 Copay***	$426 Copay
Crowns (Porcelain Fused to High Noble Metal)	2750	$280 Copay***	$466 Copay
Dentures	5110/20	$300 Copay + Lab	$642 Copay
Class IV Services: Orthodontia	**Code**	**In Network**	**In Network**
Benefit — Child to age 19	8070/8080	$1,800	$2,100
Benefit — Adults and Dependent Children (Age 19 and Over)	8090	$2,000	$2,300
Records/Treatment Planning	8070/80/90	$250 Copay	$250 Copay
Retention	8680	$450 Copay	$450 Copay

** Not a Standalone code on the AVN45 - Dentist should code for the service performed, not the office visit.*

*** Excluding Final Restoration.*

**** Copays for these services do not include the additional cost of precious (High Noble) and semi-precious (Noble) metal. The additional cost of precious metal shall not exceed $125 per unit and $75 per unit for semi-precious metal.*

Please Note the Following:

- *You **must** receive services from facilities and providers in the CompBenefits **DHMO** or **Advantage Network** for benefits to be covered.*
- *Participants covering young children may be seen by a pediatric dental provider up to the child's 7th birthdate. Once the child reaches age 7, a referral with medical documentation will be required prior to being seen by a pediatric dental provider.*

The above summary has been provided as a convenient reference. For a full listing of covered services, exclusions and stipulations please see the plan's Schedule of Benefits or contact Humana/CompBenefits Customer Service.

Dental Insurance: CompBenefits Elite Preferred 710 PPO Plan

Humana/CompBenefits
Customer Service: (800) 233-4013
www.mycompbenefits.com

The City offers dental insurance through Humana. A brief description of the Elite Preferred 710 PPO Plan is provided below, and the employee costs are shown on the premium table to the right, with a summary of the plan's schedule of benefits on the following page. For detailed coverages, exclusions and stipulations please refer to the carrier's benefit summary or contact Humana.

Group ID Numbers			
PMSA	CP 4151	FF & PBA (Grandfathered)	CP 4150
SEIU	CP 4153	COBRA	CP 4149
Unclass / None / Conf	CP 4154	Retiree's	CP 4152

In-Network Benefits

The dental PPO plan option is an "open access" plan that allows you to receive services from any dental provider without first selecting or coordinating your care through a Primary Dental Provider. This plan utilizes "**PPO network**" providers. To determine if your dentist is in the Network, contact Customer Service or visit www.compbenefits.com and under the "Providers/Search" tab, click on "Find Dental Providers." Under Plan Type Options, choose "**PPO plans**," complete your search criteria, then click "Submit."

Dental Insurance – CompBenefits Elite Preferred 710 PPO Plan Monthly Premium Deductions

Tier of Coverage	Employee Pays	City Pays	Total Premium
Employee Only	$23.20	$11.94	$35.14
Employee + 1 Dependent	$54.96	$14.32	$69.28
Employee + Family	$108.00	$12.80	$120.80

Out-of-Network Benefits

Providers who do not contract with insurance carriers because they do not accept their discounted rates are referred to as "non-participating" or "out of network." Understanding how your insurance company pays for out-of-network services is important because you will usually pay more. Therefore, you have the potential to maximize your benefits when services are received by in-network providers.

The insurance company processes charges based on the negotiated Maximum Allowable Fee (MAF) amount. When utilizing a non-participating dentist, you will be responsible for any extra amount charged by the dentist over the negotiated maximum and customary charge of the dentist. Since there is no contract in place between the insurance company and out-of-network provider, the provider may charge an amount higher than the MAF. The difference between the MAF amount and the provider's higher charge is called "balance billing." **Balance billing is in addition to your deductible and coinsurance responsibility**.

Dental Insurance – CompBenefits Elite Preferred 710 PPO Plan – Domestic Partner Monthly Reported Imputed Income Value

Tier of Coverage	Reported Income Value
Employee + Domestic Partner Value [1]	$34.14
Employee + Domestic Partner + Employee Child(ren) Value [1]	$34.14
Employee + Domestic Partner + Domestic Partner Child(ren) Value [1]	$85.66

1) Imputed income amount reportable on employee W-2 Form for value of insurance.

Please Note: *If employee is covering his/her own children AND a child(ren) of a Domestic Partner, please contact the Human Resources/Benefits Department for a customized calculation of the specific scenario.*

Plan Year Deductible

The dental PPO plan benefits begin once each covered member satisfies a $50 deductible (waived for Class I services). The deductible is applied collectively for either in or out-of-network services or any combination of both. Once any 3 covered members in a family each satisfies the $50 deductible, the deductible will then be considered met for all covered members in that family.

Plan Year Benefit Maximum

The maximum benefit (coinsurance) the dental PPO plan will pay for each covered member is $1,000 for in-network or out-of-network services or a combination of both. All services, including diagnostic and preventive, count toward your Plan Year Benefit Maximum.

Please Note the Following:

- *Each covered family member may receive up to 2 FREE cleanings per plan year covered under the preventative benefit.*
- *Service frequencies and age limitations may apply for some services.*

Dental Insurance: CompBenefits Elite Preferred 710 PPO Plan At-A-Glance

Network	PPO	
Plan Year Deductible (PYD)	**In and Out of Network Combined**	
Per Member	$50	
Per Family	$150	
Waived for Class I Services?	Yes	
Plan Year Benefit Maximum	**In and Out of Network Combined**	
Per Member	$1,000	
Class I Services: Diagnostic & Preventative	**In Network**	**Out of Network***
Oral Exam (1 Every 6 Months)	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Prophylaxis/Cleanings (1 Every 6 Months)		
X-rays (Limitations May Apply)		
Fluoride Treatments (1 Per Year; Children Under Age 16)		
Sealants (1 Every 3 Years; Children Under Age 16)		
Space Maintainers (Children Under Age 16)		
Class II Services: Basic Restorative	**In Network**	**Out of Network***
Fillings (Amalgams, Synthetic or Composite)	Plan Pays: 80% After PYD	Plan Pays: 80% After PYD *(Subject to Balance Billing)*
Emergency Palliative Treatment		
Tooth Extraction		
Endodontics (Root Canals)		
Periodontics (Includes the Treatment of Gum Diseases)		
Class III Services: Major Restorative	**In Network**	**Out of Network***
Major Restorative (Crowns, Inlays, Onlays)	Plan Pays: 50% After PYD	Plan Pays: 50% After PYD *(Subject to Balance Billing)*
Prosthetics (Bridges & Dentures)		
Bridge & Denture Repair		

*Out-Of-Network Balance Billing

For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the previous page.

A predetermination of benefits is required for non emergency treatment expected to cost more than $200. Please ask your dentist to file the predetermination with Humana prior to having treatment started.

The above summary has been provided as a convenient reference. For a full listing of covered services, exclusions and stipulations please see the plan's Schedule of Benefits or contact Humana/CompBenefits Customer Service.

Vision Insurance: Humana Vision Care Plan

Humana/CompBenefits
Customer Service: (866) 537-0229
www.compbenefits.com

The City provides vision insurance through Humana. A brief description of the Humana Vision Care Plan is provided below, and the employee costs are shown on the premium table to the right, with a summary of the plan's schedule of benefits on the following page. For detailed coverages, exclusions and stipulations please refer to the carrier's benefit summary or contact Humana.

Vision Insurance – Humana/CompBenefits
Monthly Premium Deductions

Tier of Coverage	Employee Pays	City Pays	Total Premium
Employee Only	$0.00	$4.48	$4.48
Employee + 1 Dependent	$0.00	$12.80	$12.80
Employee + Family	$0.00	$12.80	$12.80

In-Network Benefits

The vision plan offers you and your covered dependents coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, covered members can select any optometrist or ophthalmologists that participates in the **Humana Vision Care Network**. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of your appointment.

Vision Insurance – Humana/CompBenefits – Domestic Partner
Monthly Reported Imputed Income Value

Tier of Coverage	Reported Income Value
Employee + Domestic Partner Value [1]	$4.48
Employee + Domestic Partner + Employee Child(ren) Value [1]	$4.48
Employee + Domestic Partner + Domestic Partner Child(ren) Value [1]	$8.32

1) Imputed income amount reportable on employee W-2 Form for value of insurance.

Please Note: *If employee is covering his/her own children AND a child(ren) of a Domestic Partner, please contact the Human Resources/Benefits Department for a customized calculation of the specific scenario.*

Out-of-Network Benefits

Covered members may also choose to receive services from vision providers who do not participate in the vision network. If so, the cost of the services received would be paid to that provider at the time of the scheduled appointment. Humana will then reimburse the covered members based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered. Contact Humana's Customer Service for an out-of-network reimbursement schedule.

How to Locate a Provider

To search for a participating provider, contact Customer Service or go to www.compbenefits.com and under the "Providers/Search" tab click on "Find Vision Care Providers." Choose "**Vision Care Plan**" and then fill out the search criteria and click "Search."

Calendar Year Deductible

There is no Calendar Year Deductible.

Calendar Year Out-of-Pocket Maximum

There is no Out-of-Pocket Maximum. However, there are benefit reimbursement maximums for certain services per calendar year.

Please Note the Following:

- *Members receive additional fixed copayments on lens options including anti-reflective and scratch-resistant coatings. Contact Humana for more information.*
- *Members also receive a 20% retail discount on a second pair of eyeglasses. This discount is available for 12 months after the covered eye exam, and is available through the VCP network provider who sold the initial pair of eyeglasses.*
- *After copay, standard polycarbonate available at no charge for dependents under age 19.*

Vision Insurance: Humana Vision Care Plan At-A-Glance

Services	In Network	Out of Network
Eye Exam	$10 Copay	Up to $35 Reimbursement
Frequency of Services	**In Network**	**Out of Network**
Examination	12 Months	12 Months
Lenses	12 Months	12 Months
Frames	24 Months	24 Months
Contact Lenses	12 Months	12 Months
Lenses	**In Network**	**Out of Network**
Single	Paid in Full	Up to $25 Reimbursement
Bifocal		Up to $40 Reimbursement
Trifocal		Up to $60 Reimbursement
Contact Lenses	**In Network**	**Out of Network**
Non-Elective (Medically Necessary)	Paid in Full [1]	Up to $210 Reimbursement
Elective (Fitting, Follow-up & Lenses)	Up to $105 Allowance [2]	Up to $105 Reimbursement
Frames	**In Network**	**Out of Network**
Maximum Allowance	$40 Wholesale Allowance	$40 Retail Price Reimbursement
Lasik	**In Network**	**Out of Network**
Discount Programs [3]	Contact Humana's Customer Service For More Information	Discount Programs Not Available Out of Network

Group Plan Number: VS3150

Please Note:

1. *Medically necessary (prior authorization required) is defined as 1) following cataract surgery w/o intraocular lens 2) correction of extreme visual acuity problems not correctable with glasses 3) anisometropia greater than 5.00 diopters and asthenopia or diplopia, with spectacles; 4) Keratoconus; or 5) monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life.*
2. *This allowance is paid with the same frequency as lenses, in place of all other benefits. The allowance applies to materials, evaluation and fitting. Members also receive 15% discount on in-network professional services, available for 12 months after the covered eye exam.*
3. *Plan members must first contact Humana / CompBenefits for a list of providers who participate in the Vision Care Plan network.*

Flexible Spending Accounts

WageWorks (Formerly through FlexOne/Aflac)
Customer Service: (800) 950-0105
Mon. – Fri. from 8:00am – 7:00pm CST
www.takecarewageworks.com
www.fsaworksforme.com/takecare

Claims Mail: Aflac Benefit Services
1932 Wynnton Rd,
Columbus, GA 31999
Claims Fax: (877) 353-9256

The City of West Palm Beach offers Flexible Spending Accounts (FSA) administered by WageWorks.

Debit Card

Use the Take Care® Card

Use your take care® card instead of cash or credit at health care providers and pharmacies for eligible services, goods and prescriptions. Typical expenses include co-pays for doctor visits and prescriptions, dental and orthodontia expenses, vision care, prescribed over-the-counter (OTC) drugs and medication and non-drug OTC items and devices.

If you have predictable medical expenses for yourself or your family, such as deductibles and copays, or any work-related day care expenses, FSAs may be right for you. FSAs allow you to set aside money for reimbursement of medical and day care expenses you regularly pay. **The amount you set aside is not taxed and is automatically deducted from your paycheck and deposited into the FSA.** During the year, you have access to this account for reimbursement of qualified expenses that are not covered by insurance. An FSA not only results in a substantial tax savings, it also increases your spending power. There are two types of FSAs:

Health Care Reimbursement Account	Dependent Care Reimbursement Account
This account allows you to set aside up to an **annual maximum of $2,550.** This money will not be taxable income to you and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs for you or your qualified dependents. Employees can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic). Examples of common expenses that qualify for reimbursement are listed below. ***NOTE: The entire Health Care FSA election is available to you on the first day coverage is effective.**	This account allows you to set aside up to an **annual maximum of $5,000 if you are single or married and file a joint tax return ($2,500 if you are married and file a separate tax return)** for work-related day care expenses. Qualified expenses include adult and child day care centers, preschool, and before/after school care for eligible children and adults. Please note that if your family's annual income is over $20,000, this reimbursement option will most likely save you more money than the dependent care tax credit you take on your tax return. To qualify, your dependent must be: • a child under the age of 13, or • a child, spouse or other dependent that is physically or mentally incapable of self-care and spends at least 8 hours a day in your household. ***NOTE: Unlike the Health Care FSA, you will only be reimbursed up to the amount that has been deducted from your paycheck for Dependent Care expenses.**

A sample list of qualified expenses eligible for reimbursement include, but are not limited to, the following:

- Ambulance service
- Chiropractic care
- Dental fees/Orthodontic fees
- Diagnostic tests/Health screenings
- Doctor fees
- Drug addiction/Alcoholism treatment
- Experimental medical treatment
- Eyeglasses/Contact lenses (corrective)
- Hearing aids and exams
- Injections & vaccinations
- Lasik surgery
- Mental healthcare
- Nursing services
- Optometrist fees
- Physician office visits
- Prescription drugs
- Medically Necessary Sunscreen
- Wheelchairs

Log on to http://www.irs.gov/publications/p502/index.html for additional details regarding qualified and non-qualified expenses.

Flexible Spending Accounts *(Continued)*

FSA Guidelines

- **Any unused funds after a plan year ends and all claims have been filed cannot be returned to you or carried forward to the next plan year.**
- **You have a 2.5 month grace period at the end of the plan year to file for claim reimbursement on eligible expenses incurred during the period of coverage within the plan year.**
- Must be renewed annually to continue benefit for following year.
- You can enroll in either or both FSAs during open enrollment period, a qualifying event or new hire eligibility only.
- You cannot transfer money between FSAs.
- You cannot pay a dependent care expense from your Health Care FSA or vice versa.
- You cannot deduct reimbursed expenses for income tax purposes.
- You cannot be reimbursed for a service which you have not received.
- You cannot receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
- Domestic partners are not eligible as federal law does not recognize them as a qualified dependent.

Here's How It Works

An employee earning $30,000 elects to place $1,000 into their FSA Health Care Savings Account, with payroll deductions being $41.67 based on a 24 pay period schedule. As a result, the insurance premiums and health care expenses are paid with tax-free dollars, giving the employee a tax savings of $227.

	With the Plan	Without the Plan
Salary	$30,000	$30,000
FSA Contribution	- $1,000	- $0
Taxable pay	$29,000	$30,000
Estimated Tax 22.65% = 15% + 7.65 FICA	- $6,568	- $6,795
After Tax Expenses	- $0	- $1,000
Spendable Income	$22,432	$22,205
Tax Savings	**$227**	

NOTE: Be conservative when estimating your medical and/or dependent care expenses. IRS regulations state that any unused funds which remain in your FSA after a plan year ends and all claims have been filed cannot be returned to you or carried forward to the next plan year. This is known as the "USE IT OR LOSE IT" rule.

Filing a Claim

To file a claim, you must submit your completed claim form and include a copy of the receipt as proof of the expense. Once completed, you may submit your claim either by mail or fax. The IRS requires FSA participants to maintain complete documentation, including keeping copies of receipts for reimbursed expenses, for a minimum of one year.

Basic Life and AD&D Insurance

The Hartford
Customer Service: (888) 563-1124
Group Plan Number: 6770058
www.thehartfordatwork.com

Basic Term Life

The City provides Basic Term Life Insurance through The Hartford. Your benefit amount is determined by your eligibility classification as described below. Your enrollment is automatic but you are required to designate a beneficiary. Beneficiary designations can be made online at www.mybentek.com/wpb. A beneficiary confirmation statement can also be printed and retained for your records.

Eligibility Classifications		Benefit Classifications
Active Full-time Employees of Management Class 1.	**Class 1**	1 times annual earnings plus $100,000, rounded to the next higher multiple of $1,000, to a maximum of $250,000.
Active Full-time Employees of Management Class 2 other than members of Professional Managers Supervisors Association (PMSA).	**Class 2**	1 times annual earnings plus $50,000, rounded to the next higher multiple of $1,000, to a maximum of $250,000.
Active Full-time Employees of Management Class 2 who are members of the PMSA.	**Class 3**	1 times annual earnings plus $75,000, rounded to the next higher multiple of $1,000, to a maximum of $250,000.
Active Full-time Employees or Elected Officials other than Members of the PMSA, Firefighters and Police Department employees.	**Class 4**	1 times annual earnings, rounded to the next higher multiple of $1,000, to a maximum of $100,000.
Active Full-time Employees who are members of the PMSA who are not in Management Classes 1 or 2, other than Firefighters and Police Department employees.	**Class 5**	1 times annual earnings plus $25,000, rounded to the next higher multiple of $1,000, to a maximum of $100,000.
Active Full-time Employees of the Police Department who are not in Management Classes 1 or 2.	**Class 6**	1 times annual earnings, rounded to the next higher multiple of $1,000, to a maximum of $100,000.
Active Full-time Employees of the Fire Department who are not in Management Classes 1 or 2.	**Class 7**	1 times annual earnings, rounded to the next higher multiple of $1,000, to a maximum of $100,000.
Retired Employees who retired prior to October 1, 1998 other than employees of the Police and Fire Department.	**Class 8**	Flat $7,500.
Retired Employees who retired on or after October 1, 1998 other than employees of the Police and Fire Department.	**Class 9**	Flat $10,000.
Retired Employees of the Police Department.	**Class 10**	Flat $25,000.
Retired Employees of the Fire Department retired prior to February 1, 2010.	**Class 11**	Flat $25,000.
Retired Employees of the Fire Department retired on or after February 1, 2010.	**Class 12**	Flat $10,000.

Accidental Death & Dismemberment

For Classes 1 - 7, the City also provides Accidental Death & Dismemberment (AD&D) insurance which pays in addition to, and in an amount equal to, the Basic Term Life Insurance benefit when death occurs as a result of an accident. A partial AD&D benefit may also be payable based on the schedule of benefits. For detailed coverages, exclusions, and stipulations contact The Hartford Customer Service.

Please Note: *For Classes 1-7, the Basic Life / AD&D benefit amount reduces starting at age 70. For details regarding all the plan's coverages, exclusions, and stipulations, contact Customer Service or visit The Hartford online at www.thehartfordatwork.com.*

Always remember to keep your beneficiary forms updated.
You may update your beneficiary information at anytime by logging onto BenTek at www.mybentek.com/wpb

Supplemental Employee & Dependent Life Insurance

The Hartford
Customer Service: (888) 563-1124
www.thehartfordatwork.com

Supplemental Employee Life

The City offers Supplemental Employee Life Insurance through The Hartford. Enrollment is voluntary and 100% employee paid. A summary of the plan's benefit provisions is provided below followed by a premium calculation. Beneficiary designations can be made online at www.mybentek.com/wpb. A beneficiary confirmation statement can also be printed and retained for your records.

Supplemental Employee Life Plan Summary	
Eligibility	All Active Full-time Employees.
Benefit Options	1,2 or 3 times your basic annual earnings to a maximum of $300,000.
Cost to You	This benefit is 100% employee paid.
Guaranteed Issue	$250,000 for all first-time eligible employees. Employees who do not enroll when first eligible and later want to add this coverage, or employees who want to increase their current election must submit medical evidence to Hartford Life. Coverage will not be effective unless, and until, Hartford approves your application.
Portability	You can take this coverage with you if you terminate employment prior to normal retirement avge. Rates will be similar but not identical.
Age Reduction	Your benefit reduces starting at age 70.

Supplemental Employee Life Monthly Premium Calculation

_____	÷	$1,000	=	_____	x	$0.35	=	_____
Elected Benefit Amount						*Monthly Rate per $1,000 of Elected Benefit*		*Your Monthly Cost*

Supplemental Dependent Life

The City offers Supplemental Dependent Life Insurance through The Hartford. Enrollment is voluntary and 100% employee paid. A summary of the plan's benefit provisions is provided below followed by a premium calculation. Beneficiary designations can be made online at www.mybentek.com/wpb. A beneficiary confirmation statement can also be printed and retained for your records. ***Please note: Employees must participate in the Supplemental Life insurance plan for spouses/dependent child(ren) to participate.***

Supplemental Dependent Life Plan Summary	
Benefit Options	Spouse: Flat $10,000. Child(ren): Flat $5,000.
Dependent Spouse	Dependent elections cannot exceed 50% of the employee's inforce life benefit. You may not elect coverage for your spouse if your spouse is covered as an employee under this policy. If both you and your spouse are employees of the City, only one of you may elect coverage for your child(ren).
Dependent Child(ren)	Children from live birth to age 21 are covered, and may remain in the plan to age 25 if a full-time student.
Cost to You	This benefit is 100% employee paid.
Spouse Guaranteed Issue	$10,000 is the guaranteed issue amount for spouses who are newly eligible for coverage. Employees who have previously declined spouse coverage must submit medical evidence for their spouses to Hartford Life. Coverage will not be effective unless, and until, Hartford Life approves your application.
Child(ren) Guaranteed Issue	All amounts are guaranteed issue, even if enrolling late.
Age Reduction	None.

Supplemental Dependent Spouse Monthly Premium Calculation

$10,000	÷	$1,000	= 10	x	$0.35	=	$3.50	
Elected Benefit Amount					*Monthly Rate per $1,000 of Elected Benefit*		*Your Monthly Cost*	

Long Term Disability Insurance

The Hartford
Customer Service: (888) 563-1124
www.thehartfordatwork.com

The City provides Long Term Disability (LTD) insurance through The Hartford for all general employees enrolled in the Defined Contribution Retirement Plan. LTD insurance is "income replacement" insurance that pays you a percentage of your monthly earnings if you are unable to work due to illness or a non-work related injury. The City pays for this benefit 100% and your enrollment is automatic. A summary of the plan's benefit provisions is provided below. For details regarding all the plan's coverages, exclusions, and stipulations, contact Customer Service or go to www.thehartfordatwork.com.

Long Term Disability Plan Summary	
Definition of Disability	Disability means that you cannot perform one or more of the essential duties of your occupation due to a non-work related injury, illness, pregnancy or other medical condition covered by the insurance, and as a result, your current monthly earnings are 80% or less than your pre-disability earnings. Once you have been disabled for 36 months following the elimination period, you must be prevented from performing one or more of the essential duties of any occupation and as a result, your current monthly earnings are 60% less than your pre-disability earnings.
Elimination Period	Benefits begin after 90 calendar days.
Benefit Percent	The plan replaces up to 60% of basic monthly earnings.
Monthly Benefit Minimum / Maximum	$100 / $5,000
Benefit Duration	If under age 63 when disabled, benefit may be payable up to your Normal Social Security retirement age. If you are 63 or older, benefits may be payable beyond normal retirement age. Consult your certificate for full description.
Pre-existing Condition	Any condition for which you sought medical attention or took medication in the 180 days prior to your coverage becoming effective will not be covered unless the date of the disability follows 365 days of continuous coverage under this plan.
Mental & Nervous / Substance Abuse	24 month limit unless confined to a facility.
Cost to You	None. The City pays for this benefit.

Employee Assistance Program

Aetna Resources for Living
Customer Service: AETNA-EAP (888 238-6232)
www.mylifevalues.com
24 Hour Crisis Line: (800) 272-7252

Username: CWPB
Password: CWPB

The City provides, at no cost to you, a comprehensive Employee Assistance Program (EAP). The EAP program is available to you and each member of your family through Aetna Resources for Living. Aetna offers access to licensed mental health professionals through a confidential program that is protected by state and federal laws. The EAP program is available to help you gain a better understanding of problems that affect you, locate the best professional help for your particular problem, and decide upon a plan of action. All EAP counselors are professionally trained and are certified and licensed in their fields. Master-level counselors are available 24 hours a day, 7 days a week.

What is an Employee Assistance Program?

An Employee Assistance Program (EAP) offers covered employees and their family members free and convenient access to a range of confidential and professional services to help them address a variety of problems that can negatively affect their well-being. Coverage includes 6 face-to-face sessions per issue (per year), phone crisis intervention and referrals to outside resources when necessary. EAP offers counseling services on issues such as:

Emotional Well-Being

- Stress / Depression
- Grief and Loss
- Anger Management

Work Issues

- Co-worker Relationships
- Job Burnout
- Work-Related Stress
- Performance Concerns

Legal and Financial Services

- Free 30 minute legal phone or in person consultation
- Free 30 minute financial phone consultation with a financial counselor
- 25% discount when retaining attorney or using network CPA for personal income tax preparation
- Online Will and other sample legal forms
- Online ID Theft & Fraud Resolution Program
- Online access to legal and financial articles

Family Matters

- Marital issues
- Parenting problems
- Domestic violence

Addiction and Recovery

- Alcohol and drugs
- Gambling
- Eating Disorders

Online Work/Life Services

- Health and Wellness
- Finances and saving money
- Child and elder care provider search features
- Adoption
- Access to savings and rewards programs
- Pet resources and information

Are your services confidential?

Yes. Receipt of EAP Services is completely confidential. If, however, participation in the EAP is a direct result of a Management Referral (a referral initiated by a supervisor or manager), we will ask permission to communicate certain aspects of the employee's care (attendance at sessions, adherence to treatment plans, etc.) to the referring supervisor/manager. The referring supervisor will not, however, receive specific information regarding the referred employee's case. The supervisor will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

Supplemental Insurance

Aflac
Agent: Linda Carcich
Phone: (561) 784-5256
www.aflac.com
aflac@wpb.org (Lotus Note)

Aflac offers a variety of voluntary supplemental insurance plans that may be purchased separately on a voluntary basis and premiums paid by payroll deduction. Aflac pays money directly to you, regardless of what other insurance plans you may have. Available Aflac plans include:

- Cancer Classic Plan
- Critical Care Plan (Specified Health Event)
- Personal Disability Income Protector
- Accident Indemnity Advantage
- Personal Sickness Indemnity Plan (Level 3)
- Group Accident Plan
- Group Critical Illness Plan

To learn more about these Aflac plans and/or schedule a personal appointment, contact the City's Aflac Agent, Linda Carcich, at (561) 784-5256.

Preferred Legal Plan

Preferred Legal Plan
Customer Service: (888) 577-3476
www.preferredlegal.com
info@preferredlegal.com

City employees have the opportunity to enroll in a voluntary pre-paid legal program through Preferred Legal Plan. By enrolling in this plan, a participant will have direct access to attorneys who will provide legal assistance 24 hours a day / 7 days a week for a variety of situations such as those examples provided in the box below. Additional services may also be provided at discounted rates.

The cost to the employee to participate in this legal plan is $9.95 per month. This cost is the same for all employees regardless of the number of eligible dependents enrolled in the plan. All premiums will be payroll deducted on a post-tax basis for your convenience.

Preferred Legal Plan service examples:

- Divorce
- Domestic Violence
- Civil Litigation
- Child Custody and Support
- Identity Theft Issues
- Personal Injury
- Bankruptcy
- Criminal Defense
- Traffic Tickets
- Probate
- Immigration
- Wills (Member and Spouse)
- Real Estate
- Credit Report Issues
- Contract Review
- Loan Modifications
- Foreclosure Defense

Notes

Use this section to make notes regarding your personal benefit plans or to keep track of important information such as doctor's names and addresses or prescription medications.

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GEHRING GROUP

11505 Fairchild Gardens Ave., Suite 202
Palm Beach Gardens, Florida 33410
Toll Free: (800) 244-3696; Fax: (561) 626-6970
www.gehringgroup.com

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June 16, 2015 1:39 PM

CITY OF Clearwater

2016 Employee Benefits Highlights

IMPORTANT CONTACT INFORMATION		
City of Clearwater	**Contact Name**	**Contact Information**
Human Resources Department	Lisa Goodrich Donna Cacciatore Morgan Douglass Michelle Kutch	lisa.goodrich@myclearwater.com donna.cacciatore@myclearwater.com morgan.douglass@myclearwater.com michelle.kutch@myclearwater.com Phone: (727) 562-4870
Finance Department	Jennifer Moulton, Senior Pension Payroll Analyst	Phone: (727) 562-4523 jennifer.moulton@myclearwater.com
Parks and Recreation	Regina Novak, Wellness Specialist	Phone: (727) 793-2339 ext. 238 regina.novak@myclearwater.com
Service	**Contact Name**	**Contact Information**
Online Enrollment	BenTek	Technical Support: (888) 523-6835 support@mybentek.com www.mybentek.com/clearwater
Employee Health Center	Cigna On-Site Health	Phone: (727) 298-1788
Medical Insurance (Mental Health/Chemical Dependency)	Cigna	Stacy Lambert, Onsite Cigna Representative Phone: (727) 562-4503 Stacy.Lambert@myclearwater.com Customer Service: (800) 244-6224 www.cigna.com
Dental Insurance	Assurant	Customer Service: (800) 443-2995 www.assurantemployeebenefits.com
	Humana	Customer Service: (800) 342-5209 www.compbenefits.com
Vision Insurance	Humana	Customer Service: (800) 865-3676 www.compbenefits.com
Employee Assistance Program	Cigna Behavioral Health	Customer Service: (877) 622-4327 www.cignabehavioral.com
Life Insurance	Human Resources	Phone: (727) 562-4870
Supplemental Insurance	Aflac	Frank D'Ascoli, Agent Phone: (727) 514-7977 frank.dascoli@verizon.net
Flexible Spending Account	WageWorks/Aflac	Frank D'Ascoli, Agent Phone: (727) 514-7977 frank.dascoli@verizon.net www.takecarewageworks.com

Table of Contents

Introduction

The City of Clearwater's Employee Benefit Highlights booklet provides summaries of the City's group insurance offerings for all benefit-eligible employees. This information is provided when you are first hired and during the City's annual open enrollment. It is important that you make knowledgeable decisions when it comes to your benefits. Please refer to each plan's Summary Plan Description to learn about any enrollment conditions or coverage stipulations. If you have any questions regarding the contents of this booklet, please contact Human Resources at (727) 562-4870.

Online Benefit Enrollment

BenTek
Technical Support - Email: support@mybentek.com
Technical Support - Phone: (888) 5-BenTek (523-6835)

Online Enrollment with BenTek!

The City of Clearwater provides an electronic enrollment option through BenTek's Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to make group insurance benefit elections as a new hire, during open enrollment or upon experiencing a qualifying event.

To access the Employee Benefits Center:

1. Log on to www.mybentek.com/clearwater
2. Enter your user name and password.
3. If you have forgotten your username and/or password, click on the link "Forgot Username" or "Forgot Password" and follow the instructions.
4. Click on the "Menu" button and select the appropriate benefit election option (ie. open enrollment, qualifying event, new hire). You can review current elections, learn about your benefit options, and make any elections or changes.
5. You may also update your life insurance beneficiary designation(s).
6. Be sure to click on the submit button when you have completed your selections.
7. You have the option to print out your enrollment confirmation statement containing all your benefit elections for you and your family, including your life insurance beneficiary designations.

Accessible 24 hours a day, you may view your election options, including premiums and carrier information, to help you make informed decisions. You can also log on to the EBC at any time to review your benefits, access carrier links, or update life insurance beneficiaries.

If any technical questions arise while visiting the EBC, please email BenTek Support at **support@mybentek.com** or call **(888) 5-BenTek (523-6835)**, Monday through Friday, during regular business hours.

To access your group insurance benefits online, log on to www.mybentek.com/clearwater

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for each medical plan option is **provided as a supplement** to this booklet which is being distributed to new hires and existing employees during open enrollment. These summaries are an important item in understanding your benefit options. Free paper copies of the SBC documents are available upon request or as follows:

From:	City of Clearwater Human Resources Department
Address:	100 South Myrtle Avenue Clearwater, FL 33756
Phone:	(727) 562-4870
City Website:	http://clearwater/Departments/humres/Benefits/medical.asp
BenTek Enrollment Website:	www.mybentek.com/clearwater

The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the actual group certificate of coverage can be reviewed and/or obtained by contacting Human Resources or at the following web address: www.mybentek.com/clearwater.

If you have any questions about the plan offerings or coverage options, please contact Human Resources at (727) 562-4870.

Group Insurance Eligibility

The City's group insurance plan year is January 1st through December 31st.

Employee Eligibility

Eligible employees working a minimum of 37.5 hours per week will be eligible to participate in all City insurance plans.

Eligible employees working an average of 30 to 37.5 hours per week will be eligible to participate in the City's medical, dental, vision, FSA and AFLAC insurance plans only, excluding life insurance and retirement benefit offerings.

Coverage for all employees will be effective on the first day of the month following the date of hire. For example, if you are hired on April 11th, your coverage will begin on May 1st.

Termination

If you separate employment from the City, insurance will continue through the end of the month in which the separation occurred. COBRA continuation of coverage may be available as applicable by law (see page 20).

Dependent Eligibility

A dependent is defined as the legal spouse/domestic partner and/or dependent child(ren) of the participant or spouse/domestic partner. The term "child" includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A foster child
- A newborn of a covered dependent (up to 18 months old - Florida)
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse

Medical Coverage: Dependent children may be covered through the end of calendar year in which they turn 26. Over-age dependents may continue to be covered under the medical plan to the end of the calendar year in which the dependent reaches the age of 30, if the dependent meets the following requirements:

- Unmarried with no dependents; AND
- A Florida resident, or full-time or part-time student; AND
- Otherwise uninsured; AND
- Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is handicapped.

Please see the Taxable Dependents section below if you are covering eligible over-age dependents.

Dental Coverage: Dependent children may be covered through the end of the month in which they turn 26.

Vision Coverage: Dependent children may be covered through the end of the month in which they turn 26.

Disabled Dependents

Coverage for an unmarried dependent child may be continued beyond age 26 if:

1. The dependent is physically or mentally disabled, primarily supported by you and incapable of self-sustaining employment (prior to age 26); AND
2. The dependent is eligible for coverage under the group medical plan; AND
3. The dependent has been continuously insured; AND
4. Coverage with the City began prior to the age of 26.

Proof of disability will be required upon request. Please contact Human Resources if further clarification is required.

Group Insurance Eligibility *(Continued)*

Taxable Dependents

Employees covering adult children under the City's medical insurance plan may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which the child reaches age 26. Beginning January 1st of the calendar year in which the child reaches age 27 through the end of the calendar year in which the child reaches age 30, employees insuring over-age dependents will see the insurance premium deductions on a post-tax basis and any amount subsidized by the employer will be reported as (imputed income) to the employee. Check with Human Resources for further details if you are covering an adult child who will turn 27 any time in the upcoming calendar year or for more information.

Domestic Partner

A Domestic Partner and any eligible dependent(s) will be provided the same benefits afforded to all employees and eligible dependents excluding American Family Life Assurance Company of Columbus (Aflac) and Family Medical Leave Act (FMLA). A Domestic Partner is defined as a person of the same or opposite sex with whom an employee or retiree has established a domestic partnership in accordance with the Policy, rules, and procedures determined by the City and will be required to complete an Affidavit of Domestic Partnership. IRS guidelines state that an employee may not receive a tax advantage on any portion of premium paid related to domestic partner coverage. Employees insuring domestic partners and/or child dependents of a domestic partner will see the insurance premium deductions on a post-tax basis and any amount subsidized by the employer will be reported as "imputed income" to the employee.

A Domestic Partnership will be required to meet all of the following eligibility requirements:

1. Both individuals are at least eighteen (18) years old and mentally competent to consent to a contract.
2. Both are each other's sole domestic partner and intend to remain so indefinitely.
3. Both have common residence and at the time of submitting an affidavit and have resided together on a continuous basis for the preceding six (6) months intending to continue the arrangement.
4. Both are not married under Florida law nor are domestic partners with anyone else and have not been so during the preceding six (6) months.
5. Both are not related by blood in any way that would prohibit legal marriage in the State of Florida.
6. Both share responsibility for a significant measure of each other's common welfare and financial obligations.

You may contact Human Resources for further details and rates if you are covering a domestic partner at any time during the upcoming plan year.

Qualifying Events and IRS Code Section 125

IRS Code Section 125

Premiums for medical, dental, vision insurance, and/or certain supplemental policies and contributions to FSA accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) on a pre-tax basis to the extent permitted. Under Section 125, changes to your pre-tax benefits can be made ONLY during the Open Enrollment period unless you or your qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event. Under certain circumstances, you may be allowed to make changes to your benefit elections during the plan year, if an event affects your own, your spouse's, or your dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125. Any requested changes must be consistent with and on account of the qualifying event.

Examples of qualifying events

- Marriage, divorce or registration/termination of Domestic Partnership
- Birth of a child
- You gain legal custody or adopt a child
- Your spouse and/or other dependent(s) die(s)
- You, your spouse, or dependent(s) terminate or start employment
- An increase or decrease in your work hours causing eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with an ex-spouse
- Change of coverage under an employer's plan
- Gain or loss of Medicare coverage
- Losing eligibility for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)
- Becoming eligible for State premium assistance under Medicaid or CHIP (60 day notification period)

IMPORTANT

The City of Clearwater operates under strict IRS Guidelines, therefore if you experience a qualifying event, you must notify the Human Resources Department within 30 days of the qualifying event (or within 60 days for a newborn or adoption) in order to make the appropriate changes to your coverage. After 30 days, your request for changes in coverage may be denied and/or you may be responsible for any claim or expense incurred by you or a dependent who does not meet eligibility requirements.

If your qualifying event is approved, you will have the option to have your coverage become effective on the date proof was provided to City or on the first day of the month following the date you provided the City proof; except in the event of a newborn or adoption, in which you may elect coverage effective the date of birth or adoption (if you notify within 30 days) in addition to the previous options. You may be required to furnish valid documentation supporting a change in status or qualifying event. Please contact the Human Resources Department if you have any questions or require assistance regarding a qualifying event.

Employee Health Center

City of Clearwater Employee Health Center

The Employee Health Center is available to employees, retirees, and their eligible dependents enrolled in the City's medical insurance plan. The EHC provides the care you and your dependents need for all non-emergency illnesses. Schedule an appointment with the medical staff to learn more about the Employee Health Center or **refer to your Summary of Benefits and Coverage (SBC).**

The EHC is now administered by Cigna On-Site Health, a third-party vendor. Utilization is entirely voluntary. All visits with Employee Health Center staff are completely confidential and no personal information is shared with your employer.

Why choose the Employee Health Center?

- Full range of primary care services available for no charge
- Dedicated appointment times
- No charge for prescriptions dispensed at the EHC (a list of available Rx's can be found on the City's Intranet site)
- 100% confidential and HIPAA compliant

Upon enrollment in the City's medical plans, participants will have access to register and create an account on the patient portal. The patient portal will allow you to view your personal health history and personal health information, as well as to connect with EHC doctors.

To schedule an appointment at the Employee Health Center, contact Cigna On-Site Health by calling (727) 298-1788.

Hours of operation are 7:00 a.m. to 5:00 p.m., Monday through Friday. Appointments are **required**; however, walk-ins may be accommodated based on availability and/or the severity of the issue.

Please Note: *Employees will be allowed up to one hour, with no charge to their sick leave, to attend a scheduled appointment at the Employee Health Center.*

Employee Health Center
Powell Professional Center
401 Corbett Street, Suite 240
Clearwater, FL 33756
(727) 298-1788

The Health Center will be closed New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thanksgiving & day after, and Christmas Day.

Medical Insurance Premiums

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your Cigna medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan please contact Cigna's Customer Service at (800) 244-6224.

The City provides medical insurance through Cigna to benefit-eligible employees. The Employee and Retiree costs are listed in the premium tables below. **For information about your medical plan please refer to the Summary of Benefits and Coverage (SBC) provided.**

Cigna Healthcare will continue to be the provider for the City's medical insurance in 2016. There are two plan options available. The plan you are enrolled in will depend on whether or not you have completed a Personal Health Assessment (PHA) through the health center staff or the equivalent. If you have not completed a PHA, you will be enrolled in the Cigna OAP Base Plan. If you have completed a PHA, you will have the option to enroll in either the Cigna OAP PHA or Cigna OAP Base Plan. Please note that if you are unable to complete the PHA, upon approval, an alternative may be available.

2016 Medical Insurance - Cigna Open Access Plus (OAP) PHA Plan

Employee Semi-Monthly Premium Deductions

Tier of Coverage	Employee Cost
Employee Only	$0.00
Employee + One Dependent	$141.74
Employee + Family	$297.70
Dual Coverage	$0.00

Retiree/COBRA* Monthly Premium Rates

Tier of Coverage	Retiree Cost
Retiree Only	$661.78
Retiree + One Dependent	$1,133.93
Retiree + Family	$1,860.63

**A 2% administrative charge will be added to the monthly rate for COBRA.*

2016 Medical Insurance - Cigna Open Access Plus (OAP) Base Plan

Employee Semi-Monthly Premium Deductions

Tier of Coverage	Employee Cost
Employee Only	$0.00
Employee + One Dependent	$141.74
Employee + Family	$297.70
Dual Coverage	$0.00

Retiree/COBRA* Monthly Premium Rates

Tier of Coverage	Retiree Cost
Retiree Only	$661.78
Retiree + One Dependent	$1,133.93
Retiree + Family	$1,860.63

**A 2% administrative charge will be added to the monthly rate for COBRA.*

Medical Insurance

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your Cigna medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan please contact Cigna's Customer Service at (800) 244-6224.

Other Available Plan Resources

The City provides medical insurance through Cigna to benefit-eligible employees. The Employee and Retiree costs are listed in the premium tables to the left. **For information about your medical plan please refer to the Summary of Benefits and Coverage (SBC) provided. Contact Cigna's Customer Service at (800) 244-6224 or visit www.cigna.com.**

How the Deductible and Co-Insurance Works

- For services requiring a co-payment, you pay only the co-payment amount each time you receive the service.
- For services requiring co-insurance, you pay the full cost of services up to the deductible amount, and then you pay a percentage (co-insurance) of the remaining cost of services up to your out-of-pocket limit.
- Once you reach your out-of-pocket limit, the plan pays the full cost of any services (including prescriptions) normally covered by your plan.
- Only services requiring co-insurance go toward satisfying the deductible. All services, including the deductible, co-insurance and co-payments, including prescription drugs, will go toward satisfying the out-of-pocket limit.

Please remember that out-of-network providers may balance bill for charges that exceed the allowed billed amount, even once the Out-of-Pocket Limit has been reached.

How to Locate a Provider

Cigna Open Access Plus (OAP) Plans (PHA and Base Plan)

To search for a participating provider please contact Cigna's Customer Service or visit www.cigna.com. Select the "Find a Doctor" tab and then choose "For plans offered through work or school... Find a Doctor or Dentist using this Directory" option. Under "Select a Plan," click "Pick," and then "Medical Plans" and choose "**Open Access Plus, OA Plus, ChoiceFund OA Plus**" for your plan type then click "Choose." Complete the additional search criteria and select "Search."

Medical Insurance: Cigna Open Access Plus (OAP) PHA Plan At-A-Glance

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your Cigna medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan please contact Cigna's Customer Service at (800) 244-6224.

Network	CIGNA Open Access Plus (OAP)	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network**
Single	$2,000	$2,000
Family	$4,000	$4,000
Coinsurance	**In-Network**	**Out-of-Network**
Member Responsibility	10%	30%
Calendar Year Out-of-Pocket Maximum	**In-Network**	**Out-of-Network**
Single	$3,500	$3,500
Family	$7,000	$7,000
What Applies to the Out-of-Pocket Maximum?	Deductible, Coinsurance, Copays and Rx	
Physician Services	**In-Network**	**Out-of-Network****
Primary Care Physician (PCP) Office Visit	$40 Copay	30% After CYD
Specialist Office Visit	$60 Copay	
Non-Hospital Services; Freestanding Facility	**In-Network**	**Out-of-Network****
Clinical Lab (Blood Work): Quest or LabCorp*	No Charge	30% After CYD
X-rays/Advanced Imaging (MRI, PET, CT) (i.e. West Coast Radiology & Rose Radiology)		
Outpatient Surgery in Surgical Center (Per Visit)	$300 Copay + 10% After CYD	$300 Copay + 30% After CYD
Outpatient Physician Services	10% After CYD	30% After CYD
Hospital Services	**In-Network**	**Out-of-Network****
Hospital Pre-admission Requirement	Yes, or you pay 100%	Yes, or you pay 100%
Inpatient (Per Admission)	$500 PAD + 10% After CYD	$500 PAD + 30% After CYD
Physician Services at Hospital	10% After CYD	30% After CYD
Emergency Room (Per Visit; Waived if Admitted)	$150 Copay	$150 Copay
Ambulance (Emergency Services Only)	10% After CYD	10% After CYD
Urgent Care Center (Per Visit; Waived if Admitted)	$75 Copay	$75 Copay
Outpatient Rehabilitation	**In-Network**	**Out-of-Network****
Facility Charge (60 visits annual maximum)	$60 Per Visit	30% After CYD
Mental Health/Substance Abuse	**In-Network**	**Out-of-Network****
Inpatient (Prior Authorization is Required)	$100 Copay Per Admission	30% Coinsurance
Outpatient Facility (Prior Authorization is Required)	$10 Copay Per Visit	30% Coinsurance
Prescription Drugs (Retail 30 Day Supply)	**In-Network**	**Out-of-Network****
Generic	$30 Copay	30% Coinsurance
Preferred Brand Name	$40 Copay	
Non-Preferred Brand Name	$60 Copay	
Mail-Order Drug (90 Day Supply)	2x Retail Copay	Not Covered

PAD = Per Admission Deductible

**Quest Diagnostics and LabCorp are the preferred labs for bloodwork through Cigna. When using a lab other than LabCorp or Quest, please be sure to confirm they are contracted with Cigna's Open Access Plus Network prior to receiving services.*

****Out-of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by an out-of-network provider, please refer to the Summary of Benefits and Coverage (SBC).*

Medical Insurance: Cigna Open Access Plus (OAP) Base Plan At-A-Glance

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your Cigna medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan please contact Cigna's Customer Service at (800) 244-6224.

Network	CIGNA Open Access Plus (OAP)	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network**
Single	$3,000	$3,000
Family	$6,000	$6,000
Coinsurance	**In-Network**	**Out-of-Network**
Member Responsibility	20%	40%
Calendar Year Out-of-Pocket Maximum	**In-Network**	**Out-of-Network**
Single	$4,000	$4,000
Family	$8,000	$8,000
What Applies to the Out-of-Pocket Maximum?	Deductible, Coinsurance, Copays and Rx	
Physician Services	**In-Network**	**Out-of-Network****
Primary Care Physician (PCP) Office Visit	$50 Copay	40% After CYD
Specialist Office Visit	$75 Copay	
Non-Hospital Services; Freestanding Facility	**In-Network**	**Out-of-Network****
Clinical Lab (Blood Work): Quest or LabCorp*	No Charge	40% After CYD
X-rays/Advanced Imaging (MRI, PET, CT) (i.e. West Coast Radiology & Rose Radiology)		
Outpatient Surgery in Surgical Center (Per Visit)	$300 Copay + 20% After CYD	$300 Copay + 40% After CYD
Outpatient Physician Services	20% After CYD	40% After CYD
Hospital Services	**In-Network**	**Out-of-Network****
Hospital Pre-admission Requirement	Yes, or you pay 100%	Yes, or you pay 100%
Inpatient	$500 PAD + 20% After CYD	$500 PAD + 40% After CYD
Physician Services at Hospital	20% After CYD	40% After CYD
Emergency Room (Per Visit; Waived if Admitted)	$150 Copay	$150 Copay
Ambulance (Emergency Services Only)	20% After CYD	20% After CYD
Urgent Care Center (Per Visit; Waived if Admitted)	$75 Copay	$75 Copay
Outpatient Rehabilitation	**In-Network**	**Out-of-Network****
Facility Charge (60 visits annual maximum)	$75 Per Visit	40% After CYD
Mental Health/Substance Abuse	**In-Network**	**Out-of-Network****
Inpatient (Prior Authorization is Required)	$100 Copay Per Admission	40% Coinsurance
Outpatient Facility (Prior Authorization is Required)	$10 Copay Per Visit	40% Coinsurance
Prescription Drugs (Retail 30 Day Supply)	**In-Network**	**Out-of-Network****
Generic	$30 Copay	40% Coinsurance
Preferred Brand Name	$40 Copay	
Non-Preferred Brand Name	$60 Copay	
Mail-Order Drug (90 Day Supply)	2x Retail Copay	Not Covered

PAD = Per Admission Deductible

**Quest Diagnostics and LabCorp are the preferred labs for bloodwork through Cigna. When using a lab other than LabCorp or Quest, please be sure to confirm they are contracted with Cigna's Open Access Plus Network prior to receiving services.*

*****Out-of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by an out-of-network provider, please refer to the Summary of Benefits and Coverage (SBC).*

Dental Insurance: Assurant and Humana Plans

Assurant
Customer Service: (800) 443-2995
www.assurantemployeebenefits.com

Humana
Customer Service: (800) 342-5209
www.compbenefits.com

The City offers a variety of dental insurance options to eligible employees through Humana and Assurant Employee Benefits. Dental insurance is 100% employee paid and semi-monthly premiums are deducted from your paycheck 24 times a year. The employee costs are shown on the premium table below. A brief description of the dental plan options and a summary of the benefits are shown below and on the following page. For detailed coverages, exclusions, and stipulations, please refer to the carrier's benefit summary or contact the carrier's customer service number.

The Prepaid Dental DHMO Plans: Assurant Low Option, Humana CS150, Humana Advantage Open Access

If you enroll in a prepaid dental plan, you must choose your dentist from a list of participating providers and make copays for your general dental needs. If a specialist is required, you must select a specialist from a list of participating specialists. You can either pay the appropriate copays from the provider's Schedule of Benefits and Subscriber copays or pay at discounted prices. Covered members must be treated by in-network dentists or specialists. Prepaid dental plan highlights include the following:

- NO deductibles or claim forms
- NO maximum benefit level
- NO preexisting condition limitation
- NO benefit waiting period for any service

The PPO/Traditional (Indemnity) Dental Insurance Plan: Humana Elite Preferred 510

Humana provides a PPO/Traditional (indemnity) dental plan that gives you freedom of choice when selecting your dental care providers. You pay the cost of dental care at the time you receive service and file a claim form. After satisfying a deductible, you will be responsible for the applicable coinsurance level depending on the type of dental service performed. Highlights of the PPO/Traditional (indemnity) Plan include the following:

- Freedom to visit a dentist of your choice at any time
- Claims must be filed
- Reduced out-of-pocket expenses when visiting participating PPO dentist
- Annual Deductible - $50 per participant for basic, major, and orthodontic services – maximum of 3 deductibles assessed per family
- Annual benefit maximum - $1,000 per person
- Orthodontics - $1,000 lifetime maximum
- No benefit waiting period for preventive and basic services; 12-month wait for major and orthodontic services

Contact Information

If you elect dental coverage, identification cards will be furnished by the carrier at the time your coverage becomes effective. If you have questions regarding claims, services or providers, please call the carrier's customer service department.

Dental Insurance – Active Employees 2016 Semi-Monthly Pay Period Premium Deductions

Tier of Coverage	Assurant Low Option	Humana CS150	Humana Advantage Open Access	Humana Elite Preferred 510
Employee Only	$4.25	$9.25	$13.93	$19.65
Employee + One Dependent	$7.19	$17.21	$25.95	$39.83
Employee + Family	$11.33	$22.40	$33.78	$58.72

Dental Insurance – Retirees 2016 Monthly Premium Rates

Tier of Coverage	Assurant Low Option	Humana CS150	Humana Advantage Open Access	Humana Elite Preferred 510
Retiree Only	$8.49	$18.50	$27.86	$39.30
Retiree + One Dependent	$14.37	$34.42	$51.90	$79.66
Retiree + Family	$22.66	$44.80	$67.56	$117.44

Dental Insurance: Assurant and Humana Plans At-A-Glance

Prepaid Dental DHMO Summary of Benefits		Assurant Low Option Plan*	Humana Plan CS150*	Humana Advantage Open Access	Aflac
Codes	Sample Procedures	Copay / Fee Schedule			Aflac Pays
	Examinations				
9430	Consultation/Office Visit	$10	$5	$0	$30
0120	Periodic Oral exam & diagnosis	$0	$0	$0	$30
	X-Rays				
0272	Bitewings 2 films	$0	$0	$0	$15
0210	Complete Series	$5	$0	$0	$15
	Preventative Care				
1110	Complete Prophylaxis (adult)	$5	$0	$0	$30
1510	Space maintainer	$70 + Lab	$45 + Lab	$137	$95
	Restorative				
2140	Amalgam-one surface	$20	$0	$19	$55
2150	Amalgam-two surfaces	$25	$0	$25	$60
2330	Resin-one surface, anterior	$45	$35	$21	$70
	Endodontics				
3310	Anterior tooth (Excludes Final Restoration)	$155	$100	$271	$175
3330	Molar Tooth	$275	$250	$428	$230
	Periodontics				
4210	Gingivectomy/ gingivoplasty (per quadrant)	$150	$125	$278	$150
4260	Osseous surgery (per quadrant)	$425	$350	$529	$150
	Prosthodontics				
5110	Complete Upper Denture	$325 + Lab	$300 + Lab	$498	$405
5120	Complete Lower Denture	$410 + Lab	$300 + Lab	$498	$405
	Fixed Crown & Bridge				
6240	Bridge pontic-porcelain fused to high noble metal/unit	$280 + Lab	$280 + Lab	$373	$290
6750	Crown-porcelain fused to high noble metal/unit	$280 + Lab	$280 + Lab	$426	$290
	Oral Surgery				
7140	Extraction single tooth	$20	$0	$58	$45
7220	Extraction-soft tissue impaction	$75	$50	$114	$100
7240	Extraction-full bony impaction	$140	$85	$177	$150
	Orthodontics* **				
8080	Orthodontics - Child (24 months)	25% discount	$1,800	$2,100	
8090	Orthodontics - Adult (24 months)	25% discount	$2,000	$2,300	

PPO / Traditional Summary of Benefits	Humana Elite Preferred Plan 510	
Benefit Schedule	In Network	Out of Network**
Annual Deductible		
Per Person	$50	$50
Family Maximum	$150	$150
Waived for Preventative?	Yes	Yes
Benefit Level		
Preventative	100%	100%
Basic	80%	80%
Major	50%	50%
Orthodontia *** (24 months)	50%	50%
Maximum Benefit		
Annual Benefit Maximum	$1,000	$1,000
Orthodontia Annual Maximum	$500	$500
Orthodontia Lifetime Maximum	$1,000	$1,000
Out-of-Network Benefits		
Payable Level	N/A	70th Percentile
Major Services	12 months	
Benefit Classification:		
Endodontics	Basic	Basic
Periodontics	Basic	Basic

** Out-of-Network Balance Billing is the difference between the "allowed amount" an insurance company will pay to an in-network provider and the higher amount that an out-of-network provider charges you. Balance Billing is in addition to your deductible and coinsurance and is your responsibility (not covered by your plan).

*** Treatment extending over 24 months is not covered and will be charged at the provider's reasonable and customary rates.

* Members must select a participating dentist from the provider listing and notify the carrier of your selection in order for benefits to be payable.

Vision Insurance: HumanaVision Care Plan

Humana
Customer Service: (800) 865-3676
www.compbenefits.com

The City offers vision insurance through Humana's CompBenefits. A brief description of the HumanaVision Care plan and summary of benefits is provided below. Vision insurance is 100% employee paid and semi-monthly premiums are deducted from your paycheck 24 times a year. The employee costs per pay period are shown on the premium table to the right. For detailed coverages, exclusions and stipulations, please refer to the carrier's benefit summary or contact Humana's Customer Service.

Vision Insurance – HumanaVision Care Plan
Employee 2016 Semi-Monthly Premium Deductions

Tier of Coverage	Employee Cost
Employee Only	$2.96
Employee + One Dependent	$5.92
Employee + Family	$7.91

Vision Insurance – HumanaVision Care Plan
2016 Monthly Premium Rates

Tier of Coverage	Retiree Cost
Retiree Only	$5.92
Retiree + One Dependent	$11.84
Retiree + Family	$15.82

In-Network Benefits

The vision plan offers you and your covered dependents coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, covered members can select any optometrist or ophthalmologist that participates in the **HumanaVision Care Network**. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic services and optional upgrades are available at an additional wholesale cost. There is no Calendar Year Deductible or Out-of-Pocket Maximum, however, there are benefit reimbursement maximums for certain services per calendar year.

How to Locate a Provider

To search for a participating provider please contact Humana's Customer Service or visit www.compbenefits.com. Under the "Providers/Search" tab, select "Find Vision Providers." Then, choose "**VisionCare Plan**" as your plan type, complete the additional search criteria and click "Search."

Please Note: *Member options, such as Lasik, UV coating, progressive lenses, etc. are not covered in full, but may be available at a discount.*

Services	In Network
Eye Exam	$10 copay (once every 12 months)
Lenses (single, bifocal, trifocal)	$15 copay (once every 12 months)
Frames	$90 credit on retail (once every 24 months) $45 credit on wholesale price (once every 24 months)
Contact Lenses Non-elective (Medically Necessary)*	100% after $15 copay (once every 12 months)
Contact Lenses Elective (Fitting, Follow-up & Lenses)*	Up to $105 Allowance (once every 12 months)

Contact Humana's Customer Service for an out-of-network reimbursement schedule.

*Contact lenses are in lieu of lenses/frames. Medically necessary contact lenses require prior authorization.

Employee Assistance Program

Cigna Behavioral Health
Customer Service: (877) 622-4327
www.cignabehavioral.com
Employer ID: clearwater

The City provides at no cost to you a comprehensive Employee Assistance Program (EAP), which is available to you and each member of your family covered under the City's medical insurance through Cigna's Employee Assistance Program. The EAP offers unlimited telephonic counseling and up to 5 face-to-face sessions, per member per issue, with a licensed professional through a confidential program that is protected by state and federal laws. The EAP program is available to help you gain a better understanding of problems that affect you, locate the best professional help for your particular problem, and decide upon a plan of action. All EAP counselors are professionally trained, certified, and licensed in their fields.

What is an Employee Assistance Program?

An Employee Assistance Program (EAP) offers covered employees and their family members free and convenient access to a range of confidential and professional services to help them address a variety of problems that can negatively affect their well-being such as:

- Anxiety
- Stress
- Depression
- Life improvement
- Family and/or marriage problems
- Grief and bereavement
- Substance abuse
- Gambling and other addictions
- Legal and financial concerns

Are Services Confidential?

Yes. Voluntary participation in EAP services is completely confidential. However, participation in the EAP may be the direct result of a Management Referral (a referral initiated by a supervisor or manager), in which case permission to communicate certain aspects of the employee's care (attendance at sessions, adherence to treatment plans, etc.) to the referring supervisor/manager may be requested or required. The referring supervisor will not receive specific information regarding the referred employee's care. The supervisor will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

Please Note: *Mental Health and Substance Abuse is a covered medical benefit under the City's group medical insurance plans with Cigna. However, there is still some assistance available through the City's EAP program that may be beneficial for acute situations, such as face-to-face or telephonic counseling sessions. For more information regarding the EAP offerings for these conditions, please contact Customer Service or log onto the cignabehavioral.com site using the employer ID above.*

Life Insurance

Contact: Human Resources
Phone: (727) 562-4870

The City provides each benefit eligible employee with life insurance in the following amounts at no cost to the employee:

- CWA – One and one-half times your annual base salary up to a maximum of a $50,000 benefit
- FOP and IAFF – $2,500 benefit
- SAMP – $2,500 benefit plus one times your annual base salary
  - SAMP employees also have the ability to purchase additional coverage in increments of $50,000 up to a maximum of 5 times annual salary or $500,000. Newly hired or newly eligible SAMP employees can elect up to $150,000 coverage without submission of Evidence of Insurability for up to 31 days following their initial date of eligibility. Any election of life insurance more than 31 days after the date of initial eligibility and/or the election of any amount exceeding $150,000 will require the submission of Evidence of Insurability and approval by the carrier.

Contact Human Resources for plan details and premium rates.

Voluntary Supplemental Insurance: Aflac Individual Plans

Aflac
Agent: Frank D'Ascoli
Phone: (727) 514-7977
email: Frank.DAscoli@verizon.net

The City offers a variety of supplemental insurance plans through Aflac. Aflac plans may be purchased separately on a voluntary basis and premiums payroll deducted. Aflac pays money directly to you, regardless of what other insurance plans you may have. A description of each available plan and bi-weekly premium rates have been provided below. To learn more about these Aflac plans and/or schedule a personal appointment, contact the City's Aflac Agent, Frank D'Ascoli, at (727) 514-7977.

Aflac Individual Accident Plan

Covers on-the-job and off-the-job injuries due to accidents for the employee and covered family members. Since this plan is an individual policy you can keep your current accident plan and add this individual policy (or) you can replace your current accident plan. However; if you drop your individual accident plan, you will not be able to enroll in it again as it is no longer available for sale

Clerical employees not involved in labor. 80% office.			
Employee	$9.69	**One Parent Family**	$15.67
Employee & Spouse	$13.65	**Two Parent Family**	$19.63

Hospital Advantage Plan

Aflac will pay a hospital confinement benefit of $2,000 when a covered person is confined for 23 hours or more. $2,000 benefit will be paid if hospital confinement occurs 90 days from the previous confinement. No Lifetime Maximum. Benefits also include $25 physician visit reimbursements, Diagnostic Imaging, in-patient and out-patient surgery and daily hospital confinement. See policy brochure for details.

	Option 1	Option 1 & 2	Option 1, 2 & 3	Option 1, 2, 3 & 4
Individual	$28.41	$32.37	$36.08	$40.89
One Parent Family	$36.40	$43.81	$47.97	$53.04
Employee & Spouse	$43.68	$51.94	$58.70	$67.63
Two Parent Family	$45.96	$55.64	$62.27	$69.42

Voluntary Supplemental Insurance: Aflac Individual Plans *(Continued)*

Cancer Care Plan

Although medical insurance is usually adequate for most illnesses, it cannot always withstand the financial burden cancer can impose on you and your family.

Individual: $14.04	**One Parent Family**: $14.04	**Employee & Spouse** $25.42	**Two Parent Family**: $25.42

Critical Care and Recovery Plan

Level I with $500 Annual Building Benefit Rider - Medical science and early, fast detection have increased survival rates for many serious medical conditions. Aflac provides the financial assistance to help you get back on your feet if you are faced with expensive treatment and loss of income for any of the specified health events listed.

Ages	Individual	One Parent Family	Employee + Spouse	Two Parent Family
18 - 35	$5.72	$6.31	$8.84	$9.95
36 - 45	$9.23	$9.62	$15.15	$16.38
46 - 55	$12.35	$12.74	$21.32	$22.82
56 - 70	$16.06	$16.51	$29.45	$31.20

Short Term Disability

Guaranteed Issue Benefits. Provides coverage for disabilities resulting from a covered sickness or off-the-job injury. 3-month Disability Benefit Period. 7-day Elimination Period. Benefits payable when policyholder's earnings are less than 80% of pre-disability salary.

Annual Income		$17,000	$22,000	$24,000	$26,000	$27,000	$29,000	$32,000	$34,000	$36,000	$38,000	$39,000
Monthly Benefit		$1,000	$1,100	$1,200	$1,300	$1,400	$1,500	$1,600	$1,700	$1,800	$1,900	$2,000
Age	18-64	$11.05	$12.16	$13.26	$14.37	$15.47	$16.58	$17.68	$18.79	$19.89	$21.00	$22.10
	65-74	$13.65	$15.02	$16.38	$17.75	$19.11	$20.48	$21.84	$23.21	$24.57	$25.94	$27.30

Aflac Dental Plan

Aflac's dental plan supplements your current dental plan by providing cash benefits directly to you for dental services. There is no network however; waiting periods may apply depending on services needed. Policy annual maximum $1,400 per covered person. See page 12 for benefits.

Individual: $11.64	**One Parent Family**: $20.35	**Employee & Spouse** $20.48	**Two Parent Family**: $29.32

Flexible Spending Accounts

Administered by: WageWorks/Aflac
Agent: Frank D'Ascoli
Phone: (727) 514-7977
Fax forms to: (877) 353-9256
www.takecarewageworks.com

If you have predictable healthcare expenses for yourself or your family, such as deductibles and copays, or any work-related day care expenses, the City of Clearwater offers Flexible Spending Accounts (FSA) administered through Aflac by WageWorks. FSA allow you to redirect a portion of your salary to pay for unreimbursed medical and dependent care expenses you may incur. The amount you set aside is not taxed and is automatically deducted from your paycheck and deposited into the FSA. During the year, you have access to this account for reimbursement of some expenses that are not covered by insurance. An FSA not only results in a substantial tax savings, it also increases your spending power. There are two types of FSAs:

Health Care Reimbursement Account	Dependent Care Reimbursement Account
This account allows you to redirect up to an **annual maximum of $2,550.** These dollars will not be taxable income to you and may be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs for you or your qualified dependents. Employees may also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic). Examples of common expenses that qualify for reimbursement are listed below. ***NOTE: The entire Health Care FSA election is available to you on the first day coverage is effective.**	This account allows you to redirect up to an **annual maximum of $5,000 if you are single or married and file a joint tax return ($2,500 if you are married and file a separate tax return)** for work-related day care expenses. Qualified expenses include adult and child day care centers, preschool, and before/after school care for eligible children and adults. Please note that if your family's annual income is over $20,000, this reimbursement option will most likely save you more money than the dependent care tax credit you take on your tax return. To qualify, your dependent must be: • a child under the age of 13, or • a child, spouse or other dependent that is physically or mentally incapable of self-care and spends at least 8 hours a day in your household. ***NOTE: Unlike the Health Care FSA, you will only be reimbursed up to the amount that has been deducted from your paycheck for Dependent Care expenses.**

A sample list of qualified expenses eligible for reimbursement include, but are not limited to, the following:

- Ambulance service
- Chiropractic care
- Dental fees/orthodontic fees
- Diagnostic tests/health screenings
- Doctor fees
- Drug addiction/alcoholism treatment
- Experimental medical treatment
- Eyeglasses/contact lenses (corrective)
- Hearing aids and exams
- Injections & vaccinations
- Lasik surgery
- Mental healthcare
- Nursing services
- Optometrist fees
- Physician office visits
- Prescription drugs
- Sunscreen
- Wheelchairs

Log on to http://www.irs.gov/publications/p502/index.html for additional details regarding qualified and non-qualified expenses.

Flexible Spending Accounts *(Continued)*

FSA Guidelines

- **You must make a new election in BenTek each year.**
- **You may carry over up to $500 of unused funds from your Healthcare Reimbursement Account into the next plan year after a plan year ends and all claims have been filed. Dependent Care funds CANNOT be carried over.**
- **After a plan year ends and all claims have been filed any unused funds cannot be returned to you or carried forward to the next plan year, with the exception of the $500 carry over that may be allowed for the Healthcare Reimbursement Account.**
- You can enroll in either or both FSAs during open enrollment period, a qualifying event, or new hire eligibility only.
- You cannot transfer money between FSAs.
- You cannot pay a dependent care expense from your Health Care FSA or vice versa.
- You cannot deduct reimbursed expenses for income tax purposes.
- You cannot be reimbursed for a service which you have not received.
- You cannot receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
- You have a run out extension at the end of the plan year (90 days) to claim reimbursement for eligible expenses incurred during your period of coverage within the plan year (January 1st - December 31st).
- Domestic Partners are not eligible, as federal law does not recognize them as qualified dependents.
- **Irrevocable Election Rule: IRS rules prohibit the modification and/or revocation of elections before the beginning of the next plan year unless there is a qualifying change in status (i.e., change in marital status, employment status, work schedule, number of tax dependents, dependents' eligibility or worksite, or as otherwise defined by the IRS). The change must be a result of and correspond with the change in status (as determined by your employer/plan administrator)**

Here's How It Works

An Employee earning $30,000 elects to place $1,000 into an FSA Health Care Savings Account, with payroll deductions amounting to $41.66 based on a 24 pay schedule. Health care expenses can then be paid with tax-free dollars from the account; resulting in a tax savings of $165 for the employee.

	With FSA	Without FSA
Salary	$30,000	$30,000
FSA Pre-Tax Contribution	- $1,000	- $0
Taxable Pay	$29,000	$30,000
Estimated Tax (16.45% = 15% Payroll + 1.45% Medicare)	- $4,770	- $4,935
Unreimbursed After-Tax Expenses	- $0	- $1,000
Spendable Income	$24,230	$24,065
Tax Savings	**$165**	

NOTE: Be conservative when estimating your medical and/or dependent care expenses. IRS regulations state that any unused funds which remain in your FSA after a plan year ends and after all claims have been filed, cannot be returned to you or carried forward to the next plan year, with the exception of the $500 carry over that may be allowed for the Healthcare Reimbursement FSA. This is known as the "USE IT OR LOSE IT" rule.

Debit Card

Employees who are electing an FSA for the first time will be provided with a debit card pre-loaded with the dollar amount available. Employees who currently have a debit card from the prior year can keep their card and new elections will be pre-loaded for 2016. If you do not still have your debit card from 2015, you can request a new one online through the EBC. Your elected amount will continue to be deducted semi-monthly from your paycheck just as it is now, but there will be no need for submitting paperwork to receive reimbursements. Just present your debit card to pay for FSA eligible expenses. Most eligible services or items are automatically tabulated as FSA qualified when you use your debit card. As a reminder, over-the-counter items are no longer considered a qualified expense, unless prescribed by a physician. You can find a list of qualified and non-qualified expenses at http://irs.gov/publications/p502/index.html.

Filing a Claim

Some service providers may not have the ability to accept a debit card, so you may want to confirm with them beforehand. If a service provider does not accept the debit card, you may pay for the services and submit a paper claim for reimbursement to WageWorks, which will be administering the FSA benefits on behalf of Aflac. Paper claim forms may be obtained from Human Resources, on the City Intranet or the online Employee Benefits Center, or directly from the Wageworks website at www.takecarewageworks.com, where you can also view the status of your account at any time. Documentation may also be required for some claims. Please maintain all receipts for FSA related services for the entire plan year.

Notices

COBRA Continuation of Medical Coverage Benefits

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), employees and/or dependents may be able to continue their enrollment in certain health plans such as medical and dental, if such coverage is terminated or changed due to a qualifying event.

Medicare D Creditable Coverage

Clearwater's prescription drug coverages are considered Creditable Coverage under Medicare Part D. If you or your dependents are or will be eligible for Medicare, you may obtain more information by requesting a Medicare D Disclosure of Creditable Coverage Notice.

Notice of Privacy Practice of City of Clearwater

The Privacy Notice of the City is available and you can obtain a copy by contacting Human Resources.

More information is available on the above notices by contacting Human Resources/Benefits.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end.

An employee, spouse/domestic partner of an employee or a dependent child of an employee covered by the City's group health plan has the right to choose this continuation coverage when coverage is lost for any of the reasons provided below:

Employee:	1) Reduction in hours of employment (that disqualifies group insurance participation eligibility); or 2) Termination of employment (for reasons other than gross misconduct).
Spouse/Domestic Partner of an Employee:	1) The death of your spouse/domestic partner; or 2) A termination of your spouse's/domestic partner's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment; or 3) Divorce or legal separation from your spouse/domestic partner; or 4) Your spouse/domestic partner becomes entitled to Medicare.
Dependent Child of an Employee:	1) The death of a parent; or 2) A termination of the parent's employment (for reasons other than gross misconduct) or a reduction in the parent's hours of employment with the City; or 3) Parent's divorce or legal separation; or 4) A parent becomes entitled to Medicare; or 5) The dependent child ceases to be a "dependent child" under the City's group health plan.

COBRA and HIPAA

COBRA - Continuation of Group, Medical, Dental and Vision Insurance, Under the City's Employee Benefit Plans

Do I Have to Notify the City of Any Qualifying Events Under COBRA?

Employees or their families must notify the City within 60 days of the date coverage would otherwise terminate in the event of a divorce, legal separation, or when a child no longer qualifies as a covered dependent under the plan. Individuals failing to notify the Human Resources Department of these events within the 60-day period will not be permitted to continue coverage.

How Long Can I Continue Coverage?

In general, you can continue coverage for up to 18 or 36 months, depending on the qualifying event. If the qualifying event is employment termination or reduction in hours, the maximum period of time you can continue coverage is 18 months from the date of the qualifying event. For other qualifying events, the maximum period is 36 months. If a second qualifying event occurs, the maximum coverage period will be extended from 18 months to 36 months, measured from the date of the first qualifying event.

Can the City Terminate My Continuation Coverage Before the Maximum Coverage Period Ends?

The City can terminate a person's continuation coverage before the maximum coverage period ends for any of the following reasons:

- **Payment for the person's coverage is not received on a timely basis;**
- **The person becomes covered by another group health plan maintained by another employer that does not limit or exclude coverage for any preexisting medical condition of the person;**
- **The person becomes covered by Medicare (except a person covered by Medicare because of end stage renal disease or because the person is a disabled active individual); and/or**
- **The City ceases to provide group health plan coverage for all active employees.**

Do I Have to Pay for My Continuation Coverage?

You must pay the full cost of continuation coverage plus 2% for the City's administrative costs. The information on the cost of continuation coverage and the payment terms will be included in notices to individuals who have a qualifying event.

May I Obtain Conversion Coverage When My Continuation Coverage Terminates?

When continuation coverage terminates, you can purchase an individual medical policy without proof of insurability. This conversion privilege is also available if you decline continuation coverage.

Who Can I Contact If I Have Questions About Continuation Coverage?

If you have any questions about continuation coverage, please contact the Human Resources Department at 562-4870.

Can I Have More Than One Qualifying Event?

Sometimes, a spouse or dependent child can have more than one qualifying event. A second qualifying event occurs if these three conditions are met:

- The first event is the employee's employment termination or reduction in hours;
- The second event gives rise to 36 months of continuation coverage (i.e., a covered employee's death or divorce); &
- The second event takes place while continuation coverage was effective.

What Is HIPAA?

HIPAA is the Health Insurance Portability and Accountability Act of 1996. The Act is intended to provide protection from preexisting conditions limitations for employees and their dependents (qualified beneficiaries) when moving from job to job. Health plans now must provide qualified beneficiaries with proof or "certification" of the dates of their most recent period of "creditable coverage." This certification provides the qualified beneficiary proof of their coverage from the receiving plan. Certificates are provided to qualified beneficiaries losing coverage at the following times:

- **When the qualified beneficiary loses coverage – whether or not coverage continues under COBRA;**
- **When the individual loses coverage under COBRA; and/or**
- **Upon request within 24 months of the loss of coverage.**

Retirement Benefit Summary

The City of Clearwater allows employees upon retiring to continue almost all benefits. Retirees that elect to continue City benefits will have premiums paid as an after-tax deduction from their pension benefit. Retirees will be responsible for the full monthly premium cost for each benefit continued; the City does not subsidize any portion of benefits for retirees. Upon retiring, if the retiree opts out of coverage, he/she will no longer be eligible to participate in the City's plans.

Retirees will not be able to continue flexible spending accounts (which may be continued through COBRA) and the life insurance (which may be continued through direct payment to the provider).

Disability Retirement Benefit

The City allows retirees to apply for non-work related disability benefit. This benefit matches the active employee disability benefit but is only available upon retirement if the employee has completed at least 10 years of pensionable service.

Retirees will also be allowed to apply for work related disability benefit. This benefit will either match the active employee disability benefit or a minimum percentage of the final monthly compensation (42% for Non-Hazardous Duty or 66 2/3% for Grandfathered and Hazardous Duty participants) whichever is greater, as long as they are participating in the plan.

Pension Benefits

The City of Clearwater Employees' Pension Plan is an IRS-qualified, defined benefit plan, self-administered by the City of Clearwater and created for the sole purpose of providing retirement benefits to its participants. The contribution and benefit will depend on an employee's job classification and participation date, prior to retiring.

Please Note: *The reference "Granfathered" is defined as an employee who was eligible for normal retirement and contributing to the pension prior to the ordinance changes on 1/1/13.*

How much of my own earnings do I contribute to the pension?

- Grandfathered - Participants contribute 8% of pensionable earnings, including special pays and overtime.
- Non-Hazardous Duty - Participants contribute 8% of base compensation.
- Hazardous Duty - Participants contribute 10% of pensionable earnings, including special pays and overtime (up to 300 hours per calendar year).

The City contributes an amount determined annually by the plan actuary based on the plan's performance. Not less than 7% of basic compensation for all employees participating. Also, all deductions are on a pre-tax basis. Employees participating in the pension plan do not contribute to Social Security (OASDI) during that time; although most do have Medicare (HI) taxes deducted.

Pension Benefits *(Continued)*

Participants may opt to elect other forms of retirement, each of which will be calculated at the actuarial equivalent of the normal form based on the biographical data of the participant and the beneficiary.

- **Joint and Survivor Annuity** - An annuity paid monthly for the life of the participant. Upon death, 100% paid to the surviving spouse, and if none, the surviving children under the age of 18, for a period of five years, after which time the benefit is reduced by 50% for the life of the beneficiary or until the spouse remarries or the child reaches the age of 18, whichever comes first. (*Non-Hazardous Duty employees, if you are not Granfathered, this option is not available*).
- **Single Life Annuity** - An annuity paid monthly for the life of the participant.
- **10-Year Certain and Life Annuity** - An annuity paid monthly for the life of the participant with 120 payments guaranteed.
- **50, 75, 100 or 66 ⅔% Joint and Survivor Annuity** - An annuity paid monthly for the life of the participant. Upon death, 50%, 75%, 100% or 66 ⅔% is paid to the surviving beneficiary for life.

In addition to the above options, **a Partial Lump Sum** option is available. This allows retirees to receive 10%, 20% or 30% of their normal retirement benefit as a one-time lump sum payment received in the first pension benefit payment, with the monthly benefits reduced accordingly thereafter. This lump sum amount is eligible for rollover.

When can I retire on pension?

- **Grandfathered** – Participants must either complete 30 years of pensionable service, 20 years of service and be at least age 55 or 10 years of service and be at least age 65.
- **Non-Hazardous Duty** - Participants must either complete 25 years of pensionable service and be at least age 60 or complete 10 years of pensionable service and be at least age 65.
- **Hazardous Duty** - Participants must either complete 20 years of pensionable service or complete ten years of pensionable service and be at least age 55. (*There is an early retirement option for Hazardous Duty participants, which pays as early as age 50 after ten years of pensionable service, with a 3% reduction for each year below the age of 55*).

How is my retirement benefit calculated?

- For Granfathered and all Hazardous Duty participants, the normal monthly benefit formula is: 2.75% multiplied by the number of years of credited service multiplied by final monthly compensation.

Example:	
Final Avg. Compensation	$43,200
X Pension Factor	0.275
X Credited Service	25
Annual benefit	$29,700
Monthly Benefit	**$2,475**

- For Non-Hazardous Duty participants, the normal monthly benefit formula is: 2% multiplied by the number of years of credited service multiplied by final monthly compensation.

Example:	
Final Avg. Compensation	$43,200
X Pension Factor	0.2
X Credited Service	25
Annual benefit	$21,600
Monthly Benefit	**$1,800**

What if I leave the City of Clearwater before I am eligible to retire?

- If you have completed at least ten years of pensionable service, you may vest your interest in the plan and begin to collect a retirement benefit when you would otherwise have been eligible, while working for the City of Clearwater.
- If you have less than ten years of pensionable service or do not wish to vest, you may elect to receive a refund of your contributions to the plan plus 5% simple interest.

What if I pass away as an active employee?

- If you have a named beneficiary on file, that person will be able to select either a refund of employee contributions or a monthly retirement benefit, depending on his/her preference and whether or not you completed at least ten years pensionable service.
- If there is no beneficiary on file, a refund of contributions will be paid to your estate unless you are married or have minor children at the time of death, in which case they may receive a limited benefit.

What are the rules regarding a beneficiary to my pension benefit?

- Participants are encouraged to elect a beneficiary to be kept on file in the event of pre-retirement death. Until retirement, participants may elect to change the beneficiary at any time.
- After retirement, the beneficiary may be changed twice, depending on the option selected, which will result in a recalculation of the monthly benefit amount.
- Only one beneficiary may be named at a time.

For more information regarding your retirement benefits and options available, you can visit the City intranet site and view the City Code of Ordinances which describes, in detail, the provisions of the retirement plans. You may also contact Jennifer Moulton, the Senior Pension Payroll Analyst, at (727) 562-4523 or Jennifer.Moulton@MyClearwater.com with additional questions, request an estimate or to make an appointment to complete retirement paperwork.

Notes

Use this section to make notes regarding your personal benefit plans or to keep track of important information such as doctor's names and addresses or prescription medications.

GEHRING GROUP

11505 Fairchild Gardens Ave., Suite 202
Palm Beach Gardens, Florida 33410
Toll Free: (800) 244-3696; Fax: (561) 626-6970
www.gehringgroup.com

FINAL Revised 2 – Last Modified:
March 29, 2016 1:42 PM

EXHIBIT 3
Sample Employee Communications

2013-2014

August 1st - 22nd
OPEN ENROLLMENT

Employees who are not making any changes do not need to do anything as you will automatically be re-enrolled in your current coverage. If you are making changes for the 2013-2014 Plan Year, such as adding or deleting dependents, changing your beneficiary, or adding or dropping different lines of coverage, follow these simple steps:

1. Log on to https://www.mybentek.com/charlottecounty.
2. Enter your username and password.
3. Select the Open Enrollment menu option.
4. Enter the Employee Benefits Center (EBC) to review current elections and make any elections or changes.
   - Make sure your life insurance beneficiary is current or update accordingly.
5. Once you complete your elections, print out your confirmation statement containing all your benefit elections for you and your family including your life insurance beneficiary designations.

Return to the Employee Benefits Center at any time to review your benefits, access carrier links, update life insurance beneficiaries and obtain other important benefit-related information.

Enrolling For Your Benefits Has Never Been Easier!

To access your benefits online, visit the Employee Benefits Center at:
www.mybentek.com/charlottecounty

Hernando County

2014|2015

EMPLOYEE BENEFIT ON-LINE OPEN ENROLLMENT

BEGINS THURSDAY, JULY 31 — ENDS MONDAY, AUGUST 18

Representatives from Florida Blue, Florida Combined Life, Hartford, Aflac, and Gehring Group will be present to answer any questions regarding your insurance plans.

BENEFIT MEETING SCHEDULE

General Benefit Information Provided.

Monday, Aug. 4

10:00 am – 11:00 am
Spring Hill Library

3:00 pm – 4:00 pm
Westside Library

Tuesday, Aug. 5

10:00 am – 11:00 am
Govt Ctr Jury Room

2:30 pm – 3:30 pm
DPW

Wednesday, Aug. 6

8:00 am – 9:00 am
Development

11:00 am – 12:00 pm
Utilities Admin

3:00 pm – 4:00 pm
Govt Ctr Jury Room

Thursday, Aug. 7

8:00 am – 9:00 am
Utilities – Wiscon Maintenance Facility

10:00 am – 10:30 am
10:30 am – 11:00 am
Westside Government Center, Utilities Customer Service Office

FOLLOW-UP EMPLOYEE SERVICE DATES

As needed one-on-one assistance with benefits.

Friday, Aug. 8

8:00 am – 12:00 pm
HCFRD Spring Hill Training Rm.

Monday, Aug. 11

10:00 am – 3:00 pm
Govt Ctr, Clerk Training Room

Thursday, Aug. 14

8:00 am – 12:00 pm
HCFRD Headquarters

10:00 am – 3:00 pm
Govt Ctr, Clerk Training Room

Friday, Aug. 15

8:00 am – 12:00 pm
HCFRD Headquarters

1:00 pm – 4:00 pm
HCFRD Spring Hill Training Rm.

Tuesday, Aug. 12

7:45 am – 10:00 am
Utilities – Wiscon Maintenance Facility

10:00 am – 3:00 pm
Govt Ctr, Clerk Training Room

1:00 pm – 3:00 pm
Northwest Landfill

Monday, Aug. 18

9:00 am – 5:00 pm
Govt Ctr – HR Room 264

Wednesday, Aug. 13

7:00 am – 10:00 am
DPW

10:00 am – 3:00 pm
Govt Ctr, Clerk Training Room

11:00 am – 1:00 pm
Westside Government Center in the Utilities Customer Service Office

3:00 pm – 4:30 pm
Development Office

During open enrollment, employees may view current benefit elections and make plan changes as well as UPDATE life insurance beneficiaries on BenTek!

www.mybentek.com/hernandocounty

BenTek Support Line: (888) 5-BenTek (523-6835)

Martin County

BOARD OF COUNTY COMMISSIONERS

PLAN YEAR: JANUARY 1, 2014 - DECEMBER 31, 2014

OPEN ENROLLMENT

Benefit eligible employees may make new benefit elections or changes to their current elections during the 2014 Open Enrollment period which begins October 21st and runs through November 19th.

All new elections or changes made during Open Enrollment will be effective January 1, 2014.

All benefit eligible employees are invited to attend one of the Open Enrollment information meetings scheduled below.

MEETING SCHEDULE

Tuesday, October 22 – 10:00 AM & 11:00 AM
Martin County Property Appraiser's

Thursday, October 24 – 9:00 AM
Martin County Tax Collector (Willoughby Blvd)

Thursday, October 24 – 11:00 AM
Martin County Public Safety Complex –
Fire Rescue Conference Room

Thursday, October 24 – 1:30 PM & 3:30 PM
Martin County Courthouse - Jury Assembly Room

Friday, October 25 – 8:30 AM
Martin County Public Safety Complex –
Fire Rescue Conference Room

Friday, October 25 – 11:00 AM
Martin County General Services – GSD Conference Room

Friday, October 25 – 2:00 PM
Martin County Admin Bldg - Workshop Conference Room

Monday, October 28 – 9:00 AM
Building Department - BD Conference Room

Monday, October 28 – 11:00 AM
Martin County Admin Bldg - Workshop Conference Room

Monday, October 28 – 2:00 PM ***RETIREES ONLY***
Martin County Admin Bldg - Commission Chambers

Tuesday, October 29 – 9:00 AM
Martin County Tax Collector (Hobe Sound)

Tuesday, October 29 – 11:00 AM
Martin County Public Safety Complex –
Fire Rescue Conference Room

Wednesday, October 30 – 9:00 AM
Parks Department - Frances Langford Dockside Pavillion

Tuesday, November 19 – 9:00 AM - 4:00 PM
Martin County Admin Bldg –
Growth Management Conference Room

THIS IS THE LAST DAY TO MAKE CHANGES!
A Benefits Administrator and Aflac Representative will be onsite to assist those with last minute changes.

BENEFITS FAIR

WEDNESDAY, OCTOBER 23, 2013

9:00 AM - 1:00 PM

Blake Library – John F. Armstrong Wing
2351 SE Monterey Road, Stuart, Florida

AVOID THE PREMIUM INCREASE

For the 2013/2014 Health Insurance Plan Year employee contributions will be increased by $50.00 per month. This contribution increase will occur with the first pay period in January 2014. However, to encourage employee wellness a waiver of this premium increase will be made available for employees who test negative for nicotine or through completion of a tobacco cessation program for those employees who use tobacco. Both the nicotine testing and tobacco cessation program are at no cost to the employee and are provided through the Employee Health Center.

How do I qualify for the premium increase waiver?

1. Complete a nicotine test between May 1, 2013 and September 1, 2013. Nicotine tests will be administered at the Employee Health Clinic and can be requested at the time of your Personal Health Risk Assessment.
2. Testing negative for nicotine will automatically qualify you for the premium increase waiver.
3. If you test positive for nicotine you can complete a Tobacco Cessation Program through the Employee Health Center to qualify for the premium increase waiver. You must complete the Tobacco Cessation Program by December 1, 2013 to get the premium increase waiver.
4. Employees that do not take the nicotine test between May 1, 2013 and September 1, 2013 or that test positive for nicotine and do not complete a Tobacco Cessation Program by December 1, 2013 will **NOT BE ELIGIBLE** for the premium increase waiver.

THE HIGH COST OF TOBACCO

According to the Centers for Disease Control (CDC) tobacco use adds an average of between **$1,300 and $1,600** per year in medical costs, and $1,700 absenteeism and loss of productivity as compared to a non-tobacco user.

Businesses pay an average of **$2,189 in workers' compensation** costs for tobacco users, compared with $176 for non-tobacco users.

Tobacco use causes numerous cancers including cancers of the lung, bladder, oral cavity, larynx, esophagus, cervix, kidney, pancreas, and stomach. **Smoking causes 87% of lung cancer cases.**

Tobacco users have approximately **30%** higher risk of hospitalization than non-tobacco users and die 13 to 14 years earlier than non-tobacco users.

SMOKING IS THE LEADING CAUSE OF PREVENTABLE DEATH IN THE U.S. AND GLOBALLY!

Tobacco users are **2-4 times** more likely to develop heart disease and 2 times more likely to have a stroke than non-tobacco users.

Please contact risk management for tobacco cessation programs that are available to you at no cost.

We want to be a healthy, fit, and happy Charlotte County!

The Human Resources Department cordially invites all employees and their family members to attend the:

Osceola County Sheriff's Office

2015 HEALTH FAIR

FRIDAY, NOVEMBER 6 • 2:00 PM UNTIL 6:00 PM

OCSOWell 25

Attendance is worth **25 points** for your Wellness Reimbursement Program
Payable to those who complete the Minimal Requirements

WHERE:
911 Communications Parking Garage

COME BY THE HEALTH FAIR TO RECEIVE:


Cooking Demonstration With Food Tasting


Health Screenings


Chair Massages


Flu Shots

2013 - 2014

Employee Benefits Open Enrollment

All benefit eligible employees may make new insurance elections or changes to their current coverage for the new plan year effective October 1, 2013. To learn more about your insurance benefits, you may attend one of the following informational meetings:

Wednesday, July, 31

Room 166, Lecanto Government Building

9:30am – 10:15am

11:00am – 11:45am

1:30pm – 2:15 pm

Plan Year Effective October 1, 2013 through September 30, 2014

CSC Flu Shot Clinic

Tuesday, October 28, 2014

9:00 am to Noon, Located in the Conference Room 149

CSC Cigna Members:
Please remember to bring your Cigna ID card for a complimentary flu vaccination.

CSC Non-Cigna Members:
The cost is $25 and can be paid direct to CSC via check.

If you have any questions and to schedule an appointment, please contact Paulina at ext. 2173.

Children's Services Council
PALM BEACH COUNTY

yourLOGO

Healthfully PROUD

LUNCH & LEARN

Baptist Health Presents:

The Heart Truth
Heart Healthy Eating

Tuesday, March 5th, 2013
12:00pm – 1:00pm
City Hall - Activity Room

Heart disease is the leading cause of death in both men and women in the United States. Many of us don't know the warning signs and symptoms that may prevent a heart related fatality. Join us to learn about heart disease prevention and management today!

Lunch will be provided!

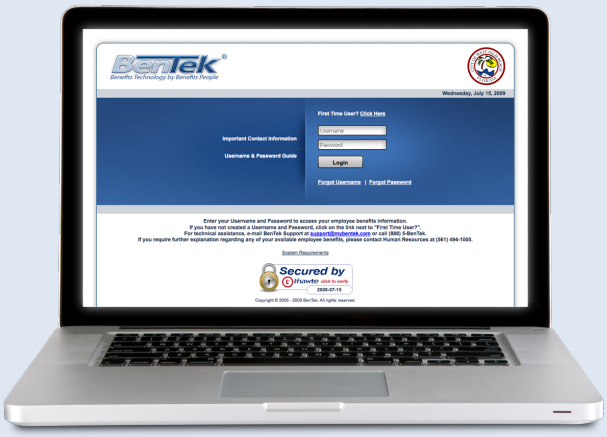
Please RSVP with Yaritza Ferrer by Wednesday, February 27th at extension 4130.

2013

Open Enrollment

Begins November 1st and lasts thru November 30, 2012

General Employee



What you should be thinking about NOW:

- Medical, Dental, Vision and Voluntary Life Insurance plans
- Do you need to enroll your dependents or modify overage dependent coverage (age 27-30)? (Proper Documentation Required)
- Learn more about Medical / Dependent Care Flexible Spending Accounts (FSA)
- Review your AFLAC policies
- Review/Change Beneficiaries for Life Insurance and Defined Contribution/ Deferred Compensation Retirement Plans, (*should be reviewed annually/make changes as necessary*)
- The City offers domestic partner benefits to a person whom the employee shares a mutual residence within the context of a committed relationship and **who has registered** with the City pursuant to Section 42/48, Code of Ordinances, City of West Palm Beach Florida.

What you need to do beginning November 1, 2012:

- Go On-line at: www.mybentek.com/wpb
- View your current 2012 benefit elections
- Make 2013 plan year changes such as:
  Add/delete dependents, elect Flexible Spending Account dollars (*needs to be done annually – max. $2,500*), Life Insurance, etc.

Cigna, Aflac and BenTek will be present at the following locations and times

Tuesday, November 6
Waste Water
7:00 am - 9:00 am
City Hall Commission Chambers
1:30 pm - 3:30 pm

Wednesday, November 7
Complex
7:00 am - 9:00 am
Water Treatment
3:00 pm - 5:00 pm

Thursday, November 8
Water Treatment Plant
7:00 am - 9:00 am
Waste Water
3:00 pm - 5:00 pm

Tuesday, November 13
Police Dispatch
6:00 am - 8:00 am
Police Community Room
12:00 pm - 2:00 pm
Police Dispatch
4:00 pm - 7:00 pm

Wednesday, November 28
Gaines Park
8:30 am - 10:00 am

Online at: www.mybentek.com/wpb

CITY OF WEST PALM BEACH FLORIDA

(Poster shrunk to fit 8.5x11)

Feel the Beat
Dance to Fitness!

Come Join Us For Our

ANNUAL WELLNESS & BENEFITS FAIR

THURSDAY, MARCH 21ST

Civic Center - 128 E. Ocean Avenue, Boynton Beach

9 AM - 3 PM

Enjoy smoothies, complimentary health screenings, raffle prizes, and so much more!

All employees are welcome to attend!

(Poster shrunk to fit 8.5x11)

THE CITY OF MIRAMAR

SPRINTING 2WELLNESS

Employee Health Fair

Tuesday, September 18th, 2014

10am – 2pm

Location: Miramar Cultural Arts Center

Come visit local health and wellness vendors, complete your Vitality Check, Biometric Screening, and Flu Shot, enjoy a Chair Massage and more!

Employees who attend the event will be entered into a raffle for various vendor prizes!

Save the Date and remember to visit this annual event!

EXHIBIT 4
Sample Analytical Reports

Sample Client - 700 Employees
Claims Experience Report - BlueCross BlueShield of Florida
October 2013 - Present

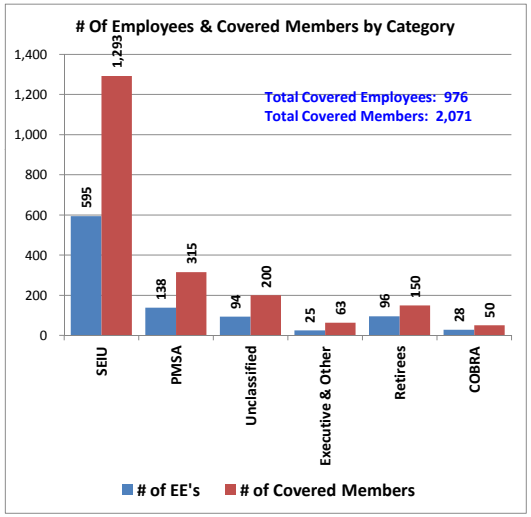
BlueChoice PPO	MONTHLY FUNDING	Inpatient Hospital	Outpatient Hospital	Physician	Other	Pharmacy Retail/Mail	TOTAL PAID CLAIMS	Florida Blue & Trust Admin Fee	Stop Loss Premium	Stop Loss Payments	Total Plan Cost	Funding vs. Cost	EE	EE+S	EE+C	EE+F	TOTAL
October-13	**$ 746,651**	$ 191,615	$ 194,578	$ 241,108	$ 90,534	$ 195,890	**$ 913,724**	$ 44,150	$ 53,564	$ -	**$ 1,011,438**	$ (264,787)	169	81	84	324	**658**
November-13	**$ 748,970**	$ 151,060	$ 126,471	$ 174,878	$ 59,874	$ 161,325	**$ 673,608**	$ 44,307	$ 53,698	$ -	**$ 771,612**	$ (22,642)	166	82	80	328	**656**
December-13	**$ 752,243**	$ 222,027	$ 136,486	$ 176,073	$ 67,062	$ 171,329	**$ 772,976**	$ 44,542	$ 53,968	$ -	**$ 871,487**	$ (119,244)	174	80	80	329	**663**
January-14	**$ 755,127**	$ 112,012	$ 109,419	$ 176,014	$ 47,513	$ 210,505	**$ 655,463**	$ 44,737	$ 54,166	$ -	**$ 754,366**	$ 761	174	80	78	332	**664**
February-14	**$ 757,999**	$ 146,907	$ 126,526	$ 178,757	$ 47,133	$ 197,058	**$ 696,381**	$ 44,959	$ 54,385	$ -	**$ 795,725**	$ (37,726)	175	78	78	335	**666**
March-14	**$ 754,908**	$ 114,370	$ 162,735	$ 293,681	$ 65,018	$ 204,830	**$ 840,634**	$ 44,794	$ 54,188	$ -	**$ 939,616**	$ (184,708)	176	76	80	333	**665**
April-14	**$ 751,702**	$ 678,762	$ 184,654	$ 221,835	$ 48,146	$ 239,384	**$ 1,372,781**	$ 44,589	$ 53,958	$ (380,477)	**$ 1,090,850**	$ (339,149)	174	76	81	331	**662**
May-14	**$ 754,431**	$ 208,525	$ 160,128	$ 226,582	$ 74,613	$ 188,211	**$ 858,059**	$ 44,743	$ 54,167	$ (24,325)	**$ 981,293**	$ (226,862)	176	76	83	331	**666**
June-14	**$ 751,663**	$ 211,599	$ 147,063	$ 220,484	$ 28,637	$ 205,611	**$ 813,394**	$ 44,565	$ 53,988	$ (107,610)	**$ 1,019,557**	$ (267,895)	175	75	87	328	**665**
July-14	**$ 752,948**	$ 97,067	$ 133,597	$ 191,627	$ 72,252	$ 265,488	**$ 760,031**	$ 44,660	$ 54,090	$ (28,944)	**$ 887,725**	$ (134,777)	175	74	88	329	**666**
August-14	**$ 750,783**	$ 126,671	$ 161,789	$ 192,259	$ 98,511	$ 239,429	**$ 818,659**	$ 44,545	$ 53,945	$ (28,944)	**$ 946,093**	$ (195,309)	176	73	88	328	**665**
September-14	**$ 750,051**	$ 103,870	$ 151,286	$ 180,116	$ 99,247	$ 258,547	**$ 793,067**	$ 44,515	$ 53,930	$ (28,944)	**$ 920,456**	$ (170,405)	180	71	91	326	**668**
Estimated Stop Loss Reimbursement												**$ 731,503**					
Pharmacy Rebate Program												**$ 37,021**					
2013-2014	**$ 9,027,477**	**$ 2,364,485**	**$ 1,794,732**	**$ 2,473,414**	**$ 798,538**	**$ 2,537,608**	**$ 9,968,778**	**$ 535,106**	**$ 648,047**		**$ 10,990,220**	**$ (1,194,220)**					**7964**
Rolling 12	**$ 9,017,610**	**$ 2,727,481**	**$ 1,756,073**	**$ 2,537,203**	**$ 767,181**	**$ 2,443,655**	**$ 10,231,593**	**$ 546,147**	**$ 638,055**		**$ 11,083,851**	**$ (2,066,241)**					**7949**

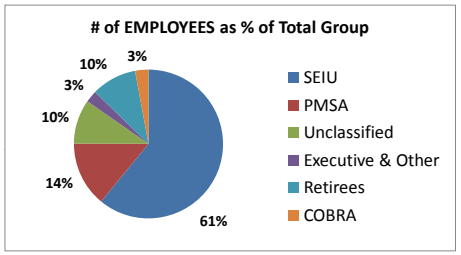
Monthly Funding		Monthly Fee	Stop Loss
EE Only	$ 497.17	$ 29.50	$ 38.67
EE & Spouse	$ 1,122.15	$ 48.40	$ 73.98
EE & Child(ren)	$ 867.57	$ 47.36	$ 65.83
EE & Family	$ 1,539.69	$ 96.50	$ 109.59

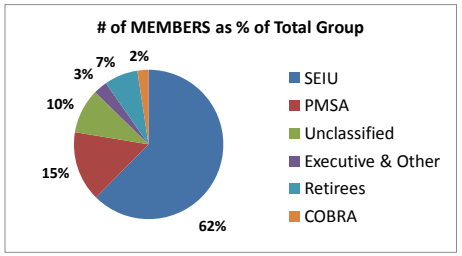
GEHRING GROUP
INSURANCE BROKERS & CONSULTANTS

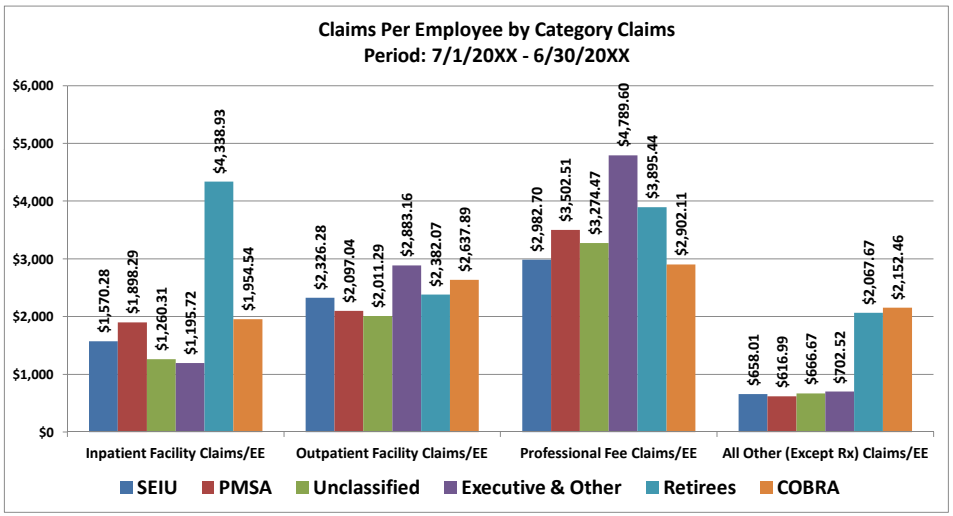
Sample Client
Claims Experience by Product and Branch
(Prescription Drug Claims Not Included)
Period: Incurred 7/20XX - 6/20XX & Paid thru 9/20XX

					Inpatient Facilty					Outpatient Facility			Professional Fees			All Other Excluding Rx			TOTAL CLAIMS		
BRANCH	# of EE's	% of EE Group	# of Covered Members	% of Member Group	Inpatient Events	% of Total Events	Total Inpatient Claims	% of Total	Inpatient Facility Claims/EE	Total Outpatient Claims	% of Total	Outpatient Facility Claims/EE	Total Professional Fee Claims	% of Total	Professional Fee Claims/EE	Total All Other Claims	% of Total	All Other (Except Rx) Claims/EE	Total Claims	% of Total	Total Paid/EE
SEIU	595	61%	1,293	62%	96	55%	$934,314	51%	**$1,570.28**	$1,384,135	62%	**$2,326.28**	$1,774,707	57%	**$2,982.70**	$391,518	48%	**$658.01**	$4,484,674	56%	**$7,537.27**
PMSA	138	14%	315	15%	21	12%	$261,964	14%	**$1,898.29**	$289,392	13%	**$2,097.04**	$483,347	15%	**$3,502.51**	$85,144	10%	**$616.99**	$1,119,847	14%	**$8,114.83**
Unclassified	94	10%	200	10%	15	9%	$118,469	7%	**$1,260.31**	$189,061	8%	**$2,011.29**	$307,800	10%	**$3,274.47**	$62,667	8%	**$666.67**	$677,997	8%	**$7,212.73**
Executive & Other	25	3%	63	3%	2	1%	$29,893	2%	**$1,195.72**	$72,079	3%	**$2,883.16**	$119,740	4%	**$4,789.60**	$17,563	2%	**$702.52**	$239,275	3%	**$9,571.00**
Retirees	96	10%	150	7%	36	21%	$416,537	23%	**$4,338.93**	$228,679	10%	**$2,382.07**	$373,962	12%	**$3,895.44**	$198,496	24%	**$2,067.67**	$1,217,674	15%	**$12,684.10**
COBRA	28	3%	50	2%	4	2%	$54,727	3%	**$1,954.54**	$73,861	3%	**$2,637.89**	$81,259	3%	**$2,902.11**	$60,269	7%	**$2,152.46**	$270,116	3%	**$9,647.00**
TOTAL	976	100%	2,071	100%	174	100%	$1,815,904	100%	$1,860.56	$2,237,207	100%	$2,292.22	$3,140,815	100%	$3,218.05	$815,657	100%	$835.71	$8,009,583	100%	$8,206.54









**All Charts represent data for period of 7/1/20XX - 6/30/20XX.*

GEHRING GROUP
INSURANCE BROKERS & CONSULTANTS

Sample Client - 700 Employees
Large Claimant Evaluation 2013-2014
Claims Exceeding $110,000
Aggregating Specific Deductible of $200,000

GEHRING GROUP
INSURANCE BROKERS & CONSULTANTS

		Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Claimant	Relationship	Total Paid Claims	Total Paid Claims	Total Paid Claims	Total Paid Claims	Total Paid Claims	Total Paid Claims	Total Paid Claims	Total Paid Claims	Total Paid Claims	Total Paid Claims	Total Paid Claims	Total Paid Claims
1	Employee	$ 64,238	$ 83,790	$ 105,389	$ 109,779	$ 112,040	$ 114,116	$ 690,477	$ 693,724	$ 738,496	$ 738,775	$ 741,432	$ 745,866
2	Employee		$ 56,268	$ 56,914	$ 57,887	$ 58,957	$ 59,810	$ 60,066	$ 60,227	$ 61,195	$ 61,488	$ 61,511	$ 61,859
3	CHILD				$ 50,858	$ 50,858	$ 51,788	$ 51,931	$ 52,473	$ 52,587	$ 52,668	$ 52,784	$ 53,099
4	Employee					$ 53,587	$ 54,068	$ 57,672	$ 58,428	$ 58,485	$ 72,575	$ 74,956	$ 88,655
5	SPOUSE					$ 50,944	$ 65,612	$ 66,383	$ 77,782	$ 79,735	$ 81,241	$ 82,192	$ 82,621
6	Employee						$ 59,611	$ 70,882	$ 84,742	$ 96,616	$ 109,082	$ 153,509	$ 162,917
7	SPOUSE						$ 98,193	$ 106,771	$ 124,635	$ 142,368	$ 153,224	$ 175,135	$ 196,096
8	CHILD						$ 72,669	$ 98,757	$ 116,442	$ 117,365	$ 135,041	$ 159,948	$ 176,902
9	Employee						$ 55,771	$ 63,691	$ 72,629	$ 7,769	$ 82,441	$ 87,677	$ 90,065
10	Employee								$ 93,458	$ 154,182	$ 154,317	$ 154,317	$ 154,606
11	SPOUSE								$ 78,025	$ 79,260	$ 79,737	$ 80,319	$ 80,494
12	Employee								$ 58,493	$ 73,064	$ 76,218	$ 80,583	$ 90,316
13	SPOUSE								$ 56,364	$ 71,541	$ 75,400	$ 88,842	$ 106,199
14	Employee								$ 50,078	$ -	$ -	$ -	$ -
15	Employee								$ 60,195	$ 62,198	$ 63,917	$ 64,104	$ 64,910
16	Employee								$ 51,539	$ 51,796	$ 52,226	$ 52,226	$ 52,226
17	Spouse									$ 54,449	$ 59,221	$ 67,686	$ 68,212
18	CHILD									$ 50,444	$ 58,938	$ 67,420	$ 75,787
19	Employee										$ 55,830	$ 61,246	$ 65,081
20	SPOUSE										$ 54,066	$ 59,800	$ 64,526
21	Employee										$ 52,779	$ 104,240	$ 155,116
22	Employee										$ 51,196	$ 89,226	$ 91,967
23	CHILD											$ 54,484	$ 57,809
24	Employee											$ 57,023	$ 86,572
	Total	**$ 64,238**	**$ 140,057**	**$ 162,304**	**$ 218,524**	**$ 326,386**	**$ 631,637**	**$ 1,266,631**	**$ 1,789,236**	**$ 1,951,549**	**$ 2,320,378**	**$ 2,670,659**	**$ 2,871,899**
Total	**Stop Loss Recoverable**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 380,477**	**$ 404,802**	**$ 512,412**	**$ 541,356**	**$ 634,340**	**$ 731,503**

*This report contains Proprietary and Confidential Information

**Total pending reimbursements reflect the sum total of individual reimbursements less $200,000 to adjust for aggregating specific deductible

Sample Client - 1,100 Employees
Self Funded Claims Experience Report - BlueCross BlueShield of Florida
Plan Effective Date: October 1, 2010 - Sept 30, 2012
Paid in Plan Month

Date	Plan Funding	ASO Fees	ISL Premium ($100,000)	ASL Premium	Total Fixed Costs	Rx Claims	Medical Claims	Stop Loss Reimbursement	Total Plan Cost	Surplus/ (Deficit)	EE Only	EE + 1	EE + 2 or more	Total EE's	Claims / EE / Month
October-10	$ 308,101.38	$ 15,960.00	$ 26,265.48	$ 1,463.00	$ 43,688.48	$ 29,159.21	$ 98,228.85	$ -	$ 171,076.54	$ 137,024.84	162	48	56	266	$ 478.90
November-10	$ 307,357.51	$ 15,960.00	$ 26,265.48	$ 1,463.00	$ 43,688.48	$ 31,613.45	$ 656,965.08	$ -	$ 732,267.01	$ (424,909.50)	162	48	56	266	$ 2,588.64
December-10	$ 306,182.07	$ 15,960.00	$ 26,265.48	$ 1,463.00	$ 43,688.48	$ 27,803.74	$ 189,121.18	$ (451,276.87)	$ (190,663.47)	$ 496,845.54	162	48	56	266	$ (881.02)
January-11	$ 306,778.02	$ 15,960.00	$ 25,906.56	$ 1,463.00	$ 43,329.56	$ 34,459.64	$ 459,056.28	$ (5,473.26)	$ 531,372.22	$ (224,594.20)	166	47	53	266	$ 1,834.75
February-11	$ 313,062.35	$ 15,960.00	$ 25,996.29	$ 1,463.00	$ 43,419.29	$ 26,175.47	$ 465,781.57	$ (21,180.91)	$ 514,195.42	$ (201,133.07)	165	46	55	266	$ 1,769.84
March-11	$ 307,771.08	$ 16,020.00	$ 26,149.68	$ 1,468.50	$ 43,638.18	$ 32,944.94	$ 204,619.51	$ (10,470.90)	$ 270,731.73	$ 37,039.35	165	47	55	267	$ 850.54
April-11	$ 308,482.73	$ 16,080.00	$ 26,303.07	$ 1,474.00	$ 43,857.07	$ 21,974.36	$ 97,420.44	$ (99,157.81)	$ 64,094.06	$ 244,388.67	165	47	56	268	$ 75.51
May-11	$ 284,763.68	$ 16,020.00	$ 26,239.41	$ 1,468.50	$ 43,727.91	$ 26,683.98	$ 107,188.36	$ (301,335.12)	$ (123,734.87)	$ 408,498.55	164	47	56	267	$ (627.20)
June-11	$ 261,057.33	$ 15,900.00	$ 26,112.09	$ 1,457.50	$ 43,469.59	$ 33,709.89	$ 122,131.21	$ (7,556.88)	$ 191,753.81	$ 69,303.52	162	47	56	265	$ 559.56
July-11	$ 357,560.63	$ 15,780.00	$ 25,895.04	$ 1,446.50	$ 43,121.54	$ 26,169.13	$ 177,773.30	$ (9,670.59)	$ 237,393.38	$ 120,167.25	161	47	55	263	$ 738.68
August-11	$ 330,991.31	$ 15,900.00	$ 25,842.90	$ 1,457.50	$ 43,200.40	$ 33,665.70	$ 312,307.03	$ (94,343.11)	$ 294,830.02	$ 36,161.29	165	45	55	265	$ 949.55
September-11	$ 307,542.13	$ 15,900.00	$ 25,932.63	$ 1,457.50	$ 43,290.13	$ 24,176.53	$ 124,872.78	$ (21,206.53)	$ 171,132.91	$ 136,409.22	164	45	56	265	$ 482.43
Annual Total	$ 3,699,650.22	$ 191,400.00	$ 313,174.11	$ 17,545.00	$ 522,119.11	$ 348,536.04	$ 3,015,465.59	$ (1,021,671.98)	$ 2,864,448.76	$ 835,201.46				3190	$ 734.27
Monthly Costs					Net Claim Cost			$ 2,342,329.65							
EE Only	$ 717.37	$ 60.00	$ 63.66	$ 5.50											
EE + 1	$ 1,260.36	$ 60.00	$ 153.39	$ 5.50											
EE + 2 or more	$ 1,496.24	$ 60.00	$ 153.39	$ 5.50											

Date	Plan Funding	ASO Fees	ISL Premium ($100,000)	ASL Premium	Total Fixed Costs	Rx Claims	Medical Claims	Stop Loss Reimbursement	Total Plan Cost	Surplus/ (Deficit)	EE Only	EE + 1	EE + 2 or more	Total EE's	NET Claims / EE / Month
Balance Forward										$ 835,201.46					
October-11	$ 308,844.93	$ 15,900.00	$ 45,651.83	$ 1,537.00	$ 63,088.83	$ 23,294.66	$ 113,097.77	$ -	$ 199,481.26	$ 109,363.67	164	44	57	265	$ 514.69
November-11	$ 309,225.02	$ 15,960.00	$ 45,916.30	$ 1,542.80	$ 63,419.10	$ 31,380.16	$ 225,176.97	$ -	$ 319,976.23	$ (10,751.21)	164	45	57	266	$ 964.50
December-11	$ 309,010.05	$ 15,960.00	$ 45,767.32	$ 1,542.80	$ 63,270.12	$ 25,514.86	$ 163,570.86	$ -	$ 252,355.84	$ 56,654.21	165	43	58	266	$ 710.85
January-12	$ 309,010.05	$ 16,200.00	$ 46,229.28	$ 1,566.00	$ 63,995.28	$ 20,491.55	$ 141,432.64	$ (9,401.25)	$ 216,518.22	$ 92,491.83	169	43	58	270	$ 564.90
February-12	$ 309,225.02	$ 16,140.00	$ 46,262.77	$ 1,560.20	$ 63,962.97	$ 31,596.19	$ 183,511.46	$ (6,339.18)	$ 272,731.44	$ 36,493.58	167	45	57	269	$ 776.09
March-12	$ 309,605.11	$ 16,200.00	$ 46,527.24	$ 1,566.00	$ 64,293.24	$ 29,861.62	$ 218,331.31	$ (17,948.04)	$ 294,538.13	$ 15,066.98	167	46	57	270	$ 852.76
April-12	$ 309,605.11	$ 16,200.00	$ 46,527.24	$ 1,566.00	$ 64,293.24	$ 26,009.72	$ 195,704.13	$ (6,988.22)	$ 279,018.87	$ 30,586.24	167	46	57	270	$ 795.28
May-12	$ 309,605.11	$ 16,260.00	$ 46,642.73	$ 1,571.80	$ 64,474.53	$ 33,528.22	$ 209,381.97	$ (5,465.25)	$ 301,919.47	$ 7,685.64	168	46	57	271	$ 876.18
June-12	$ 310,150.32	$ 16,140.00	$ 46,560.73	$ 1,560.20	$ 64,260.93	$ 29,888.67	$ 98,056.09	$ (5,576.79)	$ 186,628.90	$ 123,521.42	165	46	58	269	$ 454.90
July-12	$ 311,075.62	$ 16,200.00	$ 46,974.18	$ 1,566.00	$ 64,740.18	$ 50,591.65	$ 317,861.76	$ (13,143.79)	$ 420,049.80	$ (108,974.18)	164	47	59	270	$ 1,315.96
August-12	$ 310,695.53	$ 16,140.00	$ 46,709.71	$ 1,560.20	$ 64,409.91	$ 34,453.62	$ 165,732.14	$ (2,444.52)	$ 262,151.15	$ 48,544.38	164	46	59	269	$ 735.10
September-12	$ 310,860.65	$ 16,080.00	$ 46,594.22	$ 1,554.40	$ 64,228.62	$ 30,524.70	$ 269,364.57	$ (1,750.53)	$ 362,367.36	$ (51,506.71)	163	45	60	268	$ 1,112.46
Annual Total	$ 3,716,912.52	$ 193,380.00	$ 556,363.55	$ 18,693.40	$ 768,436.95	$ 367,135.62	$ 2,301,221.67	$ (69,057.57)	$ 3,367,736.67	$ 349,175.85				3223	$ 806.48
RX Refund										$ 9,382.07					
Total**										$ 1,193,759.38					
Monthly Costs					Net Claim Cost	$		2,599,299.72							
EE Only	$ 717.37	$ 60.00	$ 115.49	$ 5.80	$ -										
EE + 1	$ 1,260.36	$ 60.00	$ 264.47	$ 5.80	$ 380.09										
EE + 2 or more	$ 1,496.24	$ 60.00	$ 264.47	$ 5.80	$ 545.21										

***Does not include reserves for IBNR claims and run-out if plan is terminated*

GEHRING GROUP
INSURANCE BROKERS & CONSULTANTS

Sample Client
Claims Projection: Effective: January 1, 2015
Claims Year: Aug 2013 - July 2014

Standard Underwriting
15 Months Trend

		Claims Projection (01/01/15 Effective Date)
Medical		
Total Paid Claims		$ 14,189,389
Less Pooled Claims (2 claimants exceeding $300,000)	-	$ (969,178)
Net Medical Claims	=	$ 13,220,211
Maturation Factor (0%)	x	1.00
Total Adjusted Paid Claims	=	$ 13,220,211
Trend @ 9% / year Projected for 15 months	x	1.1137
Trended Claims	=	$ 14,723,854
Plus Pooled Claims (2 claimants exceeding $300,000)	+	$ 600,000
Total Trended & Pooled Claims	=	$ 15,323,854
Average Setback Lives	/	1637
Average Claims Per Employee Per Year	=	$ 9,361
Current In Force	x	1628
Adjusted Projected Annual Claims	=	$ 15,239,606
Plan Change Credit/Decrements	x	1.000
Expected Medical Claims	**=**	**$ 15,239,606**
ASO Fees 2015 (0% Increase Est.)	+	$ 994,748
Reinsurance Premiums 2015 (+10% Increase Est.)	+	$ 881,509
PPACA - Comparative Effectiveness Research Fee ($2 PMPY)	+	$ 5,236
PPACA - Transitional Reinsurance Fee ($3.5 PMPM - 12 months)	+	$ 109,956
Estimated Total Medical ASO, Reinsurance, & PPACA Cost		**$ 1,991,448**
Expected Annual Medical Program Cost (2015)	**=**	**$ 17,231,054**
Current Funding (Annualized)	**/**	**$ 15,532,144**
Dollar Amount Increase Needed (2015)	**=**	**$ 1,698,910**
Percentage Increase Needed (2015)	**=**	**10.9%**
Estimated Reserve Requirement (60 days claims + IBNR)		***$2,790,580***

Sample Client (2,500+ Employees)

Health Insurance Provider Disruption Analysis

Top 50 Utilized Providers

Provider	# of Claimants	CIGNA	AETNA HMO/POS	BCBSFL HMO/PPO
SCHIFF MD THEODORE A	477	Yes	Yes	Yes
MULLEN JR MD SANFORD A	354	Yes	Yes	Yes
GORODETSKY MD JEFFREY S	295	Yes	Yes	Yes
SORRENTINO DO ANTHONY J	233	Yes	Yes	Yes
FRIEDMAN MD/JOEL	215	Yes	Yes	Yes
WEISBERG MD RICHARD B	180	Yes	Yes	Yes
WICINA MD GENON M	176	Yes	Yes	Yes
LEE-NUNEZ MD WYNNE S	172	Yes	Yes	Yes
HEROUX KIMBERLY A MD	169	Yes	Yes	Yes
MEDSTAT URGENT CARE CTR	165	Yes	Yes	Yes
HOCHMAN MD MICHAEL H	162	Yes	Yes	Yes
KADINGO MD RICHARD M	153	Yes	Yes	Yes
WUBBENA MD JON F	151	Yes	Yes	Yes
PARE JR MD ROBERT H	146	Yes	Yes	Yes
JACOBSON DAN G MD	137	Yes	Yes	Yes
WILLERT CRAIG S MD	132	Yes	Yes	Yes
KRABBE MD/JANICE M	128	Yes	Yes	Yes
LYONS DO GLYNNIS J	127	Yes	Yes	Yes
GLASPEY BEN L DO	123	Yes	Yes	Yes
BLOMER ALLISON MD	122	Yes	Yes	Yes
VAN VLIET DO ROBERT J	120	Yes	Yes	Yes
COLLINS EVAN M MD	119	Yes	Yes	Yes
DUBE MD RICHARD A	117	Yes	Yes	Yes
HUTCHINSON ANN R MD	116	Yes	NO	Yes
NUNEZ MD ROBERT A	116	Yes	Yes	Yes
HILLMANN JEFFREY S MD	106	Yes	NO	Yes
HARVEY MD STANLEY CHAD	103	Yes	NO	NO
CONNOLLY MD ROBIN J M	100	Yes	NO	NO
DESMAN MD SCOTT M	97	Yes	Yes	Yes
DWECK MD MURRAY F	96	Yes	Yes	Yes
KATER MD GABRIELLE	84	Yes	NO	Yes
DAYTON MD PETER M	66	Yes	Yes	Yes
LIBMAN MD MICHELE F	66	Yes	Yes	Yes
SINGER MD JEREMY S	63	Yes	Yes	Yes
BRICENO MD JACKELIN D	62	Yes	NO	NO
DICKENS MD FRANK E	60	Yes	Yes	Yes
OMURA MD NAYOMI E	58	Yes	Yes	Yes
MC NANEY-FLINT MD HEIDI M	56	Yes	Yes	Yes
SHARKEY MD DANIEL E	55	Yes	Yes	Yes
RITTER MD WILLIAM S	50	Yes	Yes	Yes
CARANO KRISTIN S MD	49	Yes	NO	Yes
EVERSOLE MD AMY M	49	Yes	Yes	Yes
KANTOR MD LAWRENCE R	49	Yes	Yes	Yes
LAGUERRE MD BEAUVAIS	46	Yes	Yes	Yes
SCHROEDER MD TODD R	46	Yes	NO	Yes
SHERMAN MD MICHAEL S	46	Yes	Yes	Yes
HAAS MD GEORGE J	45	Yes	Yes	Yes
KRATHEN MD RICHARD A	45	Yes	Yes	Yes
PFEIFFER MD ERIC A	45	Yes	NO	Yes
% Match		**100%**	**82%**	**94%**

Medical Insurance Renewal Evaluation (NEGOTIATED)
Effective Date: October 1, 20

GEHRING GROUP PROFESSIONAL SERVICES

		CURRENT		ALTERNATE TWO		ALTERNATE TWO with Enhanced Rx		ALTERNATE THREE	
SCHEDULE OF BENEFITS		CIGNA HealthCare Network Open Access POS		CIGNA HealthCare Open Access Plus with CIGNA Care PPO Plan A		CIGNA HealthCare Open Access Plus with CIGNA Care PPO Plan A		CIGNA HealthCare Open Access Plus with CIGNA Care PPO Plan B	
Plan Basics		*In Network*	*Out of Network*	*In Network*	*Out of Network*	*In Network*	*Out of Network*	*In Network*	*Out of Network*
Lifetime Maximum		$5 million		$5 million		$5 million		$5 million	
Out of Pocket CYM									
Single		$1,500	$4,500	$500	$2,000	$500	$2,000	$1,000	$4,000
Family		$3,000	$6,000	$1,000	$4,000	$1,000	$4,000	$2,000	$8,000
Calendar Year Deductible (CYD)									
Single		No Deductible	$500	$500	$1,000	$500	$1,000	$1,000	$2,000
Family		No Deductible	$1,500	$1,000	$2,000	$1,000	$2,000	$2,000	$4,000
Coinsurance		0%	40%	0%	30%	0%	30%	0%	50%
Physician Services									
Primary Care Physician		$10	40%	$15	30%	$15	30%	$15	50%
Specialist		$25	40%	$25 / $40	30%	$25 / $40	30%	$25 / $40	50%
Pre-Natal		$10 / $25	40%	$25 / $40	30%	$25 / $40	30%	$25 / $40	50%
Physical Exam Benefit		$15	40%; $250 CYM	$25 / $40	30%; $250 CYM	$25 / $40	30%; $250 CYM	$25 / $40	50%; $250 CYM
Chiropractic Services		$25; 20 visits CYM	40%; 20 visits CYM	$25 / $40; 20 visits CYM	30%; 20 visits CYM	$25 / $40; 20 visits CYM	30%; 20 visits CYM	$25 / $40; 20 visits CYM	50%; 20 visits CYM
Laboratory Services		No Charge	40%; No Ded	No Charge	30%; No Ded	No Charge	30%; No Ded	No Charge	50%; No Ded
Physical Therapy		$25; 20 visits CYM	40%; 20 visits CYM	$25 / $40; 20 visits CYM	30%; 20 visits CYM	$25 / $40; 20 visits CYM	30%; 20 visits CYM	$25 / $40; 20 visits CYM	50%; 20 visits CYM
Hospital Services									
Inpatient Hospital		$500 per admission	40%	CYD	30%	CYD	30%	CYD	50%
Outpatient Hospital		$250	40%	CYD	30%	CYD	30%	CYD	50%
Emergency Room		$100	40%	$150	30%	$150	30%	$150	50%
Physician Services		No Charge	40%	CYD	30%	CYD	30%	CYD	50%
Ambulance		No Charge	40%	CYD	30%	CYD	30%	CYD	50%
Outpatient Therapy		$10 / $25; 20 visits CYM	40%; 20 visits CYM	$25 / $40; 20 visits CYM	30%; 20 visits CYM	$25 / $40; 20 visits CYM	30%; 20 visits CYM	$25 / $40; 20 visits CYM	50%; 20 visits CYM
Mental and Nervous Services		*25 days CYM; 20 visits CYM*		*30 days CYM ; 20 visits CYM*		*30 days CYM ; 20 visits CYM*		*30 days CYM ; 20 visits CYM*	
Inpatient Hospital		$50 per day	Not Covered	$50 per day	Not Covered	$50 per day	Not Covered	$50 per day	Not Covered
Outpatient Services		$30	Not Covered	$25	Not Covered	$25	Not Covered	$25	Not Covered
Substance Abuse Services		*25 days CYM; 20 visits CYM*		*30 days CYM; 44 visits CYM*		*30 days CYM; 44 visits CYM*		*30 days CYM; 44 visits CYM*	
Inpatient Hospital		$50 per day	Not Covered	$50 per day	Not Covered	$50 per day	Not Covered	$50 per day	Not Covered
Outpatient Hospital		$30	Not Covered	$25	Not Covered	$25	Not Covered	$25	Not Covered
Pharmacy Plan									
Generic		$15	Not Covered	$15	Not Covered	$10	Not Covered	$15	Not Covered
Preferred Brand		$30		$40		$35		$40	
Non Preferred Brand		$50		$70		$50		$70	
Mail Order Copay		2x		2.5x		2.5x		2.5x	
Employee	49	$487.81		$477.22		$492.97		$454.33	
Employee + Spouse	10	$1,043.92		$1,021.27		$1,054.97		$972.28	
Employee + Child(ren)	8	$902.44		$882.87		$912.00		$840.52	
Family	25	$1,463.43		$1,431.69		$1,478.94		$1,363.01	
Monthly Premium		**$78,147.16**		**$76,451.69**		**$78,974.60**		**$72,784.38**	
Annual Premium		**$937,765.92**		**$917,420.28**		**$947,695.15**		**$873,412.56**	
$ Increase		**N/A**		**-$20,345.64**		**$9,929.23**		**-$64,353.36**	
% Increase		**N/A**		**-2.2%**		**1.1%**		**-6.9%**	

Sample Client
Administrative Services and Reinsurance RFP Evaluation
$250,000 Specific Deductible
Effective Date: January 1, 2015

		CURRENT	NEGOTIATED RENEWAL	ALTERNATE #1	ALTERNATE #2	ALTERNATE #3	ALTERNATE #4
		Cigna	Cigna	ACE (AmWins)	National Union Fire Ins (AmWins)	SYMETRA	SYMETRA
MEDICAL ADMINISTRATIVE FEE	*Enrollment*			CIGNA	CIGNA	CIGNA	CIGNA
Composite Rate	*1,129*	$41.45	$41.45	$42.14	$42.14	$42.14	$42.14
Annual Administrative Cost		**$561,565**	**$561,565**	**$570,913**	**$570,913**	**$570,913**	**$570,913**
% Increase		0.0%	0.0%	1.7%	1.7%	1.7%	1.7%
ASO Rate Guarantee		Through 12/31/15	Through 12/31/15				
SPECIFIC STOP LOSS		**Cigna**	**Cigna**	**ACE**	**NUFI**	**SYMETRA**	**SYMETRA**
Specific Deductible		**$250,000**	**$250,000**	**$250,000**	**$250,000**	**$250,000**	**$250,000**
Benefits Covered		Med & Rx	Med & Rx	Med & Rx	Med & Rx	Med & Rx	Med & Rx
Contract Basis		Paid	Paid	24/12	24/12	15/12	12/15
Annual Maximum Reimbursement		Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Aggregating Deductible Amount		N/A	N/A	N/A	N/A	N/A	N/A
Composite Rate (PEPM)	*1,129*	$52.78	$61.22	$56.66	$52.74	$61.84	$64.37
Annual Premium		**$715,063**	**$829,409**	**$767,630**	**$714,522**	**$837,808**	**$872,085**
% Increase		N/A	16.0%	7.4%	-0.1%	17.2%	22.0%
AGGREGATE STOP LOSS							
Claims Basis				24/12	24/12	15/12	12/15
Claims Corridor		25%	25%	25%	25%	25%	25%
Benefits Covered		Med & Rx	Med & Rx	Med & Rx	Med & Rx	Med & Rx	Med & Rx
Annual Maximum Reimbursement		Unlimited	Unlimited	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Aggregate Premium (PEPM)	*1,129*	$3.50	$3.75	$3.12	$3.07	$3.09	$3.09
Annual Premium		**$47,418**	**$50,805**	**$42,270**	**$41,592**	**$41,863**	**$41,863**
% Increase		N/A	7.1%	-10.9%	-12.3%	-11.7%	-11.7%
Total Fixed Costs		**$1,324,046**	**$1,441,778**	**$1,380,812**	**$1,327,027**	**$1,450,584**	**$1,484,861**
$ Increase		**N/A**	**$117,732**	**$56,766**	**$2,981**	**$126,538**	**$160,815**
% Increase		**N/A**	**8.9%**	**4.3%**	**0.2%**	**9.6%**	**12.1%**
EXPECTED CLAIMS COSTS							
OAPIN Low (Gold)	***759***	$857.36	$1,035.62	$949.08	$902.62	$926.94	$941.89
OAP (Teal)	***337***	$893.25	$1,096.95	$949.08	$902.62	$889.70	$904.05
HDHP	***33***	$736.15	$1,096.95	$949.08	$902.62	$763.91	$776.24
Annual Expected Claims Costs	***1129***	**$11,712,646**	**$14,302,930**	**$12,858,136**	**$12,228,750**	**$12,342,973**	**$12,542,077**
$ Increase		($51,082)	$2,590,284	$1,245,332	$615,946	$730,169	$929,273
% Increase		N/A	22.1%	9.8%	4.4%	5.4%	7.1%
TOTAL EXPECTED COST		**$13,036,692**	**$15,744,708**	**$14,238,948**	**$13,555,777**	**$13,793,557**	**$14,026,938**
$ Increase (Decrease)		**N/A**	**$2,708,016**	**$1,202,256**	**$519,085**	**$756,865**	**$990,246**
% Increase (Decrease)		**N/A**	**20.8%**	**9.2%**	**4.0%**	**5.8%**	**7.6%**
MAXIMUM CLAIMS COST							
OAPIN Low (Gold)	***759***	$1,071.70	$1,294.53	$1,186.35	$1,128.28	$1,158.67	$1,177.36
OAP (Teal)	***337***	$1,116.56	$1,371.19	$1,186.35	$1,128.28	$1,112.12	$1,130.06
HDHP	***33***	$920.19	$1,371.19	$1,186.35	$1,128.28	$954.89	$970.30
Maximum Claims Cost	***1129***	**$14,640,807**	**$17,878,663**	**$16,072,670**	**$15,285,937**	**$15,428,716**	**$15,677,596**
% increase (Decrease)		N/A	22.1%	9.8%	4.4%	5.4%	7.1%
TOTAL MAXIMUM COST		**$15,964,854**	**$19,320,441**	**$17,453,482**	**$16,612,964**	**$16,879,300**	**$17,162,457**
$ Increase (Decrease)		**N/A**	**$3,355,587**	**$1,488,628**	**$648,111**	**$914,447**	**$1,197,604**
% Increase (Decrease)		**N/A**	**21.0%**	**9.3%**	**4.1%**	**5.7%**	**7.5%**

**** Quote valid through 9/2/14***

GEHRING GROUP INSURANCE BROKERS & CONSULTANTS

Sample Client
Administrative Services and Reinsurance RFP Evaluation
$250,000 Specific Deductible
Effective Date: January 1, 2015

		CURRENT	NEGOTIATED RENEWAL	ALTERNATE #5	ALTERNATE #6	ALTERNATE #7	ALTERNATE #8
		Cigna	**Cigna**	**SYMETRA**	**SUNLIFE**	**VOYA**	**VOYA**
MEDICAL ADMINISTRATIVE FEE	***Enrollment***			**CIGNA**	**CIGNA**	**CIGNA**	**CIGNA**
Composite Rate	*1,129*	$41.45	$41.45	$42.14	$42.14	$42.14	$42.14
Annual Administrative Cost		**$561,565**	**$561,565**	**$570,913**	**$570,913**	**$570,913**	**$570,913**
% Increase		0.0%	0.0%	1.7%	1.7%	1.7%	1.7%
ASO Rate Guarantee		Through 12/31/15	Through 12/31/15				
SPECIFIC STOP LOSS		**Cigna**	**Cigna**	**SYMETRA**	**SUNLIFE**	**VOYA**	**VOYA**
Specific Deductible		**$250,000**	**$250,000**	**$250,000**	**$250,000**	**$250,000**	**$250,000**
Benefits Covered		Med & Rx	Med & Rx	Med & Rx	Med & Rx	Med & Rx	Med & Rx
Contract Basis		Paid	Paid	24/12	24/12	15/12	12/15
Annual Maximum Reimbursement		Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Aggregating Deductible Amount		N/A	N/A	N/A	N/A	N/A	N/A
Composite Rate (PEPM)	*1,129*	$52.78	$61.22	$63.10	EE: $35.77 EE+1: $72.77 EE+Fam: $107.43	$110.79	$120.12
Annual Premium		**$715,063**	**$829,409**	**$854,879**	**$845,253**	**$1,500,983**	**$1,627,386**
% Increase		N/A	16.0%	19.6%	18.2%	109.9%	127.6%
AGGREGATE STOP LOSS							
Claims Basis				24/12	24/12	15/12	12/15
Claims Corridor		25%	25%	25%	25%	25%	25%
Benefits Covered		Med & Rx	Med & Rx	Med & Rx	Med & Rx	Med & Rx	Med & Rx
Annual Maximum Reimbursement		Unlimited	Unlimited	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Aggregate Premium (PEPM)	*1,129*	$3.50	$3.75	$3.09	$2.12	$3.25	$3.25
Annual Premium		**$47,418**	**$50,805**	**$41,863**	**$28,671**	**$44,031**	**$44,031**
% Increase		N/A	7.1%	-11.7%	-39.5%	-7.1%	-7.1%
Total Fixed Costs		**$1,324,046**	**$1,441,778**	**$1,467,655**	**$1,444,837**	**$2,115,927**	**$2,242,329**
$ Increase		**N/A**	**$117,732**	**$143,609**	**$120,791**	**$674,148**	**$800,551**
% Increase		**N/A**	**8.9%**	**10.8%**	**9.1%**	**59.8%**	**69.4%**
EXPECTED CLAIMS COSTS							
OAPIN Low (Gold)	***759***	$857.36	$1,035.62	$904.14	$926.00	$898.76	$915.88
OAP (Teal)	***337***	$893.25	$1,096.95	$904.14	$926.00	$898.76	$915.88
HDHP	***33***	$736.15	$1,096.95	$904.14	$926.00	$898.76	$915.88
Annual Expected Claims Costs	***1129***	**$11,712,646**	**$14,302,930**	**$12,249,235**	**$12,545,448**	**$12,914,507**	**$13,160,509**
$ Increase		($51,082)	$2,590,284	$636,431	$932,644		
% Increase		N/A	22.1%	4.6%	7.1%		
TOTAL EXPECTED COST		**$13,036,692**	**$15,744,708**	**$13,716,889**	**$13,990,285**	**$15,030,434**	**$15,402,838**
$ Increase (Decrease)		**N/A**	**$2,708,016**	**$680,197**	**$953,593**	**$1,993,742**	**$2,366,146**
% Increase (Decrease)		**N/A**	**20.8%**	**5.2%**	**7.3%**	**15.3%**	**18.1%**
MAXIMUM CLAIMS COST							
OAPIN Low (Gold)	***759***	$1,071.70	$1,294.53	$1,130.17	$1,157.50	$1,123.45	$1,144.85
OAP (Teal)	***337***	$1,116.56	$1,371.19	$1,130.17	$1,157.50	$1,123.45	$1,144.85
HDHP	***33***	$920.19	$1,371.19	$1,130.17	$1,157.50	$1,123.45	$1,144.85
Maximum Claims Cost	***1129***	**$14,640,807**	**$17,878,663**	**$15,311,543**	**$15,681,810**	**$15,220,501**	**$15,510,428**
% increase (Decrease)		N/A	22.1%	4.6%	7.1%	4.0%	5.9%
TOTAL MAXIMUM COST		**$15,964,854**	**$19,320,441**	**$16,779,198**	**$17,126,647**	**$17,336,427**	**$17,752,757**
$ Increase (Decrease)		**N/A**	**$3,355,587**	**$814,344**	**$1,161,794**	**$1,371,574**	**$1,787,904**
% Increase (Decrease)		**N/A**	**21.0%**	**5.1%**	**7.3%**	**8.6%**	**11.2%**

**** Quote valid through 9/2/14***

GEHRING GROUP INSURANCE BROKERS & CONSULTANTS

Sample Client
Employee Medical Benefits Evaluation - Caveats
Effective Date: January 1, 2015

Carrier	Proposed Medical Plan Caveats
ACE (through AMWINS)	*Assumes duplication of current plans and networks. *Rates, attachment factors and group deductible are subject to change if enrollment changes by >10% *Must provide a Large Claims Disclosure to include update for the $409,577 Cancer Claimant *Assumes the premature infants are completely resolved. *Need diagnosis/prognosis on all large, potentially large, ongoing or pending claims as higher deductibles (lasers) or exclusions may apply. *Must provide updated large claims data through 10/31/2014 to include paid claim amount, diagnosis and prognosis. *Assumes no large open, ongoing or pending claims.
National Union Fire Insurance Company (through AMWINS)	*Assumes duplication of current plans and networks. *Rates, attachment factors and group deductible are subject to change if enrollment changes by >10% *Need diagnosis/prognosis on all large, potentially large, ongoing or pending claims as higher deductibles (lasers) or exclusions may apply. *Must provide updated paid claims and enrollment through 10/31/2014.
SYMETRA	*Require paid and large claim experience through September 30, 2014. Offer valid through October 31, 2014. *Terms are subject to change if final enrollment varies by >10% from proposal assumptions. *Symetra reserves the right to re-price if the administrator backlog exceeds 2 weeks. *Terms assume that all retirees (if eligible) over the age of 65 are Medicare Primary. *Must provide details on any individual who has been hospital confined for 30 days or more in the most recent 12 months or is currently on an organ transplant list.
SUNLIFE	***Large claimant data has not been evaluated. Additional info may be requested and/or individual lasers may be applied.** ***Rates and factors are subject to change upon receipt and review of requested data.** *We have large claims from 1/1/14-7/31/14. We will review it upon receipt of updated large claims through 9/30/14. Rates may be adjusted and lasers may be applied. *Costs relating to experimental or investigational treatment are not covered. *For claims over $100,000 from 1/1/14 to 9/30/14, must provide diagnosis and prognosis. *Proposal assumes no increase in retirees over the current 52% retirees and current 28% enrollment being Medicare primary going forward. *Proposal assumes the police/fire employees are 13% of the group. *Coverage excluded for expenses "approved by the plan administrator for alternative care, alternative treatment, or treatment not otherwise covered under your plan".
VOYA (Formerly ING)	*Plan must have medical case management and utilization review *Medicare is primary for retirees age 65 and over *Any costs charged by the claim administrator for reports required to substantiate claims will be paid by the employer. *Aggregate and large claim data will be required through 09/30/2014 in order to finalize and determine any individual Adjusted Deductibles. *Voya Employee Benefits requests the following reports for disclosure: 50% report (must include a unique identifier, primary diagnosis and paid amount), transplant list, pended/denied report and trigger report. At a minimum, a 50% report and transplant list is required to finalize data.

This page is a high level summary of the key caveats taken from the respective proposals. Please refer to the proposals for a more detailed description.

EXHIBIT 5
Sample Health Care Reform Seminar/Webinar

Mastering Your Form 1094-C

Client Webinar

Presented by:
Kate Grangard, CPA, CFO/COO

April 19, 2016

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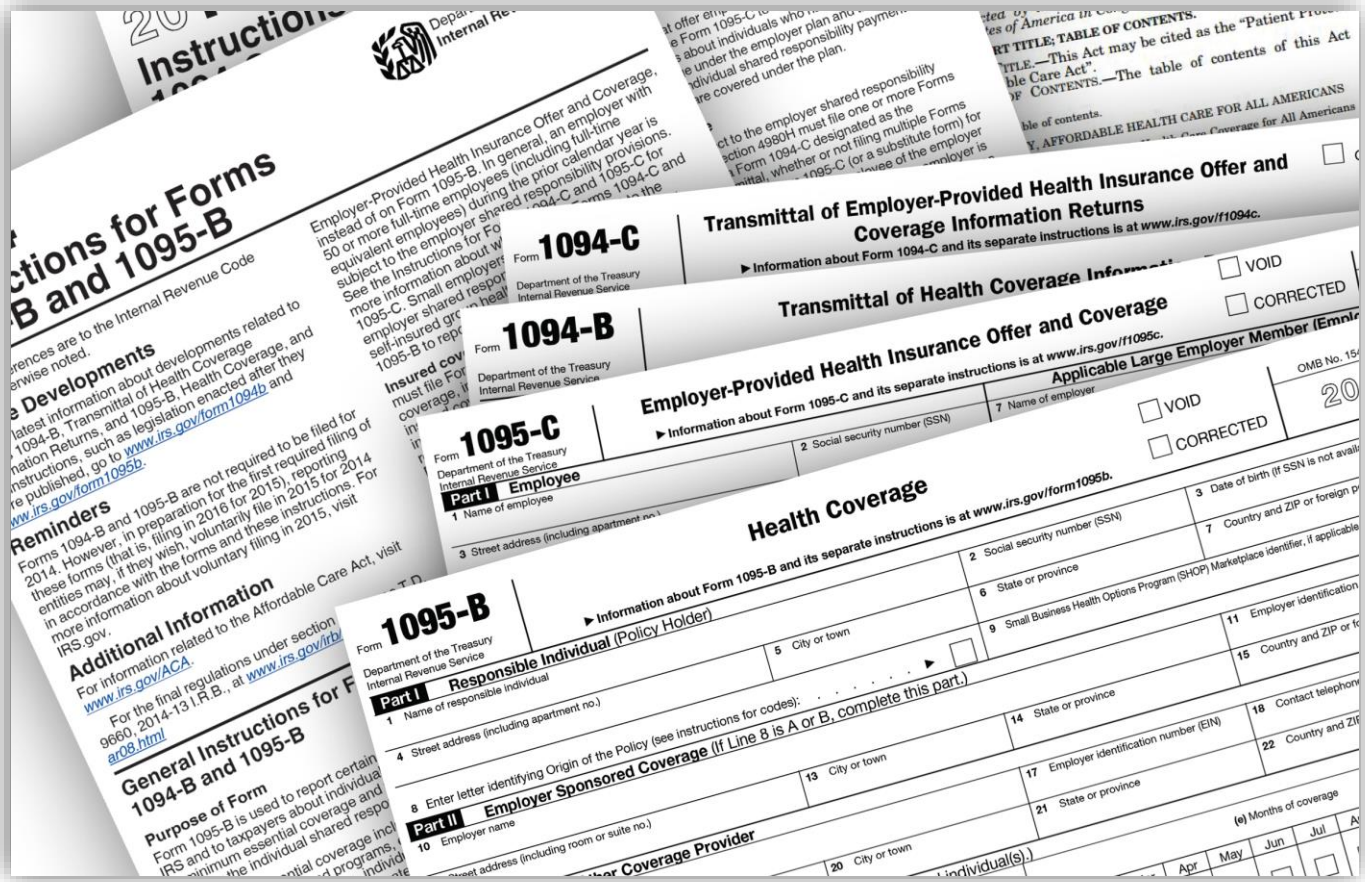
Reporting Summary



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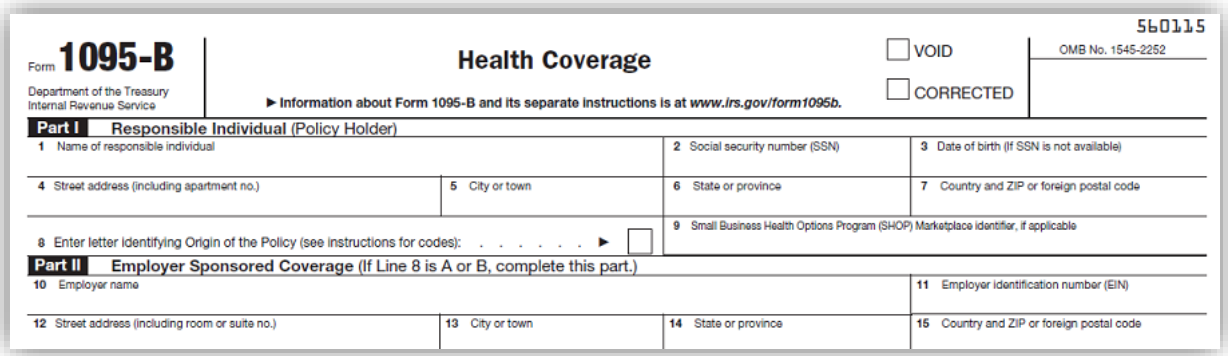
Reporting Summary

MEC – Minimum Essential Coverage Reporting Form 1095-B and Transmittal Form 1094-B

- Member and Dependent Coverage by Month
- Self Insured Employers
- Non ALE Employers/RHS Accounts/Non-employees
- Combined on Form 1095-C if also ALE
- Reporting due 2016 based on Calendar Year 2015 (W-2 deadlines)
- Section 6055
- Due to EE's 3/31/16



560115

Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

► Information about Form 1095-B and its separate instructions is at *www.irs.gov/form1095b.*

☐ VOID
☐ CORRECTED

OMB No. 1545-2252

Part I Responsible Individual (Policy Holder)

1 Name of responsible individual		2 Social security number (SSN)	3 Date of birth (If SSN is not available)
4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
8 Enter letter identifying Origin of the Policy (see instructions for codes): . . . . . ► ☐		9 Small Business Health Options Program (SHOP) Marketplace identifier, if applicable	

Part II Employer Sponsored Coverage (If Line 8 is A or B, complete this part.)

10 Employer name			11 Employer identification number (EIN)
12 Street address (including room or suite no.)	13 City or town	14 State or province	15 Country and ZIP or foreign postal code

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Reporting Summary

ALE – Applicable Large Employer Reporting Form 1095-C and Transmittal Form 1094-C

- Employer Level Reporting
- 50+ employees (FT + FTE) – Fully Insured & Self Insured
- Report due for any employee eligible for at least 1 month of year
- Offer of Coverage & Coverage Code/Safe Harbor/Cost
- Reporting due 2016 based on Calendar Year 2015 (W-2 deadlines)
- Comprehensive Transmittal including various elections
- Section 6056
- Due to EE's 3/31/16

Deadlines & Penalties

Due Dates:

IRS Deadline for 1094/1095	2015 Return (filed in 2016)	2016 Return (filed in 2017)
Distribute 1095-B and 1095-C Forms to employees by:	March 31, 2016	January 31, 2017
Deadline to file 1094/1095-B and 1094/1095-C with IRS by:	***If Filing Paper***: May 31, 2016 ***If Filing Electronically***: June 30, 2016	***If Filing Paper***: Feb 28, 2017 ***If Filing Electronically***: March 31, 2017

- "Good faith effort" penalty relief

Deadlines & Penalties

Penalty Exposure Related to Reporting

IRS Rev Proc 2016-11:
Penalties assessed under:Section 6721 (file with IRS) & 6722 (furnish to recipient)
https://www.irs.gov/pub/irs-drop/rp-16-11.pdf

.06 Failure to File Correct Information Returns. For taxable years beginning in 2015, the penalty amounts under § 6721 are:

(1) for persons with average annual gross receipts for the most recent three taxable years of more than $5,000,000, for failure to file correct information returns are:

Scenario	Penalty Per Return	Calendar Year Maximum
General Rule (§ 6721(a)(1))	$260	$3,178,500
Corrected on or before 30 days after required filing date (§ 6721(b)(1))	$50	$529,500
Corrected after 30th day but on or before August 1 (§ 6721(b)(2))	$100	$1,589,000

(2) for persons with average annual gross receipts for the most recent three taxable years of $5,000,000 or less, for failure to file correct information returns are:

Scenario	Penalty Per Return	Calendar Year Maximum
General Rule (§ 6721(d)(1)(A))	$260	$1,059,500
Corrected on or before 30 days after required filing date (§ 6721(d)(1)(B))	$50	$185,000
Corrected after 30th day but on or before August 1 (§ 6721(d)(1)(C))	$100	$529,500

.07 Failure to Furnish Correct Payee Statements. For taxable years beginning in 2015, the penalty amounts under § 6722 are:

(1) for persons with average annual gross receipts for the most recent three taxable years of more than $5,000,000, for failure to file correct payee statements are:

Scenario	Penalty Per Return	Calendar Year Maximum
General Rule (§ 6722(a)(1))	$260	$3,178,500
Corrected on or before 30 days after required filing date (§ 6722(b)(1))	$50	$529,500
Corrected after 30th day but on or before August 1 (§ 6722(b)(2))	$100	$1,589,000

(2) for persons with average annual gross receipts for the most recent 3 taxable years of $5,000,000 or less, for failure to file correct payee statements are:

Scenario	Penalty Per Return	Calendar Year Maximum
General Rule (§ 6722(d)(1)(A))	$260	$1,059,500
Corrected on or before 30 days after required filing date (§ 6722(d)(1)(B))	$50	$185,000
Corrected after 30th day but on or before August 1 (§ 6722(d)(1)(C))	$100	$529,500

INTENTIONAL DISREGARD: $520/RETURN with NO LIMIT

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Topics of Discussion

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Deadlines & Penalties

Discussion Topics

- Correcting the Forms 1095-C
- Review the 1094-C Form in Detail
- Review Completed Form 1094-C Forms
- Q&A: E-mail to cindy.Thompson@gehringgroup.com

Topics of Discussion

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The 1095-C Boomerang Effect

Form 1095-C:

- Two types of Reporting Solutions:
  1. Complete and file the Form 1094-C at the same time as 1095-C's
     - Corrections to 1095-C's: CORRECTED FORM now
  2. Complete and mail 1095-C's, send corrected forms as needed, complete and file Form 1094-C by later due date based on corrected info
     - Corrections to 1095-C's: UPDATED FORM before 1094-C filed, CORRECTED FORM after

The 1095-C Boomerang Effect

Form 1095-C:

- Two error notification sources:
  - Errors noticed by the Employee
  - Errors noticed by the IRS
    - IRS is using a "robust validation set"- not the same E-verify or Social Security Number Verification Service that are used for verifying SSN for Form W-2's
      - No indication if error is employee or dependent if applicable
    - Greatland - Approximately 6% of 1095 Forms are being returned for Invalid PIN type errors – 5% on C Forms and 9% on B Forms.
    - IRS bouncing some returns due to internal errors – currently being fixed
- Errors hould be more prevalent in 1st year of reporting

The 1095-C Boomerang Effect

Completing the Updated Form 1095-C:

- Psst ACA-Track - until Form 1094-C Filed (1094-C reporting availability expected early May)
  - Log into site and make correction
  - New pdf run and return reviewed
  - Updated return mailed by ACA-Track
- Worxtime - until Form 1094-C Filed (1094-C reporting availability expected shortly – currently in client testing)
  - Few changes - Log into site and make correction
  - Batch changes – Reach out to Worxtime contact or GG/BT for assistance
  - Returns batched 2x per week for print and mail, or print and mail by ER

The 1095-C Boomerang Effect

Completing the Updated Form 1095-C:

- Greatland – Go into system and file CORRECTED returns

Views: **1254** Created: **2016-03-22 12:46** Last Updated: **2016-04-07 11:22**

SYMPTOM

I received a correction needed status for the reason of TIN Validation Failed. What is this and how do I fix it?

SOLUTION

A "Correction Needed" or "TIN Validation Failed" message indicates that the IRS found a Name/TIN combination on a 1095 form that does not match IRS records. These error messages can be confusing because the IRS does not specify which name(s)/TIN(s) caused the error, and there may be multiple errors of this type on a single form. This article is intended to lead you through the process of correcting TIN errors so that your ACA filing can reach an "Accepted" status.

How do I know if I have a TIN Validation error?

Greatland will inform you of a TIN validation error via e-mail, within the product message center on Your Filing Home, and on the Correction Report which is available within Form Filing History. To access the report either click on the link displayed in the product message center or select Form Filing History from Your Filing Home.

Within Form Filing History select the yellow caution symbol next to the confirmation number of the 1095 filing. Choose View Correction Report. A report will be downloaded that lists forms that need corrections and the related error message. The sample below indicates that recipients John Doe and Jane Smith both have TIN validation errors on their 1095-C forms.

Form Title	Payer TIN	Payer Name	Recipient TIN	Recipient Name	Error Message
1095-C	12-3456789	ABC Company	123-45-6789	John Doe	TIN Validation Failed
1095-C	12-3456789	ABC Company	123-45-6789	John Doe	TIN Validation Failed
1095-C	12-3456789	ABC Company	123-45-6789	John Doe	TIN Validation Failed
1095-C	98-7654321	XYZ Corporation	987-65-4321	Jane Smith	TIN Validation Failed

How do I know which name or TIN on the form is incorrect?

Unfortunately, the IRS does not provide specific information on TIN validation errors. The only information that is provided is the name and TIN of the recipient; however, the TIN validation error could be the name/TIN combination for the recipient, or a covered individual of the recipient, or both. Since it is impossible to know which name/TIN combination caused the error, it will be necessary to validate all name/TIN fields on the form, both the recipient and the covered individuals. Also note that if you find that the name/TIN field on the recipient is incorrect, you will also need to correct their information in the Covered Individuals section of the form.

The Correction Report above indicates that John Doe, with recipient TIN 123-45-6789, has three TIN validation errors on his Form 1095-C. However, since the IRS does not specify which name/TIN fields on the form caused the errors any of the following are possible and need to be validated:

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The 1095-C Boomerang Effect

Completing the Updated Form 1095-C:

- Greatland – Go into system and file CORRECTED returns

John Doe's name/TIN combination is incorrect in the Employee Name field AND in the Covered Individuals field and one other individual listed in the Covered Individuals section has an incorrect name/TIN combination.

John Doe's name/TIN combination is incorrect in the Employee Name field OR in the Covered Individuals field and two other individuals listed in the Covered Individuals section have incorrect name/TIN combinations.

Three individuals listed in the Covered Individuals section (not John Doe) have incorrect name/TIN combinations.

This example also shows that Jane Smith has one TIN validation error on her Form 1095-C. Again, the error could indicate that the recipient name/TIN information is incorrect, or that there is an incorrect name/TIN in the Covered Individuals section of the 1095 form. Either of the following are possible and need to be validated:

Jane Smith's name/TIN combination is incorrect in the Employee Name field OR in the Covered Individuals section.

One individual listed in the Covered Individuals section (not Jane Smith) has an incorrect name/TIN combination.

How do I obtain the correct TIN information?

Follow these steps to ensure you have met all requirements to obtain the correct name/TIN information:

Check your records (HR/Benefits, Payroll data) to verify that all name/TIN combinations were entered correctly on Form 1095.

Contact the employee or employer to validate the recipient name/TIN combination and covered individuals name(s)/TIN(s).

1095-B Forms - check with the sponsoring employer or responsible individual to validate the name/TIN information.

1095-C Forms - check with your employee to validate the name/TIN information.

Contact your local Social Security Administration (SSA) office to determine if your information matches SSA's information.

If still not resolved, delete TINs for the Responsible Individual (1095-B) and the Covered Individuals (1095-B and 1095-C) and enter the applicable date(s) of birth in the appropriate fields. The date of birth cannot be used for the employee listed on the Form 1095-C

Once you have identified the incorrect name/TIN fields and have obtained the correct data, you may enter a 1095 correction in Yearli Performance. Submit your corrected forms as soon as possible. **If you do not change any data on your forms, do not resubmit your forms to the IRS.**

What if I can't resolve a TIN issue?

You may be unable to resolve a TIN issue if you can't reach a particular employer or individual to validate their TIN or obtain their date of birth. It is also possible that you have taken all required steps and believe that your data is accurate. In these cases, *make sure you have documented your process thoroughly to avoid potential fines and penalties*. The IRS has outlined the following process for 1095 forms:

Make an initial solicitation of recipient and covered individuals' TINs at an individual's first enrollment or, if already enrolled by September 17, 2015, the next open season.

If you do not receive the TINs, make the second solicitation at a reasonable time thereafter.

If TINs are still not provided, make a third solicitation by December 31 of the year following the initial solicitation. You are not required to solicit a TIN from an individual whose coverage is terminated.

How do I enter a correction in Yearli Performance?

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The 1095-C Boomerang Effect

Completing the Updated Form 1095-C:

- Greatland – Go into system and file CORRECTED returns

How do I enter a correction in Yearli Performance?

To submit a 1095 correction for the TIN Validation Failed forms:

1. Select the View Details button in the Message Center.
2. Or, select Form Filing History and click the yellow caution triangle next to the confirmation number.
3. Select the Correct button.
4. All of the forms will be moved to Forms in Progress.
5. Select the Edit link next to the form that needs to be corrected.
6. Make the necessary changes and choose the Save button.
7. Select the previous employee or next employee arrow to move through the additional forms quickly. See the sample below.
8. Repeat steps 6 and 7 for all remaining forms that need to be corrected.
9. Once complete, select the File Forms button.

What is the deadline to correct TIN Validation errors?

We recommend correcting the forms as soon as possible. For the tax year 2015 1095 forms, the IRS is allowing the corrections to be filed until November 30, 2016.

- Does not appear Employers can validate SSN through SSNVS, except Employee for Form W-2: https://www.ssa.gov/employer/ssnvshandbk/ssnvs_bso.htm#&a0=1

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The 1095-C Boomerang Effect

Completing the Updated Form 1095-C:

- Other systems – understand the process and the requirements
  - ASK:
    - Was the Form 1094-C filed already?
      - If yes, how are corrected returns input and processed (Form 1094-C refiled)
    - If not, when will the Form 1094-C form filing capability be available?
      - How are corrections made before the Form 1094-C is filed

The 1095-C Boomerang Effect

Form 1095-C Corrected/Updated Forms Review

- Know your system – corrected vs updated
- “File ASAP after an error is discovered”
- First year errors may be more extensive
- We’re all in this together!

Form 1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

Said no one - EVER!

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Form 1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

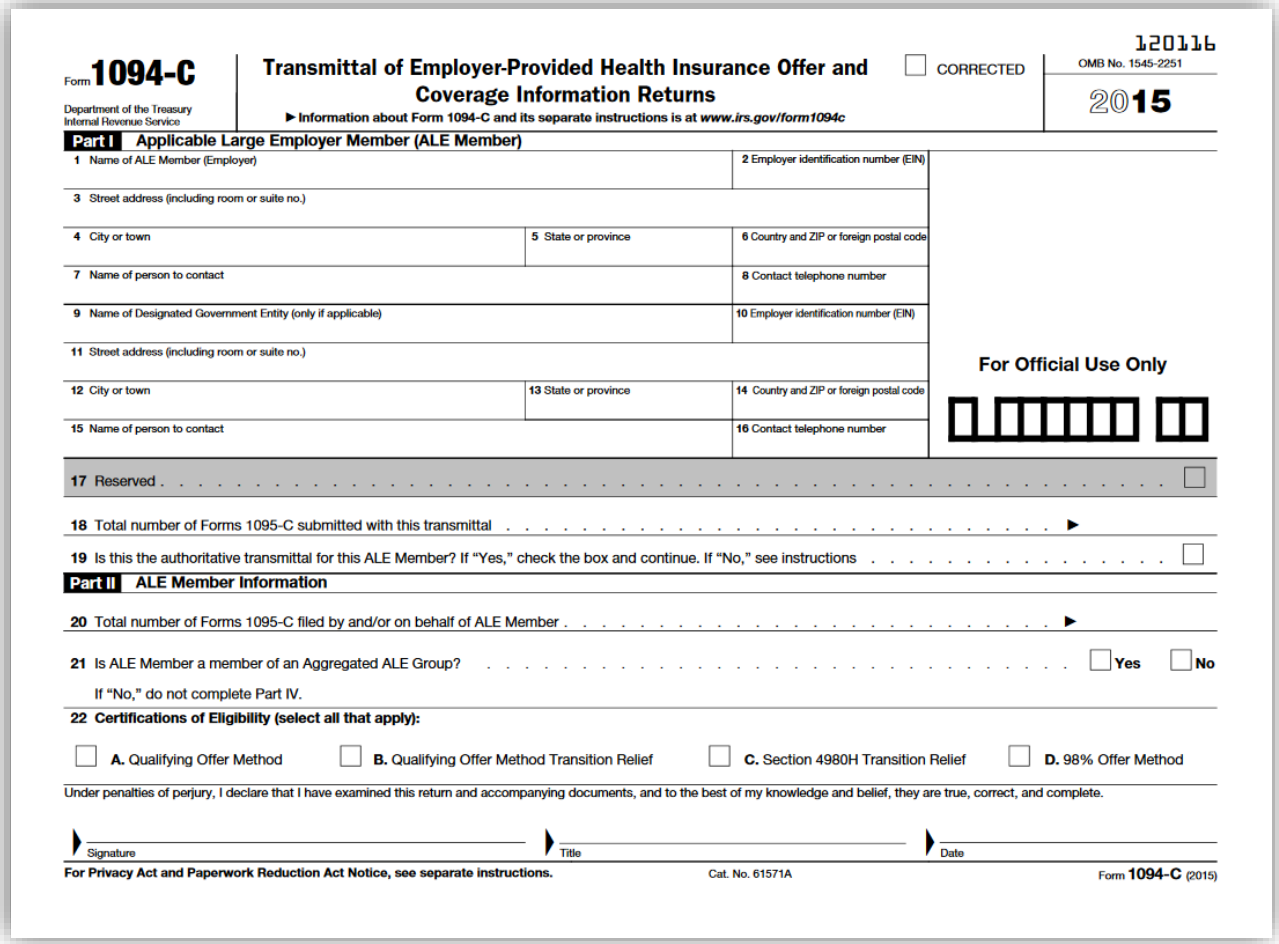
Review of Form 1094-C (Transmittal)

Federal Regulations:
https://www.gpo.gov/fdsys/pkg/FR-2014-03-10/pdf/2014-05050.pdf

IRS Instructions:
https://www.irs.gov/pub/irs-pdf/i109495c.pdf

1094 Form:
https://www.irs.gov/pub/irs-pdf/f1094c.pdf

Section 6056 FAQ:
https://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Reporting-of-Offers-of-Health-Insurance-Coverage-by-Employers-Section-6056



Form **1094-C**
Department of the Treasury
Internal Revenue Service

Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

▶ Information about Form 1094-C and its separate instructions is at *www.irs.gov/form1094c*

☐ CORRECTED

120116
OMB No. 1545-2251
2015

Part I Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer) | 2 Employer identification number (EIN)
3 Street address (including room or suite no.)
4 City or town | 5 State or province | 6 Country and ZIP or foreign postal code
7 Name of person to contact | 8 Contact telephone number
9 Name of Designated Government Entity (only if applicable) | 10 Employer identification number (EIN)
11 Street address (including room or suite no.)
12 City or town | 13 State or province | 14 Country and ZIP or foreign postal code
15 Name of person to contact | 16 Contact telephone number

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17 Reserved ☐
18 Total number of Forms 1095-C submitted with this transmittal ▶
19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions ☐

Part II ALE Member Information

20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member ▶
21 Is ALE Member a member of an Aggregated ALE Group? ☐ Yes ☐ No
If "No," do not complete Part IV.
22 **Certifications of Eligibility (select all that apply):**

☐ **A.** Qualifying Offer Method ☐ **B.** Qualifying Offer Method Transition Relief ☐ **C.** Section 4980H Transition Relief ☐ **D.** 98% Offer Method

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

▶ Signature ▶ Title ▶ Date

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 61571A Form **1094-C** (2015)

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Form 1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

Review of Form 1094-C (Transmittal)

120216

Form 1094-C (2015) Page 2

Part III ALE Member Information—Monthly

		(a) Minimum Essential Coverage Offer Indicator		(b) Full-Time Employee Count for ALE Member	(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Section 4980H Transition Relief Indicator
		Yes	No				
23	All 12 Months	☐	☐			☐	
24	Jan	☐	☐			☐	
25	Feb	☐	☐			☐	
26	Mar	☐	☐			☐	
27	Apr	☐	☐			☐	
28	May	☐	☐			☐	
29	June	☐	☐			☐	
30	July	☐	☐			☐	
31	Aug	☐	☐			☐	
32	Sept	☐	☐			☐	
33	Oct	☐	☐			☐	
34	Nov	☐	☐			☐	
35	Dec	☐	☐			☐	

Form **1094-C** (2015)

GEHRING GROUP INSURANCE BROKERS & CONSULTANTS

Form 1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

Review of Form 1094-C (Transmittal)

120315

Form 1094-C (2015) Page 3

Part IV **Other ALE Members of Aggregated ALE Group**

Enter the names and EINs of Other ALE Members of the Aggregated ALE Group (who were members at any time during the calendar year).

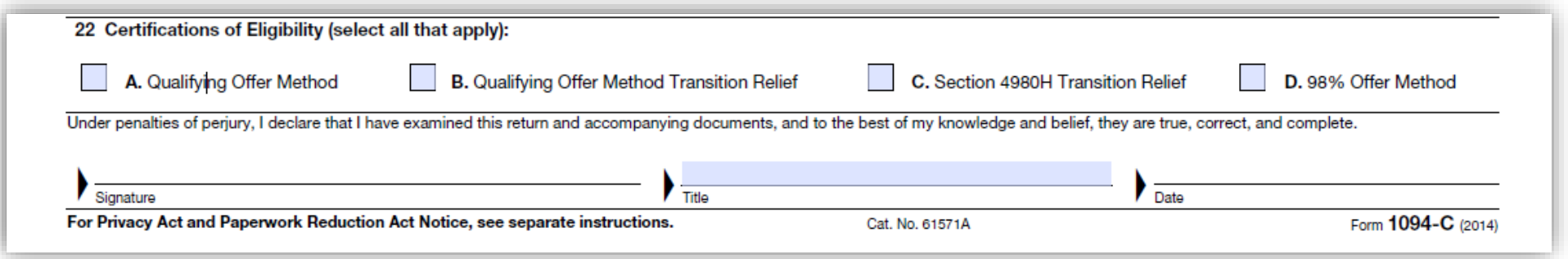
	Name	EIN		Name	EIN
36			51		
37			52		
38			53		
39			54		
40			55		
41			56		
42			57		
43			58		
44			59		
45			60		
46			61		
47			62		
48			63		
49			64		
50			65		

Form **1094-C** (2015)

GEHRING GROUP INSURANCE BROKERS & CONSULTANTS

Form 1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

Available Elections on Transmittal for Simplified Reporting & Transitional Relief



22 Certifications of Eligibility (select all that apply):

☐ **A.** Qualifying Offer Method ☐ **B.** Qualifying Offer Method Transition Relief ☐ **C.** Section 4980H Transition Relief ☐ **D.** 98% Offer Method

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

Signature Title Date

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 61571A Form **1094-C** (2014)

GEHRING GROUP INSURANCE BROKERS & CONSULTANTS

Form 1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

Three Affordability Safe Harbors:

1. Form W-2 Safe Harbor – Employee contribution for lowest cost employee only coverage does not exceed 9.66 (2016 of employee's Box 1 W-2 wages for the applicable calendar year.
2. Rate of Pay Safe Harbor – Test using monthly salary at the beginning of the plan year as base. Employee only cost cannot exceed 9.5% of earnings as of the first day of the plan year

Form 1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

Three Affordability Safe Harbors:

3. "Federal Poverty Line" (FPL) Safe Harbor – Coverage will be "affordable" if self-only coverage does not exceed 9.5% of Federal Poverty Level for single individual.
   - 2015 individual FPL is $11,770 * 9.5% Monthly Cost ≤ $93.18)
   - 2016 Individual FPL is $11,880 * 9.66% Monthly Cost ≤ $95.64)

2015 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family/household	Poverty guideline
1	$11,770
2	15,930
3	20,090
4	24,250
5	28,410
6	32,570
7	36,730
8	40,890
For families/households with more than 8 persons, add $4,160 for each additional person.	

2016 Poverty Guidelines for the 48 Contiguous States and the District of Columbia Back to Top

Persons in family/household	Poverty guideline
1	$11,880
2	16,020
3	20,160
4	24,300
5	28,440
6	32,580
7	36,730
8	40,890
For families/households with more than 8 persons, add $4,160 for each additional person.	

http://aspe.hhs.gov/poverty/15poverty.cfm & https://www.federalregister.gov/articles/2016/01/25/2016-01450/annual-update-of-the-hhs-poverty-guidelines#t-1

Form 1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

- Available Elections on Transmittal
  - **Qualifying Offer Method (line 22A)** – available if Employer made a qualifying offer of coverage to 1 or more full-time employees for all months of the year for which an employer shared responsibility payment (ESRP) could apply to that employee. Offer of coverage must be minimum essential coverage (MEC), minimum value (MV), and affordable under FPL safe harbor. Enter 1A on 1095-C, Part II line 14, and leave line 15 blank for applicable employee.

Line 22, Box A - Qualifying offer. Check this box if ER is eligible to use, and is using code "1A" on Form 1095-C, for 1 or more employees, for all months in which they were eligible. Use of this election is optional, but ER must check this box A on Line 22 if using Indicator Code 1A on line 14.

Form 1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

- Available Elections on Transmittal
  - **Qualifying Offer Method Transition Relief – (line 22B)** – available if ER made a qualifying offer of coverage to 95% or more of it's full time employees, for 1 or more months of the year. Enter 1A or Code 1I only on 1095-C, Part II line 14, and MUST leave line 15 blank for all months for applicable employee. Use only Codes 1A (for months offered coverage) and 1I (for any months not offered coverage regardless of the reason). An employee in wait period is not counted toward the monthly 95%.

Line 22, Box B - Qualifying offer Method Transition Relief. Check this box if you are eligible to use, and are using code "1A" and code "1I" only on line 14 of Form 1095-C. The employer is certifying they made a qualifying offer of coverage to at least 95% of FT eligible employees 1 or more months. This is a 2015 election only. Use of this election is optional, but you must check Box B on line 22 if using Indicator Code 1I on line 14. This election is optional.

Form 1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

- Available Elections on Transmittal
  - **Section 4980H Transition Relief (line22C)**– available if ER qualifies and is electing transition relief due to:
    - Midsize Employer Transition Relief
      - 50-99 FTE+FTEE and meet the requirements of transition relief
    - Relief when Calculating Assessable Penalties
      - 100>= FTE + FTEE Calendar Year Plan
    - Checking this box AND signing form is the Employers Certification that the employer qualifies for this Transition Relief from ESRP as applicable.

Form 1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

- Available Elections on Transmittal
  - **Section 4980H Transition Relief (line22C)**

    Midsize Employer Transition Relief Requirements:

    - Not modified plan after February 9, 2014 to begin on later calendar date
    - Not reduced workforce size or overall hours of service to qualify for delay
    - Not eliminated or materially reduced coverage in effect of February 9, 2014. A material reduction includes:
      - ER Contribution is either less that 95% of dollar amount of single only ER Contribution on 2/9/2014 or is a small % that the ER was paying on 2/9/2014
      - A change was made to the benefits in place on 2/9/2014 that caused the plan to fall below MV
      - The class of employees or dependents eligible for overage on February 9, 2014 has been reduced
    - Delays requirement to offer health benefits until 1st day of plan year starting on or after 1/1/2016

Line 22, Box C – Section 4980H Transition Relief. Check this box if ER is eligible to elect, and is electing Midsize ER Relief. Use of this election is optional, but ER must check this box C on Line 22 and use CODE "A" in Column (e) of Part III.

Form 1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

- Available Elections on Transmittal
  - **Section 4980H Transition Relief (line22C)**

    Relief when Calculating Assessable Penalties:

    - If any FT eligible employee not offered coverage qualifies for and receives a subsidy on the exchange; then the employer with 100 or more employees that failed to offer coverage to 70% or more of FT eligible employees will owe $2,000 penalty multiplied by Total FT Employees. The penalty is reduced by the first 30 employees.
    - Checking this box allows a reduction of the first 80 employees when calculating this penalty.

Line 22, Box C – Section 4980H Transition Relief. Check this box if ER size is more than or equal to 100 FT employees, and is electing this Relief when calculating Assessable Penalties. Use of this election is optional, however, it could provide a safety net in the event less than 100% of eligible employees were offered coverage. Check this box C on Line 22 and use CODE "B" in Column (e) of Part III.

Form 1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

- Available Elections on Transmittal
  - **98% Offer Method (22D)**– available if ER made an offer of minimum value, affordable health coverage (under any of the safe harbors) to 98% of its employees for whom it is filing a Form 1095-C , (regardless of if they are FT or PT). ER certifies that calculation based on all months in which employees were employed, discarding months in wait period; and an offer of MEC coverage was made to dependents. Would not need to identify FT vs PT employees, but need to file a Form 1095-C for all FT employees if ER is SI or FI, and for PT employees when self-insured.

Line 22, Box D – 98% Offer Method. Check this box if ER is eligible to elect, and is electing the 98% Offer Method. Use of this election is optional, but ER making this election is not required to complete the FT Employee Count in Part III, Column (b) of Form 1094-C.

Form 1094-C – ALE Transmittal

Completed for EMPLOYER (By ER or DGE)

120116

Form **1094-C**

Department of the Treasury
Internal Revenue Service

Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

▶ Information about Form 1094-C and its separate instructions is at *www.irs.gov/form1094c*

☐ CORRECTED

OMB No. 1545-2251

2015

Part I Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer)

2 Employer identification number (EIN)

3 Street address

4 City or town

6 Country and ZIP or foreign postal code

7 Name of person to contact

8 Contact telephone number

9 Name of Designated Government Entity (only if applicable)

10 Employer identification number (EIN)

11 Stree

12 City

14 Country and ZIP or foreign postal code

15 Name of person to contact

16 Contact telephone number

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17 Reserved . . . . . ☐

18 Total number of Forms 1095-C submitted with this transmittal . . . . .

19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continu . . . ☐

Part II ALE Member Information

20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member . . . . . ▶

21 Is ALE Member a member of an Aggregated ALE Group? . . . . . ☐ Yes ☐ No

If "No," do not complete Part IV.

22 **Certifications of Eligibility (select all that apply):**

☐ **A.** Qualifying Offer Method ☐ **B.** Qualifying Offer Method Transition Relief ☐ **C.** Section 4980H Transition Relief ☐ **D.** 98% Offer Method

U enalties of perjury, I declare that I have e ed this return and accompanying documents, and to the b my knowledge and belief, they are true, corre mplete.

ork Rec ns. ▶ Title ▶

Reporting Employer Information

Designated Government Entity (DGE). A DGE is a person or persons that are part of or related to the Governmental Unit that is the ALE Member and that is appropriately designated for purposes of these reporting requirements.

If single employer plan or employer of controlled group plan, Check Box 19 yes and complete remainder of Part 2.

If #21 is yes, complete Part IV (Control Group Rules)

Full-time EE 1 or more months, MV, FPL safe harbor. 1A on Line 14 of 1095-C. Line 15 blank.

Qualifying offer (MV, FPL) to 95% of full-time EE's in one or more CY 2015 months; Line 14 code 1A or 1I only. 2015 only

50-99 EE's "A" in column (e); 100+ employees not 100% offered coverage, "B" in column (e) on Part III

Offered MV, Affordable coverage to 98% of all employees for whom 1095-C filed; and MEC to dependents all months of reporting year. Don't complete

Form 1094-C – ALE Transmittal

Completed for EMPLOYER (By ER or DGE)

120215

Form 1094-C (2014) Page 2

Part III ALE Member Information—Monthly

		(a) Minimum Essential Coverage Offer Indicator		(b) Full-Time Employee Count for ALE Member	(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Section 4980H Transition Relief Indicator
		Yes	No				
23	All 12 Months	☐	☐			☐	
24	Jan	☐	☐			☐	
25	Feb					☐	
26	Mar						
27	Apr						
28	May						
29	June						
30	July						
31	Aug					☐	
32	Sept					☐	
33	Oct					☐	
34	Nov	☐	☐			☐	
35	Dec	☐	☐				

Form **1094-C** (2014)

Check "Yes" for all months coverage MEC offered to 95% of full-time employees plus dependents.

In 2015, also check "Yes" box for Transition Relief month (if needed).

- **Non Calendar Plan Year**
- *** Offer Made to 70% FT EE**
- **No Dependents 2015**
- **Jan 2015 only relief – coverage as of 1st pay in 2015**

Full-time employees not including those in Limited Non-Assessment Period i.e. 1) 1st three months of calendar year (Jan-Mar) in which ALE if ER didn't offer; 2) wait period under monthly measurement method; 3) initial waiting period for FT EE & initial measurement period + admin period PT/VAR EE measured in look back measure period, 4)wait period after change in status from PT/VAR to FT; 5) First fractional month of employment, coverage in prior year

Monthly employee count on (1) first or (2) last day of each month, or (3) the 12th day of each month; or (4) first or (5) last day of first pay period of each month = FT + PT + Variable + Seasonal + EE's in LNA

Check for months in which part of controlled group

Enter "A" employer has 50-99 employees and claiming Midsize Employer Transition Relief – no penalties in 2015.

Enter "B" if Relief when Assessing Penalties Elected– 100+ employees claiming 80 exemption relief

Part II Line 22 Box C must be checked

Should total (FT EE Offer Code on Line 14 incl Code 1I) PLUS (FT EE's reported 1H on line 14 and 2I on line 16) EXAMPLE

GEHRING GROUP INSURANCE BROKERS & CONSULTANTS

Form 1094-C – ALE Transmittal

Completed for EMPLOYER (By ER or DGE)

120315

Form 1094-C (2014) Page 3

Part IV Other ALE Members of Aggregated ALE Group

Enter the names and EINs of Other ALE Members of the Aggregated ALE Group (who were members at any time during the calendar year).

	Name	EIN		Name	EIN
36			51		
37			52		
38			53		
39					
40					
41					
42					
43					
44			59		
45			60		
46			61		
47			62		
48			63		
49			64		
50			65		

Complete if Checked YES on Line 21.
Complete Part III Column D.
Only include other members of Controlled Group. List top 30 in descending order – highest # monthly average FT EE's to lowest.

Form 1094-C (2014)

Form 1094-C – ALE Transmittal

Completed for EMPLOYER (By DGE)

120116

Form 1094-C

Department of the Treasury
Internal Revenue Service

Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

► Information about Form 1094-C and its separate instructions is at *www.irs.gov/form1094c*

☐ CORRECTED

OMB No. 1545-2251

2015

Part I Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer)		2 Employer identification number (EIN)
ACALAND County Clerk of Court		28-0334688
3 Street address (including room or suite no.)		
2550 Fiduciary Way		
4 City or town	5 State or province	6 Country and ZIP or foreign postal code
Reportaway	FL	34888
7 Name of person to contact		8 Contact telephone number
Cindy Thompson		561-626-7770
9 Name of Designated Government Entity (only if applicable)		10 Employer identification number (EIN)
ACALAND County Board of County Commissioners		28-6683440
11 Street address (including room or suite no.)		
2555 Legislation Way		
12 City or town	13 State or province	14 Country and ZIP or foreign postal code
Reportaway	FL	34888
15 Name of person to contact		16 Contact telephone number
Kate Grangard		561-626-6797

County
DGE – Non AG
Qualify Offer-1A
100+ EE's

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18 Total number of Forms 1095-C submitted with this transmittal . . . . . ► 268

19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions . . . . . ☒

Part II ALE Member Information

20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member . . . . . ► 268

21 Is ALE Member a member of an Aggregated ALE Group? . . . . . ☐ Yes ☒ No

If "No," do not complete Part IV.

22 **Certifications of Eligibility (select all that apply):**

☒ **A.** Qualifying Offer Method ☐ **B.** Qualifying Offer Method Transition Relief ☒ **C.** Section 4980H Transition Relief ☐ **D.** 98% Offer Method

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

► Signature _____ ► Title _____ ► Date _____

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 61571A Form **1094-C** (2015)

Form 1094-C – ALE Transmittal

Completed for EMPLOYER (By DGE)

120216

Form 1094-C (2015) Page 2

Part III ALE Member Information – Monthly

		(a) Minimum Essential Coverage Offer Indicator		(b) Full-Time Employee Count for ALE Member	(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Section 4980H Transition Relief Indicator
		Yes	No				
23	All 12 Months	☒	☐			☐	B
24	Jan	☐	☐	238	250	☐	
25	Feb	☐	☐	239	252	☐	
26	Mar	☐	☐	250	260	☐	
27	Apr	☐	☐	252	262	☐	
28	May	☐	☐	260	270	☐	
29	June	☐	☐	260	270	☐	
30	July	☐	☐	262	285	☐	
31	Aug	☐	☐	260	283	☐	
32	Sept	☐	☐	245	255	☐	
33	Oct	☐	☐	250	265	☐	
34	Nov	☐	☐	252	262	☐	
35	Dec	☐	☐	252	265	☐	

Form 1094-C (2015)

Form 1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

Potential Penalties for Non Compliance

May be waived if:

- Limited relief for incomplete/incorrect returns & statements filed in 2016 for 2015 - transitional relief for "good faith" efforts
- Failure due to reasonable cause (not willful neglect)
- Penalties can increase if "intentional disregard"
- Penalties can be assigned 2 times per return: for 1) not sending to employees and 2) not filing with IRS

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The Reporting Challenge

Topics Discussed

- Correcting the Forms 1095-C
- Review the 1094-C Form in Detail
- Review Completed Form 1094-C Forms
- Q&A: E-mail to cindy.Thompson@gehringgroup.com

Future Webinar & Seminar Topics

- Cadillac Tax Update
- ACA Update – SBC, Notice of Benefits & Payments
- Legal Update – (Seminar)
- ACA Audits – DOL ERISA Audit & Section 1411 Letter

The Reporting Challenge

GEHRING GROUP
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The Reporting Challenge

Q&A?

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Kate cell: (561) 629-2001

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EXHIBIT 6
Sample Employee Benefit Newsletters

Brought to you by Gehring Group

ATTENTION SELF-INSURED EMPLOYERS!
Reinsurance Fee Contribution Form Due Nov. 16, 2015

The Affordable Care Act (ACA) imposes a fee on health insurance issuers and self-funded group health plans in order to fund a transitional reinsurance program for the first three years of Exchange operation (2014-2016). The fees will be used to help stabilize premiums for coverage in the individual market.

Entities that must pay these fees, called "contributing entities," are generally required to submit their annual enrollment count to the Department of Health and Human Services (HHS) by **Nov. 15** of each benefit year.

Annual enrollment counts are submitted via www.pay.gov using the Annual Enrollment and Contributions Submission Form. **There is a specific form for each benefit year. The contribution form for the 2015 benefit year became available on Oct. 1, 2015.** Once logged in, use the search terms "**2015 ACA Transitional Reinsurance**" to access the form to file the Annual Enrollment Count and schedule the contribution payment(s).

For the 2015 benefit year, the deadline for submitting the reinsurance fee contribution form is Nov. 16, 2015 (as Nov. 15 is a Sunday). The payment deadlines for entities making two payments are Jan. 15, 2016, and Nov. 15, 2016. For entities making one payment, the full contribution amount is due Jan. 15, 2016.

Contributing Entities

A contributing entity is defined as a health insurance issuer or a third-party administrator (TPA) on behalf of a self-insured group health plan.

- ***Fully-insured Group Health Plans***—For insured health plans, the **issuer of the health insurance policy** (most often an insurance carrier) is required to pay reinsurance fees. However, issuers will likely shift the cost of the fees onto sponsors through premium increases.
- ***Self-insured Group Health Plans***—For self-insured group health plans, the **plan sponsor** is liable for paying reinsurance fees, although a TPA or an administrative-services-only (ASO) contractor may pay the fee at the plan's direction. For a plan maintained by a single employer, the employer is the plan sponsor.

However, there is a limited exception for self-insured, self-administered plans. For 2015 and 2016, the term "contributing entity" excludes self-insured group health plans that do not use a TPA for the core administrative functions of claims processing or adjudication (including management of appeals) or plan enrollment.

Deadlines

Contributing entities are required to submit their annual enrollment count to HHS, generally by Nov. 15 of each benefit year. Because Nov. 15, 2015, is a Sunday, contributing entities must submit the annual enrollment count by **Nov. 16, 2015**.

These fees may be paid in two installments—one at the beginning of the calendar year following the applicable benefit year, and then one at the end of that calendar year. However, contributing entities may choose to make the full payment at one time.

Reinsurance Fee Contribution Form Due Nov. 16, 2015

Key deadlines for the 2015 benefit year are:

- ***Oct. 1, 2015***—The 2015 ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form is expected to become available on www.pay.gov on Oct. 1, 2015.
- ***Nov. 16, 2015***—Entities must submit their annual enrollment counts using the Annual Enrollment and Contributions Submission Form by Nov. 15, 2015. Entities must also schedule payment at this time (entities making two payments should submit the contribution form and schedule payment of the first collection, then duplicate the form and schedule payment of the second collection).
- ***Jan. 15, 2016***—For entities making two payments, the first contribution amount of $33 per covered life is payable by Jan. 15, 2016. For entities making one payment, the full contribution amount of $44 per covered life is payable by Jan. 15, 2016.
- ***Nov. 15, 2016***—For entities making two payments, the second contribution amount of $11 per covered life is payable by Nov. 15, 2016.

Reinsurance Contribution Amounts

The reinsurance program's fees are based on a national contribution rate, which HHS announces annually.

For 2014, the annual contribution rate was **$63 per enrollee** per year, or $5.25 per month.

For 2015, the annual contribution rate is **$44 per enrollee** per year, or about $3.67 per month.

For 2016, the annual contribution rate is **$27 per enrollee** per year, or $2.25 per month.

Several methods are available to determine the number of covered lives under a health plan:

- The Actual Count Method;
- The Snapshot Count Method;
- The Snapshot Factor Method;
- The Member Months or State Form Method; and
- The Form 5500 Method.

The permitted counting method depends on whether the contributing entity is a health insurance issuer or a self-insured group health plan, and whether, in the case of a group health plan that is a contributing entity, the plan offers more than one coverage option.

The Collection Process

A contributing entity can complete all of the required steps (that is, registration, submission of annual enrollment count and remittance of contributions) on www.pay.gov. Using a contribution form, entities will provide basic company and contact information and the annual enrollment count for the applicable benefit year. The contribution form for 2015 is expected to become available via www.pay.gov on **Oct. 1, 2015**.

The form will auto-calculate the contribution amounts. To complete the submission, entities will also submit payment information and schedule a payment date for the contributions. Supporting documentation must also be submitted through www.pay.gov with the contribution form.

NOTE: If you are reporting for three (3) or fewer entities, the Suppoting Documentation (.CSV) file is **NOT** required. If you are reporting for four (4) ore more entities, the Supporting Documentation (.CSV) file **IS** required.

More Information

HHS offers training for the www.pay.gov collection process. To receive notices from HHS regarding upcoming training and to review training resources, register at www.regtap.info.

HHS also provided an Annual Enrollment and Contributions Submission Form Manual, which provides step-by-step instructions for completing and submitting the contribution form and supporting documentation, details on key elements and business concepts, and resources to further assist the contributing entity. A Supporting Documentation Job Aid Manual is also available to help contributing entities create the supporting documentation.

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PCORI FEE REMINDER

It's July and for those of you that are self-insured plan administrators, we wanted to remind you to file your PCORI Fee which is **due by July 31, 2015**. The PCORI (Patient Centered Outcome Research Institute) Fee is the annual fee assessed for 7 years under the ACA that is assessed on all plans, fully insured and self-insured. For fully insured plans, the carrier collects and remits the fee. For self-insured plans, the plan sponsor is responsible for remitting the fee on behalf of the plan. The amount due is calculated on a per belly button basis counting all plan members, including dependents for the plan year. Below is a link to the form that was updated April 2015:
http://www.irs.gov/pub/irs-pdf/f720.pdf

GETTING THE "COUNT"

There are various methods to calculate the belly button count for the PCORI fee. Most entities use the Snapshot Method which is further described in our May 22, 2014 webinar slide deck under the *Webinars & Seminars* tab of our client portal entitled: ***Calculating the Count & Completing the Form 720 for PCORI Fees.***

If you are a BenTek client, you can produce a snapshot report from BenTek by accessing the PCORI Report in the Reports section of BenTek and entering the applicable reporting period. Call your account manager if you would like their assistance. If you are self-insured without BenTek, please contact your Gehring Group analyst to see if this reporting is available from your carrier. Updated IRS has recently updated the instructions that can be found here:
http://www.irs.gov/pub/irs-pdf/i720.pdf

CALCULATING THE FEE

If your plan year ended on/between October 1, 2013 and September 30, 2014, this is your 2nd filing year and the fee per belly button is $2.00 for this return.

If your plan year ends on/between October 1, 2014 and September 30, 2015, this is your 3rd year filing the fee and the fee per belly button is $2.08 for this return.

The fee is due to be paid no later than July 31st of the calendar year immediately following the last day of the plan year to which the fee applies. All self-insured plans should have a filing requirement this July if the plan year ended any time during the 2014 calendar year. In summary, plan years that ended January 1 – September 30, 2014 will pay the $2.00 rate, and plans that ended Octover 1 – December 31, 2014 will pay the $2.08 rate, per belly button, respectively on this July 31, 2015 Form 720 return. Please note that the rate is not included on the Form itself as it was in prior years, but a Table to calculate the fee is provided for your convenience on page 9 of the instructions (you would use lines 4 or 5 only).

PCORI FEE REMINDER

REPORTING & PAYING THE FEE (Excerpted from the instructions)

File Form 720 annually to report and pay the fee on the second quarter Form 720, no later than July 31 of the calendar year immediately following the last day of the policy year or plan year to which the fee applies. Because the rate used to determine the fee varies from year to year, you should determine the fee using the instructions for the second quarter Form 720.

If you file Form 720 only to report the fee, do not file Form 720 for the first, third, or fourth quarters of the year. If you file Form 720 to report quarterly excise tax liability for the first, third, or fourth quarter of the year (for example, filers reporting the foreign insurance tax (IRS No. 30)), do not make an entry on the line for IRS No. 133 on those filings.

Deposits are not required for this fee, so issuers and plan sponsors are not required to pay the fee using Electronic Federal Tax Payment System (EFTPS). However, if the fee is paid using EFTPS, the payment should be applied to the second quarter. See Electronic deposit requirement under Payment of Taxes, later.

Report the average number of lives covered in column (a). Apply the applicable rate and enter the fee in column (c).

***Note.** Enter the fee only, not the $2.00 applicable rate or the $2.08 applicable rate. Combine the fees for specified health insurance policies and applicable self-insured health plans and enter the total in the tax column on the line for IRS No. 133. Use Table for IRS No. 133 below, if you have policies or plans subject to both the $2.00 applicable rate and the $2.08 applicable rate.*

If you have any further questions, please don't hesitate to reach out to your Gehring Group service team.

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IRS Releases Final Forms and Instructions for ACA Reporting

Quick Facts

- On Feb. 8, 2015, the IRS issued final forms and instructions for Section 6055 and 6056 reporting.
- Final instructions provide a new option for some ALEs reporting information for nonemployees.
- Although these forms are not required to be filed for 2014, employers may voluntarily file in 2015 for 2014 coverage, using these forms and instructions.

The Affordable Care Act (ACA) created new reporting requirements under Internal Revenue Code (Code) Sections 6055 and 6056. Under these new reporting rules, certain employers must provide information to the IRS about the health plan coverage they offer (or do not offer) to their employees.

On Feb. 8, 2015, the Internal Revenue Service (IRS) **released final versions** of forms and related instructions that employers may use to report under Sections 6055 and 6056 for 2014. These forms are **not required to be filed for 2014,** but reporting entities may voluntarily file them in 2015 for 2014 coverage.

Forms and instructions for calendar year 2015 reporting have not yet been released and may contain some changes from the 2014 versions.

On Feb. 9, 2015, the IRS also issued Publication 5196, Understanding Employer Reporting Requirements of the Health Care Law, to help employers prepare for reporting in 2016.

> On Feb. 8, 2015, the IRS released final versions of forms and instructions that employers will use to report information about the health plan coverage they offer (or do not offer) to employees.

Few Changes in Final Forms

The final versions of the forms do not differ significantly from the draft versions. In general, the final instructions were edited to clarify existing requirements. However, the final instructions for Forms 1094-C and 1095-C did include a **new option for applicable large employers (ALEs) reporting information for nonemployees** (such as nonemployee directors, retired employees or nonemployee COBRA beneficiaries) covered under employer-sponsored self-insured health coverage.

Section 6055 Forms and Instructions

The following forms and instructions are available for use under Section 6055:

IRS Releases Final Forms and Instructions for ACA Reporting

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

Section 6056 Forms and Instructions
The following forms and instructions are available for use under Section 6056:

- **Form 1094-C**, Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Return
- **Form 1095-C,** Employer-Provided Health Insurance Offer and Coverage
- Instructions for Forms 1094-C and 1095-C

Section 6055 Reporting
Under Section 6055, every person that provides minimum essential coverage (MEC) to an individual during a calendar year must file Forms **1094-B** (a transmittal) and **1095-B** (an information return), including:

- Health insurance issuers or carriers;
- Self-insured health plan sponsors;
- Government agencies that administer government-sponsored health insurance programs; and
- Any other entity that provides MEC.

Self-insured plan sponsors that are also ALEs subject to the employer shared responsibility rules will report information about the coverage in **Part III of Form 1095-C**, instead of on Form 1095-B. In general, an employer with 50 or more full-time employees (including full-time equivalents) during the prior calendar year is considered an ALE.

Section 6056 Reporting
All ALEs (as defined under the employer shared responsibility rules) must file **Form 1094-C** (a transmittal) and **Form 1095-C** (an information return) for each full-time employee.

- Form 1094-C is used to report summary information for each employer to the IRS as a transmittal for filing the Forms 1095-C to the IRS.
- Form 1095-C is used to report information about each employee. A copy is filed with the IRS with the Form 1094-C and a copy is sent to each applicable employee.

These forms help the IRS determine whether an ALE owes penalties under the employer shared responsibility rules, as well as whether an employee is eligible for premium tax credits.

Combined Reporting
Form 1095-C will generally be used by ALEs to satisfy both the Section 6055 and 6056 reporting requirements, as applicable.

- An ALE that sponsors a self-insured plan will complete all sections of Form 1095-C to report the information required under both Sections 6055 and 6056. Therefore, these ALEs will be able to use a single form to report information regarding whether an employee was covered.
- An ALE that provides insured coverage will also report on Form 1095-C, but will complete only the sections of Form 1095-C related to Section 6056.

ALEs will also be providing only a single employee statement (with the Section 6056 information, and, with respect to employers with a self-insured group health plan, Section 6055 information).

IRS Releases Final Forms and Instructions for ACA Reporting

New Option for ALEs Reporting Enrollment Information for Nonemployees

The final instructions for Forms 1094-C and 1095-C include a new option for ALEs reporting information for nonemployees (such as nonemployee directors, retirees or nonemployee COBRA beneficiaries).

This new option allows employers to report employer-sponsored self-insured health coverage for nonemployees (and their family members) using either Forms 1094-B and 1095-B or Form 1095-C, Part III.

This option applies only for ALEs offering self-insured health coverage for any individual who enrolled in the coverage for one or more calendar months of the year, but was not an employee for any calendar month of the year, such as:

- A nonemployee director;
- A noncompensated elected official;
- A retired employee who retired in a previous year;
- A terminated employee receiving COBRA coverage who terminated employment during a previous year; and
- A nonemployee COBRA beneficiary.

A nonemployee does *not* include an individual who obtained coverage through the employee's enrollment, such as a spouse or dependent obtaining coverage when an employee elects family coverage.

Under this new option, ALEs may report enrollment for these individuals using either:

- Forms 1094-B and 1095-B; or
- Form 1095-C, Part III.

If the Form 1095-C is used with respect to an individual who was not an employee for any month of the calendar year, Part II must also be completed by using Code 1G on Line 14 in the "All 12 Months" box (or the box for each month of the calendar year).

In the case of a nonemployee who enrolls in the coverage under a self-insured health plan, all family members who are covered individuals due to the individual's enrollment must be included on the same Form 1095-B or Form 1095-C as the individual who is offered, and enrolls in, the coverage.

Changes to Alternative Methods of Reporting Under Section 6056

The final instructions for Forms 1094-C and 1095-C also made several changes to the alternative methods of reporting under Section 6056. Two alternative methods of reporting are available under Section 6056—the **Qualifying Offer Method** (and the Qualifying Offer Method Transition Relief for 2015) and the **98 Percent Offer Method**.

The **Qualifying Offer Method** (and the Qualifying Offer Method Transition Relief for 2015) allows eligible ALEs to provide simplified employee statements to certain employees, in lieu of a copy of the Form 1095-C. The final instructions added to the list of information that must be included in these simplified employee statements. A statement is now required that directs the employee to see IRS Publication 974, Premium Tax Credit (PTC), (currently in draft form) for more information on eligibility for the premium tax credit.

Also, the final instructions clarified that ALEs may not use the alternative method of furnishing Form 1095-C to employees under the Qualifying Offer Method (or the Qualifying Offer Method Transition Relief for 2015) for **employees who enrolled in self-insured coverage**.

For these employees, the ALE must furnish the information reporting enrollment in the self-insured coverage on Form 1095-C, Part III. The ALE may provide this information to the employee by furnishing a copy of Form 1095-C as filed with the IRS (with or without the statements regarding any qualifying offer the employee received or the employee's premium tax credit eligibility).

The 98 Percent Offer Method is generally available to ALEs that offer MEC that is affordable and provides minimum value to at least 98 percent of the employees on whom it reports in its Section 6056 return. The final instructions clarify that **ALEs must also offer MEC to those employees' dependents** to be eligible to use the 98 Percent Offer Method. For this purpose, the term "dependent" is defined to include an employee's child, but does not include a spouse.

Additional Changes in the Final Instructions
The final instructions also made the following changes and clarifications:

- The Employer Identification Number (EIN) *may* be truncated on any statements furnished to employees or individuals, but *not* on any forms filed with the IRS (previously, truncation of EINs was not allowed on any forms).
- When determining the total employee count for the ALE for purposes of Form 1094-C, Part III, Column (c), an ALE may now choose to use either the first or last day of **the first payroll period** that starts during each month, or the first or last day of each month.
- All ALEs, including U.S. ALEs, should include a country code with the employee's address in Part I of Form 1095-C.
- An offer of coverage is treated as having been made to an employee's dependents only if the offer of coverage is made to an unlimited number of dependents, regardless of the actual number of dependents (if any) an employee has during any particular calendar month.
- If spouses (or employee and dependent) are employed by the same ALE, and one employee enrolled in a coverage option that also covered the other employee(s) (for example, family coverage that provided coverage to the other employee spouse and their employee dependent child), the enrollment information should be reflected only on the Form 1095-C for the employee who enrolled in the coverage (but it would report the other employee family members as covered individuals).
- An ALE is not required to file a Form 1095-C for an individual who, for all months of a calendar year, is either not an employee of the ALE or is in a limited non-assessment period. However, for the months in which the employee was an employee of the ALE, he or she would be included in the total employee count reported on Form 1094-C, Part III, Column (c). (Also, if the employee enrolled in self-insured employer-sponsored coverage during the limited non-assessment period, the employer must file a Form 1095-C for the employee in order to report coverage information for the year.)
- For purposes of reporting, an offer to a spouse includes an offer to a spouse that is subject to a reasonable, objective condition, regardless of whether the spouse meets the condition. For example, an offer to a spouse that is available only if the spouse certifies that he or she does not have access to health coverage from another employer is treated as an offer of coverage to the spouse for

reporting purposes. (Note that this treatment is for reporting purposes only, and generally will not affect the spouse's eligibility for the premium tax credit if the spouse did not meet the condition and therefore did not have an actual offer of coverage.)

Gehring Group remains committed to educating our clients with regard to ACA compliance. We will be scheduling webinars that will be specifically directed to the various scenarios of our client population size and funding arrangement. For example, we anticipate hosting separate webinars for 1094/1095 reporting for clients with the following size and funding combinations:

- **Small Group < 50 – Fully insured**
- **Small Group < 50 – Self insured**
- **Large group 100 ≥ – Fully insured**
- **Large group 100 ≥ – Self insured**
- **Large group 50-99 – Fully insured**
- **Large group 50-99 – Self insured**

More Information

Please contact Gehring Group for more information on reporting under Code Sections 6055 and 6056, or see the IRS' Q&As on Section 6055 and Q&As on Section 6056. Thank you as always for placing your trust in us throughout these changing times.

STATE EMPLOYMENT LAWS

Provided By Gehring Group

Benefits for Same-sex Couples and Domestic Partners

A significant number of U.S. companies provide benefits, such as health insurance coverage, for their employees' domestic partners or same-sex spouses. Businesses may decide to offer these benefits to attract and retain talented employees or because they desire to provide equal benefits regardless of marital status or sexual orientation.

At the federal level, there are no laws that require or prohibit domestic partner or same-sex spouse benefits in the workplace. However, employee benefits for domestic partners generally do not receive the same favorable federal tax treatment as benefits for spouses. Also, a number of states have enacted same-sex marriage, civil union and domestic partnership laws that affect benefits for domestic partners and same-sex spouses.

This Employment Law Summary provides an overview of the federal and state laws that affect domestic partner and same-sex spouse benefits for Florida employers. It also outlines action steps for employers to consider when providing benefits for employees' same-sex spouses and domestic partners.

Effective **Jan. 6, 2015**, Florida law allows two persons of the same sex to marry.

STATE LAW

Overview

Laws on same-sex marriage, civil unions and domestic partnerships vary from state to state. Up until recently, most states had laws or constitutional amendments that prohibited same-sex marriage. Now, same-sex marriage is legal in the majority of states. This legal change is due in large part to a string of federal court decisions that, beginning in late 2013, have declared state bans on same-sex marriage unconstitutional. Although many states had their same-sex marriage bans invalidated by court decisions, other states passed laws to legalize same-sex marriage.

Also, a small number of states have laws granting spousal-like rights to unmarried couples through civil unions and domestic partnerships.

Same-sex Marriage

Florida had a law that limited the terms "marriage" and "spouse" to unions between one man and one woman. On Aug. 21, 2014, a federal district court ruled that Florida's ban on same-sex marriage is unconstitutional. However, following the court's ruling, same-sex couples were not permitted to marry because the ruling was put on hold until Jan. 5, 2015, pending appeal.

On Dec. 3, 2014, the 11th U.S. Circuit Court of Appeals declined to extend the hold that expired on Jan. 5, 2015. This means that same-sex marriages are permitted in Florida, effective Jan. 6, 2015.

The judicial hold on same-sex marriages in Florida expired on Jan. 5, 2015. Therefore, same-sex couples in Florida are permitted to marry, effective Jan. 6, 2015.

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Benefits for Same-sex Couples and Domestic Partners

Other State Laws

Florida does not have a civil union or domestic partnership law that grants spousal-like rights to unmarried couples.

Florida's fair employment law does not cover discrimination based on sexual orientation or gender identity. However, in 1991, a Florida court concluded that discrimination based on gender identity falls under a fair employment prohibition on disability discrimination.

Also, since Florida does not have a state income tax on wages, health plan coverage for same-sex spouses is tax-free at both the federal and state levels in Florida.

FEDERAL LAW

Supreme Court's DOMA Ruling

The U.S. Congress enacted the Defense of Marriage Act (DOMA) in 1996 in response to concerns about state legalization of same-sex marriage. DOMA banned federal recognition of same-sex marriage by solely defining "marriage" as the legal union between one man and one woman as husband and wife.

On June 26, 2013, the U.S. Supreme Court struck down a key part of DOMA by ruling that the law's definition of marriage violates the U.S. Constitution's guarantee of equal protection.

> As a result of the Supreme Court's ruling, legally married same-sex couples are entitled to the **same benefits and protections under federal law** as opposite-sex married couples.

The Supreme Court's ruling did not invalidate state laws prohibiting same-sex marriages. However, since the Court's DOMA decision, most federal courts reviewing challenges to state bans on same-sex marriage have concluded that the state bans are unconstitutional.

Same-sex Marriages

Due to the Supreme Court's decision, **same-sex marriages must be recognized on the same terms as opposite-sex marriages for purposes of federal employee benefits laws.** The Supreme Court's DOMA decision provides that the federal government may not discriminate against same-sex couples who are legally married. The decision does not require employers to provide the same benefits to opposite-sex and same-sex spouses.

After the Supreme Court's DOMA decision, the Internal Revenue Service (IRS) and Department of Labor (DOL) adopted a **"state of celebration" policy** for determining when a same-sex marriage will be treated as valid for purposes of federal tax law. Under the state of celebration policy, same-sex couples who are legally married in states (including foreign jurisdictions) that recognize their marriages will be treated as married for federal purposes. This rule applies regardless of whether the couple lives or works in a jurisdiction that recognizes same-sex marriage.

Due to the Supreme Court's DOMA ruling, these rules apply to employee benefits under federal law:

- An employer should not impute additional income to an employee who covers his or her same-sex spouse as a dependent under the employer's health plan.
- An eligible employee may pay for a same-sex spouse's health coverage on a pre-tax basis through a cafeteria (or section 125) plan in the same way as an employee with an opposite-sex spouse.
- An eligible employee may receive tax-free reimbursements for expenses of his or her same-sex spouse through a health flexible spending account (FSA), health reimbursement account (HRA) or health savings account (HSA).
- If a health plan provides coverage for same-sex spouses, special enrollment rights under HIPAA will be triggered when an employee acquires a same-sex spouse and same-sex spouses will have their own COBRA election rights.

Benefits for Same-sex Couples and Domestic Partners

Additionally, a same-sex spouse is considered a spouse or family member for purposes of taking leave under the federal **Family and Medical Leave Act** (FMLA). For purposes of the FMLA, the term "spouse" includes a same-sex spouse if the marriage is recognized under the laws of the state where the employee resides. However, on June 20, 2014, the DOL issued a proposed rule that would change the definition of "spouse" under the FMLA to look to the law of the jurisdiction in which the marriage was entered into, as opposed to the law of the state in which the employee resides. Until final guidance is issued extending FMLA rights to all legally married same-sex spouses (regardless of residence), employers will not be required to make FMLA leave available to a same-sex spouse who resides in a state that does not recognize same-sex marriage.

The administration of benefits for same-sex couples may be complicated in states that do not recognize same-sex marriages. For example, even though health coverage for a same-sex spouse is tax-free at the federal level, it may still be taxable at the state level. Also, state law employee leave rights may not be available to same-sex spouses in states that do not recognize same-sex marriages.

Civil Unions and Domestic Partnerships

The Supreme Court's DOMA decision applies only to same-sex marriages that are valid under state law. It does not affect same-sex couples in civil unions or domestic partnerships. **These couples will generally remain ineligible for the federal benefits and protections provided to spouses.** However, some states have laws that provide benefits and protections to couples in civil unions or domestic partnerships.

At the federal level, domestic partner benefits are non-taxable only if the domestic partner qualifies as a dependent under the Internal Revenue Code's definition of "qualifying relative." To qualify as a dependent under this definition, the domestic partner must generally:

- Have the same primary address as the employee/taxpayer for the year;
- Be a member of the employee/taxpayer's household;
- Receive more than half of his or her support for the year from the employee/taxpayer;
- Not be anyone's "qualifying child" for tax purposes; and
- Be a citizen or national of the U.S., or a resident of the U.S. or a country contiguous to the U.S.

If a domestic partner does not qualify as a tax dependent of the employee, employers are required to report and withhold taxes on the value of employer-provided health coverage for the domestic partner. In addition, an employee cannot pay for a domestic partner's coverage on a pre-tax basis through a cafeteria (or section 125) plan if the partner is not the employee's tax dependent.

It is common for employers to "gross up" an employee's salary to offset the tax consequences of domestic partner benefits (that is, reimburse employees for the extra taxes they are required to pay on the value of domestic partner benefits).

Due to the Supreme Court's DOMA decision, there has been speculation that employers may discontinue their domestic partner benefits, particularly in states where same-sex marriage has been legalized. However, domestic partner benefits will likely remain popular with employers that want to provide benefits to same-sex couples and have employees in states that have not legalized same-sex marriage.

HEALTH PLAN COVERAGE FOR SAME-SEX SPOUSES

Federal law does not require employers to offer coverage to same-sex spouses under their health plans. However, employers with fully-insured plans that offer spousal coverage may be required by **state insurance law** to offer coverage to both opposite-sex and same-sex spouses. This is generally the case in states that have legalized same-sex marriage.

Also, even if an employer is not required by state insurance law to offer coverage to same-sex spouses (for example, because the employer has a self-funded plan), the employer may be at risk for **discrimination lawsuits** if coverage is offered only to opposite-sex spouses.

In addition, if an employer wants to offer coverage to same-sex spouses, the Affordable Care Act (ACA) prohibits health insurance issuers from discriminating based on sexual orientation. This means that a

Benefits for Same-sex Couples and Domestic Partners

health insurance issuer in the group or individual market that offers coverage for an opposite-sex spouse is prohibited from refusing to offer coverage to a same-sex spouse. While issuers were encouraged to offer coverage for same-sex spouses in 2014, issuers must fully comply with this requirement for plan or policy years beginning on or after **Jan. 1, 2015**.

Employers with Insured Health Plans

- Review state insurance law to determine if it requires equal coverage for same-sex and opposite-sex spouses.
- In states that have legalized same-sex marriage, equal coverage is likely required.
- Even if state insurance law does not require coverage for same-sex spouses, employers that do not offer equal benefits to same-sex spouses may be at risk for discrimination lawsuits.

Employers with Self-funded Health Plans

- Self-funded plans are generally not subject to state insurance law.
- Even if an employer is located in a state that has legalized same-sex marriage, state insurance law will generally not require the plan to cover same-sex spouses.
- However, employers that do not offer equal benefits to same-sex spouses may be at risk for discrimination lawsuits.

ACTION STEPS

Effective Jan. 6, 2015, same-sex marriage is permitted in Florida and employers are generally required to treat employees in a same-sex marriage the same as employees in an opposite-sex marriage. This equal treatment also extends to federal benefits and protections, such as the FMLA leave, due to the Supreme Court's DOMA decision.

In addition, employers that are interested in providing domestic partner benefits should:

- Review their employee benefits package to determine which benefits should be offered to domestic partners;
- Consult with tax advisors and payroll vendors regarding the tax implications of providing benefits to domestic partners; and
- Communicate benefit changes to employees on a periodic basis, including changes for domestic partners and tax implications.

Live Well, Work Well

May 2014

Presented by: Gehring Group

Fat Myths

When it comes to fat consumption, it often seems like there's a lot of noise and little agreement about how much (or how little) you should eat. This can be frustrating for people who are trying to be healthy and follow expert recommendations, and it's tempting to try to eliminate fat intake altogether and let the experts fight it out.

But is the amount of fat you eat really the issue? According to the Harvard School of Public Health, it's time to end the low-fat myth. Research has shown that the number of calories from fat that you eat, whether high or low, isn't really linked with disease. What really matters is the *type* of fat.

Unsaturated fats, which are found in nuts, avocadoes, fish and vegetable oils, are considered "good" fats. Some of these, like omega-3 fatty acids, are considered essential fats that must be eaten regularly because the body cannot produce them internally.

Saturated fats, which are found in cheese, butter, red meat and some oils, have long been seen as a key culprit of heart disease and high cholesterol.

The American Heart Association, along with the Harvard School of Public Health, recommends limiting saturated fat consumption, but cautions against doing so by choosing products that replace fat with sugars and other refined carbohydrates.

In fact, a 2009 review published in the American Journal of Clinical Nutrition concluded that replacing saturated fats with carbs had no discernable benefits, while replacing saturated fats with unsaturated fats reduced the risk of heart disease.

Finally, there are trans fats, found in heavily processed breads, baking mixes, shortening, snack foods and fried foods. For once, there is little disagreement—the overwhelming scientific consensus suggests that trans fats are dangerous. Last year, the Food and Drug Administration took the dramatic step of seeking to redefine artificial trans fats as "generally not recognized as safe."

As for obesity, the trend is clear: Over the past 30 years in the United States, the percentage of calories from fat in people's diets has gone down, but obesity rates have skyrocketed. This suggests that limiting fat intake is not a silver bullet for weight loss.

With the exception of trans fats, eliminating all fat to make your overall diet healthier is a bad idea. The key to a healthy diet, including fat intake, has always been balance.

Stroke is among the leading causes of death in the United States and is a major cause of adult disability.

Provided by: GEHRING GROUP INSURANCE BROKERS & CONSULTANTS

Stroke Awareness Month

Stroke is among the leading causes of death in the United States and is a major cause of adult disability. There are two types of strokes that cause damage to the brain by stopping blood flow: ischemic and hemorrhagic. Ischemic strokes are caused by a blood clot, while hemorrhagic strokes are caused by ruptured blood vessels.

If the stroke occurs in the brain's right side, the left side of the body and face will be affected, which could produce paralysis, vision problems and inquisitive behavior. A stroke occurring on the left side of the brain may produce paralysis on the right side of the body, speech or language problems and slow, cautious behavior.

The chance of having a stroke approximately doubles for each decade of life after age 55. Gender, ethnicity and heredity have also been found to be determining factors in the likelihood of suffering a stroke. However, there are preventive measures you can take to reduce your risk of stroke, including eating a healthy diet, maintaining a healthy weight, getting enough exercise, reducing alcohol consumption and not smoking.

Pilates 101

Pilates is a style of exercise that has recently surged in popularity. It builds flexibility, muscle strength and endurance in your body's core.

Its inventor and namesake Joseph Pilates developed the system in the first half of the 20th century. Drawing on bodybuilding, yoga and gymnastics, Pilates refined his system while held in an internment camp during World War I. Having access to only bare-bones equipment, he designed a crude series of resistance machines, and even today, some Pilates equipment resembles furniture that might be found in a prison hospital. After the war, he immigrated to the United States and opened a studio in New York City, where he taught until the 1960s.

Despite its relative newness on the fitness scene, Pilates has been embraced for the emphasis it puts into improving coordination and balance, as well as developing strong arms, legs, hips, back and abdominal muscles.

People of all fitness levels can enjoy the benefits of Pilates, and it can be an integral part of a total fitness program. Pilates allows for different exercises to be modified for difficulty ranging from beginning to advanced. Intensity can be increased over time as the body conditions and adapts to the exercises.

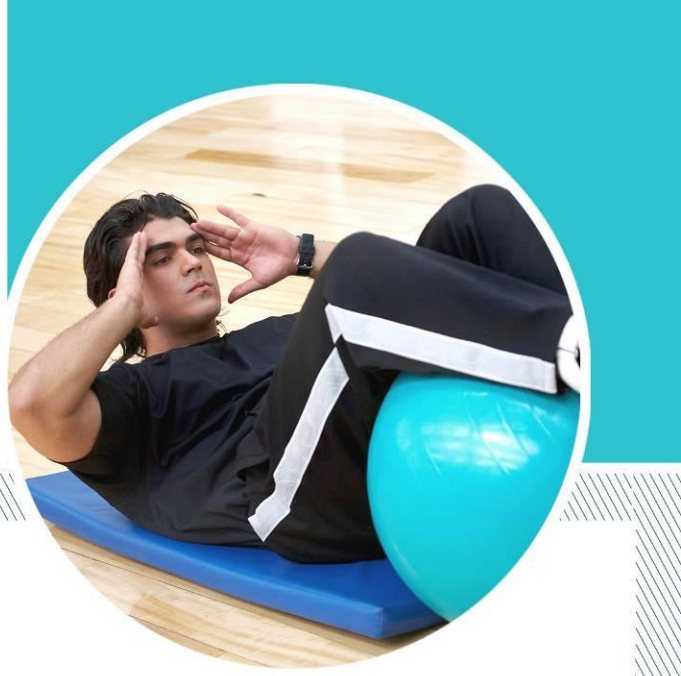
A word of caution, however, when looking for a Pilates studio or trainer: There is no mandatory accreditation process for Pilates instruction, and anyone with no prior training can offer "Pilates" to the public. To find a qualified instructor in your area, check with local gyms and don't be afraid to ask about background training and apprenticeships.

Emergency Savings

No one can predict the future, but it's a pretty safe bet that everyone will run into unforeseen expenses. If an expense is large enough, it can put an unprepared person into the position of having to borrow money or withdraw investments to cover costs.

Emergency savings accounts are an incredibly helpful precaution to guard against uncertainty. Using extra money from paychecks, you should make regular deposits until you have built up a sum large enough to cover your expenses through a prolonged emergency, such as major medical bills, car repairs or the loss of a job. Most experts recommend saving enough to cover at least three months' worth of bills and living expenses.

An emergency savings account has the added benefit of generating interest—even if you stop making contributions, money will still be added. With a fully funded account, you can handle unexpected expenses worry-free.



Sensational Six-Layer Dinner

This delicious casserole brings full restaurant flavor for a fraction of the cost ($1.03 per serving). For a variation, use peas or corn instead of green beans, or use your favorite cream soup instead of tomato soup.

- 2 medium potatoes, sliced
- 2 cups sliced carrots
- ¼ tsp. black pepper
- ½ cup onion, sliced
- 1 pound ground beef, browned and drained
- 1½ cups green beans
- 1 can tomato soup

Lightly grease a baking dish, or spray with cooking spray. Layer ingredients into the dish in the order listed. Cover dish and bake at 350° F for 45 minutes or until tender and thoroughly heated. Remove cover and bake an additional 15 minutes.

Yield: 6 servings. Each serving provides 260 calories, 6g of fat, 2.5g of saturated fat, 65mg of cholesterol, 480mg of sodium and 3g of fiber.

Source: USDA

Brought to you by Gehring Group

IRS Expands Rules for Mid-Year Election Changes Under Cafeteria Plans

Quick Facts

- IRS Notice 2014-55, issued on Sept. 18, 2014, allows cafeteria plans to permit mid-year election changes in certain situations related to the availability of Exchange coverage.
- This guidance is effective immediately.
- Allowing these changes is optional, but cafeteria plan documents must be amended if these options will be included.

On Sept. 18, 2014, the Internal Revenue Service (IRS) issued Notice 2014-55, which expands the situations in which individuals can change their health coverage elections under an Internal Revenue Code (Code) Section 125 cafeteria plan.

This guidance will be welcomed by individuals whose ability to enroll in coverage under a Health Insurance Exchange would have been limited by current IRS regulations.

The IRS intends to modify the regulations under Code Section 125 to be consistent with this notice, but taxpayers may rely on this guidance immediately.

Notice 2014-55 addresses cafeteria plan elections in two specific situations related to the availability of coverage through a Health Insurance Exchange (or Marketplace).

Cafeteria Plan Elections

In most cases, a participant may not change his or her elections under a cafeteria plan during the period of coverage (usually the plan year). However, there are limited exceptions for certain changes in status, if permitted by the plan and if the election change is consistent with the change in status.

Notice 2014-55 addresses cafeteria plan elections in two specific situations related to the availability of coverage through a Health Insurance Exchange (or Marketplace). An employee may want to revoke an election under his or her employer's plan in order to purchase coverage through an Exchange if:

- The employee's hours of service are reduced so that the employee is expected to average less than 30 hours of service per week, but the reduction does not affect eligibility for coverage under the employer's group health plan; or

- The employee would like to cease coverage under the employer's group health plan and purchase coverage through an Exchange, without having a period of either duplicate coverage or no coverage.

In each of these situations, Notice 2014-55 permits a cafeteria plan to allow an employee to prospectively revoke his or her election for coverage under the employer's group health plan during a period of coverage, as long as the plan:

- Is not a health FSA; and
- Provides minimum essential coverage.

Certain conditions must be met for the change to be permitted. Also, an election to revoke coverage on a retroactive basis is not allowed.

Interaction with the Pay or Play Rules

Under the Affordable Care Act's employer shared responsibility (or "pay or play") rules, applicable large employers (ALEs) may have to pay penalties if they do not offer minimum essential coverage (MEC) to all full-time employees. Penalties are triggered if a full-time employee receives a premium tax credit for Exchange coverage.

ALEs may use the **look-back measurement method** to determine whether an employee is full-time or not full-time. Under the look-back measurement method, an employee who works, on average, at least 30 hours of service per week during a measurement period must be treated as full-time during a subsequent stability period, regardless of the employee's hours of service during the stability period.

Under this method, an employee could have a change in employment status (for example, a change from a full-time position to a part-time position) resulting in a reduction in hours that does not change the employee's status as a full-time employee, at least for some period of time.

Employers might offer coverage to employees for all periods that they qualify as full-time, to avoid any potential penalties under the pay or play rules. In these cases, the change in employment status would not result in a change in an employee's eligibility for the group health plan. Therefore, under the current regulations, the employee would not have been able to change his or her elections during the period of coverage.

Interaction with Exchange Enrollment

Under the current change in status regulations, a cafeteria plan may not allow an employee to revoke an election under the group health plan during a period of coverage solely to enroll in an Exchange plan.

This rule does not pose a problem for individuals enrolled in a group health plan with a calendar plan year. These employees may continue their coverage under the plan for the remainder of the employer's plan year, and then immediately begin coverage under a plan purchased through an Exchange.

However, the rule can cause issues for an individual in a non-calendar year plan, because the Exchange enrollment rules do not allow individuals to purchase coverage that would begin after the end of the non-calendar cafeteria plan year. Enrolling in a plan during the Exchange open enrollment would require these individuals to have either overlapping coverage or a period without any coverage.

Also, existing special enrollment rules for health plans do not permit employees to revoke a cafeteria plan election in order to enroll in Exchange coverage, even if they qualify for special enrollment in an Exchange. To expand access to Exchange coverage, Notice 2014-55 allows employees to revoke a cafeteria plan election to obtain coverage through an Exchange.

Conditions for Election Changes Due to Reduction in Hours of Service

A cafeteria plan may allow an employee to prospectively revoke an election of coverage under a group health plan if both of the following conditions are met:

- An employee who was reasonably expected to average at least 30 hours of service per week has a change in employment status so that the employee will reasonably be expected to average less than 30 hours of service per week after the change (even if that reduction does not result in the employee ceasing to be eligible under the group health plan); and
- The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee (and any related individuals who cease coverage due to the revocation) in another plan that provides MEC. The new coverage must be effective no later than the first day of the second month *after* the month in which the original coverage is revoked.

A cafeteria plan may rely on an employee's reasonable representation that he or she and related individuals have enrolled (or intend to enroll) in another plan that provides MEC within the required timeframe.

Conditions for Election Changes Due to Exchange Enrollment

A cafeteria plan may allow an employee to prospectively revoke an election of coverage under a group health plan if both of the following conditions are met:

- The employee is eligible for special enrollment in an Exchange plan OR the employee wants to enroll in an Exchange plan during the Exchange's annual open enrollment period; and
- The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee (and any related individuals who cease coverage due to the revocation) in an Exchange plan. The Exchange coverage must be effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

IRS Expands Rules for Mid-Year Election Changes Under Cafeteria Plans

A cafeteria plan may rely on the reasonable representation of an employee who has an enrollment opportunity for an Exchange plan, that he or she and related individuals have enrolled (or intend to enroll) in an Exchange plan for new coverage that is effective within the required timeframe.

Plan Amendments Required

Allowing the changes permitted by Notice 2014-55 is optional. Employers do not have to permit these changes under their cafeteria plans. However, if the employer chooses to allow the new permitted election changes under Notice 2014-55, a cafeteria plan must be amended to provide for the election changes.

In general, the amendment must be adopted on or before the last day of the plan year in which the elections are allowed. It may be effective retroactively to the first day of that plan year, if:

- The cafeteria plan operates in accordance with guidance under Notice 2014-55; and
- The employer informs participants of the amendment.

However, a cafeteria plan may be amended to adopt the new permitted election changes for a plan year that begins in 2014 **at any time on or before the last day of the plan year that begins in 2015**.

Effective Date

The guidance contained in Notice 2014-55 is effective on Sept. 18, 2014. The IRS intends to amend the current cafeteria plan regulations to reflect the guidance in this notice. However, taxpayers may rely on the guidance in Notice 2014-55 until further guidance is issued.

Source: Internal Revenue Service

EXHIBIT 7
Client Letters of Recommendation

Administrative Services
65 Stone Street I Cocoa, FL 32922
Phone: (321) 433-8665

April 6, 2015

To Whom It May Concern:

I am writing to recommend the Gehring Group as a resource in implementing your Employee Health Center. The City of Cocoa has used Gehring since 2012 as our City's benefit broker and they have been instrumental in reducing and maintaining our overall insurance costs.

Last year, with Gehring's great support, we were able to launch our Employee Health Center to all employees and retirees on our health plan. Gehring wrote the Request for Proposal (RFP); provided an extensive review and analysis of each proposal; and assisted step-by-step with the selection and implementation of our new Health Center. This was all completed under intense deadlines and within budget. Without Gehring's support, our Health Center project would not have been a success. Their extensive knowledge and attention to detail on health centers put our worries at ease.

I feel confident in recommending Gehring for their benefit broker services. If you have any further questions, please do not hesitate to contact me.

Sincerely,

Tammy B. Gemmati

Tammy B. Gemmati
Administrative Services Director
City of Cocoa
tgemmati@cocoafl.org

City of Naples
HUMAN RESOURCES
TELEPHONE (239) 213-1810 • FACSIMILE (239) 213-1845
735 EIGHTH STREET SOUTH • NAPLES, FLORIDA 34102-6796

To Whom It May Concern:

In 2010 the City of Naples contracted with the Gehring Group for brokerage and consulting services related to the City's employee benefit program. We have enjoyed a mutually beneficial relationship since that time. The Gehring Group has assisted the City in making significant plan design changes including the implementation of a high deductible plan and phase out/elimination of our low deductible/high cost plan. In addition, Gehring provides monthly financial analysis and has been instrumental in assisting the City with navigation and compliance of the Affordable Care Act.

In addition, the City uses BenTek for benefit administration and enrollment. Paperless enrollment has really helped us to manage the employee benefits process making it easier, more efficient, more secure and less time consuming. The user friendly program enables employees to go online and enter their own enrollment data. The data is then transmitted directly to the insurance carriers which eliminates data entry errors. In addition, the BenTek team is extremely knowledgeable and helpful. Customer service is top priority. Their dedicated team has been there every step of the way from implementation to training to daily support. With the help of BenTek we have streamlined our benefit enrollment and benefit administration process.

Please do not hesitate to contact me at (239) 213-1833 if I can be of any further assistance.

Sincerely,

Lori McCullers

Lori P. McCullers
Risk Manager

City of Stuart

121 SW Flagler Avenue * Stuart * Florida 34994-2139
Human Resources Department
Telephone: (772) 288-5322
FAX: (772) 600-1226
www.cityofstuart.us

Linda J. Toppi, M.S, PHR, PPP, Director
Email address: ltoppi@ci.stuart.fl.us

April 1, 2015

To Whom it May Concern:

I am pleased to recommend the Gehring Group for all services pertaining to employee benefits and on-site health clinic consulting services.

The City of Stuart has utilized the Gehring Group to administer all professional service aspects of our group health benefit program to include open enrollment, provider negotiation services, reporting and cost analysis, employee wellness initiatives, and consulting and facilitation of our employee health clinic.

Three years ago we called upon the professional expertise of the Gehring Group for the endeavor to set up an on-site employee health clinic. Due to the small size of our organization, less than 300 employees, Gehring was able to arrange for the City to partner with other local entities to establish an employee health clinic in a cost sharing agreement. This innovative solution maximized our cost savings on the front end by sharing expenses among three entities. We have been most pleased to report to our Commission a reduction in healthcare costs each subsequent year by this arrangement.

We have found our working relationship with the Gehring Group most beneficial on many levels in the administration our employee group health programs. I highly recommend their expert consulting services. Please feel free to contact me directly if you require additional information.

Sincerely,

Linda Toppi

Linda Toppi

The City of West Palm Beach

"The Capital City of the Palm Beaches"

Department of Human Resources
401 Clematis Street, 3rd Floor
West Palm Beach, FL 33401
Telephone (561) 494-1000
Facsimile (561) 494-1035

April 3, 2015

Kurt Gehring
The Gehring Group
11505 Fairchild Gardens Ave.
Suite 202
Palm Beach Gardens, FL 33410

It is with great pleasure that I have the opportunity to recommend the Gehring Group for all services related to Employee Benefits and Onsite Health Clinic Consulting. During the City's 17+ year relationship with the Gehring Group, they have provided a superior level of employee benefit consulting expertise with a high priority on customer service.

As part of the City of West Palm Beach's employee benefits cost saving strategy, the Gehring Group guided the City through the RFP design, evaluation, selection and implementation of our onsite health clinic. Our Gehring Group team was involved in every aspect of the process – through finalist presentations, provider interviews, facility selection and educating our employees on the benefits and use of the onsite clinic.

The addition of an employee clinic has proven to be an asset in attracting talented employees, cost savings to the employees and a great ROI for the City.

The City has always had great confidence with the Gehring Group and their ability to problem solve and bring forth ideas that help the City to be a top choice for employees due the benefits it offers.

I am pleased to recommend the Gehring Group to any organization for employee benefits and onsite clinic consulting services.

Sincerely,

Patricia A. Brosamer

Patricia Brosamer, CBP, CCP
HRIS & Benefits Manager
City of West Palm Beach

Sheriff Robert E. "Bob" Hansell

OSCEOLA COUNTY SHERIFF'S OFFICE

2601 E. Irlo Bronson Memorial Hwy., Kissimmee, Florida 34744
Telephone: 407-348-1100 • *www.osceolasheriff.org*

August 10, 2012

RE: Recommendation for the Gehring Group

Dear Representative:

This letter is written as an excellent recommendation for The Gehring Group, which has served as health insurance broker and benefits consultant for the Osceola County Sheriff's Office for the past two years.

We have found the entire Gehring Group team to be extremely knowledgeable, customer service oriented, and helpful. The staff members have a very strong and consistent depth of knowledge, and they are clearly problem solvers. The Gehring Group also assisted us in saving more than $150,000 per year compared to our previous health benefits broker.

If you have any questions, please feel free to call.

Sincerely,
Robert E. Hansell, Sheriff
Osceola County

BY: _____
Dave M. Sklarek
Chief Deputy

PALM BEACH COUNTY
SHERIFF'S OFFICE
RIC L. BRADSHAW, SHERIFF

October 21, 2009

Ladies & Gentlemen:

The Palm Beach County Sheriff's Office has enjoyed a long relationship with the Gehring Group, as they have been our Agent of Record for Employee Benefits for over 15 years. During this extensive period of service, Gehring Group has provided outstanding service to our organization. They are highly regarded by me and my staff and have been a source of unqualified support and expertise to us throughout the years.

It is with pleasure that I recommend Gehring Group to other organizations. Please do not hesitate to call for further information.

Sincerely,

Ric L. Bradshaw
Sheriff

3228 Gun Club Road ▪ West Palm Beach, Florida 33406-3001 ▪ (561) 688-3021 ▪ Email: BradshawR@pbso.org

THOMAS M. KNIGHT, SHERIFF
SARASOTA COUNTY SHERIFF'S OFFICE
Post Office Box 4115
Sarasota, Florida 34230-4115
Telephone (941) 861-5800
Fax (941) 861-4039
www.sarasotasheriff.org

October 14, 2010

Mr. Kurt Gehring, President
Gehring Group Professional Services
11505 Fairchild Gardens Avenue
Suite 202
Palm Beach Gardens, FL 33410

Dear Mr. Gehring, Kurt

The process of branching out and doing something that is outside of ones expertise and comfort zone is a difficult undertaking. We carefully selected you as our broker and I want you to know we are extremely pleased with the services you have provided.

On many occasions during this process you have dropped everything and came to our offices or answered our telephone calls and emails. While we as a staff did not possess the expertise to ask the questions and examine the data, you did. I am confident in saying that had we not engaged your firm to examine the costs imposed on us by county government we would not have reached the resolution that we did. While there may be more savings to be had, the agreement we have come to with county staff guarantees our employees will see real savings in their pockets in 2011. This could not have been accomplished without the help of your dedicated staff.

I have asked Major Kurt Hoffman and Captain Paul Marshall to remain in contact with your group because I firmly believe that this issue will remain one that requires constant examination. During recent meetings in Tallahassee, Major Hoffman was contacted by several majors and undersheriffs from various agencies inquiring as to how we initiated this process. I have instructed him to share with them your RFP for broker services in the hopes that they may avail themselves of your services.

If you have any current projects that you wish to list the Sarasota County Sheriff's Office as a reference, you have my express permission to do so. Please accept this letter with my humble appreciation for what you did for us and may do for us again in the future.

Sincerely,

Thomas M. Knight, Sheriff
Sarasota County, Florida