Acadia
BENEFITS INC.

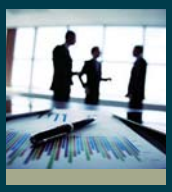
UBA HealthPlanSurvey

The Standard for Benefit Plan Comparison and Strategic Cost Management

2017 EXECUTIVE SUMMARY

Benefit Plan Design and Cost Benchmarking Key Results

UBA United Benefit Advisors
PARTNER FIRM



2017 EXECUTIVE SUMMARY | Benefit Plan Design and Cost Benchmarking Key Results

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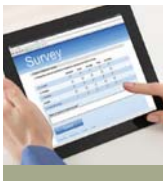


INTRODUCTION

For more information on how the 2017 survey was conducted, its scope and who participated, see page 22, "About This Survey."

I'm happy to report that this year's UBA Health Plan survey achieved a milestone. For the first time, we surpassed 20,000 health plans entered—20,099 health plans to be exact, which were sponsored by 11,221 employers. What we were able to determine from all this data was that a tumultuous Presidential election likely encouraged many employers to stay the course and make only minor increases and decreases across the board while the future of the Patient Protection and Affordable Care Act (ACA) became clearer.

There were, however, a few noteworthy changes in 2017. Premium renewal rates (the comparison of similar plan rates year over year) rose nearly 7%, representing a departure from the trend the last five years. To control these costs, employers shifted more premium to employees, offered more lower-cost CDHP and HMO plans, increased out-of-network deductibles and out-of-pocket maximums, and significantly reduced prescription drug coverage as six-tier prescription drug plans exploded on the marketplace. Self-funding, particularly among small groups, is also on the rise.

UBA has conducted its Health Plan Survey since 2005. This longevity, coupled with its size and scope, allows UBA to maintain its superior accuracy over any other benchmarking survey in the U.S. By providing our Partners with this depth of benchmarking data, we've given them the upper hand when advising their clients, and the employees they serve, who depend on this thought leadership.

The importance of this granular data is especially apparent on page 7 where we break out the state of California from the rest of the Western region. The differences—some subtle, some significant—help employers better understand and communicate the value of their benefits in order to help attract and retain employees. Without analyzing the depth of this granular data, such plan comparisons would not be possible.

Proactive employers who want a more detailed study of their plan compared to industry, state, regional, and group size benchmarking data would be wise to seek the power of a UBA Partner to help them make the most strategic renewal decisions to better manage costs.

In health,

Peter S. Weber, M.S., CAE
President
United Benefit Advisors

TREND CHECKLIST

Below is a list of the top trends revealed by the 2017 UBA Health Plan Survey. The trends result from the complex legislative changes employers face and their ongoing efforts to manage health care costs.

✓ Cost-shifting, plan changes, and other protections work to hold rates steady.

- Sustained prevalence of and enrollment in lower-cost consumer-driven health plans (CDHPs) and health maintenance organization (HMO) plans.
- For yet another year, "grandmothered" employers continue to have the options they need to select cheaper plans (ACA-compliant community-rated plans versus pre-ACA composite/health-rated plans) depending on the health status of their groups.
- Increased out-of-network deductibles and out-of-pocket maximums, with greater increases for single coverage rather than family coverage, as well as prescription drug cost shifting, are among the plan design changes influencing premiums.
- UBA Partners leverage their bargaining power.

✓ Overall costs vary significantly by industry and geography.

- Retail, construction, and hospitality employees cost the least to cover; government employees (the historical cost leader) continue to cost among the most.
- As in 2016, plans in the Northeast cost the most and plans in the Central U.S. cost the least.
- Retail and construction employees contribute above average to their plans, so those employers bear even less of the already low costs in these industries, while government employers pass on the least cost to employees despite having the richest plans.

✓ Plan design changes strain employees financially.

- Employee contributions are up, while employer contributions toward total costs remained nearly the same.
- Although copays are holding steady, out-of-network deductibles and out-of-pocket maximums are rising.
- Pharmacy benefits have even more tiers and coinsurance, shifting more prescription drug costs to employees.

✓ PPOs, CDHPs have the biggest impact.

- Preferred provider organization (PPO) plans cost more than average, but still dominate the market.
- Consumer-driven health plans (CDHPs) cost less than average and enrollment is increasing.

✓ Wellness programs are on the rise despite increased regulations and scrutiny.

- Slow, but steady: increase in self-funding, particularly for small groups.

✓ Metal levels drive plan decisions.

- Most plans are at the gold or platinum metal level. In the future, we expect this to change since it will be more difficult to meet the ACA metal level requirements and still keep rates in check.

✓ Key trends to watch in 2017.

- Slow, but steady: increase in self-funding for all group sizes, increase in plan options, and mail order pharmaceutical programs more for convenience than cost savings.
- Cautious trend: increased CDHP prevalence/enrollment.
- Rapidly emerging: increase of five-tier and six-tier prescription drug plans.

SURVEY HIGHLIGHTS & KEY FINDINGS

The following are selected highlights and key findings from this year's survey.

1. Health Plan Options—More than half (54.8%) of all employers offer one health plan to employees, while 28.2% offer two plan options, and 17.1% offer three or more options. The percentage of employers now offering three or more plans decreased slightly in 2017, but still maintains an overall increase in the last five years as employers are working to offer expanded choices to employees either through private exchange solutions or by simply adding high-, medium-, and low-cost options; a trend UBA Partners believe will continue. Not only do employees get more options, but employers also can introduce lower-cost plans that may attract enrollment, lower their costs, and meet ACA affordability requirements.

2. Health Plan Costs—The average annual health plan cost per employee for all plan types is $9,934, a slight increase from 2016, when the average cost was $9,727. However, employees' share of total costs rose 5% from $3,378 to $3,550, while employers' share rose less than 1%, from $6,350 to $6,401. Factors holding rates relatively steady (as discussed further in this report) include increased prevalence/enrollment in lower-cost CDHP and HMO plans, increased out-of-network deductibles and out-of-pocket maximums, continued extensions on the ability to "grandmother," reduced prescription drug coverage, and UBA Partners' negotiating power.

Plan Type	Total Cost	Employee Cost	Employer Cost
PPO	$10,311	$3,728	$6,543
HMO	$8,877	$3,318	$5,699
POS	$10,580	$4,347	$6,264
CDHP	$9,601	$3,133	$6,507
EPO	$10,646	$3,645	$6,945
All Plans (Average)	$9,934	$3,550	$6,401

TOP 5 INDUSTRIES BY HIGHEST AVERAGE TOTAL COST

1. Government/Education/Utilities - $11,936

2. Finance and Insurance - $10,735

3. Professional/Technology - $10,170

4. Manufacturing - $9,909

5. Health Care - $9,643

The table above shows the cost breakdown for different plan types. Here is a closer look at data for these plan types.

Health maintenance organizations (HMOs)—HMOs have the lowest total annual cost at $8,877, as compared to the total cost of a PPO of $10,311.

Consumer-driven health plans (CDHPs)—Conversely, CDHP plan costs have risen 2.2% from last year. However, CDHP prevalence and enrollment continues to grow in most regions, indicating interest among both employers and employees.

Preferred provider organizations (PPOs)—PPOs continue to cost more than the average plan, but despite this, PPOs still dominate the market in terms of plan distribution and employee enrollment. PPOs have seen an increase in total premiums for single coverage of 4.5% and for family coverage of 2.2% in 2017 alone. Despite this rise, employers are decreasing their share of the contribution for PPO plans by approximately 1%.

3. Costs and Contributions by Industry—Total costs per employee for the agriculture, retail, construction, and hospitality sectors are 11% to 23% lower than the average, making employees in these industries among the least expensive to cover. This is typically due to the lower average age among this workforce combined with less rich plans; however, it's noteworthy that this year some of these perennial cost leaders experienced increases in total annual cost for employees, particularly in the agriculture industry (2.8% increase over 2016) and hospitality (4.4% increase over 2016). Employees in the retail and construction sectors pay 8.7% and 3.1% above the average employee contribution, respectively, so employers bear even less of the already low costs in these industries. Hospitality employees pay noticeably less than the average employee contribution, paying 14.3% less than average.

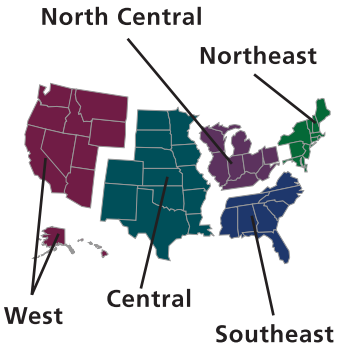
On the other end of the cost spectrum, the government/education/utilities sector has the priciest plans, at $11,936 per employee. In addition to offering the richest plans, government employers also pass on the least cost to employees, whose average contributions are more than 44% less than average.

4. Out-of-Pocket Costs—Median in-network deductibles for singles and families across all plans remain steady at $2,000 and $4,000, respectively. (PPO deductibles also remained steady at $1,500 for singles and $3,000 for families.) Families this year did catch a break as out-of-network median deductibles remained unchanged from 2016 to 2017. Single out-of-network median deductibles saw an increase from $3,000 to $3,400 in 2016. In 2017, the number saw a 17.6% increase from $3,400 to $4,000. Both singles and families are facing continued increases in median in-network out-of-pocket maximums (up $560 and $1,000, respectively, to $5,000 and $10,000). Families were bearing the brunt of the increase in median out-of-network out-of pocket maximums, going from $18,000 in 2015 to $20,000 in 2016, but then holding steady in 2017 at $20,000, while singles saw an increase to $10,000, up from $9,000 in 2016.

(PPO deductibles also remained steady at $1,500 for singles and $3,000 for families.)

5. Premium Increases—Premium renewal rates (the comparison of similar plan rates year over year) have increased an average of 6.6% for all plans—a significant increase from the five-year average increase of 5.6%. Some smaller groups, hard hit last year, are continuing to find protection with grandmothering this year. Other groups are keeping premiums in check by raising out-of-pocket costs for employees and turning to lower-cost CDHP and HMO plans. Average employee premiums for all employer-sponsored plans rose from $509 in 2016 for single coverage to $532 in 2017 and from $1,236 to $1,272 for family coverage (a 4.5% and 3% increase, respectively). For an employee electing single coverage, employers cover 69% of the monthly premium; meanwhile, employers are covering only 52.7% of a family premium.

6. Prevalence of Plan Type by Region—PPO plans, most prevalent in the Central U.S., generally dominate nationwide, except in the Northeast where CDHPs are most prevalent.



Plan Type	Northeast	Southeast	North Central	Central	West
PPO	22.1%	39.3%	47.2%	57.2%	48.5%
HMO	17.9%	12.5%	9.0%	6.4%	23.1%
POS	9.0%	14.8%	4.9%	8.5%	8.4%
CDHP	37.3%	28.9%	36.6%	22.7%	19.0%
EPO	13.5%	0.5%	0.8%	4.3%	0.8%

CALIFORNIA'S HEALTH PLANS are an anomaly, and "The Prevalence of Plan Type by Region" and "Enrollment by Plan Type by Region" tables on pages 6-7, while accurately reflecting the Western region, do not accurately reflect that state. In California, HMOs are king, followed by PPO plans. Whereas, in the rest of the U.S., including the Western region, PPOs and CDHPs are the top two predominant plans.

7. Enrollment by Plan Type by Region—PPO plans have the greatest enrollment in the West, and the least enrollment in the Northeast. HMO enrollment continues to drop across most of the country, but held steady in the Southeast, capturing 9.8% of the market in 2017. CDHP enrollment, meanwhile, is highest in the North Central U.S. at 46.3%, but grew in every region of the United States except the West, where it decreased to 14.7% of the market. Although HMO enrollment continues to drop in general, it is worth noting that HMOs account for nearly half of the plan types and plan enrollment in the state of California, at 50% and 48.9%, respectively.

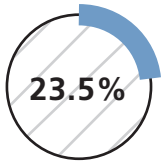
Plan Type	Northeast	Southeast	North Central	Central	West
PPO	28.2%	51.6%	45.5%	61.0%	61.4%
HMO	13.3%	9.8%	3.0%	3.6%	20.0%
POS	7.5%	10.3%	3.4%	6.9%	2.7%
CDHP	38.3%	24.5%	46.3%	25.6%	14.7%
EPO	12.7%	2.2%	1.3%	2.4%	1.0%

8. Dependent Coverage—44.3% of all covered employees elect dependent coverage, a decrease from 2016. UBA had previously pointed out fluctuation in this, and continues to watch this number closely since many experts believe higher costs will lead to decreased employer contributions toward dependent coverage. Generally, the larger the group size, the greater the percentage of employees with dependent coverage.

9. Spouse/Partner Coverage—60.2% of all employers provide no domestic partner benefits. This is likely still due to the Supreme Court's decision in *Obergefell v. Hodges*, which legalized same-sex marriage, giving employers a less complicated method to provide coverage for same-sex partners. As a result, many employers are covering just legal spouses rather than legal spouses and domestic partners.

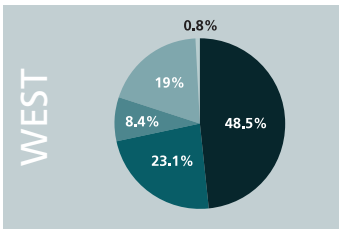
10. Infertility Services—In 2017, plans are slightly more apt to offer only evaluation benefits, or no infertility coverage at all. A little more than one-third (37.5%) of all plans provided no benefits for infertility services (a 5% increase from last year). Meanwhile, 40% of plans provided benefits for evaluation only (a 6.7% increase), and 22.4% provided benefits for evaluation and treatment (a 16.7% decrease).

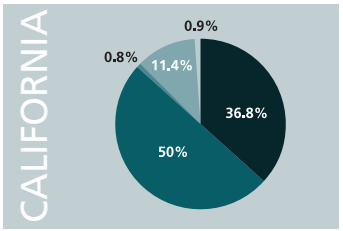
11. Comprehensive Wellness Programs—23.5% of all employers offer comprehensive wellness programs, an increase from 2016. Of these employers, 73.5% include health risk assessments, 70% offer employee incentives for participation, 61.2% offer biometric screenings or physical exams, 59.3% include on-site or telephone coaching for high-risk employees, and 39.3% include seminars or workshops. Health risk assessments increased slightly between 2016 (72.5%) and 2017 (73.5%), but they are still below the three-year (2014) number (80.3%). The use of health risk assessments is worth watching closely due to the government's increased scrutiny and regulation regarding use of health risk assessments in relation to wellness programs. Compared to 2016, telephone coaching for high-risk employees is up 8.6% and seminars/workshops are up 1.3%. Wellness programs are most prevalent among Northeast employers, CDHP plans, plans sponsored by health care employers, and larger groups (100 to 1,000+ employees)—36.8%, 32.6%, 30.6%, and 46.4% to 63.8%, respectively. Interestingly, all of these groups experienced increases over their already leading 2016 prevalence.



PLAN OFFERED

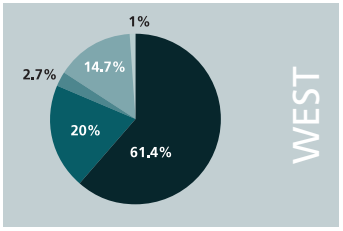
PPO HMO POS CDHP EPO

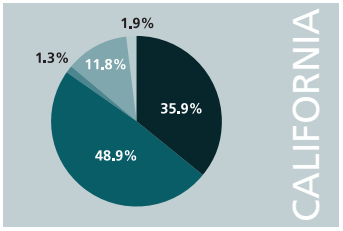




PLAN ENROLLED

PPO HMO POS CDHP EPO





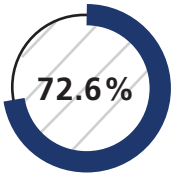
12. Bonuses to Waive Coverage—More employers are offering bonuses to waive coverage. The number increased from 2.8% in 2016 to 3.4% in 2017, and for those that do, the bonus amount is on the rise. The average annual single bonus in 2017 is $1,915, a 1.6% increase from last year. Opt-outs are under increasing scrutiny by multiple federal agencies. In particular, the Centers for Medicare and Medicaid Services (CMS) is still rumored to be looking into whether opt-outs, even when offered to all employees, violate the prohibition to offer incentives to Medicare-eligible employees, or their spouses, to leave the group health plan. In addition, the IRS issued guidance making unconditional opt-outs part of the affordability calculation (which hurts employers), and opt-outs are still prohibited from being used to pay for individual premiums. This increased scrutiny has led some employers to drop opt-outs before they become a compliance problem.

13. Grandfathering—The percentage of grandfathered plans continues to remain quite small. Only 7.3% of plans are considered grandfathered plans. Grandfathering allows an employer group to maintain a health plan that was in place prior to March 23, 2010, and be exempt from many changes required under the Affordable Care Act (ACA). Typically, plans lose their grandfathered status by making changes that reduce benefits or increase the employee's cost for benefits. Although grandfathered health plans have no regulatory expiration, the strict limitations on acceptable changes to plans and employee cost of coverage lead to a natural tendency for employers to drop their grandfathered plan once it is no longer financially or practically feasible. Plans retaining grandfathered status are typically provided by employers with personal objections to certain ACA mandates, or because a grandfathered plan remains popular with employees.

14. Grandmothering—Similarly, just 10.6% of plans are considered "grandmothered," compared to 17% in 2015, only two years ago. Grandmothering continues to provide some small employers the option to temporarily maintain a pre-ACA health plan in relation to avoiding community rating among other items, but is a method that is theoretically in its sunset years. More than 30 states recognize grandmothered plans, and the last grandmothered plans are set to expire in December 2018, due to regulation. This is the third extension grandmothered plans have been given; there is no way of knowing how long this trend will continue.

15. Self-Funding—Overall, 12.8% of all plans are self-funded, up from 12.5% in 2016, while slightly less than two-thirds (60.9%) of all large employer (1,000+ employees) plans are self-funded. Self-funding has always been an attractive option for large groups, but UBA Partners believe that self-funding will be increasingly desirable to employers of all sizes in the coming years as a way to avoid various cost and compliance aspects of health care reform. Self-funding may be particularly attractive to small employers with healthy groups since fully insured community-rated plans under the ACA don't give them any credit for a healthy population. Self-funding grew 48% for employers with 25 to 49 employees in 2017 (5.8% of plans), and 13.4% for employers with 50 to 99 employees (9.3% of plans).

16. Prescription Drug Plans—For a second year, prescription drug plans with four or more tiers are exceeding the number of plans with one to three tiers. Almost three-quarters (72.6%) of prescription drug plans have four or more tiers, while 27.4% have three or less. Increased tiering defrays the cost of more expensive drugs, so it's not surprising that it's a rapidly growing cost-control strategy. Employers are also moving away from copay-only payment structures, favoring coinsurance and blended copay/coinsurance models to further contain costs. A little less than half (47.4%) of prescription drug plans utilize copays only, down 13% from 2016, which was down from 61.5% from 2015. Blended models of either copay or coinsurance are the most popular after copay only, capturing 31.7% of plan designs. Median retail copays have remained unchanged for two-tier plans, at $10/$30, but this once favored plan design now only makes up 1.4% of plans, as opposed to the newest design, 6-tier plans, which constitute 32.6% of plans.



IN DEPTH ON THE ISSUES

This section delves deeper into the major findings of the 2017 survey and explores some of their implications for the future of health care plans and the possible consequences for employers and employees.

IMPACT OF THE ACA

As the seventh year of ACA implementation and regulation draws to an end, employers continue to change their plan designs in order to offer benefits that both meet federal regulations and appeal to their employees. In this section, we look at some of the key impacts of the ACA.

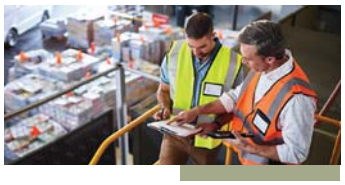
Premium Rate Trends

Premium renewal rates (the comparison of similar plan rates year over year) have increased an average of 6.6% for all plans—a significant increase from the five-year average increase of 5.6%. Some smaller groups continue to find temporary protection this year through grandmothering.

Plan Type	Renewal Rate Increase
POS	7.3%
PPO	6.8%
EPO	6.4%
CDHP	6.2%
HMO	5.8%
Overall Average	6.6%

Grandmothering provides some small employers the option to maintain a pre-ACA health plan. Although not every state allows grandmothering of policies and not all insurance carriers offer the option in those states endorsing it, there are still some employers in the more than 30 states that allow grandmothering who are able to be composite rated (rates based on the health status of the group), which protects young, healthy groups in particular. Grandmothered groups with older, unhealthy populations could still move to community-rated ACA-compliant plans, which were generally less costly for them, giving all groups the flexibility to save money. Though this grandmothered group remains relatively steady (10.6% of all plans), these employers have helped to keep overall average increases in check. They could, however, see increases whenever CMS stops granting extensions to grandmothered plans, when their plan costs will begin to reflect the expiration of grandmothering (the last grandmothered plans expire in December 2018, due to regulation).

Employers not under the protection of grandmothering have kept premiums in check by raising out-of-network deductibles and out-of-pocket maximums for employees, reducing prescription drug coverage, and turning to lower-cost CDHP and HMO plans (as described in this report). Average employee premiums for all employer-sponsored plans rose from $509 in 2016 for single coverage to $532 in 2017 and from $1,236 to $1,272 for family coverage (a 4.5% and 3% increase, respectively). For an employee electing single coverage, the employer covers, on average, 69% of the annual cost of the employee's coverage.



Looking at premium changes among different size groups, all groups are experiencing slightly increased premiums. Average single premiums in companies with fewer than 25 employees decreased 4.1%, going from $540 in 2015 to $518 in 2016 (still above average). In 2017, the average single premium for employers with fewer than 25 employees ($541) increased to just higher than what it was in 2015. However, this is an increase of 4.4% over 2016. Average family premiums in these groups rose from $1,221 in 2015 to $1,245 in 2016 to $1,287 in 2017 (above average)—likely due to age rating under the ACA, which is driving average family costs up (compared to flat family rates under composite rating), and younger dependents finding coverage elsewhere, leaving an older, more costly population.

Regionally, most groups are experiencing slightly increased premiums, with the Northeast experiencing the largest jump of 9.5%. However, some states experienced significant increases, and some enjoyed decreases. Of note:

- Connecticut saw a 24% increase in premiums in 2017, up to $655 from $530, which state officials had previously attributed to rising costs and an increased demand for services.
- New York also saw a large increase of 14%, up to $712 in 2017 over $624 in 2016.

On the other side, some states saw decreases in premiums:

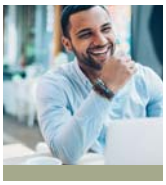
- Washington enjoyed a decrease of 10%, with premiums down to $493 in 2017 from $546 in 2016.
- Arizona saw a 2% decrease, with premiums down to $442 in 2017 from $453 in 2016.

California, which had enjoyed an 11.4% decrease in average single premiums in 2016, saw it jump back up 3% to $543 in 2017 (from $527), but still below the 2015 figure of $595.

UBA Partners also help keep premiums in check by bringing their bargaining power to bear for 11,221 employers with 20,099 plans nationwide. Comparing proposed rates from carriers to final rates, UBA Partners aided employers of all sizes at the bargaining table, not just the largest ones where savings are more likely. Looking at UBA savings by industry and region, UBA Partners were able to offer above-average savings in the health care industry and among Northeast employers.

What Does the Future Hold for Rate Trends?

Continued regulatory guidance on ACA implementation will shape plan design and costs going forward. The industry continues to await federal guidance on non-discrimination for fully insured group health plans, which could affect plan design. Similarly, Cadillac tax implementation remains on the horizon, but has been delayed to 2020, versus the original implementation date of 2018. Many employers are expected to trim down their group health plans or consumer-based accounts once it is understood how plan value will be calculated. Furthermore, the Trump administration has had difficulty getting its desired changes relating to health care policy off the ground. Furthermore, until the Trump administration health care policy becomes clearer, employers and employees will likely continue to make changes cautiously and slowly.



Out-of-Pocket Cost Increases for Employees

While the rate impact of the regulatory environment plays out, one thing is certain: employers continue to shift a greater share of expenses to employees through out-of-pocket cost increases. This year, singles were hit more heavily than families as compared to years past.

While average annual total costs per employee increased from $9,727 to $9,934, employees' share of total costs rose 5%, from $3,378 to $3,550, while employers' share rose less than 1%, from $6,350 to $6,401. The good news for employees is that, for a second year in a row, median in-network deductibles for singles and families held steady at $2,000 and $4,000, respectively. Similarly, some out-of-network deductibles remained flat, with families' median out-of-network deductible remaining at $8,000 in 2017. Conversely, singles, who had been holding steady in 2014 and 2015 at a $3,000 median out-of-network deductible, saw a 13.3% increase to $3,400 in 2016, and another jump in 2017 to $4,000. Since deductible increases help employers avoid premium increases, we will likely see this trend continue, especially as insurance carriers are required to meet the ACA metal levels.

Both singles and families also are seeing continued increases in median in-network out-of-pocket maximums, up to $5,000 and $10,000, respectively. Families bore the brunt of the increase in median out-of-network out-of-pocket maximums between 2014 and 2016, going from $16,000 in 2014 to $18,000 in 2015, to $20,000 in 2016, but then holding steady at $20,000 in 2017. The maximum for singles, which had remained steady at $9,000 in 2015 and 2016, increased in 2017 to $10,000.

Interestingly, out-of-network expenses are not subject to ACA limitations, so it was theorized that they'd likely continue to skyrocket with more plans eliminating out-of-pocket maximums for non-network services. Perhaps to offset that, more employers adopted plans with no deductible for out-of-network services, while employees saw a massive decrease in the number of employers offering no deductible for in-network services. Looking at deductibles and out-of-pocket costs just among the ever-dominant PPO plans, in-network and out-of-network deductibles for families and singles are generally below average. However, the median in-network single deductible for PPO plans has held steady at $1,500 in 2016 and 2017, along with the family deductible at $3,000. The increases were seen in the out-of-pocket maximums, which rose in 2017 to $4,500 for single (up from $4,000 in 2016), and to $10,000 for family coverage (up $1,000 from $9,000 in 2016).

PPO	In-Network Benefits	Out-of-Network Benefits
Single Deductible	$1,500	$3,000
Family Deductible	$3,000	$6,000
Single Out-of-Pocket Maximum	$4,500	$9,000
Family Out-of-Pocket Maximum	$10,000	$20,000



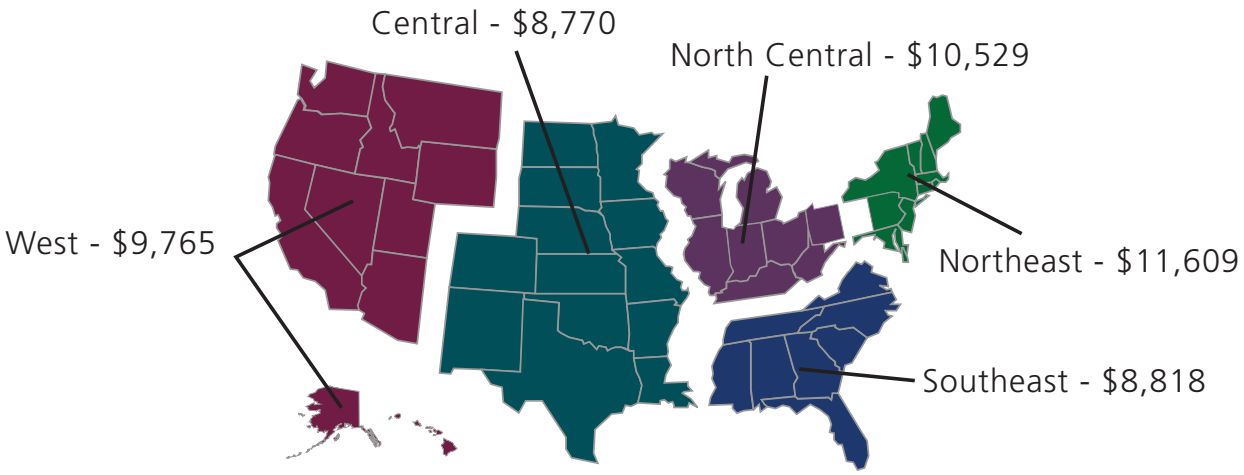
COSTS BY REGION, INDUSTRY, AND SIZE

Given the fluid nature of implementing the ACA, it's essential that businesses benchmark their medical plan costs using more than national or carrier data. Especially given the regional or state-by-state nature of health care and insurance.

Costs by Region

Overall costs per employee are relatively flat: $9,934 in 2017, a slight increase from the average cost in 2016 of $9,727. However, regional cost averages vary, making it essential to benchmark both nationally and regionally. For example, a significant difference exists between the cost to insure an employee in the Northeast versus the Central U.S.—plans in the Northeast continue to cost the most since they typically have lower deductibles, contain more state-mandated benefits, and feature higher in-network coinsurance, among other factors. Plans in the Central U.S. experienced the largest increase in premiums in 2017, rising 4.4% as compared to the 1.2% increase in the West.

TOTAL COST PER EMPLOYEE



OVERALL AVERAGE - $9,934



Costs by Industry

Costs by industry also vary, making it important for employers to benchmark by industry.

Industry	Average Cost per Employee
Government, Education, Utilities	$11,936
Financial, Insurance, Real Estate	$10,735
Professional, Scientific, Technology Services	$10,170
Manufacturing	$9,909
Health Care, Social Assistance	$9,643
Wholesale, Retail	$9,497
Construction, Agriculture, Transportation	$9,446
Information, Arts, Accommodations & Food	$8,798
All Plans	$9,934

Total costs per employee for the construction, agriculture, retail, and hospitality sectors are all lower than average, making employees in these industries among the least expensive to cover. This is typically due to the lower average age among this workforce combined with less rich plans. However, it's noteworthy that this year some of these perennial cost leaders experienced increases in total annual cost for employees, particularly in the agriculture industry (2.8% increase over 2016) and hospitality (4.4% increase over 2016). Employees in the retail and construction sectors pay 8.7% and 3.1% above the average employee contribution, respectively, so employers bear even less of the already low costs in these industries. Hospitality employees pay noticeably less than the average employee contribution, paying 14.3% less than average.

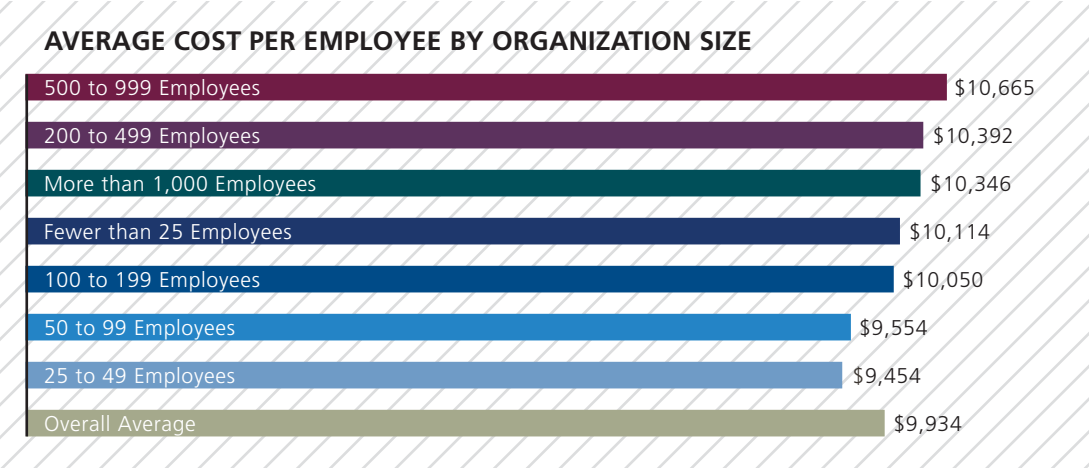
On the other end of the cost spectrum, the government/education/utilities sector has the priciest plans, at $11,936 per employee. In addition to offering the richest plans, government employers also pass on the least cost to employees, whose average contributions are more than 44% less than average

Employer/Employee Contribution by Industry in 2017

Average Contribution by Industry in 2017	Employer	Employee
Construction, Agriculture, Transportation	$5,678	$3,768
Wholesale, Retail	$5,644	$3,854
Professional, Scientific, Technology Services	$6,268	$3,902
Financial, Insurance, Real Estate	$7,077	$3,658
Manufacturing	$6,559	$3,350
Information, Arts, Accommodations & Food	$5,515	$3,283
Health Care, Social Assistance	$6,174	$3,469
Government, Education, Utilities	$9,074	$2,862
All Plans	$6,401	$3,550

Costs by Organization Size

Generally, larger groups (those with 100 to 1,000+ employees) pay more than average per employee due to more generous benefit levels, but those costs have remained virtually flat again in 2017 as compared to 2016. This is due to these employers' ability to negotiate better rates and the fact that, unlike small groups, they are not required to comply with age and community rating, which drives costs higher. For small groups, grandmothering and plan design choices have helped contain, or even slightly decrease, costs. Employers have kept premiums in check by reducing prescription drug coverage, and turning to lower-cost CDHP and HMO plans.



OUT-OF-POCKET COST BENCHMARKING SNAPSHOT

Although some premiums continue to rise, prompting many employers to manage this expanding price tag by shifting costs to their employees, other costs stayed relatively, if not completely, stable—particularly for copays for primary care, urgent care, emergency rooms, and hospital admissions. Employers, faced with uncertainty over the 2016 Presidential election, were likely hesitant to make significant changes until they understood what was on the horizon—which as of fall of 2017, is still uncertain. Having experienced significant median in-network deductible increases for singles last year, employers overall chose to keep the median single and family in-network deductibles flat for the second year in a row at $2,000 and $4,000, respectively.

AVERAGE IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS, COPAYS, AND PRESCRIPTION COPAYS FOR 2016 AND 2017

Costs (All Plans)	2017	2016	% Change
Average In-Network Deductible—Single	$2,249	$2,127	5.7%
Average In-Network Deductible—Family	$4,828	$4,632	4.2%
Median In-Network Deductible—Single	$2,000	$2,000	—
Median In-Network Deductible—Family	$4,000	$4,000	—
Average In-Network Out-of-Pocket Maximum—Single	$4,648	$4,407	5.5%
Average In-Network Out-of-Pocket Maximum—Family	$10,828	$9,165	18.2%
Median In-Network Out-of-Pocket Maximum—Single	$5,000	$4,440	12.6%
Median In-Network Out-of-Pocket Maximum—Family	$10,000	$9,000	11.1%
Average Out-of-Network Deductible—Single	$4,475	$4,128	8.4%
Average Out-of-Network Deductible—Family	$9,650	$9,068	6.4%
Median Out-of-Network Deductible—Single	$4,000	$3,400	17.7%
Median Out-of-Network Deductible—Family	$8,000	$8,000	—
Average Out-of-Network Out-of-Pocket Maximum—Single	$10,395	$9,611	8.2%
Average Out-of-Network Out-of-Pocket Maximum—Family	$21,990	$20,358	8.0%
Median Out-of-Network Out-of-Pocket Maximum—Single	$10,000	$9,000	11.1%
Median Out-of-Network Out-of-Pocket Maximum—Family	$20,000	$20,000	—
Median Primary Care Physician Copay	$25	$25	—
Median Specialty Care Physician Copay	$45	$40	12.5%
Median Urgent Care Center Copay	$50	$50	—
Median Emergency Room Copay	$200	$200	—
Median Per Admission Copay	$300	$300	—
Tier 1 Median Prescription Retail Copay in 4-Tier Plan	$10	$10	—
Tier 2 Median Prescription Retail Copay in 4-Tier Plan	$38	$35	8.6%
Tier 3 Median Prescription Retail Copay in 4-Tier Plan	$60	$60	—
Tier 4 Median Prescription Retail Copay in 4-Tier Plan	$100	$100	—

Out-of-network deductibles have risen for singles, rather than families, in 2017. Singles, which had been holding steady in 2014 and 2015 at a $3,000 median out-of-network deductible, saw a 13.3% increase to $3,400 in 2016, followed by a 17% increase in 2017 to $4,000. Conversely, families received a break in 2017 and held steady at $8,000 after seeing an increase to $8,000 in 2016, up from $7,000 in 2015.

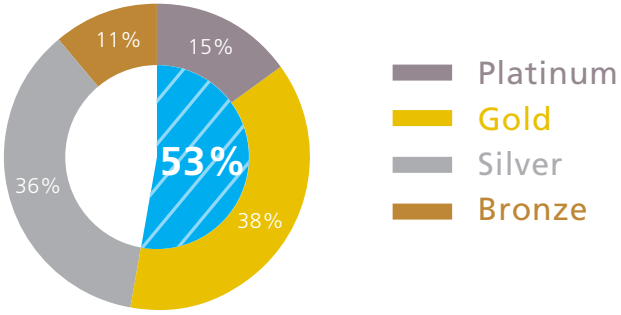
Both singles and families also are seeing continued increases in median in-network out-of-pocket maximums, respectively, up to $5,000 and $10,000. Families bore the brunt of the increase in median out-of-network out-of-pocket maximums between 2014 and 2016, going from $16,000 in 2014 to $18,000 in 2015, to $20,000 in 2016, but then held steady at $20,000 in 2017. Singles, which had remained steady at $9,000 in 2015 and 2016, increased in 2017 to $10,000.

Copays, on the other hand, have once again remained virtually unchanged for a second year in a row (except for median specialty copays, which rose a total of $5 to $45). Employers are reticent to increase copays and are looking at other cost levers instead (such as deductibles and out-of-pocket maximums discussed here, as well as increased share of premium and decreased prescription drug benefits as discussed elsewhere in this report).

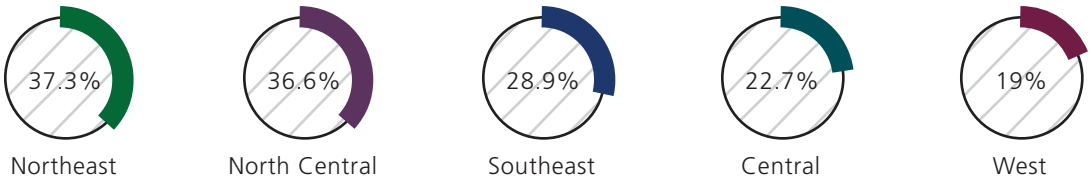
There was an interesting small increase in plans with no out-of-network deductible, while there was a significant decrease in plans with no in-network deductible.

SPOTLIGHT ON KEY PLAN TRENDS

Trend #1: More than half (53%) of respondents' plans reached gold or higher metal level, down from 55% last year. While gold and platinum plans are more likely to have the lower out-of-pocket maximums (versus the maximum allowed by law, which is found more on silver and bronze plans), deductibles can take a hit as a result (as they did this year) in order to avoid premium hikes and still meet the ACA metal level. Gold and platinum plans tend to reflect pre-ACA benefit levels, so employers are actively trying to keep these levels for as long as possible. If the overall costs can't continue to be managed, or the employee financial burden becomes too great, we could see an increase in silver and bronze plans in the future.



Trend #2: Growth in CDHPs—28.6% of all plans are CDHPs. Regionally, CDHPs account for the following percentage of plans offered.



CDHPs have increased in prevalence in all regions except the West. The North Central U.S. saw the greatest increase (13.2%) in the number of CDHPs offered.

Employers offering the most CDHPs	Employers avoiding CDHPs
Northeast and North Central employers	Western employers
Employers with 100-199 or 500-999 employees	Employers with fewer than 25 employees
Finance, government and technology employers	Mining, oil, and gas extraction, hospitality and retail employers

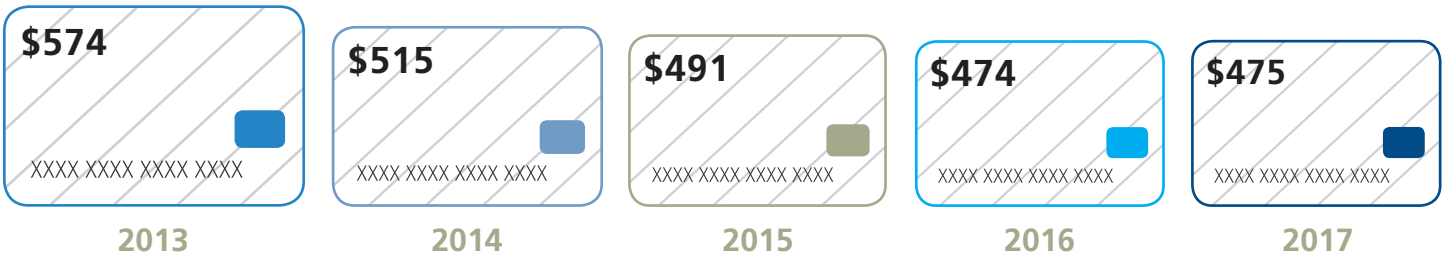
When it comes to enrollment, 31.5% of employees enroll in CDHP plans overall, an increase of 19.3% from 2016, after last year's stunning increase of 21.7% from 2015. CDHPs see the most enrollment in the North Central U.S. at 46.3%, an increase of 40.7% over 2016. For yet another year in the Northeast, CDHP prevalence and enrollment are nearly equal; CDHP prevalence doesn't always directly correlate to the number of employees who choose to enroll in them. Though the West held steady in the number of CDHPs offered, there was a 2.6% decrease in the number of employees enrolled. The 12.6% increase in CDHP prevalence in the North Central U.S. garnered a large 40.7% increase in enrollment. CDHP interest among employers isn't surprising given these plans are less costly than the average plan. But like all cost benchmarks, plan design plays a major part in understanding value. The UBA survey finds the average CDHP benefits are as follows:

CDHP	In-Network Benefits	Out-of-Network Benefits
Single Deductible	$2,850	$5,200
Family Deductible	$6,000	$10,400
Coinsurance Percentage	90%	60%
Single Out-of-Pocket Maximum	$5,000	$10,000
Family Out-of-Pocket Maximum	$10,000	$20,000

Although CDHP prevalence and enrollment are on the rise overall, there have been regional spikes and dips in this trend every year. Given the higher than average out-of-pocket costs of CDHPs, this turbulence indicates that employers and employees are still determining the value and success of these plans, making it a cautious upward trend to watch. For employers struggling with the cost of health care in relation to the affordability requirements for applicable large employers, CDHPs can help provide a middle ground.

Trend #3: HSA enrollment is down for the second year in a row, despite contributions holding relatively steady. Survey results show that 38.7% of all plans offer a health savings account (HSA) or health reimbursement arrangement (HRA), which is a slight increase. An HSA is offered in 27.6% of plans, but HSA enrollment is at 15.9%. The average employer contribution to an HSA is $475 for a single employee and $790 for a family.

AVERAGE HSA SINGLE CONTRIBUTION



The prevalence of HRAs has remained relatively flat at 11.1%, with HRA enrollment at 10.2%. The average employer contribution for an HRA is $1,983 for a single employee (compared to 2016, which was $1,810) and $3,727 for a family. As employers seek to find affordable health benefit options for their workforce, a continued drive to HRAs, or CDHPs with HSAs, is expected. These plan designs are often provided at a lower cost than more traditional plan arrangements.

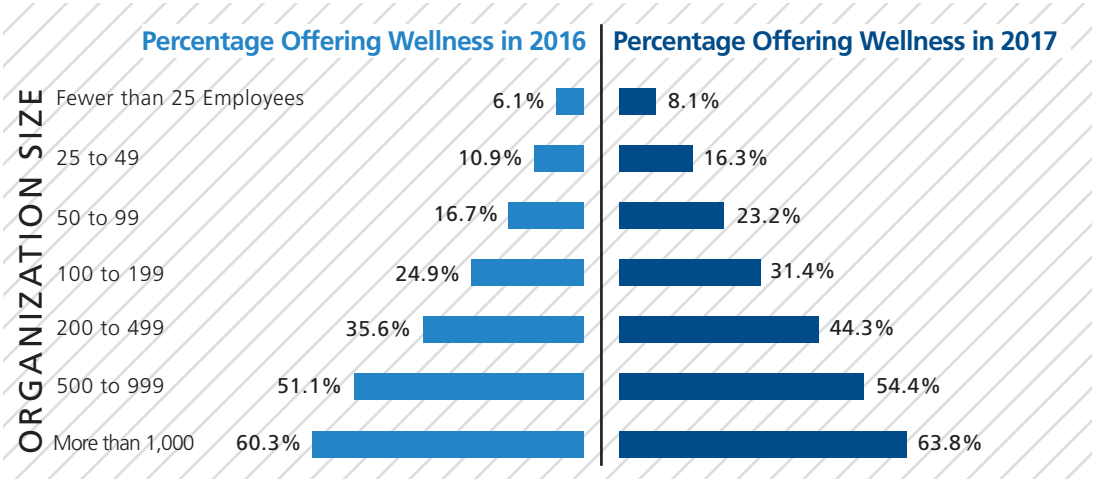
	2016	2017
HSA Enrollment	17.0%	15.9%
HRA Enrollment	10.7%	10.2%

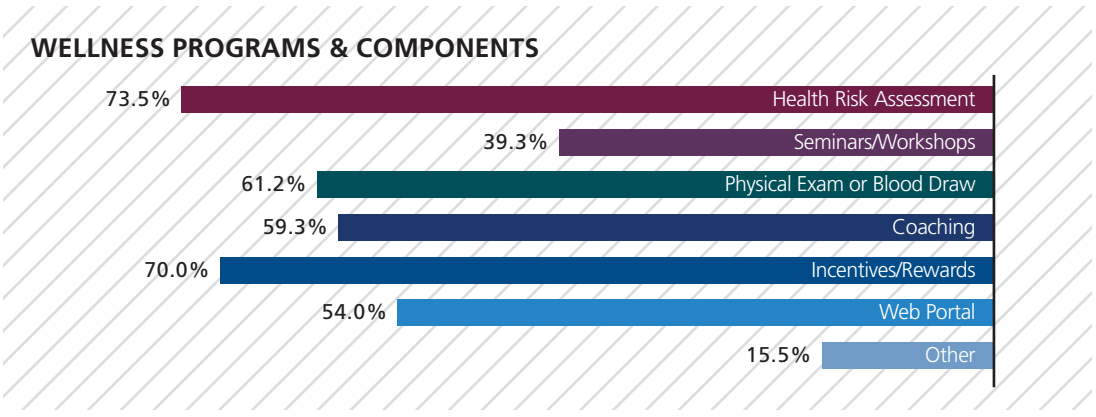
WELLNESS PROGRAM DATA

Wellness programs are offered by 23.5% of all employers, an increase over last year's 18.9%. As one might expect, the highest percentage (63.8%) of plans offering wellness benefits came from employers with 1,000 or more employees. The next two largest percentages—54.4% and 44.3%—came from organizations with 500 to 999 employees and 200 to 499 employees, respectively. The lowest percentage (8.1%) of plans offering wellness benefits came from organizations employing fewer than 25 people, but even that group saw a modest increase in participation, up from 2016's 6.1%. The largest increase was seen by employers with 200 to 499 employees, with an increase to 44.3% from 2016's 35.6%.

Wellness programs remain popular with employers despite the increasing regulations and scrutiny surrounding wellness programs. Major regulations were issued in the second half of 2016 by the Equal Employment Opportunity Commission (EEOC) that significantly limits how employers structure wellness programs involving health risk assessments and biometric screenings. The 8.6% drop in employers offering biometric screenings and physical examinations is likely due to the strict regulations.

Among employers offering wellness programs, 73.5% include health risk assessments, 70% offer employee incentives for participation, 61.2% offer biometric screenings or physical exams, 59.3% include on-site or telephone coaching for high-risk employees, and 39.3% include seminars or workshops.





Regulations aside, employers and wellness consultants are increasingly using claims data as a replacement for the health risk assessment. In general, health risk assessments are subjective, which calls their relevance into question. Many employees complain about the content and length of time it takes to complete the assessment, as well as its intrusiveness and the privacy concerns it raises. Nonetheless, using a health risk assessment can have its benefits. The results of a health risk assessment provide users with good feedback regarding their current state of health and often make valuable connections to programs and resources available through carriers or wellness vendors.

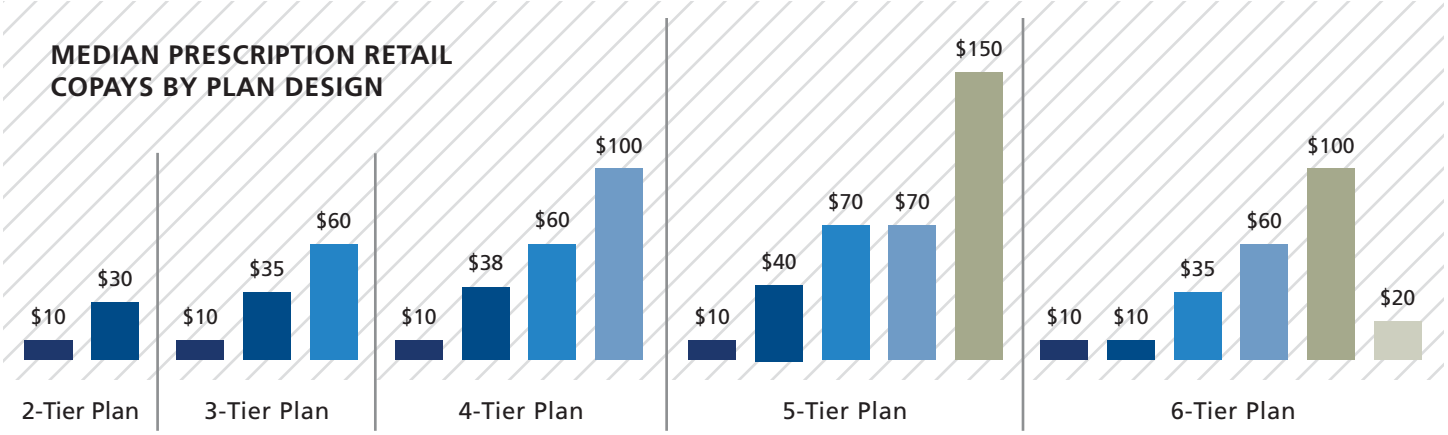
Since 10% to 20% of employees typically drive 70% to 80% of the high cost claims, supporting those with chronic or high-risk conditions is as important as keeping the healthy employees healthy. As a result, an increase in telephone coaching for high-risk employees is a growing component of wellness programs, particularly when coupled with the lower implementation cost of telephone coaching. Employers offering a Web portal component to their wellness program increased by 12%, followed by an 8.6% increase in employers offering coaching either on-site or on the telephone. Wellness programs continue to evolve, especially in the ways they connect with employees and assist them in making lifestyle improvements. Changes in the methods of delivery and the tools used in programming are a normal part of growth. Wellness programs remain the most popular in the Northeast and the least popular in the Central U.S., while CDHP plans and EPO plans are the most likely to be offered in combination with a wellness program. It will come as no surprise that employers in the health care industries are most likely to offer wellness programs (46.4%) whereas only 16.5% of manufacturing employers offer wellness programs. Large employers are more likely to offer wellness programs, with 44% of employers with 200 to 499 employees offering a wellness program as compared to only 16.3% of employers with 25 to 49 employees.

PRESCRIPTION PLAN DATA

Copays and Coinsurance Models: 47.4% of prescription drug plans use copays only, down 13% from last year (54.5%). Breaking down coinsurance-only models versus blended copay/coinsurance models, 8.3% of plans use only coinsurance—a 20.2% increase from last year. Meanwhile, 33.6% of plans use a blended copay/coinsurance model, up slightly from last year (33.0%). In blended copay/coinsurance models, some plans may use a copay structure in the first two tiers and then employ a coinsurance model for the higher tiers. Other plans contain a percent-based cost-sharing model to accommodate higher priced "specialty" medications (for example, 20% with a $100 maximum). Coinsurance models are more desirable from an employer's perspective since they are somewhat inflation-proof. As the costs of all drugs go up, a percentage-based model adjusts, whereas a fixed copayment model does not. With coinsurance or blended copay/coinsurance models on the rise after being virtually nonexistent five years ago, the move away from a copay-only plan design continues.

Tiers: In 2016, employers had a major shift in the use of tiers for prescription drug plans. In 2016, 40.7% of prescription drug plans used three tiers (generic, formulary brand, and non-formulary brand), and the percentage of four-tier plans (41.6%) surpassed the percent of three-tier plans. Furthermore, in 2016, 10% of employers were using five tiers and 2% using six tiers. In 2017, these trends continued, and a shocking 32% of employers moved to a six-tier design. With a 35% increase over 2016, 72.6% of employers provided four or more tiers. The fourth, fifth, and sixth tiers pay for biotech drugs, which are the most expensive. By segmenting these drugs into other categories with significantly higher copays, employers are able to pass along a little more of the cost of these drugs to employees. As evidenced by the changes in 2017 alone, this is a rapidly growing strategy to control costs. Meanwhile, only 5.3% of plans use one or two tiers.

Copay Amounts: Although employers might have made radical changes in the number of preferred tiers, median retail copays remained stable in 2017, with $10/$38/$60/$100 for four-tier plans. These amounts have remained largely flat since 2014. Generic drugs in the lowest tier generally cost the least, so employees are often paying all or most of the generic cost with the tier 1 copay. This makes it difficult to raise that amount, especially if employers are concerned about medication adherence. But in four-tier models, the tier 2 copay did increase from $35 to $38, likely in an effort to control the soaring costs of non-formulary brand drugs. In 2016, the first UBA-reported median copays for five-tier plans were $10/$45/$70/$80/$150. In 2017, they shifted slightly to $10/$40/$70/$70/$150. The six-tier plans came in with copays of $10/$10/$35/$60/$100/$20.



Brand vs. Generic: In 66% of plans, employees are required to pay more when they elect brand-name drugs over an available generic drug; 39.1% of those plans require the added cost even if the physician notes "dispense as written." And 34% of plans offer no added cost coverage for brand-name drugs. While most employers aren't completely penalizing those who choose brand-name drugs, more and more plans are requiring employees to pay higher copays when they elect brand-name drugs. Some plans have a mandated step therapy program that makes sure employees try a lower class alternative before they move to a medication in a higher class (or require they try a generic or generic equivalent in a particular therapeutic class). Some plans exclude certain drugs altogether. This cost pressure has made employers more aware of drug costs so many are beginning to educate employees about using benefits cost effectively.

Drug Supplies and Mail Order: Almost one-third (30.5%) of prescription drug plans provide a 90-day supply at a cost of two-times-retail copays, while only 4.1% of plans require a single retail copay for mail order. Meanwhile, 3.9% of plans now provide no reduced copay incentive for using mail order (keep in mind that some states prohibit mail order incentives). While mail order benefits are high for specialty drugs, the gap is closing on many maintenance drugs. As the cost escalates, mail order plans can't cover the 90-day cost with a single or even two-times-retail copay. UBA Partners believe that soon mail order will offer only the convenient delivery of these drugs, not cost savings for the employee.

ABOUT THIS SURVEY

Data in the 2017 UBA Health Plan Survey are based on responses from 11,221 employers sponsoring 20,099 health plans nationwide. This unparalleled number of reported plans is nearly three times larger than the next two of the nation's largest health plan benchmarking surveys combined. The resulting volume of data provides employers of all sizes more detailed—and therefore more meaningful—benchmarks and trends than any other source.

The scope of the survey allows regional, industry-specific, and employee size differentials to emerge from the data. In addition, the exceptionally large number of plans represented allows for both a broader range of categories by plan type than traditionally reported and a larger number of respondents in each category. Historically, these types of benchmark data were unavailable to small and mid-size employers.

For larger employers, the survey provides benchmarking data on a more detailed level than ever before. By using these data, the independent benefit advisory firms that comprise UBA can help employers more accurately evaluate costs, contrast the current benefit plan's effectiveness against competitors' plans, and adjust accordingly. This gives employers a distinct competitive edge in recruiting and retaining a superior workforce.

HOW WE CONDUCT OUR HEALTH PLAN SURVEY

Respondents to the survey compose a nonprobability sample, in which a factor other than probability—employers' shared contact with UBA, in this case—determines which population sample elements will be included.

Using a nonprobability sample does not mean the sample is unrepresentative of the larger employer population. It simply means UBA cannot formally calculate sampling error, a less consequential source of total error than human error. The full survey provides highly accurate benefit data for employers within narrow industry, size, and regional subsets.

We devote significant resources to reducing errors, individually reviewing and validating the data from each health plan respondent. All questionable data were either verified, re-recorded, or eliminated.

Additionally, we compared key variables from the 2017 UBA Health Plan Survey with those of three national employer health benefit benchmark surveys that are widely considered to contain accurate population representations. We have consistently produced results well within comparable and acceptable credibility ranges.

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Earl Bacon Agency, Inc. - Tallahassee
GCD Insurance Consultants, Inc. - Tampa
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Leading Edge Benefit Advisors, LLC - Ft. Myers
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Selden Beattie - Coral Gables
Sihle Insurance Group, Inc. - Altamonte Springs
The Stoner Organization, Inc. - St. Petersburg
Whipple & Company, Inc. - Coconut Creek

Georgia
Alexander & Company - Tifton, Woodstock
Arista Consulting Group - Alpharetta
The Benefit Company - Atlanta
Providence Insurance Group, Inc. - Marietta
Snellings Walters Insurance - Atlanta

Hawaii
Atlas Insurance Agency, Inc. - Honolulu

Idaho
Fredriksen Health Insurance, LLC - Boise

Illinois
AHT Insurance - Chicago
Byrne, Byrne and Company - Chicago
Coordinated Benefits Company - Schaumburg
RJLee & Associates, LLP - Moline
R.W. Garrett Agency, Inc. - Lincoln

Indiana
Benefits 7, Inc. - Evansville, Vincennes
The DeHayes Group - Fort Wayne
LHD Benefit Advisors, LLC - Indianapolis

Iowa
Frank Berlin & Associates - West Des Moines
TrueNorth Companies, LLC - Cedar Rapids

Kansas
Creative Planning Benefits, LLC - Leawood

Kentucky
Benefit Insurance Marketing - Lexington
HORAN - Fort Mitchell
Schwartz Insurance Group - Louisville

Louisiana
Becker Suffern McLanahan, Ltd. - Mandeville
Dwight Andrus Insurance - Lafayette

Maine
Acadia Benefits, Inc. - Bangor, Portland

Maryland
Insurance Associates, Inc. - Laurel, Rockville, Towson
Insurance Solutions - Annapolis, Prince Frederick

Massachusetts
360 Corporate Benefit Advisors - Wayland
Borislow Insurance - Methuen
EBS - Newton
The Gaudreau Group - Wilbraham
Sullivan Benefits - Marlboro

Michigan
44North - Cadillac, Grand Rapids, Marquette, Saginaw
BenePro - Royal Oak
Comprehensive Benefits, Inc. - Southfield
Keyser Insurance Group - Kalamazoo
Saginaw Bay Underwriters - Saginaw
Strategic Services Group, Inc. - Rochester Hills

Minnesota
Cleveland Company - Minneapolis
Horizon Agency, Inc. - Eden Prairie
Johnson Insurance Consultants - Duluth
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Mississippi
Executive Planning Group, P.A. - Jackson

Missouri
Bryant Group, Inc. - St. Louis
Employee Benefit Design, LLC - Springfield
Winter-Dent & Company - Columbia, Jefferson City

Nebraska
Swartzbaugh-Farber & Associates, Inc. - Omaha

New Hampshire
Granite Group Benefits, LLC - Manchester

New Jersey
Innovative Benefit Planning, LLC - Moorestown
Katz/Pierz, Inc. - Cherry Hill

New York
Austin & Co., Inc. - Albany
Brio Benefit Consulting, Inc. - New York
HR Benefit Advisors, Ltd. - Buffalo, Rochester, Utica
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Paradigm Benefits, Inc. - Utica

North Carolina
Dennis Insurance Group - Greensboro
ECM Solutions - Charlotte
GriffinEstep Benefit Group, Inc. - Wilmington
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Ohio
ClearPath Benefit Advisors LLC - Columbus
HORAN - Cincinnati, Dayton
Kaminsky & Associates, Inc. - Maumee
Schwendeman Agency, Inc. - Marietta
Todd Associates, Inc. - Beachwood

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Benefit Plan Strategies - Tulsa
Dillingham Benefits, LLC - Oklahoma City

Oregon
Davidson Benefits Planning, LLC - Tigard
KPD Insurance, Inc. - Springfield

Pennsylvania
Commonwealth Benefits Group - Dillsburg
Lehigh Valley Benefits Group, Inc. - Allentown
Lillis, McKibben, Bongiovanni & Co. - Erie
The MEGRO Benefits Company - Conshohocken
Power Kunkle Benefits Consulting - Wyomissing
Roller Consulting Company, Inc. - King of Prussia

South Carolina
ECM Solutions - Greenville

Tennessee
Insurance Consulting Group, Inc. - Memphis
Paradigm Group, LLC - Nashville
Russ Blakely & Associates - Chattanooga, Knoxville
Trinity Benefit Advisors - Knoxville

Texas
Advantage Benefit Solutions - Houston
AMCORP - San Antonio
Brinson Benefits, Inc. - Austin, Dallas, Fort Worth
Carlisle-Corrigan Benefits, LLC - Corpus Christi
Forté Benefits - Fort Worth
Insgroup, Inc. - Houston
Kainos Partners, Inc. - Jersey Village
Shepard & Walton Employee Benefits - Austin, Harlingen, McAllen
TrueNorth Companies - Fort Worth
Upshaw Insurance Agency - Amarillo

Utah
Davis Pacific Benefits - Salt Lake City
Fringe Benefit Analysts, LLC - Layton
McDermott Company & Associates - South Jordan

Vermont
The Richards Group - Bellows Falls, Brattleboro, Norwich, Rutland, Williston

Virginia
AHT Insurance - Leesburg
D & S Agency - Roanoke
Insurance Associates - Fairfax
Managed Benefits, Inc. - Glen Allen
Tower Benefit Consultants, Inc. - Virginia Beach

Washington
AHT Insurance - Seattle
Albers & Company, Inc. - Tacoma
GHB Insurance - Olympia
Trutina Financial - Bellevue

West Virginia
Schwendeman Agency, Inc. - Parkersburg

Wisconsin
Diversified Insurance Solutions, Inc. - Brookfield
Hemb Insurance Group, LLC - Madison
Hierl Insurance, Inc. - Appleton, Fond du Lac

Wyoming
Wyoming Benefits & Services, Inc. - Casper

Canada
Selectpath Benefits & Financial, Inc. - London, Point Edward, Ont.

United Kingdom
Churchills International Consulting, Ltd. - Edingley, Notts.

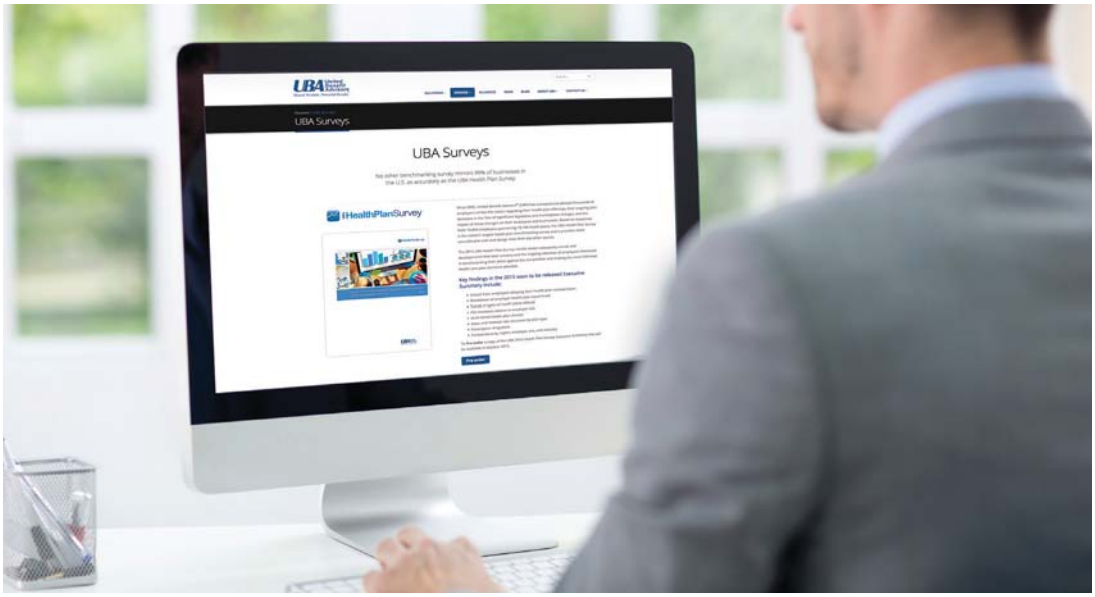
UBA PARTNER FIRM SERVICES

UBA Partner Firms offer a wealth of other services. The list below provides an overview of the categories of products and services that they can provide. Additional details on the items listed, including pricing information, can be obtained by contacting your nearest UBA Partner Firm.

- Consultative & Strategic Plan Design
- Health & Welfare Plan & Qualified Plan Brokerage
- Renewal Pricing Evaluation & Plan Cost Forecasting
- Medical Stop Loss, IBNR & Reserve Calculations
- Health Care Cost-Containment Strategies
- Medical Claims Analysis & Individual Predictive Modeling
- Actuarial Consulting: Medical, Retiree Medical & Pension Plans
- FSA, HRA, HSA & COBRA Administration
- HR Consulting
- HIPAA Compliance Solutions
- Health Care Claims Auditing Solutions
- Worksite Marketing Programs & Voluntary Product Placement
- Executive Compensation & Benefits
- Personal Financial Planning & Asset Management
- Customized Employee Benefits Website & Document Library
- Web-Based Employee Enrollment & Benefit Communication Systems
- Daily Benefits & HR Updates, Legislative Guides, Document Center, & Links Library
- ACA Resource Center
- Compliance Webinars, Alerts & Newsletters
- Private Insurance Exchange
- Wellness Consulting & Employee Assistance
- Total Compensation Statements
- Prescription Drug Management

ABOUT UBA

United Benefit Advisors is the nation's leading independent employee benefits advisory organization with more than 200 offices throughout the United States, Canada, and the United Kingdom. As trusted and knowledgeable advisors, UBA Partners collaborate with more than 2,100 fellow professionals to deliver expertise, thought leadership, and best-in-class solutions that positively impact employers and make a real difference in the lives of their employees and families. Employers, advisors, and industry-related organizations interested in obtaining powerful results from the shared wisdom of our Partners should visit UBA online at ***www.UBAbenefits.com***.



SHARED WISDOM. POWERFUL RESULTS.®

With the shared knowledge and expertise of thousands of other UBA benefits professionals, UBA Partner Firms can meet the needs of any size business. UBA Partners help more than 36,000 employers design competitive medical plan strategies to clearly identify cost savings opportunities and encourage employee acquisition and retention. UBA Partners educate nearly 2 million employees and their families to become better health care consumers and lead healthier lives, easing the strain on health care claims and costs. UBA Partners saved employers, on average, 4% on the most recent medical plan renewals.

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