The City of Danville Broker RFP

February 2020

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Agenda

1. Better Source Benefits
2. Better Source Benefits Expertise
3. Insurance Carrier & Health Plan Selection Process
4. Corporate Wellness
5. Legislative/Compliance
6. Other Services
7. Compensation
8. References
8. Appendices

01

Better Source Benefits

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Our Company

1. Name of the proposed firm and name of the representative submitting the proposal. Include all contact information.

Better Source Benefits
340 Clifty St., Suite 4
Somerset, KY 42501

www.BetterSourceBenefits.com

RFP Response Author: John Clay

j.clay@bettersourcebenefits.com

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Our Company

2. Briefly describe your firm's history and background.

Organization & Management: BetterSource benefits is a Kentucky based, Subchapter S Corp formed in 1999. John Clay is its President and principal advisor. The BetterSource ownership model is one that encourages and rewards hard work and provides stability for customers. As client advisors build a client base valued at $375,000, they are offered the opportunity to join the partnership. Each partner owns their respective client base and joins with other BetterSource partners to build the support teams that service clients.

Lead Consultant: John Clay, LIC

John Clay has been advising employers on health care cost reduction strategies for nearly two decades. An expert in self-funded medical plans, John has helped employers implement varied solutions focused on reducing the cost of health care, such as direct contracting, direct primary care, and others, as a means to return the crown jewel of employee benefit packages to its place of prominence rather than the liability that it has become for many. Understanding that pre-packaged fully insured medical plans eliminates all employer control over their health care supply chain, John Co-Wrote an Amazon Bestseller; "Breaking Through the Status Quo, How innovative companies are changing the benefits game to help their employees and boost their bottom line" which spawned the concept of the Total Control Health Plan. John is passionate about putting employers in a position to use the same techniques they use to manage all other aspects of their business on their health plans. By doing so, employers have not only experienced dramatic cost reductions and minimal annual increases, but they have done so while providing better plans to their employees. Since 2018, John has been invited to speak at industry conferences in Nashville, TN, Denver, CO, and the World Healthcare Congress in Washington DC.

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3. Provide an overview of your firm and its ownership/organizational structure, philosophy/culture and number of employees.

John is a graduate of the University of Kentucky, Gatton College of Business & Economics, holding a bachelor's degree in Business Administration with Concentration in Supply Chain Management. John has served as a Board member and past-President of the Rotary Club of Somerset and other multiple non-profit organizations.

Account Manager: Will Wilson

Will has been serving employers as their key, day to day, contact since 2018. An expert in Benefit Administration systems, Will has thrived serving multiple location, highly complex, self-funded clients with the implementation of multiple technology platforms. Prior to joining BetterSource, Will managed a sustainable farming production facility and earned his degree in Physics and Mathematics from Emory & Henry College. Will oversees project implementation, reporting, and general service for our most complex clients.

- **Kathy Clay, M.Ed.**

Employee Benefits Account Coordinator. Kathy has 27.5 years of experience in Education. She began her career working for the Somerset Schools, and joined BetterSource after retirement from teaching, moving into the agency setting with BetterSource in 2018. Kathy is an Account Coordinator, helping to organize, schedule & service all of BetterSource Benefits' clients.

Our Company

3. Provide an overview of your firm and its ownership/organizational structure, philosophy/culture and number of employees.(continued...)

Philosophy: Making a difference driving real strategy. BetterSource does not view our role as that of a broker or that of a "middleman" who simply works to negotiate the best price on a commodity. Rather, we view ourselves as advisors/consultants whose role is to partner with our clients to help them achieve the best performing custom benefits plan for their business. Speaking with regards to health plans specifically, Our Cost Containment & Strategy Division using Total Control Health Plans is dedicated to delivering better healthcare outcomes with less risk at a lower price yet unique to each employer. We believe it is important for our compensation to be tied to the performance and success of the plans we advise on, so that our objectives and focus align with those of our clients. Our ideal client is one who believes that through access to information and effective management their health plan can be a benefit engine delivering high quality healthcare to plan participants.

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4. Describe, if applicable, how your firm is functionally tied to any insurer or provider of service and how that relationship may influence your ability to provide Broker services to The City of Danville.

Better Source Benefits is a fully independent insurance agency with complete autonomy. We are fiercely independent Insurance Agents & Brokers and Employee Benefits Consultants. We solve best fit with a variety of strategies, solutions and partners to design the best fit for potential clients and review and audit contracts on an ad hoc basis for each client's profile. Data Analytics, Actuarial Services and Contracts are audited in-house, and we partner with independent nationally known vendors and experts that deliver actionable data and advice. We have preferred partner access to over 21 Cost & Transparency tools.

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5. Identify members of your staff that would be assigned to this contract and provide a summary of their qualifications, percentage of their time you anticipate they would be dedicating to this contract and their availability to travel to our corporate headquarters and/or field locations.

Lead Consultant:
John Clay
Account Manager:
Will Wilson
Will has been serving employers as their key, day to day, contact since 2018. An expert in Benefit Administration systems, Will has thrived serving multiple location, highly complex, self-funded clients with the implementation of multiple technology platforms. Prior to joining BetterSource, Will managed a sustainable farming production facility and earned his degree in Physics and Mathematics from Emory & Henry College. Will oversees project implementation, reporting, and general service for our most complex clients.

- **Kathy Clay, M.Ed.**

Employee Benefits Account Coordinator. Kathy has 27.5 years of experience in Education. She began her career working for the Somerset Schools, and joined BetterSource after retirement from teaching, moving into the agency setting with BetterSource in 2018. Kathy is an Account Coordinator, helping to organize, schedule & service all of BetterSource Benefits' clients.

Our Company

6. Describe your view of the role of a Broker in this type of relationship and what differentiates your firm from other brokerage-consulting firms.

Better Source Benefits does not view our role as that of a broker or that of a "middleman" who works to negotiate the best price on a commodity. Rather, we view ourselves as advisors/consultants whose role is to partner with our clients to help them achieve the best performing custom benefits plan for their business. Speaking with regards to health plans specifically, our Total Control Health Plans division is dedicated to working with our clients to build a health plan that delivers higher quality care at lower costs that is unique to each employer. We believe it is important for our compensation to be tied to the performance and success of the plans we advise on, so that our objectives and focus align with those of our clients.
Our ideal client is one who believes that through access to information and effective management their health plan can be an asset and tool for delivering high quality healthcare to plan participants.

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Company Expertise

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Company Expertise

1. Describe your firm's expertise in each of the following areas:

- Health and Welfare – Better Source Benefits has been advising employers on Health and Welfare plans for over 30 years. We are experts in this area.

- Legal Counsel/Compliance – BetterSource Benefits takes compliance very seriously, believing that it is our role to ensure our clients have the tools and knowledge necessary to stay in compliance with all applicable laws and regulations. As a result, we not only leverage internal experts, but rely on outside resources such as our ongoing partnership with the General Counsel and ERISA Health Care Attorney, Doug Aldeen. We regularly consult with Our HR Hotline to ensure our clients can make informed decisions.

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Company Expertise

1. Describe your firm's expertise in each of the following areas:

- Benchmarking – Better Source Benefits leverages multiple sources for Benchmarking information, including but not limited to:
  - Zywave
  - The Employers Association
  - Kaiser Family Foundation
  - SHRM
  - NextGen Benefits Mastermind Partnership
  - Carrier books of business

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Company Expertise

1. Describe your firm's expertise in each of the following areas:

- Research and Technical Services – The BetterSource team is highly skilled at research and technical services as demonstrated by publishing an industry recognized book. When researching complex items, we leverage the following as key sources of information:
  - The vast amount of experience among the BetterSource Team
  - Our peers from the select national groups, Health Rosetta &NextGen Benefits Mastermind Partnership
  - Our key vendor partners
  - Other industry recognized publications
  - Independently validated websites

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Company Expertise

1. Describe your firm's expertise in each of the following areas:

- Benefits Administration – The Better Source Benefits team that would be serving The City of Danville has vast knowledge of multiple benefit administration platforms, including but not limited to:
  - Ease (formerly Ease Central)
  - Employee Navigator
  - BerniePortal
  - Benefits Guide
  - B-swift
  - Plansource
  - Paycor
  - Dominion
  - Many others

Better Source Benefits currently facilitates and manages access to multiple benefit administration platforms for various clients.

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Company Expertise

1. Describe your firm's expertise in each of the following areas:

- Benefits Communication - BetterSource takes benefit communication very seriously as this is the key to achieving the stated goals of the plans we help implement. Starting with re-naming "Open Enrollment" meetings to "Benefit Education" meetings, we focus heavily on helping individuals understand how to get the most out of their health plans. The reason behind the name change is that the objective of the annual meetings is far greater than simply getting individuals enrolled in their benefits.
- We follow up our benefit education meetings with video recordings for future reference, and then implement our custom Benefit Marketing Plan. These plans are month by month plans outlining the topics and related collateral that will be distributed to plan participants throughout the year.
- We have also assisted clients with successfully implementing the Benefits App, which is a highly flexible and customizable platform for benefit communication.

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Company Expertise

2. What size clients does your firm generally support?

As a multi-line corporate insurance agency, Better Source Benefits has corporate clients ranging in sizesize from 2 employees to 400 employees. The team that will be working with City of Danville specifically has an average client size of 100+ employees.

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

The first step in transition will be to sit down with the proper parties to determine the state of the employee benefit plan, identify priorities and create a time-line so all objectives will be met in a timely manner. An example of a proposed course of action is:

- Day 1: Agent of Record letters and Business Associates Agreement(s) generated and submitted via Docusign to The City of Danville
- Day 2 – 10: AOR's submitted to incumbent carriers and all related plan information requested from carriers.
- Day 2 – 30: All received plan information reviewed and monthly reporting templates established.
- Day 2 – 60: Multiple meetings with The City of Danville to clearly establish short, mid, and long-term objectives, deliverables, and timeline for execution.

Company Expertise

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

Our approach for supporting programs throughout the year falls into two different categories:

- General Customer Service: Better Source Benefits is committed to assisting those on the front lines interacting with employees on a daily basis. We are available outside of traditional business hours to support our clients and their employees, wherever they are located. We understand that when issues occur,we treat them like payroll issues – they need immediate resolution, especially if they have risen to the level of the HR department. At that point, the customer (the employee) is frustrated and quite possibly in serious need of help. When serving our clients and their employees we always ask ourselves the following question with regards to each customer service issue:

    - Who is our end customer? (likely the employee or their spouse)
    - What are they looking for?
    - Did your answer provide that to them?

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Company Expertise

4. Describe your approach to supporting our programs throughout the plan year (continued).

   We sometimes encounter a situation where someone wants a health plan to cover a claim, which it simply can't do. Rather than just relay that message to a plan participant, we look further and deeper to determine what other tools are available to help the member get what they are looking for (the solution to the problem).

Plan strategy and performance:

- The health plans we help our clients design and implement are not a static creation. The goal is to implement a plan that helps the members get the best possible care, while at the same time running as efficiently as possible. As a result, we provide monthly high-level reporting as to how the plan is running and why. We meet quarterly to dive more deeply into specific aspects of the plan such as pharmacy contracting, provider contracting, or stop-loss purchasing. Finally, we are interacting with the selected vendors weekly as specific situations arise that need attention, such as bringing additional resources around a plan participant based upon a particular diagnosis.

- Ultimately the plans we assist with are always in a state of evolution and we are continually monitoring their performance.

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Company Expertise

5. In your opinion, what are the two major challenges companies our size face and how will your firm help meet these challenges?

-Attraction and Retention of employees
(Due to Record Low Unemployment and Massive Retirements)

- The rising costs of healthcare and the inability to effectively address it with the solutions that have historically been presented to employers. Even at a nominal annual increase rate of 5%, healthcare costs would double in 15 years. That is not a sustainable reality for most employers and change needs to occur.

BetterSource is uniquely positioned to help The City address both challenges in the following way. As the creator of the Total Control Health Plan strategy, BetterSource specializes in putting employers in the position to be able to control and reduce the costs associated with their health plan. As a result, the employers we work with have found themselves able to:

1. Reduce the employee liability associated with the health plan (both in contributions and out of pocket expenses)
2. Enhance the benefit offerings, returning healthcare benefits to the status of a competitive advantage they once occupied.

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Company Expertise

7. Describe the process your firm would utilize to manage and administer a benefit package of our size throughout a contract year i.e. 500 employees across multiple plans across 7 states.

Initially we would work with The City of Danville to develop a master plan in an effort to identify where there are opportunities to leverage economies of scale. We would then evaluate the existing vendor partners to determine their efficacy in serving all plan participants in all locations. Ultimately, we would be seeking to leverage cost and quality strategies, such as direct contracting and narrow networks at the regional and local levels to ensure that the plan(s) are running as efficiently as possible and delivering the desired quality results. We are currently serving many employers with similar geographic diversity to that of The City of Danville and we have the expertise to meet your needs.

We believe face to face education is key, especially to achieve the engagement necessary to achieve a high performing health plan. Better Source Benefits would encourage The City of Danville to integrate an in-person employee education campaign into the broader service agreement between our organizations. We also would encourage The City of Danville to consider the investment in The Benefits App to increase the channels available for employee communication. It is likely a good portion of the cost of this tool can be offset by other sources such as carrier “tech credits”.

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Insurance Carrier & Health Plan Selection Model

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Insurance Carrier & Health Plan Selection Process

1. Describe how your firm would handle the selection of service providers for The City of Danville.

Better Source Benefits has multiple methods for helping clients determine which service providers are the best fit for them, however each method starts in the same place. Ultimately the selection of service providers is dependent on the needs and objectives of the individual employer. Once we have a clear understanding of the needs and objectives of a specific employer, we then solicit proposals from the service providers who have the ability to ensure the success of the project.

- Responses to annual requests for information to keep our internal database up to date
- Peer referrals from our national network of industry peers
- Past experience
- Attendance at industry conferences
- Presence in industry publications

Once RFP responses are received, we tally the results on an easy to digest score card using both qualitative and quantitative metrics. Examples of a qualitative metric are corporate culture and fit, experience with similar clients, and support team. Examples of quantitative metrics are price, number of clients, financial ratings, and performance guarantees.

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Insurance Carrier & Health Plan Selection Process

2. Describe your firm's consulting approach for bidding and selecting the most appropriate health plan alternative.

The definition of success varies from client to client with some purely seeking a hands off approach, and others looking for ultimate flexibility and involvement. Understanding the unique qualities and needs of a particular employer is where we start, and then specific solutions are presented that have the ability to meet the needs of the client. For example, the "most appropriate health plan alternative" is an undefined term which will surely have a different definition from employer to employer. If brand is an important factor when selecting a health plan, then the list of options is relatively short. If complete transparency and flexibility are the most important factors, then a distinctly different list of alternatives will be presented.

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Insurance Carrier & Health Plan Selection Process

3. Describe your process for negotiating renewals. Share examples of your success in negotiating renewals.

Fortunately with regards to our area of expertise, insurance, the process of pricing is relatively scientific. Historically employers have commonly felt as if they brought a knife to a gun fight when working through insurance renewals, simply because they were operating with less information than the "opposition". Our approach to insurance renewals is to obtain as much information as possible related to what future pricing will be based upon so we can have an educated conversation with the underwriting team to reach an appropriate renewal.

For example we use multiple resources, such as clinical underwriting, to proactively determine the projected liability associated with known claimants and those anticipated through predictive modeling. This information is then used to develop a realistic renewal model, which is then shared with the relevant underwriters. In one recent case a new leukemia patient was identified within days of diagnosis, prior to claims being submitted to the administrator. Through interaction with the member and their providers, a diagnosis, prognosis, and projected annual cost were all confirmed and provided to the stoploss carrier prior to the 1/1/20 renewal being finalized. Based upon the detail provided, the case had no impact on the renewal and a potential laser was averted.

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Insurance Carrier & Health Plan Selection Process

3. Describe your process for negotiating renewals. Share examples of your success in negotiating renewals (continued).

In another case A client with approximately 1000 employees on their medical plan was contemplating transitioning from a fully-insured plan to a self-funded plan. Using available claims data, we employed the use of an independent actuary to determine expected claims expense liability. We were able to provide plan design modeling and an employee contribution structure to compliment the newly designed 3 tier plan offering. We fostered a positive working relationship with the local hospital who shared the common goal of providing local quality healthcare at reasonable service rates. In the end, we built an employee benefit plan that both met the financial needs of leadership, the benefit needs of membership and the employment need to attract and retain talent. Ten years later, we continue to partner with this client.

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Insurance Carrier & Health Plan Selection Process

4. What strategy does your firm utilize to manage and forecast a benefit package over a 2-3 year period?

Many aspects of a benefit package are commodities and it is possible and common for Better Source Benefits to assist clients with locking prices in for multiple years. This is an attractive model for both insurers and employers, providing certainty and the ability for long-term planning.

Unfortunately the highest cost component of a benefit package, the health plan, is more challenging to lock in for multiple years. That being said, there are multiple methods we use to provide confidence in projections and the ability to plan long-term. For example, whenever possible we leverage the predictive modeling capabilities of the MEDai platform to project future claim costs associated with current plan participants. Additionally this same platform also provides the ability to proactively manage and mitigate future large claimants. Other strategies that may be used include direct to employer contracting with multi-year pricing commitments, and leveraging Medicare as a basis for pricing.

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Insurance Carrier & Health Plan Selection Process

5. Do you offer assistance with claims and/or coverage questions?

Yes, and the The City of Danville team, and employees, would have direct phone numbers for Better Source Benefits team members assigned to assist with these matters.

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

The answer to this question varies dramatically based upon the existing projects we are working on with clients. At a minimum we review plan performance with clients on a quarterly basis, in addition to one to three meetings related to renewal planning and execution. If a client is in the midst of the implementation of a significant plan or strategy, client meetings have occurred multiple times per week. For example, we've recently assisted clients with the implementation of:

- New self-funded medical plans
- Benefit Administration systems
- Employee Communication Smartphone Application
- Voluntary benefits

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Corporate Wellness

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Corporate Wellness:

1. Does your company provide and/or support corporate wellness initiatives?

The Better Source Benefits team serving The City of Danville has extensive and diverse experience assisting clients with the implementation and integration of corporate wellness programs into the broader benefit strategy. We've worked with...

2. Describe any programs that you provide to your clients that foster employee wellness.

Better Source Benefits has a diverse menu of educational materials that are made available to clients to support their wellness objectives. Additionally, we regularly serve as the program manager working to integrate resources available from carrier partners and third-party vendors to ensure program investments are as impactful as possible.

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Legislative/Compliance

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Legislative/Compliance:

1. How do you support your clients in ensuring their employee benefits programs remain compliant with all federal and state laws?

– BetterSource Benefits takes compliance very seriously, believing that it is our role to ensure our clients have the tools and knowledge necessary to stay in compliance with all applicable laws and regulations. As a result, we not only leverage internal experts, but rely on outside resources such as our ongoing partnership with the General Counsel and ERISA Health Care Attorney, Doug Aldeen. We regularly consult with Our HR Hotline to ensure our clients can make informed decisions.

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Legislative/Compliance:

3. Do you provide HIPAA administrative services? If yes, please explain the services provided and whether there is an additional fee associated with this service.

Yes, we do - At BetterSource safeguarding protected health information is a major priority. BetterSource stores all paper client PHI files in a locked filing cabinet. Discarded paperwork is shredded on site and recycled. We store electronic protected health information in our database software, which is maintained by OnSite Solutions, with strict password protection and HIPAA compliance, or on a secure server with encryption and password protection. All our PHI emails to carriers are sent using Sharefile encryption by Citrix, and we offer free encrypted uploads to Sharefile for PHI from clients. When there is a need to transport PHI electronically to an offsite location, we use an EAS encrypted USB stick.

There is no additional charge for this – part of doing business in our field.

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Other Services

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Other Services:

- Describe your standard package of employee communications services. Please provide samples.
    - BetterSource takes benefit communication very seriously as this is the key to achieving the stated goals of the plans we help implement. Starting with re-naming “Open Enrollment” meetings to “Benefit Education” meetings, we focus heavily on helping individuals understand how to get the most out of their health plans. The reason behind the name change is that the objective of the annual meetings is far greater than simply getting individuals enrolled in their benefits.
    - We follow up our benefit education meetings with video recordings for future reference, and then implement our custom Benefit Marketing Plan. These plans are month by month plans outlining the topics and related collateral that will be distributed to plan participants throughout the year.
    - We have also assisted clients with successfully implementing the Benefits App, which is a highly flexible and customizable platform for benefit communication.

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Other Services:

3. Describe any additional services offered by your company that may be of interest to The City of Danville.

- We offer to control the frequency & severity of claims optimizing the healthcare supply chain with transparency, active management and strong communication skills.
- Once implemented, we regularly monitor and communicate data, emergent trends, benefit adjustment options, steerage and Rx management along the way.
- How do you improve the quality of benefits to City employees?
- Eliminating waste on valueless components will improve benefits for the City of Danville: https://www.fiercehealthcare.com/payer/cigna-sees-2019-profit-nearly-double-year-over-year-reaching-5-1b
- Actionable Data will lead to better benefits while regular communication of benefits and their value are emphasized
- For those interested in allowed claims per member per year, see Chart Below. For PEPY, most would be 1.9 to 2.1x higher.

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Compensation

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Compensation:

1. Provide a description of the compensation structure proposed by the brokerage firm. The description shall include all compensation proposed by the firm, i.e., commission, fee, other.

Please reference draft of Consulting Agreement (Appendix 11).

2. Does your firm have any reservations in making available documentation of the commissions received from third parties?

Better Source Benefits is committed to complete transparency in all compensation and will provide any and all documentation requested. Ultimately, where possible, Better Source Benefits prefers a performance based compensation model where our compensation is tied to the performance of the plan(s) we recommend.

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Compensation :

3. Describe our right to terminate a contract with you. Is there a minimum contract period?

Section 5 of our proposed Consulting Agreement includes the following term and termination provisions:

Term

The initial term of this Agreement shall commence on ... end ... (Initial Term). Thereafter, this Agreement will remain in effect until terminated as described below.

Termination

This Agreement may be terminated by either party only as follows:

a. Effective upon thirty (30) days' advance written notice to the other party stating that such other party is in breach of any of the provisions of this Agreement, provided such breach (if able to be cured) is not cured within fifteen (15) days after the notice is received;
b. Effective upon six (60) days' advance written notice to the other party given with or without reason; provided such notice is given after the Initial Term; or
c. By mutual written agreement of the parties.

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Compensation :

4. Based on the information provided and the services requested, what is your proposed annual fee? Please make certain to identify any services mentioned in your proposal that are not included in your proposed fee (services that would be an additional expense).

Please see attached Consulting Agreement (Appendix 11).

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References

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References:

1. Provide three references from current clients, preferably of similar size and/or need and complexity to The City of Danville. For each reference please include:

1. KCEOC Community Action Partnership, Inc.
   - i. services you provided: Consulting
   - ii. benefit programs addressed: Medical & Rx
   - iii. number of covered employees: 146
   - iv. contact name and phone number: Paul Dole, CEO 606 546-3152
2. City of Corbin, KY
   - i. services you provided: Consulting/Implementation/Ongoing Management
   - ii. benefit programs addressed: Medical, Rx, Dental Vision, Life Vol Life, Enhanced Vol
   - iii. number of covered employees: 101
   - iv. contact name and phone number: Marlon Sams, City Manager 606 523-6521
3. Lincoln County Fiscal Court
   - i. services you provided: Consulting/Implementation/Ongoing Management
   - ii. benefit programs addressed: Medical, Rx, Dental Vision, Life Vol Life, Enhanced Vol
   - iii. number of covered employees: 66
   - iv. contact name and phone number: Jim W. Adams, County Judge Exec 606 365-2534
4. Rockcastle County Fiscal Court
   - i. services you provided: Consulting/Implementation/Ongoing Management
   - ii. benefit programs addressed: Medical, Rx, Dental Vision, Life Vol Life, Enhanced Vol
   - iii. number of covered employees: 78
   - iv. contact name and phone number: Howell Holbrook, County Judge Executive, 606 256-1293

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Compliance

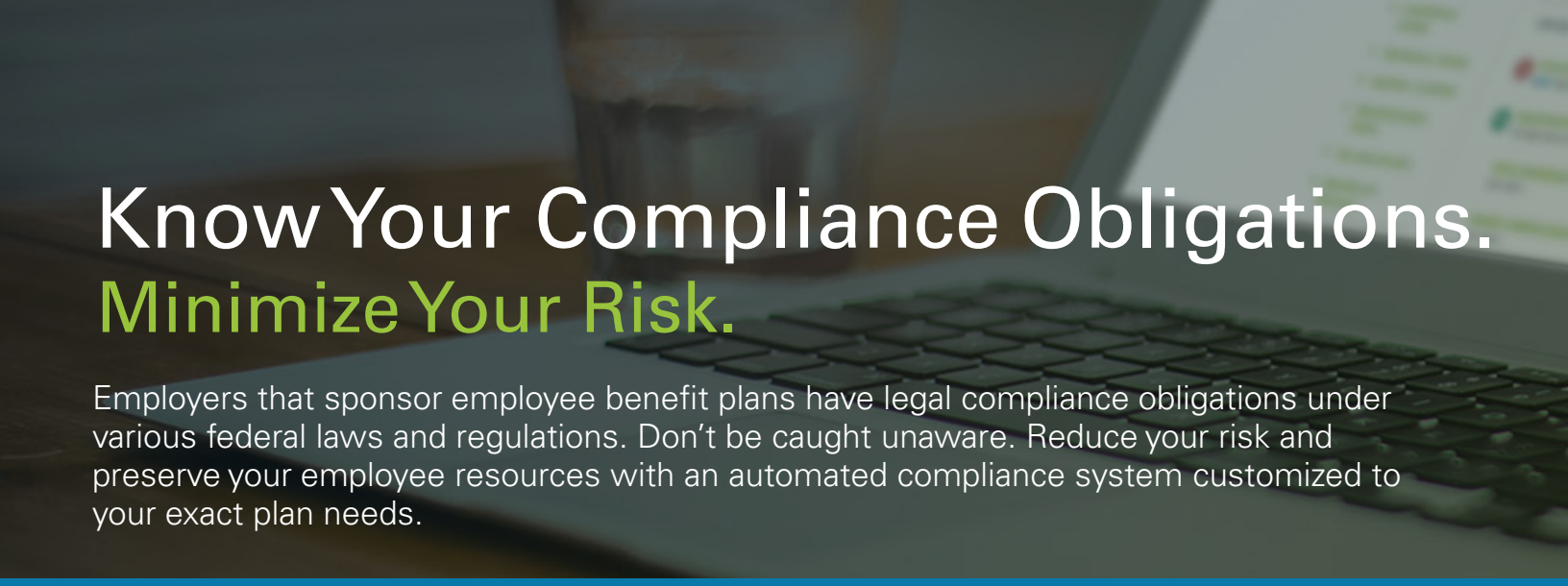
Compliance dashboard®



Making sense of compliance

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Know Your Compliance Obligations.
Minimize Your Risk.

Employers that sponsor employee benefit plans have legal compliance obligations under various federal laws and regulations. Don't be caught unaware. Reduce your risk and preserve your employee resources with an automated compliance system customized to your exact plan needs.

COMPLIANCE 101

1 **Benefit plans covered by ERISA and/or the Public Health Service Act (PHSA) are legally required to comply with a host of specific requirements.**

Responsibilities typically arise from the following regulations:

- **» ERISA**
- **» COBRA**
- **» HIPAA**
- **» Medicare**
- **» Other federal mandates**

2 **As Plan Sponsors, private sector employers are considered "Plan Administrators."**

Plan Administrators are **directly responsible** for many compliance obligations and liability (both personal and corporate) for non-compliance.

3 **Both Plan Sponsors and Plan Administrators are "Fiduciaries."**

Fiduciaries are held to a very high standard of behavior and can be **personally liable** to perform their duties in accordance with the governing laws and plan documents.

Compliancedashboard® TOP 3 BENEFITS

1. **Know exactly which legal requirements you are responsible for.**
2. **Never miss a compliance activity with our email reminder system.**
3. **Pull reports at any time for internal management or audit purposes.**

HOW IT WORKS

INFORMATION AGGREGATOR

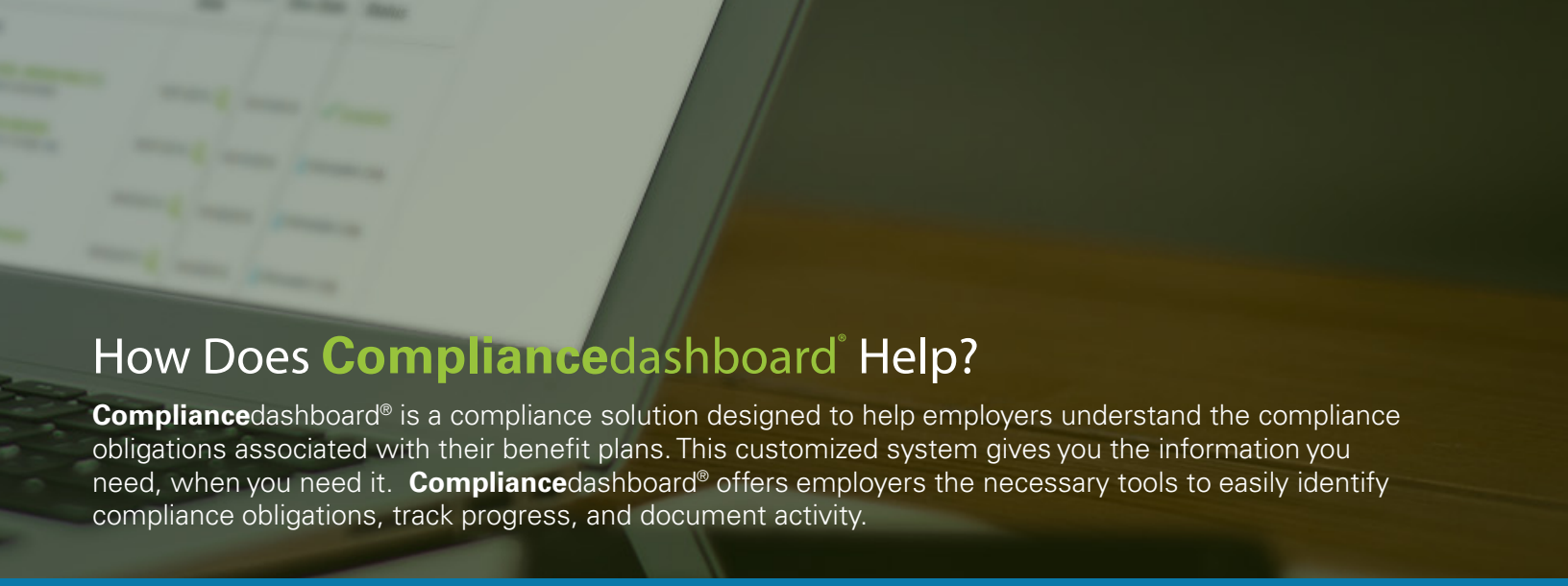


All of your compliance obligations are organized in a single calendar, customized to your plan.

ON-TIME EXECUTION



Email reminders break down your compliance responsibilities into clear, understandable activities.



How Does **Compliance**dashboard® Help?

Compliancedashboard® is a compliance solution designed to help employers understand the compliance obligations associated with their benefit plans. This customized system gives you the information you need, when you need it. **Compliance**dashboard® offers employers the necessary tools to easily identify compliance obligations, track progress, and document activity.

WHAT'S AT STAKE

Plan Administrator Liability

Typically, an employer that sponsors a group health plan is:

- **Directly responsible** for ensuring compliance obligations are met
- Liable for penalties if legal duties are not satisfied

DOL/IRS Audits

All benefit plans are subject to investigation by the DOL.

- DOL has the power to subpoena documents and witnesses
- Compliance procedures and documentation are key components of DOL investigations.

Benefits Liability

Compliance defects in documentation or eligibility can cause an employer to be liable for unintended benefits or benefits outside the plan terms that may not be covered by insurance.

Corporate Transaction Issues

Due diligence surrounding the **sale/merger of a business unit** often involves the inspection of legal compliance.

- Proper documentation and record keeping are inspected
- Deficiencies can impact the business transaction

Document Request Liability

Plan participants have the right to request and inspect plan documents. **Statutory penalties and lawsuits** may occur if employers do not maintain compliant documents.

VERIFICATION & FOLLOW-UP



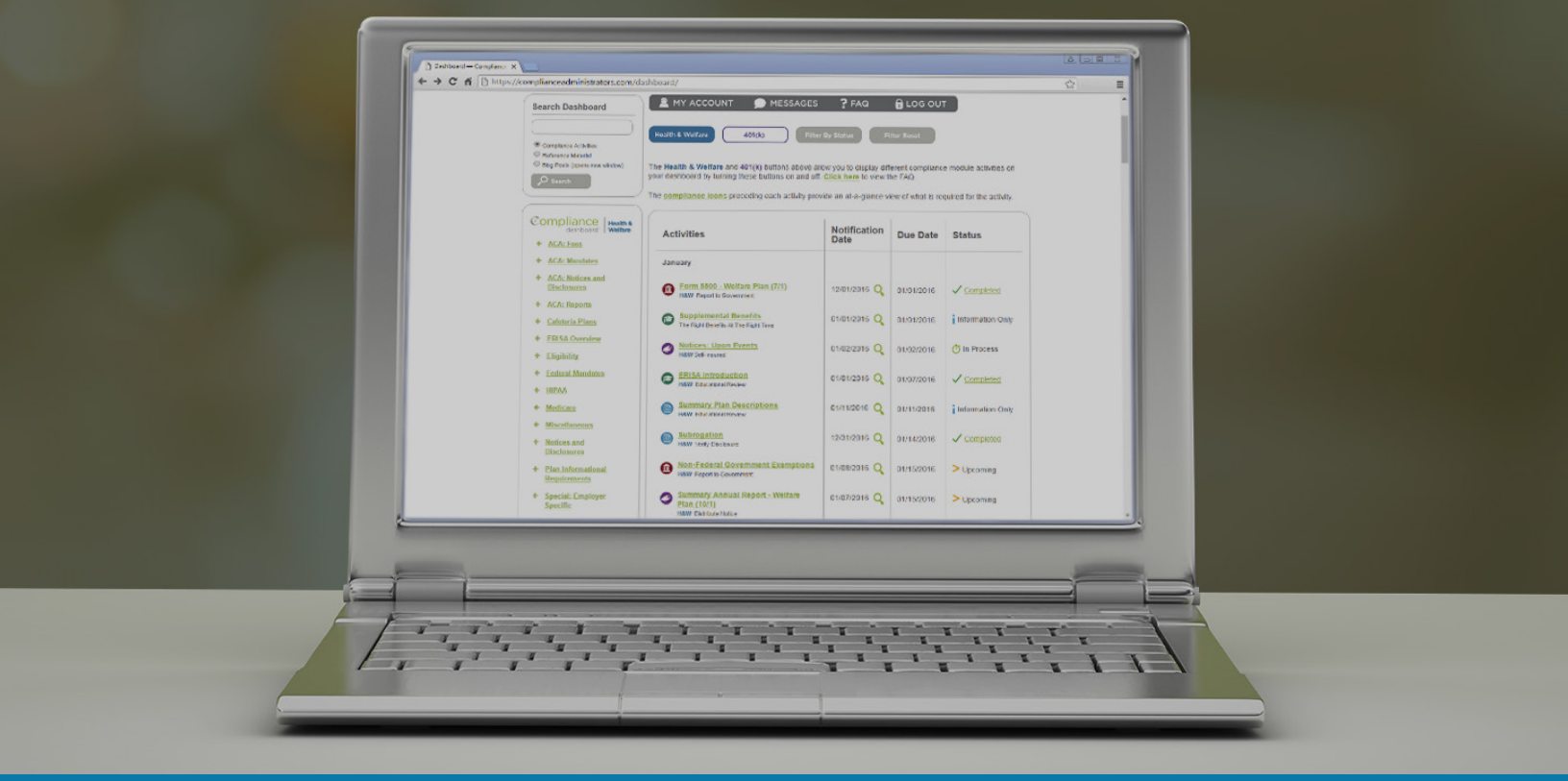
Record tasks as you complete them, and upload your own documents as proof.

AUDIT TRAILS



Generate on-demand reports of your compliance progress for audit purposes.

> "**Compliance**dashboard® has been a tremendous asset to our company. With the use of the dashboard, we no longer struggle with the confusion of which policies apply to our organization. I truly feel more confident in our company's compliance because of this valuable tool."
>
> — HR Director, Kentucky



Who Can Benefit from **Compliance**dashboard®?

SMALL EMPLOYERS

Your organization may not employ HR staff who are well-versed in regulatory compliance. Our **step-by-step guidance** includes **action-oriented instructions** to give your personnel a streamlined process for completing compliance tasks.

LARGE EMPLOYERS

Your HR staff may have experience with compliance, but they may not have an organized system in place. Our **documentation and reminder system** automatically implements an effective process that saves your HR personnel time and energy.

MULTIPLE LOCATION EMPLOYERS

You may not always have the time or ability to keep up with the compliance processes at various offices. Our system gives HR staff the **ability to assign tasks to other locations** and **track their compliance progress** from any location.

MULTIPLE EMPLOYER PLANS

With multiple entities involved, your health plan has many moving parts. Our process **caters to the unique and complex organization structure** of your plan, **clearly defining responsibilities** among all parties involved.

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Employer Compliance Checklist

Prepared For: Company Name
Plan Year: Dates

The Employer Compliance Checklist contains a detailed list of employer reporting and disclosure requirements for health and welfare benefit plans, which is reviewed annually by our legal partners, as well as your status in fulfilling these requirements to the best of our knowledge. Should you have any questions on the report card or any items listed, please feel free to contact us at any time.

Reporting Requirements	Satisfied By	Date
Medicare Part D Reporting - Must report to the Centers for Medicare & Medicaid Services (CMS) on group health plan's prescription drug coverage within 30 days of the beginning of the plan year.	Better Source Benefits Reported - Included in Master Compliance Folder	Date Compliance email sent to Group
IRS/SSA/CMS Data Match - Must be completed by employers with one or more Medicare-eligible worker and/or spouse of a Medicare-eligible employee, whenever CMS identifies those individuals to the employer. Employees must respond within 30 days of the initial inquiry, unless and extension has been requested and approved.	Employer Reported	Unknown
1094-B / 1095-B Reporting - Satisfied by carrier for fully insured groups. Required to be filed by self insured groups with less than 50 FTE. **1094-C / 1095-C Reporting -** Used to report the ACA employer mandate by monitoring the type and cost of coverage offered to employees, and the number of employees who were offered this coverage. Satisfies the ALE's reporting obligation under the pay or play penalty. Required for ALE's (>50 FTE).	Employer Reported	Due to EE's: 3/2/17 Due to IRS: 2/28/17 if by mail 3/31/17 if e-filed
PCORI FEE - All self-insured groups, which includes the HRA component of fully insured medical plans, must file the IRS form 720 in the second quarter of each year for the previous plan year. The fees associated with this filing are due on July 31st following the last day of the plan year.	N/A or Employer Will Be Required to File	N/A or July 31
Form 5500 - Must be filed for all welfare benefit plans with 100+ participants, within seven months after the close of the plan year, or within 9 1/2 months with an extension.	N/A or Better Source Benefits Will Facilitate	N/A or 7 months after renewal date
Enrollment Disclosure Requirements	**Satisfied By**	**Date**
Open Enrollment/Special Enrollment Notification - Includes notice of special enrollment rights.	Open Enrollment / New Hire Packet	Date OE Packets Provided
Employee Eligibility - Including waiting period and hourly requirements.	Open Enrollment / New Hire Packet	Date OE Packets Provided
Dependent Eligibility - Clearly defined definition of eligible dependent.	Open Enrollment / New Hire Packet	Date OE Packets Provided

Summary of Benefits and Coverage - Must provide at initial enrollment and annually with OE materials.	Open Enrollment / New Hire Packet	Date OE Packets Provided
Medicare Part D Notice of Creditable Coverage - Must provide annually to all Medicare Part D eligible.	Open Enrollment / New Hire Packet	Date OE Packets Provided
Notice of Coverage Options (Marketplace Notice) - Must provide to all new hires within 14 days.	Employer to Provide	Date of EE Hire
Coordination of Benefits - Must be made available to employees annually. Included in the Certificate of Coverage, which is provided to you each year following your renewal.	Disclosure included in Certificates of Coverage found in the Master Compliance Folder	Date Compliance email sent to Group
COBRA Notices - Includes initial notice, qualifying event notice (required of employees not employers) if applicable, unavailability notice, early termination notice, and election notice. Only required for groups with 20+ employees.	COBRA Administrator	Event Specific
Wellness / Health Risk Assessment Disclosure Requirements	**Satisfied By**	**Date**
EEOC Notice Regarding Wellness Program - Notice to employees informing them what information will be collected, how it will be used and who will receive it.	Open Enrollment / New Hire Packet on Physician Verification Form	Date OE Packets Provided
ADA Protections from Disclosure of Medical Information - Notice given to employees to show what will be done to keep their Health Risk Assessment information confidential.	Open Enrollment / New Hire Packet on Physician Verification Form	Date OE Packets Provided
Plan Documents and Legal Disclosure Requirements	**Satisfied By**	**Date**
Summary Plan Description & Plan Document - Must be provided to new participants within 90 days of being covered under the plan. Updated SPD (or Summary of Material Modification) must be provided to participants no later than 210 days after the end of the plan year in which the change is adopted it also must be provided within 60 days of the adoption of the modification, if the modification results in a material reduction in covered services or benefits.	Better Source Benefits Facilitated - Included in Master Compliance Folder / Better Source Benefits Did Not Facilitate	Date Compliance email sent to Group
The following legal disclosure requirements are included in Better Source Benefits facilitated SPDs and Model Notice Package. If you obtain your SPD from another source, please be sure to confirm the following disclosures are included. If you do not have an SPD on file, you are most likely not in compliance with these disclosure requirements.		
Look Back Language / Measurement, Admin, & Stability Period - The amount of time used to determine each on-going employee's full-time status.	Unknown or Included in Master Compliance Folder	Date Compliance email sent to Group
Children's Health Insurance Program Reauthorization Act (CHIPRA) - Must provide notice of potential opportunities for premium assistance under Medicaid annually. Not required for Michigan.	Unknown or Included in Master Compliance Folder	Date Compliance email sent to Group

Plan Documents and Legal Disclosure Requirements (continued)	Satisfied By	Date
Conversion Notice - Must provide to qualified beneficiaries where the plan provides a conversion option.	Unknown or Included in Master Compliance Folder	Date Compliance email sent to Group
DOL Claim Procedures - Must disclose and comply with claims, appeals, and external review of requirements.	Unknown or Included in Master Compliance Folder	Date Compliance email sent to Group
Family Medical Leave Act (FMLA) - Notices relating to health coverage are required for employees on FMLA leave. This only applies to employers with 50+ employees.	Unknown or Included in Master Compliance Folder	Date Compliance email sent to Group
Generic Information Nondiscrimination Act (GINA) - Notice must be provided directing individuals or health care providers not to provide generic information in any request for medical information.	Unknown or Included in Master Compliance Folder	Date Compliance email sent to Group
HIPAA Notice of Privacy Practices - Must be provided to participants upon enrollment and when there are material changes to the notice.	Unknown or Included in Master Compliance Folder	Date Compliance email sent to Group
Medical Loss Ratio Rebates - Provides notice on how, in the event a rebate is received, the rebate will be distributed.	Unknown or Included in Master Compliance Folder	Date Compliance email sent to Group
Newborns' and Mothers' Health Protection Act - Must provide notice of individual rights to plan participants.	Unknown or Included in Master Compliance Folder	Date Compliance email sent to Group
Qualified Medical Child Support Order (QMCSO) - Must provide notice of receipt of a proposed order and of determination regarding the order.	Unknown or Included in Master Compliance Folder	Date Compliance email sent to Group
Mental Health Parity Act (MDPAEA) - Provides notice of mental health and substance abuse benefits. Applicable to employers with more than 50 employees.	Unknown or Included in Master Compliance Folder	Date Compliance email sent to Group
Subrogation - Must provide notice of employer's rights of reimbursements.	Unknown or Included in Master Compliance Folder	Date Compliance email sent to Group
Uninformed Services of Employment and Reemployment Rights Act (USERRA) - Must provide notices relating to health coverage for employees performing qualified military service.	Unknown or Included in Master Compliance Folder	Date Compliance email sent to Group
Women's Health and Cancer Rights Act - Must provide to participants upon enrollment and annually.	Unknown or Included in Master Compliance Folder	Date Compliance email sent to Group

IRS Requirements	Satisfied By	Date
Section 125 or Cafeteria Plan - Must have document on file for IRS.	Kept on File	Original Creation Date



Provided by Better Source Benefits

2019 Compliance Checklist

The Affordable Care Act (ACA) has made a number of significant changes to group health plans since the law was enacted in 2010. Many of these key reforms became effective in 2014 and 2015, including health plan design changes, increased wellness program incentives and the employer shared responsibility penalties.

Certain changes to some ACA requirements take effect in 2019 for employers sponsoring group health plans, such as increased dollar limits. To prepare for 2019, employers should review upcoming requirements and develop a compliance strategy.

This ACA Overview provides an ACA compliance checklist for 2019. Please contact Better Source Benefits for assistance or if you have questions about changes that were required in previous years.

LINKS AND RESOURCES

- U.S. Department of Health and Human Services' (HHS) Final Notice of Benefit & Payment Parameters for 2019 established the cost-sharing limits for 2019
- 2018 Forms 1094-B and 1095-B (and related instructions) for reporting under Section 6055
- 2018 Forms 1094-C and 1095-C (and related instructions) for reporting under Section 6056
- Internal Revenue Service (IRS) Revenue Procedure 2018-34 indexed the affordability contribution percentages in 2019

HIGHLIGHTS

CHANGES FOR 2019

Certain percentages and dollar amounts have changed for 2019:

- Cost-sharing limits
- Coverage affordability percentages
- Maximum penalties for ACA reporting violations

EXPECTED CHANGES FOR 2019

Other updated amounts have not yet been announced, but may change for 2019, including:

- Health flexible spending account (FSA) salary contribution limits
- Dollar amounts for calculating employer shared responsibility penalties

This ACA Overview is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

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PLAN DESIGN CHANGES

Grandfathered Plan Status

A grandfathered plan is one that was already in existence when the ACA was enacted on March 23, 2010. If you make certain changes to your plan that go beyond permitted guidelines, your plan is no longer grandfathered. **However, grandfathered status does not automatically expire as of a specific date.** A plan may maintain its grandfathered status as long as no prohibited changes are made. Once a plan relinquishes grandfathered status, it cannot be regained and the plan must comply with additional reforms under the ACA.

Contact Better Source Benefits if you have questions about changes you have made, or are considering making, to your plan.

Review your plan's grandfathered status:

- ☐ If you have a grandfathered plan, determine whether it will maintain its grandfathered status for the 2019 plan year. Grandfathered plans are exempt from some of the ACA's mandates. A grandfathered plan's status will affect its compliance obligations from year to year.
- ☐ If your plan will lose its grandfathered status for 2019, confirm that the plan has all of the additional patient rights and benefits required by the ACA for non-grandfathered plans. This includes, for example, coverage of preventive care without cost-sharing requirements.
- ☐ If your plan will keep its grandfathered status, continue to provide the Notice of Grandfathered Status in any plan materials provided to participants and beneficiaries that describe the benefits provided under the plan (such as the plan's summary plan description and open enrollment materials). Model language is available.

Cost-sharing Limits

Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered health plans are subject to limits on cost sharing for essential health benefits (EHB). The ACA's overall annual limit on cost sharing (also known as an out-of-pocket maximum) applies for all non-grandfathered group health plans, whether insured or self-insured. Under the ACA, a health plan's out-of-pocket maximum for EHB may not exceed **$7,900** for self-only coverage and **$15,800** for family coverage, effective for plan years beginning on or after Jan. 1, 2019.

Health plans with more than one service provider may divide the out-of-pocket maximum across multiple categories of benefits, rather than reconciling claims across multiple service providers. Thus, health plans and issuers may structure a benefit design using separate out-of-pocket maximums for EHB, provided that the combined amount does not exceed the annual out-of-pocket maximum limit for that year. For example, in 2019, a health plan's self-only coverage may have an out-of-pocket maximum of

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Provided by Better Source Benefits

Self-insured Plans Under the ACA

The Affordable Care Act (ACA) includes numerous reforms affecting the health coverage that employers provide to their employees. Many of these reforms apply to all group health plans, regardless of their method of funding. Plans that have grandfathered status under the ACA, however, are not required to comply with select ACA requirements. In addition, self-insured plans are exempt from certain ACA requirements.

A self-insured plan is a health plan where the employer assumes the financial risk of providing health care benefits to its employees. Employers may decide to self-insure their health plans for a number of reasons, such as avoiding state insurance taxes and state benefit mandates, retaining more control over plan design and controlling reserves. There may also be disadvantages associated with self-insuring, such as a greater assumption of risk and increased administrative obligations.

This ACA Overview highlights how select ACA requirements apply to self-insured plans.

LINKS AND RESOURCES

- DOL Report on Self-Insured Health Benefit Plans for 2018
- IRS Health Care Tax Tip 2015-42: Employers Providing Self-Insured Health Coverage Must Report on Information Returns
- IRS webpage on Information Reporting by Providers of Minimum Essential Coverage

This ACA Overview is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

HIGHLIGHTS

SELF-INSURED PLANS

- The employer assumes the financial risk of providing health care benefits and paying claims.
- Benefits are not provided through an insurance policy.
- The employer may obtain stop-loss insurance to protect against large claims.
- An insurance carrier or third-party administrator may provide administrative services.

SELF-INSURING PROS AND CONS

- Self-insured plans are not subject to state insurance laws and are exempt from some ACA rules.
- An employer may assume greater risk when self-insuring benefits and may have more administrative obligations.

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ACA REFORMS THAT APPLY TO SELF-INSURED PLANS

Many ACA reforms affect all group health plans, regardless of whether they are fully insured or self-insured. For example, among many other reforms, self-insured and fully insured plans must comply with the following ACA provisions:

- Dependent coverage for adult children up to age 26;
- Coverage of preventive health services without cost-sharing (grandfathered plans are exempt);
- No rescissions of coverage, except in the case of fraud or intentional misrepresentation of material fact;
- No lifetime or annual dollar limits on essential health benefits (EHBs);
- Improved internal claims and appeals process and minimum requirements for external review (grandfathered plans are exempt);
- No waiting periods exceeding 90 days;
- No pre-existing condition exclusions for any enrollees;
- No discrimination against participants who participate in clinical trials (grandfathered plans are exempt); and
- Participants' maximum out-of-pocket expenses for covered EHBs cannot exceed specified amounts (grandfathered plans are exempt). To determine which benefits are EHB, a self-insured group health plan may choose any state benchmark plan that was approved by the Department of Health and Human Services (HHS).

Both self-insured and fully insured plans are subject to the ACA's requirement to provide participants and beneficiaries with the uniform **summary of benefits and coverage** (SBC). Sponsors of self-insured and fully insured plans alike must also comply with the ACA's requirement to report the aggregate cost of employer-sponsored group health plan coverage on their employees' **Forms W-2**.

In addition, sponsors of self-insured plans and issuers of fully insured plans are required to pay **Patient-Centered Outcomes Research Institute (PCORI) fees** under the ACA for plan years ending on or after Oct. 1, 2012, but before Oct. 1, 2019.

Employer Penalty Rules and Coverage Reporting Requirements

Applicable large employers (ALEs) must comply with the ACA's **employer shared responsibility rules and related reporting requirements**. Under the employer shared responsibility rules, an ALE may be subject to a penalty if it does not offer health coverage to substantially all of its full-time employees (and their dependents), or if it offers health coverage that is unaffordable or does not provide minimum value.

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7/12; BR 11/18



January 2019

HR BRIEF

2019 Plan Limits: Everything You Must Know

If you offer high deductible health plans (HDHPs), health savings accounts (HSAs), flexible spending accounts (FSAs) or 401(k) plans, your plans are subject to inflation-adjusted dollar limits.

The following is a list of plan limit **increases** for 2019. It does not include limits that are staying the same from 2018.

HSA Contributions	
Self-only	$3,500
Family	$7,000
HDHP Out-of-pocket Max	
Self-only	$6,750
Family	$13,500
Health FSA	
Employee pre-tax contribution	$2,700
Transportation Fringe Benefits	
Transit pass & vanpooling (combined)	$265
Parking	$265
401(k) Contributions	
Employee elective deferrals	$19,000
Adoption Assistance Benefits	
Tax exclusion	$14,080

For a comprehensive list of all the 2019 plan limits, or to determine if your plan offerings are subject to inflation, please contact ·ΩÆÆΩ∞!–≥≠∞øΩ!·Ω¥Ω°πÆ Ø today.

Gen Z is Coming: Are You Prepared?

Soon, Generation Z—those born between 1996 and 2010—will be entering the workforce. Is your company somewhere they can thrive? Is it somewhere they would even want to work?

If you want to attract this budding workforce, you need to understand Gen Zers' motivations.

For instance, Gen Zers have never known a life without technology. This means if your business still touts outdated tech, Gen Zers likely won't give you a second thought.

Consider areas where your company's tech falls short and brainstorm how you can improve. Getting new hardware may be sufficient, but another option is hiring a tech expert to conduct an audit and mal suggestions. (Hint: This might be a good job for a Gen Zer.)

Beyond prizing their tech, Gen Zers also value their company's culture. Like their millennial predecessors, Gen Zers want vibrant, collaborative spaces—think bright colors, open workspaces and natural light.

However, Gen Zers also identify as scrappier than millennials. They have a "self-made" attitude and value healthy competition.

With that in mind, your workplace and culture should accommodate some isolated spaces for Gen Zers to hunker down and get things done.

For more tips on attracting this valuable workforce, speak with us today.

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COMPLIANCE BULLETIN

Michigan Slows Timeline for $12 Minimum Wage

HIGHLIGHTS

- Michigan has scaled back the minimum wage increases it approved in September 2018.
- The state's minimum wage will remain under $12 until 2030 and will not be subject to inflation-based adjustments.
- Under the new law, Michigan's 2019 minimum wage rate is $9.45 (instead of $10) per hour.

IMPORTANT DATES

September 5, 2018
Michigan adopts minimum wage ballot proposal

December 14, 2018
Minimum wage law is amended

March 29, 2019
$9.45 per hour minimum wage becomes effective

OVERVIEW

Just months after approving a measure that would have raised the state's minimum wage to $12 by 2022, Michigan has enacted a new law that keeps the rate lower until 2030.

Signed into law on Dec. 14, 2018, Public Act No. 368 sets the state's 2019 minimum wage at **$9.45 per hour effective March 29, 2019**, and includes a schedule of annual increases that bring the rate up to **$12.05 in 2030**. The law also eliminates annual inflation-based increases that would have applied after 2023.

In addition, the new law allows employers to continue paying **tipped employees** only **38 percent** of the full minimum wage rate. Under the previous measure, the rate for tipped employees would have increased annually until it matched the full rate in 2024.

ACTION STEPS

Michigan employers with two or more employees should become familiar with the new law and ensure that they begin paying their employees at least $9.45 per hour as of March 29, 2019.

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Background

In order to keep a citizen-led initiative called the Improved Workforce Opportunity Wage Act (IWOWA) off of Michigan's ballot in the November 2018 general election, the state's legislature adopted the measure as state law on Sept. 5, 2018. This approach made the law easier to amend. On Dec. 14, 2018, the Michigan legislature enacted its expected changes.

Key Changes

The following chart summarizes the key changes that Public Act No. 368 (Amendments) makes to the IWOWA:

Effective Date	Full Minimum Wage Rate		Tipped Employees' Minimum Wage	
	Amendments	IWOWA	Amendments	IWOWA
Early 2019*	$9.45	*$10.00*	$3.60	*48% of the full rate*
Jan. 1, 2020	$9.65	*$10.65*	$3.67	*60% of the full rate*
Jan. 1, 2021	$9.87	*$11.35*	$3.75	*70% of the full rate*
Jan. 1, 2022	$10.10	*$12.00*	$3.84	*80% of the full rate*
Jan. 1, 2023	$10.33	*Adjustments for inflation*	$3.93	*90% of the full rate*
Jan. 1, 2024	$10.56		$4.03	*100% of the full rate*
Jan. 1, 2025	$10.80		$4.11	
Jan. 1, 2026	$11.04		$4.20	
Jan. 1, 2027	$11.29		$4.29	
Jan. 1, 2028	$11.54		$4.39	
Jan. 1, 2029	$11.79		$4.48	
Jan. 1, 2030	$12.05		$4.58	

*While the original IWOWA would have required employers to begin paying their employees a new minimum wage rate as of Jan. 1, 2019, the current law (as amended by Public Act No. 368) is scheduled to become effective 90 days after the state legislature adjourned. According to the state legislature's website, the effective date falls on March 29, 2019.

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ACA COMPLIANCE BULLETIN

HIGHLIGHTS

- The deadline for filing returns with the IRS for 2018 is Feb. 28, 2019, if filing on paper, or April 1, 2019, if filing electronically.
- The deadline for furnishing individual statements for 2018 was extended to March 4, 2019.
- The IRS is encouraging reporting entities to furnish statements as soon as they are able.

IMPORTANT DATES

March 4, 2019
Deadline for furnishing 2018 Forms 1095-B and 1095-C to individuals

February 28, 2019
Deadline for 2018 filing with the IRS in paper form

April 1, 2019
Deadline for 2018 filing with the IRS electronically

UPCOMING ACA REPORTING DEADLINES

OVERVIEW

Affordable Care Act (ACA) reporting under Section 6055 and Section 6056 for the 2018 calendar year is due in early 2019. Specifically, reporting entities must:

- File returns with the IRS by **Feb. 28, 2019** (or **April 1, 2019**, if filing electronically, since March 31, 2019, is a Sunday); and
- Furnish statements to individuals by **March 4, 2019**.

Originally, individual statements were due by Jan. 31, 2019. However, on Nov. 29, 2018, the Internal Revenue Service (IRS) issued Notice 2018-94 to extend the furnishing deadline by 32 days. Notice 2018-94 does not extend the due date for filing forms with the IRS for 2018.

ACTION STEPS

Despite the delay, the IRS is encouraging reporting entities to furnish statements as soon as they are able. No request or other documentation is required to take advantage of the extended deadline.

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Section 6055 and 6056 Reporting

Sections 6055 and 6056 were added to the Internal Revenue Code (Code) by the ACA.

- Section 6055 applies to providers of minimum essential coverage (MEC), such as health insurance issuers and employers with self-insured health plans. These entities will generally use Forms 1094-B and 1095-B to report information about the coverage they provided during the previous year.
- Section 6056 applies to applicable large employers (ALEs)—generally, those employers with 50 or more full-time employees, including full-time equivalents, in the previous year. ALEs will use Forms 1094-C and 1095-C to report information relating to the health coverage that they offer (or do not offer) to their full-time employees.

Generally, forms must be filed with the IRS annually, no later than **February 28** (**March 31**, if filed electronically) of the year following the calendar year to which the return relates. In addition, reporting entities must also furnish statements annually to each individual who is provided MEC (under Section 6055), and each of the ALE's full-time employees (under Section 6056). Individual statements are generally due on or before **January 31** of the year immediately following the calendar year to which the statements relate.

The IRS extended the furnishing deadline for 2018 to March 4, 2019. However, the 2018 filing deadlines are unchanged.

Extended Furnishing Deadline

The IRS has again determined that some employers, insurers and other providers of MEC need additional time to gather and analyze the information, and prepare 2018 Forms 1095-B and 1095-C to be furnished to individuals. As a result, Notice 2018-94 provides **an additional 32 days** for furnishing the 2018 Form 1095-B and Form 1095-C, extending the due date from Jan. 31, 2019, to March 4, 2019. The extended deadline is March 4, rather than March 2 as in prior years, because March 2, 2019, is a Saturday.

Despite the delay, employers and other coverage providers are encouraged to furnish 2018 statements to individuals as soon as they are able.

Filers are not required to submit any request or other documentation to the IRS to take advantage of the extended furnishing due date provided by Notice 2018-94. Because this extended furnishing deadline applies automatically to all reporting entities, the IRS will not grant additional extensions of time of up to 30 days to furnish Forms 1095-B and 1095-C. As a result, the IRS will not formally respond to any requests that have already been submitted for 30-day extensions of time to furnish statements for 2018.

Filing Deadline

The IRS has determined that there is no need for additional time for employers, insurers and other providers of MEC to file 2018 forms with the IRS. Therefore, Notice 2018-94 does not extend the due date for filing Forms 1094-B, 1095-B, 1094-C or 1095-C with the IRS for 2018.

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Employee Communication

total control HEALTH PLANS®

BENEFITS GUIDE

2019

BETTERSOURCE

BENEFITS, OPTIONS ...SOLUTIONS!

total control HEALTH PLANS

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Note: If you (and/or) your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 24 for more details.

This booklet is intended for illustration and informational purposes only. The plan documents, insurance certificates and policies will serve as the governing documents to determine plan eligibility, benefits and payments. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern.

total control HEALTH PLANS

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ELIGIBILITY & BENEFIT ELECTIONS

The City of Danville offers a comprehensive selection of benefits that you and your family can use to protect your health, finances, and future. In addition, there is flexibility built into the program so you can select the benefit options that fit the needs of you and your family.

We invite you to take some time and carefully consider each of the benefit options to decide which is right for you and your family. This guide explains each of our benefits in detail and the Human Resources team is available to answer any questions you have.

OUR EMPLOYEES ARE OUR MOST VALUABLE ASSET

That's why at The City of Danville we are committed to offering a comprehensive Employee benefit program that helps our Employees stay healthy, feel secure and maintain a work/life balance.

- Medical, Dental and Vision Care
- Health Savings Account (HSA)
- Disability Insurance
- Life and Accidental Death and Dismemberment (AD&D)
- Accident and Critical Illness Coverage
- Employee Assistance Program (EAP)

ELIGIBILITY - WHO'S ELIGIBLE TO ENROLL?

Newly hired Employees will be eligible for benefits on the first of the month following 60 days of employment if they work a minimum of 30 hours per week. You will have 30 days from your hire date to make your benefit selections. If you do not enroll within the first 30 days of your hire date, you will not be eligible for coverage until the following annual enrollment period. You may enroll your eligible dependents when you enroll yourself. Dependents who are eligible for benefit coverage include your legal spouse (if they do not have coverage available to them elsewhere) and your legally dependent children. Included in the definition of dependent child(ren) are:

- Your naturally born child(ren), legally adopted child(ren), child(ren) placed for adoption, step-child(ren), court ordered dependent child(ren) or foster children for whom you are the court-appointed legal guardian
- Your dependent child(ren) up to age 26 regardless of student status for medical, dental, vision, accident and critical illness insurance.
- Your continuously disabled dependent child(ren) [If disabled prior to age 26] who are incapable of self-sustaining employment and dependent upon you for support, regardless of age.

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WHEN CAN I CHANGE MY BENEFITS?

Your health and welfare benefits remain in effect throughout the plan year. Generally, you cannot change your benefit level, add or drop out of a plan until the next annual open enrollment. However, if there is a qualified change in your family status, you will be eligible to change your coverage as long as you notify your HR department **within 30 days** of the qualifying event.

Exceptions will be made for changes in family status during the year allowing you to make a mid-year benefit change. If you have a family status change, you must change your benefit elections within 30 days of the qualifying event, or you will need to wait until the next annual enrollment period. The only exception to the 30 day rule is new eligibility or termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP), in which you must notify HR within 60 days of the qualifying event.

Note: Documentation may be required and will need to be submitted to Human Resources.

A family status change includes:

- Change in legal marital status (marriage, death of spouse, divorce or legal separation)
- Change in the number of dependents (birth, death, adoption, or placement for adoption)
- Change in the employment status of the Employee or the Employee's spouse including start or end employment, change in eligibility (full time to part time), a strike or lockout, commencement or return from an unpaid leave of absence and a change in worksite.
- Dependent satisfies or ceases to satisfy eligibility requirements (attain particular age, student status)
- Alternate open enrollment timeframe for spouse or loss of other coverage

COBRA CONTINUATION COVERAGE:

When you or any of your dependents no longer meet the eligibility requirements for our health and welfare plans, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

TERMINATION OF EMPLOYMENT:

Your benefits will terminate on the last day of the month following your termination date.

TAX ADVANTAGE:

Your contributions to the medical, dental, vision and HSA plans are made on a pre-tax basis. Your taxable income will be reduced by the amount you contribute for each benefit—you pay income tax on the amount you contribute, thus saving you tax dollars. The fact that your taxable income will be lowered does not affect your salary-related benefits, which will continue to be paid based on your earnings before contributions.

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ENROLLING IN YOUR BENEFITS

You have online access to your benefits information 24 hours a day, 7 days a week through Employee Navigator which can be used to:

- Update personal information
- Review current benefit plans
- Review other benefit related information

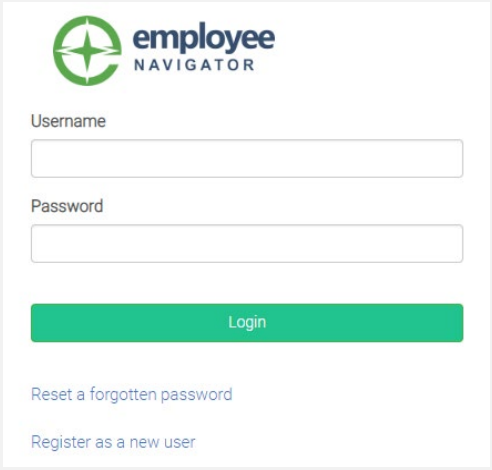
SETTING UP YOUR ACCOUNT:

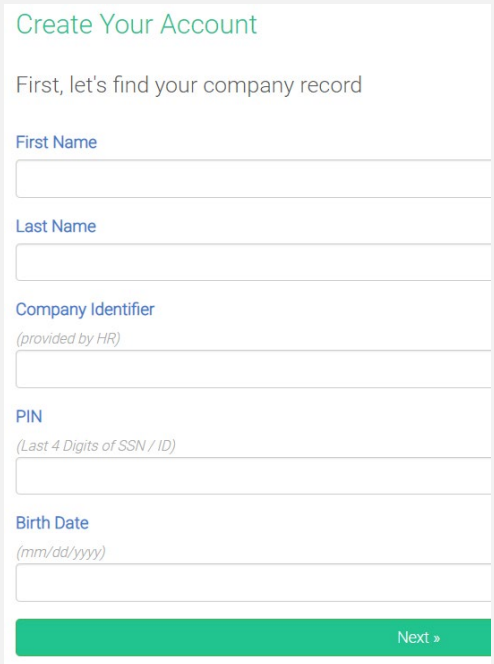
To register your account go to www.employeenavigator.com and select "register as a new user" under the Login button.

- Enter your name, date of birth, the last 4 digits of your social security number and the company identifier: Client Name1
- You will be asked to create a username. Your username should be in the following format: The City of Danville_(First initial first name, first initial middle name, first four last name).
- For Example: Joseph Timothy Smith's username will be The City of Danville_JTSmit.

IMPORTANT NOTES ABOUT THE SYSTEM:

- Confirm your profile is accurate.
- Remember to add/verify dependent information.
- Save and continue after each selection.
- Use the "Things to Consider" or "Decision Support" tools to help with benefit elections.
- Be sure to click the "Agree" button at the end to ensure enrollment is processed.





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MEDICAL BENEFITS SUMMARY

The following chart is a snapshot of the medical plans offered. You can find the full Summary of Benefits and Coverage (SBC) on the Employee Navigator page. These summaries may be helpful to provide more information about the medical plans or to compare our plans to others, such as plans available to you through your spouse's employer.

HSA PLAN			
	In Network		Out of Network
Network	Guided Network	Alternate Network	Out of Network
Individual Deductible	$1,350	$2,700	$5,000
Family Deductible	$2,700	$5,400	$10,000
Coinsurance	100%	80%	60%
Individual Out of Pocket Max	$5,000*		$10,000
Family Out of Pocket Max	$10,000*		$20,000
Virtual Visits	$45	$45	$45
Office Visits PCP/Specialty	0% after Ded.	20% after Ded.	40% after Ded.
Urgent Care Visits	0% after Ded.	20% after Ded.	40% after Ded.
Emergency Room	0% after Ded.	20% after Ded.	40% after Ded.
Hospitalization	0% after Ded.	20% after Ded.	40% after Ded.
Prescription Generic/Preferred/NonPreferred	$10/$35/$60 (If Preventive) $10/$35/$60 after Ded. (If not preventive)	$10/$35/$60 (If Preventive) $10/$35/$60 after Ded. (If not preventive)	$10/$35/$60 (If Preventive) $10/$35/$60 after Ded. (If not preventive)
Specialty Prescription Generic/Preferred/NonPreferred	20% to $200 after Ded.	20% to $200 after Ded.	20% to $200 after Ded.

TRADITIONAL PLAN			
	In Network		Out of Network
Network	Guided Network	Alternate Network	Out of Network
Individual Deductible	$0	$1,500	$2,000
Family Deductible	$0	$3,000	$4,000
Coinsurance	100%	80%	50%
Individual Out of Pocket Max	$5,000*		$10,000
Family Out of Pocket Max	$10,000*		$20,000
Virtual Visits	$0	$0	$0
Office Visits PCP/Specialty	$30/$60	$30/$60	50% after Ded.
Urgent Care Visits	$75	$75	50% after Ded.
Emergency Room	$150	$150	50% after Ded.
Hospitalization	0%	20% after Ded.	50% after Ded.
Prescription Generic/Preferred/NonPreferred	$10/$35/$60	$10/$35/$60	$10/$35/$60
Specialty Prescription Generic/Preferred/NonPreferred	20% to $200	20% to $200	20% to $200

*Out of Pocket Maximum combined for all In Network claims

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MEDICAL BENEFITS

Client Name's medical coverage is through Carrier Name. These plans are Preferred Provider Organization (PPO) plans meaning they offer both in and out of network coverage. These plans include a third tier of coverage with significantly lower out of pocket costs when utilizing an AIMM recommended provider or facility.

HIGH DEDUCTIBLE PLAN WITH HEALTH SAVINGS ACCOUNT (HSA) SPECIFICS

The HDHP is a High Deductible Health Plan that can be combined with a Health Savings Account. Under this plan, the medical is combined with prescription drug benefits which allows you to use the funds in the savings account to pay for qualified pharmacy and medical expenses.

Note: The prescription drug co-pays apply after the deductible is satisfied unless it is a preventive medication that falls under the Preventive Rx program.

Under the HDHP, if you are covering any dependents, the entire family deductible must be met prior to the plan paying for coverage.

IRS Contribution Limits for are:
2019: $3,500 for self-only; $7,000 for family
2020: $3,550 for self-only; $7,100 for family

PLAN SPECIFICS

All medical plans allow you to access providers in or out of the network without a referral or selection of a PCP. However, if you receive out of network care, you will have greater out of pocket costs such as copayments, coinsurance and deductibles.

You will need to confirm with your auto insurance provider that your auto insurance is to pay primary in the event of an auto accident on or before your effective date.

FINDING A DOCTOR

Use Cofinity's and/or First Health's online participating provider directory to locate providers, hospitals and pharmacies as well as find, select or change your primary care physician. Follow this link: www.cofinity.net

If your provider is not in network with Cofinity, search the First Health network's site using this link: www.myfirsthealth.com

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MEDICAL BENEFITS & CONTRIBUTIONS

Nothing is more important than the health of you and your family. That is why our medical plan choices through Sisco are designed to help you get the care you need at a price you can afford. The options available to you are plans that give you flexibility to receive low cost services each time you need care.

HSA PLAN			
	Monthly Contributions	Annual Contributions	Annual Difference
Employee	$103.18	$1,238.16	-
Employee + 1 Dependent	$244.53	$2,934.36	-
Family	$262.05	$3,144.60	-

TRADITIONAL PLAN			
	Weekly Contributions	Annual Contributions	Annual Difference from HSA Plan
Employee	$176.71	$2,120.52	$882.36
Employee + 1 Dependent	$418.81	$5,025.72	$2,091.36
Family	$448.85	$5,386.20	$2,241.60

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AIMM

WHEN TO CALL AIMM

The City of Danville has implemented a FREE program for you. AIMM Total Health Management Program offers all members the following services:

▪ All Hospitalizations	▪ Transplant Services (including transplant evaluation)	▪ Inpatient Rehabilitation Facility Stays
▪ All Substance Abuse Treatment	▪ All Mental Disorder Treatment	▪ Skilled Nursing Facility Stays
▪ Home Health Care	▪ Hospice Care	▪ Physical Therapy (PT)
▪ Dialysis	▪ Speech Therapy (ST)	▪ Occupation Therapy (OT)
▪ Cardiac Rehabilitation Therapy	▪ Outpatient Surgery	▪ Chemotherapy & Radiation Therapy
▪ Durable Medical Equipment Costing over $500	▪ Prenatal and Maternity Care	▪ MRI & CT Scans

PRECERTIFICATION IS EASY TO DO

As soon as you know you will be having the service, or as soon as possible after receiving an emergency service:

1. Call AIMM at 866-562-2466 between the hours of 9 a.m. and 5 p.m. Eastern Standard Time, or leave a message on the 24/7 confidential voice mail.
2. Provide the name and date of birth of the patient.
3. Provide the name, group number, ID number address and phone number of the policy holder.
4. Provide the name and phone number of the facility where the services will be performed.
5. Provide the name and phone number of the doctor ordering the services.
6. Give a brief explanation to the RN of what service is being done and why.
7. Write down the reference number that the RN gives to you and present it when you go for the services.

Precertification is not a guarantee of benefits, eligibility, payment, nor a medical treatment decision or advice.

AIMM provides information, education, resources and support to members of the health plan and the medical professionals who provide care to them. AIMM is part of your health plan management to ensure that the medical care that is covered by the health plan meets the requirements of "medically necessary and appropriate" and that patients are getting the highest quality health care available based on nationally recognized evidence-based clinical care optimum recovery guidelines.

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THE BENEFITS APP

WHAT IS THE BENEFITS APP?

This employer-sponsored benefit gives you access to Subject Matter Experts who are available 24/7 to answer all your health care related questions. Call the Toll-Free Customer Support Line with your benefit and health plan questions today!.

Get help with:

- Understanding your health plan
- Finding doctors in your network
- Making your doctor appointment
- Getting cost estimates for procedures
- Resolving billing issues
- Processing medical record transfers

THE POWER OF ADVOCACY AT YOUR FINGERTIPS

Access to all of your benefit information is available in one app.

- ID Cards stored in one place and sent seamlessly to the doctor.
- Save up to 70% on Rx through a network of licensed international pharmacies.
- Details on all benefit plans, including Medical, Dental, Vision, Life and AD&D, Disability, EAP and more.

SET UP YOUR ACCOUNT

Please take the time to set up your account as it makes the process much faster when you need immediate service. You can set up your account to access your information from any device:

- Visit www.thebenefitsapp.com/creativedining or Download The Benefits App from Google Play or the App Store
- Create an account – Enter Access Code CREATIVEDINING
- Create Username and Password

CALL ANYTIME

Call your healthcare concierge anytime at 800-000-0000

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HEALTH SAVINGS ACCOUNT (HSA)

HEALTH SAVINGS ACCOUNT SPECIFICS

A Health Savings Account (HSA) is a tax-advantaged medical savings account designed to help individuals offset the healthcare costs associated with a High Deductible Health Plan (HDHP).

WHO IS ELIGIBLE FOR AN HSA?

To qualify for an HSA, eligible individuals must meet the following requirements.

- You must be covered under a Qualified High Deductible Health Plan on the first day of the month
- You have no other health coverage (that is not a HDHP)
- You are not enrolled in Medicare
- You cannot be claimed as a dependent on another person's income tax return

THE BENEFITS OF AN HSA

- You can claim a tax deduction for contributions that you make to your HSA
- HSA distributions may be tax-free if you use them to pay for qualified medical expenses
- The interest in your account is tax free
- An HSA is "portable," so it stays with you even if you change jobs, change plans, become unemployed or retire
- You receive a VISA debit card for purchases
- At age 55, an additional $1,000 is allowed annually

HSA CONTRIBUTION LIMITS	
2019 Individual	$3,500
2019 Family	$7,000

USE YOUR HSA FOR QUALIFIED MEDICAL EXPENSES

HSA funds can be used for a variety of qualified medical, dental and vision expenses including:

- Acupuncture
- Birth Control
- Chiropractor
- Contact Lenses
- Dental Treatment
- Hearing Aids
- Lab Work
- Orthodontia and more...

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DENTAL BENEFITS & CONTRIBUTIONS

The City of Danville provides you with dental coverage through Delta Dental. The Delta Dental plan is designed to help you maintain a healthy smile through regular preventive care and to fix any problems as soon as they occur. Through the PPO, you are not required to use a network provider - you have the freedom to select any dentist. However, you save money when you visit in-network dentists. When visiting an out-of-network provider, you may be responsible for additional out of pocket costs. A summary of the plan is provided below.

PLAN COMPONENTS	PPO & PREMIER DENTIST	NON-PARTICIPATING DENTIST
Deductible waived for preventive services	$50 per person	$50 per person
Annual Maximum	$1,000 per person	$1,000 per person
Preventive Services	100%	100%
Basic Services	80%	80%
Major Services	50%	50%
Orthodontia	50%	50%
Ortho Lifetime Maximum	$1,000 per child up to age 19	$1,000 per child up to age 19

Cleanings are payable twice in any consecutive 12 months. Cleanings should be scheduled at least 6 months apart. Periodontics services are a Class 3 benefit and are therefore covered at 50% after deductible. These services are used to treat gum disease and are not part of the preventive cleaning.

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PLAN RATES	MONTHLY CONTRIBUTIONS
Employee	$8.00
Employee + 1 Dependent	$14.98
Family	$27.36

DELTA DENTAL®

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VISION BENEFITS & CONTRIBUTIONS

The City of Danville provides a comprehensive vision plan through VSP for you and your family members. VSP has a large network of providers that offer a wide selection of eyewear for you to choose from. You'll receive the most out of your benefit when you visit a VSP doctor, including discounts on non-covered services and selections.

The vision plan includes a routine vision exam by a participating provider covered once per year at a $10 co-pay. If you visit a non-network provider, there is a reimbursement schedule for eyewear and other professional services.

PLAN COMPONENTS	IN NETWORK	OUT OF NETWORK REIMBURSEMENT
Exam	$10 co-pay	Up to $45
Frames	$130 allowance; 80% off balance over $130	Up to $70
Contact Lenses Medically Necessary Elective	 Covered in Full $130 allowance	 Up to $210 Up to $105
Frequency Exam Lenses or Contact Lenses Frames	 Once every 12 months Once every 12 months Once every 24 months	

Note: Frame and Contact Lens allowances are a one-time use benefit within the specified frequency; no remaining balances can be carried over or transferred to any other covered member.

This is intended as a high-level summary. Please refer to the Certificate of Coverage for full plan details, limitations and exclusions.

PLAN RATES	MONTHLY CONTRIBUTIONS
Employee	$2.26
Employee + 1 Dependent	$3.46
Family	$6.21

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BASIC LIFE & AD&D

EMPLOYER PAID LIFE AND AD&D INSURANCE

The City of Danville provides full-time Employees with employer paid life and accidental death and dismemberment (AD&D) insurance. This benefit is provided by The City of Danville and pays for the cost of this benefit on your behalf. The amount of this benefit is equal to one time your annual earnings, rounded to the next higher $1,000 to a max of $200,000. Please see Employee Navigator for the exact benefit amount. Beneficiaries can be updated in Employee Navigator at any time.

WHAT IS THE GUARANTEE ISSUE?

The Guarantee Issue (GI) is the amount of coverage you (or your spouse) are able to elect without having to complete an Evidence of Insurability (EOI) form. Please see details below regarding when EOI is needed.

Open Enrollment:

- If you previously waived this coverage and you are enrolling for the first time
- If you would like to increase your current coverage
- If you would like to increase your coverage above the Guarantee Issue amount

New Hires:

Your enrollment will not be subject to EOI if you are enrolling within your initial eligibility period and you elect coverage below the guarantee issue amount. Any amount over the GI will be subject to EOI, regardless of enrollment date. The cost of this benefit is based on age and tobacco use. Please refer to the Certificate of Coverage for complete plan details.

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SHORT TERM DISABILITY BENEFITS

The City of Danville provides full-time Employees with short-term disability income benefits who experience a non-work-related injury or illness and are unable to work may qualify to receive disability payments to help supplement lost wages. If approved, the following disability payments are dispensed for a maximum of 26 weeks:

MANAGEMENT ONLY

- Benefit Amount – 66 2/3% of weekly earnings
- Benefit Maximum - $500 per week
- Benefits Begin After – 0 days for accident, 7 days for illness
- Maximum Benefit Period – 26 weeks
- Minimal Cost to Employee

ALL FULL TIME HOURLY EMPLOYEES

- Benefit Amount – 60% of weekly earnings
- Benefit Maximum - $500 per week
- Benefits Begin After – 15 days for disabling accident
- Maximum Benefit Period – 26 weeks

100% of Cost Paid by Employee

For more information on this program, please contact the Human Resources Department.

Mutual of Omaha

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LONG TERM DISABILITY BENEFITS

LONG TERM DISABILITY

The City of Danville provides Management Employees with the option to purchase voluntary long-term disability income benefits, which is paid for by the Employee. In the event you become disabled from a non-work-related injury or sickness, disability income benefits pay 60% of your monthly earnings to a maximum of $3,000 per month.

MANAGEMENT ONLY

- Benefit Amount – 60% of monthly earnings
- Benefit Maximum - $6,000 per month
- Benefits Begin After – 180 days
- Maximum Benefit Period – To age 65
- Minimal Cost to Employee

*If you waive voluntary disability coverage when you are initially eligible, you will be required to provide Evidence of Insurability (EOI) when enrolling at a later date. Please allow 4 to 6 weeks for underwriting review. Claims incurred prior to the approval of your coverage will not be covered. Benefits may be limited and/or denied based on the EOI results.

Please refer to the certificate of coverage for full plan details.

Mutual of Omaha

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ADDITIONAL VOLUNTARY BENEFITS

ACCIDENT INSURANCE

Accident insurance includes coverage for both on-the-job and off-the-job accidents. Having an unexpected accident can cause more than physical injury - it can hurt your bank account, too. Since accidents can happen at any time, it important to prepare for the unexpected.

This policy can help you pay for out-of-pocket expenses associated with an accident by paying you a benefit depending on the injuries you receive. You can use the money as you wish – pay for healthcare related expenses, childcare while you go to the doctor, or save it for another unfortunate accident.

Plan Highlights

- Coverage available to you, your spouse and your children
- Benefits paid to you in the event of an accident
- Benefits do not coordinate with any other coverage

CRITICAL ILLNESS INSURANCE

Critical Illness Insurance protects your family and your assets. Many people don't save money for healthcare expenses, which is why being diagnosed with a heath condition can be draining, both emotionally and financially. This policy provides you with a lump sum cash benefit in the event you or your loved one is diagnosed with a covered condition such as a heart attack, cancer or a stroke.

Plan Highlights

- Coverage available to you, your spouse and your children
- $50 cash benefit paid to you annually for completed a covered Be Well Benefit screening test
- Lump sum cash benefit paid to you if you are diagnosed with a covered condition

UNUM℠

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EMPLOYEE ASSISTANCE PROGRAM (EAP)

Mutual of Omaha's EAP assists employees and their eligible dependents with personal or job-related concerns, including:

- Emotional well-being
- Family and relationships
- Legal and financial matters
- Healthy lifestyle
- Work and life transitions

EAP BENEFITS:

- Unlimited telephone access to EAP professionals 24 hours a day, seven days a week
- Telephone assistance and referral
- Service for employees and eligible dependents
- Robust network of licensed mental health professionals
- Three face to face sessions with a counselor (per household per calendar year)
    - Face to face visits ca also be used toward legal consultation
- Legal assistance and financial services
    - Online will preparation
    - Legal library and online forms
    - Telephonic financial consultation
- Resources for:
    - Financial tools and resources
    - Substance abuse and other addictions
    - Dependent and elder care assistance and referral services
- Access to a library of educational articles, handouts and resources via mutualofomaha.com/eap

WHAT ISSUES CAN BE ADDRESSED?

You can trust your EAP professional to assess your needs and handle your concerns in a confidential, respectful manner. Our goal is to collaborate with you and find solution as that are responsive to your needs.

Your EAP benefits are provided through your employer. There is no cost to you for utilizing EAP services. If additional services are needed, your EAP will help locate appropriate resources in your area.

DON'T DELAY

If you need help, visit *mutualofomaha.com/eap* or call 800-316-2796 for confidential consultation and resource services.

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VALUE ADD SERVICES

IDENTITY THEFT PROTECTION

We care about you and want to make sure you are protected. This benefit provides education, prevention and recovery information to help you protect your identity.

Comprehensive ID theft assistance guide, tips to defend against ID theft, steps to recover from credit card and check fraud, guidelines if your Social Security Number is compromised, instructions for lost or stolen passport, contact list for financial institutions, credit bureaus and check companies. Included in the Travel Assistance benefit brought to you by Mutual of Omaha, services provided by AXA Assistance USA. Contact a representative today at 800-856-9947.

TRAVEL INSURANCE

Travel Assistance can help you avoid unexpected bumps in the road anywhere in the world. For you, your spouse and dependent children on any single trip up to 120 days in length and more than 100 miles away. Pre-trip assistance includes information regarding passport and other documentation needs, travel, health advisories and inoculation requirements for foreign countries, daily foreign currency exchange rates, consulate and embassy locations. Emergency travel support services and medical assistance are also available. Included in the Travel Assistance benefit brought to you by Mutual of Omaha, services provided by AXA Assistance USA. Contact a representative today at 800-856- 9947.

WILL PREP

Access to affordable, online will preparation services provided by Willing. Create your will at www.willing.com/mutualofomaha.

HEARING DISCOUNT

Discounted hearing testing, low price guarantee, 60 day risk free trial period, 2 years batteries with purchase. Call Amplifon at 1-888-534-1747 or visit amplifonusa.com/mutualofomaha

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KEY TERMS

COINSURANCE

The percentage of expenses that insurance will pay for healthcare services after the deductible has been met This payment is for covered services only. You may still have to pay a copay.

COPAYMENT

An amount you pay as your share of the cost for a medical services or item, like a doctor's visit.

DEDUCTIBLE

The amount you must pay for healthcare expenses before insurance begins to pay for services. Deductibles are based on your benefit period.

OUT OF POCKET MAXIMUM

Your combined deductible, coinsurance and co-pay expenses will not exceed this amount in a given plan year. The out-of-pocket maximum never includes your premium, balance-billed charges, or services your health insurance plan doesn't cover.

GENERIC DRUG

The cheapest form of a drug.

PREFERRED BRAND/SPECIALTY DRUG

A drug that does not have a generic equivalent or the cheapest form of a specialty drug.

NON-PREFERRED BRAND/SPECIALTY DRUG

A drug that does have a generic equivalent or lower cost version available.

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IMPORTANT DISCLOSURES

NOTE TO ALL EMPLOYEES

Certain Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance please contact your Plan Administrator as follows:

The City of Danville.

Address, City, State Zip

Phone

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS

If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan for the remainder of the Plan Year, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan for the remainder of the Plan Year, except as otherwise provided below.

(a.) If you decline enrollment for yourself or your dependents because you or your dependent had other health insurance or group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Health Program within 30 days of the loss of that coverage. For this purpose, "loss of coverage" will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.

However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer's Plan, you must provide a written statement from the administrator of the other health plan that you no longer have that coverage.

(b.) You are eligible to enroll yourself and your Eligible Dependent in the Health Program within 30 days of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption. (Note pre-tax payments may not be made for retroactive coverage due to marriage.)

(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within 60 days after either:

(1.) You or your Eligible Dependent's Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or

(2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.

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NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT (JANET'S LAW)

On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient, for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please call your plan administrator.

NOTICE REGARDING MICHELLE'S LAW

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.

The dependent child's change in college enrollment must meet the following requirements:

The dependent is suffering from a serious illness or injury. The leave is medically necessary.

The dependent loses student status for purposes of coverage under the terms of the plan or coverage. Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law became effective for plan years beginning on or after October 9, 2009.

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NOTICE REGARDING PATIENT PROTECTION RIGHTS

The The City of Danville. group health plan allows members to designate a Primary Care Provider. The following paragraphs outline certain protections under the Patient Protection and Affordable Care Act (Affordable Care Act) and only apply when the Plan requires or allows the designation of a Primary Care Provider.

You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals or notifying primary care provider or Plan of treatment decisions.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology health care professionals, please contact the insurer.

HIPAA PRIVACY

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy Practices that was previously given to you. A copy of this notice is available upon request.

MEDICARE NOTICE

You must notify The City of Danville. when you or your dependents become Medicare eligible. The City of Danville. is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian. The toll-free number to Medicare Coordination of Benefits is 1-800-999-1118.

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Coverage Notice below.

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MEDICARE PART D COVERAGE NOTICE – IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please note that the following notice only applies to individuals who are eligible for Medicare.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to end-stage renal disease (ESRD)

If you are covered by Medicare, please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The City of Danville. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The City of Danville. has determined that the prescription drug coverage offered by your company plan, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. If your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health Plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact your HR Representative. You will receive this notice each year and again, if this coverage through your company changes. You also may request a copy of this notice at any time.

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FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information, visit U.S. Social Security Administration's at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325- 0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (penalty).

The City of Danville.

Contact Person's Name & Title

Address, City, State Zip

Phone

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

There is an additional way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.56 percent of your household income for 2018 (9.86 percent for 2019), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

(An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information:

ALABAMA – MEDICAID	FLORIDA – MEDICAID
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – MEDICAID	**GEORGIA – MEDICAID**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – MEDICAID	**INDIANA – MEDICAID**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

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COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)	IOWA – MEDICAID
Health First Colorado Website: https:// www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – MEDICAID	**NEW HAMPSHIRE – MEDICAID**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218
KENTUCKY – MEDICAID	**NEW JERSEY – MEDICAID AND CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – MEDICAID	**NEW YORK – MEDICAID**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – MEDICAID	**NORTH CAROLINA – MEDICAID**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – MEDICAID AND CHIP	**NORTH DAKOTA – MEDICAID**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – MEDICAID	**OKLAHOMA – MEDICAID AND CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – MEDICAID	**OREGON – MEDICAID**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – MEDICAID	**PENNSYLVANIA – MEDICAID**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/Healthinsurancepremiumpayment hippprogram/index.htm Phone: 1-800-692-7462

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NEBRASKA – MEDICAID	RHODE ISLAND – MEDICAID
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – MEDICAID	**SOUTH CAROLINA – MEDICAID**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - MEDICAID	**WASHINGTON – MEDICAID**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – MEDICAID	**WEST VIRGINIA – MEDICAID**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – MEDICAID AND CHIP	**WISCONSIN – MEDICAID AND CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
VERMONT– MEDICAID	**WYOMING – MEDICAID**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – MEDICAID AND CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. DEPARTMENT OF LABOR SECURITY ADMINISTRATION	U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES
www.cms.hhs.gov 1-866-444-EBSA (3272)	www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565

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PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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HELPFUL CONTACTS

MEDICAL	Sisco Group # 000	800-457-4726	https://www.sisco.benefits.com
RX	Castia Rx Group # 000000 Rx BIN – 000000 Rx PCN – AAA Rx Group – 00000	Customer Service: 866-516-3121 Mail Order: 866-516-1121	https://membercenter.castiarx.com/auth/login
AIMM	Medical Management	866-562-2466	https://www.aim-m.com/patients/
TELADOC	Telemedicine Group ID - Client Name	1-800-835-2362	www.teladoc.com
DENTAL	Delta Dental Group # 00000	800-524-0149	www.deltadentalmi.com
VISION	EyeMed Group # 000000	866-9-EYEMED (39-3633)	www.eyemed.com
HEALTH SAVINGS ACCOUNT (HSA),	Infinisource	866-370-3040	www.infinisource.com
LIFE AND AD&D, LONG TERM DISABILITY	Mutual of Omaha	800-351-7500	www.reliancestandard.com
EMPLOYEE ASSISTANCE PROGRAM	Pine Rest	800-442-0809	www.pinerest.org/eap/employee-assistance-program/
BENEFITS CONSULTANT	Better Source Benefits	John Clay 606-678-0583	www.bettersourcebenefits.com

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Benefit Marketing Plan

2019

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Agenda

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1. Purpose
2. Approach
3. Proposed Schedule

SAMPLE

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Purpose of the Benefit Marketing Plan

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1. To reinforce the value of the benefit program
2. To increase employee engagement in the benefit program
3. To increase the level of awareness of the complexities and opportunities within the healthcare supply chain



SAMPLE

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The Approach

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Monthly Communication
Employee Memos on topical and specific subjects related to the benefit program

Bi-Annual Employee Meetings
Two additional meetings, 15-30 minutes in duration, to cover topics related to how to better leverage the resources available from the health plan.

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Proposed Schedule

- **Month 1 – January**
  - Cost Transparency
  - Telemedicine
- **Month 2* – February**
  - AIMM Reminder
    - Services available
    - Contorno Video
- **Month 3 – March**
  - Importance of Preventive Care
- **Month 4 – April**
  - Admitting Privileges - Did you know?
- **Month 5 – May**
  - Carrier Value-Add Reminders
    - Discount programs with VSP
    - Vision with Priority Health
    - PPO vs Premier Dentist
- **Month 6 – June**
  - Ancillary benefits
    - What benefits are offered?
    - How do they work?
- **Month 7* – July**
  - AIMM Reminder
    - Case Study
    - AIMM Video
- **Month 8 – August**
  - Surgery Centers, Labs and Imaging Centers
- **Month 9 – September**
  - ER vs Urgent Care
  - Most care starts with a call – Who are you calling?
- **Month 10 – October**
  - Open Enrollment – Reminder that OE is coming
- **Month 11 – November**
  - Open Enrollment – Technology Reminders
  - Open Enrollment Meetings
- **Month 12 – December**
  - Upcoming changes to the benefits
  - What to expect under the new plan(s)

**Onsite meeting*



SAMPLE

BetterSource Benefits **Renewal Timeline**

DAY 110 - 91	1	Determine Goals with the City Manager for the upcoming year. Reviewing data to suggest areas for optimization
DAY 90 - 65	2	Gather Census and go to market for client. Gather Market quotes and formalize data
DAY 64 - 55	3	Renewal decision meeting - Make decisions on plans, funding levels, and open enrollment
DAY 54 - 50	4	Communicate necessary changes to carriers and finalize paperwork
DAY 49- 45	5	Build out Ben Admin Platform and gather carrier templates for carrier enrollments
DAY 44 - 40	6	Kick off open enrollment with employee meetings
DAY 39 - 33	7	Last week to enroll, 1on1's, state 'hard' deadline
DAY 32 - 30	8	Enrollment data is processed and submitted to carriers
DAY 29 - 15	9	Carriers internally process enrollment (7 days) and start generating ID cards (7 days)
DAY 14 - 2	10	Carriers mail ID cards & start generating bills
EFFECTIVE DATE	✓	Renewed group plan with cards in hand and all systems updated

DISCOUNT PRESCRIPTIONS



$4.00 Prescription Program - Offering hundreds of generic and over-the-counter medications for only $4.00 for a 30 day supply.

Walmart

TARGET

$4.00 Generic Program - A wide variety of generic medications are available for only $4.00 for a 30 day supply.

FREE Generic Antibiotics & Prenatal Vitamins - Several leading generic antibiotics and prenatal vitamins are offered completely free!

meijer

Walgreens
The Pharmacy America Trusts

$12.99 3 Month Supply Program - Three month supplies of select medications for $12.99 and savings on over 5,000 name brand medications.

GENERIC DRUGS FREQUENTLY ASKED QUESTIONS

What is a generic drug and how are they different from brand-name drugs?
A generic drug is simply a lower-cost version of a brand-name drug. While they might have a different color or shape, the biggest difference is the cost. Most generics cost 70-90% less than their brand-name counterpart.

How many people use generic drugs?
Millions of people use generic drugs every day. In fact, 2 out of 3 prescriptions are for generic drugs.

Are generics really the same as the brand-name?
Yes! They have the same medicine, and they would not be approved by the FDA if they weren't as safe and effective as the brand-name drug. The reason brand-name drugs are so much more expensive is because large pharmaceutical companies spend so much on advertising and need to make up their losses by charging more.

If generic drugs are so good, why are brand-name drugs still prescribed?
For newer medicines, brand-names are prescribed because a generic version is not available yet.

Generic drugs cannot be sold until the brand-name drug's patent ends, which may be 10 years or more.

Advertising is another reason why people continue to use brand-name drugs. They are familiar and thought to be "better" than more affordable options.

Others use brand-name drugs because they don't understand that generics are just as safe and effective. They believe that they are getting what they pay for when they purchase more expensive medicines.

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GOODRX.COM

What is GoodRx.com?

GoodRx.com's goal is to provide you, the health consumer, with convenient, affordable prescription drugs. GoodRx.com is starting by providing you with information you have never had before.



Search for Drugs and Compare Prices

You can use GoodRx.com as a guide to compare drug prices at over 70,000 pharmacies and discover free coupons and savings tips. There are over 1 million prices for more than 6,000 drugs at every major US pharmacy chain and many local stores.



Find a Discount Drug Program

GoodRx.com provides information on manufacturer discount cards (free coupons provided by pharmaceutical manufacturers that can save you $500 or more), coupons, price-matching, pharmacy discount plans and much more.

Receive Alerts

With their new iPhone app, you can receive alerts directly to your phone so you can be more aware when drug prices change.

HEALTHCAREBLUEBOOK.COM

What is HealthcareBlueBook.com?

The Healthcare Blue Book is a free consumer guide to help you determine fair prices in your area for healthcare services. If you pay for your own healthcare, have a high deductible, or need a service your insurance does not fully cover, Healthcare Blue Book can help.



Healthcare Bluebook™

How Does Healthcare Blue Book Help?

Healthcare Blue Book will help you find fair prices in your area for surgery, hospital stays, doctor visits, medical tests and much more.

Healthcare Blue Book prices reflect the average amount that most providers in your area will accept for major insurance carriers. Surgery prices include the three major fee categories: facility, physician and anesthesia services. Prices are regularly reviewed and validated for accuracy.

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NINE REASONS TO SIGN UP FOR AN HSA

So you signed up for a High Deductible Health plan which means you are eligible to contribute to a Health Savings Account (HSA), but what does that mean and how do I benefit from the HSA?

Below are nine reasons to sign up for an HSA and how you benefit from it.

THE HSA CONTRIBUTIONS ARE PRE-TAX

HSA's are tax-deductible savings plans that allow you to put aside pre-tax dollars for future health care expenses. Pre-tax dollars are subtracted from the top of your pay before withholding for taxes is calculated, so you don't pay tax on this portion of your income.

YOU CAN PAY FOR HEALTH CARE EXPENDITURES WITH TAX-FREE MONEY

The money deposited in this account is tax-free! That's right, no income tax! The government keeps its hands off it! When you use your HSA debit card to pay for your medical expenses and deductibles, you are paying for it in pre-tax dollars, which is like getting a 20–30% discount on services rendered, depending on your tax rate. Over your lifetime, that's a huge savings.

You will need to keep records of those expenditures with your annual tax filing in case you ever get audited by the IRS. Those receipts are the only acceptable proof to the IRS that you spent the tax-free funds on approved products and services.

INTEREST EARNED IN YOUR HSA IS ALSO TAX-FREE

You own the money in your HSA. It doesn't belong to the insurance company or your employer and can't be raided for any other reason by anyone. And unlike Flex accounts, HSA funds don't have to be used in the same year as the contributions.

That's right, it's triple the tax savings when putting funds into an HSA!

YOU BECOME A MORE INFORMED HEALTHCARE CONSUMER

The insurance plans that qualify you to get all the benefits of an HSA are called High Deductible Health Plans (HDHPs), so you will be paying the full cost of your care (using the tax-free dollars in your HSA account) until your deductible is met.

You're going to start paying more attention to what is spent on your healthcare, and that's a good thing. Using resources like AIMM to help you shop around for providers. Will not only give you pricing information, but also some measures of the quality of the service provided.

YOUR HSA FUNDS CAN'T BE LOST

Even if you lose your health insurance, the account stays with you. It can't be taken away if you change employers. This is not a 'Use it or Lose it' benefit! The money just rolls over and stays with you for whenever you need it in the future. Even if you pass away, the money is yours and will be distributed to your beneficiary.

YOUR HSA CAN BE USED TO PAY FOR ANY MEDICALLY NECESSARY SERVICE

Use the HSA to pay for dental, vision, prescription drugs and over-the-counter medical items. Even if your health insurance coverage doesn't cover these items, you can use your HSA debit card to pay for them with pre-tax dollars. Over the years, this savings is huge.

Starting January 1, 2011, over-the-counter drugs were no longer considered eligible medical expenses. However, if you get a doctor's prescription for over-the-counter drugs, then you can still use your HSA to pay for the items tax-free and penalty-free.

AN HSA IS A GOOD STRATEGY FOR RETIREMENT PLANNING

Since the HSA rolls over year after year and there are no limits to how much you can accumulate in the account, the HSA is a good tool for retirement. After the age of 65, you can withdraw funds from your HSA penalty-free for any purpose. You will pay income tax on the withdrawal if it is not used to pay for health care, but that tax rate is likely to be lower in your retirement years when your income is lower. And, of course, you can continue to withdraw the money from your HSA tax-free to pay for medically necessary expenses.

That's right. You don't have to use the money for healthcare expenses after you reach retirement age. You can use it to fund that dream vacation that you never had time for while you were working.

Funding it to the maximum allowed is why the HSA has been described as a "Medical IRA."

HSA'S COME WITH A SIGNIFICANT PREMIUM SAVINGS OVER TRADITIONAL HEALTH INSURANCE PLANS

HSA plans have a higher deductible than other plans, but they come with much lower premiums. This savings is especially apparent to someone who pays the premiums all year long but doesn't go to the doctor or use medical services very often. For this person, the premium can feel like money out the window.

YOU CAN USE IT AS AN EMERGENCY SAVINGS ACCOUNT

Some HSA owners pay all their eligible medical expenses out-of-pocket and let the HSA grow a tax-deferred emergency fund. Keep the receipts and if next year the owner needs emergency cash, he can reimburse himself for the previous year's expenses up to the total of the receipts and owe no tax.

HEALTH INSURANCE COSTS

	WHAT IS IT?	HERE'S AN EXAMPLE
PREMIUM	The amount of money charged by your insurance company for the plan you've chosen. It is usually paid on a monthly basis but can be billed a number of ways. You must pay your premium to keep your coverage active, regardless of whether you use it or not.	The health plan you've chosen costs $175 per month, which is your premium. In order to keep your benefits active and the plan in force, you'll need to pay your premium on time every month.
DEDUCTIBLE	A set amount you have to pay every year toward your medical bills before your insurance company starts paying. It varies by plan and some plans don't have a deductible.	Your plan has a $1,000 deductible. That means you pay your own medical bills up to $1,000 for the year. Then, your insurance coverage kicks in. At the beginning of each year, you'll have to meet the deductible again.
COINSURANCE	The percentage of your medical bill you share with your insurance company after you've paid your deductible. Unless you have a policy with 100 percent coverage for everything, you have to pay a coinsurance amount.	You have an "80/20" plan. That means your insurance company pays for 80 percent of your costs after you've met your deductible. You pay for 20 percent. Coinsurance is different and separate from any copayment.
COPAYMENT (CO-PAY)	The flat fee you pay every time you go to the doctor or fill a prescription. It's usually a relatively small dollar amount. Copays do not count toward your deductible.	Let's say your plan has a $20 copay for routine doctor's visits. That means you have to pay $20 each time you go. Copayments are different than coinsurance.
OUT OF POCKET MAXIMUM	Your combined deductible, coinsurance and co-pay expenses will not exceed this amount in a given plan year. The out-of-pocket maximum never includes your premium, balance-billed charges, or services your health insurance plan doesn't cover.	Let's say your plan has a $10,000 out of pocket maximum. Once you've met this, you pay nothing for any services you receive. This includes prescriptions, doctors' visits, etc. The only thing you will continue to pay is your premium.

GENERIC DRUG

The cheapest form of a drug.

PREFERRED BRAND/SPECIALTY DRUG

A drug that does not have a generic equivalent or the cheapest form of a specialty drug.

NON-PREFERRED BRAND/SPECIALTY DRUG

generic equivalent or lower cost version available.

Admitting Privileges – Did you know?

Did you know that doctors have the ability to treat patients at more than one facility? It can be challenging to know which provider and facility offer the highest quality of care at the lowest cost. This is where AIMM can help to navigate this complicated and confusing system. With the exception of emergencies, most provider and facility visits start with a call. Why not make that first call to AIMM? The flyer attached outlines some differences in the admitting privileges and how AIMM can help you get the quality of care you need at the right place, the right time and for the right price.

EAP

With the busy lives we lead today, there are many different factors that can impact our mental health, as well as the health of our family members. One benefit that is offered by The City of Danville even if you are not enrolled in our benefits, is the Employee Assistance Program (EAP) through Pine Rest. I have attached a flyer from Pine Rest that outlines some of the services covered by them as well as the multiple ways to contact them. Pine Rest allows all The City of Danville employees and their immediate family members up to 3 visits per issue per person. Please take a look at the attached flyer and take advantage of this great service when needed. Additionally, Pine Rest will be onsite for a training on 05/01/2019.

Ancillary Benefits

While many of us are familiar with our medical, dental and vision plans, how familiar are you with your life and disability benefits?
The City of Danville offers life insurance and long-term disability benefits at no cost to you, as well as voluntary life insurance that you can purchase at a minimal cost.
But what does it mean to have these benefits? Did you know life insurance benefits can pay you in the event of an accident as well?
The attached flyers provide details on these benefits and how to use them should you need to. Full details on each benefit can be found on Employee Navigator.

Carrier Value Adds - BCBS Specific

We know that we use BCBS to process and pay claims and to help answer benefit questions, but did you know there are a ton of additional services that provide you more value at no cost?

Below is a list of some of the value adds available with BCBS that we recommend you take advantage of to save on out of pocket costs. All items listed below can easily be accessed from the BCBS website or from their app available in the App Store or through Google Play.

- ***Blue Cross Rewards*** *- Helps you understand your costs for care and you can be rewarded when you choose and use a non-emergency reward eligible service, such as a CT Scan, MRI or X-ray. Each family member can earn up to $550 in rewards per calendar year. It's likely that many of the providers recommended by AIMM for these services are also rewardable, getting you the highest quality care at the lowest price, and you get rewarded!*

- ***Blue Distinction Total Care*** *– This program focuses on patient focused care. With the help of your Blue Distinction Total Care doctor, you can better manage your medical needs including coordinating care, test results and prescriptions among all of the doctors, specialists and hospitals you visit. They will focus on a personalized plan to manage your health.*
- ***Cost Estimates*** *– This tool is available to help you compare costs for services. The costs will sort from low cost to highest cost at the different in-network facilities for the procedure or service you're researching. Please note, this tool does not look at quality of care scores, which can be provided by AIMM.*
- ***Medication Price Comparison*** *– Did you know generic medications have the same ingredients as brand name drugs but at a fraction of the cost? Use the BCBS app to compare medication prices.*

These tools are easy to use and can be accessed from any device to help you save on out of pocket costs. Download the app or visit www.bcbsm.com today to take advantage of these offerings.

Carrier Value Adds – Ancillary

We know that we use Delta Dental, EyeMed, and Reliance Standard to process and pay claims and to help answer benefit questions, but did you know there are a ton of additional services that provide you more value at no cost?

The attached poster outlines additional information that we recommend you take advantage of to save on out of pocket costs. All items can easily be accessed from each carriers website or from their apps available in the App Store or through Google Play.

Check out the resources available on Employee Navigator for complete details.

Insurance Basics: HSAs and Key Terms

As a participant in the health insurance coverage provided by The City of Danville do you know what the various costs are when using the plan? There are plenty of questions that come up throughout the year when it comes to our benefits that we may be too afraid to ask. What's the difference between the premium and a co-pay? How does the insurance work? I know I have one, but what exactly is an "HSA"?

Don't worry, we have the answers here for you! The two attached documents define some of the most commonly used words in your medical plan and provider a refresher on what it means to have signed up for an HSA.

Don't be afraid to ask questions! There are several resources available to help answer any of your questions. Contact information for each resource can be found in the benefit booklet on Employee Navigator.

AIMM Reminder with Contorno Video

We know how complicated the healthcare system can be and that it is incredibly confusing to try and determine which doctor is the right one to go to for your upcoming service or procedure. This video of an experienced employee benefits advisor walks

you through just how frustrating this process can be for someone who lives and breathes health insurance and still finds it incredibly challenging to navigate. *https://vimeo.com/256499327*

We are hopeful this video will help you better understand why we have partnered with AIMM and the importance of having their team of nurses in your corner with tools that are not available to the everyday consumer (you) to help you find the right care at the right place and at the right time.

The attached flyer is a reminder of how AIMM is here to help you as a third party that works for you, not the insurance company or hospitals or providers. They are your advocate and best resource for getting you what you need, when you need it.

Importance of Preventive Care

t's closing in on Flu season, but have you had your Flu shot yet? Did you know your flu shot is considered a preventive service and is covered in full? Since you're headed to the doctor for your flu shot, why not get up to date on all of your preventive services?

Did you know that your preventive exam could help you detect high blood pressure, obesity and certain cancers? You may be living with one of any number of conditions and not know it if you haven't received a physical in a while.

Not only is your physical health important, regular dental check ups can also help detect other chronic conditions such as osteoporosis and diabetes.

The attached poster is a reminder of the importance of getting regular check-ups. Additionally, the link below will take you to a list of covered preventive services, at what age you should have these preventive services complete and how often you should get them. https://www.healthcare.gov/coverage/preventive-care-benefits/

Ways to Save

We are constantly looking for ways to lower our healthcare costs and what we have to pay out of pocket to manage our health. Did you know there are resources available at little to no cost to you to help you save on out of pocket expenses?

- *GoodRx is a simple and convenient tool you can keep in your back pocket (literally) to help you compare the cost of prescriptions. This downloadable app can tell you the cost of a medication to see how costs compare between multiple pharmacies.*
- *When it comes to needing healthcare services, Teladoc is a great resource that's available 24/7 to get you and your family the care they need without having to go to your doctor's office. You can visit their website or schedule a call through their app.*

Details on both of these resources are included in the attached document. For additional questions on either of these, please contact the HR department.

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Consulting Agreement

total control HEALTH PLANS®



RISK MANAGEMENT CONSULTING AGREEMENT

Prepared November, 2019

PREPARED FOR:

Risk Management Consulting Agreement

This Consulting Agreement (Agreement) is between The City of Danville and all affiliates that have employees (Client) and Better Source Benefits (Consultant), effective as of February 1, 2020.

WHEREAS, Client wishes to obtain the assistance of Consultant with strategic benefit planning, design, funding, administration and communication with respect to its employee benefit programs;

WHEREAS, Consultant has superior knowledge and expertise in assisting employers with designing and servicing employee benefit plans; and

WHEREAS, the parties wish to set forth their respective expectations;

Now, therefore, for good and valuable consideration, the receipt and sufficiency of which is hereby mutually acknowledged, the parties hereby agree as follows:

1. Scope of Services to be Provided by Consultant

Consultant will provide Client with the consulting, actuarial and brokerage services listed below.

A. Renewal Services

- Underwriting analysis of renewal
- Creating fully insured equivalent rates
- Claims analysis to isolate problematic areas
- Interpret claims data and develop action plan
- Mid-year renewal projection
- Insurance carrier(s) contract renewal
- Carrier evaluation
- Voluntary benefit needs analysis and market study
- RFP creation and management
- Plan design modeling
- Ancillary lines of coverage renewal

B. **Strategic Services**

- Access to Alliance Healthcare Purchasing Coalition and other strategic partners
- Creation of employee benefit strategic plan
- Benchmark plan design for comparison

- Ongoing service with carrier

C. **Enrollment**

- Employee enrollment meetings at Michigan locations, and out of state locations with 40 employees or more once a per year. Travel coordinated with The City of Danville in conjunction with scheduled corporate travel to out of state locations.
- Collection, review, and processing of enrollment materials
- Eligibility communication to carrier(s)/administrator(s)
- Enrollment communication campaign

D. **Employee Communication**

- Development of Benefit Marketing Plan
- Wellness programing and vendor evaluation and management

E. **Compliance Resources**

- Health Care Reform news and information
- Health Care Reform compliance monitoring (affordability, etc.)
- Information on compliance with federal and/or state laws including:
  - COBRA
  - HIPAA
  - Medicare Part D
  - Additional employment laws
- Summary Plan Description audit/development and annual compliance review
- Assistance with 5500 Filing, to be completed by client but completion monitored by consultant

F. **Human Resources**

- Access to professional community
- Benchmark survey data

G. **Stewardship Report** Consultant will develop and implement a detailed account stewardship plan, which should include, but not be limited to, the following:

- Specific quantifiable and measurable goals and objectives for Consultant's team relating to Client's programs; and

- Work plans which lay out the account management plan, work schedules, areas of concentration, timing and information requirements.

2. Client's Responsibilities

Client will make available such reasonable information as required for Consultant to conduct its services. Such data will be made available as promptly as possible. It is understood by Consultant that the time of Client's personnel is limited, and judicious use of that time is a requirement of this Agreement. Client will make timely payments of the service fees as set forth elsewhere in this Agreement.

3. Disclosure and Recordkeeping

A. Full Disclosure.

Client has the right to approve any arrangements and/or the utilization of any intermediaries in connection with, or arising out of, or in any way related to Client's insurance and risk management program. Consultant must seek approval from Client prior to the use of any of the above in connection with the Client's insurance and risk management program.

B. Recordkeeping.

Consultant will maintain accurate and current files including, but not limited to, insurance policies and correspondence with insurers or brokers in accordance with industry standard record retention practice or as otherwise directed by Client.

4. Indemnification

A. Indemnification

The client shall Indemnify, and hold harmless Better Source Benefits, its officers, directors, trustees, employees, agents, representatives, affiliates, and permitted assigns, from and against any and all losses, liabilities, claims, damages, actions, suits, proceedings, settlements, judgments, costs and expenses (including without limitation reasonable attorney's fees) arising out of or in connection with the willful misconduct or gross negligence of the client.

5. Term & Termination

A. Term.

The initial term of this Agreement shall commence on February 1, 2020 and end February 28, 2021 (Initial Term). Thereafter, this Agreement will remain in effect until terminated as described below.

B. Termination.

This Agreement may be terminated by either party only as follows:

a) Effective upon thirty (30) days' advance written notice to the other party stating that such other party is in breach of any of the provisions of this Agreement, provided such breach (if able to be cured) is not cured within fifteen (15) days after the notice is received;

b) effective upon six (60) days' advance written notice to the other party given with or without reason; provided such notice is given after the Initial Term; or

c) By mutual written agreement of the parties.

6. Cost of Services

Consultant's Professional Fees are based upon time expended by specific individuals. Client agrees to pay Consultant Professional Fees as outlined in Exhibit 1. These annual fees may be included in the monthly TPA Billing/Carrier premiums, billed directly to client, or a combination of both.

Performance based fees will be paid on a quarterly basis as outlined in Exhibit 2 and will be due no later than sixty days following termination of this Agreement.

Consultant may receive standard commissions on Fully Insured products including but not limited to Health, Life, Disability, Dental, and Vision, at the discretion of the client. Consultant will fully disclose these commissions to the Client.

7. Personnel

Consultant will assign its personnel according to the needs of Client and according to the disciplines required to complete the appointed task in a professional manner. Consultant retains the right to substitute personnel with reasonable cause. The Account Management Team consists of the following individuals:

Primary Service Team:

Additional Key Resources:

8. Records and Information

Consultant agrees to keep any information provided by Client confidential and to exercise reasonable and prudent cautions in protecting the confidentiality of such information. If the services provided by Consultant involve the use of protected health information, Client and Consultant agree to enter into an appropriate business associate agreement.

9. Independent Contractor

It is understood and agreed that Consultant is engaged by Client to perform services under this Agreement as an independent contractor. Consultant shall use its best efforts to follow written, oral or electronically transmitted (i.e., sent via facsimile or email) instructions from Client as to policy and procedure**.**

10. Fiduciary Responsibility.

Client acknowledges that: (i) Consultant shall have no discretionary authority or discretionary control respecting the management of any of the employee benefit plans; (ii) Consultant shall exercise no authority or control with respect to management or disposition of the assets of Client's employee benefit plans; and (iii) Consultant shall perform services pursuant to this Agreement in a non-fiduciary capacity.

Client agrees to notify Consultant as soon as possible of any proposed amendments to the plans' legal documents to the extent that the amendments would affect Consultant in the performance of its obligations under this

Agreement. Client agrees to submit (or cause its agent, consultants or vendors to submit) all information in its (or their) control reasonably necessary for Consultant to perform the services covered by this Agreement.

11. Entire Agreement

This constitutes the entire Agreement between the parties, and any other warranties or agreements are hereby superseded.

Subsequent amendments to this Agreement shall only be in writing signed by both parties.

_____	_____
Signature	*Date*
_____	
Title	
Better Source Benefits	
_____	_____
Signature	*Date*
_____	
Title	

Exhibit 1: Professional Fees

Better Source Benefits' Base compensation will mirror the existing compensation structure currently in place between The City of Danville and their current benefit advisor which is approximately $32,000 on an annual basis

- The Base Compensation may be a combination of commissions on lines of coverage represented and/or a billed monthly service fee.

Exhibit 2: Fee for Performance

Better Source Benefits' Performance Based compensation for the initial term will be a maximum of $10,000 based upon a for key deliverables. Completion of each deliverable will result in earning a $2,500 performance bonus.

- The Performance Based Compensation will be billed by Better Source Benefits to Client after the successful completion of each of the key initiatives.
- The Performance Based Compensation represents approximately 1/4 of the of the entire compensation Better Source Benefits could earn on an annualized basis.
- Performance Based Compensation may be based upon completion of the following deliverables

1. **Successful Implementation of claims data feed from Priority Health to HCRM/MEDai.**

2. **Successful Implementation of claims data feed from ASR to HCRM/MEDai.**

3. **Review current health plan administrators and determine which option is the best multi-year partner for all locations. Additionally, review current benefit communication processes and provide recommendations and timeline for implementation of improvements**

4. **Review all aspects of benefits program with specific focus on the medical plan(s) and deliver findings to The City of Danville leadership. Upon completion of review of findings, establish timeline for implementation of agreed upon recommendations.**

For Employers and Plans Sponsors Subject to ERISA: This Disclosure Statement is being given to the Client (1) to make sure client knows about Better Source Benefits' income before purchasing the insurance product and (2) to plans subject to ERISA, to comply with the disclosure, acknowledgement and approval requirement of Prohibited Transaction Class Exemption No. 84.24[1], which protects both client and Better Source Benefits. Disclosure must be made to an independent plan fiduciary for the ERISA Plan(s), and Client acknowledges and confirms that this is a reasonable transaction in the best interest of participants in its ERISA Plan(s).