Village of Wellington

Request for Proposals
Insurance Brokerage Services

RFP# 003-14/ED

Due Date:
Wednesday, April 2, 2014 @ 10:00AM

Submitted by:

GEHRING GROUP
INSURANCE BROKERS & CONSULTANTS

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

GEHRING GROUP
INSURANCE BROKERS & CONSULTANTS

March 21, 2014

Ed De La Vega, CPPB
Business Services Manager
Village of Wellington
12300 Forest Hill Boulevard
Wellington, FL 33414

Re: RFP # 003-14/ED – Insurance Brokerage Services

Dear Mr. De La Vega:

Gehring Group is pleased to provide this proposal in response to the Village's RFP for Insurance Brokerage Services. As the largest public sector insurance broker in Palm Beach County and the state, we have served the Village of Wellington and its insurance needs since 1998. During this period, we have developed a comprehensive knowledge of the Village's group benefits and risk management programs, evaluated various program funding alternatives and the risks associated, delivered additional value added services and products, and provided recommendations relating to insurance placement and plan design in order for the Village to meet its annual budget goals.

Gehring Group partners with clients to design and implement the most competitively priced and comprehensive insurance programs. Our depth of staff and affiliate experience in both the risk management and benefits areas has provided the Village a business partner to serve your organization in a contributory manner not only as you navigate the changing marketplace resulting from Health Care Reform, but also the changing needs of your organization.

Employee Benefits Accomplishments

Working closely with Wellington's Human Resources, Finance, Risk Management, and other staff on a regular basis, our service team has performed numerous tasks and projects with the goal of maintaining a cost effective, yet comprehensive employee benefits program. During our tenure with the Village, we have presented to various staff and employee groups including the Village Council, providing explanation and making recommendations regarding various aspects of Wellington's employee benefits program. Additionally, we have provided many value added services at no additional cost such as BenTek, local entity surveys and other benchmark data, employee benefits highlights booklet, as well as various other employee communication pieces.

As a result of Gehring Group's consulting expertise and negotiation leverage, we have been able to achieve significant cost savings for the Village as outlined below:

- Gehring Group has negotiated over $2.3 million in savings with minimal plan design changes over the course of six years; even while carrier trend (medical inflation) factors were in the double digits for the local market. (Trend factors based on annual carrier underwriting documentation).

- For the 2009 plan year, Gehring Group negotiated savings of over $510,000 off medical renewal, with no changes to plan design, through an RFP process. Also transitioned life insurance carrier for another $26,000 of savings.
- For the 2010 plan year, negotiated savings of over $80,000 off medical renewal as well as achieving $20,000 in wellness funds from Cigna.
- For the 2011 plan year, bid all lines of employee benefits insurance saving over $600,000 from initial proposed renewals.
- For the 2012 plan year, bid all lines of employee benefits insurance resulting in a change in medical carriers, saving over $285,000.
- Also in 2012, facilitated successful contract negotiations with MD Now, achieving an estimated cost savings of over $40,000 to the medical plan. Gehring Group continues to send employee and dependent eligibility data to MD Now on an ongoing, monthly basis.
- For the 2013 plan year, negotiated the 8.7% renewal offer ($310,000+) down to a "no increase".
- For the 2014 plan year, facilitated the RFP process for medical coverage to take advantage of competing carriers and market leverage to negotiate a 24.9% renewal increase down to a 10.5%, saving the Village over $530,000.

In addition to the cost saving achievements, Gehring Group also delivers significant value added services as well as day to day interaction with Village staff. Examples of such include:

- The BenTek® online enrollment and administration system. In addition to the efficiencies associated with the open enrollment process, eligibility update reporting, and electronic administration, BenTek® includes unique audit capabilities that allow the administrator to easily identify real time discrepancies between eligibility and payroll deductions – resulting in not only the saving of reconciliation time, but also ensuring accurate payroll deduction collections.
- Our staff continuously reviews all health plans and policies to ensure compliance with the previously and currently implemented guidelines and changes pursuant to Health Care Reform Acts of 2010 (ACA/PPACA); as well as planning for the regulations set to be effective in the upcoming years.
- Gehring Group has provided Health Care Reform education and training resources including our *Client Portal*, client seminars and webinars, as well as personalized onsite meetings with HCR certified personnel.
- Gehring Group assists with the coordination, data compilation and exchange of the information needed by Wellington's OPEB actuary.
- Our staff is intricately involved in coordinating and conducting all employee open enrollment sessions, along with preparation of custom communication pieces to effectively educate employees and retirees of their benefit plan offerings.
- Our dedicated service team consistently advocates for Village employees regarding complex claim issues and appeals, assisting them through resolution.

Risk Management Accomplishments

Gehring Group currently services all aspects of the Village's Risk Management program. Our core services have been designed to meet and exceed those requested in the Scope of Work. We anticipate these services will include, but are not limited to: servicing all lines of the Village's property and casualty insurance coverages, risk management valuations, procurement of insurance, monitoring regulatory and compliance issues, continuous examination and review of claims data, safety and loss control and overall risk management and administrative support. Our team has worked diligently with Village staff towards the following achievements:

- Over the past 9 fiscal years of working with Gehring Group to initiate, implement and monitor a comprehensive safety and loss control program, the Village of Wellington's workers' compensation mod rating has not exceeded 1.0; thereby, significantly reducing the cost of workers' compensation premiums. During that time frame, Wellington actually received premium savings in 6 out of the 9 fiscal years, totaling over $516,000.
- Over the past three audit seasons, the Gehring Group has been able to assist Wellington realize a savings on their audit billings by $16,135 by providing customized verification reports of Wellington's annual workers' compensation payroll audits which include the monitoring of class codes and job descriptions.
- Gehring Group has completed 2 village-wide safety audits conducted in 2011 and 2013 respectively. They were also accompanied by a 43–page, per location, inspection discrepancy report contributed to by the Gehring Group. Both audits absorbed 112 man hours on the ground over 14 days, encompassing a total inspection of 52 parks, 28 facilities and 6 utilities.
- For years 2011, 2012 and 2013, Gehring Group has attended, contributed safety resources, provided summary minutes and monthly customized claims summary reports for Liability and Workers' Compensation, including up to date adjuster's notes, for 14 on-site safety meetings, totaling no fewer than 22 hours.
- Gehring Group has conducted 2 annual safety presentations (2011 and 2012) to all Wellington employees. Each presentation comprised of 5 one-hour sessions and 2 one-hour make-up sessions, totaling 14 hours of onsite presentations.
- Gehring Group drafted the Village's original 75-page Wellington Safety Manual, which remains in use today with planned updates in the works.
- Gehring Group continues to offer 25 specific safety-related training courses, available to all Wellington employees through our online BenTek platform.

Gehring Group has been providing employee benefits and risk management services to the Florida Public Sector community for over 20 years. Through our extensive industry experience as a broker/consultant for over 70 public Florida public sector entities' various insurance programs, Gehring Group is confident that we can continue to provide the Village with additional value and exceptional services.

It is also important to note that Gehring Group is a completely independent agency. We do not have a fund that we or a related entity holds; we do not sell related party insurance products; and we do not accept awards for the placement of premiums with carriers. This decision to remain independent is in line with our values of integrity and transparency. Our position as an independent broker allows us to

remain completely unbiased as well as the ability to bring markets such as the Florida Municipal Insurance Trust to the Village for consideration.

Our comprehensive level of benefits and risk consulting services also include, but are not limited to, plan analysis and research, procurement of insurance, communication strategies, monitoring regulatory and compliance issues, continuous examination, implementation of wellness programs, implementation of safety and loss programs, onsite clinic consulting, review of claims data and overall plan administration support. In addition, Gehring Group's pricing model is all inclusive, designed to provide all services requested in the Scope. We provide sophisticated solutions to complex problems and utilize technology and administrative capabilities to assist our clients in gaining efficiencies and develop long-range strategies to conform to the entity's overall financial goals.

Gehring Group staff is comprised of experienced forward thinkers, with a client-first, focused service approach. We work with your risk management team to anticipate, identify, and mitigate exposures rather than react to them. This approach saves premiums by keeping experience mod rates in check; and proactively approaching annual audits with an eye toward accuracy and efficiency. Our approach is to assist our clients in achieving their goals by being responsive and reactive in the short term, while being strategic for the long term. Our "How Can We Help You" attitude keeps us an involved and fully available resource to our clients on a year-round basis.

The team servicing the Village has remained consistent through the years, each member having extensive experience assisting Public Sector clients including Counties, Municipalities, Special Taxing Districts, and Constitutional Officers with placing, maintaining, and servicing their insurance programs.

Gehring Group is confident that we can continue to provide Wellington with additional value and exceptional service. We thank the members of the Evaluation Committee, in advance, for your review and consideration of our comprehensive response, and stand ready to provide any additional clarification or information requested.

Sincerely,

Kurt Gehring, CEO

11505 Fairchild Gardens Avenue, Suite 202, Palm Beach Gardens, FL 33410
Tel: (561) 626-6797 / (800) 244-3696 Fax: (561) 626-6970

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Tab 1: Proposal Submittal Form/Signed By Authorized Representative

PROPOSAL SUBMITTAL FORM (TAB #1)

To:
Wellington
12300 W. Forest Hill Boulevard
Wellington, Florida 33414

Gehring Group, Inc. agrees to provide
(Vendor)
Insurance Brokerage Services to Wellington as defined in this RFP in accordance with the requirements of the Specifications and RFP # 003-14/ED Documents.

The undersigned Proposer has carefully examined the Specifications and Proposal/Contract Documents and is familiar with the nature and extent of the Work and any local conditions that may in any manner affect the Work to be done.

The undersigned agrees to provide the service called for by the Specifications and RFP Documents, in the manner prescribed therein and to the standards of quality and performance established by the RFP.

The undersigned agrees to the right of Wellington to hold all Proposals for a period not to exceed 180 days after the date of Proposal opening stated in the RFP.

The undersigned accepts the payment policies specified in the RFP documents.

The undersigned agrees that within fifteen (15) days from the date of acceptance of this Proposal, to execute the agreement and provide the required certificates of insurance.

Dated this 31 day of March (Month), 2014 (Year)

INDIVIDUAL, FIRM OR PARTNERSHIP

By: _____ / Kurt Gehring
(Signature) **(Print name)**

Address: 11505 Fairchild Gardens Ave, Suite 202
Palm Beach Gardens, FL 33410

Telephone: (561) 626-6797 **Fax:** (561) 626-6970

Social Security Number or Taxpayer Identification Number: 65-0361295

CORPORATION

By: Kurt Gehring / Kurt Gehring
(Signature) **(Print name)**

Address: 11505 Fairchild Gardens Ave, Suite 202

Palm Beach Gardens, FL 33410

Telephone: (561) 626-6797 **Fax:** (561) 626-6970

Taxpayer (EIN) Identification Number: 65-0361295

State Under Which Corporation Was Chartered: Florida

Corporate President: Kurt Gehring
(Print Name)

Corporate Secretary: Cindy Thompson
(Print Name)

Corporate Treasurer: Kathleen Grangard
(Print Name)

CORPORATE SEAL

Attest By: Cindy A Thompson
Secretary

ADDENDA RECEIPT VERIFICATION

Proposer acknowledges the receipt of Addenda Nos. 1,2,3, 4, & 5

PROPOSAL CHECK LIST

Please check each item and make sure that all required information is included in your Proposal submission. Failure to submit this information may result in your submission being rejected as being a non-responsive and responsible Proposer.

YES X NO___ 1. Proposal Submittal Form

YES X NO___ 2. Acknowledgment of Addendums

YES X NO___ 3. Qualification of the personnel performing the Work (Including References and Firm Financials)

YES X NO___ 4. Approach and Methodology

YES X NO___ 5. Firm's Experience

YES X NO___ 6. Compensation/Pricing

YES X NO___ 7. Drug Free Workplace

YES X NO___ 8. Local Preference Application

YES X NO___ 9. Conflict of Interest Form

YES X NO___ 10. Optional Services (If Applicable)

YES X NO___ 11. Original and one (1) PDF Electronic copy (CD)

Tab 2: Acknowledgement of addendums

Response: The Village currently has a hybrid method of compensation; flat fee for Property and Casualty and commission based for employee benefits and workers compensation.

6. **Question:** Can you provide the rate of compensation if commission or the annual flat fee for both Employee Benefits and Property and Casualty and Workers Compensation?

   Response: The Property and Casualty flat rate is $24,000 annually. The Village pays an additional $24,000 annually for claims mitigation. In addition, our health insurance carrier pays the broker directly a 5% commission of the health insurance premium and the Village pays the broker 5 % of workers compensation premium.

ACKNOWLEDGEMENT: Proposers must acknowledge receipt of any and all Addenda. Failure to do so may result in rejection of the Proposal. All requirements of the proposal documents remain unchanged except as cited herein.

Signature of Proposer Acknowledging Receipt of

Addendum No. (1) One to be attached in front of Proposal

Response: See total of 4 (four) attachments.

10. **Question:** Are there any issues with current program or broker?
    Response: No response.

11. **Question:** What are the likes and/or dislikes of the current program/placements?
    Response: No response.

12. **Question:** How often does the current broker offer alternative competitive options on lines of coverage? Self-funded options?

    Response: Options are provided prior to the new fiscal/calendar year. Typically, when contracts are up for renewal.

13. **Question:** How often does the current broker attend safety meetings and on-site inspections?

    Response: Safety meetings are held bi-monthly, the brokers' representative attends these meetings. On-site inspections are performed on an annual basis (this includes random or all facility locations).

14. **Question:** What online portal is currently used?
    Response: BenTek Employee Benefits Center

15. **Question:** Has Wellington solicited for health clinics in the past? If so, what was the decision or plan of action?
    Response: On December 13, 2011, the Wellington Council awarded a contract to MD Now Medical Centers to facilitate an off-site employee health clinic. The contract is set to expire at the end of calendar year 2014.

16. **Question:** Provide a copy of 5 years loss reports for property, workers comp, auto and liability lines of insurance.
    Response: See Attached.

ACKNOWLEDGEMENT: Proposers must acknowledge receipt of any and all Addenda. Failure to do so may result in rejection of the Proposal. All requirements of the proposal documents remain unchanged except as cited herein.

Kurt Stolting

Signature of Proposer Acknowledging Receipt of

Addendum No. (2) Two to be attached in front of Proposal

ACKNOWLEDGEMENT: Proposers must acknowledge receipt of any and all Addenda. Failure to do so may result in rejection of the Proposal. All requirements of the proposal documents remain unchanged except as cited herein.

Signature of Proposer Acknowledging Receipt of

Addendum No. (3) Three to be attached in front of Proposal

Response: Wellington has a Bloodbourne Pathogen plan that used to be housed by an outside vendor (JFK Medical Center), but needs to be revised.

97. **Question**: Provide a copy of the group health MLR/running 18 month loss report or actuary report if self-funded.

Response: See Attached

ACKNOWLEDGEMENT: Proposers must acknowledge receipt of any and all Addenda. Failure to do so may result in rejection of the Proposal. All requirements of the proposal documents remain unchanged except as cited herein.

Signature of Proposer Acknowledging Receipt of
Addendum No. (4) Four to be attached in front of Proposal

RFP No. 003-14/ED
Title: Insurance Brokerage Services
RFP Opening Date: April 2, 2014 at 10:00 am
Addendum Date: March 26, 2014

ADDENDUM NO. FIVE

PURPOSE: The purpose of this Addendum/NOTICE is to make changes, additions, deletions, revisions, and clarifications to the Request for Proposal (RFP) documents for **Insurance Brokerage Services**. Proposers shall review the Addendum/NOTICE work and requirements in detail and incorporate any effects the Addendum/NOTICE may have in their proposal price.

REVISION

Revision #1: Disregard the response to Addendum #4, response #27. The revised response to this question is below:

Wellington will accept coverage on a "per occurrence" basis and a "claims-made" basis. If coverage is provided on a "claims-made" basis, please provide proof of retroactive dates, prior acts coverage or tail coverage, whichever one applies.

QUESTION

1. **Question:** Section 20 – Indemnification: Please confirm that the Village will consider a proposer that has a $20 million limitation of liability requirement as it relates to indemnification.

   Response: Wellington does not specify limits of coverage on indemnification. Wellington's Indemnification clause in RFP documents specifically states, "The successful bidder/proposer shall indemnify, save harmless and defend Wellington, its agents, servants, or employees from and against any and all claims, liability, losses and/or causes of action which may arise from any negligent act or omission of the successful bidder/proposer, its subcontractors, agents, servants or employees during the course of performing services or caused by the goods provided pursuant to these bid documents and/or resultant contract."

ACKNOWLEDGEMENT: Proposers must acknowledge receipt of any and all Addenda. Failure to do so may result in rejection of the Proposal. All requirements of the proposal documents remain unchanged except as cited herein.

Kurt Gehring

Signature of Proposer Acknowledging Receipt of

Addendum No. (5) Five to be attached in front of Proposal

TAB 3: QUALIFICATIONS OF THE PERSONNEL PERFORMING THE WORK

The following includes information regarding the qualifications of the firm and personnel who have been and will continue to service the needs of the Village of Wellington:

HISTORY OF FIRM

Gehring Group is a Florida firm incorporated as a Subchapter S corporation in 1992. Kurt Gehring founded the Gehring Group with the intention of providing year round consulting, insurance and advisory services to clients, in addition to expert negotiations and an increased service standard. Gehring Group was founded on the principle of individually addressing the needs and goals of public sector entities, businesses, industries, and labor and professional organizations through the design and servicing of insurance programs that best suit each client's particular needs and circumstances. He employed an approach that benefits programs are not cookie cutter, and communication among parties is a key to any successful program. The result was the development of Gehring Group into a service centered firm providing unparalleled expertise and services in employee benefits, risk management, and technology solutions. As agent/consultant for over 70 public sector entities in Florida, Gehring Group has extensive experience with all major insurance carriers, and a comprehensive knowledge of all available products and funding methods. In addition, our clients have grown to rely on our expertise and accessibility in dealing with all of their insurance and compliance needs.

Gehring Group works to consistently to deliver an unparalleled level of client service and industry expertise to the public sector market, serving many governmental entities including: city and county governments, special taxing districts, law enforcement agencies and school boards. Our experience with the requirements inherent in servicing this specialty market has enabled Gehring Group to become an extension of our clients' team, working with them, and for them year round to anticipate and respond to their needs, and deliver significant "value added" products. Our commitment to this high level of service is one of the many reasons that the Gehring Group continues to build long lasting client relationships.

NEGOTIATING CLOUT

Gehring Group has extensive experience in dealing with all types of funding arrangements, from fully insured to self-funded to minimum premium programs, as well as numerous insurance carriers, third party administrators and stop loss providers. We offer impartial and independent expertise, currently placing over $500 million in insurance premium annually. This clout in the marketplace affords our firm the credibility to negotiate with carriers effectively. Gehring Group is also known for the high quality of analysis provided in our evaluation and recommendation proposals, and our ability to present and communicate this information in a clear and concise manner.

As one of the top producing brokers/consultants for public sector entities throughout the state, our firm has the distinct honor of participating in the agent advisory councils of three of the top carriers in the state: Florida Blue, CIGNA HealthCare, and United Healthcare. This provides us with considerable leverage during client negotiations. We have also received additional recognitions and have been named an AETNA Preferred Producer, Florida Blue BlueDiamond Producer, CIGNA HealthCare Platinum Broker, and United Healthcare Advantage Gold membership. We represent all carriers and hold no interest or ownership in any insurer or TPA; therefore, emphasizing our independent status.

Excellent underwriting relationships allow us to obtain needed capacity/limits on behalf of our clients at the optimum cost and coverage terms available in the marketplace. We believe an aggressive negotiating team is required to achieve the desired results – minimizing our clients' overall insurance premiums, while obtaining the best coverage terms and conditions.

INDUSTRY KNOWLEDGE AND TRENDS

Gehring Group maintains a strong commitment to remain at the forefront of industry trends, new legislation, cutting edge benefits technology tools, and new types of health insurance programs offered by insurance companies and third-party administrators. We consistently attend conferences, continuing education and industry seminars in order to remain ahead of the curve. In addition, members of our qualified team are featured speakers at various HR and benefits associations meetings and conferences. Our staff has extensive experience with reviewing, implementing and servicing all types of programs that include fully and self-insured programs, Health Savings Accounts (HSA), Health Reimbursement Accounts (HRA), Consumer Driven Health Plans (CDHP), and Cafeteria Plans. Through our knowledge and expertise, Gehring Group is able to aid clients in determining which plans represent viable options in order to assist management in making informed decisions regarding new concepts and ascertaining the best interest of their organization. During Gehring Group's tenured experience, we have assisted our clients through a variety of plan and funding changes. We have assisted our clients through transition in many ways such as: changing from fully insured to self-insured, switching insurance carriers, implementing health savings vehicles such as HSA's and HRA's.

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

In recent years, our focus has turned to ensuring that our clients are fully educated on and remain compliant with all the requirements mandated under the 2010 Health Care Reform legislation. Spearheaded by our CFO, Kate Grangard, CPA, who has received her *Certified Health Care Reform Specialist* designation, we take our role as advisor in guiding our clients through the requirements of health care reform very seriously. We have assisted, and continue to assist our clients through the compliance steps mandated by the Acts such as; applying for and receiving reimbursements from the Early Retiree Reimbursement Program, assisting in the calculation and distribution of MLR rebates, providing guidance relating to the reporting of employer sponsored health benefits on employee W-2's, evaluating the penalty exposure relating to part-time and variable hour employees, evaluating the cost impact of the various new fees (PCORI, Transitional Reinsurance Fee, Health Industry fee) and planning for the future. We routinely guide our clients with compliance and preparing financially in anticipation of legislative regulations.

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

- Technical aspects of calculating, reporting, and paying the new PCORI, Health Industry Fee and Transitional Reinsurance Fee.

- Impact of having an employer sponsored group medical plan that is both "affordable" and meets "minimum value" requirements on both employers and employees
- Employer alternatives, including a health insurance exchange
- Effect of subsidies, penalties, and taxes

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

ADDITIONAL SPECIAL EXPERTISE (COMPETITIVE ADVANTAGES)

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

- **Public Sector Focus & Experience**
  Since 95% of the Gehring Group's client base consists of public entities our firm is uniquely qualified in its understanding of public entity issues. We understand the bid process and public record laws while maintaining familiarity with the constantly changing and complex Statutes that apply to governmental organizations. This specialized knowledge is especially vital when negotiating renewals and program changes with insurance carriers and health insurance consortiums. The experience we offer guarantees that no piece of the puzzle will be missing when a benefit change is implemented.

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

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

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

PROFESSIONAL MEMBERSHIPS

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

- FAC – Florida Association of Counties
- FASD – Florida Association of Special Districts
- FERMA – Florida Educational Risk Management Association
- FGFOA – Florida Government Finance Officers Association
- Florida League of Cities
- FPELRA – Florida Public Employer Labor Relations Association
- FPPA – Florida Public Personnel Association
- PRIMA – Public Risk Management Association
- RIMS – Risk & Insurance Management Society
- SHRM – Society for Human Resource Management

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

QUALIFICATIONS OF THE PERSONNEL PERFORMING THE SERVICES

1. **Name, address, and telephone number of the firm.**

   Gehring Group
   11505 Fairchild Gardens Ave., Ste. 202
   Palm Beach Gardens, FL 33410
   Tel: (561) 626-6797
   Fax: (561) 626-6970

2. **Principal company contact:**

   Kurt Gehring, CEO kurt.gehring@gehringgroup.com
   Tel: (561) 626-6797, Cell: (561) 722-2712
   Fax: (561) 626-6970

3. **Number of years for the firm in the benefit consulting business.**

   Gehring Group has specialized in benefit and risk management consulting services for over 20 years; Gehring Group is a Subchapter S-Corporation, incorporated in the State of Florida on October 6, 1992, with Kurt Gehring as 100% owner.

4. **List the last five (5) contracts held by the firm comparable to this specific project and related experience accomplished by the proposer's firms. Indicate client name, address, telephone number, e-mail address.**

   Gehring Group provides employee benefits, property/casualty and risk management consulting services to the following client references:

   Palm Beach County - Local References

   Palm Beach County Sheriff's Office
   3228 Gun Club Road
   West Palm Beach, FL 33406
   (561) 688-3003
   Hilda Gonzalez, Manager, Risk & OHS

   Email: GonzalezH@pbso.org
   Client Since: 11/1/1992

   City of West Palm Beach
   401 Clematis Street
   West Palm Beach, FL 33401
   (561) 494-1013
   Patricia Brosamer, HRIS & Employee Benefits. Manager
   Email: pbrosamer@wpb.org
   Client Since: 04/20/1998

   Village of Tequesta
   345 Tequesta Drive
   Tequesta, FL 33469
   (561) 575-6200 ext.256
   Merlene Reid, Human Resources Manager

   Email: mreid@tequesta.org
   Client Since: 5/1/2009

   Town of Lake Park
   535 Park Avenue
   Lake Park, FL 33403
   (561) 881-3310
   Bambi McKibbon-Turner, Human Resources Director
   Email: bturner@lakeparkflorida.gov
   Client Since: 5/10/1994

Village of North Palm Beach
501 US Highway 1
North Palm Beach, FL 33408
(561) 841-3358
Loren Slaydon, H.R. Director
Email: lslaydon@village-npb.org
Client Since: 6/8/2006

Town of Jupiter Island
2 Bridge Road
Hobe Sound, FL 33455
(772) 545-0103
Gwen Carlisle, Town Clerk
Email: gcarlisle@tji.martin.fl.us
Client Since: 6/6/2009

Additional Florida References

City of Dunedin
750 Milwaukee Avenue
Dunedin, FL 34698
(727) 298-3042 / Fax: (727) 298-3052
Bonnie Steinberg, Human Resources & Risk/Safety Manager
Email: bsteinberg@dunedinfl.net
Client Since: 4/1/2004

Charlotte County BOCC
18500 Murdock Circle
Port Charlotte, FL 33948-1094
(941) 743-1260
Walt Black, Risk Manager, Environmental Health & Safety/ADA Coordinator
Email: janine.hewitt@charlottefl.com
Client Since: 9/26/2000

5. Provide a list of all of the firm's Public Sector clients

The following includes Gehring Group's Florida public sector clients:

- Boynton Beach, City of
- Brooksville, City of
- Cape Coral, City of
- Charlotte County BOCC
- Citrus County BOCC
- Clearwater, City of
- Clerk & Comptroller, Palm Beach County
- Cocoa, City of
- Coconut Creek, City of
- Dania Beach, City of
- Dunedin, City of
- Fellsmere, City of
- Florida Keys Aqueduct Authority
- Hallandale Beach, City of
- Hernando County BOCC
- Indian River County BOCC
- Islamorada, Village of Islands
- Juno Beach, Town of
- Jupiter Island, Town of
- Jupiter, Town of
- Key West Housing Authority
- Key West, City of
- Keys Energy Services
- Lake Mary, City of
- Lake Park, Town of
- Lighthouse Point, City of
- Loxahatchee River District
- Manalapan, Town of
- Mangonia Park, Town of
- Marco Island, City of
- Margate, City of
- Martin County BOCC
- Martin County School District
- Martin County Sheriff's Office
- Miami Gardens, City of
- Miramar, City of
- Monroe County Board of Commissioners
- Naples, City of
- North Palm Beach, Village of
- Oakland Park, City of
- Oldsmar, City of
- Osceola County Sheriff's Office

- Oviedo, City of
- Palm Beach County Sheriff's Office
- Palm Beach Workforce Development Consortium
- Parkland, City of
- Pinellas Suncoast Fire and Rescue
- Pinellas Suncoast Transit Authority
- Port Richey, City of
- Port St. Lucie, City of
- Rockledge, City of
- Royal Palm Beach, Village of
- Sanibel, City of
- Sarasota County Sheriff's Office
- Sarasota, City of
- Satellite Beach, City of
- Seacoast Utility Authority
- Sebastian, City of
- Solid Waste Authority of Palm Beach County
- St. Lucie County Sheriff's Office
- Stuart, City of
- Tax Collector, Palm Beach County
- Tequesta, Village of
- Wellington, Village of
- West Palm Beach Police Benevolent Association
- West Palm Beach, City of

6. **Experience of the firm with similar projects. Provide examples of employee benefit projects and products that the Proposer has designed and implemented for clients that:**
    a. **Saved money**
    b. **Improved quality of benefits**
    c. **Enhanced benefits**
    d. **Increased efficiency**
    e. **Were innovative**

These are many examples in which Gehring Group has aggressively pursued a cost effective benefits program for its clients. The following includes several actual case samples of Gehring Group clients ranging in employee size, who have experienced notable savings due to Gehring Group's expert consulting, experience, service and product offerings.

Cost Reduction Strategies & Documented Savings

Example 1: County (1,100+ Employees)

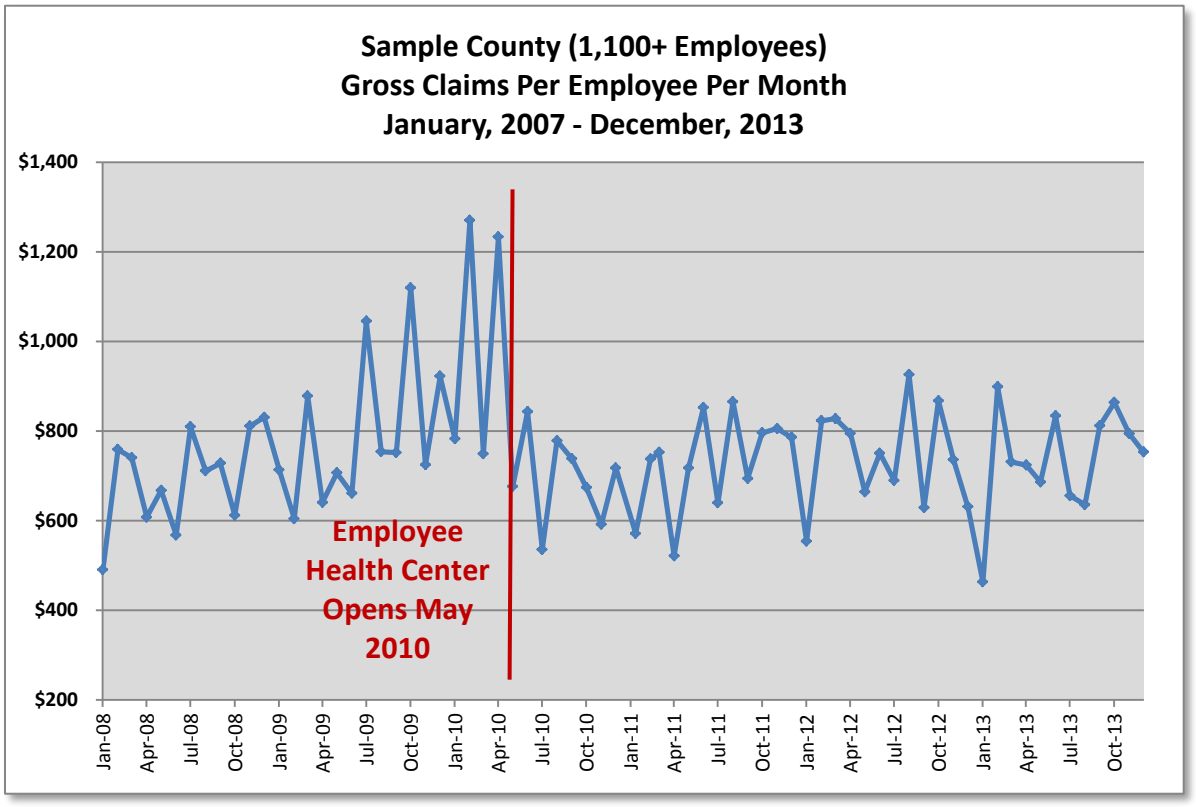
Cost Reduction Strategy: Implementation of Onsite Employee Health Center

A victim of double-digit health insurance trend, this county was seeking creative options to combat the effects of increasing medical inflation on its self-insured health insurance program. They had taken all the right steps in implementing consumer driven plan options as well as making recommended plan changes based on the results of Gehring Group's claims analysis; however, were willing to go another step further – to implement an onsite employee health center for its employees. The goals of this undertaking included:

- Providing employees and their dependents with convenient, free access to routine as well as urgent medical care;
- Providing a facility from which to offer an increased level of wellness initiatives and opportunities to focus on preventive medicine through the use of:
    - Annual Health Risk Assessments
    - Nurse/Physician outreach program
    - Disease/Case management and coaching
    - Health education training

- Better management of chronic illnesses including diabetes, cholesterol, and hypertension;
- Providing medical care at a cost lower than through the medical plan;
- Providing generic prescription drugs at a lower cost, thus increasing use of generics and other lower cost alternatives;
- Reducing the effects of medical trend on the County's self-funded health plan; and ultimately
- Reducing the overall number of claims incurred under the County's self-funded health insurance plan.

After conducting a feasibility study to determine whether this concept was a viable option for the County, Gehring Group spearheaded the process of compiling the request of proposal for a clinic vendor. We evaluated all proposals received and assisted the County throughout the selection and implementation process, attending all meetings as necessary. The County ultimately contracted with a local provider and opened its clinic doors in May, 2010. The impact to the County's health insurance claims totals was virtually immediate, as illustrated below.



As a result of the positive effects of the clinic on the County's medical claims, other local entities inquired as to the option of entering into an interlocal agreement and sharing the fixed costs of the clinic, thus allowing their employees access to the benefits of the clinic. As a result, the County, the Sheriff's Office and a local City entered into an interlocal agreement, thus providing their employees with increased access to medical care and wellness opportunities for them and their dependents while combating the effects of medical inflation on their medical insurance programs.

Example 2: City (400+ Employees)

Cost Reduction Strategy: Implementation of a Consumer Driven Health Plan Model

This City contracted in with the Gehring Group in spring of 2010 in order to review the structure, scope, competitiveness and economic efficiency of its employee benefit insurance coverages. The City wanted to consider creative and innovative approaches that would help them maintain a quality employee benefits without sacrificing fiscal soundness. Gehring Group along with City management established a three year approach in developing a fiscally conservative self-funded health plan while maintaining quality benefits.

Year One Goals

The City's self-funded health plan experience claims utilization that was higher than "the norm" and thus required a significant funding increase as reserves had been depleted. After review of the dual option plan design Gehring Group recommended several plan design changes including slight increases to deductibles and coinsurance, limitations on various other services and the removal of out of network benefits under the Health Reimbursement Account plan.

These minimal changes prompted a significant enrollment shift from the Point of Service to the less costly Health Reimbursement Account plan, which resulted in a plan savings of approximately $368,000 for the 2009/2010 plan year.

Year Two Goals

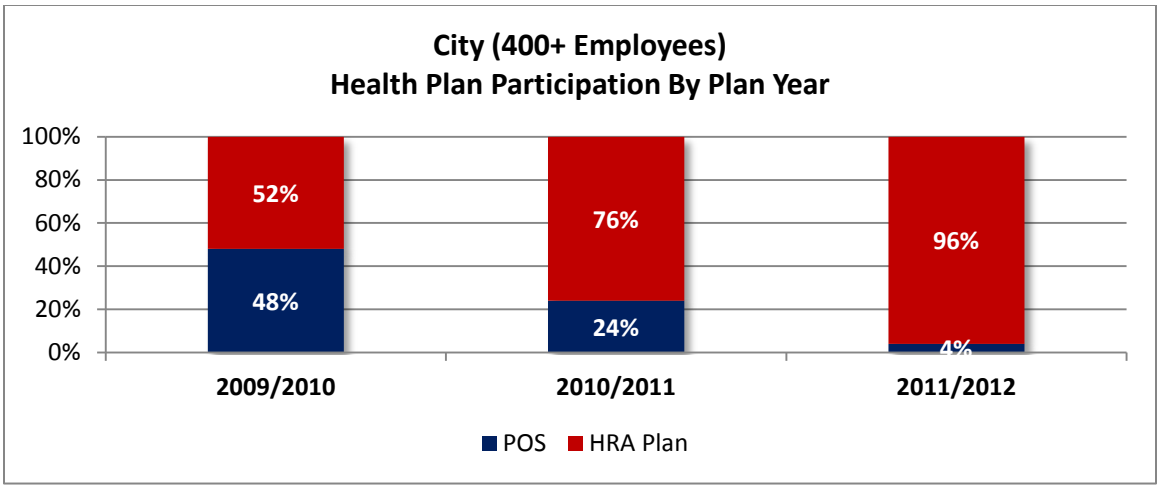
The goal for year two was to set appropriate and actuarially sound premium rate equivalents for the City's two self-funded health plan options. Gehring Group's analysis determined that the premiums charged for Health Reimbursement Account plan had been subsidizing the costs incurred under the Point of Service plan due to adverse selection (i.e. the highest utilizers remain in the most costly plan with the richest benefits, while low utilizers move to the less costly plan, leaving fewer premium dollars to cover the costs of the highest utilizers.)

Gehring Group enlisted the services of an independent actuarial firm, to complete the rate-setting study. In addition to pricing the plans appropriately, individual plan rates were also adjusted by tier of coverage based upon utilization and demographic factors. Based on these results, the City was able to price both medical plans at a level where the premium rate equivalents were in line with the actual cost of the plan regardless of which plan an employee enrolled.

During the consequent open enrollment period, there was an additional twenty percent shift from the Point of Service to the Health Reimbursement Account plan. Gehring Group also assisted the City in conducting a Dependent Audit in which every employee had to provide documentation for all eligible dependents covered under the plan. At the conclusion of the audit, it was determined that approximately fifteen dependents were not eligible for coverage and thus removed from the plan, saving the City up to $100,000 in plan funding.

Year Three Goals

By the beginning of the 2011/2012 plan year, the City had accomplished its goal of incentivizing employees to select the most cost effective health plan option as illustrated below:



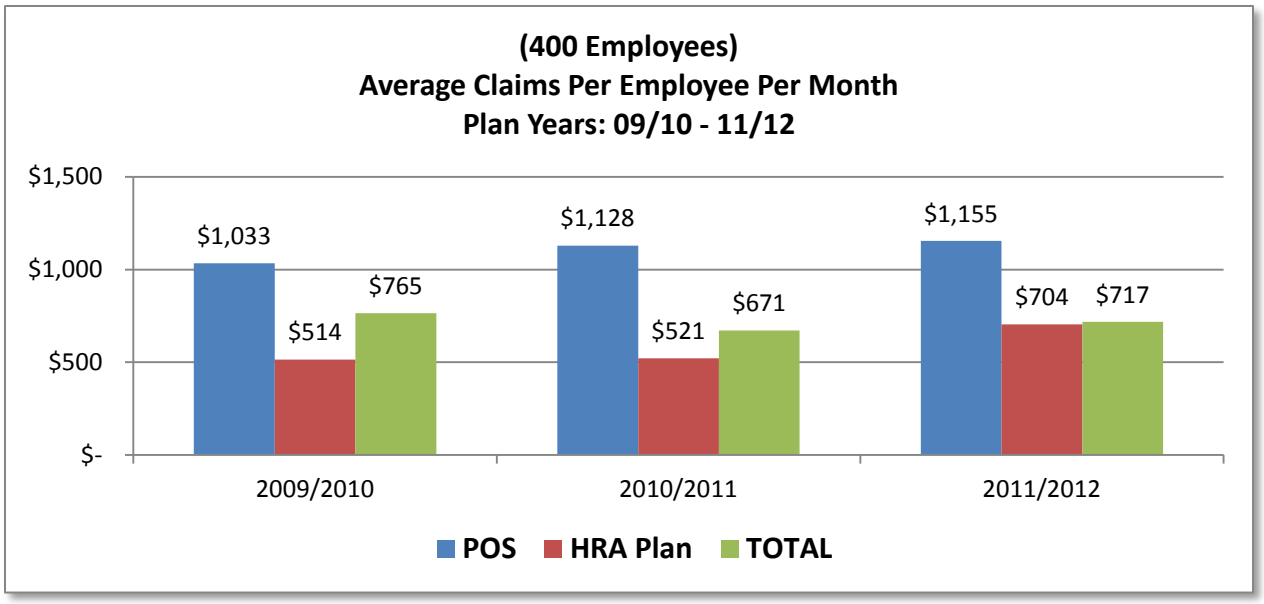
The next step was to begin the implementation of a formal Wellness Incentive Program that incorporated measureable targets and alternative incentive rewards. The City's voluntary wellness program includes such features as:

- Additional funding to Health Reimbursement Accounts for covered employees and retirees for each health target achieved
- Biometric Screenings for employees and retirees via a Primary Care Physician or at a City-sponsored event
- HIPAA compliant Wellness Target Forms submitted to Human Resources (no personal health information is exchanged with the City)
- Rewards for achieving any or all targets (maximum of five)
- Enrollment in the program is one-time per year during Open Enrollment

Incentives are achieved by meeting measurable goals for targets related to weight management, tobacco usage, blood sugar levels, triglycerides, LDL cholesterol, and blood pressure in addition to the completion of a health risk assessment.

All employees and retirees that elect to participate in the voluntary Wellness Incentive Program must visit their Primary Care Physician with the Wellness Target Form. Once their blood work is complete and the results have been sent back to the Primary Care Physician, the PCP provides the remaining measures on the Wellness Target Form. The Human Resources Department does not receive any medical information, only the number of targets met. Financial incentives are earned and credited to the employees' Health Reimbursement Account on an annual basis, and unused funds roll annually for use in future plan years.

Based upon the programs established in year one and two along with the current implementation of the Wellness Incentive Program, the City has experienced a significant reduction in average claims costs along with a reduction in a reduced trend and overall paid claims.



Example 3: County Constitutional Office (250+ Employees)

Cost Reduction Strategy: Implementation of Comprehensive Wellness Program

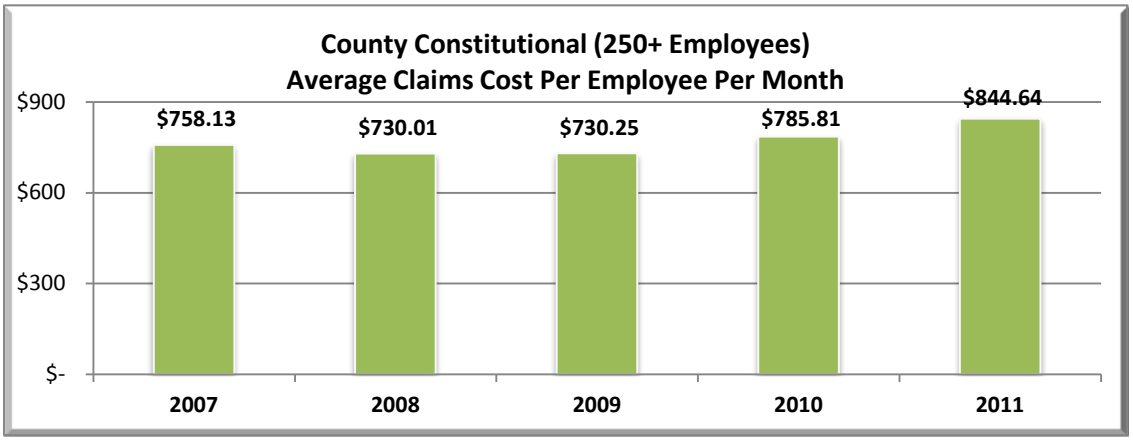
As a result of rising medical inflation and falling budgets, this constitutional implemented one of the most aggressive wellness programs in an attempt to tackle the rising cost of their employee benefits program. In 2009, they began with the introduction of their health insurance carrier's rewards program for wellness activities as well as a program that provided educational materials and self-care tools for those with chronic illnesses. Even though their 2010 renewal increase was in the single digits, utilization of these programs was not to the desired level; therefore, in 2010 they took the next step to implement a comprehensive wellness program through an independent wellness vendor. This program included annual health risk assessments and biometric screenings with optional follow-up programs for those identified to be in specific high risk categories. The primary purpose of this program was to help participants understand their risks for preventable chronic diseases and provide them with tools to help them achieve the success in improving their health risks. To complement the efforts of the wellness program, they also implemented a smoke-free workplace with premium surcharges for employees who use tobacco products and discontinued hiring smokers altogether. In addition, they also added fitness equipment at various worksites, and incentives for health risk improvements.

In 2011, the program was expanded in a number of ways to include (1) a formal incentive program including premium reductions and health reimbursement account funding; (2) risk criteria was expanded to identify additional risk groups; and (3) structured programs were added for low/moderate and high risk individuals. They achieved 73% employee participation in the health screenings in 2011 due to aggressive communication and promotion efforts as well as the full endorsement, commitment and support of the group's leadership team; with a goal of reaching 85% in 2012.

The results of their efforts have also begun to show in their claims loss ratio and the consistency of the average claims per head. While many groups continued to struggle with the effect of medical inflation on the costs of their employee's medical care, this group's health insurance renewals have been in the single digits or at 0% for the past three years:

- 2010 – 6% health insurance renewal
- 2011 – 0% health insurance renewal
- 2012 – 0% health insurance renewal

Average claims per employee have also remained fairly consistent during the same time period as reflected below:



7. Evidence of possession of required licenses and/or business.

The following is a copy of Gehring Group's agency license, authorizing the firm to provide insurance services within the State of Florida.

Florida Agency Licensing:

FLORIDA DEPARTMENT of FINANCIAL SERVICES

GEHRING GROUP, INC.
11505 FAIRCHILD GARDENS AVENUE
SUITE 202
PALM BEACH GARDENS FL 33410

Agency Registration Number R006325
Location Number: 126219

Issued On 07/17/2006

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

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

Tom Gallagher
Chief Financial Officer
State of Florida

GEHRGRO-01 MCDANIELT

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 3/10/2014

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

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

PRODUCER	CONTACT NAME: Carolyn Fowler
Insurance Office of America-JUP Abacoa Town Center 1200 University Blvd, Suite 200 Jupiter, FL 33458	PHONE (A/C, No, Ext): (561) 776-0660 FAX (A/C, No): (561) 776-0670 E-MAIL ADDRESS: Carolyn.Fowler@ioausa.com

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

INSURED

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

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

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC OTHER:			GLDO5934904781	03/12/2014	03/12/2015	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 100,000 $ 5,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS HIRED AUTOS SCHEDULED AUTOS NON-OWNED AUTOS			BAPD5934904781	03/12/2014	03/12/2015	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
B	X UMBRELLA LIAB OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $			CAP5934904781	03/12/2014	03/12/2015	EACH OCCURRENCE AGGREGATE aggregate	$ 5,000,000 $ $ 5,000,000
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N N/A (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below			21WECPO1562	03/12/2014	03/12/2015	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

The Gehring Group, Inc.
11505 Fairchild Gardens Ave.
Suite 202
Palm Beach Gardens, FL 33410

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

C. Ray Dorsey

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

Arch Insurance Group®

ARCH SPECIALTY INSURANCE COMPANY
(A Nebraska Corporation)

Home Office Address:
10306 Regency Parkway Drive
Omaha, NE 68113

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

MISCELLANEOUS PROFESSIONAL LIABILITY
NETWORK SECURITY AND PRIVACY COVERAGE POLICY
DECLARATIONS

Policy Number: SPL0055072-00 **Renewal of:** NEW

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

Item 1. Named Insured: Mailing Address	Gehring Group, Inc. BenTek, Inc. 11505 Fairchild Gardens Avenue Suite 101 and Suite 202 Palm Beach Gardens, FL 33410	
Item 2. Producer Name: Mailing Address:	AmWins Brokerage of Georgia 3630 Peachtree Road NE Suite 1700 Atlanta, GA 30326	
	Inception Date: 05/22/2013	**Expiration Date:** 05/22/2014
	(12:01 A.M. Standard time at the address shown above)	
Item 4. Retroactive Date:		
A. Miscellaneous Professional & Media Liability Coverage	• Full Prior Acts applies to $3,000,000 Limit of Liability for Gehring Group, Inc.; • May 22, 2013 applies to $2,000,000 excess of $3,000,000 Limit of Liability for Gehring Group, Inc. • March 12, 2010 applies to $1,000,000 Limit of Liability for BenTek, Inc • May 22, 2013 applies to $1,000,000 excess $1,000,000 for BenTek, Inc.	
B. Network Security Liability Coverage	May 22, 2013	
C. Privacy Violation Liability Coverage	May 22, 2013	
Item 5. Aggregate Limit of Liability -- Each "Policy Period":	$5,000,000	
Item 6. Sublimits and Deductibles	**Sublimit/Aggregate (A)**	**Deductible (B)**
A. Miscellaneous Professional & Media Liability Coverage	$5,000,000	$15,000

B. Network Security Liability Coverage	$5,000,000	$15,000
C. Privacy Violation Liability Coverage	$5,000,000	$15,000
D. Computer Network Business Interruption Coverage	No Coverage	N/A
E. Data Loss Coverage	$500,000	$15,000
F. Cyber Extortion Coverage	$5,000,000	$15,000
G. Security Breach Notice Coverage	$2,000,000	$15,000
H. Crisis Management Coverage	$2,000,000	$15,000
I. Regulatory Action Sublimit	$2,000,000	$15,000

Item 7.	**Premium:**	
	State Tax:	$ **BY BROKER**
	Stamping Fee:	$ **BY BROKER**
Item 8.	**Endorsement(s) Effective At Inception:** See attached Schedule of Forms and Endorsements	
Item 9.	**Notice Address:** Arch Specialty Insurance Company Attention: Professional Liability Claims P.O. Box 542033 Omaha, NE 68154 Phone: 877 688-ARCH (2724) Fax: 866 266-3630 E-mail: Claims@ArchInsurance.com	

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

7. (Continued)…Provide the names and positions of each professional to be assigned to this contract, including familiarity with projects similar in nature.

EMPLOYEE BENEFITS CLIENT SERVICE TEAM

Executive Staff: Kurt Gehring, President
As CEO of Gehring Group, Kurt Gehring's exposure amongst the public sector provides unparalleled practical experience within a learned understanding of the local governmental environment. Kurt will represent the Village's best interest in all insurance negotiations, oversee staff's recommendations of creative solutions and serve as an all-around resource for strategy and escalated issues.

Senior Benefit Consultant: Christian Bergstrom
As Senior Benefits Consultant, Christian Bergstrom has over 10 years' experience in the benefits arena servicing public entity clients. In his role as Senior Benefits Consultant to Wellington, he will assist in strategic and budget planning as it relates to the entity's employee benefits program, making recommendations as necessary and assisting in preparation for compliance with health care reform. Christian not only has expertise in all types of insurance programs and funding arrangements, he is also the lead analyst with regards to onsite clinic consultation, a role in which he assisted public entity groups in the successful implementation of numerous onsite clinics throughout the state.

Christian currently serves as senior benefit consultant for the following public sector clients with similar scope in nature to the Village:

- Jupiter, Town of, 350 employees
- Key West, City of, 440 employees
- Oakland Park, City of, 250 employees
- Naples, City of, 435 employees
- Solid Waste Authority of Palm Beach County, 400 employees
- Stuart, City of, 230 employees

In addition, Christian has the expertise and knowledge to serve larger entities, and currently services the Palm Beach County Sheriff's Office with over 3,000 employees.

Primary Account Manager: Rommi Upson
Rommi Upson will serve as the primary Account Manager for the Village. Her responsibilities include overseeing service staff that provides claims assistance, coordinating and conducting open enrollments and new hire orientations, coordinating wellness fairs, providing assistance with billing and carrier issues, reporting monthly eligibility data to MD Now, and acting as a resource to our clients regarding numerous compliance issues. She is bilingual and therefore has the ability to assist employees who speech English and Spanish. She is supported by several other Gehring Group staff members including other account managers, in-house account services specialists and analytical staff to ensure all client needs are met promptly.

Rommi currently serves as primary account manager for the following public sector clients with similar scope in nature to the Village:

- Oldsmar, City of, 140 employees
- Keys Energy Services, 250 employees

- Royal Palm Beach, Village of, 80 employees
- Seacoast Utility Authority, 120 employees

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

Brian currently serves as primary analyst for the following public sector clients with similar scope in nature to the Village:

- Tax Collector, Palm Beach County, 230 employees
- Key West, City of, 440 employees
- Dunedin, City of, 350 employees
- North Palm Beach, Village of, 184 employees
- Cocoa, City of, 411 employees
- Wellington, Village of, 250 employees
- Oldsmar, City of, 140 employees
- Keys Energy Services, 275 employees
- Family Central, Inc., 360 employees
- Florida Keys Aqueduct Authority, 250 employees

Wellness Coordinator: Sarah Brown
As Wellness Coordinator at Gehring Group, Sarah employs a combination of experience, knowledge, enthusiasm, coordination and empathy to deliver cost saving, achievable, proven, and innovative programs to our clients. Sarah Brown is available to coordinate and attend the Village's annual Wellness and Benefit Fair. Having already implemented many cost saving solutions with regards to wellness initiatives, Sarah has the expertise and know how to assist the Village with these innovative programs.

As Gehring Group's Wellness Coordinator, Sarah currently provides various degrees of wellness services to the following public sector clients with similar scope in nature to the Village:

- Cocoa, City of, 411 employees
- Family Central, Inc., 360 employees
- Stuart, City of, 230 employees
- Jupiter, Town of, 350 employees

RISK MANAGEMENT CLIENT SERVICE TEAM

Executive Staff: Kurt Gehring, President
As CEO of Gehring Group, Kurt Gehring's exposure amongst the public sector provides unparalleled practical experience within a learned understanding of the local governmental environment. Kurt will represent the Village's best interest in all insurance negotiations, oversee staff's recommendations of creative solutions and serve as an all-around resource for strategy and escalated issues.

Account Manager: Ellen Jones, Director – Risk Management
Ellen Jones will serve as the Primary Account Manager for the Village. Her responsibilities include providing risk analysis, marketing of the Village's program, review of coverage's for gaps or duplications in coverage, coordinating and conducting committee/staff meetings, providing assistance with policy interpretation, and acting as a resource to the Village regarding market conditions and trends. She is supported by several Gehring Group staff members including account managers, in-house account service representatives and analytical staff to ensure all client needs are met promptly.

Ellen currently serves as primary account manager for the following public sector clients with similar scope in nature to the Village:

- Palm Beach County Sheriff's Office
- North Palm Beach, Village of
- Charlotte County BOCC
- Tequesta, Village of
- Jupiter Island, Town of

Risk Analyst: Rodney Louis, Senior Analyst
Rodney Louis will be responsible for overseeing all aspects of the analytical services functions including compiling all RFP's and providing RFP evaluation and recommendations to the Village on all lines of property and casualty insurance coverage. In addition, he will work in coordination with our safety and loss control personnel to monitor claim reports in order to anticipate future program costs and to make recommendations regarding utilization patterns as well as providing budget and renewal projections.

Rodney currently serves as primary analyst for the following public sector clients with similar scope in nature to the Village:

- North Palm Beach, Village of
- Keys Energy Services
- Dunedin, City of
- Lake Park, Town of
- Clerk & Comptroller, Palm Beach County

Safety/Loss Control Account Manager: Stuart Morgan, Safety/Loss Coordinator
Should safety and loss control services be required, Stuart will serve as the Safety/Loss Control Account Manager for all safety, loss and claims services as it relates to the Village's Risk Management program. Stuart's responsibilities would include monitoring, analyzing, and report generation on client loss run data. Stuart employs a combination of experience, knowledge, and enthusiasm to deliver achievable, proven, and innovative programs.

Stuart currently serves as safety/loss coordinator for the following public sector clients with similar scope in nature to the Village:

- Keys Energy Services
- Dunedin, City of
- Lake Park, Town of
- North Palm Beach, Village of

8. **Describe the proposer's approach to organizational management and the responsibilities of the Proposer's management staff personnel assigned to perform the work under this contract.**

Gehring Group has a long standing commitment to quality assurance that starts with a team of primary and back-up professionals assigned to each client, ensuring that client requests are responded to thoroughly, timely, and with expertise. We continually bring on new talent, and strategically assign newly acquired clients to ensure that the client to professional ratio is low, and that the complexity of the client is considered in the process. We have found that our client's needs have grown as the economy has been burdened and we have increased our staff to be responsive to these needs. Over the tenure of our relationship with the Village, we have continued to be an outsourced resource, providing additional value added services such as BenTek, clinic consulting, Wellness and Health Care Reform compliance and planning. Our increased level of service is further evidenced by the fact that the number of annual employee service hours that your Gehring Group service team devotes to the Village of Wellington has increased by more than 50% since 2009.

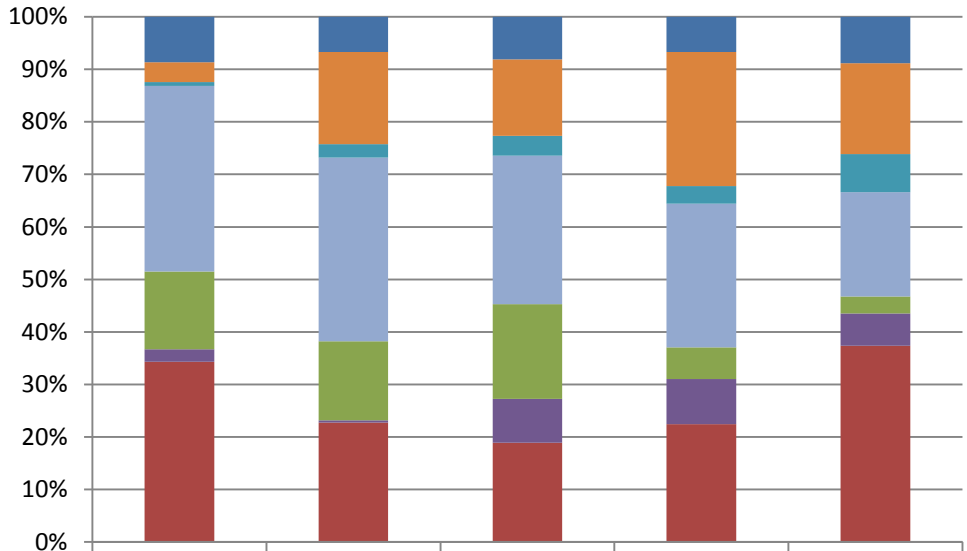
At Gehring Group, all clients are assigned a team of consultants who work on their account including: a senior benefits consultant, an account manager, a back-up account manager, an analyst, back-up analyst, and an in-house service representative. In the event a client uses BenTek, each account is additionally assigned a BenTek account manager and back up account manager. And for risk management services, a Primary Risk Manager, Risk Analyst and Safety & Loss Control personnel. This approach ensures that an entire team of experts are considering responses, resolutions, and recommendations being put forth to our clients and monitoring their success. Gehring Group's service team structure for the Village of Wellington is illustrated in **Question 11** below.

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

9. **The estimated amount of involvement expressed as a percentage of time, of each staff member assigned to this contract.**

The following chart includes actual, tracked employee service hours during the prior five-year period that illustrates the amount of involvement expressed as a percentage of time that your Gehring Group team has devoted to the Village of Wellington.

Village of Wellington Service Team
Gehring Group Employee Service Hours
Expressed as a Percentage of Time
2009-2013



	2009	2010	2011	2012	2013
Senior Benefit Consultant	9%	7%	8%	7%	9%
Risk Management	4%	18%	15%	26%	17%
Graphics/Wellness	1%	3%	4%	3%	7%
Loss Control Coordinator	35%	35%	28%	27%	20%
Analyst	15%	15%	18%	6%	3%
Account Service Specialist	2%	0%	8%	9%	6%
Account Manager	34%	23%	19%	22%	37%

10. Resumes of academic training and employment in the applicable fields of all professionals assigned to this contract.

The resumes for the members of the team servicing Wellington are included below:

EXECUTIVE STAFF

Kurt Gehring, CEO
Professional Licenses: Life, Health & Variable Annuity, General Lines Property & Casualty, Surplus Lines, Series 7
Education: Florida State University
Degree: B.S., Marketing
Kurt Gehring is an alumnus of Florida State University and an insurance industry veteran with over 25 years' experience. Kurt is an insurance expert licensed in Health, Life, and Variable Annuities, Property and Casualty Insurance, and Surplus Lines, in addition to holding his Series 7 Securities License. Kurt has successfully recommended, implemented, and serviced various types of employee

benefit, workers compensation and property and casualty insurance programs, while specializing in the large group market. Recognized for his extensive knowledge, expertise as well as his excellent communication skills, Kurt has been a featured speaker at various conferences on a variety of insurance topics.

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

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

EMPLOYEE BENEFITS CLIENT SERVICE TEAM

Senior Benefits Consultant: Christian Bergstrom
Professional Licenses: Life, Health & Variable Annuity, General Lines Property & Casualty
Education:University of Texas
Degree: B.S., Public Administration
In Christian Bergstrom's role as Senior Benefits Consultant for Wellington, he will assist in strategic and budget planning as it relates to the entity's employee benefits program, making recommendations as necessary and assisting in preparation for compliance with health care reform. He will be available as needed for meetings with decision makers and is available to make presentations as required.

For the past ten years, Christian has worked in the insurance arena. Familiar with all lines of insurance coverage, Christian is licensed to transact life, health, variable annuity, and property and casualty classes of insurance in the State of Florida. Christian Bergstrom earned a Bachelor of Science Degree in Public Administration, Cum Laude from the University of Texas. He was a Fast Track student in Public Affairs and is an alumnus of Pi Sigma Alpha, the national political science honor society.

Christian joined the Gehring Group as a Senior Evaluator in 2003. Currently in his role as Director of Analytical Services, he is responsible for directing all aspects of analysis and evaluations. His projects range from developing RFP's, bidding and compliance during the RFP process, and providing detailed analysis of the bid's analytical data in order for an appropriate recommendation to be made. During the bid and negotiation process, Christian acts as the key liaison between the client and the insurance carrier.

Mr. Bergstrom has gained a reputation within the insurance industry for his unique analytical reviews of employee benefit insurance programs. He is able to capture all aspects of a high risk, high net worth insurance program and develop a clear and concise analysis. This unique trait is appreciated by both clients and insurance carriers alike.

Primary Account Manager: Rommi Upson
Professional Licenses: Life, Health & Variable Annuity
Education: University of Florida
Degree: B.S., Business Administration
Rommi Upson, an experienced account manager with Gehring Group, will serve as the Primary Account Manager for Wellington. Her responsibilities include overseeing service staff that provides claims assistance, coordinating and conducting open enrollments and new hire orientations, coordinating wellness fairs, providing assistance with billing and carrier issues, and acting as a resource to our clients regarding numerous compliance issues. She is supported by several other Gehring Group staff members including other account managers, in-house account services representatives and analytical staff to ensure all client needs are met promptly.

A Florida Gator, Rommi earned a Bachelor of Science in Business Administration graduating Cum Laude from The University of Florida, Gainesville. Rommi is a valuable asset to Gehring Group as well as to the clients she serves due to her strong commitment to the client, her advocacy for employees, and her experience in managing both implementation and renewal of clients benefits programs with an attention to detail and deadlines. In addition to claims and billing issues, Rommi serves her clients throughout the year with enrollment support, health and wellness fair assistance, new hire orientations and a multitude of other employee benefits program services, as well as serving as the day to day contact for the organizations human resources and benefits team. Fluent in Spanish, Rommi is able to provide additional value with her ability to meet with and personally assist employees for whom English is not their primary language.

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

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

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

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

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

RISK MANAGEMENT CLIENT SERVICE TEAM

Primary Risk Manager: Ellen M. Jones, Director - Risk Management Services
Professional Licenses: General Lines Property & Casualty, Life, Health & Variable Annuities
Education: Indian River State College/Florida Atlantic University
Degree: Associates – Accounting & Business Administration
As Wellington's primary risk manager, Ellen will serve as the lead consultant and day to day contact person for Wellington's insurance program. The Village will benefit from Ellen's vast array of experience in servicing insurance and risk management programs. She has strong experience in servicing groups whose risk programs are insured by trusts, layered markets, or a combination of both.

Ellen began her insurance career in 1999, working in the Workers' Compensation arena. Currently licensed for Property and Casualty General Lines as well as Life and Health products, her wealth of experience has provided our clients with a vast knowledge of all insurance lines and the comprehensive management that is required in successfully placing and implementing these insurance programs.

In 2003, Ellen joined the Gehring Group as a senior level Account Manager. In her current position as Director of Risk Management Services, she continually assists clients in the bidding and renewal of insurance programs as well as providing them with analytical reports on loss control and safety procedures. Her primary function is to ensure that all necessary steps and procedures are accomplished while remaining involved in the continuity and effective outcome of all processes. Her organizational and professional experience is an invaluable asset to our clients throughout the policy term as unexpected needs may arise or as questions or concerns present themselves. Analytical, detailed, and proactive – Ellen is a valuable member to the employer organizations she services.

Ellen also brings with her six years of experience in the public sector. During her municipal tenure, she was responsible for State and Federal grant programs verifying accuracy and compliance within each process. Her responsibilities included purchasing operations where she gained extensive familiarity with public entity requirements to include the RFP process.

An active member of the Chapter of the Risk and Insurance Management Society (RIMS), Ellen is a uniquely qualified and talented professional industry embodying a depth of knowledge and experience in both property and casualty and employee benefits insurance programs.

Primary Risk Analyst: Rodney Louis, Senior Analyst
Professional Licenses: General Lines Property & Casualty, Life, Health & Variable Annuities
Education: Florida State University
Degree: B.S., Finance
Rodney will serve as the primary analyst for Wellington for all services related to the Village's property and casualty insurance program. Rodney will work with Ellen Jones in the marketing, renewal and recommendation for placement of this coverage, providing services to the Village that include but are not limited to:

- Evaluation of the Village's insurance program
- Preparation of insurance specifications
- Analyzing bid responses and evaluation of proposals
- Contract review and interpretation as necessary or requested

Rodney Louis, a Florida State Alumni, has been an insurance industry professional since 1997 and is licensed in property, casualty, life and health products. When he joined the Gehring Group as an analyst, he brought with him 12 years of industry experience. His broad experience and extensive licensing provides our Gehring Group clients with an invaluable resource to assist in the development and recommendation of a comprehensive, competitive risk program.

Rodney spent the early part his career working for a national rating firm providing crucial analysis on the stability and creditworthiness of both the insurance and banking markets. Rodney then broadened his scope of the insurance industry by becoming licensed for property and casualty insurance. From 2003-2009, he was a managing partner of a full service brokerage firm and managed their underwriting, agent development and program analysis divisions.

Rodney's proficiency in property & casualty and workers' compensation insurance make him an ideal fit for the Gehring Group and our endeavor to provide wide-ranging, professional services and solutions to our clients.

Safety/Loss Control Account Manager: Stuart J. Morgan, Safety/Loss Coordinator
Professional Licenses: Airline Transport Pilot
Education: Embry-Riddle University
Degree: B.S., Aeronautical Science
Stuart will serve as the Safety/Loss Control Account Manager for all safety, loss and claims services as it relates to the Village's Risk Management program. Stuart's responsibilities would include monitoring, analyzing, and report generation on client loss run data. Stuart employs a combination of experience, knowledge, and enthusiasm to deliver achievable, proven, and innovative programs.

After graduating with honors from Embry-Riddle University, Stuart Morgan began his career as a commercial airline pilot for one of the major airline carriers. With his 20+ years in the industry, Stuart brings a lengthy background in the aviation safety services arena. He joined the Gehring Group team in 2004 with the responsibility of providing our clients with safety and loss control services. His responsibilities include monitoring, analyzing, and report generation on client loss data for the purpose of identifying hazards and trends in the workplace. He then utilizes this data for use in facilitating safety programs based upon client needs and trends. These reports are also shared

with account management and analytical staff for use in the renewal process. Stuart also assists clients and staff by attending and participating in safety committee meetings to help identify hazards or training deficiencies which may require unique, specialized training parameters. Through coordination with outside vendors to include equipment manufacturers/reps, chemical handling specialists, and motor vehicle safety operations, a training program will be developed.

Another area of Stuart's expertise involves coordination and implementation of the BenTek/Summit On-line safety training program, whereby select safety training courses are conducted via the internet, effectively increasing employee standardization and efficiency. Our program allows clients to further craft a safety program tailored to specific needs of a department and affords staff the ability to print certificates and track safety program attendance.

ADDITIONAL TECHNICAL RESOURCES:

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

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

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

Kate brings her extensive management, finance, audit and analytical experience, and customer service commitment to her leadership role with the Gehring Group. Kate is a legislative compliance lead on the Health Care Reform Acts for our clients, and is respected as a highly regarded speaker on

health care reform updates for various conferences and groups. Additionally, administratively, Kate is responsible for overseeing the growth and development of the Company's finances, infrastructure, and staff so that Gehring Group is able to meet its commitment to provide the highest level of customer service to its clients.

Cindy Thompson, Vice President – Operations
Professional Licenses: Life, Health & Variable Annuity
Education: Palm Beach Atlantic University
Degree: B.S., Finance & Banking
As Vice President of Operations for Gehring Group, Cindy is responsible for providing senior level leadership and operations guidance to the organization and its team members. An 18 year veteran of Gehring Group, holding her Health, Life, and Variable Annuity Insurance License, Cindy brings a full array of talents and experience to her position, and serves as a valuable resource in various benefit related areas including employee benefits best practices, compliance and legislative issues, and technical and analytical tools. Her quest for in depth, rather than cursory understanding of the complexities of employee benefits laws complement her experience in servicing all aspects of an employee benefits program including analytical services, account management and wellness. Her responsibilities have included developing Requests for Proposals, preparing bid evaluations from responses received from the insurance market, and negotiating with carriers on behalf of many large employers throughout the State of Florida. Her expertise also extends to the various insurance plan funding arrangements including fully insured, self-insured and minimum premium arrangements, implementation of new programs and/or new carriers, enrollment and communication of group insurance benefits, as well as the day to day service requirements associated with administering a cost effective and administratively efficient employee benefits program.

Cindy's participation in coordinating and designing innovative program solutions to clients ranging from 50 employees to 20,000 employees that are fully insured, self-insured or under other types of funding arrangements brings value to every discussion as she offers history and experience, together with a methodical implementation and troubleshooting perspective, while considering and recommending forward thinking solutions. A valued member of the executive team, Cindy works with management to ensure overall client satisfaction and quality expectations. Cindy holds a Bachelor's degree from Palm Beach Atlantic University, where she majored in Finance, Banking, and Business Administration.

Anna Maria Studley, Managing Director
Professional Licenses: Life, Health & Variable Annuity
Education: Suffolk Community College
Degree: Associates – Accounting and Business Administration
Anna Maria Studley is a seasoned professional with 30 years of experience in the insurance industry and has obtained vast experience undertaking many roles in the insurance sector. Her work history includes time as a General Agent and a Consultant, experience with two national insurance carriers, owning and operating a third party administration company, and experience as Director of Account Management with a national brokerage firm. Her responsibilities have included: providing analysis of benefit plans and claims utilization, oversight of the RFP and evaluation process, management of various funding arrangements, coordination of open enrollments and health fairs, and the handling

of escalated member issues and billing reconciliation. Licensed in 26 states, she has also serviced such large employers as IBM and FPL where she managed several multi-state employee benefit programs, performed health insurance claim audits and assisted with the completion of required Form 5500's. Her expertise in compliance issues, state and federal regulations also make her a valuable asset the Gehring Group team and the clients she serves.

In addition, Anna Maria brings invaluable insight and experience from her employment experience with two national health insurance carriers. Her years at these carriers enabled her to gain special expertise regarding the inner workings of an insurance carrier and provided the opportunity for the establishment of significant industry relationships. As the Managing Director of Gehring Group's client service staff, Anna Maria is responsible for overseeing all aspects of account management and technical analysis to ensure delivery of the highest level of service with the ultimate goal of achieving both client and member satisfaction. She is supported by several other Gehring Group staff members including account managers, benefits specialists and analytical staff.

Brien Muschett
Managing Director – Software Development & Architecture
Education: University of Miami
Degree: Masters, Computer Science
Brien Muschett completed his undergraduate studies in Computer Science at Florida Atlantic University, after which he earned his Master's in Computer Science from the University of Miami. Brien brings over 20 years of experience in software development across operating systems, technology domains and client/server topologies. During his 20+ years as a Senior Software Engineer at IBM, he was the lead software developer or team lead for numerous software and integration assignments.

In his current role as BenTek's Managing Director – Software Development & Architecture, Brien is responsible for BenTek's software architecture as well as overseeing product development. His ability to quickly identify software deficiencies and integrate solutions to accomplish practical applications has quickly made him a valuable member of the BenTek team. Additionally, Brien's resume includes several publications and 15+ patents in the United States, Korea and China.

Julie Curtis, Director of Client Management
Professional Licenses: Life, Health & Variable Annuity
Julie Curtis graduated Cum Laude with a Bachelor of Arts Degree in Psychology from Rowan University. During this time, she also began her career in the public sector as the Employee Benefits Specialist for this New Jersey State University, learning the many facets of employee benefits administration as well as taking on the responsibility for many human resources duties. During her tenure, Julie earned recognition for her achievement in managing a successful benefits program, pension programs, coordinating annual open enrollments, and the development and implementation of new processes and procedures within her department.

This knowledge of benefits administration within the public sector has proven a valuable asset in her current position as Director of Client Management for BenTek, Inc. Over the past six years, she has been extensively involved in the development and evolution of BenTek as the system of choice for online enrollment and benefits administration amongst Florida public sector entities. During the

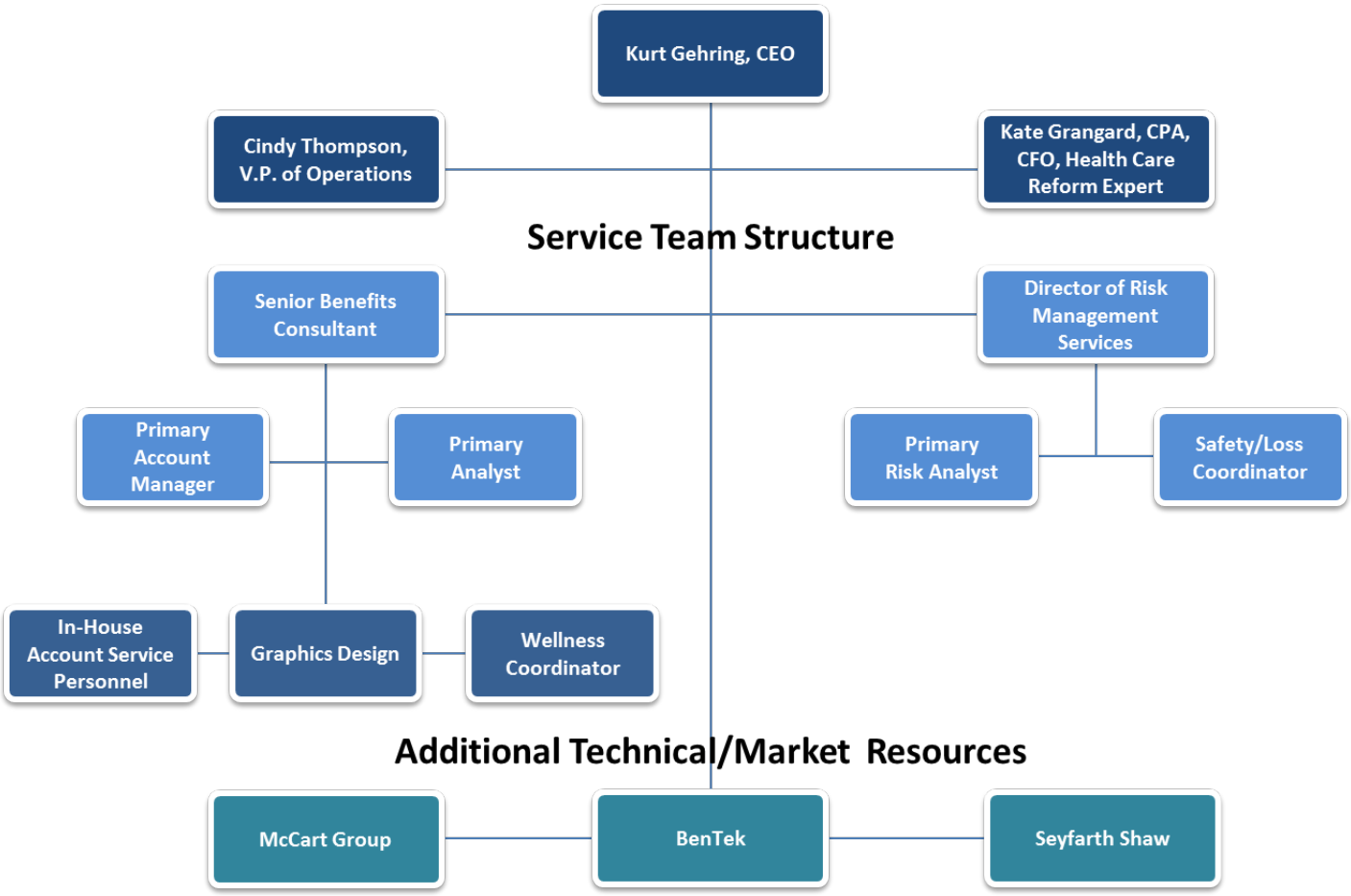
system's initial development phases, Julie was responsible for evaluating all BenTek® functionality, ensuring smooth client implementations, and providing technical and administrative support to clients. As the Director of Client Management, Julie is responsible for overseeing all BenTek® implementation processes, and in her tenure has implemented over twenty-five public sector clients within the state.

Julie also oversees the BenTek® Support Department that is known for providing excellent technical support, assisting clients and their employees with any questions or concerns regarding BenTek applications. Using her extensive knowledge of the BenTek® system, Julie continues to provide innovative and cutting-edge ideas to enhance the system's applications to better serve both existing and new clients.

11. Submit an outline of the elements and organizational structure of the team established to manage the project. Include the administrative operation and key personnel and their area of responsibility.

As stated in **Question 7** above, Gehring Group's service team for the Village of Wellington consists of highly qualified personnel whose resumes include years of consulting on and servicing public sector clients. Your service team includes the following personnel and their service roles are outlined in the corresponding chart below:

Employee Benefits:	**Property/Casualty (Risk Management)**
Executive Staff: Kurt Gehring, CEO	Executive Staff: Kurt Gehring, CEO
Senior Benefits Consultant: Christian Bergstrom	Risk Manager: Ellen Jones
Account Manager: Rommi Upson	Risk Analyst: Rodney Louis
Primary Analyst: Brian Beatty	Safety & Loss Control: Stuart Morgan
Account Service Specialist: Cheryl Marciano	
Wellness Coordinator: Sarah Brown	



The areas of responsibility for the above personnel are outlined in detailed in Question 7 above.

12. Provide years of experience and background of personnel assigned to Wellington including any projects/contracts comparable and specific to this project.

Gehring Group's proposed service team includes the following individuals:

EMPLOYEE BENEFITS CLIENT SERVICE TEAM

Senior Benefits Consultant:	Christian Bergstrom, Senior Benefits Consultant
Industry Tenure:	13 years
Years with Gehring Group:	10 years
Comparable Public Sector Accounts:	Jupiter, Town of, 350 employees
	Key West, City of, 440 employees
	Oakland Park, City of, 250 employees
	Naples, City of, 435 employees
	Solid Waste Authority PBC, 400 employees
	Stuart, City of, 230 employees

Primary Account Manager:	Rommi Upson, Account Manager
Industry Tenure:	2 years
Years with Gehring Group:	2 years
Comparable Public Sector Accounts:	Oldsmar, City of, 140 employees Keys Energy Services, 250 employees

Primary Analyst:	Brian Beatty, Analyst
Industry Tenure:	4 years
Years with Gehring Group:	2 years
Comparable Public Sector Accounts:	Tax Collector, Palm Beach County, 230 employees Key West, City of, 440 employees Dunedin, City of, 350 employees North Palm Beach, Village of, 184 employees Cocoa, City of, 411 employees Wellington, Village of, 250 employees Oldsmar, City of, 140 employees Keys Energy Services, 275 employees Family Central, Inc., 360 employees Florida Keys Aqueduct Authority, 250 employees

Wellness Coordinator:	Sarah Brown, Wellness Coordinator
Industry Tenure:	4 years
Years with Gehring Group:	1 year
Comparable Public Sector Accounts:	Cocoa, City of, 411 employees Family Central, Inc., 360 employees Stuart, City of, 230 employees Jupiter, Town of, 350 employees

RISK MANAGEMENT CLIENT SERVICE TEAM

Executive Staff:	Kurt Gehring, CEO
Industry Tenure:	25 years
Years with Gehring Group:	21 years

Account Manager:	Ellen Jones, Director – Risk Management
Industry Tenure:	15 years
Years with Gehring Group:	10 years
Comparable Public Sector Accounts:	Palm Beach County Sheriff's Office North Palm Beach, Village of Charlotte County BOCC Tequesta, Village of Jupiter Island, Town of

Analyst:	Rodney Louis, Senior Analyst
Industry Tenure:	16 years
Years with Gehring Group:	4 years
Comparable Public Sector Accounts:	Clerk & Comptroller, Palm Beach County North Palm Beach, Village of Keys Energy Services Dunedin, City of Monroe County Board of Commissioners

Safety/Loss Control Account Manager:	Stuart J. Morgan, Safety/Loss Coordinator
Industry Tenure:	10 years
Years with Gehring Group:	10 years
Comparable Public Sector Accounts:	Keys Energy Services Dunedin, City of Lake Park, Town of

Additional information regarding experience and background are included the individual resumes included under **Question 10** above.

13. **Financial Capability/Stability: To evaluate the financial ability of the proposer to perform the required services, an individual or corporation financial statement shall accompany this proposal which includes a full fiscal year and current date of income statements and balance sheets. The proposer shall provide a statement of its financial condition as of the close of business as of December 31, 2013, and shall certify that the information provided on the financial statement is true, accurate and complete, correctly reflecting the financial condition of the proposer on the aforementioned date.**

Gehring Group is organized as a Florida Subchapter S corporation, of which Kurt Gehring is the Principal owner. As a non-public company, Gehring Group does not prepare or file audited financial statements for public distribution or file with the Securities and Exchange Commission. Under the direction of Kate Grangard, CFO, a Florida Certified Public Accountant, Gehring Group employs a conservative fiscal approach and prudent decision making. The predominant portion of Gehring Group's revenue is received from monthly commissions and consulting fees and Gehring Group has enjoyed continuous, year to year operating profitability. Gehring Group maintains a positive capital balance and reinvests its profits into the development of client oriented services and technology such as BenTek®. In addition, Gehring Group maintains a strong banking relationship, reference to which is available upon request.

REFERENCE FORM (To be included with TAB#3)

COMPANY NAME, ADDRESS, CITY, STATE, ZIP PHONE & FAX NUMBER		
Company Name: Palm Beach County Sheriff's Office		
Address: 3228 Gun Club Road		
West Palm Beach, FL 33406		
Contact Name: Hilda Gonzalez, Manager, Risk & OHS		
Phone: (561) 688-3003	Fax: (561) 688-3538	E-Mail: GonzalezH@pbso.org
Company Name: City of West Palm Beach		
Address: 401 Clematis Street		
West Palm Beach, FL 33401		
Contact Name: Patricia Brosamer, HRIS & Employee Bfts. Mgr.		
Phone: (561) 494-1013	Fax: (561) 494-1035	E-Mail: pbrosamer@wpb.org
Company Name: Village of North Palm Beach		
Address: 501 US Highway 1		
North Palm Beach, FL 33408		
Contact Name: Loren Slaydon, H.R. Director		
Phone: (561) 841-3358	Fax: (561) 848-3344	E-Mail: Walt.Black@charlottefl.com
Company Name: Town of Jupiter Island		
Address: 2 Bridge Road		
Hobe Sound, FL 33455		
Contact Name: Gwen Carlisle, Town Clerk		
Phone: (772) 545-0103	Fax: (561) 748-0381	E-Mail: gcarlisle@tji.martin.fl.us

REFERENCE FORM (To be included with TAB#3)

COMPANY NAME, ADDRESS, CITY, STATE, ZIP PHONE & FAX NUMBER		
Company Name: Town of Lake Park		
Address: 535 Park Avenue		
Lake Park, FL 33403		
Contact Name: Bambi McKibbon-Turner, Human Resources		
Phone: (561) 881-3310	Fax: (561) 881-3314	E-Mail: bturner@lakeparkflorida.gov
Company Name: Village of Tequesta		
Address: 345 Tequesta Drive		
Tequesta, FL 33469		
Contact Name: Merlene Reid, Human Resources Manager		
Phone: (561) 575-6200 ext.256	Fax: (561) 768-6203	E-Mail: mreid@tequesta.org
Company Name: City of Dunedin		
Address: 750 Milwaukee Avenue		
Dunedin, FL 34698		
Contact Name: Bonnie Steinberg, Human Resources & Risk/Safety Manager		
Phone: (727) 298-3042	Fax: (727) 298-3052	E-Mail: bsteinberg@dunedinfl.net
Company Name: Charlotte County BOCC		
Address: 18500 Murdock Circle		
Port Charlotte, FL 33948-1094		
Contact Name: Walt Black, Risk Manager, Environmental Health & Safety/ADA Coorinator		
Phone: (941) 743-1260	Fax: (941) 743-1254	E-Mail: Walt.Black@charlottefl.com

EMPLOYEE BENEFITS TECHNICAL APPROACH

Gehring Group has assisted the Village in accomplishing the goal of maintaining a competitive, yet cost effective employee benefits program year over year. The services we provide include expert knowledge of the insurance industry and all available programs and funding options, consistent monitoring of the program claims experience, review of contract language, and the provision of budgetary projections and funding recommendations. Inherent in this process is marketing and renewal analysis, the RFP and evaluation process, recommendations to staff and assistance with compliance issues such as domestic partner and overage dependent imputed income administration. Additional provided services include benefits communication and graphics services, new hire and open enrollment assistance, assistance with claims and billing issues and legislative compliance include Health Care Reform. In addition, your Gehring Group team is available year-round for onsite meetings with Staff, committees, Council, or the general employee population. Our in-house graphics department is also available to design and produce various employee communication pieces in addition to our annual Employee Benefits Highlights booklet that is customized according to your benefits options.

Gehring Group operates under a unified service approach, whereby all staff is responsible for the successful servicing of all clients. We are able to employ this approach, as we do not have commissioned sales representatives on staff. Each staff member is considered an important part of the team. We hire highly qualified, professional, productive individuals who bring the skills and capabilities to meet our stringent expectations. As a Company, we provide our employees the technology and tools to perform their duties and responsibilities as required, including the use of a web based task management system to track items needing resolution.

When onboarding a new client, Gehring Group's first priority is to meet with Staff to determine what they deem to be the positive aspects of their program as well as any areas of particular concern. This includes a review of all lines of coverage and benefits included in their total employee benefits program package. In addition, we would want to determine the budget impact of the 2014 requirements relating to the new definition of "full time employee" under the PPACA legislation. This includes ensuring that group's waiting period for benefits does not exceed 90 days and determining which of Wellington's current "part-time employees" may be working an average of 30-hours per week and thus would become eligible for benefits in 2014. Our goal is to make recommendations regarding health plan options and planning strategies to aid our clients in preparing for 2014. Since many employers may already be in the "Measurement Period" of determining which "Part-time" employees will be eligible for benefits in 2014, it is imperative that this aspect of the law be addressed as timely as possible in order to incorporate into any potential marketing or RFP process. **Due to Gehring Group's longstanding relationship with the Village, we have already met with Village Staff to address each of the above processes for the current plan year.**

Gehring Group's traditional marketing process includes a comprehensive analysis of the current programs, past programs, claims history, in addition to numerous other factors including demographics and the local market. In addition to reviewing the incumbent carriers' renewal quotes, we would review a list of prospective carriers, coalitions & trusts with Staff in discussing whether to release any RFP's for the various lines of coverage. As an independent agent, our goal is to ascertain that all available products and insurers are considered to ensure that Wellington finds the best match for its needs. In addition, Gehring Group staff is also focusing on preparing our client employers for the 2014 compliance

requirements of **Health Care Reform** which must now be a consideration in any bid or renewal process. Our marketing process typically includes the following steps which are further explained below:

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

STEP ONE: INFORMATION GATHERING PROCESS

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

STEP TWO: PRESENTATION OF INITIAL FINDINGS

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

STEP THREE: PRESENTATION TO THE MARKET

Gehring Group would assist in conducting all phases of the procurement process for those lines of insurance deemed suitable for bidding. Our involvement in this process can be as comprehensive as Wellington wishes. Once we have reviewed all necessary background information, we will work with staff to compile all RFP's for submission to the insurance market. This includes negotiating renewal rates, working with the procurement division to maintain integrity with the bid process as well as issuing bid specifications directly to the market. Gehring Group has vast experience in the solicitation of all types of insurance and we are confident that acquisition of various competitive options will be accomplished.

To effectively market an employee benefits plan, we at Gehring Group consider many factors. We must present and negotiate a plan that is in line with our clients' goals, contribution structure, plan design, network availability and entity structure. In addition to the required information such as census data, plan design and claims experience, we also consider the various other aspects involved in the decision making process. One of these aspects is the current employer/employee contribution structure and the entity's ability to maintain current levels based on fiscal limitations or budgetary constraints. Another consideration is the 9.5% affordability rule as it relates to the Pay or Play penalty under PPACA. Yet another consideration is the level of benefits included in the plan design and the 2014 PPACA

requirement that the plan be “Affordable” and provide a level of coverage that is of “Minimum Value”. Health insurance and employee benefit plans are often considered significant recruiting tools for public sector employers; therefore, some employers place a high priority on offering the most competitive benefits program they can afford. Another important consideration is the physical location of the entity. Location with the state may have an impact on how robust each provider network is as well as the level of provider discounts.

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

STEP FOUR: PROPOSAL ANALYSIS

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

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

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

STEP FIVE: PROGRAM IMPLEMENTATION

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

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

- Review all programs implemented and continue project along same format.

STEP SIX: YEAR-ROUND SERVICE

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

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

COMPREHENSIVE EMPLOYEE BENEFITS CONSULTING SERVICES

Gehring Group is a leading provider of employee benefits whose success is driven by our expertise, experience, independence and integrity as well as our people and our commitment to remain the consultant of choice to our clients. Below is a comprehensive list of services provided and available:

- Generate the Request for Proposal (RFP) upon request for all lines of employee benefits insurance
- Negotiate renewals for all lines of employee benefits insurance
- Evaluate core and voluntary coverage offerings and check for coverage gaps
- Evaluate plan designs and funding options
- Access to the Gehring Group Client Portal
- Access to Benefit Resource Center
- Access to *HR Answers Now* online Human Resources Research tool
- Produce in-depth evaluation booklets
- Make recommendations to Staff
- Make presentations to decision makers and insurance committees and/or union representatives if applicable
- Design and provide open enrollment communication materials, including employee benefits booklet, payroll stuffers and posters as requested
- Implement programs and changes
- Coordinate and make presentations at enrollment meetings upon request
- Coordinate and review all plan documents and summary plan descriptions
- Review insurance contracts for conformity with client administration of programs
- Present benefit offerings at new employee orientations
- Formulate PowerPoint presentation for New-Hire Orientations to ensure consistency
- Meet with Staff regularly to review overall program efficiency
- Coordinate and attend health fairs and wellness seminars
- Provide updates on trends affecting client's benefits plans on an ongoing basis
- Strategize with staff to develop and assist with Wellness initiatives

- Develop customized plan design options as needed (i.e., high deductible plans, three tiered medical options, flex benefit plans, etc.)
- Generate employee education materials as requested
- Assist in the resolution of employee claims issues and expedite employer resolution of contractual, coverage, eligibility and billing disputes
- Provide guidance with regard to interpretation of the health care benefit policy
- Represent client with best efforts regarding its employee benefits and when dealing with service providers.
- Obtain specific reports and information from service providers in a timely manner
- Develop, conduct and summarize the results of a variety of surveys including physician selection, employee satisfaction, and industry trends
- Provide annual actuarial filing of self-funded health plan via independent actuary
- Provide the staff/resources/consultants that possess expertise in the following fields:
  - Health Care Reform
  - Developing Requests for Proposals
  - Senior level administration
  - Group insurance underwriting
  - Statistical analysis
  - Plan design
  - Cost containment
  - Federal and State compliance regarding employee benefits
  - Employee communication materials design
- Provide legislative and regulatory updates
- Assist with compliance issues, including but not limited to:
  - ERISA compliance and Federal Form 5500 preparation
  - OPEB
  - COBRA
  - Section 125 Cafeteria Plan
  - Federal mandated benefits, such as HIPAA
  - State mandated benefits
  - Actuarial filings
- Provide periodic educational training sessions to educate staff/decision makers regarding available benefit option components for consideration (ex: HRA's, FSA's), upon request
- Conduct detailed reviews, analysis and projection sessions with decision makers at key points throughout the year: mid-year, fourth quarter, and/or pre-renewal

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

Health Care Reform Compliance

Gehring Group is proactively addressing each of the requirements on behalf of all of our clients to ensure that all policy renewals subject to the mandates are in compliance with the Health Care Reform legislation. This includes such requirements as the removal of all lifetime benefit limitations and the removal of pre-existing limitations for children under 19, and the coverage of dependents to age 26. We have proactively hosted a number of informational seminars and webinars on the new laws for our clients so that they have all the information needed to be adequately prepared for the

upcoming mandates. (Please refer to the **Exhibits** section for examples.) Topics have included MLR Rebate Distribution, W-2 Reporting of Employer Sponsored Health Coverage, Determining Seasonal and Variable Employees and the Employer Shared Responsibility Penalty (a.k.a. Pay or Play). As Health Care Reform continues to evolve, Gehring Group will diligently review all newly available product offerings to ensure that our clients are always presented with the best available options while complying with all mandates and requirements of the health care reform legislation.

Clinic Consulting

Gehring Group also assists our clients in the decision of whether to open an on-site health clinic. If requested, Gehring Group is able to conduct a feasibility analysis to determine if our clients can take advantage of the potential cost saving benefits of opening an on-site or near-site clinic. By shifting costs from the medical plan to the clinics, many groups have been better able to manage specific areas of claims costs, while providing additional access to medical care to their employees. Gehring Group has experience in conducting the bid process to determine which clinic provider and clinic model would best meet the needs of our clients, and in addition, is available to oversee the implementation process once a decision has been made. Our staff coordinated and conducted the entire bid and implementation process for over a dozen employer health clinics during the past five years. **Gehring Group navigated the Village through the RFP, evaluation, contract negotiation and implementation process with the current vendor, MD Now. Please refer to Exhibit D: Sample Analytical Reports for an 18 month Return on Investment Summary Analysis for your review.**

Continuous Plan Analysis

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

Consistent Client Contact

Gehring Group and the client determine a convenient schedule to meet. These meetings can take place quarterly, semi-annually or as needed. Gehring Group strives to be available to our clients whenever the need arises. **Currently, your Gehring Group Account Manager conducts monthly new hire orientations and attends additional onsite meeting as required.**

Development of Requests for Proposals/Quotes

Gehring Group would conduct all phases of the procurement process for those lines of insurance deemed suitable for bidding. Our involvement in this process is very comprehensive. We feel it is our job to educate you on any new products in the industry that may reduce administrative burden or aid in the reduction of health care costs. Gehring Group maintains strong relationships with all the major insurance carriers and only places business with financially stable and highly rated companies. **Gehring Group regularly bids the Villages programs to the market to ensure the most cost competitive and comprehensive program.**

Plan & Proposal Evaluation

Gehring Group will consistently provide thorough examination of all proposals received during a bid process. We will compare all proposals to the in-force program and illustrate the program differences to include the advantages and disadvantages of each. This will include a detailed cost

comparison which outlines the total cost of the program in addition to breaking down the costs related to employer and employee contributions. During this process, we will also compare provider networks to determine which proposers may be considered viable options.

Plan Renewals & Effective Negotiations

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

Program Implementation

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

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

Ongoing/On-site Service

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

Employee Surveys

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

Employee Benefits Handbook

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

Professional Employee Communications

Gehring Group employs an in-house Graphics Department. This enables us to assist our clients with employee communication materials. As part of our services, we draft and produce employee communication pieces such as payroll stuffers, department posters, mass employee mailings, etc. This allows our clients to better communicate its employee benefit offerings and keep their employees well educated with regard to their employee benefit options and responsibilities. All of

the work products and samples included in the **Exhibits** section were created and produced in house.

Legislative Compliance & Updates

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

In addition, Gehring Group has taken a very hands-on response to the 2010 health care reform legislation and will take the lead in addressing each of the requirements on behalf of the Village of Wellington to ensure that all policy renewals subject to the mandates comply with this new legislation. This includes such requirements as the removal of all lifetime benefit limitations, the removal of pre-existing limitations for children under 19 for example and the W-2 reporting of employer sponsored health benefits. With 2014 fast approaching, we are now in the process of preparing our clients to address the additional requirements of the law including but not limited to:

- Ensuring benefits waiting periods are no greater than 90 days
- Proper distribution of Summaries of Benefits & Coverage (SBC)
- Determining whether part-time, variable hour and seasonal employees will be eligible for benefits
- Evaluating exposure to penalties under the Employer Shared Responsibility Provision (a.k.a. Pay or Play)
- New Non-discrimination Rules for fully insured plans (still awaiting guidance)
- Affordability (9.5% rule) and Minimum Actuarial Value
- Notification requirements regarding the availability of the State or Federal Exchange/ Marketplace (deadline delayed to September 2013)

Gehring Group has hosted a number of informational seminars on the new laws for our clients at several locations throughout the state over the past three years in addition to one on one meetings, to ensure that they have all the information needed to be adequately prepared for the upcoming mandates and are comfortable in their understanding of the new requirements. As health care reform continues to evolve, Gehring Group will diligently review all newly available product offerings to ensure that our clients are always presented with the best available options while complying with all mandates and requirements of the health care reform legislation, and will continue to host educational seminars throughout the state. Gehring Group not only educates our clients in this ever-changing environment, but also reviews all product offerings to ensure compliance with federal, state, and local laws and regulations related to employee benefits.

Produce Formal Proposals / Make Presentations

Gehring Group is available to make presentations to all staff groups or employee committees as needed. We can create PowerPoints and customized spreadsheets and recommendations based on the specific purpose of the presentation and needs of your group.

RISK MANAGEMENT TECHNICAL APPROACH

As the Village's current Risk Management Consultant, we provide services that include expert knowledge of the insurance industry and all available programs and funding options, consistent monitoring of all open claims, including reserves and loss ratios, review of contract language, and the provision of budgetary projections and funding recommendations. Inherent in this process would be marketing and renewal analysis, the RFP and evaluation process, recommendations to staff and assistance with compliance issues. We provide thorough analysis of the potential risks our clients face and potential solutions that might be implemented to avoid, manage or mitigate those risks. Perhaps the most valuable thing we do is to develop innovative concepts and coverage's tailored to each client's specific needs. **Gehring Group has maintained longstanding relationship with the Village who has been able to benefit from our expert advice, creative approach, strong market relationships, and comprehensive, hands-on service.**

Risk Assessment and Analysis

When onboarding a new client, Gehring Group's first priority is to gather all information pertinent to current insurance programs. We meet with staff regularly to determine what they deem to be the positive aspects of their program as well as any areas of particular concern. This includes a review of all lines of coverage, potential gaps or duplications, funding philosophies and budgetary goals.

Where possible, we collect copies of insurance policies and currently valued loss runs to further our understanding of the current program. Upon further review, the Gehring Group will produce a concise analysis of each line of insurance along with a recommendation for seeking renewal quotations from the marketplace. A facility tour and completion of a *Risk Assessment Questionnaire* (see **Exhibit H**) would be requested in order to prepare documentation needed for the upcoming renewal process. Once the Village has determined and communicated its insurance risk and management objectives to Gehring Group, the design and placement of the appropriate insurance coverages represents the second phase of the risk management process.

Due to our specialization in the public entity market, we maintain access to comparative data from numerous public sector entities that is often reviewed to determine which insurance carriers and/or trusts offer coverage options best suited to the Village's risk management program.

Details of our approach:

Gehring Group's approach to servicing the Village of Wellington would begin with the following steps:

Phase 1

- Identify and meet with key managers and operational personnel.
- Collect data including existing policies, currently valued loss runs, financial documents (budget/CAFR), contracts, property leases, informational brochures and historical information on the organization, property schedules, drug free workplace and safety program documents, and any other data that would value or describe the operations and/or exposures.
- Discuss resources that identify exposures and/or coverages that are important or unique for the Village.
- Establish a timeline to follow throughout the process including budget workshops and meetings, presentations to staff and/or committees, and presentation to the Village Commission.

Phase 2

The next step would be to analyze the Village's existing insurance programs, collect data on operations to identify any duplications or gaps in coverage, also, identify how Gehring Group might best service the specific needs of the Village of Wellington with the unique services offered by our organization as outlined below:

- Review the accumulated data for understanding of the program, and identification of gaps or duplications in coverage.
- Make recommendations or additions or revisions to the existing insurance program where applicable.
- Request a Maximum Potential Loss (MPL) or Potential Maximum Loss (PML) to determine State acceptable limits of insurance.
- Analyze loss ratios by line of coverage to identify trends or specific effectiveness of safety programs being utilized.
- Assess service needs and define specific Gehring Group services that might include risk control and safety engineering, safety training, drug-free workplace and safety program credits, coverage audits (where applicable) and required reporting needs.
- Prepare a thorough submission for the insurance marketplace that includes collected data and Gehring Group coverage and service recommendations.

Loss Control

Gehring Group will assist in the enhancement of the Village's current program while maintaining the objectives and priorities established for loss control related to risk and insurance costs. Prior to developing a training schedule, a detailed review of losses would be needed to create pertinent programs for general safety, ergonomics, defensive driving, environmental exposures, etc. Safety training manuals will be reviewed and revised for the Village, if requested.

In summary, Gehring Group services may include:

- Assisting safety and loss control personnel in the enhancement of current programs through a review of losses, site inspections, safety committee meeting attendance, training, etc.
- Quarterly claims reviews.
- Review current programs to address vehicle exposures.
- Conduct and/or coordinate training programs.
- Risk control services including guidance on environmental concerns, industrial hygiene and occupational health concerns.
- Working with the Village and carriers to devise cost effective approaches to loss prevention that reduce both the severity and frequency of loss. Gehring Group will coordinate carrier loss control services and reports. Prior to transmittal to the Village, Gehring Group will review reports for quality and validity of recommendations. We will also facilitate annual review meetings with appropriate insurance carriers and discuss the quality of servicing, insurability concerns and recommendation review.

Claims

We use our claim advocate experience with insurers, third-party administrators, and others to assure proper claim reporting/administration procedures. Comprehensive claims management is vital in

controlling the cost of losses and ultimately the Total-Cost-of-Risk (TCOR). The Village will benefit greatly when there is intensive, consistent and ongoing oversight of the claims management process.

We will assist the Village in the following areas:

- Act as liaison between the Village and the claims service provider(s).
- Assist in reporting of claims (where appropriate) and act as the Village's advocate in settlement/reserve dispute situations.
- Review, analyze and assist in the resolution of large claims.
- Audit claim files to evaluate reserves.
- Make recommendations on settlements and appeal claim denials on complex claims.
- Provide education for claim procedures and reporting requirements (if needed).

Loss Reporting

- Review coverage, deductibles, limits and restrictions.
- Analyze large losses, review reserves for adequacy.
- Analyze presumption claims and review reserves.
- Arrange for quarterly meetings with appropriate attendees.
- Monitor loss development and provide reporting on frequency. (Sample Workers' Compensation Injury Analysis Report included in **Exhibit D.**)

Loss Coordination

- Gain agreement with the adjuster on steps to be taken.
- Evaluate potential exposures in light of coverage.
- Establish a preparation time frame.
- Implement a means of capturing all loss expenses.
- Prepare a strategy to resume operations.
- Review coverage and identify policy limitations and requirements, respond to reservation of rights letters.
- Advice in pursuing responsible third parties for the recovery of uninsured portions of loss. After final settlement, we continue to maintain contact with adjusters regarding subrogation efforts.
- Track claims to identify trends in frequency and severity, and develop remedial measures if necessary.

We review available claims reports no less than quarterly to determine whether your programs are running favorably and to develop safety and loss programs that will help to minimize future claims from occurring.

Marketing

Gehring Group would conduct all phases of the procurement process for those lines of insurance deemed suitable for bidding. Our involvement in this process can be as comprehensive as the Village wishes. Once we have reviewed all necessary background information, we will work with staff to compile all RFP's for submission to the insurance marketplace. This includes working with the procurement division to maintain integrity with the bid process as well as issuing bid specifications

directly to the market. Gehring Group has vast experience in the solicitation of all types of insurance and we are confident that the acquisition of various options will be accomplished.

Gehring Group's team includes seasoned marketing specialists who develop placement strategies tailored to each client's profile and needs. It should be noted that:

- Each client must be differentiated from its peers, not homogenized in the marketplace.
- Insurance should not be a volume business.
- Every client deserves its own best deal.
- Underwriters respond to Gehring Group because of our hands-on knowledge of our clients and the delivery of complete underwriting information to them during the renewal process.

Market Security & Canvassing

A sample of the wholesale agents/brokers utilized by the Gehring Group includes AmWins, CRC Insurance, Hull & Company, and Absolute Underwriters. Additionally, Gehring Group has unique knowledge of Florida governmental trusts that offer coverage, and could evaluate and make recommendations on the options that may be available through these various entities. Many of our clients have been able to efficiently utilize these packages and, in many cases, achieved discounted programs that have been employed as a creative option based on the entity's current financial standing and market trends. Gehring Group's understanding of the variances among these programs offers a unique advantage over other Agents; an advantage which should result in improved outcomes through increased competition. The result is that Gehring Group is uniquely positioned to provide unbiased consultation regarding the key public entity insurance providers in this State, and this increased competition can result in more favorable terms and conditions for the Village's insurance program.

Gehring Group also has access to many other public entity markets through financially stable surplus lines carriers. These carriers provide alternatives when standard markets are unable to deliver the level of protection the Village of Wellington may demand. In some cases, these carriers offer property, liability, or workers' compensation coverage at a competitive price to the standard markets and these options will be explored to their fullest.

Gehring Group's RFP process would:

- Identify the markets based on appetite and relationship that would most likely pursue your account aggressively.
- Explain the opportunity to succeed and develop a timetable for specific activities to be scheduled or completed within the underwriting process.
- Anticipate and address potential underwriting objections or challenges such as prior loss history issues or specific large claims. Know the details and be able to explain them.
- Identify and explain changes going forward that will alter existing hazards or prevent similar claims that might have been adverse from happening again. Point out any new services that Gehring Group will provide that will improve the overall character of your risks.

Upon receipt of all proposals submitted in response to the RFP process, Gehring Group will perform a detailed analysis of each submission. Our staff will compare all proposals against the in force program and illustrate the differences to include the advantages and disadvantages of each. This will include a detailed cost comparison by line of coverage which outlines the total cost of the program. A sample renewal evaluation is included in **Exhibit D** for your review. During this stage in the procurement

process, Gehring Group will schedule a meeting with staff to review our initial findings. Once our analysis has determined that particular vendors are viable, we then attempt to clear up any details that must be established prior to any changes being made. This process is a second level request for clarification and is developed following the review of submitted proposals.

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

As an independent agent/consultant, Gehring Group focuses on recommending proposals that best meet the needs of our clients. We take into consideration how coverage provisions may vary from carrier to carrier as well as A.M. Best rating in our goal of providing each client with the program that is most in line with the client's philosophy and budgetary constraints. **Tab E: Markets** includes, but is not limited to, insurance providers with whom Gehring Group has a current relationship.

Communication

As previously mentioned, our first priority would be to meet with Village staff to determine what they deem to be the positive aspects of their program as well as any areas of particular concern. In addition, Gehring Group staff would outline the various program options available to the Village for all lines of coverage including self-insurance, fully insured options, alternative risk design models, and other cost saving ideas.

The next step would be to review the current loss runs for all lines of coverage. As a rule for all of our clients, we consistently track the available loss run data of your program throughout the policy term in order to more effectively prepare for the renewal process. We would review available loss run reports to determine whether your programs are running favorably in order to forecast renewal projections and negotiate with your current vendors. In order to assure the broadest possible insurance coverage and most favorable terms, conditions and pricing, we recommend that all exposure and underwriting data be developed and provided to us 90-120 days prior to renewal, which will allow adequate time for marketing.

RISK MANAGEMENT INSURANCE SERVICES

Gehring Group is a leading provider of employee benefits whose success is driven by our expertise, experience, independence and integrity as well as our people and our commitment to remain the consultant of choice to our clients. Below is a comprehensive list of services provided and available:

Gehring Group provides workers compensation consulting services and employs risk management and administrative professionals that specialize in implementing and managing risk insurance programs. We prepare, provide, and present creative, informative risk management and loss control materials to clearly illustrate information, thus providing effective communication to individuals who are not normally involved in insurance and risk management issues on a daily basis.

Gehring Group provides innovative services for innovative companies in various industries. We understand the unique needs of our clients and do not provide cookie cutter solutions. In our experience, the best way to manage a property and liability insurance program is comprehensively and proactively. The evaluation of a client's insurance program entails a balance between the desired limits of risk and the cost to insure against these risks.

Gehring Group's team of staff and resources can create customized risk management solutions by identifying opportunities and key risk factors unidentified by the client. We remain involved with our clients on a year round basis, not only at renewal time. We perceive our commitment to be an ongoing extension of your risk management team. This hands-on approach enhances our ability to address the specific needs of each of our clients by becoming more familiar with the client's staff, properties, and assets, thus enabling us to provide the most efficient recommendations regarding their risk management program.

Our Worker's Compensation Services Include:

1. **Injury Management**

    - Assist with establishing written policies and procedures for work place injuries
    - Assist with establishing incident and injury reporting procedures
    - Provide training and education to supervisors and employees regarding workers' compensation procedures and statutory requirements
    - Work with medical providers to implement consistent treatment and reporting policies
    - Provide service to assist management with initial claim assessment
    - Review injuries within forty-eight (48) hours of occurrence upon request
    - Assist with establishing written policy and assignment of "light duty"
    - Act as liaison to adjuster to facilitate complete treatment, MMI assessment and release to "full duty"

2. **Legal Administration Support**

    - Assist in production of records to claimant counsel
    - Act as liaison to claimant attorney and carrier assigned counsel as needed
    - Assist with mediation following through to claim settlement as needed

3. **Safety Programs**

    - Provide written safety procedure templates as requested
    - Provide safety training and education to supervisors & employees
    - Conduct monthly/quarterly departmental safety meetings as required
    - Provide literature and topics for monthly safety meetings
    - Assist with updating safety programs as necessary
    - Participate and assist with on-site safety inspections
    - Act as liaison to safety/loss control inspections with outside examiners
    - Provide research and recommendations regarding safety incentive programs
    - Write safety incentive program and present to management
    - Implement safety incentive program

4. **Analytical Services**

    - Produce annual audit, based on actual payroll and exposure
    - Provide projected workers' compensation costs for budgetary purposes
    - Review quarterly losses and assess reserves with adjuster as necessary
    - Produce RFP for workers' compensation coverage

- Evaluate RFP submittals consistent with the needs of the Client
- Prepare final written recommendation for coverage
- Present evaluation recommendation to management and staff

Our Property, Casualty & Liability Services Include:

1. **Claim and Loss Management**

    - Assist with establishing written policies and procedures for losses, incident investigations, accidents and liability claims
    - Assist with establishing property loss, incident and accident reporting procedures
    - Provide training and education to management regarding reporting procedures
    - Work with adjusters, appraisers and investigators to research and assess losses, accidents and claims
    - Provide service to assist management with initial claim and loss assessment
    - Review losses, accidents and incidents within forty-eight (48) hours of occurrence upon request
    - Assist in claim filing and notification to carrier
    - Act as liaison to adjuster to facilitate closing of claim
    - Assist with restitution recoveries and in-house subrogation

2. **Legal Administration Support**

    - Assist in production of records to claimant/plaintiff counsel
    - Act as liaison to claimant/plaintiff attorney and carrier assigned counsel as needed
    - Assist with compilation of Requests to Produce
    - Assist with mediation following through to claim settlement

3. **Loss Control Programs**

    - Provide written loss control policies and procedure templates
    - Provide loss control training and education to management and supervisory staff
    - Update loss control programs as necessary
    - Participate and assist with on-site loss control inspections
    - Act as liaison to loss control inspections with outside examiners

4. **Analytical Services**

    - Assist with production of annual audit, based on actual budget, schedules and exposure
    - Provide projected coverage costs for budgetary purposes
    - Review quarterly losses and assess reserves with adjuster as necessary
    - Assist with annual property appraisals
    - Review contracts for coverage sufficiency
    - Assist with compilation of property schedules
    - Produce RFP for property, casualty and liability coverage
    - Evaluate RFP submittals consistent with the needs of the Client
    - Prepare final written recommendation for coverage
    - Present evaluation recommendation to staff

SCOPE OF SERVICES

Based on our review of the RFP, it is evident that Wellington desires to maintain a competitive, yet cost effective employee benefits and risk management program and is seeking the aid of an experienced insurance professional to provide comprehensive year-round services in order to accomplish this goal. These services would include expert knowledge of the insurance industry and all available programs and funding options, consistent monitoring of the program claims experience, review of contract language, and the provision of budgetary projections and funding recommendations. Inherent in this process would be marketing and renewal analysis, the RFP and evaluation process, recommendations to staff and assistance with compliance issues.

It is Gehring Group's goal to assure the Village of our dedication to excellence in providing Insurance Brokerage Services. We are confident in illustrating our superior services and meticulous attention to detail by addressing each line item provided in the **RFP# 003-14/ED: Scope of Services**.

ON-GOING SERVICES FOR HEALTH INSURANCE

1. **Monitor the programs' operations throughout the year to ensure that benefit providers are meeting all customer service requirements and standards.**

   Gehring Group will conduct meetings with the carriers in order to monitor plan performance and in order to identify any service issues. Gehring Group is cognizant of how unresolved issues and poor performance can affect the client. Therefore, Gehring Group is proactive in our monitoring of plan performance so that there are no unforeseen circumstances and that are report findings are entirely accurate when presented to the Village. In addition, as part of our continued service, Gehring Group is able to conduct employee surveys and/or focus groups to determine employee satisfaction.

2. **Provide ongoing administrative support, as requested, by acting as a liaison between Wellington and providers to assist promptly with resolving claim disputes, contract administration and interpretations, and other issues.**

   Gehring Group's services include ongoing benefits administration support as well as assistance to employees with provider and claim issues. We often meet with employees individually to facilitate a quick resolution to any claim issues they may be experiencing. Oftentimes, Gehring Group staff acts as the intermediary between the employee, provider and insurance carrier, to expedite the process. Consider your Gehring Group team as a true extension of your HR and Benefits staff. Supporting our client's needs is a fundamental objective at Gehring Group. We take the role of advocacy to heart when representing your employees on claims issues, and we advocate for the organization when negotiating your renewal and communicating with all vendors. Gehring Group will coordinate with vendors to resolve issues on delivery, enrollment, interpretations and other contract issues. One example of our extensive involvement with the Village's vendors is our significant role in the negotiations and contracting of MD Now as the Village's selected clinic provider.

3. **Provide dedicated personnel as the primary contact for managing the account relationship with Wellington (specify names and areas of responsibility for each person).**

   At Gehring Group, all clients are assigned dedicated personnel to work on their account including: a senior benefits consultant, an account manager, an analyst, and an in-house service representative.

Our service team model for Wellington is represented as follows:

- Executive Staff: Kurt Gehring, CEO
- Senior Benefits Consultant: Christian Bergstrom
- Primary Account Manager: Rommi Upson
- Primary Analyst: Brian Beatty
- Account Services Specialist: Cheryl Marciano
- Wellness Coordinator: Sarah Brown

Please refer to **Tab 3: Qualifications** for further details regarding the role of each team member as well as background and resumes for each.

4. **Meet with specific Wellington staff throughout the year as reasonably necessary (minimum is quarterly).**

   As the Village's current Agent of Record, we meet with Staff regularly in order to monitor plan performance and to identify any service issues. We schedule meetings at least quarterly to review claims experience and prepare budget projections for upcoming renewals. Your Account Manager also conducts new hire orientations on a monthly basis to review plan benefits and assist new employees in becoming familiar with the plans offered by the Village and enrolling via the BenTek online portal. She also meets with employees on an individual basis to help them resolve claim issues or just to answer any questions they may have. In addition to plan monitoring and new hire orientations, members of your Gehring Group service team also attend impromptu meetings with staff to review other issues such as Wellness program strategy, Dependent Audit results, domestic partner and overage dependent imputed Income administration, Clinic Return on Investment analysis, Health Care Reform compliance training and planning sessions, and much more.

5. **Coordinate annual audits of Wellington's benefits plans and associated vendors and prepare annual financial reports on the results of the completed plan year.**

   As stated in Addendum 4 of the RFP, since the Village's current benefits are fully insured, except for dental, annual audits are not currently required. In the event the Village selects and alternate program or funding method, Gehring Group will coordinate all required audits as necessary.

6. **Prepare and deliver any necessary reports to Wellington Employee Benefits Administrator, including, but not limited to, reports showing claims experience at intervals acceptable to Wellington.**

   Gehring Group requests claims utilization reports and other pertinent information from service providers in order to analyze claims trends and anomalies on a monthly basis. We make recommendations based on our analysis and will present them to the Village for review and consideration. As previously stated, Gehring Group schedules meetings at least quarterly to review the Village's claims utilization and prepare budget projections. Additional meetings also take place as needed throughout the year to review other information such as large claims data, clinic return on investment figures and other cost items that may impact the performance of the Village's employee benefits program.

7. **Provide advice and assistance in the review Wellington employee health and medical benefits program on a continuing basis to ensure that those plans are in compliance with state/federal requirements and their adequacy of benefits with respect to other plans.**

   Gehring Group has taken a proactive stance and is consistently monitoring the current events taking place amidst the current fast-paced legislative environment. Gehring Group will provide the Village with updates regarding any changes applicable to the Village's benefits programs and assist in planning and preparation to remain in compliance with all legislative requirements. To aid in this effort, Gehring Group provides educational seminars and webinars to our clients to adequately prepare for any new requirements and benefit changes associated with Health Care Reform or other legislation.

8. **Track, monitor and provide information or changes on any pending or new legislation whether state of Federal, including the Affordable Care Act, to the Village, as well as any employee benefit and funding trends that may affect the benefits program, as well as HIPAA, COBRA, etc.**

   Gehring Group has taken a proactive stance and is consistently monitoring the current events taking place amidst the current fast-paced legislative environment. We provide our clients with regular updates regarding changes in applicable laws and how they might affect your benefits program. To aid in this effort, Gehring Group provides educational seminars and webinars to our clients to adequately prepare for any new requirements and benefit changes associated with Health Care Reform or other legislation. We also communicate through our newsletters, Client Portal as well as through personalized one on one, onsite client meetings. We remain in continuous contact with our clients to ensure all applicable information is communicated effectively.

9. **Advise and assist Wellington as requested with:**
   a. **Writing employee benefits plan modifications and/or new benefits plans and any required amendment approval process;**
   b. **Submission of written reports and other documents as required by the state and/or federal government;**
   c. **Coordination of the annual employee wellness fair;**
   d. **Monthly New Hire Benefits Orientation including coordination of benefit providers;**
   e. **Open Enrollment including coordination of benefit providers;**
   f. **Partnership and guidance for the Wellness Committee to provide effective and relevant programming.**

   All of the above are included in Gehring Group's current insurance brokerage services:
   a. Your Gehring Group team is intricately involved in any resulting plan changes or modifications in order to ensure maximum benefit to the Village. Having already implemented many cost saving solutions, including but not limited to; disease management programs, risk assessments, wellness initiatives, and carve out programs, Gehring Group has the expertise and know how to assist with these cost saving programs.
   b. Should the need arise, Gehring Group is prepared to assist with the submission of written reports and other documents as required by the state and/or federal government.
   c. Your Gehring Group team is available to coordinate and attend Wellington's annual Wellness and Benefit Fair. This includes contacting current and potential vendors as well as reaching out to local community resources that may be available to the employees of the Village.

d. Gehring Group currently conducts monthly New Hire Benefits Orientations including coordination of benefit providers when necessary.
e. Gehring Group also coordinates the Village's Annual Open Enrollment meetings, including coordination of benefit provider attendance. This includes working with BenTek to ensure all plan benefits are updated in the enrollment portal and assisting employees with the enrollment process.
f. Gehring Group also partners with the Village in achieving their Wellness goals. In 2013, we spearheaded the Village's goal in creating a wellness campaign which was ultimately branded "Commit To Be Fit". While we are in the early stages of the Village's wellness efforts, Gehring Group's Wellness Coordinator has proven a valuable asset in providing strategy ideas.

10. Perform special projects as requested by Wellington, including but not limited to:
a. Development and assistance in the implementation of new insurance plans;
b. Assistance with adjudication of specific claims as requested by Wellington;
c. Recommendation of alternative benefit designs or delivery systems as dictated by emerging plan costs or benefits practices.

Gehring Group currently performs all of the above in our role as the Village's Agent of Record.
a. It is our goal to partner with the Village to ensure that the entity is able to obtain the most comprehensive and cost effective employee benefits program and take advantage of all innovative and emerging market trends.
b. We currently assist with the adjudication of specific claims as requested by the Village Staff.
c. Lastly, Gehring Group has always embraced innovative and creative ideas. We will continue to evaluate all program alternatives and emerging market trends while consistently adhering to best practices.

11. COBRA administration including notification and tracking.

In the event COBRA Administration is not provided by the Village's health insurance carrier/TPA, Gehring Group will provide COBRA administration services through a third party administrator either via competitive bid process or by utilizing one of the administrators with whom Gehring Group has a pre-negotiated relationship. Gehring Group clients utilize a number of COBRA vendors due to our independent role as agent; we offer free administration for the above requested services through the following preferred vendors:

- Benefits Workshop
- Ceridian
- Eagles Benefits by Design

12. Retiree benefits administration.

Gehring Group will continue to be a resource to the Village and its retirees regarding their benefits, recording all retiree enrollment information within the BenTek system.

13. Blood Bourne Pathogen Plan (for Hepatitis B) including tracking, notification, and education.

Gehring Group can incorporate information related to Hepatitis B and the employee's ability to receive the vaccine at the Village's clinic provider, MD Now, as part of our New Hire Orientation

presentation process. In addition, we also have the ability to include tracking and notification services to the Village under the additional pricing options outlined in **Tab 5: Compensation & Pricing.**

14. Ensure personnel availability for meetings, phone calls, and e-mail correspondence as required.

Gehring Group personnel are available for meetings, presentations, phone calls, and e-mail correspondence as required. Due to our close proximity to Wellington's City Hall, we are readily available for meetings with minimal notification. Gehring Group ensures that the Village will have the necessary access to Gehring Group staff in order to assist them with their insurance needs.

15. Maintain the confidentiality of Wellington records and data where applicable under federal and state laws.

Gehring Group and BenTek will maintain the confidentiality of Wellington records and data where applicable under federal and state laws. Gehring Group and BenTek implement a comprehensive security program that offers a high level of protection commensurate with the value of the assets. The information security program provides reasonable protection against unauthorized access, disclosure, modification, or destruction, as well as to assure the availability, integrity, usability, authenticity, and confidentiality of information. This applies to all systems that manage or store data. Gehring Group and BenTek's security program defines access rights and privileges and protects assets and data from loss or inappropriate disclosure by specifying acceptable use guidelines for users, operations staff, and management.

16. Provide assistance with any employee related Health Clinic solicitation and implementation.

As already realized by the Village, many of our clients have taken advantage of the potential cost saving benefits of opening an on-site or near-site clinic. By shifting costs from the medical plan to a clinic, many groups have been able to better manage specific areas of claims costs, while providing additional access to medical care to their employees. Gehring Group has experience in bidding, evaluating and implementing an onsite clinic for several of our current clients. This includes conducting the bid process to determine which clinic provider would best meet the needs of our clients, and overseeing the whole implementation process once a decision has been made. As a totally independent third party, Gehring Group has no tie to any specific clinic provider and can therefore offer a completely unbiased recommendation based on which proposal best meets the needs of your group. **In 2012, Gehring Group facilitated the successful contract negotiations with MD Now, achieving an estimated cost savings of over $40,000 to the medical plan. As part of our continued service, Gehring Group transmits employee and dependent eligibility data to MD Now on an ongoing, monthly basis.**

17. Provide the ability for on-line employee benefits registration (On-line portal)

Gehring Group's proposed services also include continued access to the BenTek® Online Enrollment and Administration System, an innovative tool that Gehring Group has provided to a large number of our public sector clients to much acclaim. BenTek®, Benefits Technology by Benefits People, is a comprehensive on-line benefits administration system aimed at increasing efficiencies and reducing the burden of the administration of your employee benefits program.

The current BenTek system functionality includes all of the following services:

- Employee Portal for:
  - Annual electronic open enrollment
  - New hire orientation and enrollment
  - Qualifying life event enrollment and approval process
  - Year round life insurance beneficiary updates and record keeping
- Electronic eligibility files/reports transmission for the Village's:
  - Medical
  - Dental
  - Vision
  - FSA
  - COBRA
- Production of Self Bill invoices for Village's:
  - Medical
  - Dental
  - Vision
  - Basic Life and ADD
  - Voluntary Life and ADD
  - LTD
- Personnel data import (completed each pay period upon completion of payroll)
- Payroll audit (completed each pay period upon completion of payroll)

18. Perform other related services on an "as needed basis"

Gehring Group will act as a resource to the Village in all areas related to the employee benefits insurance field and are available to assist Wellington and its employees on an "as needed basis". In addition to your assigned account manager, Gehring Group also provides in-house account service personnel specifically for this purpose, so that even if your account manager is temporarily unavailable, there will be someone accessible to you and your employees. Our In-House Account Service Personnel will review, process and administer all escalated employee claims issues on an as needed basis. These staff members are available to help employees work through claims issues by analyzing the issue and working with the carrier claims department or service representative as well as the provider's office to seek resolution. The internal account service personnel provide solutions in helping to resolve escalated claims issues by assisting with writing appeal letters in the event a claim has been denied. They follow up with the applicable carrier claims department or service representative, assist in gathering all required information and documentation, and continuously follow up through resolution. They exhaust all avenues in their efforts to bring each employee issue to resolution. Coordinate with vendors to resolve issues on delivery, enrollment, and other contract issues.

RENEWAL YEAR SERVICES FOR HEALTH INSURANCE

1. Assist with annual open enrollment and provide the ability for on-line registration (On-line portal)

Gehring Group staff is available to coordinate and attend all open enrollment and new hire orientation meetings. Due to our large public sector client base, our staff is familiar with the need for some groups to have enrollment meetings outside of the 9:00 to 5:00 typical workday. For

example, we have conducted enrollment meetings at various police departments at very early morning shift changes as well as at jail facilities for night shift staff. For other clients that have various locations, we are often able to accommodate enrollment meetings at several locations at the same time. With over 25 licensed agents on staff and our team environment, we are able to pull additional staff resources as needed.

In addition, Gehring Group will prepare all annual enrollment documents and employee communications, including; custom newsletters, posters and benefit booklets all tailored for the Village's employees.

Gehring Group's open enrollment services also include access to the BenTek® Online Enrollment and Administration System is an innovative tool that Gehring Group has provided to a large number of our public sector clients to much acclaim. BenTek®, Benefits Technology by Benefits People, is a comprehensive on-line benefits administration system aimed at increasing efficiencies and reducing the burden of the administration of your employee benefits program. BenTek® segregates processes and embodies three online modules:

1. Internet based open enrollment site that allows employees to enroll in their selected benefits online in a paperless format,
2. A 24/7 employee benefits center from which employees can access provider links, policy information, report qualifying events and view their benefit elections, and
3. The benefits administration system which can perform the functions of an employee benefits data management system all year round, allowing for electronic transmission of eligibility data to carriers.

The BenTek system currently provides the following functionality to the Village of Wellington:

- Employee Portal for:
  - Annual electronic open enrollment
  - New hire orientation and enrollment
  - Qualifying life event enrollment and approval process
  - Year round life insurance beneficiary updates and record keeping
- Electronic eligibility files/reports transmission to the Village's, Medical, Dental, Vision, FSA, and COBRA vendors
- Production of Self Bill invoices for Village's Medical, Dental, Vision, Basic Life and ADD, Voluntary Life and ADD and LTD vendors
- Personnel data import (completed each pay period upon completion of payroll)
- Payroll audit (completed each pay period upon completion of payroll)

2. Using current Wellington health and medical benefit plans as benchmarks, research, design and propose employee benefit plans for Wellington as appropriate.

Gehring Group maintains a strong commitment to remain at the forefront of industry trends. Through our knowledge and expertise, Gehring Group researches and evaluates all creative plan options to determine which programs and coverages represent viable options for our clients. This information is essential in order to assist management and staff in making better-informed decisions regarding the placement of coverage that is in the best interest of their organization. During Gehring Group's tenured experience, we have assisted our clients through transition in many ways such as

proposing alternative funding methods, design and implementing innovative plan options utilizing various tax savings accounts and evaluating all cost saving options including Wellness and Clinic strategies. The experience we offer guarantees that no piece of the puzzle will be missing when any change is implemented.

3. **Meet with Wellington as necessary to discuss benefit plan options and establish goals and objectives for Wellington's Benefits program.**

   Gehring Group currently meets with Wellington Staff as necessary to discuss benefit plant options and establish goals and objectives for Wellington's Benefits program. We take into consideration all available program options in our goal of providing each client with the program that is most in line with their employee benefits philosophy and budgetary constraints. We feel it is our job to educate the client on any new products in the industry that may reduce administrative burden or aid in the reduction of health care costs, making recommendations to achieve maximum cost savings.

4. **Provide analysis of renewal of current plan, reviewing past performance.**

   Members of your Gehring Group team schedule meetings with Village staff on a quarterly basis to review plan performance and adequately prepare for upcoming renewals. By reviewing past claims experience and performing renewing underwriting projections, we are able to assist the Village in setting adequate budgets and/or determining whether an RFP process is necessary.

5. **Review additional available cost savings plan alternatives and creative funding options.**

   Gehring Group is known for being an innovator in the employee benefits marketplace. We evaluate all emerging cost saving options to determine viability for our clients. We were the first to implement consumer driven health plans as well as other cost saving strategies such as onsite clinics in the public sector. At Gehring Group, we maintain a strong commitment to remain at the forefront of industry trends, market conditions, new legislation and new types of health insurance programs being presented by insurance companies and third-party administrators. Through our knowledge and expertise of all types of plan designs and funding arrangements, Gehring Group staff is able to aid our clients in determining which carriers and programs represent viable options in order to assist management in making better-informed decisions regarding the implementation of new concepts, and ascertaining whether they are in the best interest of the organization.

6. **Determine the appropriate employee and employer benefit contribution levels.**

   At each renewal, Gehring Group aids the Village in determine the adequacy of its employer and employee contribution structure. Due to Gehring Group's specialization in the public entity market, we can provide benchmarking information in order to assist with developing and allocating competitive premium distribution between Wellington and their employees. Since the affordability of the employee's portion of health insurance premiums plays an important role in whether an employer may be subject to the Pay or Play penalty, this aspect of an employer's benefits program must be considered in future renewal planning.

7. **Review and recommend annual contribution strategy from active participants and retirees.**

   As stated above, due to Gehring Group's concentration in the public sector industry, we have a significant amount of employee benefits benchmark data in-house to aid the Village in making

contribution decisions. This includes statistics on plan benefits, employer contributions, retiree contributions, waiting periods, trend factors and other related data.

8. **Provide Wellington with information on what other municipalities of comparable size and location will be doing with their benefits in the upcoming plan year.**

   As the largest municipal broker in Palm Beach County, we have the ability to provide significant employee benefits benchmarking data. Since 95% of the Gehring Group's client base consists of public entities within the State of Florida our firm is uniquely qualified in its understanding of public entity benefits. Gehring Group will be able to provide valuable information to the Village of Wellington with regards to what other municipalities of comparable size and location are doing with their benefits programs and costs.

9. **Conduct renewal negotiations and develop appropriate information for management purposes.**

   Due to Gehring Group's large public sector client base and thus, significant premium volume with the insurance carriers, we have been very successful in negotiating competitive renewal rates with carriers. Based on our premium volume, Gehring Group has achieved significant recognition from all of the major health insurance carriers within the State. As the liaison between the insurance carriers and our clients, our firm has both premium volume and industry knowledge which enables us to negotiate renewals in our clients' best interest as evidenced by the savings achieved for the Village outlined in the cover letter included with this proposal response.

10. **Upon Wellington's request, assist in coordinating a comprehensive "Request for Proposal" (RFP) a brokerage process to identify potential high quality Benefits vendors, according to established Wellington guidelines. The scope of this RFP may include, but is not limited to: Medical, Dental, Vision, Basic Life, Voluntary Life, Accidental Death and Dismemberment, Short Term and Long Term Disability insurance providers.**

    Gehring Group will prepare and consult on all facets of the request for proposal process, including provisions established based on the needs of Wellington. Gehring Group evaluates a proposal based on many factors, the obvious includes overall cost, plan design, network of providers and compliance with the RFP, making all recommendation based on the needs and goals of Wellington. In addition, we take into consideration how plan benefits may vary from carrier to carrier as well as their A.M. Best rating in our goal of providing each client with the program that is most in line with their employee benefits philosophy and budgetary constraints. Preparation is the key to a successful outcome. We feel it is our job to educate the client on any new products in the industry that may reduce administrative burden or aid in the reduction of health care costs, making recommendations to achieve maximum cost savings. Upon the completion of any RFP or marketing process, Gehring Group can provide a written recommendation summary or PowerPoint presentation to Wellington staff for review and consideration.

11. **Act as Lead Negotiator and Consultant to Wellington during benefit contract negotiations and renewals.**

    As agent of record, it is Gehring Group's goal to represent the Village with best efforts regarding its employee benefits program. Gehring Group will act as lead negotiator and consultant to Wellington during benefit contract negotiations and renewals. As the liaison between the insurance carriers and our clients, our firm has both premium volume and industry knowledge which enables us to negotiate renewals in our clients' best interest.

12. **Prepare and present a written analytical report of the proposals received including recommendation(s) and supporting documentation for recommendations.**

    Gehring Group develops and presents written analytical reports detailing any applicable RFP or renewal evaluation and recommendation process. In addition, Gehring Group can provide a written recommendation summary or PowerPoint presentation for the purpose of presenting at committee or council meetings.

13. **Review plan documents (employee booklets) and master contracts before adoption and printing.**

    Each year, your Gehring Group Analyst and Account Manager reviews each certificate and/or contract for accuracy, completeness and compliance. Subsequently, we can design the annual employee benefits highlight booklet which outlines and summarizes all Village employee benefit programs in an easy to read format.

14. **Assist with the planning and implementation of selected changes including transition from the current to new vendors, the renewal proposal, and other benefits changes.**

    During Gehring Group's longstanding relationship, we have assisted the Village through numerous transitions: including transitions to new plan designs, new vendors, new types of programs and different funding arrangements. We guide you through the renewal process and are available to assist with implementation and educate Staff and employees regarding any applicable benefit changes.

15. **Assist with developing Wellington employee benefit program communication materials. Coordinate the design, printing and production of those materials, as edited and approved by the Wellington's Benefits Administrator.**

    Gehring Group realizes that a great employee benefits solution does not end upon acceptance of the policies negotiated, but merely begins. At Gehring Group, we understand that Employee Communications help streamline processes, increase productivity, improve employee appreciation and retention, and can increase group participation. That is why we employ our own in-house graphic design team to simplify your benefit communication needs. From conceptualization to printing, all facets of the production process occur on premises ensuring flexibility and quality efficiency. Gehring Group can implement a sophisticated multi-channel annual communication strategy that can incorporate Wellington's goals and objectives in order to fully engage your employees.

16. **Advise and assist wellington Employee Benefits Administrator with the review of contracts, plan documents, insurance policies and other documents for applicability, accuracy, consistency, and legal compliance.**

    Your dedicated Gehring Group personnel will be available to assist your Employee Benefits Administrator with the review of contracts, plan documents, insurance policies and other documents for applicability, accuracy, consistency, and legal compliance.

17. **Assist Wellington with the development of performance guarantees relating to vendors' performance of services to Wellington, and evaluation of the performance of vendors.**

Gehring Group can assist Wellington with the development of performance guarantees relating to vendor services. Gehring Group regularly meets with Wellington's management team to ensure client satisfaction and address any concerns with carrier services. If the Village has any specific concerns related to vendor service, we can assist with resolving any identified issues per Wellington's request and develop more formal performance standards with vendors.

ADDITIONAL QUESTIONS ADDED PER REVISION #2 OF ADDENDUM 4

1. Do you provide software for online employee benefits portal?

Yes, Gehring Group currently provides the Village with the BenTek Online and Enrollment System as its online employee enrollment portal as well as numerous additional administrative functions.

The BenTek system currently provides all of the following functionality to the Village of Wellington:

- Employee Portal for:
  - Annual electronic open enrollment
  - New hire orientation and enrollment
  - Qualifying life event enrollment and approval process
  - Year round life insurance beneficiary updates and record keeping
- Electronic eligibility files/reports transmission to the Village's, Medical, Dental, Vision, FSA, and COBRA vendors
- Production of Self Bill invoices for Village's Medical, Dental, Vision, Basic Life and ADD, Voluntary Life and ADD and LTD vendors
- Personnel data import (completed each pay period upon completion of payroll)
- Payroll audit (completed each pay period upon completion of payroll)

2. Is your firm willing to work with a 3rd party administrator for on-line employee benefits portal?

If requested by the Village to work with an alternate online employee benefits portal, Gehring Group would accommodate this request.

ON-GOING SERVICES FOR GENERAL PROPERTY AND CASUALTY / WORKER'S COMPENSATION

1. **Assist with establishing written policies and procedures for professional liability claims**

   As part of our on-going services, we will continue to work closely with staff to create and/or update policies and procedures for a wide range of subjects. With regards to professional liability claims, we review all applicable carrier or Trust provisions, deductibles and/or retentions, and provide Wellington with a draft policies and procedures manual for the reporting of, and ultimate processing of professional liability claims.

2. **Assist with establishing property loss, incident and accident reporting procedures**

   Historically, Gehring Group has taken the lead coordination role in the handling of property claims. Contact with Trust adjusters occur no less than quarterly; incidents and accidents detailed in our customized reports are provided to Wellington staff bi-monthly, following the regularly scheduled safety committee meetings. Our services are tailored to client needs and include reporting of all claims over deductibles and/or retentions to the appropriate carriers or Trusts. Once a property claim file is established, the Gehring Group works closely with the Trust, Synergy, and other governmental agencies to obtain the most advantageous outcome for Wellington.

3. **Provide the Village with various program options; including but not limited to limits, coverage, retention levels, terms, conditions and payment options.**

   As Gehring Group customized loss reports are updated bi-monthly, your Gehring Group team of risk management professionals, continually review claim thresholds to determine where increases or decreases in deductibles may be appropriate. When feasible, renewal proposals are requested with various coverage options, along with potential credits offered for increasing risk and retention. All potential changes to coverage terms are discussed with staff to determine budgetary needs and constraints, as well as senior management philosophies on funding options. Payment terms and conditions are reviewed and discussed amongst the carriers and Trusts providing coverage to Wellington.

4. **Providing training and education to staff and others working with the Village regarding risk management and reporting procedures.**

   Gehring Group staff is proud to have been asked to provide P&C Insurance 101 classes to senior management and insurance committee staff members prior to the start of the current fiscal year. Over the course of the last three fiscal years, Wellington has released two RFQs for insurance coverages and Gehring Group has been an integral partner in evaluating and recommending programs that meet or exceed Wellington's needs.

   As an extension of the safety and loss control services provided to Wellington, Gehring Group provides continual training and education to staff regarding risk management principles and considerations. This is accomplished through attendance at bi-monthly safety committee meetings, as well as annual on-site audits of Wellington departments, facilities and public properties for the purpose of risk assessment.

5. **Work with adjusters, appraisers, investigators, staff and attorneys to research losses, accidents, incidents and claims.**

   As an ongoing extension of our services, Gehring Group works closely with claim adjusters and staff to research specific causal factors and evaluate frequency and severity trending. A thorough claims examination assures Wellington's ability to pursue subrogation, mediation or claim denial. Collectively these efforts work to identify and mitigate potential exposures as well as ensure the appropriate policy responses for each unique type of coverage.

6. **Provide assistance to staff and management with initial claim loss review and coordination**

   Gehring Group's team of risk management professionals is available to review initial claims scenarios and potential notification to the insurance carrier or Trust. We routinely ask for and review work orders, as well as policies and procedures to determine if the claim has any potential for recovery. Depending upon the level of participation requested by the client, Gehring Group staff can coordinate the initial reporting protocols and perform follow-up claim reviews with the appropriate adjusters no less than quarterly, or until the claim reaches closure.

7. **Review losses, accidents, claims and incidents upon request from the Village staff and or management**

   Your Gehring Group risk management team reviews monthly loss data for all claims to provide periodic custom reports. Historical summary reports, detailed claims injury analysis are just several used to help identifying injury trends in the workplace. Claims are scrutinized individually to carefully identify areas such stagnancy, lag time, and reoccurrence. Thorough accident report reviews and investigation are the basis for our hazard threat assessment and safety recommendations.

8. **Assist in claim filing and notification to insurance carriers**

   If requested, Gehring Group staff will assist in the formal filing of a claim and notification to the appropriate insurance carrier or Trust.

9. **Act as liaison to adjuster to facilitate closing of claims**

   Claims are individually monitored for progression to ensure rapid closure. Periodic adjuster updates are requested and consolidated into our open claims reports, designed to assist staff in monitoring progression. Reserves are carefully reviewed, questioned when necessary, and tracked for continuity.

10. **Assist with restitution recoveries and in-house subrogation as needed**

    Gehring Group will assist in the pursuit of restitution recoveries and in-house subrogation where possible. Dependent upon the level of risk or retention, our services would entail the coordination of recoveries through the adjusting team assigned by the carrier or Trust that is providing the coverage or reinsurance associated with a particular line of coverage.

11. Provide claims services on behalf of the Village as it relates to hurricane damage on an as needed basis and claims mitigation

Gehring Group has been intimately involved with Wellington as it pertains to claims and recovery services following Hurricanes Frances, Jeanne and Wilma in 2004. Our staff members were on the ground shortly after the storms working with Wellington team members to document losses and provide insurance policies to FEMA representatives which helped to speed up the recovery process, and importantly, to obtain upfront monies to assist Wellington in contracting with vendors and securing sites from further loss. Gehring Group staff remains involved throughout the entire process, until FEMA has audited all project worksheets and has provided a close out of all open requests for reimbursement, which could take several years to accomplish. Further, Gehring Group's role as liaison allowed Wellington staff to focus on the process of reopening facilities, knowing that its trusted partner was working diligently to ensure accurate schedules were on file, and that deductibles and out of pocket dollars were in accordance with policy terms and conditions.

12. Assist with safety committee, safety inspections, safety training, and all aspects of safety administration.

Your assigned safety/loss consultant assists Wellington staff by attending and participating in regular safety committee meetings, safety inspections, safety training, safety grant application, safety manual revisions, and all aspects of safety administration. Our primary focus is to identify hazards or training deficiencies and provide recommendations along with coordination of specialized training.

Through our online BenTek LMS platform, Gehring Group has partnered with Summit Training Source, a global leader in safety training, to offer 25 OSHA certified safety-related training courses, specific to Wellington employees. Each interactive training course addresses specific OSHA CFR's encountered in the workplace. Certificates of completion along with training records are maintained in electronic format for administrative tracking. Several of our municipal clients have experienced a significant impact in reducing and maintaining favorably low Experience Modification Factors', which translate into monetary and qualitative benefits.

Gehring Group selectively utilizes the resources of various outside vendors such as the National Safety Council and Florida League of Cities to supplement Wellington's safety program. FMIT risk control services offer still another host of comprehensive safety services. We selectively research and recommend the most suitable training available. We have also conducted several annual safety presentations applicable to all Wellington employees. Each one hour presentation is typically hosted on multiple occasions to canvas the entire employee population.

In addition, Gehring Group staff has over the past three fiscal years, participated in no fewer than 38+ hours of on-site property and casualty meetings with Wellington. In addition, Gehring Group has facilitated two village-wide safety audits conducted in 2011 and 2013 respectively. Each audit provided a comprehensive 43–page, per location, inspection discrepancy report. Audits typically consist of 100+ man hours or approximately 14 days of field work, encompassing 52 community parks, 28 facilities and 6 utilities.

Gehring Group will continue working with Village staff to assist in improving Wellington's successful safety program. Implementing a Safety Incentive Program is one of the areas currently being researched.

13. **Provide brokering services including but not limited to conducting renewal negotiations, requesting quotes from various carriers for renewal and price comparison purposes and developing appropriate information for management purposes.**

Included as a core component of our brokerage services, we offer the following: Risk Analysis, Plan Design, Program Marketing & Analysis, Carrier Qualification, Claims Management and Administrative Support. During the renewal process, we present our clients loss history, funding theories, and safety culture to the commercial insurance underwriters in order to obtain quotations from the marketplace. By remaining independent and not having any interest in any carrier, trust or captive insurer, we are able to bring all available options to the table for consideration. Gehring Group is well known for its thorough, in depth, evaluation spreadsheets which provide a complete comparison of existing versus proposed coverage terms and conditions. These evaluations confirm that your program has been reviewed in great detail, and that there will not be any concerns regarding gaps or duplications in coverage. Further, these documents become a main component of the renewal recommendation which is presented to senior staff, council, commission and/or board for formal approval.

LEGAL ADMINISTRATION SUPPORT

1. **Act as liaison to claimant/plaintiff attorney or legal representative and insurance carrier assigned, coordinate with Village's legal counsel as requested or necessary**

If requested, Gehring Group will act as the liaison between Wellington staff, claimant/plaintiff attorney or legal representative, and insurance carrier assigned.

2. **Assist with compilation of Requests to Produce and other discovery requests**

If requested, Gehring Group would assist as applicable in submitting documentation in a Request to Produce, and other discovery requests, if the documentation is provided to our office.

3. **Assist with scheduling of depositions and discovery requests**

With the assistance of Wellington staff, Gehring Group staff would act as the liaison in scheduling depositions and discovery requests.

4. **Assist with mediation following through to claim settlement**

As requested by Wellington, Gehring Group staff would continue working with assigned adjusters until claims are brought to closure or settlement.

5. **Assist in any other support role as may be necessary or requested by the Village staff and or management**

Gehring Group assist in other support roles applicable to the scope of work under this contract.

ANALYTICAL SERVICES

1. **Provide projected coverage costs for budgetary purposes**

   As an ongoing extension of our services, Gehring Group works with our clients prior to budget season in order to project out anticipated costs for insurance programs. We not only look at loss runs and claims history, but also look to the market and industry trends to determine where our clients may see an increase in premium and where reductions can be obtained. We have also been involved in budget meetings, and have made presentations to finance committees, as requested.

2. **Review quarterly losses and assess reserves with adjuster, staff or management of the Village as necessary**

   Gehring Group routinely completes a quarterly analysis reviewing quarterly losses and assesses reserves with adjuster; this invaluable service will ensure that there are no surprises to the Village during the end of the year.

3. **Assist with annual property appraisals and assist with coverage issues resulting from the same**

   As requested, Gehring Group has assisted Wellington in obtaining quotations for annual property appraisals and is a leader and proponent of the need for accurate and concise property schedules. A Maximum Potential Loss study should also be requested in order to validate the total amount of insurance purchased. A post appraisal review is normally scheduled with staff to determine items that may be added to insurance coverage's or self-funded by Wellington.

4. **Review contracts for coverage sufficiency**

   Gehring Group risk management staff reviews contracts for coverage sufficiency on a daily basis. In many instances, we work directly with purchasing staff in reviewing insurance coverage's by scope of service being requested, as well as identifying potential areas of concern related to third party liability.

5. **Review certificates of insurance to ensure adequate levels of coverage**

   Gehring Group staff would review certificates of insurance to ensure adequate levels of coverage. This is a standard component of our agency services.

6. **Assist with compilation of property schedules**

   In working together with Wellington staff, we would assist in the updating or compilation of property schedules based upon additions and deletions reported to our office. We would also ensure that the carriers and Trusts are working from accurate schedules and that endorsements are processed and applied correctly.

7. **Assist in the production of RFP's for property, casualty and liability coverage and other coverage(s) on behalf of the Village**

Gehring Group has been deeply involved in the production of RFPs, RFQs for property, casualty and liability coverage during 2010 and 2012 on behalf of Wellington.

8. **Assist the Village in the evaluation of RFP's bid proposals and related matters consistent with the needs of the Village**

   Gehring Group staff members are known for their detailed evaluations of bid responses and break it down into an easy to read format that allows all parties to compare proposed coverage's against expiring policy terms and conditions. When requested, Gehring Group has also provided a line by line evaluation review to insurance committees, and staff members to ensure that all parties understand the coverage's being purchased and the attributes presented by agents, carriers and Trusts.

9. **Prepare written recommendations for coverage**

   Our evaluations are presented to staff for inclusion in all senior management renewal decisions and become a part of the agenda item summary packet provided to Council for their formal approval. A written recommendation accompanies our evaluations and provides specific details on coverage recommendations. These recommendations consider coverage terms and conditions, loss history, and pricing.

10. **Present evaluation recommendations to management, staff and the Village Council as needed**

    As stated above, our full evaluation, accompanied by a written recommendation is provided to senior staff and Council in order for a renewal decision to be determined. Gehring Group has historically attended senior staff meetings, and has been on hand at Council meetings to review coverage proposals and answer questions Council may have.

11. **Have an account executive(s) assigned to the Village's account that will be responsible for communication with the Village. The individual, along with any team members must be available on a daily basis to the Village for advise and consultation on Program related issues and concerns as they arise**

    At Gehring Group, we provide a team of account executives which are available to assist Wellington on a daily basis. Each team member has a back-up, ensuring that calls and emails are answered in a timely manner, most within a 24 hour time period. In addition, we work closely with other Gehring Group departments to ensure that there are no gaps or duplications of service being provided. A detailed listing of employees assigned to Wellington is included in **Tab 3: Qualifications**.

12. **Review any insurance company audits for accuracy**

    Gehring Group service currently includes the annual review of workers compensation audits for accuracy, not only in premium due, but in classification codes that may be examined during an audit. On a quarterly basis, our staff obtains copies of actual payroll reported and compares it against projections utilized in the renewal process to ensure that accurate premiums are being paid. The audits also account for any 1099 contract labor which may be utilized during the year, particularly as part of the parks & recreation department. From year to year, to ensure accurate application of the various statutes and regulations pertaining to workers compensation, we meet

with the Village's Payroll and Finance staff to review and verify various components of gross wages which are allowable under workers compensation remuneration definitions.

13. Maintain accurate claims loss reports

Gehring Group's risk management team reviews monthly loss data for all claims to provide periodic custom reports. Historical summary reports, detailed claims injury analysis are just several used to help identifying injury trends in the workplace. Claims are scrutinized individually to carefully identify areas such stagnancy, lag time, and reoccurrence. Thorough accident report reviews and investigation are the basis for our hazard threat assessment and safety recommendations. A sample claim loss report is included in **Exhibit D: Sample Analytical Reports.**

14. Act as a liaison between any loss professional and the carrier relating to the Program; and perform facility on-site inspections as requested by the Village. Maintain copies of all inspection reports issued for facilities and provide recommendations for safety control measures.

Whether there is a need for independent engineers, environmental specialists and/or claims mitigation specialists, Gehring Group has acted as the liaison for Wellington in obtaining needed services and third party independent opinions. As Gehring Group is involved in facility inspections and the subsequent written findings of each location, we do maintain copies of the reports and utilize the outcomes to implement safety and loss control measures that will provide the Village with fiscal savings and employee safety.

Gehring Group has facilitated two village-wide safety audits conducted in 2011 and 2013 respectively. Each audit provided a comprehensive 43–page, per location, inspection discrepancy report. Audits typically consist of 100+ man hours or approximately 14 days of field work, encompassing 52 community parks, 28 facilities and 6 utilities.

15. Attend employee safety meetings with the Village's safety committee, as requested.

Your Gehring Group assigned safety/loss consultant assists Wellington staff by attending and participating in regular safety committee meetings, safety inspections, safety training, safety grant application, safety manual revisions, and all aspects of safety administration. Our primary focus is to identify hazards or training deficiencies and provide recommendations along with coordination of specialized training.

16. Any other related services as required by the Village

Gehring Group will perform any other related services as required by the Village within the scope agreed upon under any contract resulting from this RFP.

Tab 5: Compensation and Pricing

PRICING SCHEDULE - REVISED (Tab #5)

Proposers shall provide both a commission rate and flat fee rate for the services listed below. The Selection Committee shall utilize all pricing submitted as a basis for evaluation.

BENEFIT PLAN AND MEDICAL (INCLUDING ON-LINE EMPLOYEE BENEFIT PORTAL):

Commission	**2%**
Flat – Fee	**$80,000**

DENTAL PLAN:

Commission	**$2 PEPM**
Flat – Fee	**$6,000**

VISION PLAN:

Commission	**5%**
Flat – Fee	**$1,750**

DISABILITY INSURANCE PLAN:

Commission	**5%**
Flat – Fee	**6,750$**

LIFE INSURANCE PLAN:

Commission	**5%**
Flat – Fee	**$5,000**

PROPERTY AND CASUALTY:

Commission	**6%**
Flat – Fee	**$32,500**

WORKERS' COMPENSATON:

Commission	**5%**
Flat – Fee	**$10,000**

All flat fees quoted are annual fees. Please refer to pricing notes on following page for details regarding additional services.

PRICING SCHEDULE - REVISED (Tab #5)
(CONTINUED)

*INCLUDED SERVICES: The proposed fees include the Benefits consulting scope of services requested and the following benefits enrollment and administration system features of BenTek: On-line Open Enrollment, carrier eligibility updates, standard reporting, and Employee Benefit Center access, ACA Reporting. Optional Enhanced Services currently provided and not included in this base fee are listed and additionally priced below.

OPTIONAL ENHANCED SERVICES: Gehring Group has the ability to continue to provide the following additional services referenced in the scope of services and addendum of RFP# 003-14/ED RFP. Insomuch, the following enhanced on-line enrollment, benefits assistance services, and risk management services are available for an additional cost as outlined below:

- On-line benefits system features: Self-bill reconciliation and production; reconciliation/audit of elected benefit deductions to payroll deductions.

- Benefits Assistance: Dependent auditing services; clinic consulting, bidding, evaluation, monitoring, & return on investment reporting; comparative local entity surveys; review, addendum compilation and printing of Summaries of Benefit & Coverage required under the Affordable Care Act; design & printing of professional employee benefit communication materials; and in the event of self-funding - actuarial and 112.08 filing assistance, and Form 720 for PCORI Fee and Transitional Reinsurance Fee Reporting assistance by Certified Public Accountant; COBRA administration services.

- Risk Management Services: On-site safety meetings, annual on-site property inspections, safety manual updates, and on-line safety training classes.

If you would like to continue to receive Gehring Group's current full scope of services which includes these additional services, as well as Blood Bourne Pathogen Plan services, under our current all-inclusive service model, they are available at the City's election for an additional 1% commission (or $40,000 flat fee) on medical premium, and additional 3% commission (or $16,000 flat fee) on Property & Casualty premium.

Gehring Group's goal is to work within the means of our clients to accomplish their goals and objectives. As such, we are open to additional discussion regarding all proposed compensation options for Insurance Broker Services.

Tab 6: Drug Free Workplace

DRUG FREE WORKPLACE (TAB #6)

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

1. Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.

2. Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.

3. Give each employee engaged in providing the commodities or contractual services that are under Bid a copy of the statement specified in subsection (1).

4. In the statement specified in subsection (1), notify the employees that, as a condition of working on the commodities or contractual services that are under Bid, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of chapter 893 or of any controlled substance law of the United States or any state, for a violation occurring in the workplace no later than five (5) days after such conviction.

5. Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program if such is available in the employee's community, by any employee who is so convicted.

6. Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

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

Kurt Seling

Vendor's Signature

Tab 7: Local Preference Application

LOCAL PREFERENCE APPLICATION (TAB #7)

APPLICATION TO BE CONSIDERED A LOCAL BUSINESS IN ACCORDANCE WITH WELLINGTON FLORIDA'S LOCAL PREFERENCE POLICY (SECTION 2.12.F OF WELLINGTON'S PURCHASING AND PROCUREMENT MANUAL)

Wellington gives preference to local businesses in certain purchasing situations as set forth in Section 2.12(F) of Wellington's Purchasing and Procurement Manual. In order to be considered a local business, entitled to be given preference, the business must make application with Wellington and meet one of the following criteria as such is more fully set forth in Section 2.12.F(2) of Wellington's Purchasing and Procurement Manual:

2.12.F (2) Definition of Local Businesses

Western Communities Local Business - For the purpose of determining a "Western Communities local business" a vendor must have a principal permanent business location and headquarters within Wellington of Wellington, Florida or west of the Florida Turnpike to the Palm Beach County western boundary line as depicted in Exhibit "A" hereto. This applies to all entity formations, including, but not limited to, limited liability companies, partnerships, limited partnerships and the like or sole proprietors. Further, the entity or sole proprietor must provide that it, he or she has been domiciled and headquartered in the jurisdictional boundaries of the Western Communities for at least six months prior to the solicitation. Post Office boxes will not be considered a permanent business location within the Western Communities. Home business offices shall be considered as a business location if it otherwise meets the requirements herein. In order to be eligible for such local preference the vendor shall have a local business tax receipt pursuant to the County's and/or municipalities' Code of Ordinances, having jurisdiction over the location of the business, unless otherwise exempt therefrom. Further, the vendor must be properly licensed and authorized by law to provide the goods, services or professional services to the extent applicable and the location of the business must be properly zoned in order for the vendor to conduct its business.

Palm Beach County local business - For the purpose of determining a "Palm Beach County local business" a vendor must have a principal permanent business location and headquarters within Palm Beach County, Florida. This applies to all entity formations, including, but not limited to, limited liability companies, partnerships, limited partnerships and the like or sole proprietors. Further, the entity or sole proprietor must provide that it, he or she has been headquartered and domiciled in the jurisdictional boundaries of Palm Beach County, Florida for at least six months prior to the solicitation. Post Office boxes will not be considered a permanent business location within Palm Beach County, Florida. Home business offices shall be considered as a business location if it otherwise meets the requirements herein. In order to be eligible for such local preference the vendor shall have a local business tax receipt pursuant to the Palm Beach County Code of Ordinances as amended from time to time, unless otherwise exempt there from. Further, the vendor must be properly licensed and authorized by law to provide the goods, services or professional services to the extent applicable and the location of the business must be properly zoned in order for the vendor to conduct its business.

Subcontractor utilization - In competitive bid situations, a business may also qualify as either a Palm Beach County or Western Community local business if they are utilizing subcontractors to perform the work or materialmen to supply the job and more than fifty (50%) percent of their proposed bid price will be paid to subcontractors and/or materialmen who qualify, under the above standards, as Palm Beach County and/or Western Community local businesses.

Please check the box below indicating which preference category your business is applying for:

☐ Western Communities Local Business

☒ Palm Beach County Local Business

☐ Subcontractor Utilization

1. The name of the business is:

Gehring Group, Inc.

2. The address of the business is:
11505 Fairchild Gardens Ave, Suite 202, Palm Beach Gardens, FL 33410

3. How long has the business been located at its current address:
12 Years

4. If the business has relocated within the last six months, please provide the answers to questions 1-3 for the previous location:

5. The previous name of the business is:

_____

6. The previous address of the business is:

_____

7. How long was this business at the previous location: _____

8. If the business is attempting to qualify under the subcontractor utilization provision, please provide a breakdown of the subcontractors who would qualify for either the Palm Beach County or Western Community, business classification, the requisite information, provide their responses to the above 1 - 7 questions and for each of the subcontractors, indicate the amount that they are proposed to be compensated at under the bid price.

9. The business as a local business tax receipt from: (1) Palm Beach County [X] (2) the following municipality: Palm Beach Gardens (3) located in unincorporated Palm Beach County: [ ]

10. Please provide a copy of Local Business Tax Receipts from Palm Beach County and the applicable municipality are attached.

11. Please provide a Certificate of Good Standing indicating the formation or domestication of the entity in and for the State of Florida is attached.

12. Please provide copies of licenses if applicable from the State of Florida authorizing the business to provide the good services or professional services contemplated in the bid documents.

13. Please provide a letter from the either the Palm Beach County if located in unincorporated Palm Beach County or the municipality if located within the municipality evidencing that the headquarters for the business is properly zoned for the business.

By signing below, I hereby certify that under penalty of perjury I believe my business qualifies as a Palm Beach County, Western Community or subcontractor utilization business in accordance with Wellington's Local Preference Policy and that I have submitted current and accurate information and documents relating to my qualifications. I further acknowledge and agree that any fraudulent or duplicitous information submitted in furtherance of this application will be grounds for disqualification from bidding on this project and doing business with Wellington in the future.

Applicants Federal Tax ID Number - 65-0361295

Applicants Business Address 11505 FAIRCHILD GARDENS AVE
STE 202
PALM BEACH GARDENS, FL 33410

Local Business Tax Receipt

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

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

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

TYPE OF BUSINESS	OWNER	CERTIFICATION #	RECEIPT #/DATE PAID	AMT PAID	BILL #
56-0001 ADMINISTRATIVE OFFICE	GEHRING KURT		B13.1639876 - 09/24/13	$33.00	B40132036

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

STATE OF FLORIDA
PALM BEACH COUNTY
2013/2014 LOCAL BUSINESS TAX RECEIPT

B1 - 153

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

LBTR Number: 200217782
EXPIRES: SEPTEMBER 30, 2014

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

CITY OF PALM BEACH GARDENS

No: 004464

BUSINESS TAX RECEIPT

10500 N. MILITARY TRL, PALM BCH GARDENS, FL 33410

EXPIRES SEPTEMBER 30, 2014

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

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

2013 / 2014

MUST BE POSTED CONSPICUOUSLY AT YOUR PLACE OF BUSINESS

CERTIFIED BUSINESS TAX OFFICIAL

Tab 8: Conflict of Interest Form

CONFLICT OF INTEREST STATEMENT (Tab #8)

This Proposal/Agreement (whichever is applicable) is subject to the conflict of interest provisions of the policies and Code of Ordinances of WELLINGTON, the Palm Beach County Code of Ethics, and the Florida Statutes. During the term of this Agreement and any renewals or extensions thereof, the VENDOR shall disclose to WELLINGTON any possible conflicts of interests. The VENDOR's duty to disclose is of a continuing nature and any conflict of interest shall be immediately brought to the attention of WELLINGTON. The terms below shall be defined in accordance with the policies and Code of Ordinances of WELLINGTON, the Palm Beach County Code of Ethics, and Ch. 112, Part III, Florida Statutes.

CHECK ALL THAT APPLY.

[X] To the best of our knowledge, the undersigned business has no potential conflict of interest for this Agreement due to any other clients, contracts, or property interests.

[X] To the best of our knowledge, the undersigned business has no employment or other contractual relationship with any WELLINGTON employee, elected official or appointed official.

[X] To the best of our knowledge, the undersigned business has no officer, director, partner or proprietor that is a WELLINGTON purchasing agent, other employee, elected official or appointed official. The term "purchasing agent", "elected official" or "appointed official", as used in this paragraph, shall include the respective individual's spouse or child, as defined in Ch. 112, Part III, Florida Statutes.

[X] To the best of our knowledge, no WELLINGTON employee, elected official or appointed official has a material or ownership interest (5% ownership) in our business. The term "employee", "elected official" and "appointed official", as used in this paragraph, shall include such respective individual's relatives and household members as described and defined in the Palm Beach County Code of Ethics.

[X] To the best of our knowledge, the undersigned business has no current clients that are presently subject to the jurisdiction of WELLINGTON's Planning, Zoning and Building Department.

[ ] The undersigned business, by attachment to this form, submits information which may be a potential conflict of interest due to any of the above listed reasons or otherwise.

THE UNDERSIGNED UNDERSTANDS AND AGREES THAT THE FAILURE TO CHECK THE APPROPRIATE BLOCKS ABOVE OR TO ATTACH THE DOCUMENTATION OF ANY POSSIBLE CONFLICTS OF INTEREST MAY RESULT IN DISQUALIFICATION OF YOUR BID/PROPOSAL OR IN THE IMMEDIATE CANCELLATION OF YOUR AGREEMENT, WHICHEVER IS APPLICABLE.

Gehring Group, Inc.
COMPANY NAME

Kurt Gehring
AUTHORIZED SIGNATURE

Kurt Gehring
NAME (PRINT OR TYPE)

CEO
TITLE

Tab 9: Optional Services

OPTIONAL SERVICES FOR HUMAN RESOURCES:

Flat – Fee	**$39,000**

Wellington may request to receive ***optional*** products and services from a qualified firm as a subject matter expert. The optional services ***will not*** be utilized by the selection committee as a basis for recommendation/award. Any firm interested in providing such services, please include in Tab #9, a brief description of services available and fees to perform the services. (Form Attached on page 21)

3. Provide FMLA administration including tracking and notifications
4. Complete monthly carrier invoicing and reconciliation
5. Coordinate and execute testing including but not limited to:
    a. Random drug testing
    b. Annual Motor Vehicle checks
    c. Bi-annual Background Screening

Gehring Group proposes performing the optional Human Resources services outlined above for a fee of **$3,250 per month** plus applicable pass-through outsourced vendor expenses for the following requested services:

- FMLA administration
- Random drug testing
- Annual Motor Vehicle checks
- Bi-annual Background Screening

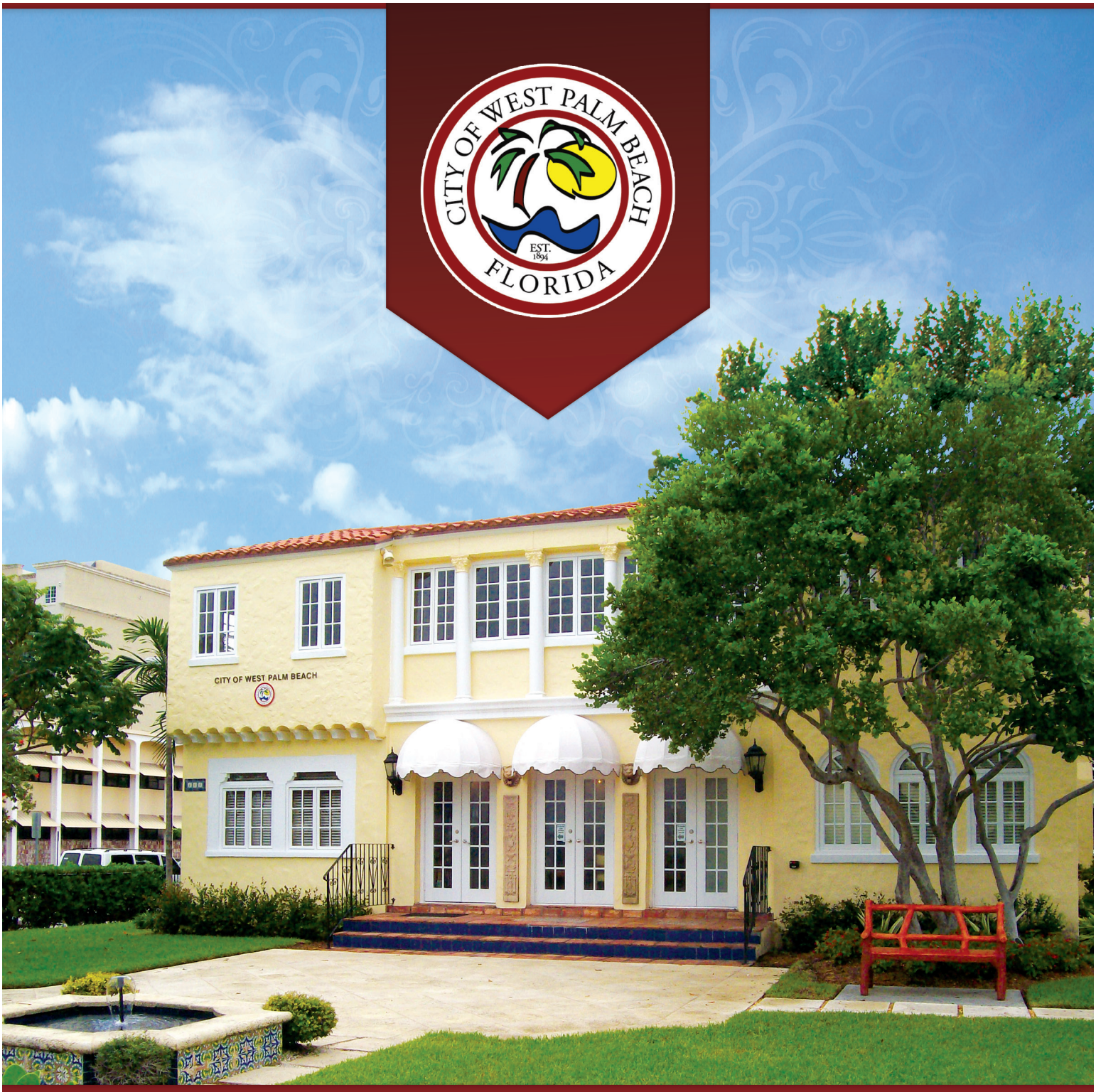
It is anticipated that these services can be performed off-site at Gehring Group's Palm Beach Gardens location.

TAB 10: EXHIBITS

Exhibit A: BenTek® Online Enrollment & Administration System

Graphics in BenTek brochure made file size too large to include in this PDF electronic copy. Please refer to hard copy to view BenTek brochure.

Exhibit B: Sample Employee Benefit Guide & Employee Communications



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

2014

Employee Benefit Highlights

GENERAL EMPLOYEES

Employee & Family Health Center

464 Fern Street, West Palm Beach, FL 33401

For an appointment call 561-822-2000

SAVE TIME AND MONEY AT YOUR EMPLOYEE & FAMILY HEALTH CENTER

When you and your family need expert treatment for routine medical needs, turn first to your Employee & Family Health Center for:

- √ **On-site convenience** – Enjoy easy access and short waits.
- √ **Excellent care** – Board-certified Physicians and Nurse Practitioners provide the highest quality care.
- √ **Peace of mind** – Our health center is part of a family of trusted health care companies and facilities that includes JFK Medical Center.
- √ **Guaranteed privacy** – Your health information is kept strictly confidential and will not be shared with your employer or anyone else without your written permission.

For an appointment and directions, call (561) 822-2000
or for more information go online to: www.cityfitmd.com • FREE PARKING

CITY OF WEST PALM BEACH
EMPLOYEE AND FAMILY HEALTH CENTER

IMPORTANT CONTACT INFORMATION

City of West Palm Beach	Contact Name	Contact Information
Human Resources Department	General Benefit Questions	Phone: (561) 494-1000
Health Center	Employee and Family Health Center	464 Fern Street West Palm Beach, FL 33401 Phone: (561) 822-2000 www.cityfitmd.com
Service	**Provider**	**Contact Information**
BenTek Online Enrollment	BenTek Technical Support	Email: support@mybentek.com Phone: (888) 5-BenTek (523-6835) www.mybentek.com/wpb
Medical Insurance	Cigna	Customer Service: (800) 244-6224 www.mycigna.com Group Plan #: 3332277
Prescription Drug Coverage & Mail-Order Program	Cigna Home Delivery	Customer Service: (800) 835-3784 www.mycigna.com
Dental Insurance	Humana	Customer Service: (800) 342-5209 www.mycompbenefits.com
Vision Insurance	Humana	Customer Service: (866) 537-0229 www.mycompbenefits.com City Contract # FL 207128
Flexible Spending Account (FSA)	WageWorks	Customer Service: (800) 950-0105 Mon. – Fri. 8:00am – 7:00pm CST www.takecarewageworks.com www.fsaworksforme.com/takecare
Basic Life and AD&D Insurance	The Hartford	Customer Service: (888) 563-1124 www.thehartfordatwork.com Group Plan # 6770058
Employee Assistance Program (EAP)	Aetna Resources for Living	24-Hour Crisis Line: (800) 272-7252 www.mylifevalues.com Login ID: CWPB Password: CWPB
Supplemental Insurance	Aflac	Customer Service: (800) 992-3522 www.aflac.com Local City Aflac Representative: Linda Carcich (561) 784-5256 aflac@wpb.org (Lotus Note)
Preferred Legal Plan	Preferred Legal Plan	Customer Service: (888) 577-3476 www.preferredlegal.com Brian Samuels Email: info@preferredlegal.com
Defined Contribution and Deferred Compensation Programs	Great-West Retirement Services	Customer Service: (800) 584-6001 www.gwrs.com On-Site Great West Representative: Helena Novakova Cell: (786) 877-9572 or On-Site HR (561) 494-1000 Email: Helena.novakova@gwrs.com

Table of Contents

Introduction

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

Notices

COBRA Continuation of Medical Coverage Benefits

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

Medicare Part D Creditable Coverage

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

Online Benefit Enrollment

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

Online enrollment with BenTek!

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

To access the Employee Benefits Center during open enrollment:

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

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

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

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

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

Summary of Benefits and Coverage

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

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

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

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

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

Group Insurance Eligibility

The City's group insurance plan year is **January 1, 2014 through June 30, 2014 (short plan year).**

Employee Eligibility

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

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

Dependent Eligibility

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

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

Dependent Eligibility Age Requirements

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

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

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

Disabled Dependents

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

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

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

Taxable Dependents

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

Group Insurance Eligibility *(Continued)*

Domestic Partner Coverage

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

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

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

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

Qualifying Events and IRS Code Section 125

IRS Code Section 125

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

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

Examples of Qualifying Events

- You get married or divorced
- You have a child, gain legal custody or adopt a child
- Your spouse and/or other dependent(s) die(s)
- You, your spouse, or dependent(s) terminate or start employment
- An increase or decrease in your work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with an ex-spouse
- Gain or loss of Medicare coverage
- Enrollment only - Eligibility for premium assistance under Medicaid or CHIP, as long as you/dependents are eligible but not already enrolled in employer plan (60 day notification period). Note: Check with the Medicaid Office for additional information regarding eligibility.
- Enrollment only - Loss of Medicaid or CHIP eligibility, as long as you/dependents are eligible but not already enrolled in employer plan (60 day notification period)

IMPORTANT

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

(Furnishing Valid documentation supporting the qualifying event is required)

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

Medical Insurance Premiums

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

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

Medical Insurance – OAPIN Plan
Monthly Premium Deductions

Tier of Coverage	Employee Pays	City Pays	Total Premium
Employee Only	$31.23	$593.39	$624.62
Employee + 1 Dependent	$329.17	$987.52	$1,316.69
Employee + Family	$457.91	$1,373.72	$1,831.63
Over-Age Dependent [1, 2]	$313.21	$0.00	$313.21

1) For the entire 2014 Benefits year, an over-age dependent is defined as: "a dependent who will reach age 27, 28, 29, or 30 during 2014".

2) Additional post tax payroll deduction.

Medical Insurance – OAPIN Plan – Domestic Partner
Monthly Reported Imputed Income Value

Tier of Coverage	Reported Income Value
Employee + Domestic Partner Value [1]	$692.07
Employee + Domestic Partner + Employee Child(ren) Value [1]	$692.07
Employee + Domestic Partner + Domestic Partner Child(ren) Value [1]	$1,207.01

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

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

Other Available Plan Resources

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

Healthy Rewards

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

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

24 Hour Help Information Hotline (800) CIGNA-24

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

The myCigna Mobile App

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

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

Medical Insurance: Cigna OAPIN Plan At-A-Glance

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

Network	Open Access Plus
Calendar Year Deductible (CYD)	**In-Network**
Single	$0
Family	$0
Coinsurance	**In-Network**
Member Responsibility	0%
Calendar Year Out-of-Pocket Limit	**In-Network**
Single	$1,500
Family	$3,000
What Applies to the Out-of-Pocket Limit?	Copays (excludes Rx)
Physician Services	**In-Network**
Primary Care Physician (PCP) thru Employee Health Clinic	**No Charge at Clinic only**
Primary Care Physician Office Visit (PCP) *(No PCP Election Required)*	$25 Copay
Specialist Office Visit *(No Referral Required)*	$35 Copay
Diagnostic Services	**In-Network**
Lab (Blood Work) thru Employee Health Clinic	**No Charge at Clinic only**
Clinical Lab (Blood Work) at Independent Facility*	No Charge
X-rays thru Employee Health Clinic	**No Charge at Clinic only**
X-rays at Independent Facility*	No Charge
Advanced Imaging at Freestanding Facility (MRI, PET, CT)*	
Hospital Services	**In-Network**
Inpatient	$300 Copay per Admission
Outpatient Surgery	$150 Copay per Admission
Physician Services at Hospital	No Charge
Emergency Room (Waived if Admitted)	$150 Copay
Urgent Care	$50 Copay
Mental Health / Alcohol & Substance Abuse	**In-Network**
Inpatient	$300 Copay per Admission
Outpatient	$35 Copay
Prescription Drugs (Rx)	**In-Network**
Generic thru Employee Health Clinic	**No Charge thru Clinic only**
Generic	$15 Copay
Preferred Brand Name	$30 Copay
Non-Preferred Brand Name	$60 Copay
Generic mail-order thru Employee Health Clinic	**No Charge thru Clinic only**
Mail-Order Drug (90 Day Supply)	2x Retail Copay

Charges may vary based on the place of service.

Dental Insurance: DMO CS150 Plan

Humana/CompBenefits
Customer Service: (800) 342-5209
www.mycompbenefits.com

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

Dental Insurance – DMO CS150 Plan
Monthly Premium Deductions

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

In-Network Benefits

The DMO CS150 Plan is an "in-network" only plan that **requires** you to select and receive services from a Primary Dental Provider. In order to receive services, you can select any participating dentist in the network. The network of participating providers who this dental plan utilizes is the "**DMO CS150 Network**." To determine if your dentist is in the DMO CS150 Network log on to www.compbenefits.com and select "Providers/Search" then "Find Dental Providers", choose the "DHMO Plans" from the "Plan Type Options" and fill in your search criteria then click "Submit".

The DMO CS150 plan's schedule of benefits is set forth by the Patient Charge Schedule (fee schedule) which is highlighted on the following pages. Please refer to your plan's certificate of coverage for a detailed listing of charges and what is covered.

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

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

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

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

Out-of-Network Benefits

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

Employee Classification	
PMSA	CP 1851
SEIU	CP 1853
Unclass / None / Conf	CP 1854
FF & PBA	CP 1850
COBRA	CP 1849
Retiree's	CP 1852

Calendar Year Deductible

There is no Calendar Year Deductible that needs to be met on this plan.

Calendar Year Benefit Maximum

This plan is not subject to any benefit maximums.

Please Note the Following:

- *Each covered family member is entitled to 2 FREE cleanings per calendar year covered under the preventative benefit. Members can also receive 2 additional cleanings at the charge of a copy.*
- *Unlisted covered dental care services may be available at the participating dentist's usual fee less 25%. Not all dentists perform all services.*
- *Should you need to see a specialist under this plan (Oral Surgeon, Periodontist, Orthodontist, etc.), you must be referred by your Primary Dental Provider.*

Dental Insurance: Advantage Plan AVN4S

Humana/CompBenefits
Customer Service: (800) 342-5209
www.mycompbenefits.com

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

Dental Insurance – Advantage Plan AVN4S
Monthly Premium Deductions

Tier of Coverage	Employee Pays	City Pays	Total Premium
Employee Only	$10.60	$11.94	$22.54
Employee + 1 Dependent	$24.44	$14.32	$38.76
Employee + Family	$44.62	$12.80	$57.42

In-Network Benefits

The Advantage AVN4S is an "in-network" only plan that allows you to receive services from any dental provider without first selecting or coordinating your care through a Primary Dental Provider. The network of participating providers who this plan utilizes is the **"Advantage" Network**. To determine if your dentist is in the Advantage Plan Network log on to www.compbenefits.com and select "Providers/ Search" then "Find Dental Providers", choose the "AdvantagePlus Plans" from the "Plan Type Options" and fill in your search criteria then click "Submit".

The Advantage AVN4S plan's schedule of benefits is set forth by the Patient Charge Schedule (fee schedule) which is highlighted on the following pages. Please refer to your plan's certificate of coverage for a detailed listing of charges and what is covered.

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

Tier of Coverage	Reported Income Value
Employee + Domestic Partner Value [1]	$16.21
Employee + Domestic Partner + Employee Child(ren) Value [1]	$16.21
Employee + Domestic Partner + Domestic Partner Child(ren) Value [1]	$34.88

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

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

Employee Classification	
PMSA	CP 4151
SEIU	CP 4153
Unclass / None / Conf	CP 4154
FF & PBA	CP 4150
COBRA	CP 4149
Retiree's	CP 4152

Out-of-Network Benefits

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

Calendar Year Deductible

There is no Calendar Year Deductible that needs to be met on this plan.

Calendar Year Benefit Maximum

This plan is not subject to any benefit maximums.

Please Note the Following:

- *Each covered family member is entitled to 2 FREE cleanings per calendar year covered under the preventative benefit. Members can also receive 2 additional cleanings at the charge of a copay.*
- *No referrals are necessary for specialty dentists in the network.*
- *Unlisted covered dental care services may be available at the participating dentist's usual fee less 20%. Not all dentists perform all services.*

Dental Insurance: DMO & Advantage Plans Side-By-Side

Procedure Code	Service Type: Diagnostic	DMO CS150	AVN4S
0120	Periodic Oral Evaluation	$0	$0
0140	Comprehensive Oral Evaluation	$0	$0
0210	X-Ray Intraoral - Complete Series	$0	$0
0220	X-Ray Intraoral - Periapical - First Film	$0	$0
0230	X-Ray Intraoral - Periapical - Additional Film	$0	$0
0270	X-Ray Bitewing - Single Film	$0	$0
0272	X-Ray Bitewing - Two Films	$0	$0
0274	X-Ray Bitewing - Four Films	$0	$0
0330	Paoramic Film	$0	$0
Procedure Code	**Service Type: Preventative Care**	**DMO CS150**	**AVN4S**
1110/1120	Prophylaxis (once every 6 months)	$0	$0
1110/1120	Prophylaxis (additional)	$20	20% Discount
1201	Topical Application of Fluoride (Prophylaxis)	$0	20% Discount
1203	Topical Application of Fluoride (Non-Prophylaxis)	$0	$0
1351	Sealant - per tooth	$10	$0
1510	Space Maintainer - Fixed - Unilateral	$45 + Lab	$0
1515	Space Maintainer - Fixed - Bilateral	$45 + Lab	$0
1520	Space Maintainer - Removable - Unilateral	$85 + Lab	$0
1525	Space Maintainer - Removable - Bilateral	$85 + Lab	$0
Procedure Code	**Service Type: Restorative**	**DMO CS150**	**AVN4S**
2140	Amalgam - One Surface, Permanent or Primary	$0	$0
2150	Amalgam - Two Surfaces, Permanent or Primary	$0	$0
2160	Amalgam - Three Surfaces, Permanent or Primary	$0	$0
2161	Amalgam - Four or More Surfaces, Permanent or Primary	$0	$0
2940	Sedative Filling	$15	$44
Procedure Code	**Service Type: Resin Restoration**	**DMO CS150**	**AVN4S**
2330	Resin - One Surface, Anterior	$35	$0
2331	Resin - Two Surfaces, Anterior	$40	$0
2332	Resin - Three Surfaces, Anterior	$50	$0
2391	Resin - One Surface, Posterior	$60	$0
2392	Resin - Two Surfaces, Posterior	$80	$0
2393	Resin - Three Surfaces, Posterior	$100	$0
2394	Resin - Four or More, Posterior	$120	$0
2510	Inlay - Metallic - One Surface	$95	$313
2520	Inlay - Metallic - Two Surfaces	$105	$355
2530	Inlay - Metallic - Three or More Surfaces	$130	$410
Procedure Code	**Service Type: Crown & Bridge**	**DMO CS150**	**AVN4S**
2740	Crown - Porcelain/Ceramic Substrate	$280 + Lab	$473
2750	Crown - Porcelain Fused to High Noble Metal	$280*	$466
2751	Crown - Porcelain Fused to Predom Base Metal	$280	$434
2752	Crown - Porcelain Fused to Noble Metal	$280*	$445

**The above copayments do not include the additional cost of precious (high noble) and semi-precious (noble) metal. The additional cost of precious metal shall not exceed $125 per unit and $75 per unit for semi-precious metal.*

Dental Insurance: DMO & Advantage Plans Side-By-Side

Procedure Code	Service Type: Crown & Bridge (continued)	DMO CS150	AVN4S
2790	Crown - Full Cast High Noble Metal	$280*	$450
2791	Crown - Full Cast Predom Base Metal	$280	$426
2792	Crown - Full Cast Noble Metal	$280*	$434
2910	Recement Inlay	$15	$41
2920	Recement Crown	$15	$42
2930	Prefabricated Stainless Steel Crown - Primary	$75	$115
2950	Core Buildup, including any pins	$45	$110
2951	Pin Retention - Per Tooth	$15	$23
2952	Cast Post and Core in addition to Crown	$90 + Lab	$168
2953	Each Additional Cast Post - same tooth	$90 + Lab	20% Discount
2954	Prefabricated Post and Core in Addition to Crown	$90	$139
2962	Labial Veneer (Porcelain Laminate) Laboratory	$280 + Lab	20% Discount
Procedure Code	**Service Type: Endodontics**	**DMO CS150**	**AVN4S**
3220	Therapeutic Pulpotomy	$35	$0
3221	Pulpal Debridement, Primary & Permanent	$100	20% Discount
3310	Root Canal Therapy - Anterior	$100	$0
3320	Root Canal Therapy - Bicuspid	$200	$0
3330	Root Canal Therapy - Molar	$250	$0
3410	Apicoectomy/Periradicular Surgery	$125	$0
Procedure Code	**Service Type: Periodontics (Gum Treatment)**	**DMO CS150**	**AVN4S**
4210	Gingivectomy/Gingivoplasty - Per Quadrant	$125	$0
4211	Gingivectomy/Gingivoplasty - Per Tooth	$40	$0
4260	Osseous Surgery - Per Quadrant	$350	$0
4271	Free Soft Tissue Graft Procedure	$225	20% Discount
4341	Periodontal Scaling and Root Planning - Per Quad	$50	$0
4355	Full Mouth Debridement	$45	$0
4910	Periodontal Maintenance Procedures	$50	$0
Procedure Code	**Service Type: Prosthodontics**	**DMO CS150**	**AVN4S**
5110	Complete Denture - Maxillary	$300 + Lab	$642
5120	Complete Denture - Mandibular	$300 + Lab	$642
5130	Immediate Denture - Maxillary	$300 + Lab	$700
5140	Immediate Denture - Mandibular	$300 + Lab	$700
5211	Maxillary Partial Denture - Resin Base	$300 + Lab	$542
5212	Mandibular Partial Denture - Resin Base	$300 + Lab	$629
5213	Maxillary Partial Denture - Cast Metal Framework	$300 + Lab	$709
5214	Mandibular Partial Denture - Cast Metal Framework	$300 + Lab	$709
5410	Adjust Complete Denture - Maxillary	$15	$35
5411	Adjust Complete Denture - Mandibular	$15	$35
5421	Adjust Partial Denture - Maxillary	$15	$35
5422	Adjust Partial Denture - Mandibular	$15	$35

**The above copayments do not include the additional cost of precious (high noble) and semi-precious (noble) metal. The additional cost of precious metal shall not exceed $125 per unit and $75 per unit for semi-precious metal.*

Dental Insurance: DMO & Advantage Plans Side-By-Side

Procedure Code	Service Type Prosthodontics (continued)	DMO CS150	AVN4S
5510	Repair Broken Complete Denture Base	$15 + Lab	$70
5520	Replace Missing or Broken Teeth	$15 + Lab	$59
5610	Repair Resin Denture Base	$15 + Lab	$76
5640	Replace Broken Teeth - Per Tooth	$15 + Lab	$64
5730	Reline Complete Maxillary Denture (Chairside)	$50	$147
5731	Reline Complete Mandibular Denture (Chairside)	$50	$147
5740	Reline Maxillary Partial Denture (Chairside)	$50	$135
5741	Reline Mandibular Partial Denture (Chairside)	$50	$135
5750	Reline Complete Maxillary Denture (Laboratory)	$35 + Lab	$196
5751	Reline Complete Mandibular Denture (Laboratory)	$35 + Lab	$196
5760	Reline Maxillary Partial Denture (Laboratory)	$35 + Lab	$193
5761	Reline Mandibular Partial Denture (Laboratory)	$35 + Lab	$193
5850	Tissue Conditioning - Maxillary	$30	$61
5851	Tissue Conditioning - Mandibular	$30	$61
Procedure Code	**Service Type: Prosthodontics (Fixed)**	**DMO CS150**	**AVN4S**
6210	Pontic - Cast High Noble Metal	$280*	$431
6211	Pontic - Cast Predom Base Metal	$280	$404
6212	Pontic - Cast Noble Metal	$280*	$420
6240	Pontic - Porcelain Fused to High Noble Metal	$280*	$426
6241	Pontic - Porcelain Fused to Predom Base Metal	$280	$393
6242	Pontic - Porcelain Fused to Noble Metal	$280*	$415
6750	Crown - Porcelain Fused to High Noble Metal	$280*	$486
6751	Crown - Porcelain Fused to Predom Base Metal	$280	$453
6752	Crown - Porcelain Fused to Noble Metal	$280*	$464
6930	Recement Fixed Partial Denture (per unit)	$10	$57
Procedure Code	**Service Type: Extractions/Oral & Maxillofacial Surgery**	**DMO CS150**	**AVN4S**
7140	Extraction, Erupted Tooth/Exposed Root	$0	$0
7210	Surgical Removal of Erupted Tooth	$40	$0
7220	Removal of Impacted Tooth - Soft Tissue	$50	$0
7230	Removal of Impacted Tooth - Partially Bony	$70	$0
7240	Removal of Impacted Tooth - Completely Bony	$85	$0
7510	Incision and Drainage of Abscess - Intraoral	$25	$0
Procedure Code	**Service Type: Orthodontics**	**DMO CS150**	**AVN4S**
8070/8080	Comprehensive orthodontic treatment of the transitional/adolescent dentition. Children up to 19 years of age. Up to 24 months of routine (full-banded) orthodontic treatment for Class 1 and 2.		
8070/8080	Consultation	$0	$0
8070/8080	Evaluation	$35	$35
8070/8080	Records/Treatment Planning	$250	$250
8070/8080	Orthodontic Treatment	$1,800	$2,100

**The above copayments do not include the additional cost of precious (high noble) and semi-precious (noble) metal. The additional cost of precious metal shall not exceed $125 per unit and $75 per unit for semi-precious metal.*

Dental Insurance: DMO & Advantage Plans Side-By-Side

Procedure Code	Service Type: Orthodontics (continued)	DMO CS150	AVN4S
8090	Comprehensive orthodontic treatment of the adult dentition. Adults over 19 years of age. Up to 24 months of routine (full-banded) orthodontic treatment for Class 1 and 2.		
8090	Consultation	$0	$0
8090	Evaluation	$35	$35
8090	Records/Treatment Planning	$250	$250
8090	Orthodontic Treatment	$2,000	$2,300
8680	Retention	$450	$450
Procedure Code	**Service Type: Adjunctive General Services**	**DMO CS150**	**AVN4S**
9215	Local Anesthesia	$0	$0
9230	Anesthesia (Nitrous Oxide - Per 15 Minutes)	$15	20% Discount
9951	Occlusal Adjustment - Limited	$25	$0
9952	Occlusal Adjustment - Complete	$150	$0
Procedure Code	**Service Type: Appointments**	**DMO CS150**	**AVN4S**
9310	Consultation - Diagnostic provided by DDS	$15	$0
9430	Office Visit - Normal Hours	$5	N/A**
9440	Office Visit - After Hours	$35	N/A**
9999	Emergency Visit - Normal Hours	$20	N/A**
9999	Broken Appointment - Without 24 hours Notice	$10	N/A**

**The above copayments do not include the additional cost of precious (high noble) and semi-precious (noble) metal. The additional cost of precious metal shall not exceed $125 per unit and $75 per unit for semi-precious metal.*

***Not standalone codes on the AVN4S - dentist should code for the procedure performed not the office visit.*

Dental Insurance: Elite Preferred 710 PPO Plan

Humana/CompBenefits
Customer Service: (800) 342-5209
www.mycompbenefits.com

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

Dental Insurance – Elite Preferred 710 PPO Plan
Monthly Premium Deductions

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

In-Network Benefits

The Elite Preferred 710 PPO Plan option is an "open access" plan that allows you to receive services from any dental provider without first selecting or coordinating your care through a Primary Dental Provider. The network of participating providers who this plan utilizes is the **"PPO" network**. To determine if your dentist is in the PPO Network log on to www.compbenefits.com and select "Providers/Search" then "Find Dental Providers", choose the "PPO Plans" from the "Plan Type Options" and fill in your search criteria then click "Submit."

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

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

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

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

Out-of-Network Benefits

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

The insurance company processes charges based on what it determines the "Usual, Customary and Reasonable (UCR)" charge is for a specific service. UCR or the "allowed amount" can be defined as the most common charge for a particular dental procedure performed in a specific geographic area. Since there is no contract in place between the insurance company and out-of-network provider, the provider may charge an amount higher than the UCR. The difference between the UCR amount and the provider's higher charge is called "balance billing." **Balance billing is in addition to your deductible and coinsurance responsibility**.

Employee Classification	
PMSA	CP 4151
SEIU	CP 4153
Unclass / None / Conf	CP 4154
FF & PBA	CP 4150
COBRA	CP 4149
Retiree's	CP 4152

Calendar Year Deductible

The Elite Preferred 710 PPO Plan benefits begin once each covered member satisfies a $50 deductible (waived for Class I services). The deductible is applied collectively for either in or out-of-network services or any combination of both. Once any 3 covered members in a family each satisfies the $50 deductible, the deductible will then be considered met for all covered members in that family.

Coinsurance

The percentage of coinsurance a covered member is responsible for is based upon Humana's discounted fee assigned to each particular service. For example, in Class II services (Basic Restorative Care), Humana pays 80% coinsurance for in-network services and the member is responsible for 20% coinsurance, once the annual deductible has been satisfied.

Calendar Year Benefit Maximum

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

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

Network	PPO	
Calendar Year Deductible (CYD)	**In and Out of Network Combined**	
Per Member	$50	
Per Family	$150	
Waived for Class I Services?	Yes	
Calendar Year Benefit Maximum	**In and Out of Network Combined**	
Per Member	$1,000	
Class I Services: Diagnostic & Preventative	**In Network**	**Out of Network***
Oral Exam (Once Per 6 Months)	Plan Coinsurance: 100% Member Coinsurance: 0% Deductible Waived	Plan Coinsurance: 100% Member Coinsurance: 0% *(Subject to Balance Billing)* Deductible Waived
Prophylaxis/Cleanings (Once Per 6 Months)		
X-rays (Limitations May Apply)		
Fluoride Treatments (Once Per 12 Months For Children Under Age 16)		
Sealants (Once Per 3 Years For Children Under 16)		
Space Maintainers (Children Under Age 16)		
Class II Services: Basic Restorative	**In Network**	**Out of Network***
Fillings (Amalgams, Synthetic or Composite)	Plan Coinsurance: 80% Member Coinsurance: 20%	Plan Coinsurance: 80% Member Coinsurance: 20% *(Subject to Balance Billing)*
Emergency Palliative Treatment		
Tooth Extraction		
Endodontics (Root Canals)		
Periodontics (Includes the Treatment of Gum Diseases)		
Class III Services: Major Restorative	**In Network**	**Out of Network***
Major Restorative (Crowns, Inlays, Onlays)	Plan Coinsurance: 50% Member Coinsurance: 50%	Plan Coinsurance: 50% Member Coinsurance: 50% *(Subject to Balance Billing)*
Prosthetics (Bridges & Dentures)		
Bridges & Denture Repair		

*Out-Of-Network Balance Billing

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

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

Vision Insurance

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

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

Vision Insurance – Humana/CompBenefits
Monthly Premium Deductions

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

In-Network Benefits

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

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

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

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

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

Out-of-Network Benefits

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

How to Locate a Provider

Go to www.compbenefits.com under the "Providers/Search" tab click "Find Vision Care Providers." Choose a "Vision Care Plan" and then fill out the search criteria and click "Search."

Calendar Year Deductible

There is no Calendar Year Deductible.

Calendar Year Out-of-Pocket Maximum

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

Please Note the Following:

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

Vision Insurance: Plan At-A-Glance

Services	In Network	Out of Network
Eye Exam	$10 Copay	Up to $35 Reimbursement
Frequency of Services	**In Network**	**Out of Network**
Examination	12 Months	12 Months
Lenses	12 Months	12 Months
Frames	24 Months	24 Months
Contact Lenses	12 Months	12 Months
Lenses	**In Network (After Copay)**	**Out of Network**
Single	Paid in Full	Up to $25 Reimbursement
Bifocal		Up to $40 Reimbursement
Trifocal		Up to $60 Reimbursement
Contact Lenses	**In Network (After Copay)**	**Out of Network**
Non-Elective (Medically Necessary)	Paid in Full [1]	Up to $210 Reimbursement
Elective (Fitting, Follow-up & Lenses)	Up to $105 Allowance [2]	Up to $105 Reimbursement
Frames	**In Network (After Copay)**	**Out of Network**
Maximum Allowance	$40 Wholesale	$40 Retail Price Reimbursement
Lasik	**In Network**	**Out of Network**
Discount Programs [3]	Silver Package: $895/Eye for Conventional Lasik	Discount Programs Not Available Out of Network
	Gold Package: $1,295/Eye for Custom Lasik	
	Platinum Package: $1,895/Eye for Custom Lasik Plus Bladeless Lasik	

Notes:

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

Flexible Spending Accounts

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

The City of West Palm Beach offers Flexible Spending Accounts (FSA) administered by WageWorks (Formerly through FlexOne/Aflac). **Please note that there will be a short plan year January 1, 2014 - June 30, 2014.**

Debit Card

Use the Take Care® Card

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

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

Health Care Reimbursement Account	Dependent Care Reimbursement Account
This account allows you to set aside up to a **maximum of $1,250** for the **short plan year January 1, 2014 - June 30, 2014.** This money will not be taxable income to you and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs for you or your qualified dependents. Employees can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic). Examples of common expenses that qualify for reimbursement are listed below. ***NOTE: The entire Health Care FSA election is available to you on the first day coverage is effective.**	This account allows you to set aside up to a **maximum of $2,500 if you are single or married and file a joint tax return ($1,250 if you are married and file a separate tax return)** for work-related day care expenses for the **short plan year January 1, 2014 - June 30, 2014**. Qualified expenses include adult and child day care centers, preschool, and before/after school care for eligible children and adults. Please note that if your family's annual income is over $20,000, this reimbursement option will most likely save you more money than the dependent care tax credit you take on your tax return. To qualify, your dependent must be: • a child under the age of 13, or • a child, spouse or other dependent that is physically or mentally incapable of self-care and spends at least 8 hours a day in your household. ***NOTE: Unlike the Health Care FSA, you will only be reimbursed up to the amount that has been deducted from your paycheck for Dependent Care expenses.**

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

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

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

Flexible Spending Accounts *(Continued)*

FSA Guidelines

- Must be renewed annually to continue benefit for following year.
- You can enroll in either or both FSAs during open enrollment period, a qualifying event or new hire eligibility only.
- You cannot transfer money between FSAs.
- You cannot pay a dependent care expense from your Health Care FSA or vice versa.
- You cannot deduct reimbursed expenses for income tax purposes.
- You cannot be reimbursed for a service which you have not received.
- You cannot receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
- Domestic partners are not eligible as federal law does not recognize them as a qualified dependent.

Here's How It Works

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

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

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

Filing a Claim

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

Basic Life and AD&D Insurance

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

Basic Term Life

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

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

Accidental Death & Dismemberment

For Eligibility Classes 1 - 7, the City also provides Accidental Death & Dismemberment (AD&D) life insurance which pays in addition to the basic benefit when death occurs as a result of an accident. The AD&D benefit pays in addition to and in an amount equal to the basic benefit amount. For example, if you are a Class 4 employee earning $35,000 annually and death occurs as an accident, the death benefit would be $35,000 (basic) + $35,000 (AD&D) for a total benefit of $70,000. A partial AD&D benefit is also payable based on the schedule of benefits. For detailed coverages, exclusions, and stipulations contact The Hartford Customer Service.

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

Supplemental Employee & Dependent Life Insurance

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

Supplemental Employee Life

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

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

Supplemental Employee Life Monthly Premium Calculation

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

Supplemental Dependent Life

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

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

Supplemental Dependent Spouse Monthly Premium Calculation

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

Long Term Disability Insurance

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

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

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

Employee Assistance Program

Aetna Resources for Living
24-Hour Crisis Line: (800) 272-7252
www.mylifevalues.com

Login ID: CWPB
Password: CWPB

The City provides a comprehensive Employee Assistance Program (EAP) to you and each member of your family through Aetna. Aetna offers access to licensed master's level mental health professionals to help you gain a better understanding of problems that affect you, locate professional help, and decide upon a plan of action. The EAP plan provides up to six (6) visits per issue; unlimited issues. Representatives are available 24-hours a day, 7 days a week.

What is an EAP?

An EAP offers covered employees and their family members free and convenient access to a range of confidential and professional services to help address a variety of problems that can negatively affect well being with programs such as:

- Critical incident stress debriefing
- Fitness for duty evaluations
- Childcare consultation
- Eldercare consultation
- Legal consultation*
- Free online will
- Identity theft
- Website webinars
- Financial consultation
- Employee wellness
- Supervisory training
- Employee orientation
- Training / Orientation programs
- Educational workshops

** Legal/Financial Services are free of charge for the first 30 minutes, then a 25% discount will be applied off of the hourly rate.*

Are Services Confidential?

Your EAP enrollment is automatic but the EAP is a confidential program protected by State and Federal laws. Information relating to your participation in the EAP will not be shared with anyone without your expressed written permission. To learn more about how the EAP works and other available services, visit Aetna online at www.mylifevalues.com.

Supplemental Insurance

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

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

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

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

Preferred Legal Plan

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

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

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

Preferred Legal Plan service examples:

- Divorce
- Adoption
- Civil Litigation
- Child Custody and Support
- Bankruptcy
- Name Changes
- Criminal Defense
- Traffic Tickets
- Wills
- Real Estate
- Credit Report Issues
- Contract Review

Notes

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

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GEHRING GROUP

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

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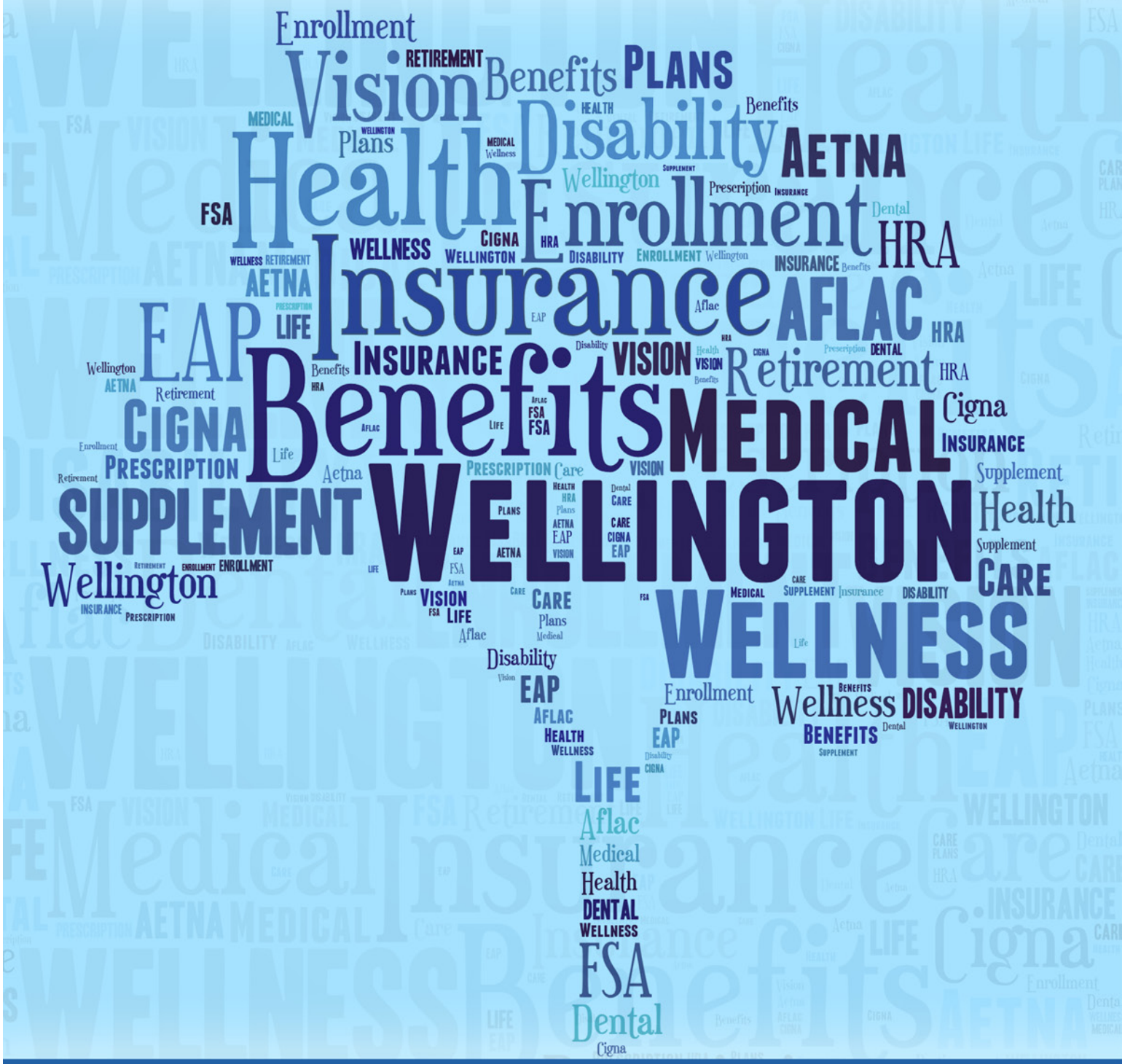

WELLINGTON

2014 EMPLOYEE BENEFIT HIGHLIGHTS

IMPORTANT CONTACT INFORMATION

The Village of Wellington		
Human Resources Department	Phone: (561) 791-4063	Fax: (561) 791-4178
Risk Management Department / Workers' Compensation	Phone: (561) 791-4021	Fax: (561) 904-5806

Service	Provider	Contact Information
Group Insurance Agency	Gehring Group	Customer Service: (561) 626-6797 Email: Wellington@gehringgroup.com www.gehringgroup.com
Online Enrollment	BenTek	Customer Service: (888) 5-BenTek (523-6835) www.mybentek.com/wellington
Medical Insurance	United Healthcare	Customer Service: (800) 357-0978 www.myuhc.com
Prescription Drug Mail Order Program	Optum Rx	Customer Service: (800) 788-4863 www.uhc.com
Health Reimbursement Account (HRA)	Benefits Workshop	Customer Service: (888) 537-3539 www.benefitsworkshop.com/wellington Mailing Address: P.O. Box 56828, Jacksonville, FL 32241 Fax: (904) 880-2830
Dental Insurance	Dental Decisions Administered by Anchor Benefit Consulting, Inc.	Customer Service: (800) 845-7629 www.anchorbenefit.com
Vision Insurance	Humana	Customer Service: (866) 537-0229 www.compbenefits.com
Flexible Spending Account (FSA)	Benefits Workshop	Customer Service: (888) 537-3539 www.benefitsworkshop.com/wellington
Basic and Voluntary Life & AD&D Insurance	Cigna	Customer Service: (800) 732-1603 www.cigna.com
Short and Long Term Disability	Cigna	Customer Service: (800) 732-1603 www.cigna.com
Employee Assistance Program (EAP)	Aetna Resources for Living	24-Hour Hotline: (800) 272-7252 www.mylifevalues.com
Preferred Legal Plan	Preferred Legal Plan	Customer Service: (888) 577-3476 www.preferredlegal.com
Supplemental Insurance	Aflac	Agent: Chris Teasdale Phone: (561) 371-3843 Email: chris_teasdale@us.aflac.com www.aflac.com
	Colonial	Agent: Keith Jordano Phone: (561) 333-6228 Email: keith@jordanogroup.com
Retirement Plans	FRS	Customer Service: (850) 488-8837 www.myfrs.com
	ICMA Retirement Corporation	Customer Service: (800) 669-7400 www.icmarc.org
	Florida Municipal Pension Trust	Customer Service: (800) 342-8112 www.flcretirement.com

Table of Contents

Introduction

The Village of Wellington provides a comprehensive compensation package including group insurance benefits. The Employee Benefit Highlights Booklet provides a general summary of these benefit options as a convenient reference. Please refer to Wellington's Policies, applicable Contracts and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If you require further explanation or need assistance regarding claims processing, please refer to the customer service telephone numbers under each benefit description heading or contact the Human Resources Department at (561) 791-4063.

Notices

COBRA Continuation of Medical Coverage Benefits

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

Medicare Part D Creditable Coverage

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

More information is available on the above Notices by contacting the Human Resources Department.

Online Benefit Enrollment

BenTek
Technical Support - E-mail: support@mybentek.com
Technical Support - Telephone: (888) 5-BenTek (523-6835)

The Village of Wellington will continue to provide an electronic enrollment through BenTek's Employee Benefits Center (EBC). The EBC provides benefit eligible employees the ability to make group insurance benefit elections and changes online during the annual open enrollment, new hire orientation and qualifying events module.

Open enrollment has never been easier. Accessible 24 hours a day during the open enrollment process, information about all of your employee benefits election options, including premiums and carrier contact information, are also available to help you make informed decisions. You can also log on to the EBC at any time to review your benefits, access carrier links, update life insurance beneficiaries, and report qualifying events.

Accessing BenTek:

- Log on to www.mybentek.com/wellington
- Sign in by using your previously created username and password or follow the instructions to set up your own username and password. You may contact BenTek support at (888) 5-BenTek (523-6835) for assistance.
- Enter BenTek to review current elections, learn about your benefit options, and make any elections or changes.
- You may also update your life insurance beneficiary designation(s).
- You have the option to print out your enrollment summary statement containing all your benefit elections for you and your family including your life insurance beneficiary designations.

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

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

Summary of Benefits and Coverage

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

From:	Human Resources Department
Address:	12300 W. Forest Hill Blvd.
	Wellington, FL 33414
Phone:	(561) 791-4063

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

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

If you have any questions about the plan offerings or coverage options, please contact the Human Resources Department at (561) 791-4063.

Group Insurance Eligibility

The Village of Wellington's group insurance plan year is January 1st through December 31st.

Employee Eligibility

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

Termination

If you separate employment from Wellington, medical, dental and vision insurance will continue through the end of the month in which the separation occurred.

Dependent Eligibility

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

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

Dependent Eligibility Age Requirements

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

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

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

Disabled Dependents

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

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

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

Taxable Dependents

Employees covering adult children under their medical and dental insurance plans may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which the child reaches age 26. Beginning January 1st of the calendar year in which the child reaches age 27 through the end of the calendar year in which the child reaches age 30, imputed income for the value of the applicable adult child's coverage for the coverage period must be reported on the employee's W-2. Imputed income is the dollar value of insurance coverage attributable to covering the adult child. There is no imputed income if an adult child is eligible to be claimed as a dependent for federal income tax purposes on the employee's tax return. Check with the Human Resources Department for further details if you are covering an adult child who will turn 27 any time in the upcoming calendar year or for more information.

Group Insurance Eligibility *(continued)*

Domestic Partner Coverage

To qualify for domestic partner benefits, an employee is required to submit a copy of a fully executed, notarized and recorded Declaration of Domestic Partnership form as required by Palm Beach County, Florida Ordinance 2006-002. Please visit www.pbcountyclerk.com and click on "Domestic Partnership" for the application, fees and additional information. If an employee is not a resident of Palm Beach County but has registered or otherwise legally established a partnership in another jurisdiction, Wellington will recognize the partnership, upon receipt of appropriate documentation and extend the same rights to an employee as if they had registered in Palm Beach County. Per IRS rules, an employee may not receive a tax advantage on any portion of premium attributable to a domestic partner; therefore, the entire portion of the premium attributable to domestic partner coverage for the period of coverage, including the value of the coverage for a domestic partner's child(ren), will be deducted on a post-tax basis.

Qualifying Events and IRS Code Section 125

IRS Code Section 125

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

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

Examples of Qualifying Events

- You get married or divorced
- You have a child, gain legal custody or adopt a child
- Your spouse and/or other dependent(s) die(s)
- You, your spouse, or dependent(s) terminate or start employment
- An increase or decrease in your work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with an ex-spouse
- Gain or loss of Medicare coverage
- Enrollment only - Eligibility for premium assistance under Medicaid or CHIP, as long as you/dependents are eligible but not already enrolled in employer plan (60 day notification period) Note: Check with the Medicaid Office for additional information regarding eligibility.
- Enrollment only - Loss of Medicaid or CHIP eligibility, as long as you/dependents are eligible but not already enrolled in employer plan (60 day notification period)

IMPORTANT

If you experience a qualifying event, *you must contact the Human Resources Department within 30 days of the qualifying event* to make the appropriate changes to your coverage. Beyond 30 days, requests will be denied and the employee may be responsible both legally and financially for any claim and/or expense incurred as a result of the employee or a dependent who continues to be enrolled but no longer meets eligibility requirements. If approved, changes will take place in accordance with the carrier's policies and procedures. However, newborns are effective on the date of birth. You may be required to furnish valid documentation supporting a change in status or "Qualifying Event."

MD Now Medical Centers

The Summary of Benefits and Coverage (SBC) Supplement, provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding the MD Now Medical Center. The information contained in this Booklet regarding the MD Now Medical Center is intended to supplement your SBC Supplement. If any information in this booklet unintentionally conflicts with the SBC Supplement, the SBC Supplement information prevails. If you have any additional questions regarding the MD Now Medical Center please contact MD Now Medical Center's Customer Service at (561) 798-9411.

MD Now – Wellington Center
Office: (561) 798-9411
www.MyMDNow.com

Wellington/Royal Palm Beach Location
11551 Southern Blvd., Ste. 4
Royal Palm Beach, FL 33411

MD Now – Wellington Center

The Village of Wellington has partnered with MD Now Medical Centers to provide Primary and Urgent Care services at little to no cost to eligible employees and their dependents currently enrolled in the United Healthcare medical insurance through Wellington.

Why Choose the MD Now - Wellington Center?

- Discounted medical services
- Online scheduling
- Convenient location and great staff
- 100% confidential and HIPAA compliant
- Certified by the Urgent Care Association of America

What services can be performed at MD Now Medical Centers?

- Primary Care
- Urgent Care
- Complete Diagnostic Services – Lab testing, rapid flu, strep tests and more
- Digital X-rays and EKGs
- Stitches and Wound Repair

Prescription Medications

The MD Now – Wellington Center staff can prescribe medication for a variety of conditions. For Primary Care visits, the staff can prescribe medication for chronic conditions, such as high blood pressure and acid reflux. For Urgent Care visits, the staff will provide up to 2 in-stock medicines at no charge for acute conditions, such as the cold or flu.

Accessing the MD Now – Wellington Center

Appointments are required for Primary Care visits and **must be scheduled 24 hours in advance by calling (561) 798-4911**. Walk-ins are considered Urgent Care and will be accommodated based on the location's appointment times and severity of the medical issue. For all visits, employees should bring their photo ID, **United Healthcare insurance card**, and **MD Now Employee Benefits Card**.

Hours of Operation			
Primary Care - Wellington Location		**Urgent Care - All Palm Beach County Locations**	
Monday - Friday	9am - 5pm	Sunday - Saturday	8am - 8pm

2014 Plan Year Rates

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your United Healthcare medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan please contact United Healthcare's Customer Service at (800) 357-0978.

The Village of Wellington offers medical insurance through United Healthcare to benefit eligible employees. The employee costs for coverage are listed in the premium tables below. **For information about your medical plan please refer to the Summary of Benefits and Coverage (SBC) provided.**

Medical Insurance – Choice Plus Plan - Monthly Payroll Deductions

Tier of Coverage	Employee Cost	Total Monthly Cost
Employee Only	$25.00	$705.52
Employee + Spouse	$232.00	$1,508.55
Employee + Child(ren)	$176.00	$1,304.73
Employee + Family	$400.00	$2,107.50

How to Locate a Provider

To search for a participating provider, contact Customer Service or log on to www.myuhc.com. Select "Find Physician, Laboratory or Facility," choose "**UnitedHealthcare Choice Plus**," as your plan type, complete the search criteria and hit "Go."

Other Available Plan Resources

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

Discount Programs & Services

UnitedHealth Allies is a FREE member discount program and offers all members access to discounted health and wellness programs at participating providers. Members can call (800) 860-8773 or log on to www.myuhc.com and select health and wellness; the health discount program; and Exclusive Health Discounts to learn more about these programs:

- Dental Care
- Vision Care
- Hearing Products
- Weight Management Programs & Nutrition Counseling
- Tobacco Cessation
- Alternative Medicine
- Health Supplies
- Long Term Care

Other Programs & Services

- **Cancer Support Program:** The program provides support and answers questions when you or a family member is diagnosed. Call (866) 936-6002 from 7 am to 7 pm to get information on Centers of Excellence, treatment, guidance and more.
- **MomMe Program:** Call (800) 411-7984 24/7 or online at www.healthy-pregnancy.com to get information or speak with a maternity consultant, about selecting a doctor, creating a birth plan, fitness, nutrition, labor or c-section, selecting a pediatrician, caring for your newborn and much more.

UHC Health4me Mobile App

The UHC "Health4me" mobile app gives users access to ID cards (which can be directly emailed or faxed to a doctor), providers within the UHC Network (locator works with your phone's GPS) "Easy Connect" for claims and benefit questions, registered nurses and deductible and out-of-pocket maximum information. Health4me is available on the iPhone and Android. You can find more information on www.uhc.com and select Health4me.

Medical Insurance: Choice Plus Plan At-A-Glance

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your United Healthcare medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan please contact United Healthcare's Customer Service at (800) 357-0978.

Network	Choice Plus	
Calendar Year Deductible (CYD)	**In Network**	**Out of Network**
Single	None	$500
Family	None	$1,000
Coinsurance	**In Network**	**Out of Network**
Member Responsibility	0%	20%
Calendar Year Out-of-Pocket Limit	**In Network**	**Out of Network**
Single	$1,500	$2,500
Family	$3,000	$5,000
What Applies to the Out-of-Pocket Limit?	Coinsurance, Copays and Deductible	
Physician Services	**In Network**	**Out of Network***
Physician Office Visit	$10 Copay	20% After CYD
Specialist Office Visit	$25 Copay	
Diagnostic Services (Freestanding Facility)	**In Network**	**Out of Network***
Clinical Lab (Blood Work) at Independent Facility**	No Charge	20% After CYD
X-rays at Independent Facility**	No Charge	
Advanced Imaging (MRI, PET, CT)	$125 Copay	
Hospital Services	**In Network**	**Out of Network***
Inpatient (Per Inpatient Stay)	$250 Copay	20% After CYD
Outpatient Surgery	$125 Copay	20% After CYD
Physician Services at Hospital	No Charge	20% After CYD
Emergency Room (Waived if Admitted; Per Visit)	$100 Copay	$100 Copay
Urgent Care Center (Per Visit)	$35 Copay	20% After CYD
Mental Health / Alcohol & Substance Abuse	**In Network**	**Out of Network***
Inpatient (Per Inpatient Stay)	$250 Copay	20% After CYD
Outpatient (Per Visit)	$10 Copay	
Prescription Drugs (Rx)	**In Network**	**Out of Network***
Tier 1	$10 Copay	$10 Copay
Tier 2	$30 Copay	$30 Copay
Tier 3	$50 Copay	$50 Copay
Mail Order Drug (90 Day Supply)	2.5x Copay	Not Covered

***Out-Of-Network Balance Billing**

For information regarding Out-Of-Network Balance Billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the Summary of Benefits and Coverage (SBC).

****Charges may vary based on place of service.**

Health Reimbursement Account

The Summary of Benefits and Coverage (SBC) Supplement, provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your Health Reimbursement Account (HRA). The information contained in this Booklet regarding your HRA is intended to supplement your SBC Supplement. If any information in this booklet unintentionally conflicts with the SBC Supplement, the SBC Supplement information prevails. If you have any additional questions regarding the plan please contact Benefit Workshop's Customer Service at (888) 537-3509.

Benefits Workshop
Customer Service: (888) 537-3539
www.benefitsworkshop.com/wellington

The Village of Wellington provides a Health Reimbursement Account (HRA) through Benefits Workshop. HRA monies are funded by the Village and can be used for any qualified medical expenses as defined by Section 213(d) of the Internal Revenue Code that are incurred under the medical plan such as deductibles and coinsurance for physician services, hospital services and prescription drugs, etc. The HRA monies provide tax-free funds to cover those expenses incurred under the medical plan. All eligible employees enrolled in the United Healthcare Choice Plus Plan will receive $995. Employees who do not elect medical coverage under Wellington's medical plan, but enroll in dental and/or vision coverage will receive a "Limited Purpose HRA" (which will be limited to dental and vision expenses only). **Please Note: employees who do not elect any coverage will not receive the HRA on January 1, 2014 due to new regulations under the Patient Protection and Affordable Care Act.**

Limited Purpose HRA

A Limited Purpose HRA for employees that are NOT enrolled in the United Healthcare Choice Plus Plan but ARE ENROLLED in dental or vision coverage will be offered for the 2014 plan year. The funding amount will be the same at $995, however, reimbursement is only for eligible dental and vision expenses allowed under section 213(d).

How does it work?

When you incur an eligible expense, you can pay the charge with your HRA debit card instead of paying from your wallet now and waiting for reimbursement later. You can utilize your debit card at health care providers and pharmacies that are providers of qualified medical services and accept debit MasterCards. The Limited Purpose HRA debit card can be used at dental and vision providers that accept the debit MasterCard.

Do I still need to keep my receipts?

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

How can I find my available HRA/Limited Purpose HRA balance for the debit MasterCard?

You can check your available balance, activity and account history (for either account) at anytime on www.benefitsworkshop.com/wellington or you can call (888) 537-3539.

Can all of my family members utilize the debit MasterCard?

Yes, however, you are provided with one debit card with your name on it. You may request additional cards, personalized for your spouse or dependents age 18 or older, by calling (888) 537-3539.

Am I still able to access the HRA/Limited Purpose HRA without the debit card?

Yes. If your provider or merchant does not accept MasterCard debit cards or you choose not to use it, simply pay for your expenses and submit a request for reimbursement. Make sure when you submit your reimbursement form you supply the appropriate documentation such as an EOB and receipt of payment for the services rendered.

What happens to my unused HRA funds at the end of the plan year?

Any remaining balance in your HRA/Limited Purpose HRA at the end of the plan year will be automatically rolled forward to the next plan year as long as you are an active participant.

Health Reimbursement Account *(continued)*

The Summary of Benefits and Coverage (SBC) Supplement, provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your Health Reimbursement Account (HRA). The information contained in this Booklet regarding your HRA is intended to supplement your SBC Supplement. If any information in this booklet unintentionally conflicts with the SBC Supplement, the SBC Supplement information prevails. If you have any additional questions regarding the plan please contact Benefit Workshop's Customer Service at (888) 537-3509.

What happens to my unused HRA funds if I discontinue participation in the HRA plan, separate employment, or retire from the Village of Wellington?

Once you are enrolled in the Village HRA/LPHRA plan for three full plan years (January 1 – December 31), you may be vested, meaning that you may have rights to use the accumulated funds even after you leave employment. Generally, if you leave employment you may continue to use the HRA/Limited Purpose HRA as normal for the remainder of the plan year. Any unused funds after the claim filing deadline for that plan year are then rolled into a Retiree Health Savings (RHS) plan if you are fully vested in the program. Contact the Human Resources Department for more details about the process.

Distributions From an HRA

Generally, distributions from an HRA must be paid to reimburse you for qualified medical expenses you have incurred. The expense must have been incurred on or after the date you are enrolled in the HRA.

What is the difference between an HRA and an FSA?

Health Reimbursement Account (HRA)

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

Flexible Spending Accounts (FSA)

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

If you have the HRA and also elect an FSA, your FSA monies will be used first since it is employee funded and does not rollover from year to year.

What are some examples of qualified expenses that would be eligible for reimbursement?

- Acupuncture
- Ambulance Service
- Birth Control Pills
- Chiropractic Care
- Contact Lenses (Corrective)
- Dental Fees
- Diagnostic Tests/Health Screenings
- Doctor Fees
- Drug Addiction/Alcoholism Treatment Prescription Drugs
- Experimental Medical Treatment
- Eyeglasses
- Hearing Aids and Exams
- Injections and Vaccinations
- In Vitro Fertilization
- Nursing Services
- Orthodontic Fees
- Surgery
- Sunscreen
- Wheelchairs

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

Dental Insurance: Direct Assignment Plan

Dental Decisions
Administered by Anchor Benefit Consulting, Inc.
Customer Service & Claims Department: (800) 845-7629
Fax: (407) 667-8765
www.anchorbenefit.com

Claims Mailing Address:
Anchor Benefit Consulting, Inc.
P.O. Box 945260
Maitland, FL 32784

Email Claims: claims@anchorbenefit.com
Payer ID#: 53085

Dental Insurance – Direct Assignment Plan
Monthly Payroll Deductions

Tier of Coverage	Employee Cost	Total Monthly Cost
Employee Only	$0.00	$54.30
Employee + Spouse	$8.31	$85.12
Employee + Child(ren)	$12.26	$99.80
Employee + Family	$16.22	$114.48

The Village of Wellington offers a "Direct Assignment" dental plan through Dental Decisions as administered by Anchor Benefit Consulting, Inc. A Direct Assignment plan pays benefits according to the dollars spent on dental care versus the type of dental treatment received (Preventative, Basic, or Major). The plan provides benefits regardless of the dental provider you visit; no network restrictions apply.

Dental Plan Summary

- The plan covers 100% of the first $400 spent on dental care each year. This is more than enough to cover the cost of two cleanings per year and the recommended number of x-rays.
- The plan then pays 60% of all remaining charges until the employee reaches their annual benefit maximum of $2,000.
- Orthodontia is covered at 60% to a lifetime maximum of $2,000.
- There are no deductibles associated with this plan and employees may visit the dentist of their choice.
- If their dentist accepts "assignment", meaning the dentist is willing to contact Dental Decisions to verify coverage and file the claim, the employee would pay only the portion of the bill that would not be covered by the plan.
- If the dentist does not accept assignment, the employee must make payment in full and submit a claim to Dental Decisions for reimbursement. The employee would then be reimbursed the amount paid less a $5 processing fee.

Vision Insurance: Humana VisionCare Plan

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

The Village of Wellington offers vision insurance through Humana. A brief description of the Humana VisionCare Plan is provided below, and the premium payroll deductions are shown on the table to the right. A summary of benefits is provided on the following page. For detailed coverages, exclusions and stipulations, please refer to the carrier's benefit summary or contact Humana's Customer Service.

Vision Insurance – Humana VisionCare Plan
Monthly Payroll Deductions

Tier of Coverage	Employee Cost	Total Monthly Cost
Employee Only	$0.00	$3.92
Employee + Spouse	$1.56	$7.84
Employee + Child(ren)	$4.24	$14.51
Employee + Family	$5.80	$18.43

In-Network Benefits

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

Out-of-Network Benefits

You may also choose to receive services from vision providers that do not participate in the vision network. If you go out of network you would be required to make payment at the time of your appointment. Humana will then reimburse you based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

How to Locate a Provider

To obtain a listing of providers that participate in the Humana VisionCare network, contact Customer Service or visit Humana online at www.compbenefits.com. Click "Providers/Search," then "Find Vision Providers." Select "VisionCare Plan" as the network, complete the search criteria and search.

Plan Year Deductible

There is no Plan Year Deductible.

Plan Year Out-of-Pocket Maximum

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

Please Note the Following:

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

Vision Insurance: Humana VisionCare Plan At-A-Glance

Services	**In Network**	**Out of Network**
Eye Exam	$10 Copay	Up to $35 Reimbursement
Frequency of Services	**In Network**	**Out of Network**
Examination	12 Months	
Lenses	12 Months	
Frames	24 Months	
Contact Lenses	12 Months	
Lenses	**In Network**	**Out of Network**
Single	Paid in Full After $15 Materials Copay	Up to $20 Reimbursement
Bifocal		Up to $40 Reimbursement
Trifocal		Up to $60 Reimbursement
Frames	**In Network**	**Out of Network**
Allowance	$35 Wholesale Allowance	$35 Retail Allowance
Contact Lenses*	**In Network**	**Out of Network**
Non-Elective (Medically Necessary) *Prior Authorization Required*	Paid in Full	Up to $150 Reimbursement
Elective (Fitting, Follow-up & Lenses)	$100 Allowance	Up to $100 Reimbursement

***Contact lenses are in lieu of spectacle lenses and a frame**

Flexible Spending Accounts

Benefits Workshop
Customer Service: (888) 537-3539
www.benefitsworkshop.com/wellington

Mailing Address for Claims:
P.O. Box 56828
Jacksonville, FL 33421
Fax Claims To: (904) 880-2830

The Village of Wellington offers Flexible Spending Accounts (FSAs) administered through Benefits Workshop.

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

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

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

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

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

Flexible Spending Accounts *(continued)*

FSA Guidelines

- Health Care FSA – your plan year ends December 31, 2014. **Note: You have a grace period at the end of your plan year that allows you to claim reimbursement for eligible expenses incurred through March 15, 2015.** Additionally you will have until March 31, 2015 to file claims for expenses incurred through the grace period (March 15, 2015).
- Dependent Care FSA - your plan year ends December 31, 2014. You will have until March 31, 2015 to file claims for expenses incurred through the end of the plan year (December 31, 2014).
- **Any unused funds after a plan year/your grace period ends and all claims have been filed cannot be returned to you nor carried forward to the next plan year.**
- You can enroll in either or both FSAs during open enrollment period, new hire eligibility, or a qualifying event only.
- You cannot transfer money between FSAs.
- You cannot pay a dependent care expense from your Health Care FSA or vice versa.
- You cannot deduct reimbursed expenses for income tax purposes.
- You cannot be reimbursed for a service which you have not received.
- You cannot receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
- Domestic partners are not eligible, as federal law does not recognize them as a qualified depedent.

Here's How It Works

An employee earning $30,000 elects to place $1,000 into their FSA Health Care Savings Account, with payroll deductions being $38.46 based on a 26 pay period schedule. As a result, the insurance premiums and health care expenses are paid with tax-free dollars, giving the employee a tax savings of $227.

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

NOTE: Be conservative when estimating your medical and/or dependent care expenses. IRS regulations state that any unused funds which remain in your FSA after a plan year ends and all claims have been filed cannot be returned to you nor carried forward to the next plan year. This is known as the "USE IT OR LOSE IT" rule.

Filing a Claim

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

Debit Card

FSA participants can request a debit card for payment of eligible expenses. Participants are able to pay for most qualified services and products at the point of sale versus paying out of pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities and most pharmacy retail outlets. *If you have a healthcare FSA, funds will be deducted first from the FSA until depleted and then from the HRA, when using the debit card.*

Basic Life and AD&D Insurance

Cigna
Customer Service: (800) 732-1603
www.cigna.com

Basic Term Life

The Village of Wellington provides Basic Term life insurance at no cost to eligible employees through Cigna. All full-time general employees are covered for a benefit amount of one times their basic annual salary, rounded to the next higher $1,000, subject to a minimum of $25,000 and a maximum of $100,000.

All full-time benefit-eligible employees in the management class are covered for a benefit amount equal to two and a half times their basic annual salary, rounded to the next higher $1,000, up to a maximum of $350,000.

Accidental Death & Dismemberment

Wellington also provides Accidental Death & Dismemberment (AD&D) insurance which pays in addition to the basic life benefit when death occurs as a result of an accident. The AD&D benefit amount equals the basic term life benefit and a partial benefit is also payable based on the schedule of benefits. For detailed coverages, exclusions and stipulations, please refer to the carrier's benefit summary or contact Cigna's Customer Service.

Always remember to keep your beneficiary forms updated.
Beneficiary information may be updated at any time through BenTek.

Voluntary Life and AD&D Insurance

Cigna
Customer Service: (800) 732-1603
www.cigna.com

Voluntary Employee Life Insurance

Eligible employees may elect to purchase additional life insurance on a voluntary basis through Cigna. This coverage may be purchased in addition to the Basic Term Life and AD&D coverages. Voluntary Life insurance offers coverage for yourself, your spouse and your dependent children at different benefit levels.

New Hires can purchase Voluntary Employee Life insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), up to the Guaranteed Issue amount of $80,000.

- Units can be purchased in increments of $5,000 from a minimum of $10,000 to a maximum of 5x times salary up to $300,000.
- Benefits are reduced to the following amounts according to the age reduction schedule:
  - 65% at age 65
  - 57% at age 70
  - 50% at age 75
- Employees may also purchase additional Accidental Death & Dismemberment Insurance. Voluntary employee AD&D is available in increments of $5,000 to a maximum of 7x times salary, rounded to the next higher $5,000, up to $300,000.

Voluntary Life and AD&D Insurance *(continued)*

Voluntary Spouse/Domestic Partner Life Insurance

New Hires can purchase Voluntary Spouse/Domestic Partner Life insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), up to the Guaranteed Issue amount of $10,000.

- Employees must participate in the Voluntary plan for Spouse/Domestic Partner to participate.
- Spouse/Domestic Partner coverage is available in increments of $5,000, not to exceed $150,000.
- Spouse coverage benefit elections cannot exceed 50% of the employees Voluntary life coverage amount.
- Coverage for Spouse/Domestic Partner Life insurance ends at age 70.
- Employees may also purchase Voluntary Spouse/Domestic Partner Accidental Death & Dismemberment insurance. Voluntary Spouse/Domestic Partner AD&D is available in increments of $5,000 to a maximum of $150,000.

Voluntary Dependent Life Insurance

- Employees must participate in the voluntary plan for unmarried dependent children to participate.
- A flat $10,000 benefit is offered to child(ren) 6 months to 19 years of age or up to age 25 if unmarried and a full time student.
- Children 14 days to 6 months will be covered for a $500 benefit.
- Voluntary Dependent Life Insurance can be purchased for a rate of $2.33 per month and covers all children.
- Accidental Death & Dismemberment Insurance is included.

Short Term Disability Insurance

Cigna
Customer Service: (800) 732-1603
File a Claim: (800) 36-CIGNA (362-4462)
www.cigna.com

The Village of Wellington provides Short Term Disability (STD) at no cost to all benefit-eligible employees through Cigna. Employees are eligible on the 1st of the month following 30 days of employment and must work a minimum of 30 hours per week.

STD Plan Summary

- The Short Term Disability program offers a benefit of 66.67% of weekly earnings up to a maximum of $2,000 per week.
- An employee must be sick or incur a non-work related injury for 14 calendar days prior to becoming eligible for benefits.
- The maximum benefit period is 24 weeks.
- An employee unable to return to work after the 24 week maximum is exhausted will be automatically transitioned from Short Term Disability to Long Term Disability.
- Benefits may be reduced by other income.

Long Term Disability Insurance

Cigna
Customer Service: (800) 732-1603

File a Claim: (800) 36-CIGNA (362-4462)
www.cigna.com

The Village of Wellington provides Long Term Disability (LTD) at no cost to all benefit-eligible employees through Cigna. Employees are eligible on the 1st of the month following 30 days of employment and must work a minimum of 30 hours per week.

LTD Plan Summary

- The Long Term Disability program offers a benefit of 66.67% of monthly earnings up to a maximum of $10,000 per month.
- An employee must be disabled for 180 days prior to becoming eligible for benefits.
- Benefit payments will commence on the 181st day of disability.
- If you return to work on a part-time basis, you may continue to be eligible for partial benefits.
- Periodic evaluations will occur at the discretion of Cigna.
- Benefits will be payable for the first 24 months if the employee is unable to return to their own occupation.
- After 24 months, if the employee can return to any occupation in which they are suitably trained, educated, and capable of performing, the employee must return to that occupation.
- Benefits may be reduced by other income.

Employee Assistance Program

Aetna Resources for Living
24-Hour Help Line: (800) 272-7252
www.mylifevalues.com

Username: vwell
Password: vwell

Provided by the Village of Wellington at no cost to you, a comprehensive Employee Assistance Program (EAP) is available to you and each member of your family through Aetna Resources for Living. Aetna Resources for Living offers access to mental health professionals through a confidential program that is protected by state and federal laws. The EAP program is available to help you gain a better understanding of problems that affect you, locate the best professional help for your particular problem, and decide upon a plan of action. Counselors are available 24 hours a day, 7 days a week.

What is an Employee Assistance Program?

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

- Anxiety
- Legal and financial concerns
- Depression
- Life improvement
- Family and/or marriage problems
- Stress
- Grief and bereavement
- Substance abuse
- Eldercare issues

What is Aetna Resources for Life?

Wellington recognizes that employees' personal responsibilities may, at times, spill over into the workplace. To help ensure employees are able to address these concerns with minimal disruption, the program provides employees and their family members assistance through a variety of ways including face-to-face sessions, telephonic consultation, online work, life sessions and webinars.

Are your services confidential?

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

Supplemental Insurance

Aflac
www.aflac.com

Agent: Chris Teasdale
Phone: (561) 371-3843
Email: chris_teasdale@us.aflac.com

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

- Hospital Protector
- Life Protector (Life Insurance)
- Accident Advantage Indemnity
- Personal Cancer Indemnity Plan
- Personal Sickness Indemnity Plan
- Critical Care & Recovery

To learn more about these Aflac plans and/or schedule a personal appointment, contact Wellington's Aflac Agent, Chris Teasdale, at (561) 371-3843.

Colonial Life
Customer Service: (407) 648-0311
www.coloniallife.com

Agent: Keith Jordano
Phone: (561) 333-6228
Email: keith@jordanogroup.com

Employees have the option to purchase supplemental insurance through Colonial Life. Purchasing supplemental insurance is done on a voluntary basis and the premiums paid by payroll deduction. Supplemental insurance pays money directly to you regardless of what other insurance plans you may have. Available Colonial Life plans include:

- Accident Insurance
- Cancer Insurance
- Hospital Confinement Insurance
- Specified Critical Illness Insurance
- Short Term Disability Insurance
- Term Life Insurance
- Universal Life Insurance

Colonial Life's coverage has some important features:

✓ Coverage is available for your spouse and children with most products.
✓ Benefits are paid directly to you, unless specified otherwise.
✓ Some products can be Guaranteed Issue (contact your Colonial representative for more details).
✓ With most plans, you can continue coverage when you retire or change jobs, with no increase in premiums.
✓ With most plans, you receive benefits regardless of any other insurance you may have with other insurance companies.

Retirement Plans

ICMA Retirement Corporation
Customer Service: (800) 669-7400
www.icmarc.org

Retirement Plan Specialist: Steven Feigelis
Office: (561) 963-1681
Cell: (202) 701-5969
Email: sfeigelis@icmarc.org

Florida Municipal Pension Trust
Customer Service: (800) 342-8112
www.flcretirement.com

Financial Analyst: Jeremy Button
Office: (800) 616-1513 x3625
Email: JButton@flcities.com

The 457 Deferred Compensation Programs allow employees to set aside tax deferred dollars toward retirement savings through automatic payroll deductions. There is no employer matching for this program.

The money contributed into this type of account, including earnings, accumulates on a tax-deferred basis. Employees can consolidate their retirement savings by rolling other eligible retirement assets into this account. Minimum and maximum participation amounts apply.

Florida Retirement System

Division of Retirement
2639-C North Monroe Street
Tallahassee, FL 32399-1560
(850) 488-8837
www.myfrs.com

Florida Retirement System
The Village of Wellington participates in the Florida Retirement System (FRS) Plan for all full-time and OPS (Other Personnel Services) employees working in regularly established positions. Positions that are scheduled and budgeted as "lump sum" positions or are temporary or seasonal are not eligible.

The plan year is July 1 through June 30. Members are eligible for this benefit with 6 years of service vesting for the Pension Plan and 1 year vesting for the Investment Plan. One of the special features of membership in the FRS is portability — the ability to keep your retirement credit when you change FRS employers. This means if you separate employment with one FRS employer, and later go to work with any other FRS employer your service credit will be retained from your previous job and combined with the new service credit.

The monthly benefit payment you receive when you retire depends on your years of creditable service, retirement age, average final compensation, and the retirement plan options you select. The formula for calculating your monthly benefit will be provided upon enrollment.

Preferred Legal Plan

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

The Village of Wellington employees have the opportunity to enroll in a voluntary pre-paid legal program through Preferred Legal Plan. By enrolling in this plan, a participant will have 24-hour direct access to attorneys who will provide a variety of legal assistance and services such as those listed below. Additional services may also be provided at discounted rates.

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

Preferred Legal Plan

- Free unlimited legal advice via phone consultation
- Free face-to-face consultations with attorneys
- Free review of legal documents (real estate contracts, lease agreements, simple Wills, etc.) and notary services
- Free letters and phone calls on your behalf
- Free Identity Theft information and restoration
- Free access to legal forms

Other Benefits

Safety Shoes

Employees in eligible positions will receive an annual safety shoe benefit allowance of $120.00 each January. The $120.00 allowance is a taxable benefit as defined by IRS Rules and Regulations.

Credit Union of Palm Beach County

Wellington is a member of the Credit Union of Palm Beach County. All Wellington employees and their family members are eligible to participate in the credit union's services. Employees may direct that a specified amount of their net pay be forwarded to the Credit Union for checking, savings and loans.

Wellington Sponsored Seminars and Continuing Education Payment

From time to time, Wellington may request employees to attend seminars or continuing education courses consistent with their job title or position. Employees required to participate in these educational opportunities shall have the registration or other fees paid directly by Wellington.

The course work and exam time shall be considered regular hours worked when one of the following conditions is met:

1. Active work is performed for employer during the education
2. The education occurs during normal work hours
3. Wellington requires mandatory attendance
4. Attendance is related to current job

Retiree Benefits

Medical, dental and vision insurance coverage is available for eligible retirees. The cost to the retiree is the amount billed to Wellington for the tier of coverage selected by the retiree. The retiree must remit payment to Wellington by the 10th of each month to continue coverage and payment shall be made in a manner specified by the Finance Department. The retiree's failure to pay insurance premiums as specified shall result in cancellation of their insurance coverage without notice.

Workers' Compensation

Wellington Risk Management Department
Phone: (561) 791-4021
Fax: (561) 904-5806

Florida League of Cities
Customer Service: (800) 756-3042

In order to provide timely and suitable medical care to employees injured on the job, the Village of Wellington has instituted a Managed Care Arrangement (MCA) with the Florida League of Cities, our Workers' Compensation carrier, and Care Management Systems, a national managed health care company and Preferred Provider Organization.

On the job injuries must be reported immediately to your Manager/Supervisor and to the Risk Management Department. Upon being notified of an on the job injury, the Risk Management Department will direct you to an MCA physician. **Non-emergency treatment must be rendered by an approved MCA physician and be pre-authorized or payment will be your responsibility.** In the event of an emergency, please proceed immediately to the nearest emergency facility. When possible, notify your Manager / Supervisor and the Risk Management Department before obtaining treatment or notify them as soon as you are physically able to, after obtaining medical treatment.

Workers' Compensation Overview

- On the job injuries must be reported immediately to your Supervisor and the Risk Management Department.
- The Risk Management Department will direct you to an MCA physician.
- Non-emergency treatment must be rendered by an approved MCA physician.
- If you are not satisfied with your physician, you may request a change of physician once during the course of your injury.
- During the course of your treatment, you may request a second opinion from another physician in the same specialty as your MCA physician.
- Whenever feasible, Wellington will provide temporary work to accommodate activity limitations identified by your MCA physician.
- Your authorized MCA physician is the only person that can determine that you cannot work, in which case you will be eligible to receive lost wages benefits.
- If you feel you have not received appropriate medical treatment, contact the Risk Management Department regarding the Grievance / Complaint procedure.

Benefits At-A-Glance		
Benefit	**Employee Eligibility**	**Initial Enrollment Eligibility**
COBRA	Regular & Supplemental, Full-time	Upon occurrence of a COBRA qualifying event
Deferred Compensation Plan 457(b) with ICMA & Florida Municipal Pension Trust Fund	Regular & Supplemental, Full-time	Upon employment
Employee Assistance Program (EAP)	All Employees	Upon employment
Medical, Dental, Vision, Life, Long- & Short-Term Disability, Health Reimbursement Accounts. Optional Benefits: Voluntary Life, Aflac Supplemental Insurance & Pre Paid Legal Plan	Regular & Supplemental, Full-time	1st of the month following 30 days of employment
Family Medical Leave	All Employees	Upon occurrence (must meet FMLA criteria)
Florida Retirement System Plan	Regular & Supplemental, Full-time & OPS	Upon employment
Paid Bereavement Leave	Regular & Supplemental, Full-time	Upon occurrence following 90 days of employment
Paid Holiday(s)	Regular & Supplemental, Full-time	Upon occurrence of Wellington observed holidays.
Paid Jury Duty Leave	Regular & Supplemental, Full-time	Upon occurrence
Paid Major Illness Leave	Regular & Supplemental, Full-time	Following 90 days of employment
Paid Military Leave	Regular & Supplemental, Full & Part-time	As specified by applicable law
Paid Time Off (PTO) Celebration PTO	Regular, Full-time Supplemental, Full-time	Following 90 days of employment
Paid Witness Duty Leave	Regular & Supplemental, Full-time	Upon occurrence
Safety Shoe Allowance	Designated positions	Upon employment/assignment to designated position
Seminars & Continuing Education	All Employees	As specified by management
Travel Reimbursement	All Employees	Upon occurrence for travel authorized in advance by the department director
Uniforms	Designated Positions	Upon employment/assignment to designated position
Workers' Compensation	All Employees	Upon employment
Receipt of benefits under these programs is subject to applicable terms, conditions, and laws related to each individual program.		

Notes

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

Notes

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

GEHRING GROUP

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

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WELLINGTON

2013 OPEN ENROLLMENT

The Village of Wellington's Open Enrollment Period will be held

November 26 – December 7, 2012

Employees who are not making any changes will automatically be enrolled in the same coverage. If you are making changes for the 2013 Plan Year, such as adding or deleting dependents, changing your beneficiary, or adding or dropping different lines of coverage, you may attend one of the Open Enrollment meetings or enroll online at:

www.mybentek.com/wellington

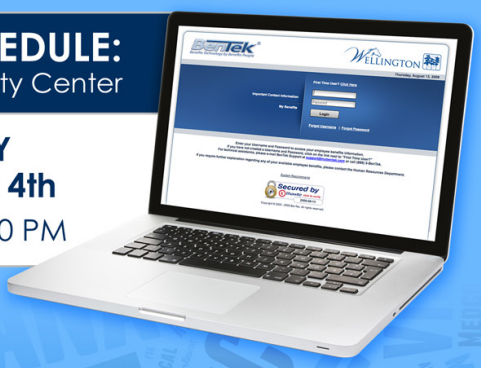
BenTek is open for Open Enrollment beginning November 26th and will continue through midnight December 7th.

Representatives from United Healthcare, Humana, Aflac, MD Now, Cigna, Florida League of Cities, ICMA, and Preferred Legal will be at the meetings listed below.

OPEN ENROLLMENT MEETING SCHEDULE:

All meetings are located in the Village Community Center

WEDNESDAY NOVEMBER 28th	TUESDAY DECEMBER 4th
7:00 AM - 1:00 PM	1:00 PM - 6:00 PM



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2014

OPEN ENROLLMENT

NOVEMBER 1ST THROUGH NOVEMBER 30TH, 2013

PBA Employees

Plan Year January 1st, 2014 through June 30th, 2014 (Short Plan Year)

What you should be thinking about NOW:

- Medical, Dental, Vision and Voluntary Life Insurance plans
- Do you need to enroll your dependents or modify overage dependent coverage (age 27-30)? (Proper Documentation Required)
- Learn more about Medical / Dependent Care Flexible Spending Accounts (FSA) (for January 1, 2014 through June 30, 2014)
- Review your AFLAC policies
- Review/Change Beneficiaries for Life Insurance and Defined Contribution/ Deferred Compensation Retirement Plans, (*should be reviewed annually*)
- The City offers domestic partner benefits to a person whom the employee shares a mutual residence within the context of a committed relationship and **who has registered** with the City pursuant to Section 42/48, Code of Ordinances, City of West Palm Beach Florida.
- Opposite or Same Sex Domestic Partners (Rev-Rul 2013-17) who become legally married need to notify Human Resource/Benefits Department during Open Enrollment or within 30 days of the Marriage.

What you need to do beginning November 1, 2013:

- **Go On-line at: www.mybentek.com/wpb**
- View your current 2013 benefit elections
- Make 2014 plan year changes such as: Add/delete dependents, elect Flexible Spending Account dollars (*elections for Short Plan Year*), Life Insurance, etc.

Cigna, Aflac and BenTek will be present at the following locations and times

Tuesday, November 12
Flagler Room • 9:00 am - 11:00 am
Flagler Room • 1:30 pm - 3:30 pm

Friday, November 15
HR Training Room • 10:00 am - 2:00 pm

Monday, November 18
Police Dispatch • 6:00 am - 8:00 am
Police Patrol Briefing Room
12:00 pm - 2:00 pm
Police Dispatch • 4:00 pm - 7:00 pm

Wednesday, November 20
Gaines Park • 8:30 am - 10:30 am
HR Training Room • 1:30 pm - 3:30 pm

Online at: www.mybentek.com/wpb

CITY OF WEST PALM BEACH FLORIDA

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Exhibit C: Sample Health Care Reform Training

WELLINGTON

Health Care Reform's Impact on the Employer Workplace

Planning Today for Tomorrow

Presented by:
Christian Bergstrom, Director
Senior Benefits Consultant

May 16, 2013

GEHRING GROUP
INSURANCE BROKERS & CONSULTANTS

Overview of Health Care Reform

- PPACA Passed on 3/23/10
- Goal: make coverage affordable, accessible, and comprehensive
- Compliance – from disclosures to reporting
- Planning & preparing for related employer costs 2014 forward

Employer Shared Responsibility Provision Industry Related Fees

- PCORI Fee
- Health Insurance Industry Fee
- Transitional Reinsurance Program

The Other Incremental Costs of Insurance

Patient Centered Outcomes Research Institute Fee

- $1 PMPY in year 1; $2 PMPY in years 2-6 (indexed for medical inflation)
- Included in fully insured premiums for medical plans
- Not included in standalone health reimbursement accounts
- 1st payment due 7/31/13 for calendar year plans
  - IRS Form 720
  - Wellington payment due = **approximately $564**

The Other Incremental Costs of Insurance

Health Insurance Industry Fee

- Fee to assist the government in subsidizing coverage for lower income individuals and families
- Paid by the carrier providing **fully insured plans**
- Fee is ongoing (no planned end)

Year	Fee
2014	$8 billion
2015 & 2016	$11.3 billion
2017	$13.9 billion
2018	$14.3 billion
Years after 2018	Prior year amount indexed by rate of annual premium growth

- Result = premium increase of 2.1% – 3.5% for 2014
- **Approximately $133,384 at current premiums**

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The Other Incremental Costs of Insurance

Transitional Reinsurance Program

- Temporary program intended to stabilize premiums in the individual market from 2014 – 2016.
- Protects insurers from uncertainty in rate setting. (PCIP and other high risk pools to flow into Exchange(s))
- Applies to:
  - **Fully insured grandfathered and non-grandfathered plans**
    - Insurance carrier pays fee
  - Self insured grandfathered and non-grandfathered plans
    - TPA's may make payment on behalf of plan sponsor or plans may pay directly, although plan liable for the fee.

The Other Incremental Costs of Insurance

Transitional Reinsurance Program (cont.)

– How much is the fee?

Year	Total Fee to be Collected*	Self Insured
2014	$12 billion	TPA to bill/collect/remit or plan sponsor direct pay at estimated rate** of **$63** PEPY or $5.25 PEPM for 2014. Estimates expected to decrease to $42.00 and $26.25 in years 2015 and 2016 respectively.
2015	$8 billion	
2016	$5 billion	

**State has option to add an additional a state-level fee.*

***To be confirmed through HHS Notice of Benefit and Payment Parameters 2013-2015*

The Other Incremental Costs of Insurance

Transitional Reinsurance Program (cont.)

– Impact to Wellington (in premium)

Reinsurance Fee Calculation		
Transitional Reinsurance Fee/Month	$	5.25
Monthly Expense	$	2,961.00
Annual Expense	**$**	**35,532.00**

Based on Current Insured

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Employer Shared Responsibility Provision a.k.a. Pay or Play

- Defining the Employer Shared Responsibility Provision:

  The ESRP states that large employers must offer coverage that is "affordable" and of "minimum value" to "full-time employees" and their dependents.

Employer Shared Responsibility Provision Effective Date

- ESRP is effective on the first day of the plan year beginning on or after January 1, 2014
  - Fiscal Year Plan Transition Relief available (n/a)
  - Penalty is calculated monthly, not annually

Employer Shared Responsibility Provision Penalty Exposure

- Penalties – Monthly Test
  1. No Coverage Penalty - $2,000 / Full-time employee
     - Margin of Error Rule: Must offer coverage to substantially all full-time employees and dependents, a.k.a., **the 95% Rule**. Offer coverage to all but greater of 5% of employees or 5 employees.
     - Note: If Employer offers coverage under the 95% Safe Harbor, Employer will still be subject to $3,000 penalty for those full-time employees who receive tax credits/subsidies from the Exchange.
     - Also applied if coverage not offered to dependents.
  2. Inadequate Coverage Penalty - $3,000 / Full-time employee
     - Coverage is unaffordable and employee obtains federally subsidized coverage through an Exchange, OR
     - Coverage does not meet "minimum value" requirements and employee obtains federally subsidized coverage through an Exchange.
  3. Pay and Play penalty exposure

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Employer Shared Responsibility Provision Penalty Exposure

Wellington Plan Enrollment Summary	
Total Workforce	243
Plan Participants	243
Addl Covered Members	321
Total Covered Lives (Belly Buttons)	564

PAY AND PLAY PENALTY EXPOSURE CALCULATION	Exposure Calculation
Total Current Enrolled Participants	243
Pay & Play Exp	
Elig not offered >	6
Pay AND Play Penalty	
Employees	243
Not Eligible	66
	309
Less Allowance	(30)
Total Subject to Penalty	279
Annual Penalty Amount/EE	$ 2,000
Total Annual Pay AND Play Penalty	**$ 558,000**

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Employer Shared Responsibility Provision Determining Affordability

- Employers may be assessed a penalty for offering coverage to full-time employees that is not "affordable".
- Three Affordability Safe Harbors:
  1. Form W-2 Safe Harbor – Employee contribution for lowest cost employee only coverage does not exceed 9.5% of employee's Box 1 W-2 wages for the applicable calendar year.

Employer Shared Responsibility Provision Determining Affordability

2. Rate of Pay Safe Harbor – Test using monthly salary at the beginning of the plan year as base. Employee only cost cannot exceed 9.5% of earnings as of the first day of the plan year
3. "Federal Poverty Line" (FPL) Safe Harbor – Coverage will be "affordable" if self-only coverage does not exceed 9.5% of Federal Poverty Level for single individual.
   - Current individual FPL is $11,170

Employer Shared Responsibility Provision Determining Minimum Value

- 60% Actuarial Value
- Essential Benefits – Large employers
  - Physician and mid-level practitioner care
  - Hospital and emergency room services
  - Pharmacy benefits
  - Laboratory and imaging services
- Exchange (Marketplace) Bronze equivalent

Employer Shared Responsibility Provision
Defining a "Dependent" & "Maximum Waiting Period"

- PPACA indicates coverage must be made available to employees and their dependents. Dependents defined through this further guidance as:
  - Child of an employee who has not attained age 26
  - Spouse coverage not necessary to be offered – if offered, not necessary to be "affordable"
- Waiting period for coverage can be no greater than 90 days (not three months)
  - Recommend 1st of the month following 45 days OR do not hire the 1st five days of the month to allow for 1st of the month following 60 days

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Employer Shared Responsibility Provision Defining a "Full-Time Employee"

- An employee who is employed on average at least 30 "hours of service" per week or 130 hours per month
  - Include compensable hours – those worked, also hours paid when no work is performed
  - Special periods of unpaid leave may not be counted against to reduce average hours of service including:
    FMLA, Military Service, Leave of absence, Jury duty, Vacation, Sick, Personal, Holiday, Incapacity including disability
  - Re-hired employees
    - Breaks in service greater than 26 weeks
    - Parity rule for breaks in services less than 26 weeks
- Qualifying part-time, seasonal and variable employees

Determining Eligibility of Part-Time Seasonal, & Variable Hour Employees

Safe Harbor Rule

- Seasonal, Variable and Part-time employees
  - Measurement, Administrative and Stability Periods to determine average hours of service
  - All employees of all entities consistently assessed

Determining Eligibility of Part-Time Seasonal, & Variable Hour Employees

- Definitions

Measurement Period

A "standard" look-back period f 3-12 consecutive months used to determine employees' full time status for purposes of determining benefits eligibility and employer penalty responsibility during subsequent Stability Period for variable/seasonal employees. For new hires, this "initial" period must start no later than the first day of the calendar month following employee start date.

Administration Period

A period of up to 90 days between the Standard Measurement Period and the associated Stability Period to determine eligibility, notification and enrollment.

Stability Period

A period of time following a Measurement Period in which a variable or seasonal employee is/is not considered a full time employee for purposes of determining benefits eligibility and accordingly, pay or play penalty, regardless of hours worked during this period as long as still employed.

Determining Eligibility of Part-Time Seasonal, & Variable Hour Employees

- Rules

ONGOING EMPLOYEE	NEW EMPLOYEE
Standard Measurement Period ➢ Must be 3 – 12 consecutive months **Administration Period** ➢ Up to 90 days (not 3 months) ➢ Must overlap prior stability period (no lapse for FT EE's both years) **Stability Period** ➢ Must be 6 – 12 consecutive months, but ➢ Not shorter than Measurement Period ➢ If not full-time employee, Stability Period cannot be longer than Measurement Period	**Initial Measurement Period** ➢ Must be 3 – 12 consecutive months ➢ Must start no later than the first day of the calendar month following employee start date. **Administration Period** ➢ A period of up to 90 days ➢ Administration Period plus Initial Measurement Period cannot exceed last day of first calendar month beginning on/after one year anniversary of employee start date. (13 + fraction month) **Stability Period** ➢ Must be 6-12 consecutive months ➢ Period must be as long as Stability Period for ongoing employees.

Defining a Variable Employee

Ongoing Employee

Ongoing variable, part-time and seasonal employee assessment cycle:

EMPLOYER A: Plan Year 10/1/14

Cycle 1

Cycle 2

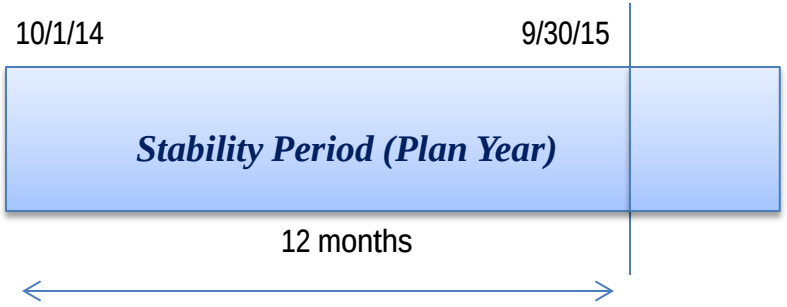
Defining a Variable Employee

Ongoing Employee

Ongoing variable, part-time and seasonal employee assessment cycle:

EMPLOYER A: Plan Year 10/1/14

Cycle 1



Cycle 2

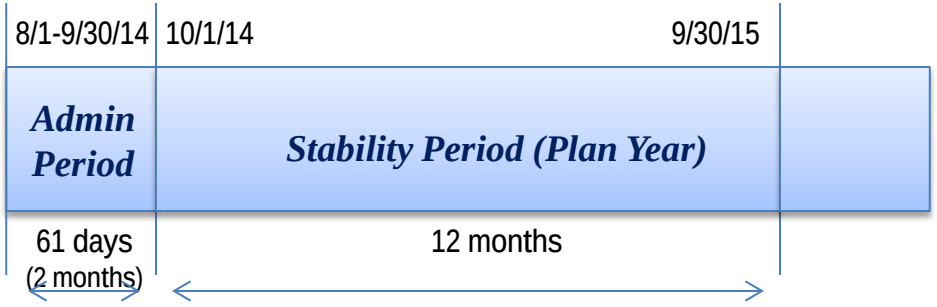
Defining a Variable Employee

Ongoing Employee

Ongoing variable, part-time and seasonal employee assessment cycle:

EMPLOYER A: Plan Year 10/1/14

Cycle 1



Cycle 2

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Defining a Variable Employee

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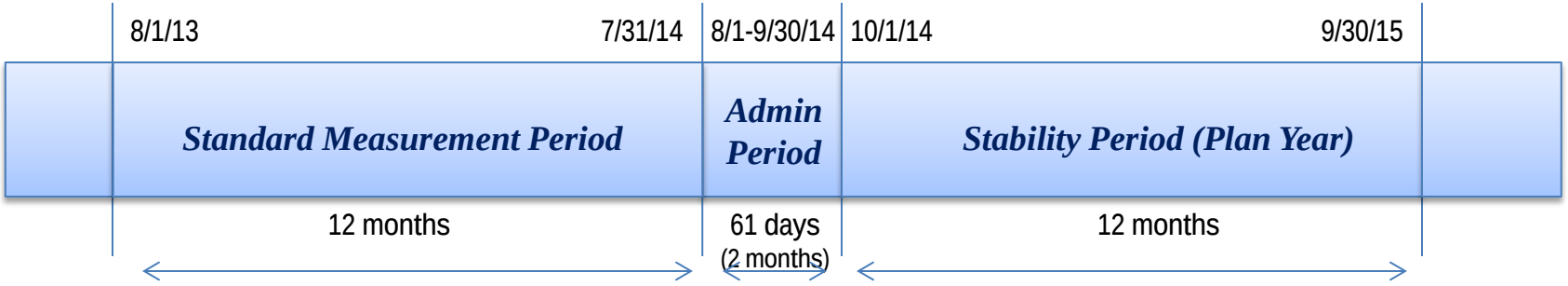

Cycle 2

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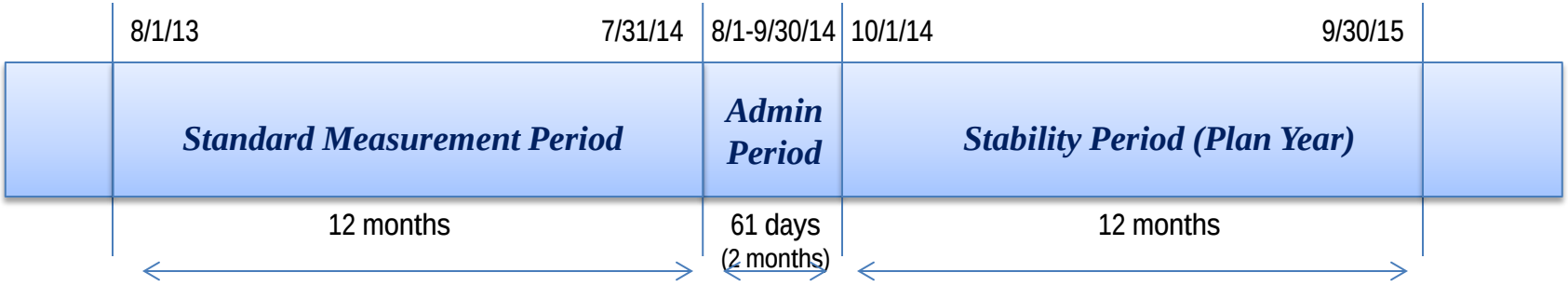

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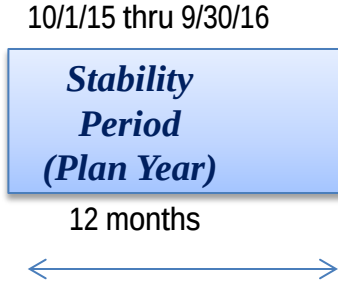

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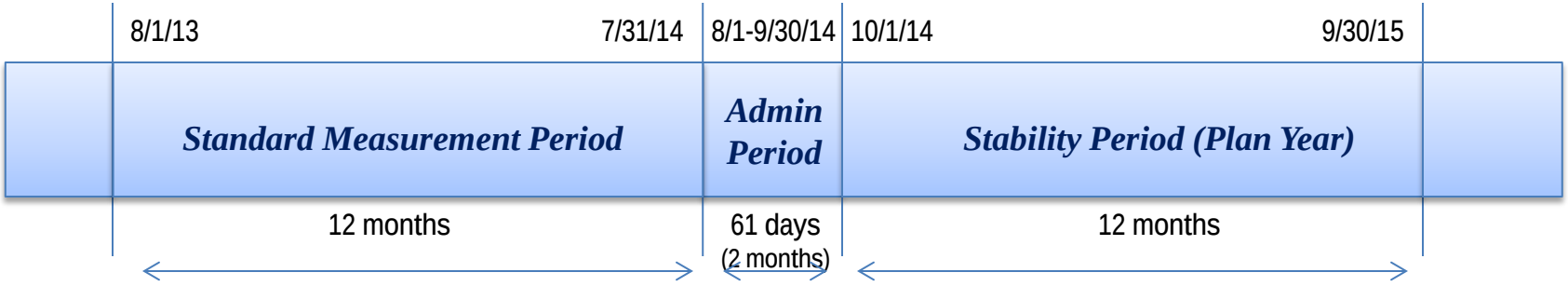
Defining a Variable Employee

Ongoing Employee

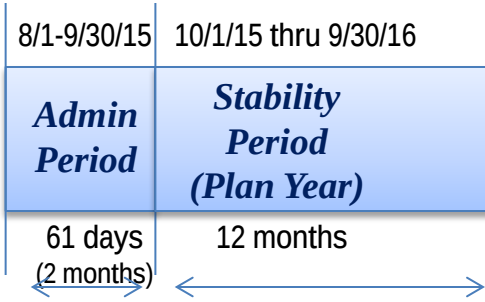
Ongoing variable, part-time and seasonal employee assessment cycle:

EMPLOYER A: Plan Year 10/1/14

Cycle 1



Cycle 2



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Defining a Variable Employee

Ongoing Employee

Ongoing variable, part-time and seasonal employee assessment cycle:

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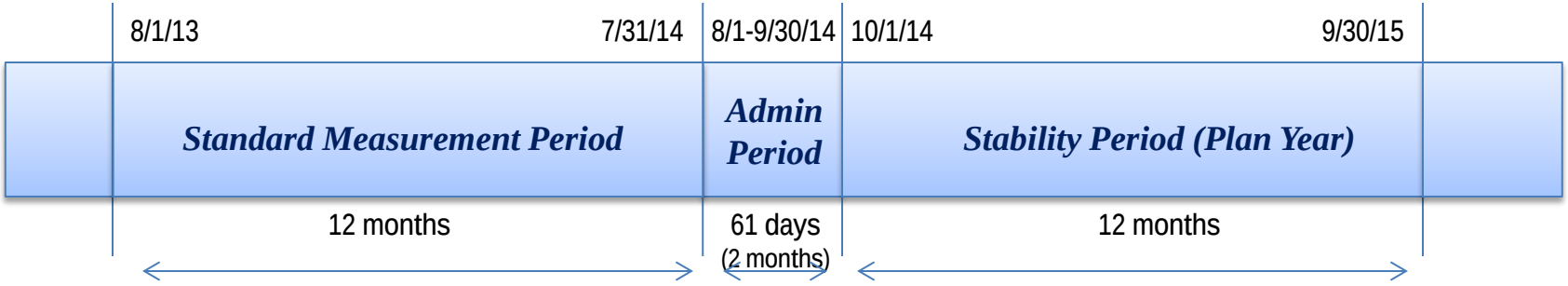
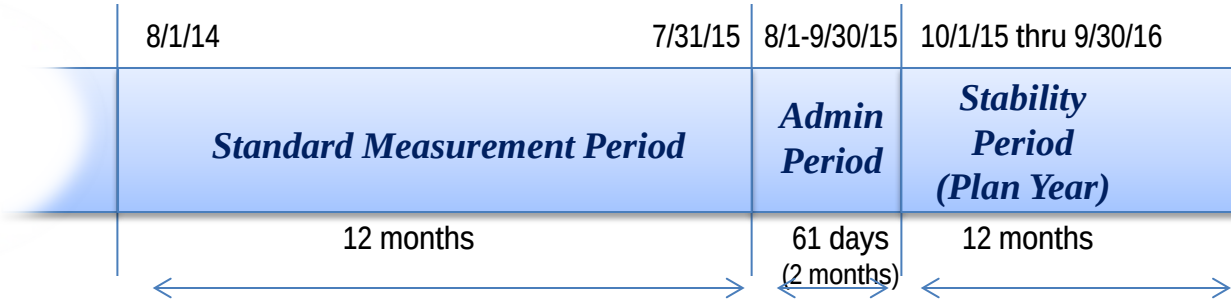


Cycle 2



Measure Period	✓ Must be 3 – 12 consecutive months ✓ *Uniform and consistent basis for all employees in same category*
Admin. Period	✓ Up to 90 days (not 3 months) ✓ Must overlap prior stability period (no lapse for FT EE's both years)
Stability Period	✓ Must be 6 – 12 consecutive months, but ✓ Not shorter than Measurement Period ✓ *If not full-time employee, Stability Period cannot be longer than Measurement Period*

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Determining Eligibility of Part-Time Seasonal, & Variable Hour Employees

Wellington Potential Cost Analysis

PT/SEASONAL/VARIABLE POTENTIAL COST ANALYSIS	EMPLOYER COST TO COVER EMPLOYEES		
All Employees	Min 30-40 Hours	Expanded 21-40 Hours	Max 1-40 Hours
EE's	6	14	66
ER Contribution	$ 613.50	$ 613.50	$ 613.50
Fees*	$ 22.44	$ 22.44	$ 22.44
PCORI	$ 0.08	$ 0.08	$ 0.08
Monthly	$ 636.02	$ 636.02	$ 636.02
	12	12	12
Annual	$ 7,632.28	$ 7,632.28	$ 7,632.28
Annual Cost	**$ 45,793.68**	**$ 106,851.92**	**$ 503,730.48**

*Based on Employee Coverage Only in current plan

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Employer Shared Responsibility Provision Penalty Assessment Process

- IRS will notify employer of potential liability and provide opportunity to respond
- Notification will be given after:
  - Employees' individual tax returns are due
  - Employer has filed an informational report (more info to come) identifying full-time employees and describing coverage offered
- If penalty deemed assessable, IRS to bill and expect immediate payment
- Penalty to employers will not be paid on any tax return

Discussion & Questions

Exhibit D: Sample Analytical Reports

MDNow Medical Centers

Return on Investment

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Cost Analysis: February 2012 – July 2013

Item	MDNow Utilization[1]	Average United Cost[2]	**Claims Avoidance**	Cost for Services at MDNow	MDNow Cost[3]	**Savings**
Primary Care	65	$112.00	**$7,280**	$85	$5,525	**$1,755**
Urgent Care	316	$170.27	**$53,805**	$100	$31,600	**$22,205**
Prescriptions	258	$81.63	**$21,061**	$20	$5,160	**$15,901**
Medical Total			**$82,146**		**$42,285**	**$39,861**
Employee Savings	Primary Care @ $10 Copay Urgent Care @ $35 – $25 Cpy Prescription @ $10 Copay		**$650** **$3,160** **$2,580**			
Total Savings			**$88,536**		**$42,285**	**$46,251**

[1]Representative of unique visits. [2]Average plan cost based on office visits payments, professional service fee costs, laboratory payments, and capitation payments. [3]Cost based upon TOTAL costs since inception. Data does not include workers' compensation & occupational health avoidance.

Village of Wellington
Over Age Dependent Report - Plan Year: 2014

(Names have been removed for illustrative purposes)

Employee Last Name	Employee First Name	Dependent Last Name	Dependent First Name	Dependent Coverages	Coverage Term Date
Dependents Reaching Age 26 in 2014					
Last Name 1	First Name 1	Last Name 1	Dep First Name 1	Medical, Dental, Vision	n/a
Last Name 2	First Name 2	Last Name 2	Dep First Name 2	Medical, Dental, Vision	n/a
Last Name 3	First Name 3	Last Name 3	Dep First Name 3	Medical	n/a
Last Name 4	First Name 4	Last Name 4	Dep First Name 4	Dental	n/a
Last Name 5	First Name 5	Last Name 5	Dep First Name 5	Medical, Dental, Vision	n/a
Last Name 6	First Name 6	Last Name 6	Dep First Name 6	Medical, Dental, Vision	n/a
Last Name 7	First Name 7	Last Name 7	Dep First Name 7	Dental	n/a
Last Name 8	First Name 8	Last Name 8	Dep First Name 8	Medical, Dental	n/a
Last Name 9	First Name 9	Last Name 9	Dep First Name 9	Medical, Dental, Vision	n/a
Last Name 10	First Name 10	Last Name 10	Dep First Name 10	Medical, Dental	n/a
Last Name 11	First Name 11	Last Name 11	Dep First Name 11	Medical, Dental, Vision	n/a
Last Name 12	First Name 12	Last Name 12	Dep First Name 12	Dental, Vision	n/a
Last Name 13	First Name 13	Last Name 13	Dep First Name 13	Medical, Dental, Vision	n/a
Last Name 14	First Name 14	Last Name 14	Dep First Name 14	Medical, Dental, Vision	n/a
Last Name 15	First Name 15	Last Name 15	Dep First Name 15	Medical, Dental, Vision	n/a
Last Name 16	First Name 16	Last Name 16	Dep First Name 16	Medical, Dental, Vision	n/a
Last Name 17	First Name 17	Last Name 17	Dep First Name 17	Medical, Dental, Vision	n/a
Over Age Dependents - 2014 Imputed Income Applies					
Last Name 1	First Name 1	Last Name 1	Dep First Name 1	Medical, Dental	n/a
Last Name 2	First Name 2	Last Name 2	Dep First Name 2	Medical, Dental	n/a
Last Name 3	First Name 3	Last Name 3	Dep First Name 3	Medical, Dental	n/a
Last Name 4	First Name 4	Last Name 4	Dep First Name 4	Medical, Dental	12/31/2014*
Last Name 5	First Name 5	Last Name 5	Dep First Name 5	Medical, Dental	n/a
Last Name 6	First Name 6	Last Name 6	Dep First Name 6	Medical, Dental	n/a
Last Name 7	First Name 7	Last Name 7	Dep First Name 7	Medical, Dental	n/a
Last Name 8	First Name 8	Last Name 8	Dep First Name 8	Dental	n/a
Last Name 9	First Name 9	Last Name 9	Dep First Name 9	Medical, Dental	n/a
Vision Coverages to be Terminated in 2014					
Last Name 1	First Name 1	Last Name 1	Dep First Name 1	Vision	12/31/2014
Last Name 2	First Name 2	Last Name 2	Dep First Name 2	Vision	9/30/2014
Last Name 3	First Name 3	Last Name 3	Dep First Name 3	Vision	9/30/2014
Last Name 4	First Name 4	Last Name 4	Dep First Name 4	Vision	9/30/2014
Last Name 5	First Name 5	Last Name 5	Dep First Name 5	Vision	9/30/2014
Last Name 6	First Name 6	Last Name 6	Dep First Name 6	Vision	7/31/2014
Last Name 7	First Name 7	Last Name 7	Dep First Name 7	Vision	4/30/2014
Last Name 8	First Name 8	Last Name 8	Dep First Name 8	Vision	9/30/2014
Last Name 9	First Name 9	Last Name 9	Dep First Name 9	Vision	11/30/2014
Last Name 10	First Name 10	Last Name 10	Dep First Name 10	Vision	2/28/2014
Last Name 11	First Name 11	Last Name 11	Dep First Name 11	Vision	10/31/2014
Last Name 12	First Name 12	Last Name 12	Dep First Name 12	Vision	5/31/2014
Vision Coverages to be Terminated Immediately (no longer eligible)					
Last Name 1	First Name 1	Last Name 1	Dep First Name 1	Vision	10/31/2013
Last Name 2	First Name 2	Last Name 2	Dep First Name 2	Vision	9/30/2013
Last Name 3	First Name 3	Last Name 3	Dep First Name 3	Vision	8/31/2013

*Dependent reaches age 30 in 2014 and will not be eligible for coverage in 2015 unless disabled

Village of Wellington
Dependents Who Will Reach Age 27 in 2014 - Imputed Income Analysis
Effective Date: January 1, 2014

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Plan	Monthly Premium Rate	Monthly Employer Cost	Monthly Employee Cost	Value Attributable to Overage Dependent	Monthly Pre-Tax Deduction	Monthly Post-Tax Deduction	Monthly Imputed Income*
				(17.1% of Family Rate)			
Medical							
Employee	$705.52	$680.52	$25.00	**n/a**	**n/a**	**n/a**	**n/a**
EE + Spouse	$1,508.55	$1,276.55	$232.00	**n/a**	**n/a**	**n/a**	**n/a**
EE + Child	$1,304.73	$1,128.73	$176.00	**$360.38**	**n/a**	**$176.00**	**$184.38**
EE + Family	$2,107.50	$1,707.50	$400.00	**$360.38**	**$39.62**	**$360.38**	**n/a**
Dental							
Employee	$54.30	$54.30	$0.00	**n/a**	**n/a**	**n/a**	**n/a**
EE + Spouse	$85.12	$76.81	$8.31	**n/a**	**n/a**	**n/a**	**n/a**
EE + Child	$99.80	$87.54	$12.26	**$19.58**	**n/a**	**$12.26**	**$7.32**
EE + Family	$114.48	$98.26	$16.22	**$19.58**	**n/a**	**$16.22**	**$3.36**

**Monthly Imputed Income represents the amount of premium that is attributable to the coverage of the overage dependent that is subsidized by the employer.*
NOTE: Per IRS rules, Employees covering adult children under their health insurance plan may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which the child reaches age 26. Beginning January 1st of the calendar year in which the child reaches age 27 through the end of the calendar year in which the child reaches age 30, premiums must be deducted "post-tax" and "imputed income" must be reported on the employee's W-2 for any portion of the value of premium that is subsidized by the employer and attributable to the applicable adult child's coverage for the coverage period.

Village of Wellington
Florida Municipal Insurance Trust Package Renewal
2013/2014 Program Evaluation

GEHRING GROUP INSURANCE BROKERS & CONSULTANTS

Estimated 2012/2013 ROP Credit

	Current				***Renewal Proposal***				
Policy	**Carrier**	**SIR/ Deductible**	**Limits/TIV**	**Premiums**	**Carrier**	**SIR/ Deductible**	**Limits/TIV**	**Premiums**	**% Change**
Property (Incl Contents)	FMIT	$25,000 AOP 5% Named Storm	$ 72,516,503	$ 331,069	FMIT	$25,000 AOP 5% Named Storm	$ 74,167,000	$ 388,088	
Equipment Breakdown	FMIT	$25,000 AOP 5% Named Storm	As Stated Above	Included in property premium	FMIT	$25,000 AOP 5% Named Storm	As Stated Above	Included in property premium	
Business Income	FMIT		$ 500,000	Included in property premium	FMIT		$ 500,000	Included in property premium	
Extra Expense	FMIT		$ 1,000,000	Included in property premium	FMIT		$ 1,000,000	Included in property premium	
Inland Marine	FMIT	Per Schedule	$ 1,917,453	$ 39,821	FMIT	Per Schedule	$ 2,480,892	Included in property premium	
Sub Total				**$ 370,890**				**$ 388,088**	**5%**
General Liability Stop Loss:	FMIT	$25,000 $273,840	$ 2,000,000	$ 56,969	FMIT	$25,000 $295,011	$ 2,000,000	$ 54,460	**-4%**
Public Officials Liability/ Employment Practices Liability Stop Loss:	FMIT	$25,000 $273,840	$ 2,000,000	$ 46,786	FMIT	$25,000 $295,011	$ 2,000,000	$ 50,486	**8%**
Automobile Liability Stop Loss:	FMIT	$25,000 $75,000	$1,000,000 $10,000 PIP $20,000 UM $5,000 Med Pay	$ 26,480	FMIT	$25,000 $75,000	$1,000,000 $10,000 PIP $20,000 UM $5,000 Med Pay	$ 28,368	**7%**
Automobile Physical Damage	FMIT	Per Schedule	N/A	$ 15,977	FMIT	Per Schedule	N/A	$ 17,218	**8%**
Crime	FMIT	$0 Money/Securities $1,000 Employee Theft	$20,000/$20,000 $500,000	$ 189	FMIT	$0 Money/Securities $1,000 Employee Theft	$20,000/$20,000 $500,000	Included in property premium	
Honesty Blanket Bond	FMIT	$1,000	$ 500,000	$ 688		$1,000	$ 500,000	Included in property premium	
Workers' Compensation	FMIT Exp. Mod = .90	Payroll: $15,638,351	$ 1,000,000	$ 181,610	FMIT Exp. Mod = .93	Payroll: $15,937,048	$ 1,000,000	$ 211,777	**17%**
Sub Total				**$ 328,699**				**$ 362,309**	**10%**
Sub Total Annual Premium				**$ 699,589**				**$ 750,397**	
$ Increase / Decrease								***$ 50,808***	
% Increase / Decrease								***7%***	
Return of Premium Credit - Minium Return				***$ (131,779)***				***$ (92,755)***	
Total Annual Premium less ROP Credit				***$ 567,810***				***$ 657,642***	
$ Increase / Decrease								***$ 89,832***	
% Increase / Decrease								***12.8%***	

Property coverage: valuation basis Replacement Cost; Coverage Form Special; Coinsurance Agreed Amount

***Deductibles:** Named Storm: Within 1/2 mile of Coastal Waters, 5% per building, per location or $25,000 whichever is greater

Inland Marine: Items greater than $100,000 Deductible is either listed amount or 2% of limit, whichever is greater.

Attorney Selection: Trust appoints counsel.

General Liability: Includes a Deductible Stop Loss of $295,011. Once that amount is met, the Trust will pay 100%. Bert Harris Act/Inverse Condemnation $300,000 included. Higher limits available.

Automobile Liability: Members are only responsible for the deductible if a judgment or settlement occurs. Legal expenses are outside of the deductible and are paid by the Trust.

Village of Wellington
Florida Municipal Insurance Trust Package Renewal
2013/2014 Program Evaluation

GEHRING GROUP INSURANCE BROKERS & CONSULTANTS

Actual 2012/2013 ROP Credit

	Current				*Renewal Proposal*				
Policy	**Carrier**	**SIR/ Deductible**	**Limits/TIV**	**Premiums**	**Carrier**	**SIR/ Deductible**	**Limits/TIV**	**Premiums**	**% Change**
Property (Incl Contents)	FMIT	$25,000 AOP 5% Named Storm	$ 72,516,503	$ 331,069	FMIT	$25,000 AOP 5% Named Storm	$ 74,167,000	$ 388,088	
Equipment Breakdown	FMIT	$25,000 AOP 5% Named Storm	As Stated Above	Included in property premium	FMIT	$25,000 AOP 5% Named Storm	As Stated Above	Included in property premium	
Business Income	FMIT		$ 500,000	Included in property premium	FMIT		$ 500,000	Included in property premium	
Extra Expense	FMIT		$ 1,000,000	Included in property premium	FMIT		$ 1,000,000	Included in property premium	
Inland Marine	FMIT	Per Schedule	$ 1,917,453	$ 39,821	FMIT	Per Schedule	$ 2,480,892	Included in property premium	
Sub Total				**$ 370,890**				**$ 388,088**	**5%**
General Liability Stop Loss:	FMIT	$25,000 $273,840	$ 2,000,000	$ 56,969	FMIT	$25,000 $295,011	$ 2,000,000	$ 54,460	**-4%**
Public Officials Liability/ Employment Practices Liability Stop Loss:	FMIT	$25,000 $273,840	$ 2,000,000	$ 46,786	FMIT	$25,000 $295,011	$ 2,000,000	$ 50,486	**8%**
Automobile Liability Stop Loss:	FMIT	$25,000 $75,000	$1,000,000 $10,000 PIP $20,000 UM $5,000 Med Pay	$ 26,480	FMIT	$25,000 $75,000	$1,000,000 $10,000 PIP $20,000 UM $5,000 Med Pay	$ 28,368	**7%**
Automobile Physical Damage	FMIT	Per Schedule	N/A	$ 15,977	FMIT	Per Schedule	N/A	$ 17,218	**8%**
Crime	FMIT	$0 Money/Securities $1,000 Employee Theft	$20,000/$20,000 $500,000	$ 189	FMIT	$0 Money/Securities $1,000 Employee Theft	$20,000/$20,000 $500,000	Included in property premium	
Honesty Blanket Bond	FMIT	$1,000	$ 500,000	$ 688		$1,000	$ 500,000	Included in property premium	
Workers' Compensation	FMIT Exp. Mod = .90	Payroll: $15,638,351	$ 1,000,000	$ 181,610	FMIT Exp. Mod = .93	Payroll: $15,937,048	$ 1,000,000	$ 211,777	**17%**
Sub Total				**$ 328,699**				**$ 362,309**	**10%**
Sub Total Annual Premium				**$ 699,589**				**$ 750,397**	
$ Increase / Decrease								***$ 50,808***	
% Increase / Decrease								***7%***	
Return of Premium Credit - Minium Return				***$ (133,152)***				***$ (92,755)***	
Total Annual Premium less ROP Credit				***$ 566,437***				***$ 657,642***	
$ Increase / Decrease								***$ 91,205***	
% Increase / Decrease								***13.0%***	

Property coverage: valuation basis Replacement Cost; Coverage Form Special; Coinsurance Agreed Amount

***Deductibles:** Named Storm: Within 1/2 mile of Coastal Waters, 5% per building, per location or $25,000 whichever is greater

Inland Marine: Items greater than $100,000 Deductible is either listed amount or 2% of limit, whichever is greater.

Attorney Selection: Trust appoints counsel.

General Liability: Includes a Deductible Stop Loss of $295,011. Once that amount is met, the Trust will pay 100%. Bert Harris Act/Inverse Condemnation $300,000 included. Higher limits available.

Automobile Liability: Members are only responsible for the deductible if a judgment or settlement occurs. Legal expenses are outside of the deductible and are paid by the Trust.

Wellington - Workers' Compensation - Annual Claims
Management Summary Report 2012 - 2013 as of Oct. 31, 2013

NCCI - Experience Modification Factor 10/1/2013 .82

2012 - 2013	
Total Claims YTD (1 Auto)	14
Open Claims	2
Lost Time Claims	2
Experience Modification Factor	0.90
Earned Premium To Date	$ 181,810.00
Earned Losses To Date	$ 20,215.65
Loss Ratio To Date	11.1%

2011 - 2012	
Total Claims YTD (9 Auto)	33
Open Claims	3
Lost Time Claims	5
Experience Modification Factor	0.90
Earned Premium To Date	$ 208,127.00
Earned Losses To Date	$ 156,983.50
Loss Ratio To Date	75.4%

2010 - 2011	
Total Claims (18 Auto)	38
Open Claims	1
Lost Time Claims	1
Experience Modification Factor	0.87
Earned Premium To Date	$ 272,260.00
Earned Losses To Date	$ 23,505.94
Loss Ratio To Date	8.6%

2009 - 2010	
Total Claims (9 Auto)	30
Open Claims	0
Lost Time Claims	7
Experience Modification Factor	1.0
Earned Premium To Date	$ 359,958.00
Earned Losses To Date	$ 135,767.76
Loss Ratio To Date	37.7%

2012 - 2013 Department	Claims	Percent of Claims	Open Claims	Paid To Date Indemnity	Medical	* Other	Total	Reserves	** Total Incurred
Public Works	9	64%	0	$ 1,231	$ 5,163	$ 11	$ 6,405	$ 430	$ 6,834
Parks & Rec.	2	14%	0		$ 381	$ 3	$ 384		$ 384
Utilities	1	7%	0		$ 391		$ 391		$ 391
Recreation	1	7%	1		$ 584		$ 584	$ 1,416	$ 2,000
Administration	1	7%	1	$ 2,414	$ 7,570	$ 622	$ 10,606		$ 10,606
Total	**14**	**100%**	**2**	**$ 3,645**	**$ 14,090**	**$ 636**	**$ 18,370**	**$ 1,846**	**$ 20,216**
2011 - 2012									
Public Works	13	39%	2	$ 35,677	$ 37,134	$ 11,170	$ 83,981	$ 44,535	$ 128,302
Utilities	10	30%	1	$ 801	$ 18,102	$ 1,488	$ 20,391	$ 306	$ 20,697
Administration	7	21%	0		$ 7,488		$ 7,488		$ 7,488
Parks	3	9%	0		$ 497		$ 497		$ 497
Total	**33**	**100%**	**3**	**$ 36,478**	**$ 63,220**	**$12,658**	**$ 112,357**	**$ 44,841**	**$ 156,984**
2010 - 2011									
Public Works	17	45%	0		$ 3,216	$ 975	$ 4,191	$ -	$ 4,191
Utilities	8	21%	0		$ 2,749	$ 400	$ 3,149	$ -	$ 3,149
Parks	6	16%	0		$ 2,331	$ 825	$ 3,156	$ -	$ 3,156
PZ&B	4	11%	0		$ 470		$ 470	$ -	$ 470
Administration	3	8%	1	$ 1,745	$ 9,727	$ 22	$ 11,493	$ 1,047	$ 12,540
Total	**38**	**100%**	**1**	**$ 1,745**	**$ 18,493**	**$ 2,222**	**$ 22,459**	**$ 1,047**	**$ 23,506**
2009 - 2010									
Public Works	13	43%	0	$ 13,030	$ 56,481	$ 2,289	$ 71,799	$ -	$ 69,713
Utilities	9	30%	0	$ 765	$ 28,745	$ 967	$ 30,477	$ -	$ 30,477
Parks	3	10%	0	$ -	$ 1,485	$ 700	$ 2,185	$ -	$ 2,185
Administration	2	7%	0	$ -	$ 3,307	$ -	$ 3,307	$ -	$ 3,307
Code Compliance	1	3%	0	$ 2,357	$ 16,607	$ 443	$ 19,406		$ 19,406
Env. & Eng.	1	3%	0		$ 10,204	$ 475	$ 10,679		$ 10,679
PZ&B	1	3%	0	$ -	$ -	$ -	$ -	$ -	$ -
Total	**30**	**100%**	**0**	**$ 16,152**	**$ 116,828**	**$ 4,873**	**$ 137,854**	**$ -**	**$ 135,768**

Note: Earned Premium to Date reflects remitted figures thru Oct. 31, 2013 and does not include: Expense constant, Incentive credit or Service fee. Claims may have closed since FMIT Loss Report dated Oct. 31, 2013.

*** Other - Reflects legal and or other administrative charges.**

**** Total Incurred = (Total PTD + Reserves) - Recoveries**

Yellow denotes years used in computing NCCI Experience Modification Factor

GEHRING GROUP
INSURANCE BROKERS & CONSULTANTS

SCHEDULE OF YOUR CURRENT INSURANCE
Prepared For: Village of Wellington

A SERVICE OF:
Gehring Group, Inc.
11505 Fairchild Gardens Ave, Suite 202
Palm Beach Gardens, FL 33410
(561)626-6797 - phone
Date Prepared: 12/02/2013

COVERAGE	AMOUNTS OR LIMITS	DEDUCTIBLE	EFFECTIVE	EXPIRES	COMPANY	POLICY NUMBER	PREMIUM
Automobile Liability	$1,000,000 $10,000 PIP $20,000 UM $5,000 Med Pay	$25,000 DSL	10/1/2013	10/1/2014	Florida Municipal Insurance Trust (FMIT)	FMIT#0001	$28,368
Automobile Physical Damage	Per Schedule	Per Schedule	10/1/2013	10/1/2014	FMIT	FMIT#0001	$17,218
General Liability	$2,000,000	$25,000 DSL	10/1/2013	10/1/2014	FMIT	FMIT#0001	$54,460
Public Officials/Employment Practices Liability	$2,000,000	$25,000 DSL	10/1/2013	10/1/2014	FMIT	FMIT#0001	$50,486
Information Security & Privacy Liability	$250,000	$50,000	10/1/2013	10/1/2014	FMIT	FMIT#0001	Included in GL Premium
Property/Equipment Breakdown	$74,167,000	$25,000 AOP 5% Named Wind	10/1/2013	10/1/2014	FMIT	FMIT#0001	$388,088
Inland Marine	$2,480,892	Per Schedule	10/1/2013	10/1/2014	FMIT	FMIT#0001	Included in Property Premium
Crime	$20,000	$0	10/1/2013	10/1/2014	FMIT	FMIT#0001	Included in Property Premium
Honesty Blanket Bond	$500,000	$1,000	10/1/2013	10/1/2014	FMIT	FMIT#0001	Included in Property Premium
Workers' Compensation	$1,000,000 $1,000,000 $1,000,000	$0	10/1/2013	10/1/2014	FMIT	FMIT#0001	$211,777

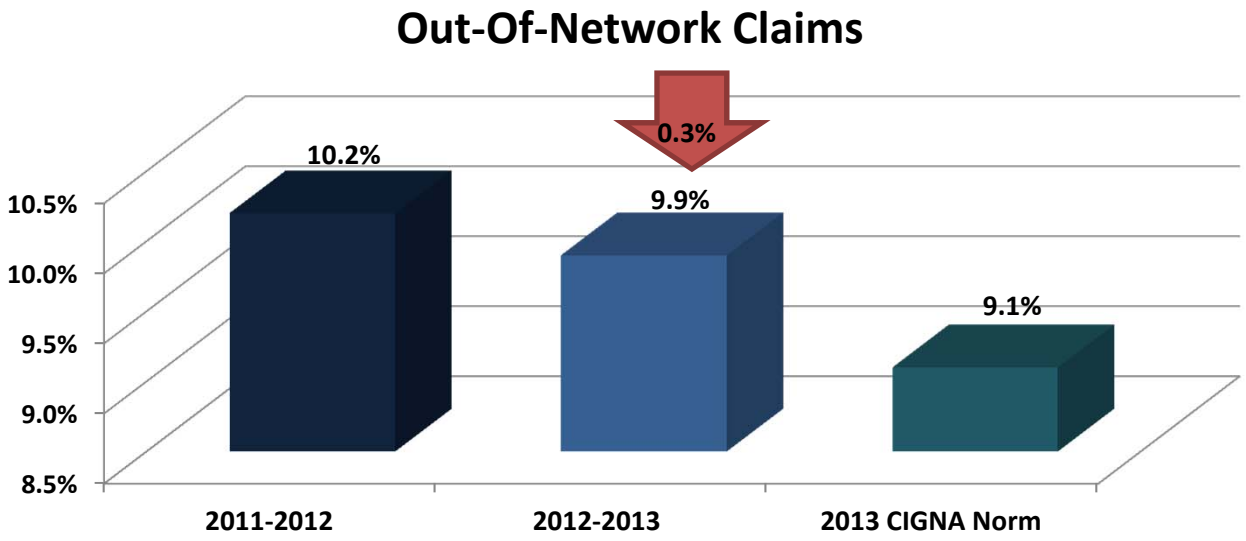
GEHRING GROUP
INSURANCE BROKERS & CONSULTANTS

COMPANY LOGO

MEDICAL Utilization Summary

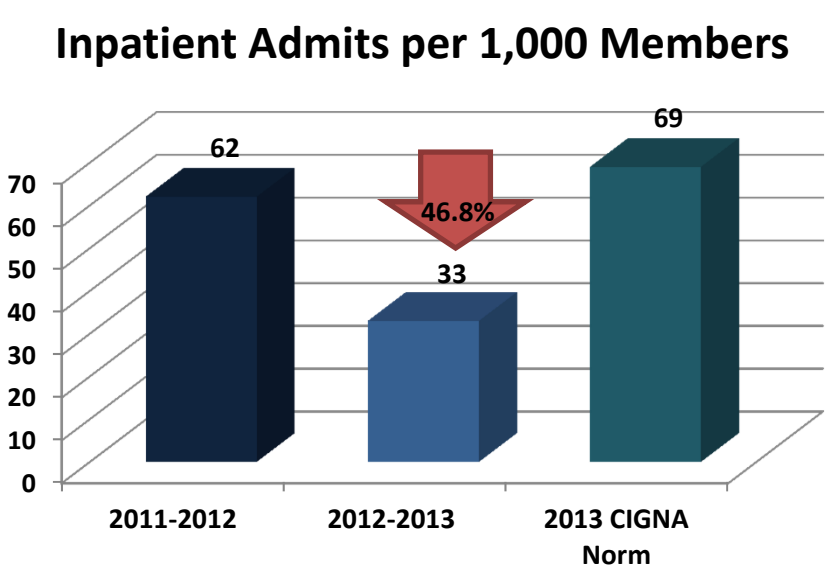
2011 - 2013

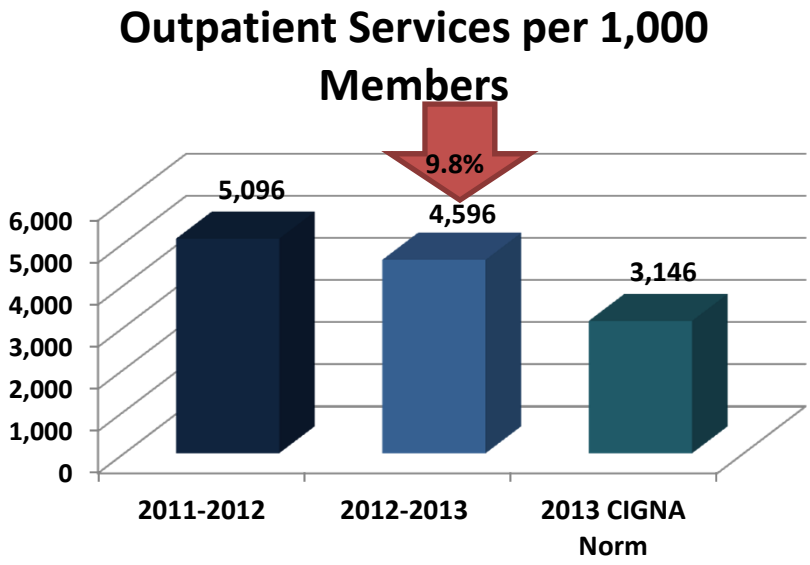
Key Metric Summary



	2011-2012	2012-2013	2013 CARRIER Norm
	(Jul '11 - Aug '12)	(Mar '12 - Feb '13)	
Key Metric			
Average Number of Employees	93	101	
Average Number of Members	204	223	
Out-Of-Network Claims	10.2%	9.9%	9.1%
# of Catastrophic Claimants (Over $50k)	3	2	

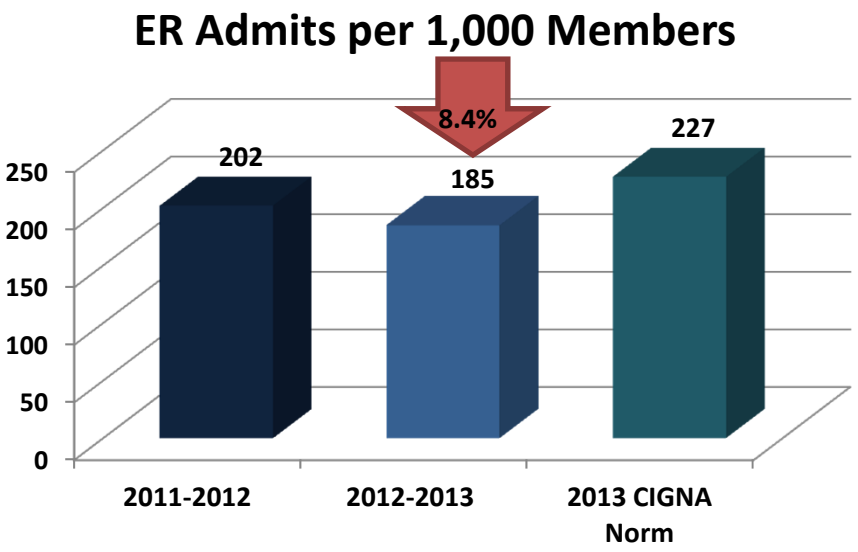
Inpatient / Outpatient Summary

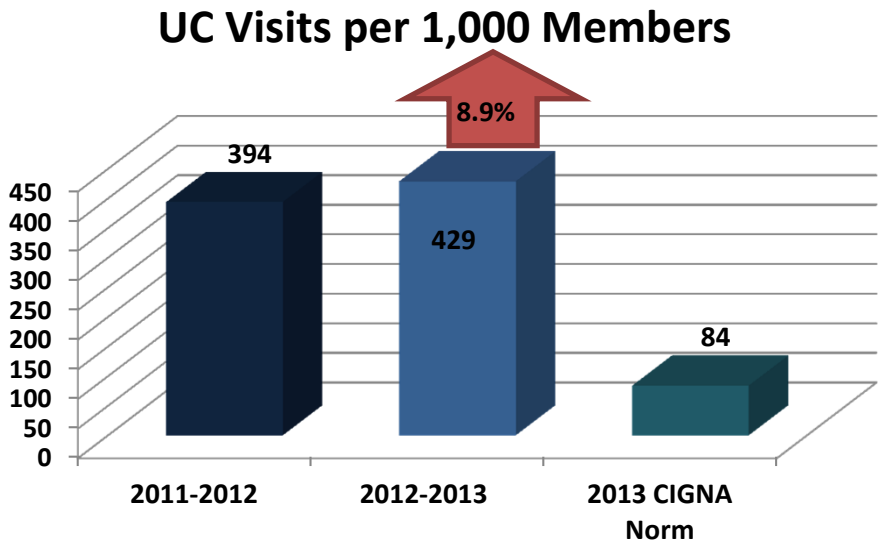




	2011-2012	2012-2013	2013 CARRIER Norm
	(Jul '11 - Aug '12)	(Mar '12 - Feb '13)	
Inpatient Statistics			
Inpatient Spend as % of Total Cost	14.7%	10.1%	24.0%
Inpatient Admits per 1000 Members	62	33	69
Outpatient Statistics			
Outpatient Spend as % of Total Cost	22.5%	22.1%	29.7%
Outpatient Services per 1000 Members	5,096	4,596	3,146

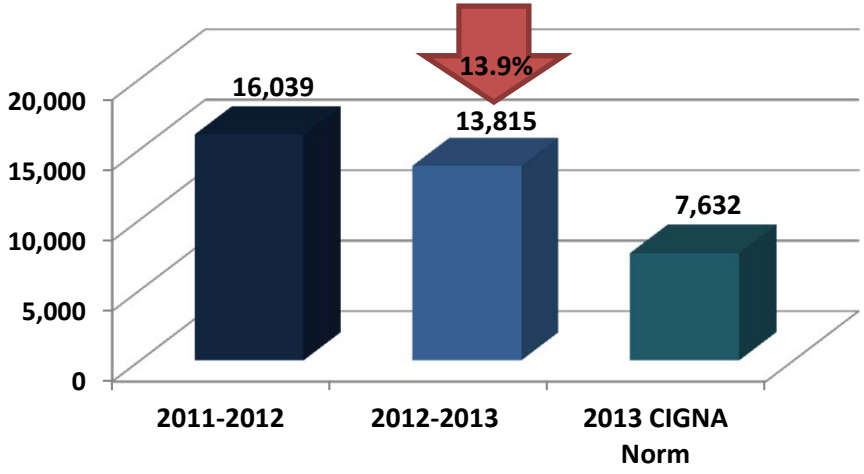
Emergency Room / Urgent Care Summary

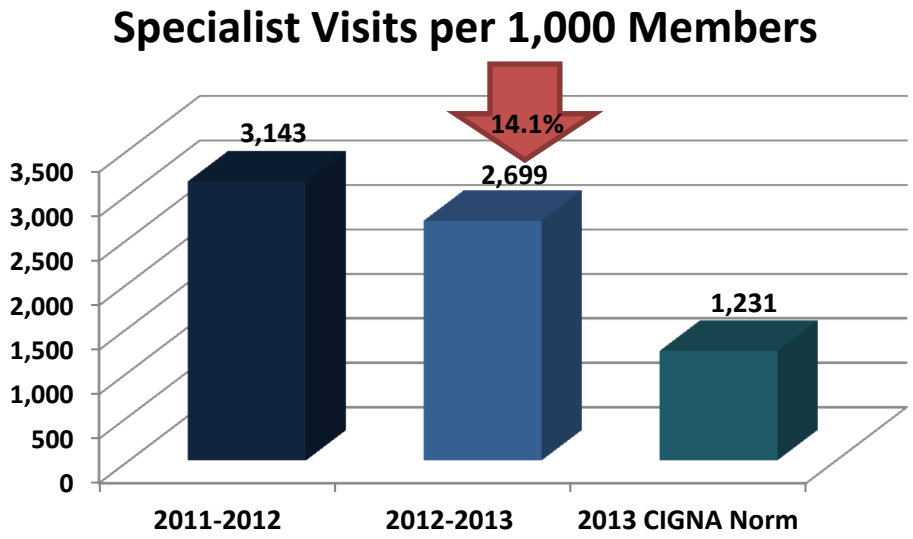




	2011-2012	2012-2013	2013 CARRIER Norm
	(Jul '11 - Aug '12)	(Mar '12 - Feb '13)	
Emergency Room Statistics			
ER Spend as % of Total Cost	4.3%	5.5%	5.3%
ER Admits per 1000 Members	202	185	227
Urgent Care Statistics			
UC Spend as % of Total Cost	0.9%	1.2%	0.3%
UC Visits per 1000 Members	394	429	84

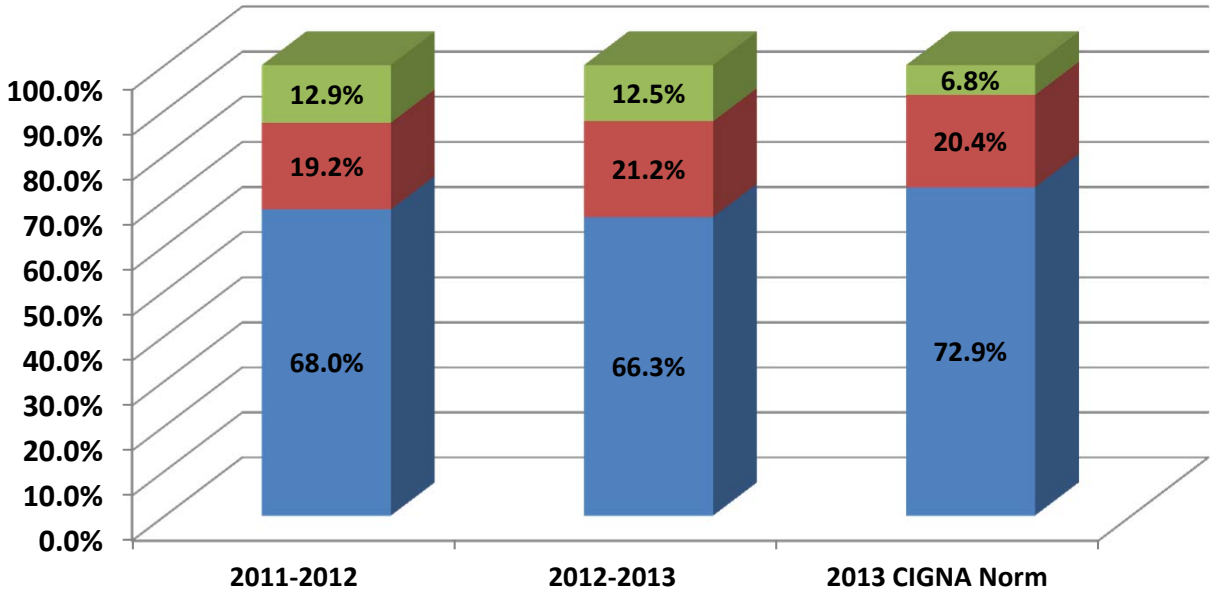
Diagnostic / Specialist Summary





	2011-2012	2012-2013	2013 CARRIER Norm
	(Jul '11 - Aug '12)	(Mar '12 - Feb '13)	
Diagnostic Statistics			
Total Number of Lab Tests per 1000	16,039	13,815	7,632
Advanced Radiology Services per 1000	91	129	
Specialist Office Visit Statistics			
Specialist Visit Spend % of Total Cost	8.3%	9.2%	4.5%
Specialist Visits per 1000 Members	3,143	2,699	1,231

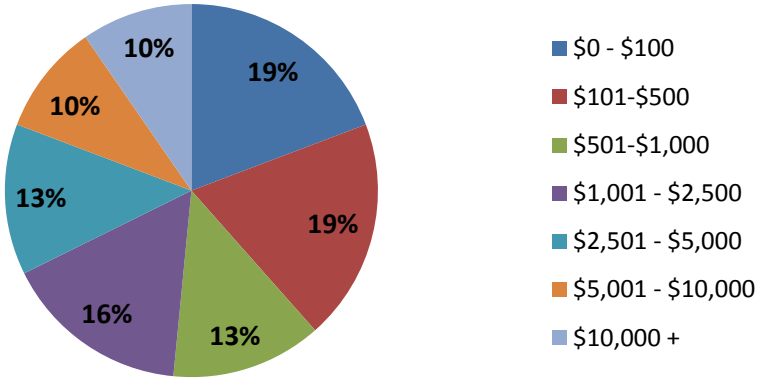
Pharmacy Summary



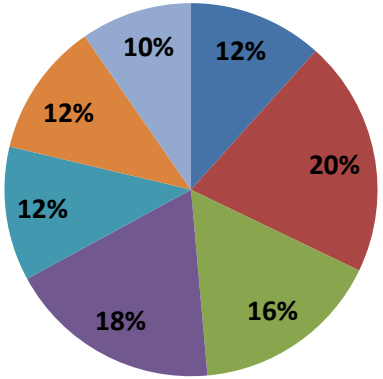
	2011-2012	2012-2013	2013 CARRIER Norm
	(Jul '11 - Aug '12)	(Mar '12 - Feb '13)	
Pharmacy Statistics			
Pharmacy Spend as % of Total Cost	23.4%	26.0%	
Mail Order Use as % of Total Rx Claims	7.8%	7.7%	10.6%
Generic Scripts	68.0%	66.3%	72.9%
Brand Preferred Scripts	19.2%	21.2%	20.4%
Brand Non-Preferred Scripts	12.9%	12.5%	6.8%

Claims Distribution Summary

2011-2012 Claim Distribution



2012-2013 Claim Distribution



	2011-2012	2012-2013
	(Jul '11 - Aug '12)	(Mar '12 - Feb '13)
Claim Payment Distribution Summary		
$0 - $100	50	29
$101-$500	50	51
$501-$1,000	34	41
$1,001 - $2,500	42	46
$2,501 - $5,000	34	29
$5,001 - $10,000	25	29
$10,000 +	25	24

ABC Public Entity

Stop Loss Analysis

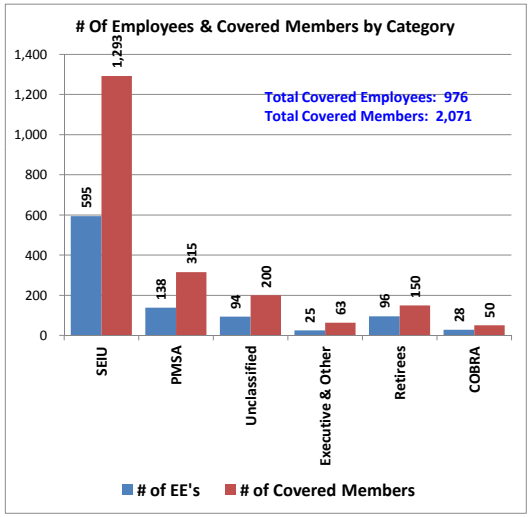
10/11-9/12 Plan Year Claims

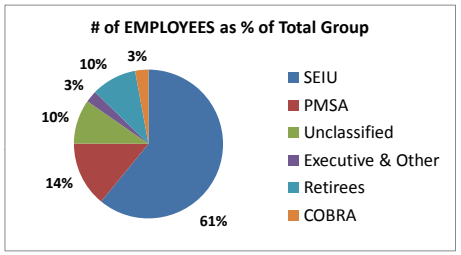
			Current				Lowest Cost
Cost Rank			**5**	**4**	**3**	**2**	**1**
				Claims Cost (After Stop-Loss Reimbursements)			
Claimant		*Paid Claims*	**$250,000**	**$250,000 / $300,000**	**$300,000**	**$350,000**	**$500,000**
1		*$210,555*	$210,555	$210,555	$210,555	$210,555	$210,555
2		*$181,005*	$181,005	$181,005	$181,005	$181,005	$181,005
3		*$177,235*	$177,235	$177,235	$177,235	$177,235	$177,235
4		*$165,945*	$165,945	$165,945	$165,945	$165,945	$165,945
5		*$156,682*	$156,682	$156,682	$156,682	$156,682	$156,682
6		*$143,273*	$143,273	$143,273	$143,273	$143,273	$143,273
7		*$142,709*	$142,709	$142,709	$142,709	$142,709	$142,709
8		*$142,083*	$142,083	$142,083	$142,083	$142,083	$142,083
9		*$139,535*	$139,535	$139,535	$139,535	$139,535	$139,535
10		*$126,455*	$126,455	$126,455	$126,455	$126,455	$126,455
a)	Claims Cost	**$1,585,477**	**$1,585,477**	**$1,585,477**	**$1,585,477**	**$1,585,477**	**$1,585,477**
b)	*Stop Loss Pays*		*$0*	*$0*	*$0*	*$0*	*$0*
c)	ISL Premium		$1,099,022	$926,205	$892,785	$708,433	$432,984
d)	Aggregate Premium		$88,268	$88,356	$90,033	$93,652	$100,184
a+c+d	***Total County Cost***		***$2,772,767***	***$2,600,038***	***$2,568,295***	***$2,387,562***	***$2,118,645***
Variance from lowest cost option			***$654,122***	***$481,393***	***$449,650***	***$268,917***	

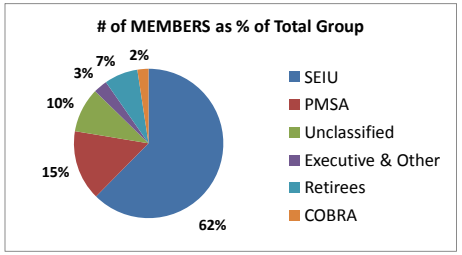
For illustrative purposes only.

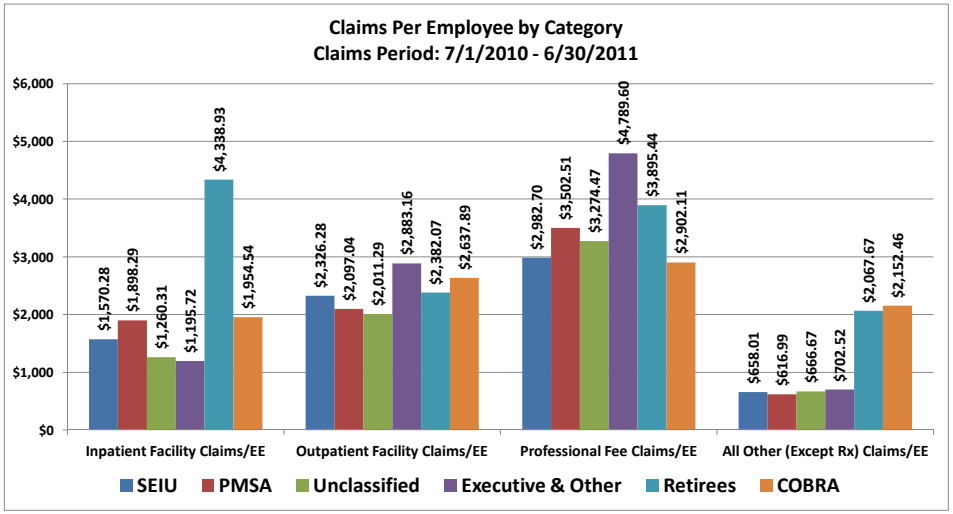
Sample Client
Claims Experience by Product and Branch
(Prescription Drug Claims Not Included)
Period: Incurred 7/2010 - 6/2011 & Paid thru 9/2011

					Inpatient Facilty					Outpatient Facility			Professional Fees			All Other Excluding Rx			TOTAL CLAIMS		
BRANCH	# of EE's	% of EE Group	# of Covered Members	% of Member Group	Inpatient Events	% of Total Events	Total Inpatient Claims	% of Total	Inpatient Facility Claims/EE	Total Outpatient Claims	% of Total	Outpatient Facility Claims/EE	Total Professional Fee Claims	% of Total	Professional Fee Claims/EE	Total All Other Claims	% of Total	All Other (Except Rx) Claims/EE	Total Claims	% of Total	Total Paid/EE
SEIU	595	61%	1,293	62%	96	55%	$934,314	51%	**$1,570.28**	$1,384,135	62%	**$2,326.28**	$1,774,707	57%	**$2,982.70**	$391,518	48%	**$658.01**	$4,484,674	56%	**$7,537.27**
PMSA	138	14%	315	15%	21	12%	$261,964	14%	**$1,898.29**	$289,392	13%	**$2,097.04**	$483,347	15%	**$3,502.51**	$85,144	10%	**$616.99**	$1,119,847	14%	**$8,114.83**
Unclassified	94	10%	200	10%	15	9%	$118,469	7%	**$1,260.31**	$189,061	8%	**$2,011.29**	$307,800	10%	**$3,274.47**	$62,667	8%	**$666.67**	$677,997	8%	**$7,212.73**
Executive & Other	25	3%	63	3%	2	1%	$29,893	2%	**$1,195.72**	$72,079	3%	**$2,883.16**	$119,740	4%	**$4,789.60**	$17,563	2%	**$702.52**	$239,275	3%	**$9,571.00**
Retirees	96	10%	150	7%	36	21%	$416,537	23%	**$4,338.93**	$228,679	10%	**$2,382.07**	$373,962	12%	**$3,895.44**	$198,496	24%	**$2,067.67**	$1,217,674	15%	**$12,684.10**
COBRA	28	3%	50	2%	4	2%	$54,727	3%	**$1,954.54**	$73,861	3%	**$2,637.89**	$81,259	3%	**$2,902.11**	$60,269	7%	**$2,152.46**	$270,116	3%	**$9,647.00**
TOTAL	976	100%	2,071	100%	174	100%	$1,815,904	100%	$1,860.56	$2,237,207	100%	$2,292.22	$3,140,815	100%	$3,218.05	$815,657	100%	$835.71	$8,009,583	100%	$8,206.54









**All Charts represent data for period of 7/1/2010 - 6/30/2011.*

Sample Public Sector client
Self Funded Claims Experience Report - BlueCross BlueShield of Florida
Plan Effective Date: October 1, 2010 - Sept 30, 2012
Paid in Plan Month

Date	Plan Funding	ASO Fees	ISL Premium ($100,000)	ASL Premium	Total Fixed Costs	Rx Claims	Medical Claims	Stop Loss Reimbursement	Total Plan Cost	Surplus/ (Deficit)
October-10	$ 308,101.38	$ 15,960.00	$ 26,265.48	$ 1,463.00	$ 43,688.48	$ 29,159.21	$ 98,228.85	$ -	$ 171,076.54	$ 137,024.84
November-10	$ 307,357.51	$ 15,960.00	$ 26,265.48	$ 1,463.00	$ 43,688.48	$ 31,613.45	$ 656,965.08	$ -	$ 732,267.01	$ (424,909.50)
December-10	$ 306,182.07	$ 15,960.00	$ 26,265.48	$ 1,463.00	$ 43,688.48	$ 27,803.74	$ 189,121.18	$ (451,276.87)	$ (190,663.47)	$ 496,845.54
January-11	$ 306,778.02	$ 15,960.00	$ 25,906.56	$ 1,463.00	$ 43,329.56	$ 34,459.64	$ 459,056.28	$ (5,473.26)	$ 531,372.22	$ (224,594.20)
February-11	$ 313,062.35	$ 15,960.00	$ 25,996.29	$ 1,463.00	$ 43,419.29	$ 26,175.47	$ 465,781.57	$ (21,180.91)	$ 514,195.42	$ (201,133.07)
March-11	$ 307,771.08	$ 16,020.00	$ 26,149.68	$ 1,468.50	$ 43,638.18	$ 32,944.94	$ 204,619.51	$ (10,470.90)	$ 270,731.73	$ 37,039.35
April-11	$ 308,482.73	$ 16,080.00	$ 26,303.07	$ 1,474.00	$ 43,857.07	$ 21,974.36	$ 97,420.44	$ (99,157.81)	$ 64,094.06	$ 244,388.67
May-11	$ 284,763.68	$ 16,020.00	$ 26,239.41	$ 1,468.50	$ 43,727.91	$ 26,683.98	$ 107,188.36	$ (301,335.12)	$ (123,734.87)	$ 408,498.55
June-11	$ 261,057.33	$ 15,900.00	$ 26,112.09	$ 1,457.50	$ 43,469.59	$ 33,709.89	$ 122,131.21	$ (7,556.88)	$ 191,753.81	$ 69,303.52
July-11	$ 357,560.63	$ 15,780.00	$ 25,895.04	$ 1,446.50	$ 43,121.54	$ 26,169.13	$ 177,773.30	$ (9,670.59)	$ 237,393.38	$ 120,167.25
August-11	$ 330,991.31	$ 15,900.00	$ 25,842.90	$ 1,457.50	$ 43,200.40	$ 33,665.70	$ 312,307.03	$ (94,343.11)	$ 294,830.02	$ 36,161.29
September-11	$ 307,542.13	$ 15,900.00	$ 25,932.63	$ 1,457.50	$ 43,290.13	$ 24,176.53	$ 124,872.78	$ (21,206.53)	$ 171,132.91	$ 136,409.22
Annual Total	$ 3,699,650.22	$ 191,400.00	$ 313,174.11	$ 17,545.00	$ 522,119.11	$ 348,536.04	$ 3,015,465.59	$ (1,021,671.98)	$ 2,864,448.76	$ 835,201.46
Monthly Costs					Net Claim Cost			$ 2,342,329.65		
EE Only	$ 717.37	$ 60.00	$ 63.66	$ 5.50						
EE + 1	$ 1,260.36	$ 60.00	$ 153.39	$ 5.50						
EE + 2 or more	$ 1,496.24	$ 60.00	$ 153.39	$ 5.50						

EE Only	EE + 1	EE + 2 or more	Total EE's	Claims / EE / Month
162	48	56	266	$ 478.90
162	48	56	266	$ 2,588.64
162	48	56	266	$ (881.02)
166	47	53	266	$ 1,834.75
165	46	55	266	$ 1,769.84
165	47	55	267	$ 850.54
165	47	56	268	$ 75.51
164	47	56	267	$ (627.20)
162	47	56	265	$ 559.56
161	47	55	263	$ 738.68
165	45	55	265	$ 949.55
164	45	56	265	$ 482.43
			3190	$ 734.27

Date	Plan Funding	ASO Fees	ISL Premium ($100,000)	ASL Premium	Total Fixed Costs	Rx Claims	Medical Claims	Stop Loss Reimbursement	Total Plan Cost	Surplus/ (Deficit)
Balance Forward										$ 835,201.46
October-11	$ 308,844.93	$ 15,900.00	$ 45,651.83	$ 1,537.00	$ 63,088.83	$ 23,294.66	$ 113,097.77	$ -	$ 199,481.26	$ 109,363.67
November-11	$ 309,225.02	$ 15,960.00	$ 45,916.30	$ 1,542.80	$ 63,419.10	$ 31,380.16	$ 225,176.97	$ -	$ 319,976.23	$ (10,751.21)
December-11	$ 309,010.05	$ 15,960.00	$ 45,767.32	$ 1,542.80	$ 63,270.12	$ 25,514.86	$ 163,570.86	$ -	$ 252,355.84	$ 56,654.21
January-12	$ 309,010.05	$ 16,200.00	$ 46,229.28	$ 1,566.00	$ 63,995.28	$ 20,491.55	$ 141,432.64	$ (9,401.25)	$ 216,518.22	$ 92,491.83
February-12	$ 309,225.02	$ 16,140.00	$ 46,262.77	$ 1,560.20	$ 63,962.97	$ 31,596.19	$ 183,511.46	$ (6,339.18)	$ 272,731.44	$ 36,493.58
March-12	$ 309,605.11	$ 16,200.00	$ 46,527.24	$ 1,566.00	$ 64,293.24	$ 29,861.62	$ 218,331.31	$ (17,948.04)	$ 294,538.13	$ 15,066.98
April-12	$ 309,605.11	$ 16,200.00	$ 46,527.24	$ 1,566.00	$ 64,293.24	$ 26,009.72	$ 195,704.13	$ (6,988.22)	$ 279,018.87	$ 30,586.24
May-12	$ 309,605.11	$ 16,260.00	$ 46,642.73	$ 1,571.80	$ 64,474.53	$ 33,528.22	$ 209,381.97	$ (5,465.25)	$ 301,919.47	$ 7,685.64
June-12	$ 310,150.32	$ 16,140.00	$ 46,560.73	$ 1,560.20	$ 64,260.93	$ 29,888.67	$ 98,056.09	$ (5,576.79)	$ 186,628.90	$ 123,521.42
July-12	$ 311,075.62	$ 16,200.00	$ 46,974.18	$ 1,566.00	$ 64,740.18	$ 50,591.65	$ 317,861.76	$ (13,143.79)	$ 420,049.80	$ (108,974.18)
August-12	$ 310,695.53	$ 16,140.00	$ 46,709.71	$ 1,560.20	$ 64,409.91	$ 34,453.62	$ 165,732.14	$ (2,444.52)	$ 262,151.15	$ 48,544.38
September-12	$ 310,860.65	$ 16,080.00	$ 46,594.22	$ 1,554.40	$ 64,228.62	$ 30,524.70	$ 269,364.57	$ (1,750.53)	$ 362,367.36	$ (51,506.71)
Annual Total	$ 3,716,912.52	$ 193,380.00	$ 556,363.55	$ 18,693.40	$ 768,436.95	$ 367,135.62	$ 2,301,221.67	$ (69,057.57)	$ 3,367,736.67	$ 349,175.85
RX Refund										$ 9,382.07
Total**										$ 1,193,759.38
Monthly Costs					Net Claim Cost	$		2,599,299.72		
EE Only	$ 717.37	$ 60.00	$ 115.49	$ 5.80	$ -					
EE + 1	$ 1,260.36	$ 60.00	$ 264.47	$ 5.80	$ 380.09					
EE + 2 or more	$ 1,496.24	$ 60.00	$ 264.47	$ 5.80	$ 545.21					

EE Only	EE + 1	EE + 2 or more	Total EE's	NET Claims / EE / Month
164	44	57	265	$ 514.69
164	45	57	266	$ 964.50
165	43	58	266	$ 710.85
169	43	58	270	$ 564.90
167	45	57	269	$ 776.09
167	46	57	270	$ 852.76
167	46	57	270	$ 795.28
168	46	57	271	$ 876.18
165	46	58	269	$ 454.90
164	47	59	270	$ 1,315.96
164	46	59	269	$ 735.10
163	45	60	268	$ 1,112.46
			3223	$ 806.48

***Does not include reserves for IBNR claims and run-out if plan is terminated*

Sample Client (2,500+ Employees)

Health Insurance Provider Disruption Analysis

Top 50 Utilized Providers

Provider	# of Claimants	CIGNA	AETNA HMO/POS	BCBSFL HMO/PPO
SCHIFF MD THEODORE A	477	Yes	Yes	Yes
MULLEN JR MD SANFORD A	354	Yes	Yes	Yes
GORODETSKY MD JEFFREY S	295	Yes	Yes	Yes
SORRENTINO DO ANTHONY J	233	Yes	Yes	Yes
FRIEDMAN MD/JOEL	215	Yes	Yes	Yes
WEISBERG MD RICHARD B	180	Yes	Yes	Yes
WICINA MD GENON M	176	Yes	Yes	Yes
LEE-NUNEZ MD WYNNE S	172	Yes	Yes	Yes
HEROUX KIMBERLY A MD	169	Yes	Yes	Yes
MEDSTAT URGENT CARE CTR	165	Yes	Yes	Yes
HOCHMAN MD MICHAEL H	162	Yes	Yes	Yes
KADINGO MD RICHARD M	153	Yes	Yes	Yes
WUBBENA MD JON F	151	Yes	Yes	Yes
PARE JR MD ROBERT H	146	Yes	Yes	Yes
JACOBSON DAN G MD	137	Yes	Yes	Yes
WILLERT CRAIG S MD	132	Yes	Yes	Yes
KRABBE MD/JANICE M	128	Yes	Yes	Yes
LYONS DO GLYNNIS J	127	Yes	Yes	Yes
GLASPEY BEN L DO	123	Yes	Yes	Yes
BLOMER ALLISON MD	122	Yes	Yes	Yes
VAN VLIET DO ROBERT J	120	Yes	Yes	Yes
COLLINS EVAN M MD	119	Yes	Yes	Yes
DUBE MD RICHARD A	117	Yes	Yes	Yes
HUTCHINSON ANN R MD	116	Yes	NO	Yes
NUNEZ MD ROBERT A	116	Yes	Yes	Yes
HILLMANN JEFFREY S MD	106	Yes	NO	Yes
HARVEY MD STANLEY CHAD	103	Yes	NO	NO
CONNOLLY MD ROBIN J M	100	Yes	NO	NO
DESMAN MD SCOTT M	97	Yes	Yes	Yes
DWECK MD MURRAY F	96	Yes	Yes	Yes
KATER MD GABRIELLE	84	Yes	NO	Yes
DAYTON MD PETER M	66	Yes	Yes	Yes
LIBMAN MD MICHELE F	66	Yes	Yes	Yes
SINGER MD JEREMY S	63	Yes	Yes	Yes
BRICENO MD JACKELIN D	62	Yes	NO	NO
DICKENS MD FRANK E	60	Yes	Yes	Yes
OMURA MD NAYOMI E	58	Yes	Yes	Yes
MC NANEY-FLINT MD HEIDI M	56	Yes	Yes	Yes
SHARKEY MD DANIEL E	55	Yes	Yes	Yes
RITTER MD WILLIAM S	50	Yes	Yes	Yes
CARANO KRISTIN S MD	49	Yes	NO	Yes
EVERSOLE MD AMY M	49	Yes	Yes	Yes
KANTOR MD LAWRENCE R	49	Yes	Yes	Yes
LAGUERRE MD BEAUVAIS	46	Yes	Yes	Yes
SCHROEDER MD TODD R	46	Yes	NO	Yes
SHERMAN MD MICHAEL S	46	Yes	Yes	Yes
HAAS MD GEORGE J	45	Yes	Yes	Yes
KRATHEN MD RICHARD A	45	Yes	Yes	Yes
PFEIFFER MD ERIC A	45	Yes	NO	Yes
% Match		**100%**	**82%**	**94%**

Sample Public Sector Client
Health Insurance Renewal Projection
Plan Year 2010

Claims Period: July 2008 - June 2009

		Medical	Dental	TOTAL PLAN
Plan Formula Detail				
Total FFS Medical Claims & Fixed Costs		$ 35,665,835	$ 1,424,887	$ 37,090,722
Less Excess Claims Over $200,000	-	$ (2,538,965)	$ -	$ (2,538,965)
Less Capitation	-	$ (2,486,107)	$ -	$ (2,486,107)
Total FFS Medical Claims Only	=	$ 30,640,763	$ 1,424,887	$ 30,640,763
Claims Margin	x	*1.0500*	*1.0500*	
Estimated Incurred FFS Claims	=	$ 32,172,801	$ 1,496,131	$ 33,668,933
Average Setback Lives	/	3689	2551	
Incurred Average Claims / EE / Year	=	$ 8,721	$ 586	
Current Inforce	x	3755	2597	
Adjusted Projected Annual Claims	=	$ 32,748,406	$ 1,523,110	$ 34,271,515
Trend (Includes Rx)		*12.2%*	*6.4%*	
Effective Trend for 18 months	x	1.1830	1.0960	
Projected Mature FFS Claims	=	$ 38,741,364	$ 1,669,328	$ 40,410,692
Excess Claims	+	$ 1,800,000	$ -	$ 1,800,000
Estimated Capitation	+	$ 2,486,107	$ -	$ 2,486,107
Total Claims & Costs	=	$ 43,027,471	$ 1,669,328	$ 44,696,799
Desired Loss Ratio (89%)	/	*0.89*	*0.89*	
Projected Unpooled Premium Needed	=	$ 48,345,473	$ 1,875,650	$ 50,221,123
Proposed Pooling Premium	+			$ -
Projected Premium Needed	=			$ 50,221,123
Current Annual Program Cost				$ 48,225,306
$ Change Required				**$ 1,995,817**
% Change Required				**4.1%**

**Data Utilized from May 1, 2007 - April 30, 2008*

**Network Access Fees, Capitation, & Pooling Premium are Guaranteed*

GEHRING GROUP PROFESSIONAL SERVICES

City
Medical Network Evaluation
County, Florida

GEHRING GROUP
PROFESSIONAL SERVICES

Network Discount	CURRENT Gulf Coast Provider Network	PROPOSED AETNA Open Access Select	PROPOSED BlueCross BlueShield BlueCare/BlueOptions	PROPOSED CIGNA HealthCare Open Access Plus
Inpatient Facility	**54%**	**68%**	**61%**	**68%**
Outpatient Facility	35%	65%	65%	68%
Outpatient Laboratory	45%	63%	57%	68%
Outpatient X-Ray	40%	51%	71%	52%
Outpatient Combined	**43%**	**63%**	**68%**	**62%**
Mental Health / Substance Abuse	22%	52%	29%	57%
Primary Care Physician (PCP)	17%	51%	45%	54%
Specialist	24%	55%	46%	59%
PCP & Specialist Combined	**21%**	**54%**	**46%**	**58%**
TOTAL	**41%**	**62%**	**56%**	**66%**

Network Disruption Analysis	Current Gulf Coast Provider Network	PROPOSED AETNA Open Access Select	PROPOSED BlueCross BlueShield BlueCare/BlueOptions	PROPOSED CIGNA HealthCare Open Access Plus
Current - Unique Tax ID		82%	78%	88%
Current - Matched Records		87%		93%
Current - % of Claims Paid		96%		97%

*Utilized networks for comparison with most current membership (EPO1)

Wellington, Florida
Village of Wellington

Employee Benefits Executive Cost Summary
Effective Date: January 1, 20XX

GEHRING GROUP

COVERAGE		CURRENT			RENEWAL		
HEALTH		**United HealthCare**			**United HealthCare or CIGNA HealthCare**		
POS CHOICE PLUS 38		**Total**	**Employer**	**Employee**	**Total**	**Employer**	**Employee**
Employee	106	$583.84	$583.84	$0.00	$538.76	$513.76	$25.00
EE+Spouse	41	$1,249.42	$1,077.55	$171.87	$1,152.95	$956.09	$196.86
EE+Child(ren)	36	$1,080.10	$951.95	$128.15	$996.71	$843.56	$153.15
EE+Family	72	$1,745.71	$1,445.70	$300.01	$1,610.90	$1,285.89	$325.01
MONTHLY PREMIUM		**$277,687.98**	**$244,427.19**	**$33,260.79**	**$256,245.87**	**$216,610.49**	**$39,635.38**
ANNUAL PREMIUM		**$3,332,255.76**	**$2,933,126.28**	**$399,129.48**	**$3,074,950.44**	**$2,599,325.88**	**$475,624.56**
$ INCREASE		**N/A**	**N/A**	**N/A**	**-$257,305.32**	**-$333,800.40**	**$76,495.08**
% INCREASE		**N/A**	**N/A**	**N/A**	**-7.7%**	**-11.4%**	**19.2%**
DENTAL		**Dental Decisions**			**Dental Decisions**		
DIRECT ASSIGNMENT		**Total**	**Employer**	**Employee**	**Total**	**Employer**	**Employee**
Employee	106	$65.10	$65.10	$0.00	$65.10	$65.10	$0.00
EE+Spouse	41	$102.04	$92.08	$9.96	$102.04	$92.08	$9.96
EE+Child(ren)	36	$119.63	$104.93	$14.70	$119.63	$104.93	$14.70
EE+Family	72	$137.23	$117.79	$19.44	$137.23	$117.79	$19.44
MONTHLY COST		**$25,271.48**	**$22,934.24**	**$2,337.24**	**$25,271.48**	**$22,934.24**	**$2,337.24**
ANNUAL COST		**$303,257.76**	**$275,210.88**	**$28,046.88**	**$303,257.76**	**$275,210.88**	**$28,046.88**
$ INCREASE		**N/A**	**N/A**	**N/A**	**$0.00**	**$0.00**	**$0.00**
% INCREASE		**N/A**	**N/A**	**N/A**	**0.0%**	**0.0%**	**0.0%**
HRA FUNDING		**Benefits Workshop**			**Benefits Workshop**		
		Total	**Employer**	**Employee**	**Total**	**Employer**	**Employee**
Employee	106	$791.25	$791.25	$0.00	$800.75	$800.75	$0.00
EE+Spouse	41	$1,055.00	$1,055.00	$0.00	$1,067.66	$1,067.66	$0.00
EE+Child(ren)	36	$1,055.00	$1,055.00	$0.00	$1,067.66	$1,067.66	$0.00
EE+Family	72	$1,318.75	$1,318.75	$0.00	$1,334.58	$1,334.58	$0.00
ANNUAL COST		**$260,057.50**	**$260,057.50**	**$0.00**	**$263,179.08**	**$263,179.08**	**$0.00**
$ INCREASE		**N/A**	**N/A**	**N/A**	**$3,121.58**	**$3,121.58**	**$0.00**
% INCREASE		**N/A**	**N/A**	**N/A**	**1.2%**	**1.2%**	**0.0%**
HRA / FSA ADMINISTRATION		**Benefits Workshop**			**Benefits Workshop**		
		Total	**Employer**	**Employee**	**Total**	**Employer**	**Employee**
HRA Administration	255	$6.00	$6.00	$0.00	$6.00	$6.00	$0.00
FSA Administration	25	$5.00	$5.00	$0.00	$5.00	$5.00	$0.00
MONTHLY PREMIUM		**$1,655.00**	**$1,655.00**	**$0.00**	**$1,655.00**	**$1,655.00**	**$0.00**
ANNUAL PREMIUM		**$19,860.00**	**$19,860.00**	**$0.00**	**$19,860.00**	**$19,860.00**	**$0.00**
$ INCREASE		**N/A**	**N/A**	**N/A**	**$0.00**	**$0.00**	**$0.00**
% INCREASE		**N/A**	**N/A**	**N/A**	**0.0%**	**0.0%**	**0.0%**
LIFE		**Jefferson Pilot**			**Jefferson Pilot**		
		Total	**Employer**	**Employee**	**Total**	**Employer**	**Employee**
Life Rate		$0.20	$0.20	$0.00	$0.20	$0.20	$0.00
AD&D Rate		$0.03	$0.03	$0.00	$0.03	$0.03	$0.00
Total Life and AD&D		***$0.23***	***$0.23***	***$0.00***	***$0.23***	***$0.23***	***$0.00***
Life Volume		*$17,891,300.00*	*$17,891,300.00*	*$0.00*	*$17,891,300.00*	*$17,891,300.00*	*$0.00*
MONTHLY PREMIUM		**$4,115.00**	**$4,115.00**	**$0.00**	**$4,115.00**	**$4,115.00**	**$0.00**
ANNUAL PREMIUM		**$49,379.99**	**$49,379.99**	**$0.00**	**$49,379.99**	**$49,379.99**	**$0.00**
$ INCREASE		**N/A**	**N/A**	**N/A**	**$0.00**	**$0.00**	**$0.00**
% INCREASE		**N/A**	**N/A**	**N/A**	**0.0%**	**0.0%**	**0.0%**
LONG TERM DISABILITY		**Jefferson Pilot**			**Jefferson Pilot**		
		Total	**Employer**	**Employee**	**Total**	**Employer**	**Employee**
LTD Rate		$0.34	$0.34	$0.00	$0.34	$0.34	$0.00
LTD Volume		*$805,491.00*	*$805,491.00*	*$0.00*	*$805,491.00*	*$805,491.00*	*$0.00*
MONTHLY PREMIUM		**$2,738.67**	**$2,738.67**	**$0.00**	**$2,738.67**	**$2,738.67**	**$0.00**
ANNUAL PREMIUM		**$32,864.03**	**$32,864.03**	**$0.00**	**$32,864.03**	**$32,864.03**	**$0.00**
$ INCREASE		**N/A**	**N/A**	**N/A**	**$0.00**	**$0.00**	**$0.00**
% INCREASE		**N/A**	**N/A**	**N/A**	**0.0%**	**0.0%**	**0.0%**
SHORT TERM DISABILITY		**Jefferson Pilot**			**Jefferson Pilot**		
		Total	**Employer**	**Employee**	**Total**	**Employer**	**Employee**
STD Rate		$0.36	$0.36	$0.00	$0.36	$0.36	$0.00
STD Volume		*$103,278.00*	*$103,278.00*	*$0.00*	*$103,278.00*	*$103,278.00*	*$0.00*
MONTHLY PREMIUM		**$3,718.01**	**$3,718.01**	**$0.00**	**$3,718.01**	**$3,718.01**	**$0.00**
ANNUAL PREMIUM		**$44,616.10**	**$44,616.10**	**$0.00**	**$44,616.10**	**$44,616.10**	**$0.00**
$ INCREASE		**N/A**	**N/A**	**N/A**	**$0.00**	**$0.00**	**$0.00**
% INCREASE		**N/A**	**N/A**	**N/A**	**0.0%**	**0.0%**	**0.0%**
SUMMARY		**Total**	**Employer**	**Employee**	**Total**	**Employer**	**Employee**
TOTAL ANNUAL PREMIUM		**$4,042,291.14**	**$3,615,114.78**	**$427,176.36**	**$3,788,107.40**	**$3,284,435.96**	**$503,671.44**
$ INCREASE		**N/A**	**N/A**	**N/A**	**-$254,183.74**	**-$330,678.82**	**$76,495.08**
% INCREASE		**N/A**	**N/A**	**N/A**	**-6.3%**	**-9.1%**	**17.9%**

Village of Tequesta
Medical Insurance Renewal Evaluation (NEGOTIATED)
Effective Date: October 1, 20ττ

GEHRING GROUP PROFESSIONAL SERVICES

	CURRENT		RENEWAL		NEGOTIATED RENEWAL		ALTERNATE ONE	
SCHEDULE OF BENEFITS	CIGNA HealthCare Network Open Access POS		CIGNA HealthCare Network Open Access POS		CIGNA HealthCare Network Open Access POS		CIGNA HealthCare Network Open Access POS	
Plan Basics	*In Network*	*Out of Network*	*In Network*	*Out of Network*	*In Network*	*Out of Network*	*In Network*	*Out of Network*
Lifetime Maximum	$5 million		$5 million		$5 million		$5 million	
Out of Pocket CYM								
Single	$1,500	$4,500	$1,500	$4,500	$1,500	$4,500	$1,500	$4,500
Family	$3,000	$6,000	$3,000	$6,000	$3,000	$6,000	$3,000	$6,000
Calendar Year Deductible (CYD)								
Single	No Deductible	$500	No Deductible	$500	No Deductible	$500	**$500**	**$1,000**
Family	No Deductible	$1,500	No Deductible	$1,500	No Deductible	$1,500	**$1,000**	**$2,000**
Coinsurance	0%	40%	0%	40%	0%	40%	0%	40%
Physician Services								
Primary Care Physician	$10	40%	$10	40%	$10	40%	**$20**	40%
Specialist	$25	40%	$25	40%	$25	40%	**$40**	40%
Pre-Natal	$10 / $25	40%	$10 / $25	40%	$10 / $25	40%	**$20 / $40**	40%
Physical Exam Benefit	$15	40%; $250 CYM	$15	40%; $250 CYM	$15	40%; $250 CYM	**$20**	40%; $250 CYM
Chiropractic Services	$25; 20 visits CYM	40%; 20 visits CYM	$25; 20 visits CYM	40%; 20 visits CYM	$25; 20 visits CYM	40%; 20 visits CYM	**$40; 20 visits CYM**	40%; 20 visits CYM
Laboratory Services	No Charge	40%; No Ded	No Charge	40%; No Ded	No Charge	40%; No Ded	No Charge	40%; No Ded
Physical Therapy	$25; 20 visits CYM	40%; 20 visits CYM	$25; 20 visits CYM	40%; 20 visits CYM	$25; 20 visits CYM	40%; 20 visits CYM	**$40; 20 visits CYM**	40%; 20 visits CYM
Hospital Services								
Inpatient Hospital	$500 per admission	40%	$500 per admission	40%	$500 per admission	40%	**$500 per admission + CYD**	40%
Outpatient Hospital	$250	40%	$250	40%	$250	40%	**$250 + CYD**	40%
Emergency Room	$100	40%	$100	40%	$100	40%	**$150**	40%
Physician Services	No Charge	40%	No Charge	40%	No Charge	40%	**CYD**	40%
Ambulance	No Charge	40%	No Charge	40%	No Charge	40%	**CYD**	40%
Outpatient Therapy	$10 / $25; 20 visits CYM	40%; 20 visits CYM	$10 / $25; 20 visits CYM	40%; 20 visits CYM	$10 / $25; 20 visits CYM	40%; 20 visits CYM	**$20 / $40; 20 visits CYM**	40%; 20 visits CYM
Mental and Nervous Services	*25 days CYM; 20 visits CYM*		*25 days CYM; 20 visits CYM*		*25 days CYM; 20 visits CYM*		*25 days CYM; 20 visits CYM*	
Inpatient Hospital	$50 per day	Not Covered	$50 per day	Not Covered	$50 per day	Not Covered	$50 per day	Not Covered
Outpatient Services	$30	Not Covered	$30	Not Covered	$30	Not Covered	**$40**	Not Covered
Substance Abuse Services	*25 days CYM; 20 visits CYM*		*25 days CYM; 20 visits CYM*		*25 days CYM; 20 visits CYM*		*25 days CYM; 20 visits CYM*	
Inpatient Hospital	$50 per day	Not Covered	$50 per day	Not Covered	$50 per day	Not Covered	$50 per day	Not Covered
Outpatient Hospital	$30	Not Covered	$30	Not Covered	$30	Not Covered	**$40**	Not Covered
Pharmacy Plan								
Generic	$15		$15		$15		**$20**	
Preferred Brand	$30	Not Covered	$30	Not Covered	$30	Not Covered	**$40**	Not Covered
Non Preferred Brand	$50		$50		$50		**$60**	
Mail Order Copay	2x		2x		2x		2x	
Employee 49	$487.81		$563.58		$539.19		$460.03	
Employee + Spouse 10	$1,043.92		$1,206.08		$1,153.88		$984.48	
Employee + Child(ren) 8	$902.44		$1,042.62		$997.50		$851.05	
Family 25	$1,463.43		$1,690.75		$1,617.58		$1,380.10	
Monthly Premium	**$78,147.16**		**$90,285.93**		**$86,378.61**		**$73,697.17**	
Annual Premium	**$937,765.92**		**$1,083,431.16**		**$1,036,543.32**		**$884,366.04**	
$ Increase	**N/A**		**$145,665.24**		**$98,777.40**		**-$53,399.88**	
% Increase	**N/A**		**15.5%**		**10.5%**		**-5.7%**	

Village of Tequesta
Medical Insurance Renewal Evaluation (NEGOTIATED)
Effective Date: October 1, 20

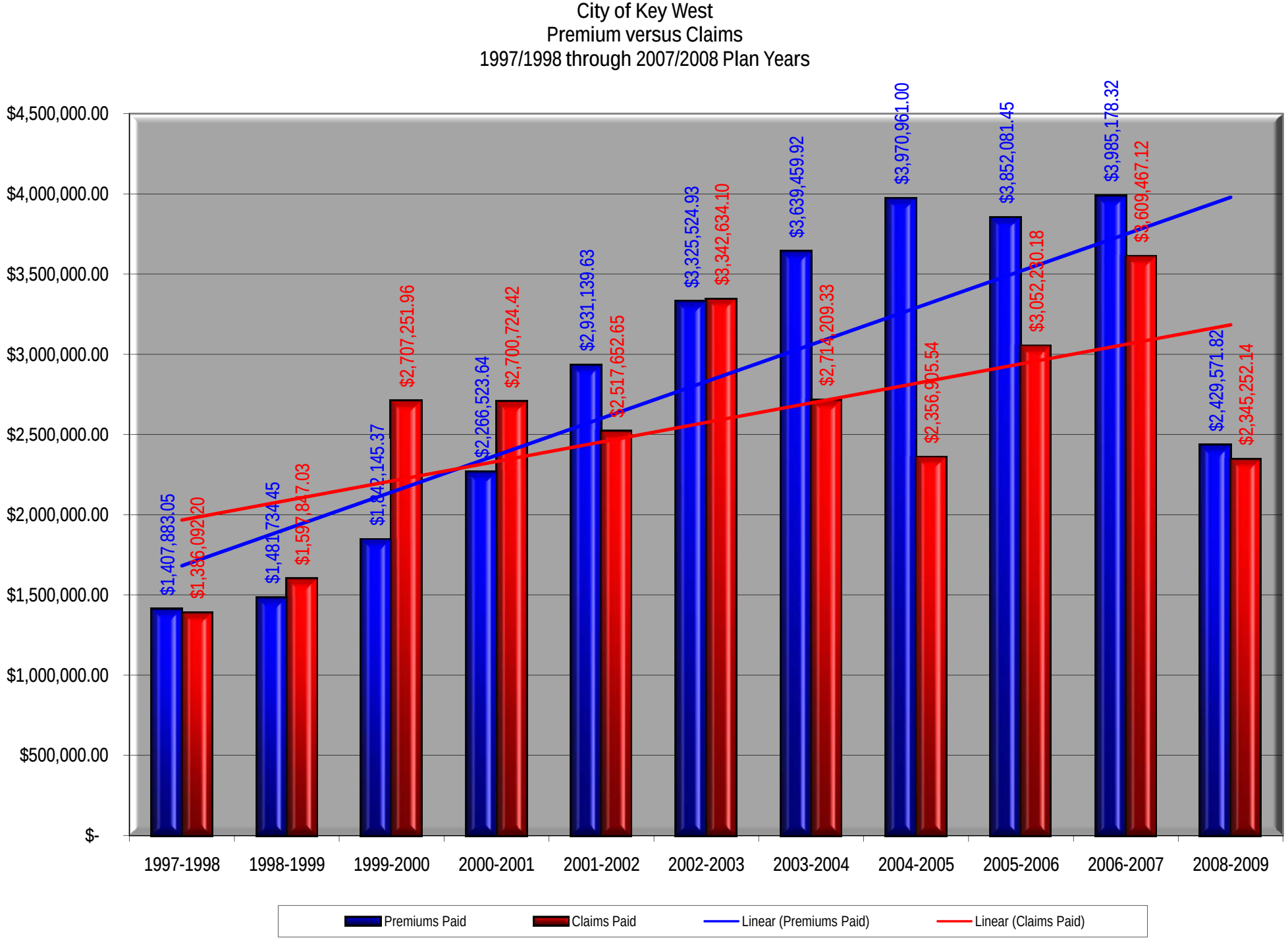
GEHRING GROUP PROFESSIONAL SERVICES

	CURRENT		ALTERNATE TWO		ALTERNATE TWO with Enhanced Rx		ALTERNATE THREE	
SCHEDULE OF BENEFITS	CIGNA HealthCare Network Open Access POS		CIGNA HealthCare Open Access Plus with CIGNA Care PPO Plan A		CIGNA HealthCare Open Access Plus with CIGNA Care PPO Plan A		CIGNA HealthCare Open Access Plus with CIGNA Care PPO Plan B	
Plan Basics	*In Network*	*Out of Network*	*In Network*	*Out of Network*	*In Network*	*Out of Network*	*In Network*	*Out of Network*
Lifetime Maximum	$5 million		$5 million		$5 million		$5 million	
Out of Pocket CYM								
Single	$1,500	$4,500	$500	$2,000	$500	$2,000	$1,000	$4,000
Family	$3,000	$6,000	$1,000	$4,000	$1,000	$4,000	$2,000	$8,000
Calendar Year Deductible (CYD)								
Single	No Deductible	$500	$500	$1,000	$500	$1,000	$1,000	$2,000
Family	No Deductible	$1,500	$1,000	$2,000	$1,000	$2,000	$2,000	$4,000
Coinsurance	0%	40%	0%	30%	0%	30%	0%	50%
Physician Services								
Primary Care Physician	$10	40%	$15	30%	$15	30%	$15	50%
Specialist	$25	40%	$25 / $40	30%	$25 / $40	30%	$25 / $40	50%
Pre-Natal	$10 / $25	40%	$25 / $40	30%	$25 / $40	30%	$25 / $40	50%
Physical Exam Benefit	$15	40%; $250 CYM	$25 / $40	30%; $250 CYM	$25 / $40	30%; $250 CYM	$25 / $40	50%; $250 CYM
Chiropractic Services	$25; 20 visits CYM	40%; 20 visits CYM	$25 / $40; 20 visits CYM	30%; 20 visits CYM	$25 / $40; 20 visits CYM	30%; 20 visits CYM	$25 / $40; 20 visits CYM	50%; 20 visits CYM
Laboratory Services	No Charge	40%; No Ded	No Charge	30%; No Ded	No Charge	30%; No Ded	No Charge	50%; No Ded
Physical Therapy	$25; 20 visits CYM	40%; 20 visits CYM	$25 / $40; 20 visits CYM	30%; 20 visits CYM	$25 / $40; 20 visits CYM	30%; 20 visits CYM	$25 / $40; 20 visits CYM	50%; 20 visits CYM
Hospital Services								
Inpatient Hospital	$500 per admission	40%	CYD	30%	CYD	30%	CYD	50%
Outpatient Hospital	$250	40%	CYD	30%	CYD	30%	CYD	50%
Emergency Room	$100	40%	$150	30%	$150	30%	$150	50%
Physician Services	No Charge	40%	CYD	30%	CYD	30%	CYD	50%
Ambulance	No Charge	40%	CYD	30%	CYD	30%	CYD	50%
Outpatient Therapy	$10 / $25; 20 visits CYM	40%; 20 visits CYM	$25 / $40; 20 visits CYM	30%; 20 visits CYM	$25 / $40; 20 visits CYM	30%; 20 visits CYM	$25 / $40; 20 visits CYM	50%; 20 visits CYM
Mental and Nervous Services	*25 days CYM; 20 visits CYM*		*30 days CYM ; 20 visits CYM*		*30 days CYM ; 20 visits CYM*		*30 days CYM ; 20 visits CYM*	
Inpatient Hospital	$50 per day	Not Covered	$50 per day	Not Covered	$50 per day	Not Covered	$50 per day	Not Covered
Outpatient Services	$30	Not Covered	$25	Not Covered	$25	Not Covered	$25	Not Covered
Substance Abuse Services	*25 days CYM; 20 visits CYM*		*30 days CYM; 44 visits CYM*		*30 days CYM; 44 visits CYM*		*30 days CYM; 44 visits CYM*	
Inpatient Hospital	$50 per day	Not Covered	$50 per day	Not Covered	$50 per day	Not Covered	$50 per day	Not Covered
Outpatient Hospital	$30	Not Covered	$25	Not Covered	$25	Not Covered	$25	Not Covered
Pharmacy Plan								
Generic	$15		$15		$10		$15	
Preferred Brand	$30	Not Covered	$40	Not Covered	$35	Not Covered	$40	Not Covered
Non Preferred Brand	$50		$70		$50		$70	
Mail Order Copay	2x		2.5x		2.5x		2.5x	
Employee 49	$487.81		$477.22		$492.97		$454.33	
Employee + Spouse 10	$1,043.92		$1,021.27		$1,054.97		$972.28	
Employee + Child(ren) 8	$902.44		$882.87		$912.00		$840.52	
Family 25	$1,463.43		$1,431.69		$1,478.94		$1,363.01	
Monthly Premium	**$78,147.16**		**$76,451.69**		**$78,974.60**		**$72,784.38**	
Annual Premium	**$937,765.92**		**$917,420.28**		**$947,695.15**		**$873,412.56**	
$ Increase	**N/A**		**-$20,345.64**		**$9,929.23**		**-$64,353.36**	
% Increase	**N/A**		**-2.2%**		**1.1%**		**-6.9%**	

Sample Client

CIGNA HealthCare - Medical Claims Experience

DATE	OAP PREMIUM	OAP CLAIMS	LOSS RATIO	TOTAL EE's	POS PREMIUM	POS CLAIMS	LOSS RATIO	TOTAL EE's	HMO PREMIUM	HMO CLAIMS	LOSS RATIO	TOTAL EE's	TOTAL PREMIUM	TOTAL CLAIMS	LOSS RATIO	TOTAL EE's	CLAIMS PER EE PER MONTH
Jan-10	$1,319,865	$891,303	68%	1040	$539,899	$375,820	70%	512	$2,213,060	$2,189,900	99%	2222	$4,072,824	$3,457,023	85%	3774	$916.01
Feb-10	$1,322,368	$902,469	68%	1035	$546,031	$754,491	138%	516	$2,213,660	$2,344,012	106%	2223	$4,082,059	$4,000,972	98%	3774	$1,060.14
Mar-10	$1,319,212	$991,606	75%	1028	$548,616	$424,376	77%	518	$2,212,654	$1,869,600	84%	2223	$4,080,482	$3,285,582	81%	3769	$871.74
Apr-10	$1,316,240	$1,248,812	95%	1023	$548,404	$527,304	96%	519	$2,213,177	$2,422,222	109%	2228	$4,077,821	$4,198,338	103%	3770	$1,113.62
May-10	$1,313,655	$1,416,021	108%	1021	$551,796	$552,864	100%	523	$2,217,359	$2,166,504	98%	2229	$4,082,810	$4,135,389	101%	3773	$1,096.05
Jun-10	$1,310,453	$1,119,055	85%	1020	$550,713	$467,239	85%	525	$2,210,499	$2,028,755	92%	2228	$4,071,665	$3,615,049	89%	3773	$958.14
Jul-10	$1,306,126	$1,198,429	92%	1016	$558,383	$556,157	100%	531	$2,219,050	$2,685,050	121%	2233	$4,083,559	$4,439,636	109%	3780	$1,174.51
Aug-10	$1,298,281	$1,049,922	81%	1014	$558,313	$670,415	120%	535	$2,224,081	$1,812,199	81%	2240	$4,080,675	$3,532,536	87%	3789	$932.31
Sep-10	$1,296,533	$1,170,520	90%	1007	$556,690	$590,724	106%	532	$2,228,751	$2,457,392	110%	2231	$4,081,974	$4,218,636	103%	3770	$1,119.00
Oct-10	$1,250,776	$1,093,965	87%	993	$554,916	$1,082,081	195%	537	$2,204,033	$2,567,944	117%	2244	$4,009,725	$4,743,990	118%	3774	$1,257.02
Nov-10	$1,265,539	$1,225,662	97%	990	$556,999	$488,851	88%	533	$2,233,343	$2,657,760	119%	2248	$4,055,881	$4,372,273	108%	3771	$1,159.45
Dec-10	$1,263,222	$1,084,619	86%	989	$556,999	$441,869	79%	535	$2,232,635	$2,136,551	96%	2244	$4,052,856	$3,663,039	90%	3768	$972.14
2010 Plan Year:	**$15,582,270**	**$13,392,383**	**86%**		**$6,627,759**	**$6,932,191**	**105%**		**$26,622,302**	**$27,337,889**	**103%**		**$48,832,331**	**$47,662,463**	**98%**	**45285**	**$1,052.50**
Jan-11	$1,175,112	$1,238,703	105%	927	$753,223	$420,673	56%	592	$2,712,664	$2,065,263	76%	2238	$4,640,999	$3,724,639	80%	3757	$991.39
Feb-11	$1,176,066	$919,820	78%	927	$752,134	$513,758	68%	591	$2,714,261	$2,102,599	77%	2229	$4,642,461	$3,536,177	76%	3747	$943.74
Mar-11	$1,170,908	$1,000,170	85%	920	$751,677	$559,499	74%	591	$2,703,797	$2,005,212	74%	2221	$4,626,382	$3,564,881	77%	3732	$955.22
Apr-11	$1,169,567	$1,197,369	102%	920	$749,323	$783,681	105%	588	$2,706,906	$2,318,065	86%	2221	$4,625,796	$4,299,115	93%	3729	$1,152.89
May-11	$1,169,068	$1,107,786	95%	919	$748,429	$511,159	68%	587	$2,698,049	$2,350,531	87%	2216	$4,615,546	$3,969,476	86%	3722	$1,066.49
Jun-11	$1,157,610	$1,113,391	96%	908	$746,959	$559,185	75%	583	$2,693,346	$2,191,335	81%	2211	$4,597,915	$3,863,911	84%	3702	$1,043.74
Jul-11	$1,153,936	$1,282,029	111%	905	$746,636	$621,330	83%	581	$2,691,074	$2,273,102	84%	2207	$4,591,646	$4,176,461	91%	3693	$1,130.91
Aug-11	$1,148,277	$1,141,882	99%	900	$745,139	$716,886	96%	580	$2,685,665	$2,404,641	90%	2202	$4,579,081	$4,263,409	93%	3682	$1,157.91
Sep-11	$1,146,689	$1,012,358	88%	899	$749,561	$507,633	68%	584	$2,680,331	$2,273,730	85%	2201	$4,576,581	$3,793,721	83%	3684	$1,029.78
Oct-11	$1,141,860	$1,095,740	96%	898	$752,951	$669,274	89%	586	$2,694,934	$2,088,892	78%	2215	$4,589,745	$3,853,906	84%	3699	$1,041.88
Nov-11	$1,142,690	$1,236,949	108%	896	$755,335	$487,850	65%	589	$2,690,698	$1,704,782	63%	2215	$4,588,723	$3,429,581	75%	3700	$926.91
Dec-11	$1,144,791	$1,175,702	103%	896	$760,331	$615,443	81%	591	$2,696,822	$2,044,688	76%	2221	$4,601,944	$3,835,833	83%	3708	$1,034.47
2011 Plan Year:	**$13,896,574**	**$13,521,899**	**97%**		**$9,011,698**	**$6,966,371**	**77%**		**$32,368,547**	**$25,822,840**	**80%**		**$55,276,819**	**$46,311,110**	**84%**	**44555**	**$1,039.41**
Jan-12	$1,091,357	$863,009	79%	886	$870,350	$597,838	69%	614	$2,906,886	$1,901,975	65%	2175	$4,868,593	$3,362,822	69%	3675	$915.05
Feb-12	$1,091,986	$955,369	87%	884	$874,164	$606,987	69%	618	$2,915,465	$2,211,691	76%	2187	$4,881,615	$3,774,047	77%	3689	$1,023.05
Mar-12	$1,085,785	$1,136,973	105%	878	$878,011	$557,150	63%	621	$2,903,797	$1,893,259	65%	2189	$4,867,593	$3,587,382	74%	3688	$972.72
Apr-12	$1,082,935	$995,595	92%	876	$880,878	$625,515	71%	624	$2,899,339	$2,001,588	69%	2177	$4,863,152	$3,622,698	74%	3677	$985.23
May-12	$1,078,136	$897,600	83%	875	$878,043	$672,975	77%	622	$2,895,676	$2,061,964	71%	2170	$4,851,855	$3,632,539	75%	3667	$990.60
Jun-12	$1,077,506	$1,135,208	105%	874	$878,736	$771,149	88%	622	$2,893,503	$1,926,032	67%	2165	$4,849,745	$3,832,389	79%	3661	$1,046.81
Jul-12	$1,079,362	$1,004,608	93%	873	$881,217	$560,814	64%	624	$2,892,282	$1,990,793	69%	2163	$4,852,861	$3,556,215	73%	3660	$971.64
Aug-12	$1,080,240	$1,000,995	93%	872	$879,926	$592,053	67%	623	$2,886,095	$2,447,391	85%	2161	$4,846,261	$4,040,439	83%	3656	$1,105.15
Sep-12	$1,079,645	$1,062,476	98%	874	$878,722	$519,383	59%	621	$2,879,533	$1,739,347	60%	2156	$4,837,900	$3,321,206	69%	3651	$909.67
Oct-12	$1,072,886	$1,187,956	111%	874	$878,722	$494,875	56%	622	$2,881,421	$2,005,905	70%	2156	$4,833,029	$3,688,736	76%	3652	$1,010.06
Nov-12	$1,078,103	$1,139,257	106%	874	$882,668	$671,564	76%	627	$2,902,189	$2,003,569	69%	2172	$4,862,960	$3,814,390	78%	3673	$1,038.49
Dec-12	$1,075,695	$1,168,658	109%	875	$888,610	$494,380	56%	630	$2,904,910	$1,666,257	57%	2171	$4,869,215	$3,329,295	68%	3676	$905.68
2012 Plan Year:	**$12,973,636**	**$12,547,704**	**97%**	**10515**	**$10,550,047**	**$7,164,683**	**68%**	**7468**	**$34,761,096**	**$23,849,771**	**69%**	**26042**	**$58,284,779**	**$43,562,158**	**75%**	**44025**	**$989.49**
Jan-13	$1,047,271	$819,119	78%	865	$950,680	$684,257	72%	681	$2,820,086	$2,062,577	73%	2126	$4,818,037	$3,565,953	74%	3672	$971.12
Feb-13	$1,044,102	$1,194,815	114%	868	$949,406	$584,965	62%	678	$2,811,376	$2,111,174	75%	2128	$4,804,884	$3,890,954	81%	3674	$1,059.05
Mar-13	$1,042,065	$1,176,949	113%	867	$948,321	$816,330	86%	680	$2,820,062	$1,993,898	71%	2129	$4,810,448	$3,987,177	83%	3676	$1,084.65
Apr-13	$1,041,292	$1,175,880	113%	867	$952,221	$815,012	86%	682	$2,820,491	$1,734,607	62%	2130	$4,814,004	$3,725,499	77%	3679	$1,012.64
May-13	$1,039,796	$1,283,155	123%	865	$954,486	$864,585	91%	683	$2,817,228	$2,033,894	72%	2132	$4,811,510	$4,181,634	87%	3680	$1,136.31
Jun-13	$1,035,346	$1,128,101	109%	863	$952,274	$746,902	78%	682	$2,815,081	$2,063,911	73%	2129	$4,802,701	$3,938,914	82%	3674	$1,072.11
Jul-13	$1,034,058	$1,223,709	118%	862	$953,646	$714,525	75%	684	$2,824,041	$1,936,175	69%	2134	$4,811,745	$3,874,409	81%	3680	$1,052.83
Aug-13	$1,035,939	$1,239,140	120%	860	$960,806	$767,393	80%	690	$2,828,063	$2,296,180	81%	2138	$4,824,808	$4,302,713	89%	3688	$1,166.68
Sep-13	$1,033,445	$1,070,159	104%	858	$959,001	$858,313	90%	689	$2,830,232	$1,793,568	63%	2140	$4,822,678	$3,722,040	77%	3687	$1,009.50
Oct-13	$1,035,655	$1,244,989	120%	859	$958,841	$618,504	65%	687	$2,841,851	$1,962,373	69%	2148	$4,836,347	$3,825,866	79%	3694	$1,035.70
Nov-13	$1,036,898	$1,021,617	99%	863	$960,709	$749,290	78%	681	$2,849,685	$2,068,170	73%	2151	$4,847,292	$3,839,077	79%	3695	$1,038.99
Dec-13	$1,032,728	$976,453	95%	861	$967,064	$444,606	46%	692	$2,859,927	$1,878,845	66%	2160	$4,859,719	$3,299,904	68%	3713	$888.74
2013 Plan Year:	**$12,458,595**	**$13,554,086**	**109%**	**10358**	**$11,467,455**	**$8,664,682**	**76%**	**8209**	**$33,938,123**	**$23,935,372**	**71%**	**25645**	**$57,864,173**	**$46,154,140**	**80%**	**44212**	**$1,043.93**


City of Key West
Premium versus Claims
1997/1998 through 2007/2008 Plan Years
$4,500,000.00
$4,000,000.00
$3,500,000.00
$3,000,000.00
$2,500,000.00
$2,000,000.00
$1,500,000.00
$1,000,000.00
$500,000.00
$-
$1,407,883.05
$1,396,092.20
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$1,842,145.37
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$2,931,139.63
$2,517,652.65
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$3,342,634.10
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$3,852,081.45
$3,052,230.18
$3,985,178.32
$3,609,467.12
$2,429,571.82
$2,345,252.14
1997-1998
1998-1999
1999-2000
2000-2001
2001-2002
2002-2003
2003-2004
2004-2005
2005-2006
2006-2007
2008-2009
Premiums Paid
Claims Paid
Linear (Premiums Paid)
Linear (Claims Paid)

EXHIBIT E: SAMPLE CLIENT SEMINAR/WEBINAR

A Review of the Rules and Considerations Surrounding the New Use It or Lost It FSA Laws

Webinar Series

Presented by:
Kate Grangard, CFO

November 22, 2013

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Flexible Spending Account Overview

- FSA Background
- IRS Notice 2013-71
  - Use It or Lose It Rule Modification Allowance
  - Special Considerations
  - Cafeteria Plan Amendment Dates
- Examples
- Take Aways

Health Flexible Spending Accounts (FSAs)

- FSA Background & Definitions
- IRS Notice 2013-71
  - Use It or Lose It Rule Modification Allowance
  - Special Considerations
  - Cafeteria Plan Amendment Dates
- Examples
- Special Election Transition Rule IX.B

Health Flexible Spending Accounts (FSAs)

- Allows for tax-free reimbursement to employees
- Funded via employee salary reduction of up to $2,500 per plan year (2013)
- If employer funded, must be alongside qualifying medical plan and funded to limit of $500 or 2x total EE Deferral
- Used to pay or reimburse eligible Section 213(d) medical expenses
  - Individual insurance premiums ineligible for reimbursement
- Administrator must review claims (substantiation method)
- Annual election
  - Except for qualifying events

Health Flexible Spending Accounts (FSAs)

- Uniform coverage rule
  (requires that the full amount of funds be available from the start of the plan)
- Run Out Period Allowed (up to 3 months) for incurred claims
  - A run out period is a period of time after the end of the plan year in which claims for reimbursement can be submitted for services received during the plan year.
- Grace Period Allowed Up to 2 ½ months
  - A grace period is a period of time after the end of the plan year in which claims for reimbursement can be incurred and submitted for reimbursement from funds contributed to an FSA in the previously ended plan year.

Health Flexible Spending Accounts (FSAs)

- ERISA applies:
  - COBRA
  - HIPAA
  - Reporting and disclosure (5500, SPD, etc.)
- Section 125 and 105(h) nondiscrimination requirements only
- HDHCP with HSA – FSA only be limited purpose excepted benefit – vision/dental
- Historically No rollover allowed
- Use it or lose it

Use It or Lose It Modification

Internal Revenue Service Notice 2013-71

Issued 10/31/13 http://www.irs.gov/pub/irs-drop/n-13-71.pdf

- Modification of "Use-or-Lose" Rule For Health Flexible Spending Arrangements (FSAs) and Clarification Regarding 2013-2014 Non-Calendar Year Salary Reduction Elections Under § 125 Cafeteria Plans Tax exempt trust or custodial account
  - Allows plans to amend 125 plans to allow **UP TO $500** of unused funds to be used for qualified medical expenses in next plan year
  - Carry over amount is **in additional to** annual max of $2,500
  - Written employer election – discretionary
- Can not also have grace period for same year in which funds were carried forward. EX: grace period for 2013 calendar year ends 3/15/14 – can't allow $500 CF from 2013 to 2014
- Eliminate grace period by end of current year if want to go to Carryover same year

Use It or Lose It Modification

- The 125 Use It or Lose It Modification Process:

Election Selection
- Retroactive or Going Forward
- Grace Period
- Up to $500 Carryover Option
- Run Out Period
- None

125 Plan Amendment Required
- General Rule: Retro to 1st day if made by last day of plan year from which money being carried over
- Special Relief for 2013 plan years– amend on/before last day plan year begins 2014

Special Rules
- Amount determined after run out
- Notify employees of carryover provision
- Consider impact/communicate to HSA plan participants (if applicable). Excepted benefits only

Special Considerations:
- Potential Budget Impact
- Administrative Costs
- Legal Exposure – Current Calendar plan w/grace period
- Culture/Climate/Philosophy

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Carryover Examples

Example 1:

Employer offers health FSA on calendar year basis with annual run out through March 31 following year. Plan has $2500 limit, amended for $500 carryover, and therefore no grace period.

Unused FSA at 12/31/13 is $800

FSA Election 2014 is $2500

2013 claim of $350 submitted in March

$450 carries forward to 2014. Employee has $2950 available for claims in 2014.

$2,700 incurred and paid July 2014

No other claims in 2014

$250 unused funds carried forward to 2015.

Carryover Examples

Example 2:

Employer offers health FSA on calendar year basis with annual run out through March 31 following year. Plan has $2500 limit, amended for $500 carryover, and therefore no grace period.

Unused FSA at 12/31/13 is $800

FSA Election 2014 is $2500

2014 claim of $2,700 submitted in January

$2500 paid from 2014 contributions and $200 paid from 2013 unused amount. Employee unused amount reduced to $600.

Employee submits 2013 claim of $300 in March 2014

No other claims in 2014

$300 unused funds carried forward to 2015.

Carryover Examples

Example 2:

Employer offers health FSA on calendar year basis with annual run out through March 31 following year. Plan has $2500 limit, amended for $500 carryover, and therefore no grace period.

Unused FSA at 12/31/13 is $800

FSA Election 2014 is $2500

2013 claim of $100 submitted in January; no other 2013 claims paid

$100 paid from 2013 balance; $500 of $700 unused balance after run out carried forward to 2014; $200 forfeited (800-100-500) from 2013 unused amount. Employee balance is $3,000.

Employee submits claims incurred in 2014 of $2,400 during 2014 and run out period in 2015

$2400 claims paid; $500 carry over of unused funds to 2015; $100 forfeited.

Special Election Clarification

Transition relief for fiscal plan year employers, at their election, to:

allow employees to change 125 election elections prospectively to either 1)increase 125 plan reductions for health coverage mid year, or 2) cease salary 125 reductions and seek coverage in the exchange, or to 3) allow both.

Large and small fiscal year plan employers

May be more restrictive but not less restrictive (ex limit period to make change)

QUESTIONS

?

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Exhibit F: Sample Employee Benefit Newsletters

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Treasury Relaxes "Use or Lose" Rule for Flexible Spending Accounts

The Treasury Department and the Internal Revenue Service have issued Notice 2013-17 which has loosened the "use it or lose it" rule for flexible spending arrangements for health care, allowing participants in health benefit plans to carry over up to $500 from their FSA from year to year.

For nearly 30 years, employees eligible for health FSAs have been subject to the use-or-lose rule, meaning that any account balances remaining unused at the end of the year are forfeited and retained by employers. Thursday's guidance permits employers to now allow employees to carry over up to $500 of the unused amounts left in their health FSAs for qualified expenses incurred in the next year.

The new ruling stipulates that with respect to a participant, the amount that may be carried over to the following plan year is equal to the lesser of (1) any unused amounts from the immediately preceding plan year or (2) $500 (or a lower amount specified in the plan). Any unused amount in excess of $500 (or a lower amount specified in the plan) that remains unused as of the end of the plan year (that is, at the end of the run-out period for the plan year) is forfeited. Any unused amount remaining in an employee's health FSA as of termination of employment also is forfeited (unless, if applicable, the employee elects COBRA continuation coverage with respect to the health FSA).

Some plan sponsors currently allow employees a "grace period" of 2 months and 15 days after the end of the plan year to use the previous years remaining balance. (Please note the difference between a grace period and a run out period. A "run-out period" is a period immediately following the end of a plan year during which a participant can submit a claim for reimbursement of expenses incurred for qualified benefits incurred during the applicable plan year). This existing option for plan sponsors to allow employees a grace period after the end of the plan year remains in place. However, a health FSA cannot have both a carryover allowance and a grace period: it can have one or the other or elect to allow neither.

Use of the newly allowed carryover option does not affect the ability of a health FSA to provide for the payment of expenses incurred in one plan year during a permitted run-out period at the beginning of the following plan year (just as a run-out period can also be provided when using the grace period rule). Thus, for plans using the new carryover option, a participant's unused health FSA balance at the end of the prior plan year may be used (a) for expenses incurred in the prior plan year, but only if claimed during the plan's run-out period that begins at the end of the prior plan year (which effectively retroactively reduces the unused amount as of the end of the prior plan year) or (b) to the extent of the permitted carryover amount of up to $500 from the final prior plan year unused amount, for expenses that are incurred at any time in the current plan year.

It will be up to the employer offering a medical plan to decide whether or not to offer this carryover option to employees. Most employers have traditionally been able to hold onto any money left by employees in their FSA accounts. Some employers may want to allow the 2 month and 15 day grace period instead. Employers electing to allow this carryover will need to make a plan amendment to their 125 plan document by the last day of their plan year affected. For employers with a non-calendar plan year that commenced in 2013, certain transitional guidance is allowed meaning that employers may allow employees to prospectively revoke or change his or her election with respect to the accident and health plan once, during a limited period (for example, the first month of 2014 only rather than the entire plan year) without regard to whether the employee experienced a change in status event described in Treas. Reg. § 1.125–4 (the qualifying event rules). A copy of 2013-71 can be found here; a copy of a related fact sheet can be found here.

Please be reminded that Gehring Group, with guest Ben Conley, Esquire of Seyfarth Shaw will be hosting a seminar/workshop in February regarding 125 Plan documents to include review of all amendments from the recent ACA and legislative changes. Please be on the look out for the Hold the Date notice. Gehring Group will hold a webinar in mid November to review this Notice and provide examples and considerations for adoption.

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DOL Says No Penalties for Failing to Provide Exchange Notice

The Affordable Care Act requires employers to provide employees with a written notice about the ACA's health insurance exchanges beginning on Oct. 1, 2013. However, on Sept. 11, 2013, the Department of Labor issued an FAQ (found here) stating that there is no fine or penalty under the law for failing to provide the notice. PPACA has a $100-a-day penalty for noncompliance with its provisions, unless otherwise specified in the statute, and it had been expected that this penalty would apply to employers that fail to distribute the exchange notice, possibly with additional penalties for failure to comply with a provision of the FLSA. Of note, Section 18B of the FLSA that clearly states that an employer "shall provide" written notice, and the DOL's Technical Release 2013-02 issued in May 2013 states that Section 18B of the FLSA generally provides that an employer "must provide" each employee with the notice. However, the recently issued DOL FAQ stated that employers "should" provide the Exchange notices to employees and reiterated the content that should be included.

At this time we are still advising our clients to comply with distributing the Notice of Coverage Options to employees, as there may continue to be some risk for non-compliance, and it may mitigate employers having to respond to inquiries when employees apply for ineligible subsidies. However, due to this recent guidance, we anticipate that some employers may choose to send the Notice through more cost saving means than under the DOL U.S. mail safe harbor.

We at Gehring Group join you in our concern that this guidance was issued so close to the due date. We remain committed to assisting you through these changing times and thank you for placing your trust in us to keep you informed.

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Federal Tax & Benefit Rules Issued Regarding Same Sex Spouses

In response to the recent Supreme Court ruling in which Section 3 of DOMA was struck down, the Internal Revenue Service and Department of the Treasury have issued guidance indicating that same-sex spouses will be treated as married for all federal tax purposes, including income, gift and estate taxes. This includes any same-sex marriages legally entered into in one of the 50 states, District of Columbia, a U.S. territory, or a foreign country. We have referred to this previously as the "ceremony rule" – as long as the marriage took place where it is legal for same sex individuals to marry – the marriage will be recognized for federal purposes regardless of where the couple now resides – even if they reside in a state such as Florida that does recognize same sex marriage.

Guidance Issued

The agencies issued Revenue Ruling 2013-17 (click here) in which the agencies confirmed the term "spouse" for federal benefit and income tax purposes to include marriage between individuals of the same sex. Further review of the guidance and the accompanying News Release (click here) from the IRS indicates that this ruling applies to "all federal tax provisions where marriage is a factor, including filing status, claiming personal and dependency exemptions, taking the standard deduction, employee benefits, contributing to an IRA, and claiming the earned income tax credit or child tax credit." Concurrently on August 29th, the IRS issued two FAQ documents Answers to Frequently Asked Questions for Individuals of the Same Sex Who are Married Under State Law and Answers to Frequently Asked Questions for Registered Domestic Partners and Individuals in Civil Unions. The latter document affirms that the federal tax and other benefits extended to same sex spouses are NOT extended to individuals of the same sex and opposite sex who are in registered domestic partnerships and civil unions.

The *Answers to FAQ for Individuals of the Same Sex Who are Married Under State Law* provides answers to many administrative questions for employers. In particular, the following questions should be noted:

- Q10 & Q11. Employees who were legally married in prior years may file an amended Form 1040 reflecting the employee's status as married and recover federal income tax paid on the value of the health coverage of an employee's same sex spouse recognized through imputed income and/or premiums deducted from an employee's wages on a post-tax basis. These amended returns may be filed for all open years generally defined as 3 years from the date an employee filed the return, or 2 years from when the tax was paid – whichever is later. Affected employees may ask employers for the value of the imputed income included in Box 1 of their Form W-2 reports for prior years.
- Q12. Where employers paid Social Security and Medicare Tax on imputed income and post-tax premiums that an employee may amend their returns to file as pre-tax as per FAQ 10 & FAQ 11 (immediately above), the employer may claim a refund or make an adjustment for these taxes paid. A special administrative procedure for employers to file claims for refunds or make adjustments for excess Social Security and Medicare taxes paid on same-sex spouse benefits will be provided in forthcoming guidance to be issued by the IRS.
- Q13. Employers may make adjustments for income tax withholding that was over-withheld from an employee in the current year, provided that the employer has repaid or reimbursed the employee for the over-withheld income tax before the end of the calendar year (FAQ 13). Due to the timing of the release of this guidance, as this appears to be optional due to the use of the word "may", employers may prefer to conform to the requirement to put this guidance in place on a going forward basis as of 9/16/2013 and allow the employee to receive reimbursement for any over-withheld federal income tax through the filing of their annual Form 1040 with the federal government.

Federal Tax & Benefit Rules Issued Regarding Same Sex Spouses

Effective Date

The effective date of this guidance as set forth is September 16, 2013, but employers are encouraged to adopt early compliance. Employers should suspend taxing the benefits (or deducting the premium contribution for same sex spouse benefits post tax versus pre-tax, or imposing imputed income) for same sex spouses – defined as those legally married same-sex partners (domestic partners and those in civil unions must still be taxed under the imputed income rules). The pre-tax deduction treatment of premiums, and abatement of imputed income also applies to the eligible children of same sex spouses covered under an employee's plan if the same-sex spouse's dependents are the tax dependent of the employee. We understand that many of you have sophisticated payroll systems that may need reprogramming. When this circumstance was presented by the Employee Benefits Council on which Seyfarth Shaw partakes, the government indicated that the updates may be made within a reasonable time.

Summary & Follow-Up Considerations

- Employers who offer domestic partner coverage and charge imputed income will no longer need to charge imputed income to legally married same-sex employees on the value of same-sex spouse coverage
- Employers who deduct premiums for coverage for same sex spouses on a post-tax basis, should now deduct the premiums on a pre-tax basis.
- Employers may correct affected employees' gross income in the current year to reduce taxable income by current year imputed income charged, while considering the guidance outlined under FAQ 13.
- Employers may consider correcting affected employees who took post tax deductions, who are now eligible for pre-tax deductions by refunding the year to date post tax deductions and re-deducting them as pre-tax deductions.
- In accordance with the special administrative procedures (yet to be released by the IRS) employers may elect to submit a refund for SS/Medicare taxes paid on same sex spouse coverage for all open quarters.
- Employers may need to consider updating Section 125 documents to reflect the definition of spouse to include same-sex spouses if you currently offer domestic partner coverage. Note that 125 plans that define a spouse as it is defined for federal income tax purposes do not have to update their language as the federal definition is what changed pursuant to 2013-17. Also note that technically, self-funded plans have flexibility in defining who constitutes a spouse, but defining a spouse in a manner that disallows the tax-free benefit from being extended to same sex spouses, and in a manner inconsistent with this guidance, may lead to a charge of discrimination against the employer.
- Now that same-sex married couples are afforded similar rights to tax free benefits as opposite sex married couples, employers with a current domestic partner policy may wish to reconsider their domestic partner policy and determine if they wish to continue offering coverage to same sex and opposite sex domestic partners.
- Employers may expect to receive a request for same sex married employees to update their withholding election through Form W-4 to indicate "married".

Please note that at this time we are not able to confirm that the issuance of this guidance is a qualifying event for purposes of changing an affected employee's health care coverage election. We are not aware of any special administrative election guidance being issued at this time, although it is suspected, through our discussions with counsel, that some may be forthcoming.

We recommend that you forward a copy of this newsletter on to your finance director and/or payroll department leadership so they are aware of this recently issued guidance.

Please note that this information is being provided as a summary of the guidance released and should not be considered legal or tax advice. All questions of a tax, legal, or payroll nature should be forwarded to your appropriate advisors.

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Employer Mandate Penalties Delayed Until 2015

The Obama Administration has postponed the Affordable Care Act (ACA) large employer mandate penalties for one year, until 2015. The Department of the Treasury announced the delay on July 2, 2013, along with a similar delay for information reporting by large employers, health insurance issuers and self-funded plan sponsors. On July 9, 2013, the Internal Revenue Service (IRS) issued Notice 2013-45 to provide more formal guidance on the delay.

The delay does not affect any other provision of the ACA, including individuals' access to premium tax credits for coverage through an Exchange.

ONE-YEAR IMPLEMENTATION DELAY

ACA's employer mandate provisions are also known as the employer shared responsibility or pay or play rules. These rules impose penalties on large employers that do not offer affordable, minimum value coverage to their full-time employees and dependents. For purposes of these rules, a large employer is one that employs on average at least 50 full-time employees (including full-time equivalents) on business days during the preceding calendar year. These rules were set to take effect on Jan. 1, 2014.

According to the Treasury, the delay of the employer mandate penalties was required because of issues related to the reporting requirements. With the reporting rules delayed, it would be nearly impossible to determine which employers owed penalties under the shared responsibility provisions. **Therefore, these payments will not apply for 2014**.

The delayed reporting requirements are found in Internal Revenue Code sections 6055 and 6056. These rules apply to insurers, self-insuring employers and other parties that provide health coverage, along with certain large employers with respect to health coverage offered to their full-time employees. The Administration's decision is based on concerns about the complexity of the requirements and the need for more time to implement them effectively.

EFFECTS OF THE DELAY

The additional year will give employers time to understand the employer mandate rules, to make decisions about providing health coverage and to adapt their reporting systems, without worrying about potentially significant penalties. It is unclear how the new deadline will impact guidance that has already been issued, such as the transition relief for non-calendar year plans and the optional safe harbor for determining full-time status.

FUTURE GUIDANCE

The administration plans to use the additional implementation time to consider ways to simplify the new reporting requirements consistent with ACA. The Treasury also plans to discuss the rules with stakeholders, including employers that currently provide health coverage to employees, and then publish proposed rules implementing these provisions later this summer. It is the Treasury's intention to minimize the reporting requirements.

The pay or play regulations issued earlier this year left many unanswered questions for employers. The IRS highlighted several areas where it would be issuing more guidance. Presumably, the additional time will give the IRS and Treasury the opportunity to provide more comprehensive guidance on implementing these requirements.

We will continue to monitor developments and will keep you informed of the latest updates.

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KNOW YOUR EMPLOYEE BENEFITS

Benefit and insurance issues important to you—brought to you by the insurance specialists at Gehring Group.

2013 Flexible Spending Account Eligible Expenses

Your Health Care Reimbursement Flexible Spending Account lets you pay for medical care expenses not covered by your insurance plan with pre-tax dollars. The expenses must be primarily to alleviate a physical or mental defect or illness, and be adequately substantiated by a medical practitioner. The products and services listed below are examples of medical expenses eligible for payment under your FSA, to the extent that such services are not covered by your medical and dental insurance plan.

Unfortunately, we cannot provide definitive list of "qualified medical expenses." A determination of whether an expense is for "medical care" is based on all the relevant facts and circumstances. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness.

- Abortion
- Acne treatment*
- Acupuncture
- Adoption (pre-adoption medical expenses)
- Air conditioner/purifier (if to treat medical condition)*
- Alcoholism treatment
- Allergy medications*
- Alternative medicine (if to treat specific medical condition)
- Ambulance
- Analgesics*
- Antacid*
- Antibiotics
- Antihistamine*
- Anti-itch creams*
- Arthritis gloves
- Artificial limbs & teeth
- Aspirin*
- Asthma treatments
- Automobile modifications (if for physically handicapped person)
- Bactine*
- Bandages/Gauze
- Birth control pills
- Birthing classes
- Blood pressure monitoring devices
- Blood sugar test kit and test strips
- Blood storage (temporary storage for when collection is part of diagnosis, treatment or prevention of existing or imminent medical condition)
- Body scan
- Braille books/magazines
- Breast pumps (only if for medical condition)*
- Breast reconstruction surgery following mastectomy
- Calamine lotion*
- Carpal tunnel wrist supports
- Capital expenses
- Cayenne pepper (only if treating specific medical condition)*
- Chelation therapy
- Christian Science practitioner fees
- Contraceptives
- Condoms*
- Chiropractor
- Chondroitin/Glucosamine*
- Circumcision
- Co-insurance amounts and deductibles
- Cold medicine*
- Compression hose
- Contact lenses – also materials and equipment
- Copayments
- Cough suppressants*
- Counseling (except marriage)
- Crutches
- Decongestants*

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- Deductibles
- Dental treatment (except teeth whitening)
- Dentures and denture adhesives
- Diabetic supplies
- Diagnostic items/services
- Diaper rash ointments/creams*
- Diarrhea medication*
- Disabled dependent care expenses
- Doula (only if providing medical care for mother/child)
- Drug addiction treatment
- Drug overdose, treatment of
- Ear plugs (for medical purposes)
- Ear wax removal products*
- Eczema treatments
- Egg donor fees
- Egg/Embryo storage fees (only for immediate conception)
- Exercise equipment/programs (only if required by physician)
- Expectorants*
- Eye drops*
- Eye exams
- Eyeglasses, prescription
- Fertility/Infertility treatments
- Fiber supplements (only to treat medical condition)*
- First aid cream
- First aid kits
- Flu shots
- Fluoridation device or services, rinses
- Food thickeners (if required by physician)
- Gambling disorder
- Genetic testing (only to diagnose medical condition)
- Glucose monitoring equipment
- Guide dog/other animal aid
- Health institute fees (only if prescribed by a physician)
- Hearing aids
- Hemorrhoid treatments*
- Home improvements to accommodate a disability
- Hormone replacement therapy (HRT)
- Hospital services
- Hot/cold packs
- Humidifier (if for specific medical condition)
- Hypnosis
- Inclinator
- Incontinence supplies
- Insect bite creams and ointments*
- Insulin
- IVF (in vitro fertilization)
- Laboratory fees
- Lactation consultant
- Language training (for dyslexia or disabled)
- Laser eye surgery/Lasik
- Laxatives*
- Lead-based paint removal
- Legal fees involving medical care
- Lodging at a hospital or similar institution
- Lodging not at a hospital or similar institution (up to $50/night; only if involving medical care)
- Lodging of a companion (if accompanying a patient for medical reasons)
- Masks, disposable (only if to treat specific medical condition)
- Massage therapy (only if recommended by a physician to treat a specific trauma or injury)
- Mastectomy-related undergarments
- Meals at a hospital
- Medical alert bracelet or necklace
- Medical conference admission, transportation, meals, etc. (if related to chronic condition suffered by you, spouse or dependent)
- Medical information plan charges
- Medical monitoring and testing devices
- Medical records charges
- Menstrual pain relievers*
- "Morning after" contraceptive pills*
- Motion sickness pills*
- Nasal strips or sprays (only to treat sinus problems; not to prevent snoring)*
- Nicotine gum or patches*
- Norplant insertion or removal
- Nursing services provided by a nurse or attendant
- Nutritional supplements (only if they are recommended by a medical practitioner as treatment for a specific medical condition diagnosed by a physician)*
- Nutritionist's professional expenses (if treatment relates to specifically diagnosed medical condition)
- Obstetrical expenses
- Occlusal guard to prevent teeth grinding
- Optometrist
- Organ donors/transplants
- Orthodontia
- Orthopedic shoes/shoe inserts (only for treating specific medical condition)
- Osteopath fees
- Over-the-counter (OTC) drugs*
- Ovulation monitor
- Oxygen
- Pain relievers*

- Personal trainer fees (if for medical condition)
- Petroleum jelly (for medical condition)*
- Physical exams
- Physical therapy
- Pregnancy test kits
- Prenatal vitamins (only if taken during pregnancy)*
- Prescription drugs
- Preventive care screenings
- Probiotics (only for treatment of specific medical condition)
- Prostheses
- Psychiatric care
- Psychoanalysis
- Psychologist
- Radial keratotomy
- Reading glasses, prescription
- Rehydration solution
- Retin-A® (only if recommended by physician for specific condition)*
- Rubbing alcohol
- Screening tests
- Shipping/handling fees for medical item
- Sinus medications*
- Sleep deprivation treatment
- Smoking cessation programs and medications
- Special education
- Special food required for diet by physician
- Special home costs for mentally handicapped
- Special medical equipment installed in a home
- Special TV/telephone equipment for hearing impaired
- Speech therapy
- Sperm storage (only for immediate conception)
- Spermicidal foam
- St. John's Wort (only if for diagnosed medical condition)*
- Stem cell harvesting and/or storage of (only if there is a specific and imminent medical condition the cells are intended to treat)
- Sterilization procedures
- Student health fee (not including the cost of belonging to the program)
- Sunglasses, prescription
- Sunburn cream/ointments*
- Support braces
- Surgery/Operations
- Taxes on medical services and products
- Therapy
- Thermometers
- Throat lozenges*
- Toothache/teething pain relievers*
- Transportation expenses for person to receive medical care
- Trips related to medical service
- Tuition for special needs program
- Ultrasound (prenatal – only to determine health or development; not for snapshots)
- Umbilical cord freezing/storage (only if there is a specific medical condition it is intended to treat)
- Usual and customary charges, excess
- Vaccines/Immunizations
- Vasectomy/Vasectomy reversal
- Vericose veins treatment (only if medically necessary)
- Veterinary fees (for the care of seeing- or hearing-impaired assistance animals)
- Viagra® (if prescribed by a physician)
- Weight loss program/drugs (if prescribed by a physician)
- Walkers
- Wart remover treatments*
- Wheelchair
- Wig
- X-ray fees
- Yeast infection medications*

**Requires a prescription or additional documentation from a physician.*

Retin-A® is a registered trademark of Ortho Dermatologics. Viagra® is a registered trademark of Pfizer, Inc.

*The brochure is for plans that allow reimbursement of **all** eligible medical expenses as defined by the IRS and Department of Treasury.*

This brochure is for informational purposes only and is not intended to replace the advice of an insurance professional.

Rev. 8/13, 11/13

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Form 720 Revised for Reporting of PCORI Fee

The Internal Revenue Service has released a revised Form 720, Quarterly Federal Excise Tax Return, which is the form used by plan sponsors to remit the Patient-Centered Outcomes Research Institute (PCORI) fee.

The Patient Centered Outcomes Research fee is an annual fee imposed on health carriers of fully insured plans, and plan sponsors of applicable self-insured plans to help fund the Patient Centered Outcomes Research Institute. The fee is calculated based on the average lives covered under the plan. Average lives includes all belly buttons covered, not just employee participants. Membership of fully insured medical plans will be reported on Form 720 by the insurance carrier (e.g. Cigna, Florida Blue, etc). Membership of Self-Funded plans must be reported on Form 720 by the plan sponsors.

Please note: Fully insured plans that also have a health reimbursement plan (HRA) must pay the PCORI fee on Form 720 for the HRA plan (in this unique circumstance, the fee is calculated based on each participant, not each belly button.) Further instructions are outlined below for those plan sponsors responsible for completing the Form 720.

The PCORI fee will be collected for 7 years. Specifically, the fee applies to policy or plan years ending on or after October 1, 2012 and before October 1, 2019. The first plan year, the fee to be collected is $1 per average life (belly button). For years 2-7, the fee is $2 per average life (indexed for medical inflation each year). ERISA plans cannot pay this fee from plan assets (employee and employer contributed funds); however, it is a deductible expense for tax purposes. Multiemployer plans can pay the fee from plan assets if they have no source of funding other than plan assets. Nonfederal governmental plans are not specifically addressed in the regulations but it is preferred that the payment not be from plan assets if possible.

The Form 720 is due by July 31st of the year following the plan reporting year end. Below is the first Form 720 filing due date depending on your plan year:

- For plan years that end on or after October 1, 2012 but on or before December 31, 2012 – due 7/31/2013
- For plan years that end on or after January 1, 2013 through September 30, 2013 – due 7/31/2014

Please note that this is an annual reporting requirement for submission of this fee for 7 consecutive years. Even though the Form says Quarterly Federal Excise Tax Return, you will report and remit your annual fee with this Form 720. If you are only filing and paying the PCORI fee, you do not have to file the Form 720 in other quarters unless you are also remitting other quarterly reportable fees reportable on this form.

The Form 720 is to be filed and fee remitted by the plan sponsors of applicable self-insured health plans. Accordingly, if you are part of a multiple employer plan, the plan sponsor would remit the Form on behalf of all of the membership. For example, a where a County BOCC acts as the sponsor of a plan that also covers constitutional officers, the BOCC as sponsor would file the Form 720 on behalf of all of the participating entities.

The fee for a plan year ending before October 1, 2013, is $1, multiplied by the average number of lives covered under the plan for that plan year. The Form 720 has been specifically updated to show this amount due of $1 on Page 2 of

the form – IRS No. 133 entitled **Patient-Centered Outcomes Research Fee.** Generally, plan sponsors of applicable self-insured health plans must use one of the following alternative methods to determine the average number of lives covered under a plan for the plan year, although for the first year, any reasonable method of calculating this fee may be accepted.

1. **Actual Count Method** – Count the total covered lives for each day of the plan year and divide by the number of days in the plan year.
2. **Snapshot Method** – Count the total number of covered lives on a single day in a quarter (or more than one day) and divide the total by the number of dates on which a count was made. (The date or dates must be consistent for each quarter.)
    a. **Snapshot Factor Method** – In the case of self-only coverage, determine the sum of: (1) the number of participants with self-only coverage, and (2) the number of participants with other than self-only coverage multiplied by 2.35.
3. **Form 5500 Method** – For self-only coverage, determine the average number of participants by combining the total number of participants at the beginning of the plan year with the total number of participants at the end of the plan year as reported on the Form 5500 and divide by 2. In the case of plans with self-only and other coverage, the average number of total lives is the sum of total participants covered at the beginning and the end of the plan year, as reported on the Form 5500. (Note: governmental and other non-ERISA plan sponsors do not file a Form 5500).

Please refer to previous Gehring Group webinar materials, which are available on Gehring Group's client portal or from your account manager, for further description of these methods. As a reminder, we encourage you to keep all supporting documentation in your files.

BenTek is currently being programmed to produce a count under the Snapshot Method for BenTek clients, and your Gehring Group service team is reaching out to the insurance carriers to see if reporting is available for the 10/31, 11/30, and 12/31 year end clients that need to file this July 31st. Please do not hesitate to follow up with your service team directly.

Below are the links to the recently released Form 720 and instructions.

- Form 720: http://www.irs.gov/pub/irs-pdf/f720.pdf
- Form 720 Instructions: http://www.irs.gov/pub/irs-pdf/i720.pdf

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ESRP (Pay or Play) Enforcement & Sections 6055 and 6056 Reporting Requirements to be Delayed One Year Expected Guidance

According to a blog by Mark Mazur of the Department of Treasury, we can expect some forthcoming legislation this summer that will delay the following provisions of the Health Care Reform legislation:

1. The mandatory "provider of minimum essential coverage" reporting requirement under Section 6055 - delayed for one year
2. The mandatory "applicable large employer (more than 50 eligible employees)" reporting requirement under 6056 - delayed for one year
3. The enforcement of the ESRP (Pay or Play Penalty) - delayed until 2015

The link to Mr. Mazur's U.S. Treasury blog entry is below.

http://www.treasury.gov/connect/blog/Pages/Continuing-to-Implement-the-ACA-in-a-Careful-Thoughtful-Manner-.aspx

Although we had previously received guidance on the ESRP, we have been awaiting guidance on the reporting requirements under Sections 6055 and 6056 to be released. You will remember in our beginning seminars we spoke about the extensive reporting requirements under these sections that would allow the Department of Treasury and other parties to validate who was enrolled in Minimum Essential Coverage through their employer during the calendar year. Information reports were to be filed by issuers and employers both to the plan participant and to the government (ex: to the HUB) that showed more thorough coverage information including monthly coverage information. It appears that we will get this guidance sometime this summer, but in the meantime the reporting requirements under these sections have been delayed for a year.

PLEASE NOTE: This is a separate reporting requirement than the October 1 mandatory reporting requirement to employees, and the posting (link above) by Mr. Mazur from the Department of Treasury specifically states that this delay does not affect employees' access to the premium tax credits available under the ACA (the Health Insurance Industry Fee funds the credits and they are still due from the fully insured insurance carriers for 2014!).

Seth Perretta, one of our Health Care Reform counsels in Washington, D.C. had released a Benefits Brief on Sections 6055 and 6056 this past February. If you would like an overview of the reporting requirements as originally outlined in these two sections of the health care reform legislation, you may find it through this brief at: http://www.americanbenefitscouncil.org/documents2013/BBR2013-006_hcr_reporting-verification_summary-cm021413.pdf

ESRP (Pay or Play) Enforcement & Sections 6055 and 6056 Reporting Requirements to be Delayed One Year Expected Guidance

Gehring Group is on the lookout for this forthcoming additional guidance and will keep you updated on its requirements and deadlines once it has been released. As always, thank you for placing your trust in Gehring Group during this time of change.

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Model Notice of Availability of Marketplace Issued by DOL

As part of the Affordable Care Act, qualifying employers and plan sponsors must provide ALL employees a notice concerning the availability of the Health Insurance Marketplace, to be run by the federal government here in Florida, by October 1, 2013.

The Department of Labor has issued a model notice entitled "New Health Insurance Marketplace Coverage Options and Your Health Coverage" which can be found at: http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf. (Please note that this notice is for employers that offer employer sponsored health coverage.) This notice includes a Part A which includes general information about the availability of the Public Marketplace (a.k.a Public Exchange); and Part B, which includes information specific to the employer and the offered plan that an employee would require in order to apply for coverage through the Marketplace.

Although we want to make you aware of the availability and release of this model notice at this time, we are reviewing this notice with our counsel before recommending further instructions regarding the distribution of this notice. Specifically, there has been conflicting interpretation of whether Part B needs to be completed and provided to the employees by October 1, or if just Part A needs to be provided at that time. Department of Labor (DOL) Technical Release 2013-02: *Guidance on the Notice to Employees of Coverage Options under Fair Labor Standards Act §18B and Updated Model Election Notice under the Consolidated Omnibus Budget Reconciliation Act of 1985* can be found at: (http://www.dol.gov/ebsa/newsroom/tr13-02.html), but we would like to gain the assurance of a legal recommendation and see if a follow up F.A.Q document is issued swiftly. We intend to have an answer shortly and will send out a follow up newsletter and portal posting at that time.

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Skinny Plans Emerge in Group Health Market

There are new benefit programs, "Skinny Plans", being offered in the industry. These plans are being designed to assist large employers (50+ full time medical benefits eligible employees) avoid the $2,000 per employee ESRP penalty. Due to vague language in the ACA language, minimum essential coverage for large employers was not clearly defined. While small group and individual plans have to include the Essential Health Benefits, plans for large groups are being interpreted that they must cover preventative services, with no lifetime or annual max. Accordingly, a sample "skinny plan" may not have dollar limits on benefits, but cover only preventative services, 6 doctor visits, generic drugs, while NOT providing any hospital or surgical benefits.

The offering of a skinny plan will protect the large employer from the $2,000 across the board penalty (and may be a tool in avoiding the Pay AND Play Penalty), but employees who go to the exchange, now known as the Marketplace, and qualify for a subsidy will expose the employer to the $3,000 per year penalty for that employee, as Skinny Plans are not 60 percent minimum value plans. Skinny plans are being designed to be low cost ($100/month and under is goal cost), so the potential savings (cost of affordable minimum value coverage less the cost of skinny plan+$3,000 penalty exposure), as well as the organization's culture, are important considerations when contemplating utilizing these plans.

Skinny Plans are a new and evolving insurance market product and may be a good strategic tool in the large employer benefit design toolbox, as long as they can be used in a manner that meets the non-discrimination requirements. Additionally, skinny plans must be offered on a permissive basis – meaning employees have an option to waive coverage. Since these plans don't qualify as minimum value coverage, the employee could conceivably waive coverage and be eligible for a subsidy in the exchange (if they income qualify based on household income). So, we are also looking at skinny plans as a possible solution for some lower earning groups, or groups that may already have minimum essential coverage elsewhere.

We are further exploring these emerging skinny plans being offered through the carrier markets to see what plan designs are available and how these may fit our clients' needs, based on their exposures, potential savings, culture and workforce composition. Please contact your Senior Benefit Consultant for further discussions about your group, and expect a Gehring Group webinar in which these plans are further covered, to be forthcoming.

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DOL Issues Model Exchange Notice and Sets Compliance Deadline

Beginning Jan. 1, 2014, individuals and employees of small businesses will have access to insurance coverage through the Affordable Care Act's (ACA) health insurance exchanges (Exchanges). Open enrollment under the Exchanges will begin on Oct. 1, 2013. **ACA requires employers to provide all new hires and current employees with a written notice about ACA's Exchanges.** This requirement is found in Section 18B of the Fair Labor Standards Act (FLSA).

On May 8, 2013, the Department of Labor (DOL) released **Technical Release 2013-02** to provide temporary guidance on the Exchange notice requirement. This temporary guidance will remain in effect until the DOL issues regulations or other guidance. According to the DOL, future regulations or other guidance will provide employers with adequate time to comply with any additional or modified requirements.

In connection with the temporary guidance, the DOL announced the availability of **model Exchange notices** for employers to use to satisfy the Exchange notice requirement. The DOL also set a compliance deadline for the Exchange notices. Employers must provide employees with an Exchange notice by **Oct. 1, 2013**.

In addition, the DOL's temporary guidance includes a new COBRA model election notice, which has been updated to include information regarding health coverage alternatives offered through the Exchanges.

EXCHANGE NOTICE

Affected Employers

ACA's Exchange notice requirement applies to employers that are subject to the FLSA. In general, the FLSA applies to employers that employ one or more employees who are engaged in, or produce goods for, interstate commerce. In most instances, a business must have at least $500,000 in annual dollar volume of sales or receipts to be covered by the FLSA, with the exception of the following specifically included entities**: federal, state and local government agencies**; hospitals; institutions primarily engaged in the care of the sick, the aged, mentally ill, or disabled who reside on the premises; schools for children who are mentally or physically disabled or gifted; preschools, elementary and secondary schools, and institutions of higher education;

The DOL's Wage and Hour Division provides guidance relating to the applicability of the FLSA in general, including a compliance assistance tool to determine applicability of the FLSA.

Required Content

In general, the Exchange notice must:

- Inform employees about the existence of the Exchange and describe the services provided by the Exchange and the manner in which the employee may contact the Marketplace to request assistance;
- Explain how employees may be eligible for a premium tax credit or a cost-sharing reduction if the employer's plan does not meet certain requirements;
- Inform employees that if they purchase coverage through the Exchange, they may lose any employer contribution toward the cost of employer-provided coverage, and that all or a portion of this employer contribution may be excludable for federal income tax purposes; and
- Include contact information for the Exchange and an explanation of appeal rights.

Model Notices

It is important to note that there are two model notices available – one for employers who do offer a health plan to some or all employees, and a separate model notice for employers who do not offer a health plan. The DOL has provided Word version of the model Exchange notices for employers use at the following address: http://www.dol.gov/ebsa/healthreform/

Employers may use one of these models, as applicable, or a modified version, provided the notice meets the content requirements described above.

Providing the Notice

Who Must Receive a Notice?

Employers must provide the Exchange notice to each employee, regardless of plan enrollment status or of part-time or full-time status. Employers are not required to provide a separate notice to dependents or other individuals who are or may become eligible for coverage under the plan but who are not employees.

What Is the Deadline for Providing the Notice?

ACA required employers to provide the Exchange notice by March 1, 2013. However, on Jan. 24, 2013, the DOL announced that employers would not comply with the Exchange notice requirement until more guidance was issued.

AS a result of this subsequently issued guidance, employers must provide the Exchange notice to both new hires and current employees as follows:

- New Hires – Employers must provide the notice to each new employee at the time of hiring beginning Oct. 1, 2013. For 2014, the DOL will consider a notice to be provided at the time of hiring if the notice is provided within 14 days of an employee's start date.
- Current Employees – With respect to employees who are current employees before Oct. 1, 2013, employers are required to provide the notice no later than Oct. 1, 2013.

Employers that decide to inform their employees about the Exchanges earlier than the Oct. 1, 2013, deadline are permitted to use the model notices and rely on the DOL's temporary guidance.

Method of Providing Notice

The notice is required to be provided automatically, free of charge.

The notice must be provided in writing in a manner calculated to be understood by the average employee. It may be provided by first-class mail. Alternatively, it may be provided electronically if the requirements of the DOL's electronic disclosure safe harbor are met. This safe harbor allows plan administrators to send certain disclosures electronically to:

- Employees with work-related computer access; and
- Other plan participants and beneficiaries who consent to receive disclosures electronically.

The safe harbor does not require the use of any specific form of electronic media. However, plan administrators are required to use measures reasonably calculated to ensure **actual receipt** of the material by plan participants and beneficiaries. Merely placing a disclosure on a company website available to employees will not by itself satisfy this disclosure requirement. To see further guidance on these electronic notification requirements, please see 29 CFR 2520.104b-1(c) located at: http://cfr.regstoday.com/29cfr2520.aspx

DOL Issues Model Exchange Notice and Sets Compliance Deadline

MODIFIED MODEL COBRA ELECTION NOTICE

Under COBRA, a group health plan must provide qualified beneficiaries with an election notice, which describes their rights to continuation coverage and how to make an election. The election notice must be provided to the qualified beneficiaries within 14 days after the plan administrator receives the notice of a qualifying event. The DOL has a model election notice that plans may use to satisfy the requirement to provide the election notice under COBRA.

According to the DOL, some qualified beneficiaries may want to consider and compare health coverage alternatives to COBRA continuation coverage that are available through the Exchanges. Qualified beneficiaries may also be eligible for a premium tax credit for an Exchange plan.

The DOL updated the model COBRA election notice to help make qualified beneficiaries aware of other coverage options available in the Exchanges. Use of the model election notice, appropriately completed, will be considered by the DOL to be good faith compliance with the election notice content requirements of COBRA.

Source: Department of Labor

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Proposed Rule Released on Minimum Value and Affordability

On May 3, 2013, the Internal Revenue Service (IRS) released a **proposed rule** on the minimum value and affordability rules under the Affordable Care Act (ACA). In this proposed rule, the IRS provides guidance on determining whether health coverage under an employer-sponsored plan is affordable and provides minimum value for purposes of determining the employer "pay or play" penalties. In particular, the proposed regulation:

- Explains how to calculate minimum value (MV);
- Outlines special rules for determining how health reimbursement arrangements (HRAs), health savings accounts (HSAs) and wellness program incentives are counted in determining MV and affordability; and
- Provides new safe harbors for determining MV.

This proposed rule would apply for tax years ending after Dec. 31, 2013.

BACKGROUND

Effective for 2014, the Affordable Care Act (ACA) provides premium tax credits and cost-sharing reductions to eligible individuals who purchase qualified health plan coverage through a health insurance exchange (Exchange). To qualify for the premium tax credit and cost-sharing reductions, an individual cannot be eligible for other minimum essential health coverage, including coverage under an employer-sponsored plan that is affordable to the individual and provides minimum value.

A large employer may be liable for a penalty under ACA's "pay or play" rules if any of its full-time employees receives a premium tax credit or cost-sharing reduction through an Exchange. This may happen if a large employer's plan does not provide minimum value. An employer is a "large employer" for a calendar year if it employed an average of at least 50 full-time employees, including full-time equivalents, on business days during the preceding calendar year.

In addition, under ACA's individual mandate, individuals are generally required to pay a penalty if they do not have minimum essential coverage. ACA also contains reporting requirements to implement the law's penalty provisions for large employers and individuals.

MINIMUM VALUE REQUIREMENTS

ACA provides that a plan does not provide minimum value (MV) if the plan's share of total allowed costs of benefits provided under the plan is less than 60 percent. MV is calculated by dividing the cost of essential health benefits (EHBs) the plan would pay for a standard population by the total cost of EHBs for the standard population (including amounts the plan pays and amounts the employee pays through cost-sharing) and then converting the result to a percentage.

Health Benefits Measured in Determining Minimum Value

In determining the share of benefit costs paid by a plan, the proposed regulations do not require employer-sponsored large group plans to cover every EHB category or conform their plans to an EHB benchmark that applies to QHPs. Employer-sponsored group health plans are not required to offer EHBs unless they are health plans offered in the small group market. MV is measured based on the provision of EHBs to a standard population and plans may account for any benefits covered by the employer that also are covered in any one of the EHB benchmark plans.

The proposed regulations provide that MV is based on the anticipated spending for a standard population. The plan's anticipated spending for benefits provided under any particular EHB-benchmark plan for any state counts towards MV.

Rules for HRA and HSA Contributions

The proposed regulations also address how employer contributions toward HSAs or HRAs should count toward the plan's share of costs in determining MV. The proposed rule provides that all amounts contributed by an employer for the current plan year to an HSA are taken into account in determining the plan's share of costs for purposes of MV and are treated as amounts available for first dollar coverage. Amounts newly made available under an HRA that is integrated with an eligible employer-sponsored plan for the current plan year count for purposes of MV in the same manner, as long as the amounts may be used only for cost-sharing and may not be used to pay insurance premiums.

Rules for Wellness Program Cost-sharing Reductions

In addition, the proposed rule addresses how nondiscriminatory wellness program incentives that may affect an employee's cost sharing should be taken into account for purposes of the MV calculation. The proposed regulations provide that a plan's share of costs for MV purposes is determined **without regard to reduced cost-sharing available under a nondiscriminatory wellness program**.

However, for nondiscriminatory wellness programs designed to prevent or reduce tobacco use, MV may be calculated assuming that every eligible individual satisfies the terms of the program relating to prevention or reduction of tobacco use. This exception is consistent with other ACA provisions (such as the ability to charge higher premiums based on tobacco use) reflecting a policy about individual responsibility regarding tobacco use.

Standard Population

The proposed regulations provide that the standard population used to determine MV reflects the population covered by self-insured group health plans. HHS has developed the MV standard population and described it through summary statistics (for example, continuance tables). MV continuance tables and an explanation of the MV Calculator methodology and the health claims data HHS has used to develop the continuance tables are available on the Center for Consumer Information & Insurance Oversight website.

AFFORDABILITY REQUIREMENTS

Under the ACA, eligible employer-sponsored coverage is affordable only if an employee's required contribution for self-only coverage does not exceed 9.5 percent of household income. The proposed regulation includes special rules for determining how HRAs and wellness program incentives are counted in determining the affordability of eligible employer-sponsored coverage.

The proposed rule provides that amounts made newly available under an HRA that is integrated with an eligible employer-sponsored plan for the current plan year are taken into account only in determining affordability if the employee may either:

- Use the amounts only for premiums; or
- Choose to use the amounts for either premiums or cost-sharing.

Treating amounts that may be used either for premiums or cost-sharing only toward affordability prevents double counting the HRA amounts when assessing MV and affordability of eligible employer-sponsored coverage.

The proposed rules also contain clarification on affordability when premiums may be affected by **wellness programs**. Under the proposal, the affordability of an employer-sponsored plan is determined by assuming that each employee fails to satisfy the wellness program's requirements, unless the wellness program is related to tobacco use. This means the affordability of a plan that charges a higher initial premium for tobacco users will be determined based on the premium charged to non-tobacco users, or tobacco users who complete the related wellness program, such as attending smoking cessation classes.

Transition relief is provided in the proposed rules for plan years beginning before Jan. 1, 2015. Under this relief, if an employee receives a premium tax credit because an employer-sponsored health plan is unaffordable or does not provide minimum value, but the employer coverage would have been affordable or provided minimum value had the employee satisfied the requirements of a nondiscriminatory wellness program that was in effect on May 3, 2013, the employer will *not* be subject to the employer mandate penalty. The transition relief applies for rewards expressed as either a dollar amount or a fraction of the total required employee premium contribution.

NEW SAFE HARBORS FOR DETERMINING MINIMUM VALUE

In May 2012, the IRS issued Notice 2012-31 to propose several methods for determining MV: the MV Calculator, a safe harbor, actuarial certification and, for small group market plans, a metal level. The proposed regulations provide that taxpayers may determine whether a plan provides MV by using the MV Calculator. Taxpayers must use the MV Calculator to measure standard plan features (unless a safe harbor applies), but the percentage may be adjusted based on an actuarial analysis of plan features that are outside the parameters of the calculator.

Certain safe harbor plan designs that satisfy MV will be specified in additional guidance. It is anticipated that the guidance will provide that the safe harbors are examples of plan designs that clearly would satisfy the 60 percent threshold if measured using the MV Calculator. The safe harbors are intended to provide an easy way for sponsors of typical employer sponsored group health plans to determine whether a plan meets the MV threshold without having to use the MV Calculator. Plan designs meeting the following specifications are proposed as safe harbors for determining MV if the plans cover all of the benefits included in the MV Calculator:

- A plan with a $3,500 integrated medical and drug deductible, 80 percent plan cost sharing and a $6,000 maximum out-of-pocket limit for employee cost-sharing;
- A plan with a $4,500 integrated medical and drug deductible, 70 percent plan cost sharing, a $6,400 maximum out-of-pocket limit and a $500 employer contribution to an HSA; and
- A plan with a $3,500 medical deductible, $0 drug deductible, 60 percent plan medical expense cost-sharing, 75 percent plan drug cost-sharing, a $6,400 maximum out-of-pocket limit and drug co-pays of $10/$20/$50 for the first, second and third prescription drug tiers, with 75 percent coinsurance for specialty drugs.

Comments are requested on these and other common plan designs that would satisfy MV and should be designated as safe harbors. The proposed regulations require plans with nonstandard features that cannot determine MV using the MV Calculator or a safe harbor to use the actuarial certification method. The actuary must be a member of the American Academy of Actuaries and must perform the analysis in accordance with generally accepted actuarial principles and methodologies and any additional standards that subsequent guidance requires.

OTHER ISSUES IN THE PROPOSED REGULATIONS

Definition of Modified Adjusted Gross Income

The term "household income" means the modified adjusted gross income of the taxpayer plus the modified adjusted gross income of all members of the taxpayer's family required to file a tax return for the taxable year. The final regulations provide that the determination of whether a family member is required to file a return is made without regard to Code section 1(g)(7), which allows a parent to elect to include in the parent's gross income the gross income of his or her child, if certain requirements are met. If the parent makes the selection, the child is treated as having no gross income for the taxable year.

The proposed regulations remove "without regard to section 1(g)(7)" from the final regulations because that language implies that the child's gross income is included in both the parent's adjusted gross income and the child's adjusted gross income in determining household income. Thus, the proposed regulations clarify that if a parent makes an election under section 1(g)(7), household income includes the child's gross income included on the parent's return and the child is treated as having no gross income.

Retiree Coverage

An individual who may enroll in continuation coverage required under federal or state law that provides comparable continuation coverage is eligible for minimum essential coverage only for months that the individual is enrolled in the coverage. The proposed regulations apply this rule to **former employees only**. Active employees eligible for continuation coverage as a result of reduced hours should be subject to the same rules for eligibility of affordable employer-sponsored coverage offering MV as other active employees.

The proposed regulations add a comparable rule for health coverage offered to retired employees (retiree coverage). Accordingly, an individual who may enroll in retiree coverage is eligible for minimum essential coverage under the coverage only for the months the individual is enrolled in the coverage.

Coverage Month for Newborns and New Adoptees

A month is a coverage month for an individual only if, as of the first day of the month, the individual is enrolled in a QHP through an Exchange. A child born or adopted during the month is not enrolled in coverage on the first day and therefore would not be eligible for the premium tax credit or cost-sharing reductions for that month. Accordingly, the proposed regulations provide that a child enrolled in a QHP in the month of the child's birth, adoption or placement with the taxpayer for adoption or in foster care, is **treated as enrolled as of the first day of the month**.

Adjusted Monthly Premium for Family Members Enrolled for Less Than a Full Month

The premium assistance amount for a coverage month is computed by reference to the adjusted monthly premium for an applicable benchmark plan. The final regulations provide that the applicable benchmark plan is the plan that applies to a taxpayer's coverage family. The final regulations do not address whether changes to a coverage family (for example, as the result of the birth and enrollment of a child or the disenrollment of another family member) that occur during the month affect the premium assistance amount. The proposed regulations provide that the adjusted monthly premium is determined as if all members of the coverage family for that month were enrolled in a QHP for the entire month.

Premium Assistance Amount for Partial Months of Coverage

The final regulations do not address the computation of the premium assistance amount if coverage under a QHP is terminated during the month. The proposed regulations provide that when coverage under a QHP is terminated before the last day of a month and, as a result, the issuer reduces or refunds a portion of the monthly premium, the premium assistance amount for the month is prorated based on the number of days of coverage in the month.

Family Members Residing at Different Locations

The final regulations reserved rules on determining the premium for the applicable benchmark plan if family members are geographically separated and enroll in separate QHPs. The proposed regulations provide that the premium for the applicable benchmark plan in this situation is the sum of the premiums for the applicable benchmark plans for each group of family members residing in a different state.

Proposed Rule Released on Minimum Value and Affordability

Correction to Applicable Percentage Table

The applicable percentage table in the final regulations incorrectly states that the 9.5 percentage applies only to taxpayers whose household income is **less than** 400 percent of the FPL. The proposed regulations clarify that the 9.5 percentage applies to taxpayers whose household income is **not more than** 400 percent of the FPL.

Additional Benefits and Applicable Benchmark Plan

Under section 36B(b)(3)(D) and the final regulations, only the portion of the premium for a QHP properly allocable to EHBs determines a taxpayer's premium assistance amount. Premiums allocable to benefits other than EHBs (additional benefits) are disregarded. The final regulations do not address, however, whether a taxpayer's benchmark plan is determined before or after premiums have been allocated to additional benefits.

The proposed regulations provide that premiums are allocated to additional benefits before determining the applicable benchmark plan. Thus, **only EHBs are considered** in determining the applicable benchmark plan, consistent with the requirement in section 36B(b)(3)(D) that only EHBs are considered in determining the premium assistance amount. In addition, allocating premium to benefits that exceed EHBs before determining the applicable benchmark plan results in a more accurate determination of the premium assistance amount.

Source: Internal Revenue Service

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HHS Plans to Delay Key Aspect of SHOP Exchanges

Beginning in 2014, individuals and small employers will be able to purchase health insurance through online competitive marketplaces, or Exchanges. The Affordable Care Act (ACA) requires each state that chooses to operate an Exchange to also establish a Small Business Health Options Program (SHOP) Exchange. The SHOP Exchange is intended to assist eligible small employers in providing health insurance for their employees.

HHS will establish and operate a federally-facilitated Exchange (FFE) in each state that does not establish its own Exchange. The FFE will include both individual market and SHOP components.

Small employers with up to 100 employees will be eligible to participate in the Exchanges. However, until 2016, states may limit participation in the SHOP Exchanges to businesses with up to 50 employees. Beginning in 2017, states may allow businesses with more than 100 employees to participate in the Exchanges.

On March 11, 2013, HHS issued a **proposed rule** that would amend some of the standards for SHOP Exchanges. Most notably, the proposed rule creates a transition policy regarding an employee's choice of qualified health plans (QHPs) in the SHOP. **The transition policy would delay implementation of the employee choice model as a requirement for all SHOPs for one year, until 2015.**

FUNCTIONS OF THE SHOP EXCHANGE

On March 27, 2012, HHS issued a final rule on establishment of the Exchanges. This final rule describes the minimum functions of a SHOP. The final rule provides that a SHOP must allow employers the option to offer employees all QHPs at a level of coverage chosen by the employer—bronze, silver, gold or platinum. In addition, the final rule permits SHOPs to allow a qualified employer to choose one QHP for its employees.

In a separate final rule issued in March 2013, HHS provided that the federally-facilitated SHOP (FF-SHOP) would give employers the choice of offering only a single QHP, as employers customarily do today, in addition to the choice of offering all QHPs at a single level of coverage.

TRANSITION POLICY

In the proposed rule, HHS provides a transition policy for 2014 plan years that is intended to provide all SHOPs (both state SHOPs and the FF-SHOP) with additional time to prepare for the employee choice model.

Under the transition policy, for plan years beginning on or after Jan. 1, 2014, and before Jan. 1, 2015, state SHOPs would not have to allow employers to offer their employees a choice of QHPs at a single level of coverage. However, a SHOP may decide to provide this option to employers for 2014 plan years.

In addition, for plan years beginning on or after Jan. 1, 2014, and before Jan. 1, 2015, FF-SHOPs would not allow qualified employers to offer their employees a choice of QHPs at a single level of coverage. For 2014 plan years, the FF-SHOP would assist employers in choosing a single QHP to offer their qualified employees.

According to HHS, the transition policy would increase the stability of the small group market while providing small groups with the benefits of SHOP in 2014 (for example, choice among competing QHPs and access for qualifying small employers to the small business health insurance tax credit).

The 2012 final rule also included a premium aggregation function for the SHOP that was designed to assist employers whose employees were enrolled in multiple QHPs. Because this function will not be necessary in 2014 for SHOPs that delay implementation of the employee choice model, the proposed rule would make the premium aggregation function optional for plan years beginning before Jan. 1, 2015.

HHS Plans to Delay Key Aspect of SHOP Exchanges

Gehring Group will continue to monitor health care reform developments and will provide updated information as it becomes available.

Exhibit G: Available Online Safety Training Courses

1210-0044

SUMMIT Trainingweb®

ONLINE TRAINING COURSE LIST

Accident Investigation
Aerial Lift Safety
Air Emissions
Asbestos Awareness
Back Injury Prevention
Back Safety
Benzene
Bloodborne Pathogens
Bloodborne Pathogens: Exposure Prevention
Crane Safety: Mobile Cranes
Crane Safety: Pendant Controlled
Compressed Gas Cylinders
Concrete & Masonry
Confined Space: Permit Required
Confined Space: Emergency Rescue
Container Labeling
Construction Safety Orientation
Decision Driving
Decision Driving – Truck
Decontamination
Disaster Readiness
DOT: Driver Logs
DOT: Driver Qualifications
DOT Drug Testing: Supervisor Training
DOT Drug Testing: Employee Awareness
DOT: Pre & Post Trip Inspections
DOT/CSA: Profiled in Safety
Driver Awareness: 15-Passenger Van Safety
Drug Testing Awareness
Electrical Safety
Electrical Safety – High Voltage Awareness
Electrical Safety – High Voltage Safe Work Practices
Electrical Safety – NFPA 70E
Electrical Safety – Part 2
Employee Safety Orientation
Energized Electrical Work Permit
Environmental Awareness
Excavations, Trenching & Shoring
Eye Safety
Fall Protection
Fall Protection - Construction
Fall Protection - Construction Part 2
Fall Protection
Fire Safety
Fire Protection & Prevention
First Aid
First Responder Awareness Level
Food Allergens
Food Manufacturing: Contamination Prevention
Food Manufacturing: Microbiology for Dairy
Food Manufacturing: Sanitation
Food Manufacturing: Site Security
Food Manufacturing: Tracebility Management
Food Manufacturing: Quality Assurance
Forklift Safety
Formaldehyde Safety
GHS: Chemical Labeling and Classification
GMPs: Food Production Excellence
HACCP: Food Hazard Prevention
Hand Safety
Hand & Power Tools
Hazard Communication
Hazard Communication: Knowledge to Protect
Hazard Recognition
Hazardous Waste
HAZWOPER
Hearing Safety*
Heat Stress*
Hexavalent Chromium
HMT: Bulk Transport
HMT: General Awareness
HMT: Non Bulk
HMT: Safe Work Practices
HMT: Safety Requirements for Drivers
HMT: Security Awareness
HMT: Shipping Requirements
Hoists & Slings
Hot Work
Hydrogen Sulfide Safety
Incident Investigation
Industrial Ergonomics
Introduction to OSHA
Job Safety Analysis
Lab Safety
Ladder Safety
Laser Safety
Lead Safety
Leadership Skills for Safety
Lifesaving Measures
Lockout/Tagout
Lockout/Tagout: Energy Control*
Machine Guard Awareness
Machine Guarding
Marine Security
Muscle Strains & Sprains
Off-The-Job Safety
Office Ergonomics
Office Safety
OSHA Recordkeeping
PACE Behavioral Driving – Small Vehicles
PACE Behavioral Driving – Large Vehicles
Personal Protective Equipment
PPE: Armed for Safety*
Personal Protective Equipment – Construction
Pipeline Safety
Power Press Safety
Preventing Spills
Process Safety management
Radiation Safety
RCRA
Respirators: Air Purifying
Respirators: Air Supplying
Rigging Safety
Road Rage
Safe Behavior
Safety Attitude for Safety's Sake
Safety Orientation
Scaffolding Safety
Sexual Harassment: Understanding & Preventing
Sexual Harassment: What Supervisors Need to Know
Shock Proof Qualified Employee
Shock Proof Unqualified Employee
Silica Safety Awareness
Site Security
Slips, Trips & Falls*
Small Spill Cleanup
Static Electricity
Stormwater Management
Street Smart: Driving Skills
TSCA
Transportation of Dangerous Goods
Valve Safety
Walking Working Surfaces
Welding Safety
WHMIS
Workplace Violence: Prevent the Threat

* Alternate quiz questions version available

www.safetyontheweb.com
800.842.0466

SUMMIT TRAINING SOURCE®

Exhibit H: Risk Assessment Questionnaire

GEHRING GROUP
INSURANCE BROKERS & CONSULTANTS

ANNUAL RISK ASSESSMENT QUESTIONNAIRE

In an effort to prepare for the upcoming renewal season, please complete the following questionnaire. We appreciate you taking the time to complete the following as this is an important part of our effort to determine if there are additional exposures for which coverage is not currently in place.

?	Question	Yes	No
1	Is the named insured, as shown on your policy(ies), correct?		
2	Have you acquired Property at locations not shown on the policy?		
3	Do you have Business Personal Property (contents) at locations not shown on the policy?		
4	**Are you interested in purchasing coverage on any of the following items:**		
	• Fences		
	• Cabanas/Gazebos		
	• Playground Equipment		
	• Signs		
	• Docks/Seawalls		
	• Lighting (Sports fields)		
	• Bridges/Piers		
	• Radio Equipment/Antennas		
5	Do you have property of others in your care, custody, or control?		
6	If the insurance coverage purchased has changed substantially in limits, retentions or deductibles from prior years, have you submitted an updated Certification of Insurance Reasonableness letter to the State regarding limits and or capacity?		
7	Have there been any operational changes in your organization in the past year? If Yes, please describe.		
8	Would you like to receive a quote on Crime coverage and/or increased limits on your Crime coverage? (i.e. employee theft, disappearance, destruction)		
9	Are you self funded on liability coverage? Would you like to receive a quote which may include general liability, public official's liability, errors & omissions, employment practices liability and employee benefits liability?		
10	Higher limits of liability may be available to you. Are you interested in obtaining quotes for higher limits of liability? If so, what limits would you like to request and which lines of coverage would like to increase?		
11	Do you sell or distribute alcohol at events? Is so, please provide details.		

GEHRING GROUP
INSURANCE BROKERS & CONSULTANTS

ANNUAL RISK ASSESSMENT QUESTIONNAIRE

?	Question	Yes	No
12	Are there any special events scheduled for the upcoming plan year? (i.e. parades, concerts, festivals) for which you may need additional coverage?		
13	Have you purchased, leased, or acquired additional property locations this past year that have not already been endorsed?		
14	Do you require additional coverage for computer equipment and software?		
15	Have your purchased, leased, or acquired additional mobile equipment/machinery this past year that have not already been endorsed?		
16	Are there any changes to the vehicle schedule that have not already been endorsed?		
17	Do your operations present any potential pollution exposures for which you need coverage?		
18	Are you interested in soil sampling to ensure no potential pollution exposures?		
19	Have you added or removed any storage tanks this past year?		
20	Do you need to amend your current payrolls or workers compensation classifications?		
21	Do you administer any pension plans that need fiduciary liability protection that are aren't already covered?		
22	Do you have flood insurance on buildings in A or V zones?		
23	Do you own any moveable soundstage or theater equipment that you need to insure?		
24	Are there any other updates or changes that you would like to make to your current policy(ies)?		
25	In the event of a catastrophe, do you have a resolution in place to address the payment of overtime to employees?		
26	Have you established a tracking system for catastrophic expenses?		

GEHRING GROUP
INSURANCE BROKERS & CONSULTANTS

ANNUAL RISK ASSESSMENT QUESTIONNAIRE

?	Question	Yes	No
	Notes:		

Please return your completed form to Ellen Jones, Director – Risk Management no later than May 1, 201___. Should we not receive a response prior to this date, we will assume that no changes to the current policy(ies) are necessary and your renewal will be processed based on the expiring information we have on file. We will be sending copies of current schedules on file for your review shortly. Any required renewal applications will be provided to you electronically as they are received from the carriers.

We thank you for your cooperation and request your prompt return of this signed document to our office.

_____ _____

Signature & Title of Named Insured **Date**

Exhibit I: Letters of Recommendation

PALM BEACH COUNTY
SHERIFF'S OFFICE
RIC L. BRADSHAW, SHERIFF

October 21, 2009

Ladies & Gentlemen:

The Palm Beach County Sheriff's Office has enjoyed a long relationship with the Gehring Group, as they have been our Agent of Record for Employee Benefits for over 15 years. During this extensive period of service, Gehring Group has provided outstanding service to our organization. They are highly regarded by me and my staff and have been a source of unqualified support and expertise to us throughout the years.

It is with pleasure that I recommend Gehring Group to other organizations. Please do not hesitate to call for further information.

Sincerely,

Ric L. Bradshaw
Sheriff

3228 Gun Club Road ▪ West Palm Beach, Florida 33406-3001 ▪ (561) 688-3021 ▪ Email: BradshawR@pbso.org

THOMAS M. KNIGHT, SHERIFF
SARASOTA COUNTY SHERIFF'S OFFICE
Post Office Box 4115
Sarasota, Florida 34230-4115
Telephone (941) 861-5800
Fax (941) 861-4039
www.sarasotasheriff.org

October 14, 2010

Mr. Kurt Gehring, President
Gehring Group Professional Services
11505 Fairchild Gardens Avenue
Suite 202
Palm Beach Gardens, FL 33410

Dear Mr. Gehring, Kurt

The process of branching out and doing something that is outside of ones expertise and comfort zone is a difficult undertaking. We carefully selected you as our broker and I want you to know we are extremely pleased with the services you have provided.

On many occasions during this process you have dropped everything and came to our offices or answered our telephone calls and emails. While we as a staff did not possess the expertise to ask the questions and examine the data, you did. I am confident in saying that had we not engaged your firm to examine the costs imposed on us by county government we would not have reached the resolution that we did. While there may be more savings to be had, the agreement we have come to with county staff guarantees our employees will see real savings in their pockets in 2011. This could not have been accomplished without the help of your dedicated staff.

I have asked Major Kurt Hoffman and Captain Paul Marshall to remain in contact with your group because I firmly believe that this issue will remain one that requires constant examination. During recent meetings in Tallahassee, Major Hoffman was contacted by several majors and undersheriffs from various agencies inquiring as to how we initiated this process. I have instructed him to share with them your RFP for broker services in the hopes that they may avail themselves of your services.

If you have any current projects that you wish to list the Sarasota County Sheriff's Office as a reference, you have my express permission to do so. Please accept this letter with my humble appreciation for what you did for us and may do for us again in the future.

Sincerely,

Thomas M. Knight, Sheriff
Sarasota County, Florida

CITY OF SARASOTA

Department of
Human Resources

S. Kurt Hoverter
Director of
Human Resources

The City of Sarasota had historically participated in a local healthcare coalition and had not done a Request for Proposal (RFP) in many years. The coalition subsequently dissolved and we were faced with the need to design our new medical plan for 2010 and select a new vendor.

We selected the Gehring Group to consult with the City on plan design, cost control, vendor selection, and employee/retiree communications. We knew selecting a new plan would be a daunting task but could not have anticipated the many ways the Gehring Group assisted us in all phases of the process.

Their staff was always responsive and made many trips to the City to assist with a task force, a benefits focus group, the Human Resources staff, multiple meetings with the City Commission, RFP creation, vendor analysis, vendor selection, plan transition with the new vendor (Cigna) and design of a comprehensive benefits communications package for our employees.

Having their assistance was invaluable during this transition and I would not hesitate to recommend them to other organizations facing benefit program transitions.

Should you have other questions about their role, please feel free to contact me.

Sincerely,

Kurt Hoverter
Director of Human Resources

Cc: Gehring Group

P. O. Box 1058
Sarasota, FL 34230-1058

111 S. Orange Avenue
Room 204
Sarasota, FL 34236

Telephone
941/951-3638

Fax
941/951-3636

Job Hotline
941/951-3633

www.sarasotagov.com

Sheriff Robert E. "Bob" Hansell

OSCEOLA COUNTY SHERIFF'S OFFICE

2601 E. Irlo Bronson Memorial Hwy., Kissimmee, Florida 34744
Telephone: 407-348-1100 • *www.osceolasheriff.org*

August 10, 2012

RE: Recommendation for the Gehring Group

Dear Representative:

This letter is written as an excellent recommendation for The Gehring Group, which has served as health insurance broker and benefits consultant for the Osceola County Sheriff's Office for the past two years.

We have found the entire Gehring Group team to be extremely knowledgeable, customer service oriented, and helpful. The staff members have a very strong and consistent depth of knowledge, and they are clearly problem solvers. The Gehring Group also assisted us in saving more than $150,000 per year compared to our previous health benefits broker.

If you have any questions, please feel free to call.

Sincerely,
Robert E. Hansell, Sheriff
Osceola County

BY: _____
Dave M. Sklarek
Chief Deputy