

Local 0000

Health & Welfare Fund Marketing Project Overview - Self Insured Group Medical Alternatives

Assumed Effective Date: January 1, 2005

Insurance Carriers	Proposal Status	Comments
Carrier 1	X	N/A
Carrier 2	X	Proposed PPO Quote Only
Carrier 3	X	Not Competitive
Carrier 4	Decline	Not Competitive
Carrier 5	Decline	Not Competitive
Carrier 6	Decline	Out of State Situs
Carrier 7	Decline	Group Size (< 300)
Carrier 8	Decline	Out of State Situs & Industry
Carrier 9	ASO Quote Rec'd	Not Competitive
Carrier 10	Decline	No Taft Hartley Groups

TPAs / Reinsurers	Proposal Status	Comments
Reinsurer 1	X	TPA Services
Reinsurer 2	Pending	TPA Services
Reinsurer 3	X	Reinsurance
Reinsurer 4	X	Not Competitive
Reinsurer 5	X	Not Competitive
Reinsurer 6	X	Not Competitive

Local 0000

Group Medical and Prescription Drug Self Insured Financial Analysis - Current Plan Design
 All Proposed Reinsurance Contracts and Administrative Services Fees are 12/12 (Immature)
 Effective Date: January 1, 2005

Participation Assumption:	
Single	548
Family	492
Total	1040

	2004	2005	2005	2005
	Current	Renewal	Proposed	Proposed
			Carrier A	Carrier B
TPA & Managed Care Fees				
Medical Claim Administration Fee	\$ 12.00	\$ 12.00	\$ 22.50	\$ 24.00
Fund Administration	\$ 6.80	\$ 6.80	\$ 6.80	\$ 6.80
COBRA Administration	\$ -	\$ -	\$ -	\$ -
HIPAA Administration	\$ -	\$ -	\$ -	\$ -
Medical Review (UR) Fee	\$ 1.95	\$ 1.95	\$ -	\$ -
PPO Access Fee	\$ 3.75	\$ 3.75	\$ 4.57	\$ 9.50
Monthly	\$ 25,480	\$ 25,480	\$ 35,225	\$ 41,912
Annually	\$ 305,760	\$ 305,760	\$ 422,698	\$ 502,944
Reinsurance Premiums				
Specific Contract	Paid	Paid	12/12	12/12
Specific Deductible	\$ 100,000	\$ 100,000	\$ 100,000	\$ 100,000
Rx Included		Yes	Major Med	Major Med
Lifetime Maximum (Less Specific Deductible)	Unknown	\$ 2,000,000	\$ 2,000,000	\$ 5,000,000
Specific Rates				
Single	\$ 50.88	\$ 60.00	\$ 55.00	\$ 35.00
Family	\$ 50.88	\$ 60.00	\$ 55.00	\$ 110.00
Specific Premiums				
Monthly	\$ 52,915	\$ 62,400	\$ 57,200	\$ 73,300
Annually	\$ 634,982	\$ 748,800	\$ 686,400	\$ 879,600
Aggregate Contract				
Risk Corridor	No Coverage	No Coverage	12/12	12/12
Rx Included			125%	125%
Aggregate Maximum			Yes	Yes
			\$ 1,000,000	\$ 1,000,000
Aggregate Rate				
Composite	No Coverage	No Coverage	Proposed	
	\$ -	\$ -	8.48	\$ 7.80
Aggregate Premium				
Monthly	\$ -	\$ -	\$ 8,819	\$ 8,112
Annually	\$ -	\$ -	\$ 105,830	\$ 97,344
Estimated Claim Liability Excluding Reserves				
Aggregate Claim Factors (Monthly)	Hypothetical	Hypothetical		
Single	\$ 655.04	\$ 786.05	\$ 735.00	\$ 365.00
Family	\$ 655.04	\$ 786.05	\$ 735.00	\$ 1,050.00
Maximum Monthly Claim Liability	\$ 681,242	\$ 817,490	\$ 764,400	\$ 716,620
Maximum Annual Claim Liability	\$ 8,174,899	\$ 9,809,879	\$ 9,172,800	\$ 8,599,440
Expected Monthly Claim Liability	\$ 544,993	\$ 653,992	\$ 611,520	\$ 573,296
Expected Annual Claim Liability	\$ 6,539,919	\$ 7,847,903	\$ 7,338,240	\$ 6,879,552
Estimated Runout Liability				
	\$ -	\$ -	\$ 179,777	\$ 179,777
Total Estimated First Year Plan Costs Excluding Reserves				
Maximum Monthly Plan Costs	\$ 759,637	\$ 905,370	\$ 865,644	\$ 839,944
Maximum Annual Plan Costs	\$ 9,115,642	\$ 10,864,439	\$ 10,387,728	\$ 10,079,328
Plus Estimated Runout Liability	\$ 9,115,642	\$ 10,864,439	\$ 10,567,505	\$ 10,259,105
Expected Monthly Plan Costs	\$ 623,388	\$ 741,872	\$ 712,764	\$ 696,620
Expected Annual Plan Costs	\$ 7,480,662	\$ 8,902,463	\$ 8,553,168	\$ 8,359,440
Plus Estimated Runout Liability	\$ 7,480,662	\$ 8,902,463	\$ 8,732,945	\$ 8,539,217

Local 0000

Voluntary Group Dental Marketing Analysis

Proposed Plan

Effective Date: January 1, 2005

Dental PPO Benefit Summary	Carrier 1	Carrier 2	Carrier 3
	Proposed	Proposed	Proposed
Annual Plan Maximum (In/Out)	\$1,500	\$1,500	\$1,500 / \$1,000
Individual Deductible (In/Out)	\$25 / \$50	\$25 / \$50	\$25 / \$75
Family Deductible (In/Out)	\$75 / \$150	\$75 / \$150	\$75 / \$225
Coinsurance (In/Out)			
Preventive Services	100% / 80%	100% / 80%	100% / 80%
Basic Services	80% / 50%	80% / 80%	80% / 60%
Major Services	50% / 50%	50% / 50%	50% / 50%
Orthodontia Benefit	50% to \$1,000	50% to \$1,000	No Coverage

Dental PPO Proposal Caveats			
Participation Requirement	40% of Eligibles	50% of Eligibles	Greater of 25% or 25 Eligibles
Deductible Waived for Preventive Services?	Yes	Yes	Yes
Endodontic and Periodontic in Basic?	Yes		Endodontics Only
Waiting Period for Basic / Major Services			6 Months / 12Months

Dental PPO Rate Summary			
Single	\$29.90	\$20.38	\$26.32
Single+Child(ren)	\$65.44	\$64.20	\$54.75
Single+Spouse	\$68.02	\$46.31	\$53.96
Family	\$104.74	\$90.14	\$82.40

Local 0000

Non-Contributory Term Life and Accidental Death & Dismemberment (AD&D) Marketing Analysis
 Current Plan Design / Fully Insured Non-Participating Contracts
 Effective Date January 1, 2005
 All Rates per \$1,000 of Basic Term Life and Accident Insurance Volume

Group Term Life and Accident Proposal Summary

	Current	Renewal	Carrier 1 Proposed	Carrier 2 Proposed	Carrier 3 Proposed	Carrier 4 Proposed	Carrier 5 Proposed	Carrier 6 Proposed	Carrier 7 Proposed	Carrier 8 Proposed
Term Life Benefit for Active Members	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000
Term Life Benefit for Retirees	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000
Estimated Term Life Volume	\$19,000,000	\$19,000,000	\$19,000,000	\$19,000,000	\$19,000,000	\$19,000,000	\$19,000,000	\$19,000,000	\$19,000,000	\$19,000,000
Basic Term Life Rate per \$1,000	\$0.150	\$0.150	\$0.110	\$0.115	\$0.120	\$0.120	\$0.135	\$0.140	\$0.140	\$0.140
Estimated Monthly Term Life Premium	\$2,850	\$2,850	\$2,090	\$2,185	\$2,280	\$2,280	\$2,565	\$2,660	\$2,660	\$2,660
Estimated Annual Term Life Premium	\$34,200	\$34,200	\$25,080	\$26,220	\$27,360	\$27,360	\$30,780	\$31,920	\$31,920	\$31,920
AD&D Benefit for Active Members Only	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000
Estimated AD&D Volume	\$18,000,000	\$18,000,000	\$18,000,000	\$18,000,000	\$18,000,000	\$18,000,000	\$18,000,000	\$18,000,000	\$18,000,000	\$18,000,000
AD&D Rate per \$1,000	\$0.040	\$0.040	\$0.020	\$0.020	\$0.025	\$0.025	\$0.025	\$0.030	\$0.030	\$0.033
Estimated Monthly AD&D Premium	\$720	\$720	\$360	\$360	\$450	\$450	\$450	\$540	\$540	\$594
Estimated Annual AD&D Premium	\$8,640	\$8,640	\$4,320	\$4,320	\$5,400	\$5,400	\$5,400	\$6,480	\$6,480	\$7,128

Group Term Life and Accident Financial Summary

Combined Monthly Premiums	\$3,570	\$3,570	\$2,450	\$2,545	\$2,730	\$2,730	\$3,015	\$3,200	\$3,200	\$3,254
Combined Annual Premiums	\$42,840	\$42,840	\$29,400	\$30,540	\$32,760	\$32,760	\$36,180	\$38,400	\$38,400	\$39,048
Percent Difference to Current	N/A	0.00%	-31.37%	-28.71%	-23.53%	-23.53%	-15.55%	-10.36%	-10.36%	-8.85%
Dollar Difference to Current	N/A	\$0	-\$13,440	-\$12,300	-\$10,080	-\$10,080	-\$6,660	-\$4,440	-\$4,440	-\$3,792
Rate Guarantee Period	1 Year	1 Year	2 Years	2 Years	2 Years	2 Years	2 Years	2 Years	2 Years	2 Years
Estimated Cost Per Employee Per Month	\$3.43	\$3.43	\$2.36	\$2.45	\$2.63	\$2.63	\$2.90	\$3.08	\$3.08	\$19.37

Local 0000

Voluntary Group Vision Marketing Analysis

Proposed Plan

Effective Date: January 1, 2005

Frequency of Services	Guardian	VSP Option 1	VSP Option 2
Eye Examination	Every 12 Months	Every 12 Months	Every 12 Months
Frames	Every 24 Months	Every 12 Months	Every 24 Months
Lenses	Every 12 Months	Every 12 Months	Every 12 Months
Contact Lenses (In Lieu of Frames & Lenses)	Every 12 Months	Every 12 Months	Every 12 Months

Vision Benefit Summary

	<u>In Network</u>	<u>Out of Network</u>	<u>In Network</u>	<u>Out of Network</u>	<u>In Network</u>	<u>Out of Network</u>
Eye Examination	\$10 Copay	\$46 Allowance	\$20 Copay	\$46 Allowance	\$10 Copay	\$46 Allowance
Frames	\$25 Copay	\$47 Allowance	\$120 Allowance	\$46 Allowance	\$25 Copay	\$46 Allowance
Lenses	\$25 Copay	\$47 - \$125 Allow	\$20 Copay	\$25 - \$55 Allow	\$25 Copay	\$25 - \$55 Allow
Contact Lenses (Medically Necessary)	\$25 Copay	\$210 Allowance	\$20 Copay	\$210 Allowance	\$25 Copay	\$210 Allowance
Contact Lenses (Elective)	\$105 Allowance	\$105 Allowance	\$105 Allowance	\$105 Allowance	\$105 Allowance	\$105 Allowance

Vision Proposal Caveats

Participation Requirement	Greater of 35% or 10 Employees	50 Employees	50 Employees
---------------------------	--------------------------------	--------------	--------------

Vision Rate Summary

Single	\$8.27	\$9.29	\$8.53
Single+Child(ren)	\$14.19	\$15.97	\$14.67
Single+Spouse	\$13.92	\$15.64	\$14.38
Family	\$22.46	\$25.74	\$23.67

Local 0000

Group Medical PPO Plan Design Comparison
 Self Insured Contracts
 Assumed Effective Date: January 1, 2005

Current Plan Design

	In Network Services	Out of Network Services
Lifetime Maximum Benefit	\$1,000,000 payable per person per lifetime	
Calendar Year Deductible		
Individual	\$200	\$200
Family	\$400	\$400
Out of Pocket Limit (Includes CY Deductible)		
Individual	\$2,200 per person per calendar year	
Family	There is no family "maximum", the individual out of pocket maximum applies to each family member	
Inpatient/Outpatient Hospital Treatment Coinsurance <small>(Includes newborn hospital nursery care and outpatient surgery)</small>	85%	80%
Inpatient Room and Board - Maximum Allowable Expense		
Intensive Care Unit / Cardiac Care Unit	Hospital's ICU/CCU rate	
Semi-Private Room or Private Room	Semi-private room rate	
Physician/Specialist Office Visits	85% after CY deductible	80% after CY deductible
Urgent Care Copay	85% after CY deductible	80% after CY deductible
Emergency Room Deductible <small>(Deductible is waived if admitted to hospital)</small>	\$100 deductible then 75%	\$100 deductible then 70%
Prescription Drug Benefit	Plan pays 70% after CY deductible	
Routine Care Benefit		
Adult Physical Examinations	Plan pays 100% to a CY maximum of \$500 for active employees and spouses only	
Well Baby Care	Plan pays 70% after CY deductible for routine checkups and immunizations up to age 6	
Chiropractic Care Benefit	Plan pays 70% after CY deductible to a maximum of \$500 per person per calendar year	
Mental Nervous / Substance Abuse Benefit		
Inpatient Treatment <small>(Inpatient treatment limited to 15 days per CY and 30 days per lifetime)</small>	85% after CY deductible	80% after CY deductible
Outpatient Treatment <small>(Outpatient treatment limited to 30 visits per CY)</small>	75% after CY deductible	70% after CY deductible
Convalescent Facility Care Benefit	Maximum allowable confinements in a period of 365 days: One Maximum allowable days per confinement: 120	
Home Health Care Benefit	Maximum allowable confinements per CY: 40 visits	
Second Surgical Opinions	Plan pays 100%	
All Other Covered Medical Expenses	Plan pays 70% after CY deductible	
Pre-certification Penalty	There is a 10% coinsurance penalty for not pre-certifying	

**Carrier 1
Proposed PPO**

	In Network Services	Out of Network Services
Lifetime Maximum Benefit	\$5,000,000 combined per person per lifetime	
Calendar Year Deductible		
Individual	\$250	\$500
Family	\$500	\$1,000
Out of Pocket Limit (Includes CY Deductible)		
Individual	\$1,500	\$3,000
Family	\$3,000	\$6,000
Inpatient/Outpatient Hospital Treatment Coinsurance <small>(Includes newborn hospital nursery care and outpatient surgery)</small>	90% after Deductible	70% after Deductible
Inpatient Room and Board - Maximum Allowable Expense		
Intensive Care Unit / Cardiac Care Unit	90% after Deductible	70% after Deductible
Semi-Private Room or Private Room	90% after Deductible	70% after Deductible
Physician/Specialist Office Visits	\$20 Copay then 100%	70% after Deductible
Urgent Care Copay	\$35 Copay then 100%	70% after Deductible
Emergency Room Deductible <small>(Deductible is waived if admitted to hospital)</small>	\$50 deductible then 90%	\$50 deductible then 70%
Prescription Drug Benefit	\$10 / \$20 / \$30 Retail Copay (2x for Mail Order)	
Routine Care Benefit		
Adult Physical Examinations	\$20 Copay then 100%	70% after Deductible
Well Baby Care	\$20 Copay then 100%	70% after Deductible
Chiropractic Care Benefit	\$20 Copay - 12 Visits per Year	No Coverage
Mental Nervous / Substance Abuse Benefit		
Inpatient Treatment <small>(Inpatient treatment limited to 15 days per CY and 30 days per lifetime)</small>	Same as Any Other Illness	Same as Any Other Illness
Outpatient Treatment <small>(Outpatient treatment limited to 30 visits per CY)</small>	Same as Any Other Illness	Same as Any Other Illness
Convalescent Facility Care Benefit	90% after Deductible	70% after Deductible
Home Health Care Benefit	90% after Deductible	70% after deductible
Second Surgical Opinions	Plan pays 100%	
All Other Covered Medical Expenses	DME is 80/60 Hospice and Ambulance at 100%	70% after deductible
Pre-certification Penalty	No Penalty (Doctor will Precert)	30% Penalty for not pre-certifying out of network services

**Carrier 2
Proposed PPO**

	In Network Services	Out of Network Services
Lifetime Maximum Benefit	\$5,000,000 payable per person per lifetime	
Calendar Year Deductible		
Individual	\$200	\$200
Family	\$400	\$400
Out of Pocket Limit (Includes CY Deductible)		
Individual	\$2,200	\$2,200
Family	\$4,400	\$4,400
Inpatient/Outpatient Hospital Treatment Coinsurance <small>(Includes newborn hospital nursery care and outpatient surgery)</small>	85%	80%
Inpatient Room and Board - Maximum Allowable Expense		
Intensive Care Unit / Cardiac Care Unit	Hospital's ICU/CCU rate	
Semi-Private Room or Private Room	Semi-private room rate	
Physician/Specialist Office Visits	85% after Deductible	80% after Deductible
Urgent Care Copay	85% after CY deductible	80% after CY deductible
Emergency Room Deductible <small>(Deductible is waived if admitted to hospital)</small>	\$100 deductible then 85%	\$100 deductible then 80%
Prescription Drug Benefit	80% after Deductible	
Routine Care Benefit		
Adult Physical Examinations	\$500 In Network Only	No Benefit
Well Baby Care	\$500 In Network Only	No Benefit
Chiropractic Care Benefit	\$35 benefit per visit up to 8 visits per month to a max of \$1,000/year	
Mental Nervous / Substance Abuse Benefit		
Inpatient Treatment <small>(Inpatient treatment limited to 15 days per CY and 30 days per lifetime)</small>	Same as Any Other Illness	Same as Any Other Illness
Outpatient Treatment <small>(Outpatient treatment limited to 30 visits per CY)</small>	Same as Any Other Illness	Same as Any Other Illness
Convalescent Facility Care Benefit	Maximum allowable confinements in a period of 365 days: One Maximum allowable days per confinement: 120	
Home Health Care Benefit	Maximum allowable confinements per CY: 40 visits	
Second Surgical Opinions	Plan pays 100%	
All Other Covered Medical Expenses	85% after Deductible	80% after Deductible
Pre-certification Penalty	\$300 penalty for not pre-certifying services	

Local 0000

PPO Network Analysis - Hospitals
 Listing Current as of November 1, 2004

Hospital Name	City	Zip Code	CCN	Anthem	PHCS
Memorial Hospital	South Bend	46601	X	X	X
St. Joseph Regional Medical Center	South Bend	46617		X	
St. Joseph Regional Medical Center	Plymouth	46583		X	X
St. Joseph Community Hospital	Mishawaka	46544	X	X	X
La Porte Hospital	La Porte	46352	X	X	X
St. Anthony Hospital	Michigan City	46360	X	X	X
St. Anthony Medical Center	Valparaiso		X	X	X
St. Anthony Medical Center	Crown Point	46307	X	X	X
St. Margaret Mercy Hospital	Dyer	46311	X	X	X
St. Vincent Hospital	Indianapolis		X	X	
St. Vincent Hospital	Frankfort		X	X	
St. Vincent Hospital	Carmel		X	X	
Goshen General Hospital	Goshen	46526	X	X	
Elkhart General Hospital	Elkhart	46514	X	X	X
Portage Memorial Hospital	Portage	46368		X	
St. Catherine Hospital	East Chicago	46312	X	X	X
St. Margaret Mercy Healthcare Center	Hammond	46325	X	X	X
Community Hospital Munster	Munster	46321	X	X	X
St. Mary Medical Center	Hobart	46342	X	X	X
Porter Memorial Hospital	Valparaiso	46368	X	X	X
Methodist Hospital	Gary	46402	X	X	X
Methodist Hospital	Merrillville	46410	X	X	X
Community Hospital of Bremen	Bremen	46508	X	X	X
Starke Memorial Hospital	Knox	46534		X	X
Kosciusko Community Hospital	Warsaw	46580		X	X

Total Hospitals/Facilities In Network

20

25

19

Disclaimer: This study was performed on November 15, 2004 and was based on internet search results. PPO network affiliation is subject to change due to contract renegotiations and actual matches may vary.