Food Employers Labor Relations Association and United Food and Commercial Workers Health and Welfare Fund

PROPOSAL TO PROVIDE BENEFITS CONSULTING SERVICES

May 21, 2014

Josh D. Timm, CEBS
Vice President

Mr. Mitch Bramstaedt
Vice President

Segal Consulting

Segal Consulting

30 Waterside Drive, Suite 300, Farmington, CT 06032-3069
T 860.678.3000 F 860.371.3429 www.segalco.com

May 21, 2014

Via E-mail: billj@associated-admin.com

Mr. William R. Jensen
President
Associated Administrators, LLC
4301 Garden City Drive, Suite 201
Landover, MD 20785-6102

Re: Proposal to Provide Benefits Consulting Services

Dear Mr. Jensen:

Thank you for the opportunity to submit a proposal to provide benefit consulting services to the Food Employers Labor Relations Association and United Food and Commercial Workers Health and Welfare Fund (Fund). Our understanding is that the Fund wishes to retain a consulting firm with demonstrated successful experience with multiemployer health and welfare benefit programs. We have appreciated the opportunity to serve as your project-based consultant over the past few years, specifically working with the Fund Trustees and professionals on Mental Health Parity and Addiction Equity Act compliance and Summary of Benefits and Coverage (SBC). We realize there are numerous benefits consulting firms from which to choose and through this proposal, we will show that Segal Consulting (Segal) has the required experience and is qualified to provide the following services:

- Prepare annual reports analyzing the Funds benefit experience;
- Determine the Fund's current funding level and forecast future contribution levels;
- Calculate maintenance of benefit contribution and COBRA rates annually, in accordance with the collective bargaining agreements;
- Value plan design changes;
- Negotiate renewals with current and future healthcare providers;
- Assist with the development of benchmarks to monitor the Fund's performance;

- Calculate SOP 92-6 related liabilities;
- Determine the Medicare Part D creditable coverage status and draft the required annual notice to the Fund's participants;
- Review and coordinate compliance with the Fund's reporting obligations under the Affordable Care Act (ACA) and other applicable laws;
- Draft or review forms, participant notices, plan amendments and summaries of material modifications, as required;
- Advise and report on the financial impact of statutory and regulatory developments affecting the fund; and
- Attend four meetings of the Board of Trustees per year while being available for telephonic meetings as needed.

Segal proposes a team of consultants that has completed similar projects for the FELRA & UFCW Health and Welfare Fund (SBC's, mental health parity, bargaining assistance), United Food and Commercial Workers Union Local 919 and Contributing Employers' Health and Welfare Fund, United Food and Commercial Workers Local 1500 Welfare Fund, Heartland Health and Wellness Fund, and the Rocky Mountain UFCW Unions and Employers Health Benefit Plan. We will reference these engagements and others throughout this proposal to demonstrate the proposed team's experience with other clients that generally represent multiemployer health funds with the following characteristics that appear to be relevant to the Fund and the work you seek: Additionally, Segal has worked with Associated Administrators, LLC, and co-counsel on other similar engagements.

- Large employer groups with greater than 7,000 employees;
- Diverse employee groups that include active employees, part-time associates, retirees and COBRA participants;
- UFCW participant base where Ahold and/or Safeway is one of the employers;
- Clients for whom we have provided comprehensive benefit consulting services; and
- Multiemployer plans for which we have reviewed and analyzed benefit legislation specifically related to the ACA.

Segal has a deep understanding of the issues facing food industry multiemployer plans. Today, we are engaged by 53 food industry funds including 27 health and welfare funds. Segal is the consultant to approximately 588 multiemployer health plans.

Our approach is not set in stone. We do not simply offer an "off the shelf" program of services. Rather, we consider the unique culture and needs of each client to customize our work to fit those needs.

Experience has taught us that it is the quality of our work that gains our clients' trust. The Segal work ethic and culture is immersed in a drive for constant improvement. The information contained within is intended to fully meet the Fund's scope of services.

Requests for additional information regarding our proposal may be addressed to the following individuals:

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Vice President
30 Waterside Drive, Suite 300
Farmington, CT 06032-3069
Phone: 860.678.3040
Cell: 860.384.3541
jtimm@segalco.com

Mr. Mitch Bramstaedt
Vice President
101 North Wacker Drive, Suite 500
Chicago, IL 60606-1724
Phone: 312.984.8652
Cell: 773.551.5134
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We welcome the opportunity to meet with you to answer any questions you may have and to discuss our qualifications and experience in greater detail.

Sincerely yours,

Josh Timm, CEBS
Vice President

Mitch Bramstaedt
Vice President

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Executive Summary

Managing a health plan in today's dynamic environment requires a higher level of effort and expertise than ever before. The Fund can become a leader of multiemployer health funds by successfully implementing new ideas before they become mainstream. We look forward to the challenge of helping you build maintain and expand such a legacy. We will work with the Trustees and Fund Professionals in the following manner to meet these objectives.

Proactive

Trustees and Fund Professionals need ideas to react to and to consider. We present you with new industry trends, current compliance issues, and more importantly, proven solutions that address issues the Fund faces today and that will surface in the future.

Trustee Planning

Past experience has demonstrated the benefits of Trustees engaging in meetings and dialogue where healthcare strategic planning is a significant part of the agenda. Segal consultants typically use this time to facilitate Trustee discussion around health plan goals and objectives. We will use an approach that is illustrated in the table below and summarized in the following paragraphs.

Vendor Management	Plan Management Strategies	Individual Health Care Management & Wellness
• Competitive bidding • Contract negotiation • Vendor performance audits • Renewal negotiations	• Plan design • Plan cost modeling/actuarial services • Funding options and strategies • Reserve adequacy • Contribution strategies • Coverage rules and protocols	• Wellness and prevention programs • Disease management programs • Catastrophic claimant programs • Transparency tools

Vendor Management

Choosing the vendors that demonstrate the best fit with the Fund is the critical first step in creating a well-managed health plan. Once the correct mix of vendors is determined through procurement or selection processes, these organizations need to be monitored closely through frequent meetings, measurement of performance guarantees and performance standards, audits, and renewal negotiations.

Our approach to vendor management is described below.

- We aggressively negotiate vendor contracts and make sure clients receive a competitive price and top-ranked service. Our health analytical teams are comprised of actuaries, underwriters, and consultants, some of who were previously very senior underwriting managers or

actuaries in insurance companies. We have found that this insurance company experience brings an extra level of scrutiny (and insight) into vendor contracts.

- We negotiate meaningful and measureable caps on the fees and premiums charged by vendors. We often devise long-term provisions that hold vendors accountable to realistic price increases. This process works well with multiemployer clients who must project budget costs many months in advance of the beginning of each program year due to the collective bargaining cycle.

- Segal can conduct audits to verify that vendors are performing. Our claims audit division has been assisting clients since 1973 through onsite and desktop audits of self-funded plans administered by carriers and third party administrators nationwide. Segal auditors are specifically trained to conduct health care claim audits. Because these individuals devote 100% of their time to this function, they have a level of experience and expertise that is unequaled in the industry.

Segal maintains an array of audit tools to assist in monitoring vendor service levels and validating their achievement, including:

- Periodic onsite claim audits to meet fiduciary responsibilities, reduce plan costs, enforce or implement performance guarantees, address benefit or plan concerns, and increase employee satisfaction.

- Desktop or electronic audits that lend themselves to reviews of Rx programs administered through a pharmacy benefit manager (PBM) or analysis of claims data to determine utilization trends and comparisons.

- Dependent eligibility verifications to identify, report, and disenroll ineligible dependents from one or more benefit plans.

- Develop standards for contract performance that reflect general practices among large employers. These norms will be tailored to the specific needs of the benefit programs.

Plan Management

The ultimate goals of plan design are threefold, and at times these goals may appear to be in conflict.

- The plan must encourage appropriate utilization by paying for necessary, quality care at a high level and by paying for discretionary care at lower levels.

- The governing plan design must be established in order to assist in meeting the overall cost and financing goals of the plan.

- The plan must be flexible so it meets the ever-changing needs of members and the current industry trends.

These competing goals can best be brought into alignment through strong data management and analysis. The Fund's data contains the information to determine how to encourage appropriate utilization at a cost that is affordable and, more importantly, sustainable.

Individual Health Care Management and Wellness

The Fund may have begun work in this area by engaging in wellness benefits and related programs, and exploring deeper impact programs, such as disease management. Subsequent steps will be to coordinate the program management properly, wellness benefits and related programs, as well as to monitor the programs' effectiveness.

Segal has the experience in coordinating vendor, plan design and individual health management to help Trustees achieve their short and long-term objectives with their wellness plan.

Health Care Reform

When President Obama signed health reform into law on March 23, 2010, he set the stage for a dramatic restructuring of the entire health care sector. As result, accurate, behind-the-scenes, detailed reporting will be essential in the coming months and years for multiemployer health benefit programs with a vested interest in this regulatory transformation.

Plan sponsors will be working through the implications of health reform for years, but the first step is to review the reforms for the coming plan year.

Segal's National and Regional Compliance teams have been following the reform process throughout, including publishing a periodic Health Care Reform Insights electronic update to keep our clients fully informed of the many changes in direction as this legislation has moved through Congress and into law. We are already working with many of our Taft-Hartley clients on active projects to review how these new short-term and long-term reforms affect their benefits programs. We propose to do the same for the Fund.

Services that Segal will provide to the Fund in this area include:

- Subject matter expertise;
- Responding to questions regarding federal health reform;
- Providing guidance and recommendations for compliance and implementation;
- Providing analysis of impacts to the Fund;
- Developing and/or reviewing presentation materials;
- Participating in conference calls and workgroup meetings; and
- Coordinating compliance with all Fund professionals.

Compliance Issues

With the recent passage and signing into law of the Patient Protection and Affordable Care Act ("PPACA") and the second Act, the Health Care and Education Reconciliation Act ("HCERA"), there are extensive changes that will impact all aspects of health care. We believe the first step for plan sponsors is to understand the implications of these new laws on their benefit programs, including how the new laws may change the benefits provided and the employees and dependents covered by their programs. The changes contained in this complex new legislation have staggered effective dates over the next several years. This means that plan sponsors must understand not only what changes are effective immediately, but must also begin consideration now of changes that will not take place for several years.

Our approach during this time of rapid changes and issuance of agency regulations is to continue to keep an eye on reform progress while we help our clients identify and develop responses that make the most sense for their plans. We believe it is important to view the new laws as a series of changes that require not only an initial response, but ongoing review, reassessment and program changes as the new provisions become effective. Our objective will be to help the Fund focus on practical modifications to your programs to meet the immediate legal changes and to begin the process for future changes.

Questionnaire

1. What is the location of the office that would service the Fund? Please describe the staffing, facilities, and equipment available at that office, as well as the primary contact should your proposal be accepted.

Your Fund would be serviced from our Hartford and Chicago offices. These services would be provided by consultants Mr. Josh Timm and Mr. Mitch Bramstaedt.

Segal Consulting:

Mr. Josh Timm
30 Waterside Drive, Suite 300
Farmington, CT 06032-3069
860.678.3040
860.371.3429 (fax)

Mr. Mitch Bramstaedt
101 North Wacker Drive, Suite 500
Chicago, Illinois 60606
312.984.8500
312.896.9364 (fax)

Staffing

The multiemployer sector represents two-thirds of our total annual revenue. Of our Company's 944 employees, approximately 700 are involved in client-related services, and of those with client contact, about 350 spend more than 80% of their time consulting on multiemployer issues. 19 of our 22 offices that are located throughout the United States and Canada service multiemployer clients. Segal's system of Industry Group leaders ensures that each of the industries we serve has dedicated specialists constantly monitoring and anticipating their unique needs and challenges.

As a matter of policy and practice, we are committed to remaining independent of insurance companies, healthcare organizations (HMOs, PPOs, etc.), accounting firms and brokerage firms specifically to avoid any possible conflicts of interest. Our energy and creativity on ways to serve our clients better by providing the services that meet the highest standards of performance.

There are a number of individuals on our staff who have over 30 years' experience working with multiemployer plans. Among our actuaries, 108 are enrolled and 56 are FSAs. Many of the compliance consultants have law degrees (although Segal as a company does not practice law).

Segal's Hartford office has 24 employees and the Chicago office employs 136. Nationally, the breakdown is:

691	Consulting professionals, including: benefits consultants, actuaries, health benefits and pension analysts, administrative experts, claims auditors, communication consultants, investment solutions experts (through Segal Rogerscasey) and fiduciary liability experts (through Segal Select Insurance Services)
154	Other professional staff, including: human resources, information technology, public affairs, marketing staff, finance and legal
99	Clerical and support staff
944	Total among all offices

Mitch and Josh will be the day-to-day points of contact for the Fund. In addition, you will have direct access to all team members whenever necessary. The majority of your core team members are located in our Chicago office. However, at times we may draw on resources from other offices in order to bring the right expertise to a particular situation. Every member of your team is committed to be available in person, via phone or email as often as you deem necessary. As part of Segal's commitment to providing the greatest level of value to our clients, we endeavor to staff projects with people of different levels of skill and experience as appropriate for the tasks. We staff project teams so that our clients benefit the most from our matrix structure. We value direct client collaboration and consequently permit great accessibility to our national practice leaders to personally consult with clients and to review special situations that may arise.

Actuarial Software

Actuarial processing occurs on personal computers utilizing the most current Windows operating system on workstations connected to Windows servers located on the local area network (LAN) in the local office where actuarial work is performed. Each local office LAN is connected via a frame relay network to form The Segal Company's wide area network (WAN). Company standard software is used in every actuarial office, which facilitates inter-office client-load balancing to meet client deadlines. The Segal Company has designed and programmed its own software for all actuarial functions for many years.

The Actuarial Technology and Systems department is comprised of a group of dedicated systems developers responsible for providing and supporting the Segal Company's actuarial valuation system. The state-of-the-art actuarial valuation system has been designed internally to maintain control and flexibility to allow for modifications to best meet the unique needs of our clients.

Segal uses a DMZ as an additional layer of security to isolate Internet facing servers, in addition to appliance based CheckPoint firewalls at the network level. Windows firewall is utilized at the desktop level. Microsoft SQL Server is the company standard database for enterprise database applications. Database servers are located in the regional datacenters which are environmentally controlled and protected by card key systems which restrict access to IT and facilities personnel only. Database servers are configured in server clusters using Microsoft SQL Server. Server operating system and SQL server software are patched in accordance with Microsoft security updates after operational testing is performed.

All servers are protected with McAfee antivirus software. Access control is based Microsoft Active Directory authentication and access to specific databases is role based.

All file servers are backed up nightly. Full backups are done weekly and incrementally changed files are backed up on a daily basis. Backup tapes are stored offsite, utilizing a nationally available data archive vendor throughout the country. Backup tapes are retained following the appropriate professional standards or government regulations.

We utilize industry standard technology solutions and best practices to maintain a secure environment for the storage and transmission of ePHI, SSNs and other confidential data and information. Electronic documents, messages, and data files can be transmitted securely through using several methods. All ePHI and SSNs sent via e-mail to outside parties must be encrypted prior to transmission. Alternatively, ePHI and SSNs can be transmitted using an alternative

secured email solution (Segal Secure File Transfer), a secured Website (which we can set up for mutual exclusive access), external alternative encryption solution (e.g., public key encryption from pgp) or overnight mail (with overnight tracking service required).

2. Please outline your firm's experience in providing consulting services to group health plans, particularly multiemployer group health plans, of a similar size to the Fund.

As the only major consulting firm whose core business is dedicated to collectively bargained multiemployer plans, Segal is uniquely qualified to help multiemployer health and welfare funds find the right solutions to the issues arising from today's challenging health care environment. We have pioneered many innovations in health benefit design, purchasing, cost management and communications. Our focus has always been on carefully crafted strategies that make business, philosophical and practical sense to trustees.

Our consulting team includes experienced actuaries, insurance experts, claims auditors, managed care experts, and client managers who are dedicated to helping multiemployer health funds address their unique health and welfare benefits challenges.

Following are four client examples that show that your proposed team has completed similar proposals for similar clients in the past:

UFCW Local 919 Health and Welfare Fund

Background: Members of the FELRA proposed team, specifically, Josh as the Client Relationship Manager, work with UFCW Local 919. This Plan is represented by Union leaders and senior management from Stop and Shop. The Fund covers over 7,000 members providing medical, prescription drugs, dental, vision, life insurance, disability benefits as well as a defined benefit pension plan through the companion Pension Fund. The Fund has both a Fund Office that handles eligibility, customer service and vendor management and a third-party administrator for claims adjudication and claim payments. Segal works with a variety of vendors on this case including Express Scripts, Aetna, EyeMed and others.

Segal Services: Segal assists the Board of Trustees in a wide variety of areas including plan designs, cost containment, benefit modernization, collective bargaining assistance, PBM bid evaluation, fiduciary liability coverage, medical carrier bid evaluation, compliance assistance (SBCs), and budget projections as well as various other services. Of particular note was the work in evaluating proposals for medical carriers. The result of the RFP and the subsequent finalist presentations was that the Fund moved PPO providers. This decision saved the Fund $5,000,000 per year while providing no member disruption and saving the members almost $1,000,000 in out-of-pocket costs.

Heartland Health and Wellness Fund

Background: Many members of the Fund's proposed service delivery team also work with the Heartland Health and Wellness Fund, formerly known as the UFCW Southwest Ohio. The health plan is managed by a Board of Trustees, which is comprised of union leaders and senior management from Kroger and CVS/Caremark. The health plan programs are self-funded, covering approximately 15,000 employee and retiree participants plus their dependents.

The Fund Office Staff provides customer services, claims adjudication, eligibility management and vendor management. Recently, the Fund hired a nurse to run the wellness program.

Segal Services: Segal assisted the Board of Trustees to address cost containment objectives through rigorous budgeting processes, collective bargaining consultation, and a recent PPO bid evaluation. A result of the PPO bid was the decision to remain with the current vendor, implementing more advantageous performance guarantees and multiple-year fee arrangements that will benefit the Plan and the covered participants on a long-term basis.

The Fund has an ongoing process for evaluating and growing its wellness program. Segal has assisted the Trustees in developing program objectives and associated programs. Quarterly, we prepare a wellness dashboard that evaluates the program's costs and achievements.

Segal prepares a quarterly report that evaluates the Fund's reserve position and claims experience. We value the Fund's retiree health valuation and IBNR liability annually for the auditor.

Rocky Mountain UFCW Unions and Employers Health Benefit Plan

Background: Many members of the Fund's proposed service delivery team also work with the Rocky Mountain UFCW Unions and Employers Health Benefit Plan. The health plan is managed by a Board of Trustees, which is comprised of union leaders and senior management from Kroger, Safeway and Albertsons. The health plan programs are self-funded, covering approximately 13,500 active employee and retiree participants plus their dependents.

Zenith Administrators provides fund office support and CIGNA provides the healthcare plan and care.

Segal Services: Segal assisted the Board of Trustees in reducing plan costs. By changing the plan design, contributions were also increased. These changes were facilitated through a budgeting processes, collective bargaining consultation, and increased utilization of CIGNA programs.

UFCW Local 1500

Background: The health and welfare fund is managed by a Board of Trustees, which is comprised of union leaders and senior management from Stop & Shop, King Kullen, Pathmark and Fairway Markets. The health plan programs are both self-funded and fully insured covering approximately 18,000 employee participants and their dependents providing medical, prescription drug, dental, vision, life, AD&D, and disability benefits. Segal partners with Associated Administrators, LLC, as well as works with Blue Cross Blue Shield, MagnaCare and Express Scripts.

Segal Services: Segal assisted the Board of Trustees in addressing cost containment objectives through plan design options, collective bargaining consultation, and a recent PBM bid evaluation. The plan design process included reviewing the current status of the plan, benchmarking the plan compared to their peers and offering alternative plan options to consider. The result of the PBM bid was the decision to move to a new prescription benefit manager. The resulting savings was significant and the member disruption was minimal allowing the Fund to achieve savings without member impact.

Proposed Team

Consulting Strategy Team		
Josh Timm 860.678.3040 jtimm@segalco.com	Vice President	Mr. Timm will lead this engagement and be responsible for day-to-day support. He will be responsible for assuring that the fund's goals are met.
Mitch Bramstaedt 312.984.8652 mbramstaedt@segalco.com	Vice President	Mr. Bramstaedt will support Mr. Timm in addressing day-to-day issues for the Fund.
Actuarial Support		
Chris Heppner, ASA, MAAA 312.984.8677 cheppner@segalco.com	Senior Vice President, Health Actuary, Health Practice Leader	Mr. Heppner will be responsible for preparing budgets, contribution rates and COBRA rates. He and his staff will provide actuarial support as required by the Fund.
John Priester 312.984.7921 jpriester@segalco.com	Senior Health Benefits Analyst	Mr. Priester will support Mr. Heppner in preparing budgets, contribution rates and COBRA rates.
Compliance		
Kathy Bakich, JD 202.833.6494 kbakich@segalco.com	Senior Vice President and National Health Compliance Practice Leader	Ms. Bakich will be responsible to address compliance issues, as needed.
Communications		
Joshua Meyer 212.251.5400 jmeyer@segalco.com	Senior Communication Consultant	Mr. Meyer will be available to coordinate communications needs.

3. Please provide three references from other multi-employer group health plans.

United Food and Commercial Workers Union Local 919 H&W Fund

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President
UFCW Union Local 919
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Joel A. Boone
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United Food and Commercial Workers Local 1500 Welfare Fund

Bruce W. Both
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Heartland Health Fund

Lenny Wyatt
International Union Vice President
UFCW Union Local #75
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lennie.wyatt@ufcw75.org

Henry Taylor
Director, Health Care Labor Strategy
The Kroger Co.
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henry.taylor@kroger.com

4. Please furnish a copy of a standard consulting services agreement. Please outline any limit of liability such agreement would contain.

We have included a copy of our Sample Retainer Agreement and Sample Business Associates Agreement in the *Appendix* of this proposal.

Segal does not require limitation of liability in our multiemployer retainer agreements

5. Please advise whether your firm will receive fees or other consideration, direct or indirect, from any party other than the Fund for, or in connection with, the provision of your services to the Fund, and if applicable, describe such fees.

Segal provides life and health benefits consulting services on behalf of our group clients to assist them with the design, management and service of employee benefit programs. Our basic services include:

- Innovative Plan Design Strategy and Analysis
- Budgeting/Financials
- Cost Modeling
- Wellness/Individual Health Management
- Total Health Management
- Health Plan Compliance
- Network Analysis
- Prescription Drug Benefits
- Funding Arrangements
- Employee Contribution

While the above-mentioned services will typically be charged on a fee-for-service basis*, since the second quarter of 2014, Segal's policy has been revised to reflect the following four areas that may result in additional compensation, in the form of commissions:

1. The placement of Life, Accident and Health benefits for which we accept commissions, where insurers will not remove them from premiums or where required by public procurement rules

2. The placement of medical stop-loss coverage for which we provide the option to conduct competitive bids and services on a commission basis

3. Revenue sharing fees for project management services related to Segal's arrangement with third party technical sub-contractors

4. Voluntary Benefits design and placement

* Presently, fee for service business accounts for over 96% of total Segal revenue.

How We Are Paid

The Segal Health Practice's primary method of compensation for our services, including the placement of insurance coverage, is on a fee-for-service basis. Where we take standard commissions, we must have a written agreement setting forth the compensation arrangement. In addition, our policy is to fully disclose to our clients the amount and basis for the standard commissions. Finally, we will not return ("rebate") any commissions, excess or otherwise, to any client.

Commission or Fee Income

Commissions are paid on a formula that is set by each insurance company and filed with the state insurance regulators. Generally, commissions are set as a percent of the premiums paid for the insurance policy. In some cases, commissions set by insurers are a fixed, per member per month amount. The range of commissions can vary based upon a number of factors, such as the type of insurance, number and type of product lines sold, and volume. Commissions paid by insurance carriers to Segal are pre-set, meaning they will not be increased because of binding coverage with a particular insurer. In addition, the pre-set commissions are not dependent upon a minimum volume of business or profitability of the business placed.

In addition to standard commissions, we may accept life and health insurance carrier supplemental payments. Segal will accept supplemental payments to be used to finance national investment in research, technology, databases and client education, in order to improve client support services.

We disclose to each client, in writing, the amount of standard commissions we received during the prior year for that client. Because supplemental payments are derived from book of business results and not from individual client premiums, Segal is not able to report case specific accounting of supplemental payments back to any client.

Indirect Compensation

It is important to note that what we report to clients is the sum total of compensation that the Segal receives from a carrier based on individual client premiums. Although, as noted above, we will accept supplemental payments, we:

- **DO NOT** accept compensation or reimbursement from any carrier for any marketing expenses.

- **DO NOT** accept free entertainment, such as golf or sports tickets, or expenses associated with a carrier-sponsored conference. Segal Health Practice's staff may periodically participate in a carrier sponsored educational seminars, industry events and/or underwriting meetings, but will generally reimburse the carrier for expenses that exceed a specific de minimis dollar threshold.

No Influence on Decision Making

The approach our staff takes in analyzing insurance proposals and making recommendations regarding types and levels of coverage is objective and is free from any influence by commissions or supplemental payments. Objective analysis and neutrality are core values of Segal, and the insurance industry recognizes it. We base our recommendations solely on client requirements and objectives.

Related Party Transactions

Segal does not directly or indirectly own any insurance carrier used to provide insurance coverage to any Segal Health Practice client. Neither the Segal Health Practice nor Segal operates as a managing general agency, managing general underwriter, or wholesaler.

6. Do you contemplate subcontracting any portion of the work? If so, please describe.

Segal will not subcontract any work for the engagement proposed herein.

7. Please provide an estimated installation/startup timeline for the Fund.

Communication and collaboration on projects, strategic initiatives and day-to-day work will play a crucial role in the long-term success of the benefits program and partnership between the Fund and Segal. To support the growth of a successful partnership, Segal will work with the Fund's staff to understanding their objectives, challenges, and experiences. We will initially request historical data and reports. We will also ask to be included in vendor meetings in order to meet the group representative and to fully understand the current arrangements and programs.

Kick-Off Meeting

It is standard practice for our benefit consultants to begin any significant benefits initiative with a "strategy session" in which priorities, goals, philosophy, history, culture, timing, and dos/don'ts are discussed thoroughly and mutually agreed upon. The outcome of this session is a summary of the principles for the project that will serve as a benchmark against which ideas will be tested or measured. Difficulties or challenges that arise during the process of fleshing out project details often can be resolved by "testing" them against the principles established at the beginning of the process. At the same time, we want to ensure that everything that is done in this initial phase is in concert with long-term objectives that will incorporate other dimensions of the Fund's ultimate goals of maintaining a predictable healthcare budget, protecting a meaningful benefit plan, and providing incentives to participants to partner with the Fund to manage healthcare costs effectively by making wise choices.

Immediately upon being chosen for this engagement, we will establish a meeting with the Fund Office staff and/or assigned committee to initiate the relationship and to clarify the scope of the consulting engagement. At the kick-off meeting, we will:

1. Confirm the goals and objectives of the consulting engagement;
2. Present a preliminary consulting plan based on our understanding of the engagement, and discuss the plan, project scope and timelines in detail;
3. Establish parameters for keeping the Fund updated, adjusting the consulting plan to fit the specific needs that have been identified; and
4. Identify data needed for the overall engagement.

8. Please provide a summary of any litigation involving your firm within the last five years. Please describe any governmental investigations involving your firm within the last five years.

With over 2,500 clients firm wide (including public sector and corporate), the Segal Group is occasionally named as a party in litigation involving the performance of its services. Past litigation did not affect Segal's ability to perform services for its clients nor did any litigation have a material effect on its financial position.

9. Please provide the name of your errors and omissions carrier and describe the applicable policy limits and sublimits.

The Segal Group maintains Errors and Omissions Insurance through Indian Harbor Insurance Company, an XL Insurance Company, in the amount of $12,500,000.

10. Please provide your annual retainer for 2014 and 2015, as well as hourly rates for any additional services not covered in your standard agreement or otherwise described above. Please provide one version of your annual retainer that includes all of the standard services described above a second version that includes all of the above standard services except those described in paragraphs 2 and 3, and a third version that includes all of the above standard services except those described in paragraph 7.

We have included our Sample Retainer Agreement in the *Appendix* of this proposal.

Standard Services

Version I

To provide the services listed in the RFP as "Standard Services," we propose an annual retainer of $92,000 for 2014 and 2015. We would include an SOP 92-6 valuation every other year with a roll forward of the liabilities to determine the required disclosure information done in the off-year. Your current actuary prepares an annual retiree report separate from the SOP. We could produce a similar report which would be outside the proposed annual retainer and we would discuss that project if the Trustees so desired.

Our experience and expertise make us the preeminent multiemployer consulting firm. Further, we work hard to be efficient and use those efficiencies to offer the best fee for each client. When selecting a consulting firm, we hope that fees never keep us from being hired. If you find that our fee is not in the range of your budget, please reach out to us. It may be that we proposed more services than are necessary in an effort to address your longer-term needs, or that there is a misinterpretation regarding possible add-on costs. Whatever the case may be, we are happy to discuss pricing with you. We want to partner with you and establish a lasting relationship of value and trust.

We will include travel costs in our annual retainer and will not bill separately for travel time associated with attending the Trustees meeting held in the mid-Atlantic.

Version II

To provide the services listed in the RFP as "Standard Services," EXCEPT those listed in paragraphs 2 and 3, we propose an annual retainer of $76,000 for 2014 and 2015.

Version III

To provide all the services listed in the RFP as "Standard Services," EXCEPT those listed in paragraph 7 (the SOP 92-6 valuation), we propose an annual retainer of $81,000 for 2014 and 2015.

Additional Services (upon request)

Our fees will be based on our standard hourly time charge rates, which are shown below. An estimate of fees can be provided for Trustee approval prior to beginning a project. In order to be most cost effective, work is performed at the lowest appropriate level and reviewed by more senior members of the team.

2014 HOURLY RATES FOR VARIOUS LEVELS OF STAFF

Job Title	Hourly Rates*
Senior Vice President/Senior Benefits Consultant	$400 to $450
Vice President/Benefits Consultant	$325 to $410
Compliance Manager	$400 to $450
Compliance Analyst	$235 to $380
Health Actuary	$260 to $370
Health Analyst	$205 to $280
Associate Health Analyst	$125 to $235

*Typically, our hourly rates increase by 3% per year.

Generally, our fees for these services will be based on our regular time charge rates, which range from $125 to $510 per hour, but generally average $245 to $305 per hour for most services, depending on the nature of the work.

Additional expenses which may be incurred for special project work will be included in the fee estimate. Services provided by outside vendors (for example, design services for communication pieces) will, to the extent practicable, be billed directly to the Plan by the vendor.

Our fees are all inclusive and there are no additional administration, start-up, or implementation fees associated with the engagement. We do not bill separately for services performed by our clerical staff, duplicating, telephone calls, computer time, postage, etc. In situations where additional projects can have a project scope outlined in advance, we will devise an agreed-upon fee quote prior to beginning work. We will not assess an extra technology charge.

Summary of Proposed Services

Basic Annual Services

Segal is experienced in performing all of the services that are required by the Trustees as outlined below.

1. Prepare annual reports analyzing Fund claims experience, benefits paid, contributions, administrative expenses and other relevant items.

2. Prepare annual forecasts, reflecting the Fund's current funding level and forecasts of projected future contribution levels.

3. Calculate maintenance of benefit contribution rates annually. Review sufficiency of fixed rate contributions based on applicable bargaining agreements. Calculate COBRA premiums rates.

4. Perform actuarial costing and prepare recommendations with respect to plan design changes. It is anticipated that such cost estimates would be narrow in focus, as opposed to major plan changes.

5. Negotiate with insurance providers and health benefit vendors (other than PBM vendors) and assist in the selection of new Fund vendors or renewal of agreements with existing vendors (other than PBM vendors).

6. Assist in developing benchmarks and monitoring Fund vendor performance.

7. Provide calculation of SOP 92-6 related liability.

8. Determine Medicare Part D creditable coverage status and draft the required annual notice to the Fund's participants.

9. Review and coordinate compliance with the Fund's reporting obligations under the Affordable Care Act and other applicable laws.

10. Assist in the drafting of forms, participant notices, plan amendments, and summaries of material modifications, as required.

11. Advise and report on financial impact of statutory and regulatory developments affecting the Fund.

12. Meetings:

    - Attend four meetings of the Board of Trustees per year.
    - Be available by telephone for Board meetings, if necessary.

Supplementary Services

We are prepared and qualified to provide a wide variety of other services to the Fund on a Supplementary Service fee basis. Following is an illustrative list of supplementary services that the Trustees may wish to consider but are not usually required on an annual basis and would not be part of our Basic Annual Services. It is our practice to provide a fee estimate to the Board of Trustees for approval before commencing any supplementary work, based upon the scope of the project desired by the Trustees. Our estimated hourly rates should we be retained on a time-charge basis are listed in the previous section.

1. Prepare and circulate RFPs for vendors such as PPO and other providers.
2. Prepare cost estimates of major plan changes, benefit redesign or cost restructuring studies.
3. Prepare proposals for benefit plan alterations.
4. Analyze compliance with legislation or new regulations that affect the Fund.
5. Assist in the review of plan documents or amendments.
6. Assist in the drafting of revised summary plan description booklets.
7. Develop new procedures or actuarial calculations required by changes in accounting or auditing standards, usually as a result of guidelines issued by the Financial Accounting Standards Board.
8. Participation in litigation, lawsuits or arbitration involving the Fund.
9. Consultation and preparation of special reports and assistance in decisions with respect to mergers, spin-offs or acquisitions.
10. Redesign of basic Fund office administrative, recordkeeping and computer systems.
11. Services involving special claims audits.
12. Assisting fund counsel in the preparation of materials in support of special IRS or DOL ruling applications, reviews or appeals, including meetings with IRS or DOL staff.
13. Preparing an analysis of the impact of adding new employer groups.
14. Auditing the basic data and recordkeeping of the Fund.
15. Surveys of benefit practices within the geographical area or industry undertaken at the specific request of the Fund.
16. Non-routine work needed to analyze funding methods, funding vehicles, cost and financing of retiree health coverage, and cost management techniques and alternatives.
17. Other services requested but not specifically outlined in this document.

Appendix

Sample Retainer Agreement

This is a sample agreement for illustrative purposes only.
ANNUAL RETAINER – MULTIEMPLOYER HEALTH AND WELFARE FUND
DRAFT

[Insert date]

[Insert name of client]
[Insert address]
[Insert address]

Re: 2014 Consulting Services Agreement – Health and Welfare Trust Fund

Dear Trustees:

This Consulting Services Agreement ("Agreement") describes the consulting services that we will provide on a regular basis and the fees we will charge for these services. It also outlines how we will be compensated for additional work the Trustees may ask us to undertake.

In this Agreement, the services Segal will provide are presented in three separate sections: PART A General Consulting Services; PART B Health Benefit Analytical Services; and PART C Compliance Services. The Agreement describes the Basic Annual Services covered by the fee arrangement and outlines the kinds of additional services that are not routinely required for standard, on-going maintenance and operation of the Fund, but that may be provided as Supplemental or Specialized Consulting Services on a time charge basis or on the basis of a supplemental fee.

In this Agreement, our proposed compensation is presented in PART D Compensation for Services.

This Agreement is subject to the terms specified in PART E Miscellaneous.

It is difficult to predict whether the Fund will encounter complex or special problems, or the extent to which our assistance will be needed in areas beyond the scope of our Basic Annual Services. Supplemental and Specialized Consulting Services include any other service not specifically described or contemplated as a Basic Annual Service, as well as any new or special work required after the effective date of this Agreement and any work associated with changes in legislation or regulation. Because such Supplemental and Specialized Consulting Services require expenditures of time and expense not anticipated as a Basic Annual Service, we will advise you when possible of the work involved and provide a fee estimate, upon request. Supplemental and Specialized Consulting Services shall be subject to all of the terms and conditions set forth herein.

Segal is being engaged solely to provide the actuarial and consulting services described in this Agreement. We do not provide legal or accounting services, nor do we provide investment consulting or management services, tax advice or act as a plan fiduciary. Any information, suggestions or materials that we provide regarding statutes, regulations or other legal matters do not constitute legal advice and are subject to the review and advice of Fund legal counsel. And, while we will work closely with the Fund staff and your other professionals and outside service providers, Segal is not responsible for services, information or materials provided to the Fund by individuals or organizations other than Segal, even if they relate to services that we are providing under this Agreement.

To enable Segal to perform the Basic Annual Services and any Supplemental or Specialized Consulting Services, the Fund and its administrator, trustees, employees and agents agree to promptly provide Segal with such direction, materials, information and access to its representatives as Segal reasonably requests and all data needed to perform these services. Segal may rely upon such data and other information provided to it by such parties as being accurate and complete. For example, Segal may rely upon any information supplied by the Fund and its agents and employees regarding the administration of the Fund, including without limitation information concerning the interpretation of the Fund's plan documents or matters involving the exercise of discretion by the Fund's trustees or administrator. Segal is not required to verify or audit any data or other information so provided, nor is it liable to the Fund or others if such information is inaccurate, misleading or false.

[Language to be used with new clients where appropriate: The Fund and Segal agree that Segal shall not have any responsibility whatsoever for the condition of the Fund prior to Segal's engagement or the consequences of that condition after Segal's engagement.]

[Language to be used where we are not retained to do financial projections or an FEBP: As Segal has not been retained to provide the Fund with periodic financial projections or a Financial Experience and Budget Projections report, Segal shall not have any responsibility for the emerging position of the Fund.]

PART A. General Consulting Services

1. Consultation

Basic Annual Services. We will be available for general consultation on Fund operations in such areas as plan design, funding, provider performance, administration, compliance and communications. We will report on the plan's overall progress and development and respond to routine questions and issues regarding the benefit program.

Supplemental Services. Examples include:

- Analysis of possible changes in funding methods; for example, an evaluation of whether the Fund should consider insurance versus self-insurance,
- Special studies on plan redesign and the resulting cost implications;
- Consultation on the design and implementation of a flexible benefit plan; and
- Consultation on cost containment and managed-care, including selection or development of provider networks.

Negotiations

Basic Annual Services. In the context of a routine renewal, we will negotiate with insurance companies, managed-care organizations, and other third party providers on their renewal rates and charges. This will include reviewing year end settlements. We will assist and respond to routine dispute resolution with a vendor over claims administration. To the extent that the dispute is not routine, it will be considered a Supplemental Service.

Supplemental Services. Examples include:

- Preparation and solicitation of competitive bids from insurance companies, managed-care organizations or other types of service providers and the related analyses.
- Initial contract negotiations with a new service provider or where there is a significantly revised relationship with an existing service provider.

3. **Meetings.**

Basic Annual Services. We will attend up to [Fill in the number] meetings per year, including meetings of the Board of Trustees, Trustees committee meetings and meetings with the professional advisors of the Fund, as part of our Basic Annual Services. If we are requested to attend more than [Fill in the number] meetings in a year, we will do so for an additional fee based on our time and travel and other expenses. We will bill for our time and travel and other expenses for meetings outside of the local area.

4. **Minutes.**

Basic Annual Services. We will review minutes prepared by the administrator or legal counsel based on our notes and understanding of the events at the meetings.

Or

[Alternate Language: We will prepare draft minutes based on our notes and understanding of the events at the meetings, for review by the Trustees, Fund Legal Counsel and any other professional advisors the Trustees designate.]

5. **Trends in Legislation, Benefits, and Plan Design.**

Basic Annual Services. By means of our publications and special advisory reports, we will continue to keep you apprised of new developments in the employee health benefits field and within the universe of multiemployer plans. Questions regarding the interpretation and application of laws, regulations, rulings and court decisions are legal matters, subject to Fund legal counsel's advice; however, we will assist Fund legal counsel upon request. Depending on the specific nature of the issues raised and the time required to respond, such assistance may be treated and billed as a Supplemental Service.

Supplemental Services. Examples include:

- Individualized analysis and specific guidance and recommendations on compliance and implementation issues, and
- Surveys of benefit practices within a geographical area or industry.
- Plan design, communications, actuarial valuations, financial modeling related to legislative and regulatory activities.

6. **Specialized Consulting and other Supplemental Services**

Examples of Specialized Consulting that we provide as a Supplemental Service include:

Mergers, Spin-offs and Plan Terminations — Consultation and preparation of special reports in connection with such developments.

Compliance — Any compliance and operational review of the plan.

Communications — Specialized participant communications, including strategic communications planning, concept development, writing, benefit statements, media selection (including Internet usage and Website development) and production oversight for graphic design, print and other media.

Administration and Technology Consulting Services – Technology consulting on the design and implementation of in-house systems and the evaluation of third party vendors, operational reviews and assistance with recruitment.

Fiduciary Liability Insurance, Fidelity Bonds and other Insurance Services – We will coordinate and provide the brokerage resources to market to insurers and service initial and renewal insurance coverages, including fidelity bond coverage and/or fiduciary liability insurance coverage for the Fund. These supplemental insurance coverage services will include the submission of completed applications to insurers, receiving and negotiating coverage terms and conditions, and reporting to the Fund the results of our marketing efforts inclusive of our recommendations, as appropriate. Our report, which is prepared by our licensed, professional staff, will include a policy explanation and other informational material to assist the Trustees in evaluating the cost and scope of coverage being offered. Normal maintenance, for example participating in a Trustee meeting via conference call, filing claims, answering coverage questions and amending coverage, as appropriate, will be provided. Informational material will be periodically supplied to keep Trustees informed. This is a supplemental service and our compensation will come from the commissions paid by the insurer to us, which commissions will be fully earned upon binding of coverage with an insurer. Our commissions will be disclosed annually in writing.

These supplemental insurance coverage services do not include specialized research, such as new or unique insurance coverages, policy reviews of insurance contracts for which we are not broker, and claims advocacy work, other than the initial filing of a claim notice, routine questions and the follow-up for the carrier's claim response or reservation of rights letter.

Legal Proceedings – For assistance or participation in actual or anticipated disputes, investigations, arbitrations, litigation or other dispute resolution proceedings (collectively, "Legal Proceedings"), we will be compensated on a time charge basis. Examples of this type of Supplemental Service include (but are not limited to) time spent (whether at the request of the Fund or pursuant to a subpoena), (i) assisting Fund legal counsel in the analysis and development of the Fund's legal position, (ii) preparing for or testifying at depositions or in connection with Legal Proceedings and (iii) responding to requests for documents and information in connection with disputes and investigations to which the Fund is a party. In addition, the Fund will pay all costs and fees, including attorney's fees that Segal incurs in connection with Segal's requested or compelled participation in Legal Proceedings on behalf of the Fund.

PART B. Health Benefit Analytical Services.

Regular Annual Reporting. We will prepare, each year, [a report] [reports] of regular and routine information about the Fund for the Trustees. These reports will include budget projections for upcoming years and will contain basic information on the Fund's financial position. These reports will review contributions, other income, expenses and the Fund's reserve position. We will provide information and data on claims experience and other benefit-related expenditures and will review insurance carrier and other provider renewal proposals. For insured benefits, we will also report on insurance carrier experience accountings and policy settlement analyses.

Supplemental Services. Examples include:

- Revised budget projections for evaluating major changes in the plan of benefits or eligibility rules;
- Detailed examination of claims experience for particular benefits
- Special studies of managed-care plans relating to reimbursement methodologies, network adequacy, cost management techniques or quality issues using our Q-Val service.
- Consultation regarding service provider profile and performance, predictive modeling, disease management, and integrated medical management
- Detailed comprehensive reserve analysis

Self-Insured Benefits.

Basic Annual Services. If the Fund provides some or all of its benefits through self-funding, we will calculate the appropriate costs, reserves and claims trend factors that should be taken into account for sound plan financing and policy determinations.

Supplemental Services. Example includes:

Calculations related to the initial establishment of new self-insured benefits.

3. **Data Request and Review.**

Basic Annual Services. The review of contribution and reserve requirements, experience/rate setting and other analyses described above will require extensive data. We will prepare a detailed data request outlining what is necessary to perform these services. We will also request the financial data required from the Fund's auditor and any other data or information required to complete our analysis, including where we do not prepare plan amendments, copies of the up-to-date plan and plan amendments.

Data will be requested in a computer format compatible with our computer system and Year 2000 compliant (that is, appears in four-digit year representation, for example 2006, instead of '06).

Upon receipt of these data, we will examine them to determine whether, based solely on a review of the data, there appears to be missing information or internal consistency. When the data reconciliation exceeds a reasonable and customary allotment of time, there will be additional fees based on hourly time charge rates. These fees may include work necessary to obtain additional information, to convert data not presented in the format requested and for the additional processing time required to reconcile data that contains errors, duplicate records or missing information.

4. **COBRA.**

Basic Annual Services. We will calculate the premiums for COBRA coverage charged to former participants and family members who elect to continue the Fund's benefits. We will provide technical expertise on general COBRA administration questions, but we will not administer COBRA.

Supplemental Services. Examples include:

- Preparation of revisions to COBRA Notices and forms, including updates.
- Preparation of COBRA manuals.
- Review of COBRA procedures and report regarding the operational issues with COBRA administration.

Annual Audits and Government Filings.

Basic Annual Services. We will supply the auditor and the Fund administrator with information that is reasonably available to us for the IRS Annual Return/Report (Form 5500). We will not prepare the 5500 as a basic service, but will review the portions of the form as prepared by the auditor that relate to the matters for which we provide consulting services. We have no responsibility for certifying or validating any numbers, costs or figures prepared by the Fund's auditor or administrator.

Supplemental Services. Examples include:

- Procedures, calculations and determinations required for compliance with accounting and auditing standards.
- Preparation of Form 5500.

Customized Audits

Supplemental Services. Examples include

- Claims Audits – Auditing the accuracy and quality of insurance companies and other third party providers in their payment of claims.
- Evaluating and advising on whether performance and contract guarantees have been met and negotiating when appropriate, adjustments in the charges or services.
- Other audits including eligibility audits, Prescription Drug Plan Audits, etc.

Retiree Health Consulting Services.

We will consult with respect to a plan's retiree health benefits with the following supplemental services. The Client, and not Segal, is responsible for filing the Medicare Part D Retiree Drug Subsidy application in a timely manner.

Supplemental Services. Examples include:

- Depending on which version of the proposal the Trustees accept, SOP 92-6 work may be included or supplemental: Strategies for providing and financing retiree health coverage, including SOP 92-6 actuarial valuations,]
- Medicare Modernization Act consulting, Retiree Drug Subsidy actuarial analysis, attestation and administration; Medicare Advantage and Medicare Prescription Drug Plan bids and contracts. Segal acknowledges with respect to the Retiree Drug Subsidy that information it may provide to the plan will be used by the Plan sponsor for the purpose of obtaining federal funds.
- Medicare Part D creditable coverage testing and Notices of Creditable or Non-Creditable Coverage; filing Notices of Creditable Coverage with CMS.

PART C. Compliance Services

Application and Interpretations of the Plan

Basic Annual Services. We will consult on the cost, administrative and plan design aspects of the Health Plan and questions that arise during the normal course of operation and as a result of routine claims and appeals. As noted, however, interpretation of the plan is the responsibility of others to whom that role is entrusted under the plan and applicable law.

We do not advise on matters regarding medical or scientific judgment, such as questions on the efficacy of medical treatment or medical necessity. However, we will offer general

advice on where to find sources of qualified assistance on matters that require medical or other scientific expertise.

Supplemental Services. Examples include:

- Assistance in complying with regulations or other such guidance and with claims or appeals raising complex issues or requiring detailed record searches and review of historical plan provisions, and
- Assistance or participation in litigation, arbitration, investigations, administrative proceedings, or the analysis or documentation of claims.

Plan Changes.

Basic Annual Services. We will provide advice and assistance in evaluating and implementing routine plan changes authorized by the Trustees, including changes in plan cost, changes in premium rates, and changes in benefits.

Supplemental Services. Examples include:

- Plan amendments and formal Trustee resolutions may be required periodically to reflect plan interpretations, benefit changes made by the Trustees, new or newly effective tax laws, regulations, judicial precedents, or regulatory or administrative interpretations. Consulting, drafting or reviewing such amendments, restatements, resolutions or other plan documents are Supplemental Services.
- Any changes to the Plan or work performed in connection with a change in bargaining representation or the collective bargaining agreement.
- As noted, Segal does not provide legal services, and any draft plan amendment, Trustee resolution or similar documentation that we prepare will be prepared in draft form, subject to review and approval of Fund legal counsel and will not be considered final until it has received that review and approval.

Basic Communication with Participants

Basic Annual Services. We will consult with the Trustees, Fund administrator and Fund legal counsel in the preparation of notices to plan participants, including (i) identification of information that will be covered and (ii) review of information prepared by others.

Supplemental Services. Examples include:

- Drafting or coordination of production of a new or revised summary plan description,
- Preparation of notices and other explanatory material to participants for other than simple and routine matters.
- Preparation of notices required by regulation.
- Note that Segal does not provide legal services. Any legal notices or similar documentation that we prepare (or assist in preparing) shall be subject to the review and approval of Fund legal counsel and shall not be considered final until it has received that review and approval.

Fund Administration Support.

Basic Annual Services. We will consult with the Fund administrator as reasonably requested with regard to routine changes in forms and procedures and general recordkeeping questions. If such consultation exceeds a reasonable and customary allotment of time, Segal will bill for such additional time at its then current hourly time-charge rates. Compliance with the recordkeeping requirements of laws or regulations are matters subject to the advice of Fund legal counsel. We will be available to assist legal counsel and for consultation on non-legal issues.

Supplemental Services. Examples include:

- Preparation of, and Fund office training on substantially revised forms and new administrative procedures,
- Assistance with recruitment and other human resource matters,
- Assistance with qualified medical child support orders and other child and family support issues,
- Detailed review and analysis of Plan documentation and administration.

PART D. Compensation for Services

1. Basic Annual Services

Our annual fee for providing these Basic Annual Services will be $[Fill in the amount] for the year commencing _____ and $[Fill in the amount] for the year commencing _____. The annual fee shall be payable [monthly] [quarterly] [in advance] [in arrears], plus reimbursement of travel expenses for meetings held in a location other than in [Fill in the name of the City where the client is located or where regular quarterly meetings are held].

Additional fees may be assessed for premium services such as requests for expedited services.

Should any commissions, other than for the placement of fiduciary liability or fidelity bond coverage, be received for the placement of insurance directly related to this engagement, they will be used as an offset against our fees, but only to the extent permitted by law.

[Name of Client] may provide incidental meals or refreshments to Segal staff in connection with Client meetings and other Client events.

Routine expenses such as photocopying, telephone calls, facsimiles, mailing costs, and secretarial and word-processing services are included in our fees. Unusual or unexpected expenses may be billed separately following consultation with and approval of the Trustees.

In the event we are required to spend significantly more time than anticipated because of circumstances beyond our control, we will inform you and bill separately for those services.

To assure continuity of services to the Fund, this Agreement will renew automatically at the end of its term, subject to fees negotiated by the parties. It is understood that adjustments to this Agreement upon renewal may be made in any post-Agreement annual period, on a mutually

agreed upon basis, and may be reflected in resolutions or motions adopted by the Trustees or in separate correspondence, without formal amendment to this Agreement. This Agreement is subject to cancellation by either party upon 30 days advance written notice.

If this Agreement is terminated on a date other than an anniversary date, The Segal Company will be reimbursed for all time charges incurred from the beginning of the then current contract year to the date of termination, up to a maximum of the [balance of that year's annual fee] [balance of the time charge maximum for that contract year].

Segal is not responsible for work or work product developed prior to the date of Segal's retention as actuary and consultant even if such development is first brought to the attention of the Board of Trustees and Fund professionals as a result of Segal's provision of services to the Fund.

2. Supplemental and Specialized Consulting Services

Fees for Specialized Consulting Services and Supplemental Services generally will be charged on a time charge basis [plus the technology charge] or, in some instances, may be charged on a project basis. Supplemental and Specialized Consulting Service charges will be billed monthly in arrears unless agreed to otherwise.

[Include this language where the fee for SOP 92-6 is not included in a fixed fee arrangement: Our fee for the actuarial valuation of retiree health benefits for purposes of SOP 92-6 will be [based on hourly time charges [plus a 5% technology charge] with an annual cap of $_____.] [$[Fill in the amount] for the year commencing _____ and $[Fill in the amount] for the year commencing _____.]

PART E. Miscellaneous

This Agreement is binding on the parties to it as well as on the participants, beneficiaries, and fiduciaries of the Fund.

Any disputes relating directly or indirectly to this Agreement, or to Segal's services to the Fund, will be mediated under the auspices of the Judicial Arbitration and Mediation Service ("JAMS") as a condition precedent to the commencement of any legal proceeding regarding such dispute.

All persons bound by this Agreement waive any right to a trial by jury in any action, suit, or proceeding arising out of this agreement, or any other agreement or transaction between the parties.

This Agreement sets forth the entire agreement between the parties as to the subject matter hereof and merges all prior discussions between them. No party is bound by any conditions, definitions, warranties, understandings or representations with respect to such subject matter other than as expressly provided herein, or as set forth in a written amendment to this Agreement that is executed by all parties.

Very truly yours,

Segal Consulting

[Insert name of Segal Signatory]
[Title]

Agreed to on behalf of the Board of Trustees of the [Insert name of client] by:

_____	_____
Labor Trustee	Date
_____	_____
Management Trustee	Date

CONFIDENTIALITY/BUSINESS ASSOCIATE AGREEMENT FOR MULTIEMPLOYER HEALTH PLAN SPONSOR

The Segal Group, Inc., the parent of The Segal Company, for itself and on behalf of its subsidiaries and affiliates[1] (collectively "SEGAL") understands that its client plans and plan sponsors desire to protect the confidentiality of plan participants' and beneficiaries' health information and keep such information secure. The confidentiality of individually identifiable health information ("IIHI") and the security of electronic protected health information (ePHI) have long been a priority for SEGAL. The privacy regulation ("Privacy Rule") and the security regulation ("Security Rule") promulgated by the United States Department of Health and Human Services under the authority of the Health Insurance Portability and Accountability Act[2] ("HIPAA") furnishes SEGAL with an opportunity to reaffirm that commitment. This Agreement, effective on ("the Effective Date"), by and between SEGAL and the client executing below _____ ("Client")[3], is the integration of the Parties' understandings as to the confidentiality of IIHI and the security of ePHI and supersedes all prior understandings and other contractual provisions in that regard (the "Agreement").

WHEREAS Client sponsors one or more "health plans" ("the Plans") which are "Covered Entities" under the Privacy Rule and the Security Rule. These rules require covered entities and certain of their service providers to enter into confidentiality agreements.

WHEREAS SEGAL may create on behalf of, or receive from, the Plans or the Plans' other service providers IIHI deemed protected health information under the Privacy Rule (the "Protected Health Information" or "PHI").

WHEREAS SEGAL, in the course of providing services to Client, may on behalf of the Client and/or Plans create, receive, maintain, or transmit electronic Protected Health Information. "Electronic Protected Health Information" is Protected Health Information as defined in 45 C.F.R. 160.103 that is transmitted by electronic media or maintained in electronic media. The term "electronic media" shall have the meaning set out in 45 C.F.R. 160.103.

WHEREAS the Parties wish to confirm the appropriateness of Client and/or Plans' sharing of IIHI, PHI and ePHI with SEGAL related to the services SEGAL provides and which are various functions deemed to be "treatment," "payment," or "health care operations" under the HIPAA Regulations set forth at 45 CFR Parts 160 and 164.

WHEREAS the Parties now desire to comply with HIPAA, the Privacy Rule, and Security Rule, as amended by the Health Information Technology for Economic and Clinical Health Act of the American Recovery and Reinvestment Act of 2009 ("HITECH") and any rules promulgated thereunder.

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1 The obligations and privileges of Segal herein extend to all companies in The Segal Group, Inc., a Delaware corporation except Segal Advisors, Inc., a New York corporation.

2 Subtitle F, Public Law 104-191, Section 261, et seq.

3 Segal and Client are referred to collectively herein as "the Parties."

NOW, THEREFORE, in consideration of the premises and the mutual promises contained herein, Client and SEGAL hereby agree as follows:

1. **SEGAL Responsibilities with Respect to the Privacy of Protected Health Information.** To the extent that SEGAL is acting as a business associate under the HIPAA Privacy Rule, SEGAL hereby agrees, with regard to its use and/or disclosure of the PHI, to do the following:

   a. Subject to the provisions in Section 5 hereof, to use and/or disclose the PHI only: (i) in conjunction with the services it provides, or has contracted to provide, to Client ("the Services"), including but not limited to using data in bids and vendor selection processes; (ii) consistent with the manner which Client is permitted to use and disclose by 45 C.F.R. § 164.502 (as amended from time to time); (iii) for SEGAL's proper management and administration, or to fulfill any present or future legal responsibilities in accordance with 45 C.F.R. § 164.504(e)(4); (iv) to aggregate with the IIHI of other SEGAL engagements to furnish data analyses; (v) for use by SEGAL after being de-identified in accordance with the requirements of 45 C.F.R. § 164.514(b), (vi) as otherwise permitted or required by this Agreement; or (vii) as otherwise permitted or required by law;

   b. to report to Client, in writing, any material use and/or disclosure of the PHI that is not permitted or required by this Agreement of which SEGAL's Privacy Officials[1] become aware;

   c. to use commercially reasonable efforts to maintain the security of the PHI as required by the Privacy Rule and to prevent its use and/or disclosures contrary to this Agreement;

   d. to require all of SEGAL's non-affiliated subcontractors and agents utilized in providing the Services to agree, in writing, to adhere to equivalent restrictions and conditions on the use and/or disclosure of the PHI that apply to SEGAL pursuant to this Section;

   e. make available upon reasonable notice and during normal business hours, its internal practices, records, books, agreements, policies and procedures directly relating to the use and/or disclosure of the PHI to the United States Department of Health and Human Services for purposes of determining Client's compliance with the Privacy Rule subject to applicable privileges and confidentiality agreements;

   f. within thirty (30) days of receiving a written request from Client that Client has received a request by an individual for an accounting of the disclosures of the individual's PHI in accordance with 45 C.F.R. § 164.528, provide to Client a list of disclosures (if any) made: for public health purposes, regarding abuse, neglect or domestic violence; to a health oversight agency; in the course of a judicial or administrative proceeding; for law enforcement purposes; to coroners, medical examiners and funeral directors; to organ procurement organizations; for research; as required by law; to prevent a serious harm to health or safety; to military and veterans officials; or for workers' compensation purposes. In each case SEGAL shall provide at least the following information with respect to each such disclosure: (a) the date of

[1] As a Business Associate, Segal is not required to have a Privacy Official. However, we have created an Office of Privacy Officials for the purpose of implementing the Privacy Rule and for the convenience of our clients.

the disclosure; (b) the name of the entity or person who received the Protected Health Information; (c) a brief description of the Protected Health Information disclosed; (d) a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure.

g. at such time as the Parties agree that SEGAL holds a portion of Client's members' Designated Record Set not in Client's possession, it will provide such information to Client to allow Client to fulfill access requests made in compliance with 45 C.F.R. § 164.524 or, at its option, respond directly to such requests; and

h. at such time as the Parties agree that SEGAL holds, and has edit control over portions of the Designated Record Set with respect to the Plans' covered persons, to process at Client's costs, in the manner required by 45 C.F.R. § 526, requests for amendment to the Protected Health Information relevant to those persons.

2. **SEGAL Responsibilities with Respect to the Security of ePHI**. To the extent SEGAL creates, receives, maintains, or transmits the ePHI in its capacity as a Business Associate to the Plan, SEGAL hereby agrees to do the following:

a. implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI;

b. require all of its non-affiliated subcontractors and agents utilized in providing the Services to agree, in writing, to implement reasonable and appropriate safeguards for the ePHI as those that apply to SEGAL pursuant to this Section 2; and

c. report to Client, in writing, any security incident of which it becomes aware. For purposes of this Agreement, "security incident" shall mean successful unauthorized access or disclosure or modification, destruction or interference with the ePHI by a third party.

3. **Breach Notification under HITECH**. SEGAL shall notify Client as soon as practicable, but no later than 30 days after discovery, of a Breach of Unsecured PHI, as defined in the regulations promulgated under HITECH, 45 C.F.R. Part 164, subpart D. Such notice shall include all available information required by 45 C.F.R. §164.410, including the identity of each individual whose Unsecured PHI has been or is reasonably believed by SEGAL to have been accessed, acquired, used or disclosed during the Breach; a brief description of what happened, including the date of the breach and the date of discovery if known; a description of the type of Unsecured PHI involved in the Breach; the steps individuals should take to protect themselves from any potential harm resulting from the Breach; a brief description of the steps SEGAL is taking to investigate, mitigate harm, and protect against further breaches; and contact information for follow-up questions.

4. **Responsibilities of Client**. With regard to the use and/or disclosure of PHI by SEGAL, Client hereby agrees:

a. that the uses and disclosures which SEGAL shall carry out pursuant to this Agreement are consistent with the form of notice of privacy practices (the "Notice") that Client provides to individuals pursuant to 45 C.F.R. § 164.520;

b. to notify SEGAL, in writing and in a timely manner, of any arrangements permitted or required of Client under 45 C.F.R. parts 160 and 164 that may impact in any manner the use and/or disclosure of PHI by SEGAL under this Agreement including, but not limited to, restrictions on use and/or disclosure of PHI as provided for in 45 C.F.R. § 164.522 agreed to by Client, but to hold SEGAL harmless from the financial impact of any such agreement by Client;

c. to obtain any consent or authorization that may be required under the Privacy Rule or state law prior to furnishing the PHI to SEGAL;

d. to ensure that any third party contacting SEGAL on Client's behalf has entered into a business associate agreement with Client as necessary;

e. if Client is a plan sponsor, to (i) limit its requests for PHI to summary health information and use such data for the purpose of obtaining premium bids or for modifying, amending or terminating the group health plan, or to enrollment information or (ii) to use the PHI for plan administration functions following the provisions to the plan of the certification and amendment of the plan documents each as described in 45 C.F.R. 164.504(f)(2); and

f. that SEGAL does not have direct responsibility to process requests by participants or beneficiaries under 45 C.F.R. §§ 164.522, 164.524, 164.526 or 164.528 but shall at its option, refer such requests to Client for its processing with SEGAL's assistance pursuant to Sections 1(f), (g) and (h).

5. **Term and Termination**. Unless otherwise terminated as provided in Sections 6, 7 or 8 this Agreement shall become effective on the Effective Date and shall have a term that shall run concurrently with that of any oral or written agreement by SEGAL to provide services to Client and will terminate without any further action of the Parties upon the termination of all such agreements. Upon the event of termination of this Agreement, SEGAL agrees, where feasible, to return or destroy the PHI, which SEGAL still maintains in any form. Prior to doing so, SEGAL further agrees, to the extent feasible, to request the destruction of the PHI that is in the possession of its subcontractors or agents. Client understands that SEGAL's need to maintain portions of the PHI in records of actuarial determinations and for other archival purposes related to memorializing advice provided can render return or destruction infeasible. If it is not feasible for SEGAL or any of its subcontractors to return or destroy portions of the PHI, SEGAL shall inform Client as to the specific reasons that make such return or destruction infeasible, extend the protections of this Agreement to such PHI, and limit any further use or disclosures to the purposes that make the return or destruction of those portions of the PHI infeasible.

6. **Statutory or Regulatory Changes with respect to Protected Health Information**. If Client notifies SEGAL that SEGAL's responsibilities set out herein should be altered as a result of any changes in HIPAA, the Privacy Rule, the Security Rule or HITECH ("Additional Responsibilities"), SEGAL shall make such changes to the Services provided that appropriate fees are agreed to by Client and SEGAL. If, in its reasonable discretion SEGAL determines that the proposed, Additional Responsibilities have a material adverse financial effect on SEGAL's interest in this Agreement, and SEGAL and Client cannot come to agreement on fees and implementation schedules for the Additional Responsibilities, then SEGAL or Client may terminate the Agreement upon thirty (30) days prior written notice to the other party. Neither party shall assert any claim against the other

party for monetary damages or equitable relief or otherwise for SEGAL's failure to perform the Additional Responsibilities from the date of notice to SEGAL of the Additional Responsibilities or, if SEGAL or Client exercise a right to terminate the Agreement, through the termination date.

7. **Material Breach by SEGAL**. If Client determines that SEGAL has engaged in a pattern of activity that constitutes a material breach of SEGAL's obligations under this Agreement, Client shall, within twenty (20) days, notify SEGAL and SEGAL shall have thirty (30) days to cure the breach or end the violation. If SEGAL fails to take reasonable steps to affect such a cure within such a time period, Client may give such notice and opportunity to cure or invoke such dispute resolution as is otherwise permitted by any services agreement between Client and SEGAL. In the absence of such a procedure or in cases where such procedure has not successfully resolved the dispute relative to the pattern of activity alleged to constitute material breach, Client may terminate the relevant aspect of the services relationship, or, if not feasible to do so, may report the problem to the Secretary of Health and Human Services.

8. **Material Breach by Client**. If SEGAL determines that Client or the Plan has engaged in a pattern of activity that constitutes a material breach of Client's obligations under this Agreement, then SEGAL shall, within twenty (20) days, notify Client and Client shall have thirty (30) days to cure the breach or end the violation. If Client and/or the Plan fail to take reasonable steps to effect such a cure within such a time period, SEGAL may give such notice and opportunity to cure or invoke such dispute resolution as is otherwise required by any services agreement between Client and SEGAL or, in the absence of such a procedure, may terminate the relevant aspect of the services relationship or, if not feasible, may report the problem to the Secretary of Health and Human Services.

9. **Compliance with HITECH Act**. The Parties acknowledge that HITECH amended certain provisions of HIPAA in ways that now directly regulate, or will on future dates directly regulate, the Parties' obligations and activities under HIPAA, the Privacy Rule and the Security Rule. To the extent not referenced or incorporated herein, requirements applicable under HITECH are hereby incorporated by reference into this Agreement. The Parties agree to comply, as is necessary and appropriate, with each of the requirements imposed under HITECH, as of the applicable effective dates of each relevant HIPAA obligation.

10. **Third Party Beneficiaries**. Nothing in this Agreement shall be construed to create any third party beneficiary rights in any person, including any participant or beneficiary of the Plan.

11. **Counterparts**. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original. Facsimile copies thereof shall be deemed to be originals.

12. **Informal Resolution**. If any controversy, dispute, or claim arises between the Parties with respect to this Agreement, the Parties shall make good faith efforts to resolve such matters informally.

13. **Notices**. All notices to be given pursuant to the terms of this Agreement shall be in writing and shall be sent certified mail, return receipt requested, postage prepaid or by overnight air express mail service. If to Client, the notice shall be sent to the address set forth below Client's signature or such other address as Client notifies SEGAL of in writing. If to SEGAL, the notice shall be sent to the Privacy Official, c/o General Counsel, The Segal Company, 333 West 34th Street, New York, New York 10001, with a copy to The Segal Company, 333 West 34th Street, New York, New York 10001, ATTN President.

14. **Survival**. Section 5 shall survive the term of this Agreement.

15. **Effective Date**. The Effective Date shall be February 17, 2010, or if later, the date that SEGAL begins to perform the Services on behalf of the Client. However, to the extent that certain provisions under HITECH have effective dates that are different from February 17, 2010, those effective dates shall apply to the relevant provisions.

INTENDING TO BE LEGALLY BOUND, the Parties have duly executed this Agreement.

	The Segal Group, Inc.		**Client**
Signed	_____	Signed	_____
Print Name	_____	Print Name	_____
Title	_____	Title	_____
Date	_____	Date	_____
		Address	_____

Team Biographies

Segal Consulting

JOSHUA TIMM, CEBS
Vice President and Benefits Consultant, Hartford

Expertise

Mr. Timm is a Vice President and Benefits Consultant in Segal's Hartford office with more than a decade of experience working with multiemployer health and retirement plans. He also works with several public sector health plans. Mr. Timm has deep expertise in health plan design, budgeting, and vendor management as well as plan design and compliance with the Affordable Care Act.

Mr. Timm serves as consultant to multiple Taft-Hartley plans covering members of the United Food and Commercial Workers (UFCW) throughout New England and the Mid-Atlantic. Mr. Timm is also involved with the Pipe Trades and Ironworkers Health and Pension Funds. In addition, he provides support for numerous Taft-Hartley building trade health and welfare, pension and annuity clients throughout the Northeast.

Education/Professional Designations

Mr. Timm received a BS in Business Management from Western Oregon University. He also received a Certified Employee Benefits (CEBS) designation from the International Foundation of Employee Benefit Plans and The Wharton School of the University of Pennsylvania. Mr. Timm is a licensed insurance broker in all New England states.

Published Work/Speeches

Mr. Timm has been a participant at International Foundation of Employee Benefit Plans (IFEBP) and International Public Management Association for Human Resources (IPMA-HR) Conferences and often speaks about health care reform at regional UFCW Conferences.

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Expertise

Mr. Bramstaedt joined The Segal Company in 1992 as a Health Consultant. As Midwest Public Sector Practice Leader, he assists clients with benefits strategy and design and specializes in developing managed care carve-out programs. Mr. Bramstaedt plays an active role in developing health care cost management programs. His past responsibilities have included supervising the managed care staff of the Chicago office.

Mr. Bramstaedt has been successful in reducing client health care costs by following a process of goal setting, data evaluation, plan design modeling, vendor selection, and vendor management. He has also worked with many clients to develop effective contribution options. As a past member of Segal's National Rx Consulting group, Mr. Bramstaedt was responsible for coordinating and keeping Segal's prescription drug consulting efforts current. He was instrumental in developing innovative methods for evaluating prescription drug programs analyses that have assisted many clients in comprehensively auditing their prescription benefit managers and reducing drug spending.

Professional Background

Prior to joining Segal, Mr. Bramstaedt was the Manager of Underwriting for a Chicago-area HMO. He also served for three years as an Employee Benefits Underwriter with a consulting firm specializing in association trusts and for four years as an Underwriter with a national insurance company. Mr. Bramstaedt is a past member of URAC's Consumer-Directed Advisory Committee. This committee assists URAC with the development of accreditation standards for Consumer-Directed Health Plans.

Education/Professional Designations

Mr. Bramstaedt received a BS degree from Bradley University (Peoria, IL) and an MBA from DePaul University.

Published Works/Speeches

Mr. Bramstaedt has been quoted several times as an expert on the topic of prescription drug programs, in periodicals that include *Crain's Chicago Business*, *Employee Benefits Review*, and *Business Insurance*. He has also been a guest presenter on health benefit design and prescription drug programs at many local, regional, and national conferences.

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Expertise

Mr. Heppner is a Senior Vice President, Health Actuary and the Midwest Health Practice Leader in Segal's Chicago office with over 20 years of experience working with health plans. He provides retiree health expertise, as well as development of rating and contribution strategies, to corporate, public sector and multiemployer clients.

Mr. Heppner has been involved in a variety of projects that include flex plan pricing, PPO and prescription drug pricing, renewal negotiations, contribution strategy, plan design analysis, disability plans and valuations, Medicare Part D attestations, and reserve calculations. He also provides litigation support as a resident expert.

In a recent project, Mr. Heppner assisted clients in understanding their current cost components so that effective decisions could be made to manage those costs. He has developed interactive budget projection models to address client-specific interests, as well as engaged in successful negotiations with insurers to keep renewal increases consistently below trend. Mr. Heppner has also developed techniques to test and determine actuarial equivalents for unique plan designs.

In addition to his role as a Health Actuary for clients, Mr. Heppner develops and reviews health actuarial guidelines for the company and manages the Midwest Health Practice.

Professional Background

Prior to joining Segal, Mr. Heppner worked for a major medical insurance company conducting individual health insurance pricing and plan design analysis. He began his career at another international human resources and benefits consulting firm.

Education/Professional Designations

Mr. Heppner received a BS in Business Administration from the University of Illinois in 1991. He is an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries.

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Expertise

Mr. Priester is a Senior Health Benefits Analyst in Segal's Chicago office with over three years of experience in actuarial consulting. His responsibilities include conducting and managing the workflow of medical and prescription drug plan change analyses, claims data analysis, IBNR calculations, budget projections, fiscal year-end financial reviews and self-pay rate calculations. He is also responsible for annual renewal negotiations for stop-loss insurance, managed care organizations, dental carriers, and other health management related services.

Professional Background

Mr. Priester joined Segal in 2008 as an Actuarial Analyst in the firm's Retirement Practice. He became a Health Benefits Analyst in the firm's Health Practice in 2009.

Education/Professional Designations

Mr. Priester received a BS in Actuarial Science from the University of Illinois. He has a Certificate of Completion of the Group Insurance Course from the Health Insurance Association of America (HIAA) Insurance Education Program for Life, Accident and Health Insurance.

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Expertise

Ms. Bakich is a Senior Vice President in Segal's Washington, DC office with over 20 years of experience in health care compliance. She is the firm's National Health Compliance Practice Leader.

Ms. Bakich is one of the country's leading experts on employer sponsored health coverage. She specializes in providing research and analysis on federal laws and regulations affecting health coverage, including: ERISA, Medicare, HIPAA, COBRA, the Newborns' and Mothers' Health Protection Act, the Mental Health Parity Act, and the Women's Health and Cancer Rights Act.

Ms. Bakich is a recognized expert on the Patient Protection and Affordable Care Act passed in 2010. She speaks regularly about the law, helps plan sponsors understand its short and long term effects on their plans, and assists clients with preparing comments on the legislation for submission to regulatory Departments (Treasury, Labor, and Health & Human Services).

Ms. Bakich leads the Segal team responsible for publishing information about new health care laws and regulations, and trains internal staff on all legislation and related developments. She and her staff disseminate health compliance information, monitor federal and state laws and regulations, and prepare amendments for health plans and summary plan descriptions based on national models.

Professional Background

Prior to joining Segal, Ms. Bakich was an attorney in private practice representing multiemployer health plans and an appellate administrative law judge.

Education/Professional Designations

Ms. Bakich graduated in 1979 with a BA in Political Science, in 1982 with an MA in Public Policy, and in 1985 with a JD from the University of Missouri. She has been admitted to the Bar in the District of Columbia, United States Supreme Court, and multiple federal district and appellate courts.

Ms. Bakich is a member of the Working Committee of the National Coordinating Committee for Multiemployer Plans (NCCMP), the Health Technical Issues Taskforce of the American Benefits Council (ABC), the Employers Council on Flexible Compensation (ECFC) Flex Advisory Council, and the American Bar Association (ABA). Ms. Bakich is co-chair of the ABA Joint Committee on Employee Benefits Subcommittee on Welfare Plan Regulation. She was also appointed to the Government Liaison Committee of the International Foundation of Employee Benefit Plans (IFEBP). Ms. Bakich was named a Fellow of the American College of Employee Benefits Counsel in 2012.

Published Works/Speeches

Ms. Bakich has published multiple articles about employee health and welfare benefits, including a series of articles discussing HIPAA Administrative Simplification, EDI, and Privacy in the *Benefits Law Journal*. She is a co-author of the *Employers' Guide to HIPAA Privacy Requirements*, published by Thompson Publishing Group, and a chapter editor of *Employee Benefits Law*. Ms. Bakich speaks regularly on issues related to group health plans.

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Expertise

Mr. Meyer is a Senior Consultant in Segal's National Communications Practice with over 20 years of strategic communications consulting experience. He serves as the Multiemployer Liaison for the National Communications Practice. He is located in the firm's New York office and provides counsel to clients on a wide range of benefits communications issues using a broad array of media.

Mr. Meyer works nationally with Segal's multiemployer clients in a number of industry groups, including Carpenters, Communications Workers, Electrical Workers, Entertainment Workers, Ironworkers, Laborers, Machinists, Painters, Plumbers and Pipefitters, Operating Engineers, Service Employees, Sheet Metal Workers, Teamsters Transit Workers and United Food and Commercial Workers. He is also the editor and project manager of *Health Report,* a quarterly publication for multiemployer client subscribers.

Professional Background

Prior to joining Segal, Mr. Meyer provided strategic communications, research, and planning consulting for local, regional, and national unions, benefit funds, and affiliated organizations. His experience also includes developing public image and branding campaigns; performing organizational analyses to develop long- and short-term strategic plans, organizational goals, resource allocation, and strategies for growth and membership mobilization; creating design, structure and content for Web sites; creating and analyzing polls; and developing e-advocacy strategies and campaigns. Mr. Meyer has researched and written position papers, policy briefs, speeches and Op-Ed pieces analyzing U.S. industries such as construction, transportation, health care and hospitality. He has also written about international health care and pension systems, economic development, labor law, immigration, and international trade.

Education/Professional Designations

Mr. Meyer received a BS in Industrial and Labor Relations from Cornell University and a Masters of Public Policy from Harvard University's John F. Kennedy School of Government.

Publications/Speeches

Mr. Meyer has been a presenter at the New York Fund Administrators Seminar and the Chicago Area Administrators Summit, and has been published in *Benefits Magazine*, a publication of the International Foundation of Employee Benefit Plans.

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Sample Publications

Segal Consulting

CAPITAL CHECKUP

April 24, 2014

Medicare Part D Amounts Will Increase in 2015

The Medicare Modernization Act (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to announce each year the Medicare Part D standard defined benefit and Retiree Drug Subsidy (RDS) amounts for the coming year. On April 7, 2014, the CMS announced the rates for 2015.[1] In 2015, the deductible and out-of-pocket limit for the defined standard Part D plan will be higher than the 2014 amounts.

This *Capital Checkup* features charts comparing the 2015 numbers to the 2014 numbers. It also reviews changes to the Part D benefit, which were made by the Affordable Care Act,[2] and illustrates the impact of those changes on the 2015 benefit. Coverage for Medicare beneficiaries in the Part D prescription drug coverage gap, or "donut hole," will continue to increase in 2015.

RDS Amounts

For 2015, plan sponsors eligible for the RDS will receive 28 percent of Part D prescription drug expenses between $320 and $6,660. The table below compares those numbers to the numbers for 2014.

RDS Amounts

	2014	**2015**
Cost Threshold*	$310.00	**$320.00**
Cost Limit**	$6,350.00	**$6,600.00**

* The cost threshold is the minimum amount of covered Part D drug expenses that must be incurred by an individual before a plan sponsor is eligible to receive the RDS based on the individual's claims.

** The cost limit is the maximum amount of covered Part D drug expenses for which a plan sponsor may claim the RDS for each individual.

Standard Benefit Design Parameters

The table below compares the standard benefit design parameters for a Part D plan for 2015 to the amounts for 2014.

Standard Benefit Design Parameters

	2014	**2015**
Deductible	$310.00	**$320.00**

Initial Coverage Limit*	$2,850.00	**$2,960.00**
Out-of-Pocket Threshold**	$4,550.00	**$4,700.00**
Total Covered Part D Drug Spending before Catastrophic Coverage***	$6,455.00	**$6,680.00**

* After an individual pays the deductible, he or she is in the initial coverage period during which he or she pays 25 percent of drug costs and the Part D plan pays 75 percent of costs. Once Part D drug expenses (paid by the individual and by the Part D plan) total the initial coverage limit ($2,960 for 2015), the individual is responsible for a certain percentage of charges based on whether the drug is generic or brand until the individual has reached the out-of-pocket threshold.

** The out-of-pocket threshold is the amount that the individual must pay on his or her own before catastrophic coverage begins. This gap between the initial coverage limit and catastrophic coverage is referred to as the "donut hole."

*** Once an individual reaches the catastrophic portion of the benefit, the Part D plan covers approximately 95 percent of the Part D drug expenses incurred. Cost sharing is set at the greater of 5 percent coinsurance or fixed copayments (see below). This amount is set by CMS. It is not a total of other amounts listed in this table.

Copayments in Catastrophic Coverage Portion of Benefit

	2014	**2015**
Generic/Preferred Multi-Source Drug*	$2.55	**$2.65**
Other Drug	$6.35	**$6.60**

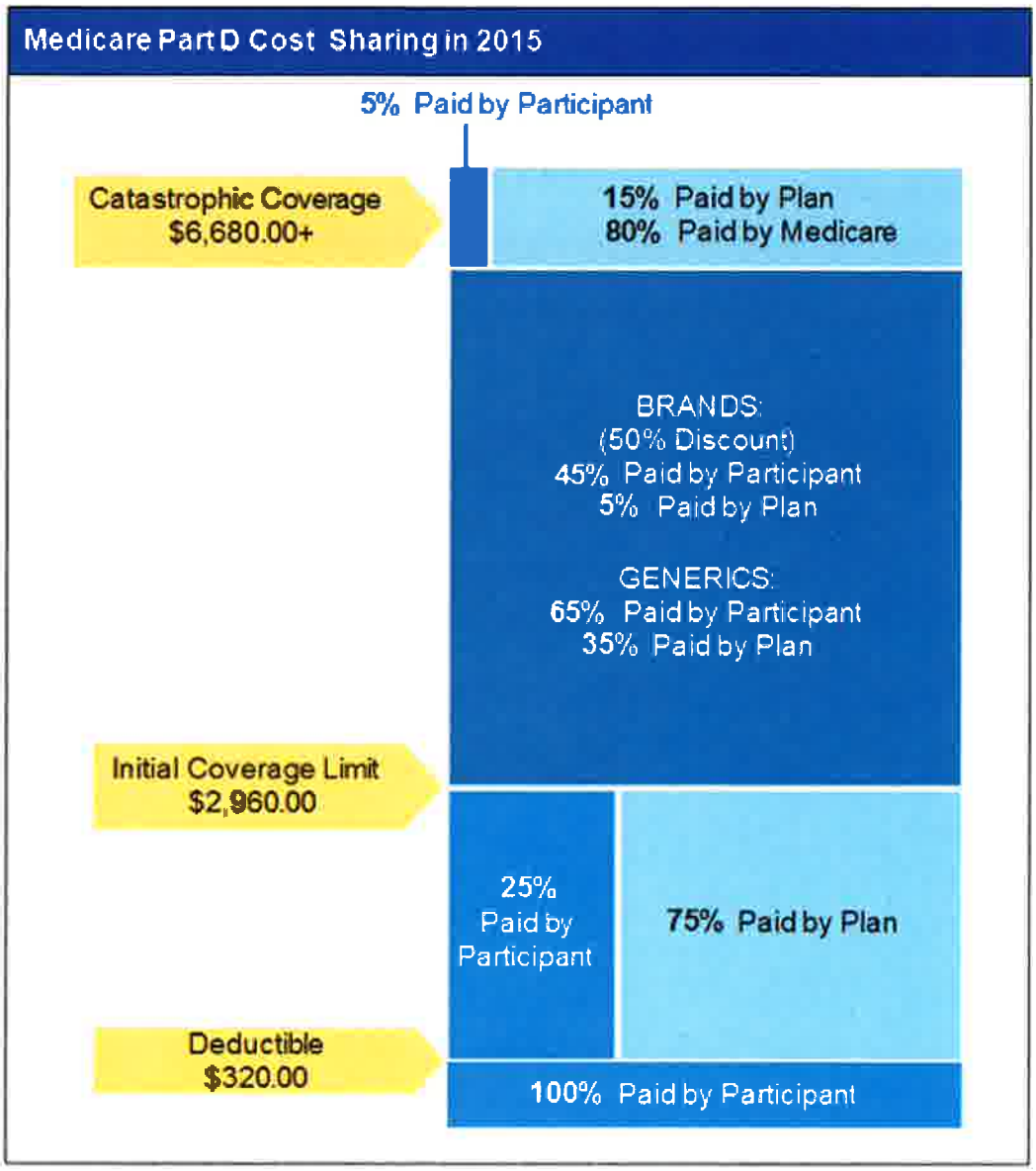
* For Part D plans that charge copayments in the catastrophic portion of the benefit (instead of 5 percent coinsurance), the amount of the copayment for a generic drug or for a preferred multiple source drug (*i.e.*, generally one for which there are two or more products that are therapeutically and pharmaceutically equivalent) is set at a lower amount than the amount for any other drug.

Part D Changes Introduced by the Affordable Care Act

The Affordable Care Act made significant changes to the Medicare program, including for Medicare beneficiaries enrolled in a Part D plan. In 2013, seniors who hit the "donut hole" received improved coverage on their brand-name drugs. Manufacturers began to cover 50 percent of the cost of the brand-name drugs and in 2013 and 2014, the plan paid another 2.5 percent, providing seniors with total coverage of 52.5 percent in the donut hole. Therefore, seniors pay 47.5 percent of the costs for brand-name drugs in the donut hole.

In 2015, manufacturers will continue to cover 50 percent of the cost of the brand-name drugs and the plan will pay another 5 percent, providing seniors with total coverage of 55 percent in the donut hole. Therefore, seniors will pay 45 percent of the costs for brand-name drugs in the donut hole. The following chart shows 2015 cost sharing for individuals in a standard Medicare Part D prescription drug plan (PDP) starting with the deductible at the bottom of the chart and ending with catastrophic coverage at the top of the chart.

Coverage of generic drugs in the gap will increase annually until it reaches 75 percent in 2020. By then, cost sharing for both brand and generic prescription drugs will be the same during the



"donut hole" as during the initial coverage period. Consequently, in 2020, individuals will pay 25 percent of drug costs, and the Part D plan will pay 75 percent. In 2015, Part D plans will pay 35 percent of the cost of generic drugs in the donut hole leaving seniors responsible for 65 percent.

Implications for Sponsors of Plans that Provide Prescription Drug Coverage for Retirees

Plan sponsors should note the new benefit amounts for planning purposes for 2015 — both with respect to expected RDS income and to the design of any Medicare Part D prescription drug plan that is offered to retirees.

Prior to making benefits designs for 2015 final, plan sponsors may wish to analyze the benefits of contracting with a Medicare PDP as opposed to retaining the RDS. In many instances, contracting with a PDP will produce a greater cost savings than the RDS because the reimbursement that insurers get from CMS can be greater than what plan sponsors obtain in direct subsidies. Plan sponsors can review potential savings for a PDP, and also review potentially new compliance obligations, and determine whether the PDP is an appropriate option for the plan retirees.

Plan sponsors that continue to apply for the RDS should take several actions to make sure that RDS income continues and that they are prepared for potential audits by the HHS Office of Inspector General:

- Review RDS income and ensure it meets expectations,
- Ensure that the contract with the RDS administrator or pharmacy benefit manager accurately reflects charges for RDS and contains all language required by CMS, and
- Review internal policies and controls to ensure that deadlines are met and only appropriate personnel have access to RDS information and the RDS website. Ensure that the RDS website is accessed at least every 60 days so that access status is maintained.

• • •

As with all issues involving the interpretation or application of laws, health plan sponsors should rely on their legal counsel for authoritative advice on the integration of Medicare with their employee benefit plans. Segal Consulting can be retained to work with plan sponsors and their attorneys on issues related to Medicare Part D.

1 The announcement (see Part D Benefit Parameters on page 58) and press release are available on the CMS website. (Return to the *Capital Checkup*.)

2 The Affordable Care Act is the abbreviated name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-148, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152. (Return to the *Capital Checkup*.)

Capital Checkup is Segal Consulting's periodic electronic newsletter summarizing activity in Washington with respect to health care and related subjects. *Capital Checkup* is for informational purposes only and should not be construed as legal advice. It is not intended to provide guidance on current laws or pending legislation. On all issues involving the interpretation or application of laws and regulations, plan sponsors should rely on their attorneys for legal advice.

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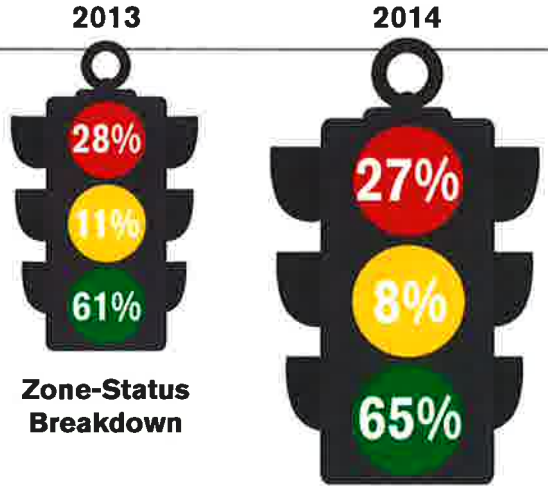
Back

Segal Consulting

"Zone Status" of Multiemployer Pension Plans Improves

The percentage of calendar-year multiemployer pension plans in the "green zone" in 2014 is **65 percent**, an increase of 4 percentage points from 2013, according to Segal Consulting's latest zone-status survey. (Plans with a January 1 plan-year start date are referred to as "calendar-year plans.")



Average Funded Percentage also Improves

Between 2013 and 2014, the surveyed plans' average Pension Protection Act of 2006 (PPA'06) funded percentage increased by 3 percentage points to reach **88 percent**.

Average PPA'06 Funded Percentage

Factors Contributing to the Recent Improvement

- Very strong investment performance: For 2013, the return for multiemployer pension funds with a 40 to 70 percent allocation to equities ranged from 11.5 to 21.4 percent.*
- Trustees have taken steps to strengthen their plans, including plan design changes and negotiated contribution rates.
- There are higher levels of employment in many industries.

* Source: Segal Rogerscasey (the SEC-registered investment solutions member of The Segal Group)

Q&As about the Survey

Q: What is the "green zone"?

A: The "green zone" refers to multiemployer pension plans that have an actuarial certification of their projected funding status that is neither "endangered" (the "yellow zone") nor "critical" (the"red zone") under the funding provisions of PPA'06.

Q: What is the significance of being in the green zone?

A: Plans in the green zone are not subject to special rules put into place by PPA'06. In contrast, trustees of plans in the yellow and red zones are required to take specific actions to improve their plans' financial status by adopting a funding improvement plan or rehabilitation plan, respectively.

Q: How is zone status determined?

A: Zone status is determined by an actuarial certification based on a projection of estimated assets and liabilities. For calendar-year plans, the projection is based on January 1, 2014 assets (reflecting investment performance for 2013) and liabilities.

Q: What is the PPA'06 funded percentage?

A: It is based on a ratio of assets to accrued benefits, measured using the plan actuary's actuarial assumptions and the actuarial asset valuation method.

Additional Survey Data Coming Soon

This infographic is a preview of results from Segal Consulting's *Survey of Calendar-Year Plans' 2014 Zone Status,* which provides data for almost 220 plans. By May, a report showing additional results from that survey, including the zone-status breakdown by industry, as well as historical data will be accessible from this page of Segal Consulting's website: http://www.segalco.com/publications-and-resources/multiemployer-publications/surveys-studies/

Segal Consulting is a member of The Segal Group (www.segalgroup.net), which is celebrating its 75th anniversary this year.

Segal Select Insurance

THE FIDUCIARY SHIELD
Insurance News for Plan Sponsors

Benefits, Compensation and HR Consulting

MARCH 2014

If a Plan Merger or Termination Is on the Horizon, Seek Tail Coverage

This issue of *The Fiduciary Shield* defines tail coverage, explains why it is needed, and describes the extra protection it provides. It also discusses how it is obtained and what it costs.

When Is Tail Coverage Needed?

Under the Employee Retirement Income Security Act (ERISA), plan trustees can be personally liable for breaches of fiduciary duty. Fiduciary liability insurance coverage is triggered when a claim is made rather than when an alleged wrongful act has occurred. Even if the alleged wrongful act took place years ago, the insurer will be responsible for any covered claim made against an insured, which generally includes past, present, and future trustees and employees, during the policy period. While a fiduciary liability policy is in force, it will cover claims reported during the policy period subject to its terms and conditions. However, once the policy expires because it is not renewed or is cancelled, all coverage for future claims relating to acts before the expiration date ceases.

"For terminations and mergers, standard ERP coverage is not enough."

Additional protection is available under extended reporting period (ERP) coverage, an optional policy provision that insurers generally contractually offer. Upon payment of an additional premium, the ERP coverage provides additional time, generally 12 months following the policy's expiration, cancellation or termination date, during which claims can be filed provided the alleged wrongful act occurred prior to the policy's expiration, cancellation or termination date. However, for terminations and mergers, standard ERP coverage is not enough.

What Additional Protection Does Tail Coverage Provide?

In a termination or a merger (for the merged-in plan), the plan ceases to exist. Yet, because most attorneys identify the statute of limitations for fiduciary breaches to be up to six years, it is clear that the trustees of these terminated or merged plans need extended claim-filing protection during the statute-of-limitations period for acts that might have occurred prior to the termination or merger. Unlike the typical ERP coverage, which only lasts 12 months, tail coverage provides this extended protection. In fact, tail coverage may be the only insurance protection these trustees of terminated or merged plans have during the six-year statute of limitations period.

"Tail coverage provides… extended protection. …[It] may be the only insurance protection… trustees of terminated or merged plans have during the six-year statute of limitations period [for acts that might have occurred prior to the termination or merger]."

How Is Tail Coverage Obtained?

In contrast to ERP coverage, tail coverage is not a contractual provision, meaning that the insurer is not obligated to provide it.[1] Both the terms of coverage and additional premium must be negotiated.

[1] While tail coverage is not a contractual provision in the basic policy, once purchased, it is endorsed into and becomes part of the basic policy.

What Are the Ideal Characteristics of Tail Coverage?

In addition to reflecting the plan's "closure" date, discussed in the next section, tail coverage will have the following four characteristics:

- ***Broad Scope of Coverage*** The scope of coverage is generally determined by and should match the fiduciary liability insurance policy in force at the time the tail coverage is requested.
- ***Reasonable Limit of Liability*** Like the scope of coverage, the limit of liability is generally dictated by the "in-force" fiduciary liability insurance policy. However, recent experience, discussed below, indicates limits of liability may become an underwriting concern.
- ***Six-Year Duration*** This time period matches the generally identified statute of limitations.
- ***"Non-Cancellability"*** This provision prevents any party from cancelling the coverage once the premium has been paid to the insurer.

What Are Some of the Challenges in Purchasing Tail Coverage?

One of the challenges in purchasing tail coverage is to understand and identify when fiduciary responsibility (and potential liability) under a plan ends in order to understand when the "in-force" policy should expire and the extended claim-filing protection of the tail policy should begin. Three examples of ongoing activities help clarify this point:

- Under Pension Benefit Guaranty Corporation regulations, a mass withdrawal is described as a termination, yet the plan may continue to operate and pay benefits for years after this termination date.
- A plan may merge into another plan and cease to exist as of the merger date. Nonetheless, months after the merger date, the independent auditor or another professional adviser may still have to file a final Form 5500 Annual Report.

"It is…extremely difficult to obtain competitive premiums because tail coverage is generally quoted only by the incumbent insurer."

- If a vacation plan is terminated and a bank account in the plan's name is left in place with funds that participants have four years to claim, ongoing activities are taking place.

In all of these instances where ongoing activities are taking place, potential fiduciary liability exists.

For purposes of fiduciary liability, the "in-force" policy should expire on and the tail policy should begin on the day after the date the plan is "closed." The "closure" date is the future date when all activities have been completed. If any of plan activities will or could take place after the termination or merger, coverage should be maintained under the "in-force" fiduciary liability policy until the "closure" date is identified and has occurred.

Another challenge in purchasing tail coverage occurs when ongoing fiduciary liability coverage is not currently or never has been in force with an insurer. Insurers are generally reluctant to offer tail coverage if there are no premiums "in the bank" from historical coverage.

"Having existing fiduciary liability insurance is possibly the most important pre-condition for purchasing tail coverage."

It is also extremely difficult to obtain competitive premiums for tail coverage because that coverage is generally quoted only by the incumbent insurer. Consequently, having *existing* fiduciary liability insurance is possibly the most important pre-condition for purchasing tail coverage.

As noted above, scope of coverage and limit of liability can also present challenges if the existing fiduciary liability policy is lacking in some respect or if a claim has been made against the current policy.

"One of the challenges in purchasing tail coverage is to understand and identify when fiduciary responsibility (and potential liability) under a plan ends in order to understand when the 'in-force' policy should expire and the extended claim-filing protection of the tail policy should begin."

Finally, recent experience has shown that, in the merger context, insurers are reluctant to provide the additional limits of liability that are being requested by trustees of plans being merged. The following example, taken from a recent transaction of which Segal Select Insurance Services is aware, illustrates the problem. An existing $15-million policy covered three plans. One was terminating and requested a $10-million tail policy. Another was merging and requested a $5-million tail policy. The last, which was continuing, wished to continue the existing $15-million limit of liability. Under this scenario, the total limit of liability being requested was $30 million.

In the most common scenario, the tail coverage will equal the pre-termination or merger limit of liability. In this instance, however, since the one existing policy is going to evolve into three separate policies with a requested limit of liability that is twice as large ($30-million versus $15-million),the insurer wanted to limit its aggregate exposure to either $15 million (the current policy's limit of liability) or $25 million (the maximum single policy limit of liability it offered.) Its concern was what would happen if there was a common claim that affected all three policies (*e.g.*, a multi-year benefit calculation error affecting all three plans because of an error in the common plan administrator's software). Alternatively, assume for years prior to the proposed termination/merger, investment assets were under a master trust, *comingled* for investment purposes, and heavily invested in an asset that, after the merger, the Department of Labor began to investigate. Under either of these scenarios, the insurer's maximum liability under the existing policy would be $15 million. Under the requested post-termination/merger policies, its maximum liability might be $30 million ($5 million plus $10 million plus $15 million).

In similar transactions of which we are aware, insurers have been offering alternative coverage options. In some cases, insurers have proposed combining the limit of liability for the terminating or merged plans under a single policy limit. In others, insurers have offered the structure requested above with the addition of a "non-pyramiding"[2] endorsement, which limits the maximum liability for a common "nexus" or "systemic" loss to the largest single limit of liability.

[2] "Non-pyramiding" means that for one or more claims having a common root or nexus, the insurer's maximum liability will be the largest limit of the various policies it has issued.

"The premium for a six-year tail policy tends to range from 200 to 300 percent of the full annual premium for the underlying fiduciary liability coverage."

How Much Does Tail Coverage Cost?

The premium for a six-year tail policy tends to range from 200 to 300 percent of the full annual premium for the underlying fiduciary liability coverage. If several independent tail policies with aggregate limits of liability greater than the original fiduciary liability policy are requested, such as in the example discussed above, a more expensive premium might be expected to compensate the insurer for the greater risk it would assume.

Tail coverage is generally paid out of the assets of the plan that is being terminated or merged. Consequently, it is important to identify the cost of tail coverage well before the termination, "closure" or merger dates. Once these plan assets are disbursed, finding alternative sources to pay for tail coverage may be extremely difficult, if not impossible.

What Alternatives to Tail Coverage Exist?

The most common alternative to tail coverage is a "merged-plan" endorsement. Under this endorsement, a tail-type coverage is effectively provided within the policy of the successor plan. This approach is fairly straightforward, but coverage must be renewed annually until the statute of limitations has been exhausted. During this multi-year period, there is no guarantee that this tail-type coverage or that the limit of liability and scope of coverage will not change. The trustees of the terminated or merged plan are subject to decisions by both the insurer and/or the trustees of the ongoing insured plans.[3]

What Other Issues Need to Be Considered?

The decision to merge two or more plans triggers a due-diligence evaluation by both affected plans. In one recent transaction, this process resulted in the "merged-in"

[3] In certain instances, the merged plan endorsement may present additional concerns. For example, assume a current policy insures both a health and welfare (H&W) plan and a vacation plan. Further, assume the vacation plan is being terminated and requests a merged plan endorsement under the current policy, which will be maintained by the H&W plan. On an ongoing basis, is it appropriate and legal for the H&W plan to maintain and pay for insurance coverage for the trustees of the former vacation plan?

plan making a filing under the Internal Revenue Service (IRS) Voluntary Compliance Program (VCP), which triggered a fiduciary claim for cost of the VCP filing fee (*e.g.*, $15,000 in this case.)[4] Before quoting a tail premium, insurers are increasingly likely to ask whether the due-diligence process is uncovering any compliance issues that may require an IRS VCP filing.

When Should Tail Coverage Be Negotiated?

Negotiations of enhancements such as tail coverage should be part of the planning process for every plan merger or termination; not an afterthought. Determining the "closed" date of a fund is critical in setting the "effective" date of a tail policy. Potential IRS VCP claims, the number of currently "in force" policies and limits of liability all needed to be identified and incorporated into the negotiations.

A plan's fiduciary policy should be regularly reviewed and monitored as a "best practice." One reason for taking that action is that the scope of coverage and limit of liability made available by tail coverage's extended claim-filing protection are generally determined by and match the coverage and limits of liability in force at the time the tail coverage is requested. The best time to negotiate coverage terms is during "normal" times when nothing that would give an insurer pause has occurred or is on the horizon.

Conclusion

The optional 12-month extended claim-filing coverage known as ERP coverage is valuable because it extends claims coverage beyond a policy's expiration, cancellation or termination date. However, ERP coverage does not always provide enough protection. When a plan merger or termination is on the horizon, tail coverage is needed.

Obtaining tail coverage is possible, but complicated. For that reason, trustees who think their plans might need tail coverage should be sure to understand all of the issues.

Ideally, negotiations with an insurance company should be a part of trustee deliberations and begin early in the process. It is crucial not to wait until the last minute — and certainly not to wait until after the fact.

■ ■ ■

Segal Select Insurance Services can help trustees of multiemployer plans to determine whether tail coverage is needed and, if it is, to identify the limits of liability and negotiate pricing and terms. To discuss any of these services, contact one of the following experts:

- *Brian L. Smith, Chief Operating Officer*
  212.251.5333
  bsmith@segalsi.com
- *Mark A. Dobrow*
  312.984.8660
  mdobrow@segalsi.com
- *Matthew Jackson*
  212.251.5387
  mjackson@segalsi.com

Trustees of multiemployer plans should always rely on fund counsel for authoritative advice on all issues involving the interpretation or application of laws and regulations. *The Fiduciary Shield* does not provide legal advice or a binding interpretation of coverage.

[4] The VCP filing fee schedule is on the following page of the IRS website: http://www.irs.gov/Retirement-Plans/Voluntary-Correction-Program-Fee-Schedule

Segal Consulting

CAPITAL CHECKUP

March 14, 2014

Final Rule Implementing the Affordable Care Act's 90-Day Waiting Period Limit Includes a Multiemployer Example

The Departments of Labor, Treasury and Health and Human Services (collectively, the "Departments"), which are responsible for implementing the Affordable Care Act,[1] have issued a final regulation implementing the law's ban on waiting periods exceeding 90 days.[2] The final rule is applicable for plan years beginning on or after January 1, 2015, and is very similar to the proposed rule published last year.[3]

The Departments also issued a proposed rule that coordinates with the final rule to address "orientation periods," which can be used in addition to the 90-day waiting period.[4] The Departments have requested comments on the proposed rule by April 25, 2014.

This *Capital Checkup* summarizes both the final rule and the proposed rule, which provide practical guidance for sponsors of group health plans. It concludes with a list of steps plan sponsors should take to implement the Affordable Care Act's 90-day waiting period rule.

The Final Rule

A summary of the key interpretations in the final rule, which follow the guidance in last year's proposed rule, follows:

- ***Definition of the "Waiting Period"*** Group health plans must cover participants within 90 days of the date on which the individual is "otherwise eligible." Being "otherwise eligible to enroll" means that the employee has met the plan's substantive eligibility conditions, such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's terms. **A new provision in the final rule adds that** a plan can require that an individual "satisfy a reasonable and bona fide employment-based orientation period" prior to receiving an offer of coverage. The orientation period is further defined by the new proposed rule, discussed below.
- ***Definition of "90 Days"*** Ninety days refers to calendar days — not three months or a quarter.
- ***Limit on Eligibility Conditions Based Solely on the Lapse of a Time Period*** Such eligibility conditions are permissible for no more than 90 days.
- ***Limit on Cumulative-Service Requirements*** Plans that require completion of cumulative hours of service may do so provided the hours-of-service requirement does not exceed 1,200 hours.
- ***Requirements for Variable Hour Employees*** If the plan conditions eligibility on a specified number of hours of service, and it cannot be determined that an employee is reasonably expected to regularly work that number of hours, the plan may have up to 12 months to measure whether the employee meets the

eligibility criteria. In that case, coverage must begin no later than 13 months from the employee's start date, plus, if the start date was not the first day of the month, the time remaining until the first day of the next month.

- ***Certificates of Creditable Coverage Eliminated*** After December 31, 2014, plans will no longer be required to issue certificates of creditable coverage, which were introduced by Health Insurance Portability and Accountability Act of 1996 (HIPAA).

An example in the final rule addresses multiemployer plans. The example refers to a multiemployer plan that aggregates hours in a calendar quarter. If enough hours are earned in that quarter, the plan provides coverage on the first day of the *next* calendar quarter. The final rule notes that such a plan has an eligibility provision that is designed to accommodate a unique operating structure and, therefore, is *not* considered to be designed to avoid compliance with the 90-day waiting period limitation. This example is consistent with the Departments' answer to a frequently asked question (FAQ) published last year.[5]

The Proposed Rule

The new proposed rule would provide that if a group health plan conditions eligibility on an employee's having completed a "reasonable and bona fide employment-based orientation period," the maximum 90-day waiting period would begin on the first day after the orientation period. Under this proposed rule, an orientation period would be considered reasonable and bona fide if it is no longer than one month. The one-month period would be determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date.

For example, if an employee's start date is October 16, the orientation period could last until November 15. The 90-day waiting period would begin on the first day after the orientation period. The employee would have to be offered coverage beginning no later than February 14 (the 91st day after the employee completes the orientation period).

The proposed rule is apparently intended to address concerns related to the inflexibility of the 90-day measurement period — particularly in light of the fact that coverage often starts at the beginning of the third or fourth month after employment begins. As noted at the beginning of this *Capital Checkup*, the Departments have requested comments on the proposed rule, which must be received by April 25, 2014.

Implications for Plan Sponsors

Because the Affordable Care Act's 90-day waiting period rule took effect for plan years beginning on or after January 1, 2014, many plan sponsors have already implemented it. Those that have not yet done so should:

- Review all eligibility requirements to determine if any are based solely on the lapse of time. Eliminate any requirements that exceed 90 calendar days, and ensure that employees already in a waiting period when the ban takes effect are not subject to a waiting period that exceeds 90 calendar days.
- Determine which groups of employees will meet the plan's eligibility requirements as of their start date and which groups should be classified as variable hour employees.
- For employees who will meet the plan's eligibility requirements as of their start date (*e.g.*, full-time employees), ensure that the waiting period between the employee's start date and the date that health coverage begins is no longer than 90 calendar days (including any election period).
- For employees who are offered health coverage once they work a certain number of hours, make sure that the hours requirement does not exceed 1,200 hours.
- Coordinate the plan's approach to the 90-day rule with the approach adopted by the employer to avoid or minimize the employer penalty. For example, consider whether similar measurement periods should be used for both determining full-time status for purposes of the employer penalty and determining whether the employee meets the plan's eligibility requirements.

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As with all issues involving the interpretation or application of laws and regulations, plan sponsors should rely on their legal counsel for authoritative advice on the interpretation and application of the Affordable Care Act and related guidance, including the guidance summarized in this Capital Checkup. *Segal Consulting can be retained*

to work with plan sponsors and their attorneys on compliance issues.

1. The Affordable Care Act is the shorthand name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-48, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152. The Affordable Care Act added Section 2708 to the Public Health Service Act, which provides that, effective for plan years beginning on or after January 1, 2014, a group health plan or health insurer offering group health insurance coverage shall not apply any waiting period that exceeds 90 days. (Return to the *Capital Checkup*.)
2. The final rule was published in the February 24, 2014 *Federal Register*. (Return to the *Capital Checkup*.)
3. The proposed rule was discussed in Segal's April 23, 2013 *Capital Checkup,* "Proposed Rule on the Affordable Care Act's 90-Day Waiting Period Provides Flexibility for Multiemployer Plans." (Return to the *Capital Checkup*.)
4. The proposed rule was published in the February 24, 2014 *Federal Register*. (Return to the *Capital Checkup*.)
5. The answer to this FAQ was discussed in Segal's September 9, 2013 *Capital Checkup,* "New Guidance Addresses Multiemployer Plan Sponsors' Concerns about the Affordable Care Act's Exchange Notice and 90-Day Rule." (Return to the *Capital Checkup*.)

Capital Checkup is Segal Consulting's periodic electronic newsletter summarizing activity in Washington with respect to health care and related subjects. *Capital Checkup* is for informational purposes only and should not be construed as legal advice. It is not intended to provide guidance on current laws or pending legislation. On all issues involving the interpretation or application of laws and regulations, plan sponsors should rely on their attorneys for legal advice.

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Segal Consulting

CAPITAL CHECKUP

March 4, 2014

Additional Guidance on the Affordable Care Act's Rules for Out-of-Pocket Maximums and Preventive Services Requirements

As discussed in this *Capital Checkup*, under the Affordable Care Act, non-grandfathered group health plans must comply with a new annual limit on cost sharing, also known as an out-of-pocket maximum. The out-of-pocket maximums that will apply for the 2015 plan year have been announced. The maximum will be $6,600 for an individual, up from $6,350 this year, and $13,200 for other than self-only coverage (*e.g.*, a family), up from $12,700 this year. The out-of-pocket maximum is no longer tied to Health Savings Account maximums, but is calculated based on a percentage increase from the previous year. The percentage increase used this year was 4.2 percent (rounded).

This information was published as part of a final rule on the Affordable Care Act's transitional reinsurance program that was published on March 11, 2014.

The Departments of Treasury, Labor, and Health and Human Services (HHS), which are responsible for implementing the Affordable Care Act[1] (collectively, the "Departments"), recently published new answers to a set of frequently asked questions (FAQs).[2] Most significant to group health plan sponsors are answers to the FAQs that address two of the law's requirements for non-grandfathered plans: the new rules applicable to out-of-pocket maximums and the preventive services requirement.

This *Capital Checkup* summarizes this guidance, which will help plan sponsors understand the law's requirements, especially as they begin the process of considering benefit changes for the 2015 plan year.

Out-of-Pocket Maximums

Effective with the plan year beginning on or after January 1, 2014, non-grandfathered group health plans must comply with a new annual limit on cost sharing, also known as an out-of-pocket maximum.[3] For the 2014 plan year, the maximum is $6,350 for an individual and $12,700 for a family. A special transition rule applies to the

2014 plan year if the plan uses multiple service providers to administer the plan's benefits. That transition rule applies the maximum to the plan's major medical benefit. If the plan's other separately-administered benefits (*e.g.*, prescription drugs) apply an out-of-pocket maximum, that maximum also cannot exceed the allowed amount.

Several FAQs about the out-of-pocket maximum rules were answered. The answers clarify the following:

- Plan sponsors may have separate out-of-pocket maximums on different categories of benefits (*e.g.*, medical and prescription drugs) as long as the combined amount of all such limits does not exceed the allowed amount. For plan sponsors relying on the transition rule for 2014, this flexibility would apply starting in 2015.
- The out-of-pocket maximum applies to in-network expenses. Out-of-network expenses are not required to be counted toward the in-network out-of-pocket maximum.
- Cost sharing includes deductibles, copayments or similar charges, as well as any other expenditure required of an individual for covered essential health benefits. Cost sharing does not include premiums, balance billing amounts for non-network providers, or spending for non-covered items or services. A plan sponsor is not required to count expenses for non-covered items or services toward the out-of-pocket maximum.

Preventive Services

Non-grandfathered plans must provide certain preventive services without imposing any cost sharing when those services are obtained from in-network providers. One category of preventive services which must be provided is services that have an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF).[4] When the USPSTF adds or updates a recommendation, that recommendation becomes a plan requirement effective with the plan year beginning one year after the USPSTF issues the new or updated recommendation.

On September 24, 2013, the USPSTF revised its "B" recommendation regarding medications for risk reduction of breast cancer in women who are at increased risk for breast cancer and at low risk for adverse medication effects. The revised recommendation is that "clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene."[5] Consequently, non-grandfathered group health plans must cover risk-reducing medications, such as tamoxifen or raloxifene, for women without cost sharing subject to reasonable medical management. This rule applies to the plan year beginning on or after September 24, 2014 (*i.e.*, January 1, 2015 for a calendar-year plan).

Implications

Plan sponsors of non-grandfathered health plans should review the rules concerning out-of-pocket maximums and their coverage for preventive services to assure that they are consistent with the new guidance in answers to FAQs.

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As with all issues involving the interpretation or application of laws and regulations, plan sponsors should rely on their legal counsel for authoritative advice on the interpretation and application of the Affordable Care Act and related guidance, including the new guidance summarized in this Capital Checkup. *Segal Consulting can be retained to work with employers and their attorneys on compliance issues.*

1 The answers to this set of FAQs are available on the Department of Labor (DOL) website. (Return to the *Capital Checkup*.)

2 The Affordable Care Act is the shorthand name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-48, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152. (Return to the *Capital Checkup*.)

3 For background information on this requirement and the transition rule for the first year of applicability, see Segal Consulting's May 10, 2013 *Capital Checkup*, "Guidance on Out-of-Pocket Maximums in 2014 for Non-Grandfathered Health Plans." (Return to the *Capital Checkup*.)

4 The USPSTF A and B Recommendations are on the Task Force's website. (Return to the *Capital Checkup*.)

5 See the September 2013 item in the list of recommendations by date on the Task Force's website. (Return to the *Capital Checkup*.)

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Segal Consulting

CAPITAL CHECKUP

February 20, 2014

Proposed Rule Would Create a New Category of Benefits Not Subject to the Affordable Care Act's Group Health Plan Mandates: Limited Wraparound Coverage

Late last year, the Departments of Treasury, Labor, and Health and Human Services, which are responsible for implementing the Affordable Care Act[1] (collectively, the "Departments"), published a proposed rule[2] that would create a new category of benefits not subject to the Affordable Care Act's group health plan mandates[3]: limited benefits that wrap around benefits provided through individual health insurance coverage. The preamble states that the purpose of this new rule is to allow employers to provide comprehensive overall coverage to employees for whom the employer's plan is unaffordable, when an employee declines the employer's primary coverage and enrolls in a plan in a health insurance Marketplace.[4] Comments are due on the proposal by February 24, 2014.

Wraparound benefits would have to meet all of the following requirements in order to avoid being subject to the Affordable Care Act's group health plan mandates:

- The coverage wraps around non-grandfathered individual health insurance coverage that provides ACA-mandated benefits.
- The wraparound plan covers benefits beyond the individual insurance, such as reimbursing the cost of out-of-network providers.
- The plan sponsor offering the limited wraparound coverage must sponsor another group health plan meeting the 60 percent minimum value standard and that plan must be affordable for a majority of the employees eligible for that plan ("primary plan"). Only individuals eligible for this primary plan may be eligible for the wraparound coverage. The subset of employees for whom the primary plan is not affordable (*i.e.*, required contribution for self-only coverage is more than 9.5 percent of their household income) would be able to receive the wrap coverage without losing the premium assistance tax credit for the plan they purchase in a Marketplace.[5]
- The total cost of coverage under the wraparound coverage must not exceed 15 percent of the cost of coverage under the primary plan, determined in the same manner as premiums for continuation of coverage under COBRA.
- The coverage may not discriminate based on a health factor, may not impose any preexisting condition exclusion, and may not discriminate in favor of highly compensated individuals.

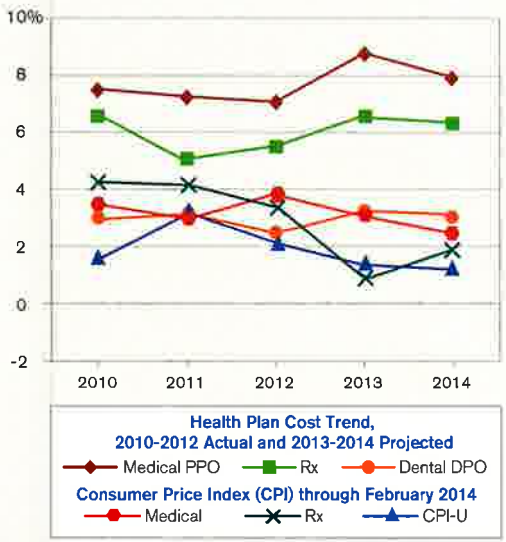
Receiving wraparound coverage would not disqualify an employee from enrolling in a Marketplace plan and receiving the premium assistance tax credit. However, it would *not* protect an employer from imposition of the employer shared responsibility penalty for not providing minimum value and affordable coverage.[6]

TRENDS Noteworthy Developments of Interest to Sponsors of Multiemployer Health Plans

SECOND QUARTER 2014

TREND AND CPI

Health benefit plan cost trend rates projected for 2014 show the slowest growth in 14 years of Segal trend forecasts.



Sources: 2014 *Segal Health Plan Cost Trend Survey* (http://www.segalco.com/publications/surveysandstudies/2014trendsurvey.pdf) and Bureau of Labor Statistics for CPI (http://www.bls.gov/cpi/)

Trend is the forecasted change in claims cost determined by insurance carriers, managed care organizations (MCOs), pharmacy benefits managers (PBMs) and third party administrators (TPAs). Trend can be influenced by a variety of factors including price inflation, the leveraging effect of copayments, cost shifting and ut lization. The **Consumer Price Index** (CPI) is a measure of the average change in prices over time of goods and services purchased by households. The CPI for All Urban Consumers (CPI-U) is often used as an economic indicator.

THE AFFORDABLE CARE ACT (ACA) AND COMPLIANCE NEWS

The Treasury Department issued final rules implementing the ACA's employer shared responsibility penalty.[1] It provides that if a contributing employer is making contributions to a multiemployer plan for covered employees pursuant to a collective bargaining agreement or participation agreement, the employer will be considered to be offering coverage to those employees. The multiemployer plan must cover both employees and dependents through the end of the month in which they turn 26, and the coverage must be affordable and minimum value.

The Department of Health and Human Services (HHS) released a final rule concerning the ACA's transitional reinsurance fee. For 2015, the fee will be $44 per person per year. While self-insured and self-administered plans must pay the fee in 2014, they do not pay it in 2015-2016. The plan must retain responsibility for claims processing, claims adjudication (including internal appeals) and enrollment. The plan may use a provider network or PBM without losing self-administered status. The plan may also have a *de minimis* amount of outsourced administration (less than 5 percent).

The Departments of Labor, HHS and Treasury (collectively, the "Departments") have issued a final rule implementing the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) for plan years beginning on or after July 1, 2014. Plan sponsors should assure that they have reviewed mental health benefits for both the old and new regulations.[2]

The Departments recently published new answers to a set of frequently asked questions (FAQs) that address two of the law's requirements for non-grandfathered plans: the new rules applicable to out-of-pocket maximums and the preventive services requirement.[3]

The Health Care Reform Guide on Segal Consulting's website links to all publications and other resources related to the ACA: http://www.segalco.com/publications-and-resources/health-care-reform/

THE VENDOR MARKETPLACE

Quest Diagnostic, the leading provider of diagnostic information services, announced that it will acquire Summit Health. Summit Health has a large network of nurses that staff onsite wellness programs, including biometric screenings, immunizations, coaching and educational seminars.

WHAT HEALTH PLAN SPONSORS ARE DOING TO MANAGE COSTS: SELECTED STRATEGIES

Plan sponsors with non-grandfathered health plans should review out-of-pocket maximums to assure that they are consistent with the new guidance. Recent guidance clarified that for 2015, plan sponsors may offer separate pharmacy and medical out-of-pocket maximums, as long as the combined total does not exceed the allowed amount. Plan sponsors should review cost implications to comply, as well as consider alternatives that are cost neutral.

ACA requirements to remove annual benefit limits for all medical plans offers an opportunity to evaluate their stop-loss coverage strategies. Plan sponsors should review their stop-loss policy coverage limits for adequate coverage and competitive premium rates. For example, many carriers now offer "dividend options" or "shared savings" provisions, which offer a premium adjustment with lower loss ratios.

Telemedicine is becoming a lower-cost alternative to more traditional face-to-face ways of providing health care. These services generally provide 24/7 access to phone or web-based consultation with physicians and other clinical professionals. Plan sponsors may want to consider evaluating the impact of telemedicine based upon their current needs, demographics and marketplace options.

Segal has announced an expansion of retiree health services for those organizations seeking a private health care Exchange platform for Medicare-eligible retirees. Through a process of pre-screening existing retiree health exchanges and establishing new minimum vendor requirements, Segal has pre-qualified three private exchange vendors. Segal can help expedite the vetting process for clients preferring to implement a retiree health exchange with uniform standards.

KEY TRENDS, DEVELOPMENTS AND STATISTICS

People who are younger, more affluent and do not have established health care relationships are more likely to use a telemedicine program according to a RAND Corporation study.[4]

Segal's 2014 *Medical Stop Loss Database* shows noteworthy changes in the stop loss market. Specific stop-loss deductibles range from $75,000 to $2 million and the most common specific deductible is $200,000.

[1] See "Shared Responsibility for Employers Regarding Health Coverage": https://www.federalregister.gov/articles/2014/02/12/2014-03082/shared-responsibility-for-employers-regarding-health-coverage

[2] See Segal's *Capital Checkup*, "Final Rule on the Mental Parity and Addiction Equity Act": http://www.segalco.com/publications-and-resources/multiemployer-publications/capital-checkup/archives/?id=2490

[3] See Segal's *Capital Checkup*, "Additional Guidance on the Affordable Care Act's Rules for Out-of-Pocket Maximums and Preventive Services Requirements": http://www.segalco.com/publications-and-resources/multiemployer-publications/capital-checkup/archives/?id=2516

[4] See "First Assessment of National Telemedicine Service Finds Efforts Appear to Expand Access to Acute Medical Care": http://www.rand.org/news/press/2014/02/03.html

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For information about the strategies above or any of the developments discussed on this page, contact your Segal benefits consultant or send an e-mail to info@segalco.com

2014 Segal Health Plan Cost Trend Survey

Segal Consulting

Slowest Rate of Increase in Health Plan Cost Trends in 14 Years Projected for 2014

Health benefit plan cost trend rates show the slowest growth in 14 years of trend forecasts, according to data compiled in the 2014 *Segal Health Plan Cost Trend Survey*, Segal Consulting's seventeenth annual survey of managed care organizations (MCOs), health insurers, pharmacy benefit managers (PBMs) and third-party administrators (TPAs).[1] (For a definition of trend, see the text box on page 2.) While this decline in the trend rate is positive news, it is important to note that medical health plan cost trends still outpace the consumer price index for all urban consumers (CPI-U) by a margin of at least three to one, which continues to serve as a drag on real wage growth.

As the Affordable Care Act[2] kicks into full gear in 2014 and as the economy continues to improve, it is unclear if health plan cost trends will continue to decline or return to the historic, inflationary underwriting cycle.

Trend Projections for 2014

Table 1 summarizes Segal's key findings on trend projections for 2014 and compares them to projections for 2013. Notes about the 2014 forecasted trends follow:

- All medical plan types are projected to experience trend rate declines in 2014.

[1] For information about the survey participants, see the text box on the last page of this report.

[2] The Affordable Care Act is the abbreviated name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-148, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152.

Table 1: Projected Medical, Prescription Drug, Dental and Vision Trends: 2013 and 2014

	2013 Projected		2014 Projected	
	(without Rx)	(with Rx)[1]	(without Rx)	(with Rx)[1]
Medical (Actives & Retirees <Age 65)				
Fee-for-Service (FFS)/Indemnity Plans	10.8%	10.0%	**10.4%**	**9.7%**
High-Deductible Health Plans (HDHPs)[2]	9.1%	8.6%	**8.3%**	**7.9%**
Open-Access Preferred Provider Organizations (PPOs)/Point-of-Service (POS) Plans[3]	8.8%	8.3%	**7.9%**	**7.6%**
PPOs/POS Plans (with PCP Gatekeepers)	9.3%	8.8%	**8.4%**	**8.0%**
Health Maintenance Organizations (HMOs)	8.2%	7.9%	**7.2%**	**7.0%**
Medical (Retirees Age 65+)				
Medicare Advantage (MA)[4] FFS Plans or PPOs	5.5%	5.4%	**3.6%**	**4.3%**
Medicare Advantage HMOs	5.8%	5.6%	**3.3%**	**4.2%**
Medicare Supplemental (Medigap)	5.3%	5.3%	**4.9%**	**5.2%**
Prescription Drug (Rx) Carve-Out[5]				
Actives & Retirees <Age 65	6.4%		**6.3%**	
Retirees Age 65+	5.3%		**5.7%**	
Dental				
Schedule of Allowance Plans[6]	4.0%		**4.0%**	
FFS/Indemnity Plans	4.0%		**3.8%**	
Dental Provider Organizations (DPOs)	3.5%		**3.4%**	
Dental Maintenance Organizations (DMOs)	4.1%		**4.5%**	
Vision				
Schedule of Allowance Plans	2.8%		**2.9%**	
Reasonable & Customary (R&C) Plans	3.7%		**3.3%**	

[1] Trend projections were derived by proportionally blending medical trends and freestanding prescription drug trends.

[2] HDHPs with an employee-directed, tax-advantaged health account — a health savings account (HSA) or a health reimbursement account (HRA) — are referred to as account-based health plans and are designed to encourage consumer engagement, resulting in more efficient use of health care services. HDHPs are defined as those plans where the deductible is at least the minimum health savings account (HSA) level required by the Internal Revenue Service ($1,250 single, $2,500 family in 2014).

[3] Open-access PPO/POS plans are those that do not require a primary care physician (PCP) gatekeeper referral for specialty services.

[4] MA plans, part of the Medicare program, can be private HMOs, FFS plans, PPOs or special-needs plans. The 2013 survey collected information about projected trends for MA PPO plans separately. The 2014 survey combines FFS plans with PPOs.

[5] Prescription drug carve-out data was captured for retail and mail-order delivery channels combined.

[6] A schedule of allowance plan is a plan with a list of covered services with a fixed-dollar amount that represents the total obligation of the plan with respect to payment for services, but does not necessarily represent the provider's entire fee for the service.

- Health maintenance organization (HMO) trend rate projections for 2014 are 3 percentage points lower than HMO projections for 2011.
- Prescription drug benefit trends for retail and mail order combined are forecasted at 6.3 percent for active participants and early retirees. These projections are relatively consistent with last year's trend rate projections of 6.4 percent.
- Medicare-eligible retiree plans are also anticipating trend rate declines for Medicare Advantage (MA) preferred provider organizations (PPOs), MA HMOs and Medicare Supplemental plans. MA PPO trends are projected to decrease almost 2 percentage points below 2013 levels to their lowest point in 17 years. This predicted rate decrease for Medicare-eligible retiree plans is more than double the rate decline projected for PPOs for actives and pre-65 retirees.
- In 2014, Medicare-eligible retirees can expect lower trend rates for medical coverage compared to prescription drug coverage. For example, MA HMO trend rates are projected to be 3.3 percent while prescription drug trends (retail and mail order combined) are forecasted at 5.7 percent. These findings are a departure from last year's trends in which the forecasted medical and prescription drug trends rates were aligned. This is largely driven by the rise in specialty drug cost and significant price inflation on brand-name drugs without dramatic new gains in generic utilization. It is noteworthy that trend projections for MA plans are lower despite cutbacks in subsidies from the Centers for Medicare & Medicaid Services (CMS).
- Overall, dental plan trend rates are projected to remain relatively unchanged in 2014. Scheduled vision plan trend rates are projected at 2.9 percent and reasonable and customary plans are forecasted at 3.3 percent in 2014.

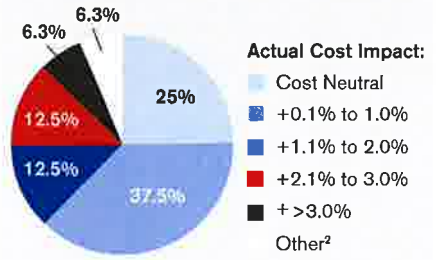
"HMO trend rate projections for 2014 are 3 percentage point lower than HMO projections for 2011."

The survey also looked for regional variations in trend rates. Projected 2014 trend rates for PPO and POS plans combined show regional variations, with the lowest rate of 5.8 percent in the South and highest rate of 10.0 percent in the West.

For the first time, Segal asked insurers to indicate 2014 expected medical PPO cost trends by group size. Results indicate that individual and small groups will trend approximately 1 percentage point higher than large group plans. This is consistent with last year's survey findings.

"For the first time, Segal asked insurers to indicate 2014 expected medical PPO cost trends by group size. Results indicate that individual and small groups will trend approximately 1 percentage point higher than large group plans."

Graph 1: Projected Cost Impact on 2014 Plan Trend of Implementing Preventive Care Coverage for Plans That Lost Their Grandfathered Status by Percentage of Survey Respondents[1]



[1] This data reflects responses from 16 of the health insurers, MCOs and TPAs that participated in the survey. Total exceeds 100% due to rounding.

[2] The survey did not collect data on what the respondents meant by "other."

Impact of Losing "Grandfathered" Status

Segal asked the survey respondents about the expected impact of the Affordable Care Act on costs. Survey findings indicate nearly two-thirds of respondents project a cost increase of 1 percent or less due to loss of "grandfathered" status,[3] with one-quarter of the respondents predicting the loss of grandfathered status will be cost neutral, as shown in Graph 1 above. Only 6 percent of survey respondents anticipate that implementing preventive care coverage for plans that lost their

[3] Group health plans in existence as of March 23, 2010, when the Affordable Care Act was signed into law, and that remain largely unchanged from that date are grandfathered.

What Is Trend?

Trend is a forecast of per capita *claims cost increases* that takes into account various factors, such as price inflation, utilization, government-mandated benefits, and new treatments, therapies and technology. Although there is usually a high correlation between a trend rate and the actual cost increase assessed by a carrier, trend and the net annual change in plan costs are *not* the same. Changes in the costs to plan sponsors can be significantly different from projected claims cost trends, reflecting such diverse factors as group demographics, changes in plan design, administrative fees, reinsurance premiums and changes in participant contributions.

grandfathered status under the Affordable Care Act will result in a cost trend increase of more than 3 percent.

Trend Components

The survey also examined 2014 projected medical trends by service type. Table 2 presents that data. Similar to prior-year projections, price inflation remains the largest component of cost increases and continues high for hospital services and brand-name medications. For prescription drugs, price inflation is projected to jump more than 1 percentage point compared to 2013 forecasts. On the other hand, the projected specialty drug/biotech trend rate, while very high at 16.5 percent, is almost 1 full percentage point lower than the 2013 projection.

In 2014, the utilization component of trend for hospital services is projected to remain unchanged at 2.2 percent. Two noteworthy results supporting lower overall trend rates are the modest price inflation for physician services (3.7 percent) and the flat prescription drug utilization rate. However, the continued upswing in generic dispensing rates based on brands losing patent protection is likely to begin leveling off.

"Price inflation remains the largest component of cost increases."

Accuracy of 2012 Projections

To assess the accuracy of the reported projections, Segal compared the average 2012 trend *forecasts* by national and regional insurers, MCOs, PBMs and TPAs for group medical, prescription drug benefit and dental plans to the *actual* average trend rates experienced by the health plans covered by those organizations for the same 12-month period, as reported by survey respondents. Actual trends for 2012 (the most recent full year for which actual data is available), were the lowest reported in more than 12 years.

Consistent with previous survey findings, this year's findings support our observation that insurers and PBMs tend to make conservative projections and confirm that forecasted trends have been generally higher than actual experience. The following are the most notable findings about the accuracy of trend projections based on the data shown in Table 3:

- The survey found a significant spread of nearly three percentage points between actual and projected trends for high-deductible health plans (HDHP), open-access PPOs/point-of-service (POS) plans for actives and retirees,

"The projected specialty drug/biotech trend rate, while very high at 16.5 percent, is almost 1 full percentage point lower than the 2013 projection."

Table 2: Components of 2013 & 2014 Projected Trends for Hospital Services, Physician Services and Prescription Drugs

	Hospitals[1]		Physicians[1]		Rx	
	2013	2014	2013	2014	2013	2014
Total Trend[2]	**8.7%**	**8.6%**	**6.8%**	**6.0%**	**6.3%**	**6.4%**
Trend Component						
Price Inflation	6.4%	6.3%	3.9%	3.7%	8.4%	6.8%
Utilization	2.2%	2.2%	2.8%	2.3%	0.2%	0.7%

[1] Hospital and physician trends are for open-access PPOs.

[2] The components do not add up to the totals because there are other components of trend not illustrated, reflecting such factors as the impact of cost shifting, technology changes and drug mix. Not all survey respondents provided a breakdown of trend by component.

Table 3: Comparison of 2012 Projected Trends to 2012 Actual Trends

	Projected	Actual
Medical (Actives & Retirees <Age 65)	(without Rx)	
FFS/Indemnity Plans	11.7%	10.0%
HDHPs	10.4%	7.7%
Open-Access PPOs/ POS Plans	10.0%	7.3%
PPOs/POS Plans (with PCP Gatekeepers)	10.4%	8.4%
HMOs	9.6%	6.7%
Medical (Retirees Age 65+)	(without Rx)	
MA PPO[1]	N/A	0.4%
MA HMOs	6.6%	3.0%
Rx Carve-Out[2] (Actives & Retirees <Age 65)	7.2%	5.5%
Rx Carve-Out[2] (Retirees Age 65+)	6.5%	2.2%
Dental		
Scheduled Plans	4.1%	2.9%
FFS/Indemnity Plans	4.2%	2.8%
DPOs	3.8%	2.6%
DMOs	4.4%	3.4%
Vision		
Scheduled Plans	3.8%	2.3%
R&C Plans	3.9%	2.9%

[1] For 2012, the survey asked for Medicare Supplement (Medigap) trends and MA HMO trends for retiree medical post-65. It did not ask for MA PPO trend rate information.

[2] The 2012 survey captured prescription drug carve-out data for retail and mail-order delivery channels combined.

PPOs/POS plans with a physician gatekeeper *and* HMOs for the active and retiree under 65 population.

- For prescription drugs, the differential between actual and forecasted trend rates was more than double for retirees age 65 and older than for actives and retirees under 65: 4.3 percentage points compared to 1.7 percentage points.

Table 4 shows selected trends (actual trends for 2002–2012 and projected trends for 2013 and 2014).

It should be noted that the accuracy of projections is subject to both underwriters' conservatism in predicting future events and a natural lag in the underwriting cycle. In periods where costs are decelerating, forecasters will tend to overestimate trends. Similarly, when costs are accelerating, trend projections will generally be underestimated for a period. Consequently, accuracy of trend assumptions is best measured by comparing projected trend to actual trend over multiple years. Graphs 2 and 3 illustrate the significant but declining variances between trend forecasts versus actual trends experienced in 2008 and 2009.

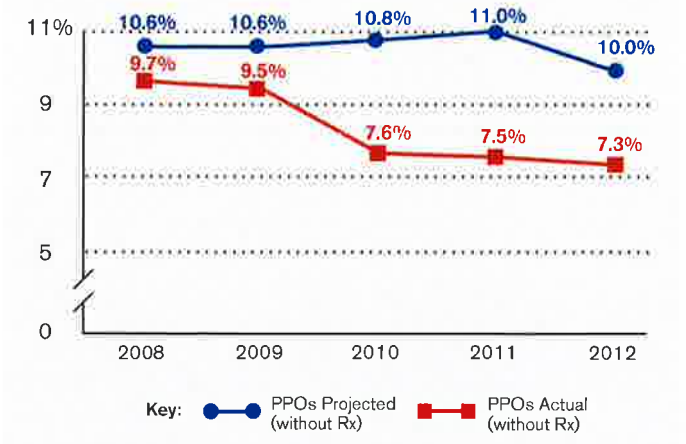
Table 4: Selected Medical, Rx Carve-Out and Dental Trends: 2002-2012 Actual and 2013 and 2014 Projected*

Year	PPOs (without Rx)	POS Plans (without Rx)	HMOs (without Rx)	MA HMOs (without Rx)	Rx	DPOs
2002 Actual	13.9%	12.2%	12.8%	12.9%	18.4%	6.4%
2003 Actual	12.0%	11.5%	11.5%	10.0%	14.3%	6.5%
2004 Actual	10.9%	11.6%	11.5%	11.4%	13.3%	6.2%
2005 Actual	10.4%	11.1%	10.6%	8.4%	10.5%	5.0%
2006 Actual	9.6%	10.0%	10.2%	7.2%	9.5%	5.1%
2007 Actual	8.9%	9.5%	9.8%	7.0%	7.9%	5.0%
2008 Actual	9.7%	9.4%	9.7%	7.7%	7.4%	5.5%
2009 Actual	9.5%	9.7%	10.2%	4.0%	7.9%	4.7%
2010 Actual	7.6%	8.3%	8.7%	3.6%	6.4%	3.0%
2011 Actual	7.5%	7.8%	8.0%	4.5%	5.0%	3.1%
2012 Actual	7.3%	8.4%	6.7%	3.0%	5.5%	2.6%
2013 Projected	8.8%	9.3%	8.2%	5.8%	6.4%	3.5%
2014 Projected	7.9%	8.4%	7.2%	3.3%	6.3%	3.4%

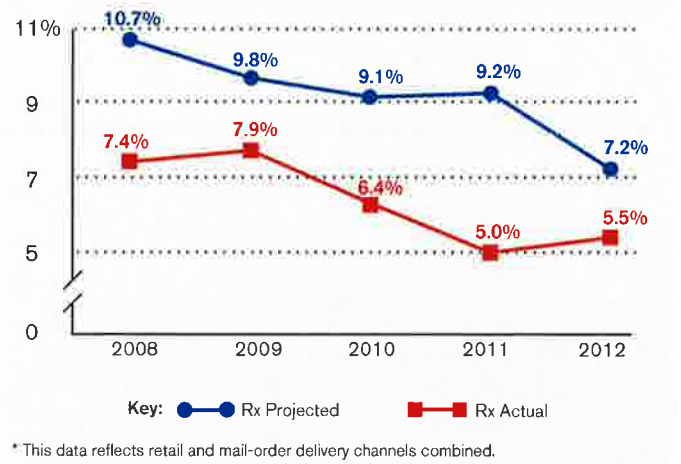
* All trends are illustrated for actives and retirees under age 65, except for the MA Plans. (A graph comparing 13 years of survey data — 2013 and 2014 projected trends to actual trends for 2002 through 2012 — is available on the following page of Segal's website: http://www.segalco.com/publications/surveysandstudies/2014TSsupp.pdf)

"The accuracy of projections is subject to both underwriters' conservatism in predicting future events and a natural lag in the underwriting cycle. In periods where costs are decelerating, forecasters will tend to overestimate trends."

Graph 2: Comparison of Projected to Actual Trends for PPOs for Actives and Retirees under Age 65: 2008–2012



Graph 3: Comparison of Projected to Actual Trends for Rx* Carve-Out Coverage for Actives and Retirees under Age 65: 2008-2012



* This data reflects retail and mail-order delivery channels combined.

Segal also asked the survey participants to indicate the top five major diagnostic categories (MDC) that had the highest actual cost trends in 2012. Table 5 shows the results, from highest to lowest, by rank in 2012 compared to rank in 2011.

In this year's survey, Segal asked the respondents to indicate the medical management strategies that are most effective in reducing medical plan cost trends based on their experience. Responses indicate that the most effective and widely used strategy is care management and specialty case management programs, such as those that focus on acute care, chronic care and oncology care. Another successful cost-containment option reported by survey respondents is the management of hospital admissions and readmissions using tools such as redirecting hospital outpatient services and overseeing inpatient admissions.

"Although it remains to be seen whether the deceleration in trends projected for 2014 has been influenced by short-term economic forces, the influence of the Affordable Care Act or some other factor not yet identified, there continue to be significant changes in the health care delivery system that could have long-term implications for health care costs."

Commentary & Outlook

Although it remains to be seen whether the deceleration in trends projected for 2014 has been influenced by short-term economic forces, the influence of the Affordable Care Act or some other factor not yet identified, there continue to be significant changes in the health care delivery system that could have long-term implications for health care costs. Some of these changes are noted below:

- Many plan designs now include greater levels of participant out-of-pocket costs.
- Provider reimbursement arrangements are beginning to shift from the fee-for-service model to alternative payment models, such as bundled payments, which are designed to encourage providers to coordinate care and reward efficiency.
- The Hospital Readmissions Reduction Program, which requires CMS to reduce payments to hospitals with excess readmissions, has helped to reduce overall hospital spending by including comprehensive strategies for discharge planning, medication management, and continuum of care.
- Participants are becoming more educated consumers through programs such as Choose Wisely, which lists five questions patients should discuss with physicians about medical tests and procedures that may be unnecessary (and, in some instances, can cause harm) and the Five-Star Quality Rating System created by CMS to help consumers compare how nursing homes' quality of care and services vary.
- Costs are becoming more transparent. A growing number of health insurers have invested heavily in new member-support decision tools that provide more information on health treatment costs. There are also publically available transparency tools, such as Hospital Compare (CMS-published data on what providers charge for common services, which shows significant variation across the country at over 4,000 Medicare-certified hospitals) and Fair Health, an independent not-for-profit

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Table 5: Top Five Major Diagnostic Categories (MDC) with Highest PMPY Cost Trends in 2012 Compared to 2011

	Rank	
	2012	2011
Diseases and disorders of the digestive system	1	2
Diseases and disorders of the musculoskeletal system and connective tissue	2	1
Pregnancy, childbirth and the puerperium*	2	3
Diseases and disorders of the circulatory system	3	2
Diseases and disorders of the nervous system	3	Not in Top 5
Lymphatic, hematopoietic and other malignancies	4	3
Infectious and parasitic diseases, systemic or unspecified sites	4	Not in Top 5

*"Puerperium" is the period of adjustment after childbirth during which the mother's reproductive organs return to their non-pregnant state.

corporation with a web portal that allows consumers to access a medical cost transparency database for determining out-of-network reimbursement.

- Plan sponsors are encouraging participants to seek care for minor illnesses at lower-cost settings, such as telemedicine and walk-in clinics.
- There is growing use of Patient-Centered Medical Homes (PCMH), which focus an increased level of comprehensive health care resources on primary care and prevention for patients with chronic conditions. Also, as Accountable Care Organizations (ACOs)[4] and PCMHs expand, they will offer new options for plan sponsors.
- Reference-based pricing, in which the plan makes a defined contribution towards covering the cost of a particular service, to steer participants towards higher-quality hospitals or physicians for specific procedures or conditions (*e.g.*, the California Public Employees' Retirement System's use of maximum allowance for hip and knee replacement), is expanding.
- Network provider contracting is being improved to remove high-cost outlier providers who cannot prove their value.

While medical plan cost trend continues to decelerate, overall health plan costs are still on the rise. Faced with this reality, plan sponsors are becoming increasingly more progressive and creative in their efforts to manage costs while delivering high-quality, cost-effective health care. Plan sponsors must be ready to implement new requirements introduced by the Affordable Care Act[5] and to determine their impact on plan costs. Plan sponsors will need to play an active role to continue to get the most for their benefit dollars.

"While medical plan cost trend continues to decelerate, overall health plan costs are still on the rise."

For assistance with health care cost management strategies, contact your Segal consultant or the nearest Segal office. A list of Segal offices can be accessed from the second hyperlink in the blue box below.

[4] ACOs, which have mainly been developed for the Medicare population, are networks of providers and suppliers that agree to be jointly accountable for managing the health of participating populations across the care continuum.

[5] New guidance on the Affordable Care Act is released on a regular basis. As guidance is issued, it is summarized in Segal publications. All of Segal's publications on the Affordable Care Act can be accessed from the Health Care Reform Guide on the Segal website: http://www.segalco.com/publications-and-resources/health-care-reform/

The Survey Participants

The 2014 *Segal Health Plan Cost Trend Survey* was conducted in May and June of 2013. Survey participants were asked to provide the trend factors they will be applying to historical claims to predict expected claims for 2014. Segal received 99 responses to the survey. The following participants agreed to disclose their names: Aetna; Amalgamated Life; Amerihealth of New Jersey; Anthem Blue Cross and Blue Shield; Anthem Blue Cross of California; Arkansas Blue Cross and Blue Shield; Assurant Employee Benefits; Benecard; Blue Cross and Blue Shield of Illinois; BlueCross and BlueShield of Tennessee; Blue Cross Blue Shield of Michigan; Capital District Physician's Health Plan; Care Plus Dental Plans; Catamaran; CIGNA; ConnectiCare, Inc.; CVS Caremark; Delta Dental of Arizona, Delta Dental of Arkansas; Delta Dental Insurance Company (DDIC); Delta Dental of California; Delta Dental of Colorado; Delta Dental of Delaware; Delta Dental of the District of Columbia; Delta Dental of Idaho; Delta Dental of Illinois; Delta Dental of Indiana; Delta Dental of Kansas; Delta Dental of Massachusetts; Delta Dental of Michigan; Delta Dental of Minnesota; Delta Dental of Nebraska; Delta Dental of New Mexico; Delta Dental of New York; Delta Dental of North Carolina; Delta Dental of Ohio; Delta Dental of Pennsylvania; Delta Dental of Tennessee; Delta Dental of Virginia; Delta Dental of West Virginia; Delta Dental of Wisconsin; EmblemHealth; Envision Pharmaceutical Services; Excellus Health Plan, Inc.; Express Scripts, Inc.; Health Alliance Medical Plans; Health Net, Inc.; Horizon Blue Cross Blue Shield of New Jersey; Humana, Inc.; Independence Blue Cross; ING; Kaiser Foundation Health Plan; Lincoln Financial Group; Medical Mutual; Moda Health; MVP Health Care; Navitus Health Solutions; Nippon Life Insurance Company of America; OptumRx; Restat; The ODS Companies; Trustmark Life; Tufts Health Plan; UnitedHealthcare; United Concordia; and US Script.