Brown & Brown INSURANCE®

EMPLOYEE BENEFITS

# 2025 Health Plan Renewal

## West Lafayette School Corporation

Presented by:

*Richard Sutton, Diane Titchenell*

# West Lafayette Community School

## 01/01/2024 - 12/31/2024 Summary of Benefits

| | PPO - Plan 1 | | HDHP/HSA - Plan 2 | |
|---|---|---|---|---|
| | Network | Non-Network | Network | Non-Network |
| Deductible (Single/Family) | $1,000/$3,000 | $2,000/$6,000 | $3,500/$6,000 | $6,000/$12,000 |
| Coinsurance | 10% | 30% | 0% | 30% |
| Out-of-Pocket Limit (Single/Family) | $2,500/$5,000 | $5,000/$10,000 | $3,500/$6,000 | $12,000/$24,000 |
| Lifetime Maximum | Unlimited | Unlimited | Unlimited | Unlimited |
| Preventive Care Services | $0 NCS | 30% | $0 NCS | 30% |
| Physician Office Visits (PCP/SCP) | $20/$20 | Coinsurance | 0% | 30% |
| Emergency Room | $100 | | 0% | 30% |
| Urgent Care | $25 | Coinsurance | 0% | 30% |
| Behavioral Health (MH SUD) | $20 | 30% | Coinsurance | Coinsurance |
| Prescription Drugs - Pharmacy | Rx Maximum out of Pocket $4,650 Single/$9,300 Family | | | |
| *Generic*<br>*Brand*<br>*Non-formulary* | $10<br>$20<br>$40 | 50%, min $40 | Subject to Medical Deductible and Coinsurance | |
| Mail Order | | | | |
| *Generic*<br>*Brand*<br>*Non-formulary* | $20<br>$40<br>$120 | Not Covered | Subject to Medical Deductible and Coinsurance | |

*Deductibles Apply to covered services listed with a percentage (%) coinsurance. NCS - No Cost Share*

*NCS - No Cost Share*

*ACA requires all plans to include a combined OOP maximum for both medical and phamacy - Single $9,450/ Family $18,900 for 2024.*

*Please refer to your SBC (Summary of Benefit Coverage) and certificate booklet for further details.*

# 2025 HSA AND HDHP LIMITS

Each year, the IRS announces inflation-adjusted limits for health savings accounts (HSAs) and high deductible health plans (HDHPs).

The following chart shows the HSA and HDHP limits for 2025 as compared to 2024. It also includes the catch-up contribution limit that applies to HSA-eligible individuals who are age 55 or older, which is not adjusted for inflation and stays the same from year to year.

| TYPE OF LIMIT | | 2024 | 2025 | CHANGE |
|---|---|---|---|---|
| **HSA Contribution Limit** | Self-only | $4,150 | $4,300 | **Up $150** |
| | Family | $8,300 | $8,550 | **Up $250** |
| **HSA Catch-up Contributions** *(not subject to adjustment for inflation)* | Age 55 or older | $1,000 | $1,000 | No change |
| **HDHP Minimum Deductible** | Self-only | $1,600 | $1,650 | **Up $50** |
| | Family | $3,200 | $3,300 | **Up $100** |
| **HDHP Maximum Out-of-Pocket Expense Limit** *(deductibles, copayments and other amounts, but not premiums)* | Self-only | $8,050 | $8,300 | **Up $250** |
| | Family | $16,100 | $16,600 | **Up $500** |

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**Embedded Deductible -** In health insurance, a deductible is a specified amount of money you must pay before your insurer will provide aid for medical expenses. Family policies under the Affordable Care Act (ACA) often have one of two deductibles: aggregate (non-embedded) or embedded deductibles.

**An embedded deductible has both an individual deductible for each family member and a family deductible that is the overall deductible for the policy. The individual deductible in an embedded policy is set lower, allowing a single family member access to medical benefits sooner. This can save families money in the event that one family member incurs a large number of medical expenses.**

**How does an embedded deductible work?**
In an embedded deductible health plan, the policy will have two deductibles: the individual deductible for each family member covered and a family deductible. Due to the two deductibles, the coverage provided by the insurer for embedded policies can be accessed sooner.
When one family member accrues enough medical expenses to the point that they meet their individual deductible, after-deductible health insurance benefits, like copays, coinsurance and cost sharing, will be provided by the insurer. However, these will be provided **solely for that family member**. Other members of the family would not yet be eligible for the same benefits.
Once multiple family members' medical expenses add up and surpass the family deductible, the insurer would begin to pay covered medical expenses for **all members of the family**. This applies even if a member did not meet their individual deductible.
**Embedded deductible example**
Say your family has a health plan with an individual deductible of $3,500 and a family deductible of $7,000. If your spouse experiences an injury with medical expenses of $3,500, your spouse would have met his/her individual deductible and he or she would have their medical expenses covered for the rest of the year. But you and your child would still need to pay expenses out of pocket until the family deductible or your individual deductible requirement is met.
Suppose that, later on in the year, you and your child have collected $3,500 of medical expenses together. Therefore, combined with the $3,500 of health care costs your spouse incurred earlier, you would fulfill the family deductible limit of $7,000. From this point onward during the plan year, you would no longer need to pay any deductibles, and the insurer would begin to pay covered medical expenses for the entire family.
**Embedded vs. non-embedded deductibles.** Family health insurance plans can have one of two types of deductibles:

- Embedded deductible (includes an individual and family deductible)
- Non-embedded deductible (includes only a family deductible)

**Embedded and non-embedded deductibles differ in how the deductible level is reached**.
Non-embedded deductible plans, also known as aggregate deductibles, do not begin to pay for medical expenses until the entire family deductible has been met. Furthermore, there are no individual deductible amounts for each family member. The two types of deductibles are similar in that once the family deductible has been met, the insurer covers medical expenses for all members of the family.
For example, an aggregate health plan could have a family deductible of $14,000. During the course of the plan year, say your family has spent $9,000 on medical expenses in total, with $8,000 of that amount attributed to an injury you sustained. At this point, you would not receive after-deductible benefits from the plan because the family deductible of $14,000 has not been met.

# West Lafayette Community School Corporation

Claims History - Rolling 12 Months

| Month | Enroll | Maximum | Expected | Medical | Rx | Specific Claims | Net Med/Rx Claims | % of Expected |
|---|---|---|---|---|---|---|---|---|
| Sep-22 | 209 | $205,430 | $164,344 | $168,209 | $60,258 | $114,013 | $114,455 | 70% |
| Oct-22 | 216 | $212,311 | $169,848 | $149,797 | $61,592 | $62,946 | $148,443 | 87% |
| Nov-22 | 216 | $212,311 | $169,848 | $164,831 | $45,542 | $67,293 | $143,080 | 84% |
| Dec-22 | 215 | $211,328 | $169,062 | $211,955 | $73,223 | $86,485 | $198,694 | 118% |
| Jan-23 | 221 | $240,169 | $192,135 | $166,551 | $64,577 | $0 | $231,128 | 120% |
| Feb-23 | 222 | $241,256 | $193,004 | $40,204 | -$12,120 | $0 | $28,084 | 15% |
| Mar-23 | 223 | $242,342 | $193,874 | $141,392 | $77,267 | $0 | $218,659 | 113% |
| Apr-23 | 222 | $241,256 | $193,004 | $83,828 | $54,034 | $0 | $137,862 | 71% |
| May-23 | 222 | $241,256 | $193,004 | $99,241 | $59,484 | $0 | $158,725 | 82% |
| Jun-23 | 224 | $243,429 | $194,743 | $136,753 | $46,829 | $11,549 | $172,033 | 88% |
| Jul-23 | 221 | $240,169 | $192,135 | $195,542 | $40,306 | $27,237 | $208,611 | 109% |
| Aug-23 | 219 | $237,995 | $190,396 | $125,334 | $44,739 | $19,741 | $150,332 | 79% |
| Sep-23 | 221 | $240,169 | $192,135 | $232,450 | $35,979 | $71,690 | $196,739 | 102% |
| Oct-23 | 223 | $242,342 | $193,874 | $102,736 | $36,674 | $21,658 | $117,751 | 61% |
| Nov-23 | 224 | $243,429 | $194,743 | $311,956 | $43,142 | $88,636 | $266,462 | 137% |
| Dec-23 | 224 | $243,429 | $194,743 | $98,394 | $38,132 | $32,870 | $103,656 | 53% |
| Jan-24 | 226 | $248,993 | $199,195 | $108,927 | $20,999 | $0 | $129,926 | 65% |
| Feb-24 | 224 | $246,790 | $197,432 | $45,473 | $24,448 | $0 | $69,921 | 35% |
| Mar-24 | 227 | $250,095 | $200,076 | $106,011 | $23,208 | $0 | $129,218 | 65% |
| Apr-24 | 226 | $248,993 | $199,195 | $151,221 | $36,627 | $1,460 | $186,388 | 94% |
| May-24 | 225 | $247,892 | $198,313 | $192,809 | $56,034 | $41,348 | $207,495 | 105% |
| Jun-24 | 225 | $247,892 | $198,313 | $67,616 | $50,787 | $793 | $117,610 | 59% |
| Jul-24 | 221 | $243,485 | $194,788 | $98,351 | $45,816 | $503 | $143,664 | 74% |
| Aug-24 | 217 | $239,078 | $191,262 | $17,670 | $33,011 | $39,036 | $11,645 | 6% |
| Current Rolling 12 | 2,683 | 2,942,585 | 2,354,068 | 1,533,613 | 444,857 | 297,993 | 1,680,477 | 71% |
| **PEPM (Current)** | | | | **$571.60** | **$165.81** | **$111.07** | **$626.34** | |
| Prior Rolling 12 | 2,630 | 2,769,250 | 2,215,400 | 1,683,638 | 615,731 | 389,264 | 1,910,105 | 86% |
| **PEPM (Prior)** | | | | **$640.17** | **$234.12** | **$148.01** | **$726.28** | |
| **% Chg. (PEPM)** | **2.0%** | | | **-10.7%** | **-29.2%** | | **-13.8%** | |

*Percentages shown represent a historical comparison with no relation to future costs.*
*All reinsurance reimbursements are estimated and subject to an audit.*
*Medical Expenses include Enhanced Personal Health costs*
*Specific Stop Loss Deductible = $100,000*

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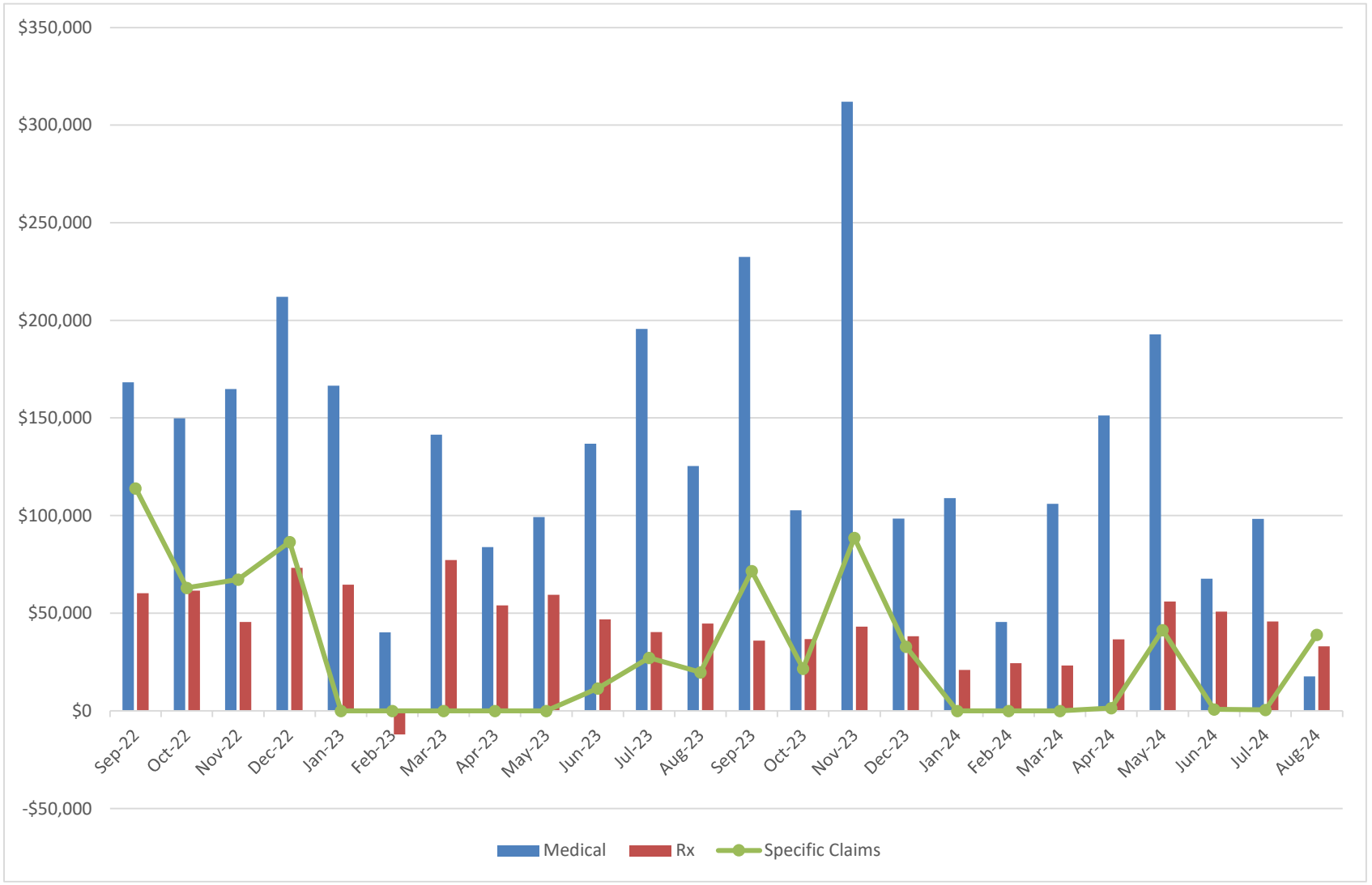
# Med, RX, and Spec. Claims by Month

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# West Lafayette Community School Corporation

## 2025 Medical & Rx Cost Plus Comparison

| | | Current Anthem | Renewal Anthem | |
|---|---|---|---|---|
| | **FIXED COSTS (Per EE/MO)** | Cost Plus | Cost Plus | **% Incr.** |
| 217 | Admin/Network/UM | $68.51 | $67.53 | -1.4% |
| | Rx Rebate Offset | ($29.07) | ($30.23) | |
| | Anthem Health & Wellness/Enhanced Clinic Package | $6.31 | $7.29 | |
| | Specific Premium Composite (Medical/Rx) | $408.96 | $408.96 | 0.0% |
| | Aggregate Premium Composite (Medical/Rx) | $13.71 | $13.71 | 0.0% |
| | PPO Network | Blue Access | Blue Access | |
| | Specific Stop Loss Deductible | $100,000 | $100,000 | |
| | PPACA Reinsurance Fee | $0.00 | $0.00 | |
| | PPACA PCORI Fee | $0.44 | $0.48 | |
| | **Total PPACA Fee** | **$0.44** | **$0.48** | |
| | Specific Contract Type | Paid | Paid | |
| | Monthly Fixed Cost Per Employee | $468.86 | $467.74 | |
| | **Total Monthly Fixed Cost** | $101,744 | $101,499 | |
| **A.** | **Total Annual Fixed Costs** | **$1,220,924** | **$1,217,988** | **-0.2%** |
| | **CLAIMS COSTS** | Med/Rx | Med/Rx | |
| | Aggregate Contract Type | Paid | Paid | |
| | Aggregate Corridor | 125% | 125% | |
| | Maximum Attachment Factor | $1,101.74 | $991.56 | |
| | Expected Attachment Factor | $881.39 | $793.25 | **-10.0%** |
| **B.** | Aggregate Attachment Point | $2,868,931 | $2,582,022 | |
| **C.** | Expected Claims (100%) | $2,295,145 | $2,065,618 | |
| **D.** | Clinic Expenses* | $204,000 | $204,000 | |
| | **Total Annualized Maximum Costs (A+B+D)** | **$4,293,855** | **$4,004,010** | |
| | **Total Annualized Expected Costs (A+C+D)** | **$3,720,068** | **$3,487,606** | **-6.2%** |
| | | | | |
| | **Monthly Deposit** | **$295,600** | **$279,800** | **-5.3%** |
| | **Annual Deposit** | **$3,547,200** | **$3,357,600** | |

*This is only an outline. Actual contract provisions will be determined by insurance company.*

# West Lafayette Community School Corporation

## 2025 Considerations

| **January 2024 - Current** | **Anthem Current** |
|---|---|
| Current Annual Premium Generated | $3,490,337 |
| Current Maximum Liability | $4,293,855 |
| Current Expected Liability | $3,720,068 |
| Current Annual Deposit | $3,547,200 |
| Current Reserves (as of 09/24/2024) | $393,460 |

| **January 2025 - Renewal** | **Anthem Renewal** |
|---|---|
| Renewal Maximum Liability | $4,004,010 |
| Renewal Expected Liability | $3,487,606 |
| Agg Corridor *(Maximum - Premium Generated)* | *$513,673* |
| Estimated IBNR* | *$206,562* |
| Target Reserve (Agg Corridor + IBNR) | $720,235 |
| Renewal Annual Deposit | $3,357,600 |
| **Funding Level Impact on Reserve** | **$2,732** |
| Increase to Fund Expected | -0.1% |

*IBNR is calculated as 10% of Expected Claims

# West Lafayette Community School

## 2025 Funding Rates

| | August 2024 Enrollment | Current Rates | Renewal Rates at 1% Increase | Renewal Rates at 2% Increase |
|---|---|---|---|---|
| **PPO Plan $1,000/$3,000** | | | | |
| Employee | 68 | $1,186.57 | $1,198.43 | $1,210.30 |
| Emp/Spouse | 2 | $2,495.29 | $2,520.24 | $2,545.19 |
| Emp/Child(ren) | 7 | $2,138.36 | $2,159.75 | $2,181.13 |
| Family | 5 | $2,969.59 | $2,999.28 | $3,028.98 |
| | **82** | **$1,385,922** | **$1,399,782** | **$1,413,641** |
| **HDHP/HSA Plan $3,500/$6,000** | | | | |
| Employee | 79 | $880.18 | $888.99 | $897.79 |
| Emp/Spouse | 6 | $1,851.01 | $1,869.52 | $1,888.03 |
| Emp/Child(ren) | 25 | $1,586.25 | $1,602.11 | $1,617.97 |
| Family | 25 | $2,202.84 | $2,224.87 | $2,246.90 |
| | **135** | **$2,104,415** | **$2,125,459** | **$2,146,503** |
| **Annual Medical/Rx Funding** | **217** | **$3,490,337** | **$3,525,241** | **$3,560,144** |
| | | | | |
| **Vision** | | | | |
| Employee | 142 | $6.38 | $6.38 | $6.38 |
| Family | 74 | $15.30 | $15.30 | $15.30 |
| **Annual Vision Funding** | **216** | **$24,458** | **$24,458** | **$24,458** |
| | | | | |
| **Dental** | | | **Renewal Rates at 9% Increase** | **Renewal Rates at 12.5% Increase** |
| Employee | 108 | $25.60 | $27.90 | $28.80 |
| Emp/Spouse | 22 | $50.40 | $54.94 | $56.70 |
| Emp/Child(ren) | 27 | $70.28 | $76.61 | $79.07 |
| Family | 52 | $105.10 | $114.56 | $118.24 |
| **Annual Dental Funding** | **209** | **$134,836** | **$146,972** | **$151,691** |
| | | | | |
| **Total Annual Funding (Medical + Vision + Dental)** | | **$3,649,632** | **$3,696,670** | **$3,736,293** |

| | | | |
|---|---|---|---|
| **Reserve Impact if 'Expected' Claims Occur (Anthem Renewal):** | **$2,732** | **$37,635** | **$72,538** |

# West Lafayette Community School Corporation

## 2025 Dental Renewal

| | Enroll | Current Anthem | Renewal Anthem | Revised 1 Year Anthem | Revised 2 Year Anthem |
|---|---|---|---|---|---|
| | | | | | |
| Employee | 108 | $25.60 | $30.20 | $27.90 | $28.80 |
| Employee/Spouse | 22 | $50.40 | $59.46 | $54.94 | $56.70 |
| Employee/Child(ren) | 27 | $70.28 | $82.92 | $76.61 | $79.07 |
| Family | 52 | $105.10 | $124.00 | $114.56 | $118.24 |
| | | | | | |
| **Annual Funding** | **209** | **$134,836** | **$159,079** | **$146,972** | **$151,691** |
| Increase | | | 18.0% | 9.0% | 12.5% |
| | | | | | |
| Network | | Essential Choice/Complete | Essential Choice/Complete | Essential Choice/Complete | Essential Choice/Complete |
| | | | | | |
| Effective Date | | 1/1/2023 | 1/1/2025 | 1/1/2025 | 1/1/2025 |
| Premium/Fee Guarantee | | | 1 year | 1 year | 2 year |
| | | | | | |
| **BENEFITS** | | | | | |
| Calendar Year Maximum | | $1,000 | $1,000 | $1,000 | $1,000 |
| Deductible (Ind./Family) | | $50/$150 | $50/$150 | $50/$150 | $50/$150 |
| Preventive | | 100% | 100% | 100% | 100% |
| Minor Restorative Services | | 80% | 80% | 80% | 80% |
| Basic | | 50% | 50% | 50% | 50% |
| Major | | 50% | 50% | 50% | 50% |
| Orthodontia | | 50% | 50% | 50% | 50% |
| Ortho Lifetime Max | | $1,000 | $1,000 | $1,000 | $1,000 |

# West Lafayette Community School Corporation

## 2025 Vision Renewal

| | | Anthem - Current | Anthem - Renewal | % Change |
|---|---|---|---|---|
| | **Enroll** | **Current Rate** | **Renewal Rate** | |
| Employee | 142 | $6.38 | $6.38 | 0.0% |
| Family | 74 | $15.30 | $15.30 | 0.0% |
| | | | | |
| **Annual Funding** | **216** | **$24,458** | **$24,458** | 0.0% |
| | | | | |
| **Rate Guarantee** | | | **2 Years** | |
| **Effective Date** | | **1/1/2023** | **1/1/2025** | |
| **BENEFITS: Network/Non-Network** | | | | |
| Exam Co-pay | | $10 | $10 | |
| Eye Exam (In/Out) | | 100% after copay / up to $42 | 100% after copay / up to $42 | |
| Lense Co-pay | | $20 | $20 | |
| Single lenses | | 100% after copay / up to $40 | 100% after copay / up to $40 | |
| Bifocal lenses | | 100% after copay / up to $60 | 100% after copay / up to $60 | |
| Trifocal lenses | | 100% after copay / up to $80 | 100% after copay / up to $80 | |
| Frames only | | Up to $150 / up to $45 | Up to $150 / up to $45 | |
| Contact lenses (elective) | | Up to $140 / up to $105 | Up to $140 / up to $105 | |
| Contact lenses (medical necessity) | | 100% / up to $210 | 100% / up to $210 | |
| Frequency - Exam | | 12 Months | 12 Months | |
| Frequency - Lenses | | 12 Months | 12 Months | |
| Frequency - Frames | | 24 Months | 24 Months | |

# 2024 West Lafayette School Corporation

Monthly Level Payment

$295,600

**$2,364,800** **August**

Monthly PEPM admin fee

$468.42

Medical

Spec Claims deleted

**$83,139**

**Claims & Enrollment by month**

| | Enroll | Med Claims | Rx Claims | EPH |
|---|---|---|---|---|
| January-24 | 226 | $108,022 | $20,999 | $905 |
| February-24 | 224 | $44,687 | $24,448 | $686 |
| March-24 | 227 | $105,385 | $23,208 | $545 |
| April-24 | 226 | $150,443 | $36,627 | $708 |
| May-24 | 225 | $192,025 | $56,034 | $714 |
| June-24 | 225 | $66,903 | $50,787 | $713 |
| July-24 | 221 | $97,639 | $45,816 | $712 |
| August-24 | 217 | $17,047 | $33,011 | $623 |
| September-24 | | | | |
| October-24 | | | | |
| November-24 | | | | |
| December-24 | | | | |
| **Total:** | 1791 | **$782,151** | **$290,930** | **$5,606** |

**Medical admin cost** **$838,940**

**Estimated settlement: $530,312**

## NOTICE OF CARRIER FINANCIAL STATUS

Brown & Brown makes every attempt to place coverage with carriers rated A- or better* through AM Best (www.ambest.com), a national credit rating agency with a specific focus on the insurance industry. Because an AM Best rating is not required by the various state departments of insurance, there are many carriers in the Employee Benefits industry that elect not to participate in AM Best's rating process for various reasons. Therefore, Brown & Brown periodically places coverage with carriers rated less than A- or non-rated by AM Best.

Please be advised that Brown & Brown does monitor carriers rated less than A- or non-rated on an ongoing basis. However, because Brown & Brown cannot certify the financial soundness or stability of any insurance company or alternative risk transfer entity, or otherwise predict whether the financial condition of a company might improve or deteriorate, we encourage you to review the financial information for each carrier at AM Best's website (www.ambest.com), a state department of insurance website, the applicable carrier website and/or with your accountant, legal counsel and other advisors.

If you need assistance identifying the appliable issuing carriers for your current coverage, renewal coverage, or the coverage options being presented to you, please feel free to contact us at 317-704-8315 for assistance. Alternative quotes with an A- or better rated carrier may also be available upon your request.

### * AM Best General Rating Guide

| Financial Strength Rating | |
|---|---|
| A++, A+ | Superior |
| A, A- | Excellent |
| B++, B+ | Good |
| B, B- | Fair |
| C++, C+ | Marginal |
| C, C- | Weak |
| D | Poor |
| E | Under Regulatory Supervision |
| F | In Liquidation |
| S | Suspended |

| Financial Size Category (in Thousands) | | | |
|---|---|---|---|
| Class I | Up to | $1,000 | |
| Class II | $1,000 | to | $2,000 |
| Class III | $2,000 | to | $5,000 |
| Class IV | $5,000 | to | $10,000 |
| Class V | $10,000 | to | $25,000 |
| Class VI | $25,000 | to | $50,000 |
| Class VII | $50,000 | to | $100,000 |
| Class VIII | $100,000 | to | $250,000 |
| Class IX | $250,000 | to | $500,000 |
| Class X | $500,000 | to | $750,000 |
| Class XI | $750,000 | to | $1,000,000 |
| Class XII | $1,000,000 | to | $1,250,000 |
| Class XIII | $1,250,000 | to | $1,500,000 |
| Class XIV | $1,500,000 | to | $2,000,000 |
| Class XV | $2,000,000 | or | Greater |

**Compensation**

Brown & Brown entities ("we") receive commissions and fees from insurance carriers and other vendors as part of our compensation for placing and servicing your policies and products. Commissions are generally a percentage of the total premium and may be based on a schedule. In some cases, we may also receive direct compensation from the plan or the plan sponsor (service and/or consulting fees).

In addition to commissions and fees paid to Brown & Brown by insurance or reinsurance carriers or third-party vendors as mentioned above, Brown & Brown entities may also receive supplemental and/or bonus compensation from the carrier or vendor based on new sales volume or retention, for example. Such supplemental and/or bonus compensation may consist of guaranteed override income based on our agency's business production and retention with the carrier or vendor, general agency fees, and/or sales or retention bonuses and is partially derived from your premium dollars, after being combined (or "pooled") with the premium dollars of other insureds that have purchased similar types of coverage. Brown & Brown may not know in advance if such a supplemental and/or bonus payment will be made by a particular carrier or vendor, or the amount of any such payments until the underwriting year is closed.

Brown & Brown entities may also receive invitations to programs sponsored and paid for by insurance carriers or other vendors to inform brokers regarding their products and services, including possible participation in company-sponsored events such as trips, seminars, and advisory council meetings, based upon the total volume of business placed with the carrier you select. We may also receive non-monetary compensation (including but not limited to the value of travel, meals and entertainment expenses associated with such meetings, gifts, tickets for sporting and entertainment events and awards). Such compensation allocated to your policy is not normally expected to equal or exceed a sum of $250.00 in aggregate, when all non-monetary compensation items received are combined.

Brown & Brown entities may, on occasion, receive loans or credit from insurance companies. Additionally, in the ordinary course of our business, we may collect and remit premiums on behalf of the carrier or vendor and may earn and retain interest on premiums or administrative fees you pay from the date we receive them until the date remitted to the carrier or vendor.

If an intermediary is utilized in the placement of coverage, the intermediary may or may not be owned in whole or part by Brown & Brown, Inc. or its subsidiaries. Brown & Brown entities operate independently and are not required to utilize other companies owned by Brown & Brown, Inc., but routinely do so. In addition to providing access to the carrier or other vendor, the Wholesale Insurance Broker/Managing General Agent may provide additional services including, but not limited to: underwriting, quoting, plan implementation assistance, claims advocacy and eligibility administration services. . Compensation paid for those services is either derived from your premium payment, which may on average be up to 15% of the premium you pay for coverage and may include additional fees charged by the intermediary or is paid to the Wholesaler/Managing General Agent via override.

**Questions and Information Requests**. Should you have any questions, or require additional information, please contact this office at 317-574-5000 or, if you prefer, submit your question or request online at http://www.bbinsurance.com/customerinquiry/

## PROPOSAL DISCLAIMS & DISCLOSURES

- The analysis of the following plans is a summary. Please refer to the policy certificate for a full list of coverage and exclusions.
- The rates and benefits in this proposal are based upon underwriting factors which include, but are not limited to, the census provided, the effective date shown, the status of employees/dependents (i.e. actively at work, COBRA, FMLA), final enrollment, etc. If any of the aforementioned changes prior to the proposed effective date, the final provisions, including rates, for these plans may vary or result in the proposed plan to be withdrawn.
- If you select to change carriers, any existing plans with other carriers should not be cancelled until advised by Brown & Brown of Indiana, LLC.
- This proposal may not be a complete listing of all available benefit options. Different benefit levels may be available.
- This presentation is the proprietary work product of Brown & Brown of Indiana, LLC and is not authorized for further use or distribution
- All insurance carriers have their own operating procedures. A change in carrier could affect certain benefits and coverage.
- Brown & Brown of Indiana, LLC representatives are available to explain any items presented. It is assumed that the recipients of this proposal will seek an explanation of any items that may be in question.
- Brown & Brown of Indiana, LLC representatives may from time to time provide guidance regarding certain requirements affecting health plans, including the requirements of federal and state health care reform legislation. Such guidance is based on good-faith interpretation of laws and regulations currently in effect and is not intended to be a substitute for legal advice. Employers should contact their own legal counsel for advice regarding legal requirements.
- The network provider/facility lists obtained via paper directories or carrier websites may contain providers and facilities that are no longer participating in the insurance carriers' networks. We cannot be responsible for any changes to the provider/facility listings that are not reflected. To ensure that a specific provider or facility is still participating in the provider's preferred network, we recommend contacting the provider/facility directly.
- Failure to adhere to provisions of the Affordable Care Act (such as pay-or-play, employer reporting requirements, benefit mandates, etc.) may result in significant fees and penalties to the employer. For a more comprehensive explanation of what fees and penalties may apply to you, you may contact your (Profit Center Name) representative at any time.
- You are required to comply with Health Care Reform's Summary of Benefits & Coverage (SBC) distribution guidelines, which include requirements for SBC distribution at the plan renewal date. If an employee must enroll to continue coverage, the SBC must be provided when open enrollment materials are distributed. If enrollment materials are not distributed, employees must receive an SBC by the first day they are eligible to enroll. For insured plans, if coverage continues automatically for the next year, the SBC must be provided at least 30 days before the beginning of the new plan year. If the policy is not issued by that date, the SBC must be provided within seven business days once the information is available. Please refer to the Department of Health & Human Services' (HHS) official guidance for complete details regarding renewal and other SBC distribution guidelines.

# Glossary of Acronyms

***A***

| | |
|---|---|
| AD&D | Accidental Death & Dismemberment |
| ASO | Administrative Services Only |
| AWP | Average Wholesale Price |

***C***

| | |
|---|---|
| CAD: | Coronary Artery Disease |
| CDC: | Centers for Disease Control (and Prevention) |
| CDHP: | Consumer Driven Health Plan |
| CHAMPUS: | Civilian Health & Medical Program of the Uniformed Services |
| CMS: | Centers for Medicare & Medicaid Services |
| COB: | Coordination of Benefits |
| COBRA: | Consolidated Omnibus Budget Reconciliation Act |
| COC: | Certificate of Coverage |
| COPD: | Chronic Obstructive Pulmonary Disease |
| CPI: | Consumer Price Index |
| CPT: | Current Procedural Terminology |
| CT: | Computerized Tomographic (scanners – CAT Scans) |
| CY: | Calendar Year |

**D**

| | |
|---|---|
| DME: | Durable Medical Equipment |
| DOB: | Date of Birth |
| DOH: | Date of Hire |
| DOS: | Date of Service |
| DOL: | Department of Labor |
| DRG: | Diagnosis Related Grouping |

**E**

| | |
|---|---|
| EAP: | Employee Assistance Program |
| EE: | Employee Only |
| ES: | Employee + Spouse |
| EC: | Employee + Child(ren) |
| EF: | Employee + Family |
| EOI: | Evidence of Insurability |
| EOB: | Explanation of Benefits |
| EPO: | Exclusive Provider Organization |
| ER: | Emergency Room |
| ERISA: | Employee Retirement Income Security Act |
| ESRD: | End State Renal Disease |

**F**

| | |
|---|---|
| FDA: | Food and Drug Administration |
| FSA: | Flexible Spending Account |

**H**

| | |
|---|---|
| HDHP: | High Deductible Health Plan (HSA Qualified) |
| HHC: | Home Health Care |
| HIPAA: | Health Insurance Portability & Accountability Act |
| HMO: | Health Maintenance Organization |
| HPW: | Hours per Week |
| HRA: | Health Reimbursement Account |
| HSA: | Health Savings Account |

**I**

| | |
|---|---|
| IBNR: | Incurred but Not Reported |
| ICD-9: | International Classification of Diseases |
| ICU: | Intensive Care Unit |
| IDOI: | Indiana Department of Insurance |

***L***

| | |
|---|---|
| LOS | Length of Stay |
| LTC | Long Term Care |
| LTD | Long Term Disability |
| LTM | Lifetime Maximum |

**M**

| | |
|---|---|
| M&N: | Mental & Nervous |
| MAC: | Maximum Allowable Costs |
| MEBT: | Ministry Employee Benefits Trust |
| MEWA: | Multiple Employer Welfare Agreement |
| MRI: | Magnetic Resonance Imaging |
| MSA: | Medical Savings Account |

**N**

| | |
|---|---|
| NAIC: | National Association of Insurance Commissioners |
| NDC: | National Drug Code |

**O**

| | |
|---|---|
| OBRA: | Omnibus Budget Reconciliation Act |
| OON: | Out of Network |
| OOP: | Out of Pocket |
| OTC: | Over the Counter |

**P**

| | |
|---|---|
| PBM: | Pharmacy Benefits Manager |
| PCP: | Primary Care Physician |
| PEO: | Professional Employer Organization |
| PHO: | Physician Hospital Organization |
| PEPM: | Per Employee Per Month |
| PMPM: | Per Member Per Month |
| POS: | Place of Service or Point of Service |
| PPO: | Preferred Provider Organization |

**R**

| | |
|---|---|
| R&C: | Reasonable & Customary |
| RBRVS: | Resource-Based Relative Value Scale |
| ROI: | Return on Investment |

**S**

| | |
|---|---|
| SIC: | Standard Industrial Classification |
| SLR: | Stop Loss Reinsurance |
| SNF: | Skilled Nursing Facility |
| SPD: | Summary Plan Description |
| STD: | Short Term Disability |

**T**

| | |
|---|---|
| TPA: | Third Party Administrator |

**U**

| | |
|---|---|
| U&C: | Usual & Customary |
| UCR: | Usual, Customary & Reasonable |

# Glossary of Commonly Used Terms

## *Medical*

**Balance Billing:** The practice of charging full fees in excess of covered amounts and then billing the patient for that portion of the bill that the payer does not cover.

**Breakpoint:** Amount to which the plan and the participant co-insure covered expenses, after which the plan pays 100%.

**Capitation Fee:** A fixed predetermined amount paid to a provider for each person served, without regard to the actual number or nature of services provided to each person in a set period of time. Capitation is the characteristic payment method in HMOs.

**Carryover Deductible:** A feature whereby covered charges in the last three months of the year may be carried over to be counted toward the next year's deductible.

**Coinsurance:** A policy provision by which both the insured person and the insurer share covered medical expenses in a specified ratio (e.g., 80%/20%), after the deductible is met.

**Copayments:** Payments made by consumers, in addition to deductibles and coinsurance, to help finance health benefit plans.

**Deductible:** The amount of out-of-pocket expenses that must be paid for health services by the insured before becoming payable by the carrier.

**Exclusive Provider Organization (EPO):** A more rigid type of PPO, closely related to an HMO. Provides benefits or levels of benefits only if care is rendered by providers within a specific network (with some exceptions for emergency and out-of-area services).

**Explanation of Benefits (EOB):** A description, sent to patients by health plans, of benefits received and services for which the health care provider has requested payment.

**Fee for Service:** A method of billing for health services, under which a health provider charges separately for each service rendered. This is the usual method of billing by the majority of physicians.

**Formulary Doctor's List:** A listing of prescription medications that will be covered by a plan or insurance contract that often fosters substitution of generic or therapeutic equivalents on a cost-effective basis.

**Gatekeeper:** The primary care provider responsible for managing medical treatment rendered to an enrollee of a health plan.

**Health Maintenance Organization (HMO):** A prepaid medical plan that provides a comprehensive predetermined medical care benefit package.

**Inpatient:** A person who occupies a hospital bed while under observation, care, diagnosis or treatment for at least 24 hours.

**Mandated Benefits:** A specific set of benefits required by law to be provided by all insurance carriers and reimbursed under all insurance policies.

**Maximum Benefit:** The highest annual or lifetime benefit that can be received under an insurance contract.

**Maximum Out-of-Pocket Payments:** The maximum amount of money a person will pay in addition to premium payments. The out-of-pocket payment is usually the sum of the deductible and coinsurance payments, and does not include copayments or non-covered expenses.

**Medical Case Management:** This option, often offered by insurance companies, provides coordinators to handle high cost claims and recommends specialized care and services targeted to an individual's treatment goals and needs. Case management is most often used to deal with catastrophic illnesses. The case management coordinator helps to oversee overall management of the patient, from the onset of the illness or injury into acute care hospitalization, specialized care programs and follow-up treatment.

**Outpatient:** A person who visits a clinic, emergency room or health facility and receives health care without being admitted as an overnight patient.

**Outpatient Surgery:** Same day surgery without anticipation of the overnight stay of patients. This is often performed at an ambulatory care facility.

# Glossary of Commonly Used Terms

**Outpatient Surgical Facility:** A freestanding center or entity within the hospital that is approved and licensed by the state to perform outpatient diagnostic services or surgical treatment of an illness or injury.

**Point of Service Plan (POS):** Members do not have to choose how to receive services until services are needed. In some plans, for example, members decide whether to use a network provider or an outside provider. Although the services of an outside provider are covered, benefits are greater if members select a preferred provider (example 70% vs. 100% coverage).

**Preferred Provider Organization (PPO):** A group of hospitals and physicians that contract on a fee-for-service basis with employers, insurance companies or other third party administrators to provide comprehensive medical service. Providers exchange discounted services for increased volume. Participants' out-of-pocket costs are usually lower than under a fee-for-service plan.

**Preventive Care:** Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examinations, immunization and well person care.

**Primary Care (PCP):** Routine medical care, normally provided in a doctor's office. Professional and related services administered by an internist, family practitioner, general practitioner, or pediatrician.

**Specialist (Spec):** Physician who concentrates on medical activities in a particular specialty of medicine.

***Prescription Drugs***

**Average Wholesale Price (AWP):** The published suggested wholesale price of a drug. It is often used by pharmacies as a cost basis for pricing prescriptions. While a reliable pricing reference for brand-name drugs, it can be misleading in the case of generic drugs since each manufacturer establishes its own AWP for the generic drug. This can result in a broad range of prices for the identical product.

**Brand-Name Drugs:** A drug protected by a patent issued to the original innovator or marketer. The patent prohibits the manufacture of the drug by other companies as long as the patent remains in effect.

**Formulary:** A listing of prescription medications that will be covered by a plan or insurance contract that often fosters substitution of generic or therapeutic equivalents on a cost-effective basis.

**Generic Equivalent Drugs:** Drug that is equal in therapeutic power to the brand-name originals because they contain identical active ingredients at the same doses.

**Legend Drugs:** Drugs that must be obtained by doctor prescription, as opposed to those prescribed by a doctor but available over the counter.

**Over the Counter (OTC**): Drugs available without a prescription.

# Glossary of Commonly Used Terms

***Dental***

**Balance Billing:** The practice of charging full fees in excess of covered amounts and then billing the patient for that portion of the bill that the payer does not cover.

**Coinsurance:** A policy provision by which both the insured person and insurer share covered dental expenses in a specified ratio (e.g., 80%/20%), after the deductible is met.

**Deductible:** The amount of out-of-pocket expenses that must be paid for services by the insured before becoming payable by the carrier.

**Dental Maintenance Organization (DMO):** Provides comprehensive dental services to a particular group for a fixed fee.

**Direct Reimbursement:** A self-funded program in which the individual is reimbursed based on a percentage of dollars spent for dental care provided and which allows beneficiaries to seek treatment from the dentist of their choice.

**Endodontics:** Diagnosis and treatment of diseases of the tooth pulp, root canal, and apex (tip of the tooth root).

**Explanation of Benefits (EOB):** A description, sent to patients by health plans, of benefits received and services for which the health care provider has requested payment.

**Oral and Maxillofacial Surgery:** Deals with diseases, injuries, and defects of the jaw and related structures.

**Orthodontics:** Aligns teeth with a variety of appliances.

**Percentile:** A range of distribution of provided charges determined by a third party payer for specific services. For example, if the third party uses a 90$^{th}$ percentile, maximum payment may be made for any charge at or below that level.

**Periodontics:** Involves the tissues that surround the teeth – the gingival, cementum, periodontal membrane, and supporting bone.

***Section 125 - Premium Only Plan***

**Cafeteria Plan:** Defined by the Internal Revenue Code as a plan that permits the participant to choose between two or more benefits consisting of cash and qualified benefits.

**Dependent Care Spending Account:** Employer-sponsored flexible benefit plan feature that permits employees to use pretax (tax-free) dollars from their paychecks to pay the cost of care for children or elderly dependents up to a certain legislated limit and within very specific guidelines.

**Flexible Benefit Plan:** A benefit program under Section 125 of the Internal Revenue Code that offers employees a choice between permissible taxable benefits, including cash, and nontaxable health and welfare benefits such as life and health insurance, vacation pay, retirement plans and child care. Although a common core of benefits may be required, the employee can determine how his or her remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes employee contributions may be made for additional coverage.

**Flexible Spending Accounts (FSAs):** Many flexible benefit programs include flexible spending accounts, which give employees a choice between taxable cash and nontaxable compensation in the form of payment or reimbursement of eligible, tax-favored welfare benefits. FSAs can be funded through salary reduction, employer contributions or a combination of both. Employees can purchase additional benefits, pay health insurance deductibles and copayments, or pay for child care benefits with the money in their FSAs.

**Section 125 Plan:** A plan in compliance with Section 125 of the Internal Revenue Code, which protects an employee from constructive receipt of the cash he or she has as a choice of benefits under a cafeteria plan.

**Use-It-or-Lose-It Rule:** A rule forbidding cafeteria plans to let participants defer receipt and taxation of compensation from year to year by carrying over unused pretax contributions or plan benefits.

# Glossary of Commonly Used Terms

***Miscellaneous Terms***

**Adverse Selection:** The tendency of an individual to recognize his or her health status in selecting the option under a retirement system or insurance plan that tends to be most favorable to him or her (and more costly to the plan). In insurance usage, a person with an impaired health status or with expected medical care needs applies for insurance coverage financially favorable to himself or herself and detrimental to the insurance company. Also known as anti-selection.

**Carve-Out:** A program separate from the primary plan designed to provide a specialized type of care, such as a mental health carve-out; or for a designated group of employees, such as a management carve-out.

**Contributory Plan:** A benefit plan under which employees bear part of the cost.

**Employee Assistance Plan (EAP):** Designed to help employees whose job performance is being adversely affected by personal problems. The program may also apply to many types of health education, prevention, counseling and control of specific conditions (e.g. alcoholism, smoking, fitness, etc.).

**Employee Contribution:** Made by an employee into a plan. May or may not be required for participation.

**Experience:** Usually expressed as a ratio or percentage, it is the relationship of premium to claims, coverage or benefits of a plan for a specified period of time.

**Experience-Rated Premium:** A premium based on the anticipated claims experience of, or utilization of service by, a contract group according to its age, sex and any other attributes expected to affect its health service utilization. Such a premium is subject to periodic adjustment in line with actual claims or utilization experience.

**Experience Rating:** The process of determining the premium rate for a group risk, wholly or partially on the basis of that group's experience.

**Minimum Participation Requirement:** Minimum number of eligible employees that must elect coverage in order for a carrier to write a policy, normally expressed as a percentage.

**Noncontributory Provision:** A term applied to employee benefit plans under which the employer bears the full cost of the benefits for the employees. One hundred percent of eligible employees must be insured.

**Preexisting Condition:** A physical and/or mental condition of an insured person that existed prior to the issuance of his or her policy. Excluded from coverage under some policies.

**Reasonable and Customary (R&C) Charge:** The prevailing charge made by providers of similar expertise for a similar procedure in a particular geographic area. See also Usual, Reasonable and Customary Fees.

**Trend Factor:** The measurement for actuarial purposes of the change in the cost of health care after weighing inflationary changes, changes in utilization and technology.

**Usual, Customary and Reasonable (UCR) Fees:** *Usual* is the fee usually charged for a given service by a provider; *customary* is a fee in the range of usual fees charged by similar providers in area; *reasonable* is a fee, according to the review committee, that meets the lesser of the two criteria or is justified in the circumstances.

**Voluntary (Employee-Pay-All) Benefits**: Specific benefits that the employer administers and the employees pay for. Commonly used for benefits that employees want but which the employer is unable or unwilling to contribute toward.

***Disability***

**Partial Disability:** Due to injury or sickness, the insured, while unable to perform all the material duties of his regular occupation on a full-time basis, is:

1. Performing at least one of the material duties of his regular occupation or another occupation on a part-time of full-time basis;

# Glossary of Commonly Used Terms

2. Earning currently at least 20% less per month than his indexed pre-disability earnings due to that same injury or sickness.

**Partial Plus:** Product enhancement which will not offset with return to work earnings for the first twelve months of an attempted return to work until the gross benefit combined with the claimant's return to work earnings exceed 100% of their pre-disability earnings.

**Residual Disability:** "Disability" and "disabled" mean that because of injury or sickness:

2. After benefits have been paid for (24) months, the insured cannot perform each of the material duties of any gainful occupation for which he is reasonably fitted by training, education, or experience; or

3. The insured, while unable to perform all the material duties of his regular occupation on a full-time basis is:

A. performing at least some of the material duties of his regular occupation or another occupation a part-time or full-time basis;

B. earning currently at least 20% less per month than his indexed pre-disability earnings due to that same injury or sickness.

**NOTE:** Total disability is not required to qualify for disability benefits.

**Survivor Benefit:** If after an insured has been continuously disabled for at least 180 days, upon receipt of proof that the insured employee has died while receiving a benefit, the company will pay to the eligible survivor, or estate if there are no survivors, a lump sum benefit equal to three times the gross monthly benefit paid.

**Tolerable Loss Ratio:** "Break-Even Point". The maximum percentage of premium available to cover incurred claims without losing money on the case. For example, a tolerable loss ratio of 80% means we can allocate up to 80 cents of every premium dollar to cover incurred claims and still remain profitable. The remaining 20 cents covers our expenses and profit. The tolerable loss ratio varies with premium size.

**Zero Day Residual:** Satisfying the elimination period with any combination of total or partial disability. See Residual.

**Social Security Freeze:** Provides that is an insured employee is disabled after the date the Social Security Freeze is effective and becomes entitled to receive a monthly benefit, then the monthly benefit cannot be reduced in the future due to any cost-of-living increase in Social Security benefits payable.

**Primary Integration:** The LTD benefit is reduced, dollar for dollar, by social security benefits paid or payable to the insured because of the worker's disability. This does not include benefits payable to the eligible spouse and/or children.

**Full or Family Integration:** The LTD benefit is reduced, dollar for dollar, by all Social Security benefits paid or payable because of a worker's disability. This includes any benefits payable to eligible spouse and/or children.

**Exclusions:** Specified conditions or circumstances for which the policy does not provide benefits.

# Compensation Disclosure

**Compensation**. In addition to the commissions or fees received by us for assistance with the placement, servicing, claims handling, or renewal of your insurance coverages, other parties, such as excess and surplus lines brokers, wholesale brokers, reinsurance intermediaries, underwriting managers and similar parties, some of which may be owned in whole or in part by Brown & Brown, Inc., may also receive compensation for their role in providing insurance products or services to you pursuant to their separate contracts with insurance or reinsurance carriers. That compensation is derived from your premium payments. Additionally, it is possible that we, or our corporate parents or affiliates, may receive contingent payments or allowances from insurers based on factors which are not client-specific, such as the performance and/or size of an overall book of business produced with an insurer. We generally do not know if such a contingent payment will be made by a particular insurer, or the amount of any such contingent payments, until the underwriting year is closed. That compensation is partially derived from your premium dollars, after being combined (or "pooled") with the premium dollars of other insureds that have purchased similar types of coverage. We may also receive invitations to programs sponsored and paid for by insurance carriers to inform brokers regarding their products and services, including possible participation in company-sponsored events such as trips, seminars, and advisory council meetings, based upon the total volume of business placed with the carrier you select. We may, on occasion, receive loans or credit from insurance companies. Additionally, in the ordinary course of our business, we may receive and retain interest on premiums you pay from the date we receive them until the date of premiums are remitted to the insurance company or intermediary. In the event that we assist with placement and other details of arranging for the financing of your insurance premium, we may also receive a fee from the premium finance company.

If an intermediary is utilized in the placement of coverage, the intermediary may or may not be owned in whole or part by Brown & Brown, Inc. or its subsidiaries. Brown & Brown entities operate independently and are not required to utilize other companies owned by Brown & Brown, Inc., but routinely do so. In addition to providing access to the insurance company, the Wholesale Insurance Broker/Managing General Agent may provide additional services including, but not limited to: underwriting; loss control; risk placement; coverage review; claims coordination with insurance company; and policy issuance. Compensation paid for those services is derived from your premium payment, which may on average be 15% of the premium you pay for coverage, and may include additional fees charged by the intermediary.

**Questions and Information Requests:** Should you have any questions, or require additional information, please contact this office at 317-574-5000 or 1-800-759-2777. If you prefer, please submit your question or request online at http://www.bbinsurance.com/customerinquiry.shtml.