

1. Who is your Health Insurance Provider? **Blue Cross Blue Shield**

We are self-insured meaning we pay our own claim expenses while utilizing the BCBS network of doctors, hospitals and pharmacies. It has been very successful and the plan has been able to control the cost of monthly premiums that are shared by the company and the employees. Since going self-insured in October 2004 there have only been 3 premium increases.

- What are the premiums paid by the employee? (Individual, Family, etc)
 - Medical: Single - \$39.81 / bi-weekly; Family - \$100.96 / bi-weekly
- Coverage Specifics? (Copay?, Deductible?, Prescriptions?, Limits?)
 - Attached
- Will your insurance cover employees with pre existing conditions with no waiting period?
 - Yes, as long as they have prior creditable coverage

2. Who is your Dental Insurance Provider? **Blue Cross Blue Shield**

- What are the premiums paid by the employee? (Individual, Family, etc.)
 - Dental: Single - \$10.35 / bi-weekly; Family – 28.20 / bi-weekly
- Coverage Specifics?
 - Attached

3. Who is your Vision Insurance Provider? **Humana**

- What are the premiums paid by the employee and coverage specifics?
 - Vision: Single - \$4.31 / bi-weekly; Family - \$10.47 / bi-weekly
 - Coverage specifics are attached.

4. Do you offer Life Insurance, Accidental Death and Dismemberment Insurance, Cancer Policies, and other supplemental insurance policies? (Specifics?)

- Long Term Disability, Life and AD&D insurance are provided through OneAmerica. LTD coverage starts after 90 days of disability. It covers 60% of gross monthly salary with a

maximum of \$5,000/month. The Life is 2x annual salary with a maximum of \$50,000. Both are 100% paid by CWS. All cancer and supplement insurance policies are provided through AFLAC and paid by the employee.

5. Do you offer a retirement plan? If so, please give specifics regarding employee contributions vs employer contributions and any other important details about the plan.

- CWS provides a 401K plan with assets held by ING. There are approximately 35 different investment options. CWS also provides opportunities for professional investment advice for each employee in conjunction with the 401k plan. CWS matches a percentage of the employee's gross salary each year.

6. Paid Leave

- What is the accrual rate for vacation and sick time?

- Vacation: 1 year employment – 1 week; 2-10 years employment – 2 weeks; 10 years plus employment – 3 weeks. Vacation leave is accrued bi-weekly

- Sick: Salaried employees receive 12 days per year and hourly employees receive 6 days per year. Sick leave is accrued bi-weekly.

- Will city employees be able to maintain their current amount of accrued vacation and sick leave when they come to work for you or will they start with a zero balance?

- Yes, they will be able to keep their current amount of accrued vacation and sick leave

- If your paid leave accrual rate is based on years of service, will the employee's years of service with the City of Gautier count towards their awarded leave time with your company?

- Yes, their years of service with the City of Gautier will count toward their leave time with CWS

7. What other types of leave do you offer and what are the specifics? (Bereavement, Jury Duty, Military, etc.)

- Jury Duty – we encourage all staff members to serve when asked, as it is an obligation and privilege of citizenship. Employees are paid regular wages during this time.

- Bereavement Leave – provided for all employees with a death in the immediately family. An employee is allowed up to three days leave depending on the circumstances.

- Family and Medical Leave Act – if eligible under the FMLA, the employee can take up to 12 weeks of unpaid leave within a 12-month period.

8. What holidays will the employees be given off?

➤ Employees will continue to recognize the City's current holiday schedule

9. Do you intend to hire ALL City of Gautier Public Works employees that pass a drug screen and physical exam?

➤ Yes, ALL of them

10. Will the employees be paid commensurate to what they are being paid currently with the city and do you intend to give any raises or bonuses at the start of this contract?

➤ Raises will be given immediately to cover the difference in cost between the employee's current health insurance through the City and the health insurance provided by CWS.

ClearWater Solutions, LLC.

BlueCard PPO

Effective June 1, 2011

Medical

ClearWater Solutions, LLC
BlueCard PPO
Effective June 1, 2011

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<p><i>Benefit payments are based on the amount of the provider's charge that Blue Cross and Blue Shield recognizes for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received.</i></p> <p><i>Some services require a copay, coinsurance, calendar year deductible or deductible for each admission, visit or service.</i></p>		
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS		
<p>Preadmission Certification is required for inpatient admissions (except maternity); notification within 48 hours for emergencies. Call 1-800-248-2342 (toll free) for precertification.</p>		
Inpatient Hospital	Covered at 100% after \$170 per day hospital copay days 1-6 for each admission	Covered at 80% after \$750 per admission deductible Note: In Alabama, available only for accidental injury
Inpatient Physician Visits and Consultations	Covered at 100% subject to the calendar year deductible	Covered at 50% subject to calendar year deductible
OUTPATIENT HOSPITAL BENEFITS		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 100% after \$170 hospital copay	Covered at 80% subject to calendar year deductible; in Alabama, not covered
Emergency Room (Medical Emergency)	Covered at 100% after \$170 hospital copay	Covered at 80% subject to calendar year deductible; in Alabama, not covered
Emergency Room (Accident)	Covered at 100% after \$170 hospital copay	Covered at 80% subject to calendar year deductible
Emergency Room Physician	Covered at 100% after \$40 physician copay	Covered at 50% subject to calendar year deductible
Outpatient Diagnostic Lab, X-ray & Pathology Note: The first covered mammogram each calendar year is not subject to the hospital copay	Covered at 100% after \$170 hospital copay	Covered at 80% subject to calendar year deductible; in Alabama, not covered
Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100%; no copay or deductible	Covered at 80% subject to calendar year deductible; in Alabama, not covered
PHYSICIAN BENEFITS		
IN-NETWORK SERVICES NOT SUBJECT TO \$400 CALENDAR YEAR DEDUCTIBLE		
Office Visits, Outpatient Consultations & Second Surgical Opinions	Covered at 100% after \$40 physician copay	Covered at 50% subject to calendar year deductible
Diagnostic Lab, X-ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100%; no copay or deductible	Covered at 50% subject to calendar year deductible
IN-NETWORK SERVICES SUBJECT TO \$400 CALENDAR YEAR DEDUCTIBLE		
Surgery & Anesthesia	Covered at 100% subject to the calendar year deductible	Covered at 50% subject to calendar year deductible
Maternity Care	Covered at 100% subject to the calendar year deductible	Covered at 50% subject to calendar year deductible
PREVENTIVE CARE BENEFITS		
Routine Newborn Exam (in hospital)	Covered at 100%; no copay or deductible	Not covered
Routine Well Child Care Exams Nine visits during first 24 months of life and one visit each year thereafter through age six	Covered at 100% after \$40 physician copay	Not covered
Routine Developmental Screening Three exams between 9 and 30 months of life	Covered at 100%; no copay or deductible	Not covered
Routine Immunizations Age limitations apply to certain immunizations	Covered at 100%; no copay or deductible	Not covered
Routine Office Visit When eligible for a routine pap smear, routine mammogram or routine PSA/Digital Rectal Exam	Covered at 100% after \$40 physician copay	Not covered
Routine Pap Smear One per calendar year	Covered at 100%; no copay or deductible	Not covered
Routine Human Papillomavirus (HPV) Testing One routine test every three calendar years for females ages 30 and over	Covered at 100%; no copay or deductible	Not covered
Routine Chlamydia Screening One per calendar year for females ages 15-24	Covered at 100%; no copay or deductible	Not covered
Routine/Screening Mammogram One exam for females ages 35-39 and one per calendar year for females ages 40 and over	Covered at 100%; no copay or deductible	Not covered

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Routine Prostate Cancer Screening Males age 40 and over <ul style="list-style-type: none"> Prostate Specific Antigen (PSA) each calendar year Digital Rectal Exam each calendar year 	Covered at 100%; no copay or deductible	Not covered
Routine Colorectal Cancer Screening Ages 50 and over <ul style="list-style-type: none"> Hemocult stool check/ Fecal occult blood test each calendar year Flexible sigmoidoscopy every three calendar years Double-contrast barium enema every five calendar years Colonoscopy every 10 calendar years 	Covered at 100%; no copay or deductible for physician charges (outpatient hospital services may require a copay)	Not covered
Note: In case of illness or family history of cancer, services generally are not considered preventive and may be covered by other plan provisions		
PRESCRIPTION DRUG BENEFITS		
Prescription Drug Card <ul style="list-style-type: none"> 90 day supply may be purchased but copay applies for each 30 day supply; some copays combined for diabetic supplies Some drugs may require prior authorization View the Prescription Drug lists at www.bcbsal.com 	100% after the following copays: Generic Drugs: \$20 copay per prescription Preferred Brand Drugs: \$35 copay per prescription Other Brand Drugs: \$80 copay per prescription	Not covered
SUMMARY OF COST SHARING PROVISIONS		
Calendar Year Deductible	\$400 individual; \$1,200 aggregate amount per family	
	4 TH Quarter Carryover Deductible: Any covered expenses incurred in the last 3 months of any benefit period which have been allocated toward all <u>or</u> a portion of the Calendar year Deductible for that year may also be allocated toward next years Calendar year Deductible.	
Calendar Year Out-of-Pocket Maximum Applies to: <ul style="list-style-type: none"> Other Covered Services Home Health and Hospice 	\$1,500 individual plus calendar year deductible; \$4,500 aggregate amount per family Only the coinsurance amounts you pay for the listed services will apply to the maximum. Fixed copays do not apply to the maximum. After you reach the Calendar Year Out-of-Pocket Maximum, applicable expenses are covered at 100% for the remainder of the calendar year.	
Lifetime Maximum	There is no Lifetime Maximum	
BENEFITS FOR OTHER COVERED SERVICES		
Allergy Testing & Treatment \$200 per person per calendar year	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
Ambulance Service	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
Participating Chiropractic Services \$600 per person per calendar year	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible; in Alabama, covered at 50% subject to calendar year deductible
Durable Medical Equipment (DME)	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
Occupational and Physical Therapy	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible; in Alabama, covered at 50% subject to calendar year deductible
Speech Therapy	Covered at 80% subject to calendar year deductible	Covered at 80% subject to calendar year deductible
HOME HEALTH AND HOSPICE		
Home Health and Hospice <ul style="list-style-type: none"> Recertification required for services rendered outside Alabama For recertification call 1-800-821-7231 	Covered at 100% subject to the calendar year deductible	Covered at 80% subject to calendar year deductible; in Alabama, not covered
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS		
Mental Health and Substance Abuse	Mental Health and Substance Abuse benefits not administered by Blue Cross and Blue Shield of Alabama.	

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
HEALTH MANAGEMENT BENEFITS		
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury.	
Disease Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease.	
Baby Yourself	A prenatal wellness program; For more information, please call 1-800-222-4379. You can also enroll online at www.behealthy.com .	
Contraceptive Management	Covers prescription contraceptives, which include: birth control pills, injectables, diaphragms, IUDs and other non-experimental FDA approved contraceptives; subject to applicable deductibles, copays and coinsurance.	
Air Ambulance Services	Air ambulance service to a hospital near home if hospitalized while traveling more than 150 miles from home; to arrange transportation, call AirMed at 1-877-872-8624.	

Useful Information to Maximize Benefits

- To maximize your benefits, always use In-Network providers for services covered by your health benefit plan. To find In-Network providers, check a provider directory, provider finder web site (www.bcbsal.com) or call 1-800-810-BLUE (2583).
- In-Network hospitals, physicians and other health care providers have a contract with a Blue Cross and/or Blue Shield Plan for furnishing health care services at a reduced price (examples: BlueCard PPO, PMD, Preferred Care). In-Network Pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or its Pharmacy Benefit Manager(s).
- Out-of-Network providers generally do not contract with Blue Cross and/or Blue Shield Plans. If you use Out-of-Network providers, you may be responsible for filing your own claims and paying the difference between the provider's charge and the allowed amount. The allowed amount may be based on the negotiated rate payable to In-Network providers in the same area or the average charge for care in the area.
- Please be aware that providers/specialists may be listed in a PPO directory or provider finder web site, but not covered under this benefit plan. Please check your benefit booklet for more detailed coverage information.
- In-network Certified Registered Nurse Practitioners (CRNPs) /Certified Nurse Midwives (CNMs) are considered eligible providers; no coverage out-of-network for services provided by CRNPs and CNMs.
- Physician assistants and physician assistants who assist with surgery acting under the supervision of PMD/PPO physicians are eligible providers.
- Bariatric Surgery, Gastric Restrictive procedures and complications arising from these procedures are not covered under this plan. Please see your benefit booklet for more detail and for a complete listing of all plan exclusions.

Your group believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, this plan does not have to include certain consumer protections of the Affordable Care Act that apply to non-grandfathered plans. Benefits are subject to the terms, limitations and conditions of the group contract. Check your benefit booklet for more detailed coverage information. Please visit our website at www.bcbsal.com

ClearWater Solutions, LLC.
Dental

Effective June 1, 2006

PREFERRED DENTAL

Blue Cross and Blue Shield of Alabama's Dental Network is a statewide dental network. This managed care program is designed to promote quality and cost effective dental care. Currently more than 1,260 dentists, approximately 74% of the dentists in Alabama, have joined this program.

Dental Network Provisions:

- Network dentists will file all claims and accept the Blue Cross payment as payment in full (after any deductible and coinsurance you owe).
- Payments for covered services provided by in-network dentists in Alabama are based on the dental network fee schedule that offers an average savings of approximately 20% off billed charges.
- Payments for covered services provided by out-of-network dentists in Alabama will be made according to the dental network fee schedule at the same level as in-network services. However, you may be responsible for the difference between the Blue Cross payment and the dentist's charge (plus any deductible and coinsurance). You may also have to file the claim if your dentist's office will not.
- Payments for covered services received outside Alabama will be paid at the lesser of the amount Blue Cross will recognize as the "allowed amount" or the amount charged by the dentist.

***The Managed Dental Network - another reason why
Blue Cross and Blue Shield of Alabama is the leader in managed care.***

ClearWater Solutions, LLC.
Dental Benefits
Effective June 1, 2006

GENERAL PROVISIONS	
Deductible	\$25 deductible per member per calendar year; maximum of 3 deductibles per family each calendar year.
Maximum	\$1,000 per member each calendar year.
DIAGNOSTIC AND PREVENTIVE (Exams and Cleanings)	
Covered at 100%, subject to the deductible.	
Includes:	
<ul style="list-style-type: none"> • Dental exams up to twice per benefit period. • Full mouth x-rays, one set during any 36 consecutive months. • Bitewing x-rays, up to twice per benefit period. • Other dental x-rays, used to diagnose a specific condition. • Routine cleanings, twice per benefit period. • Tooth sealants on teeth numbers 3, 14, 19, and 30, limited to one application per tooth each 48 months. Benefits are limited to a maximum payment of \$20 per tooth. Limited to the first permanent molars of children through age 13. • Fluoride treatment for children through age 18 twice per benefit period. • Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18. 	
RESTORATIVE (Fillings and Root Canals)	
Covered at 100%, subject to the deductible.	
Includes:	
<ul style="list-style-type: none"> • Fillings made of silver amalgam and synthetic tooth color materials. • Simple tooth extractions. • Direct pulp capping, removal of pulp and root canal treatment. • Repairs to removable dentures. • Emergency treatment for pain. 	
SUPPLEMENTAL (Oral Surgery and Anesthesia)	
Covered at 100%, subject to the deductible.	
Includes:	
<ul style="list-style-type: none"> • Oral surgery for tooth extractions and impacted teeth. • General anesthesia given for oral or dental surgery. This means drugs injected or inhaled for relaxation or to lessen pain, or to make unconscious, but not analgesics, drugs given by local infiltration, or nitrous oxide. • Treatment of the root tip of the tooth including its removal. 	
PROSTHETIC (Crowns and Dentures)	
Covered at 50%, subject to the deductible.	
Includes:	
<ul style="list-style-type: none"> • Full or partial dentures. • Fixed or removable bridges. • Inlays, onlays, or crowns to restore diseased or accidentally broken teeth, if less expensive fillings are not adequate. 	
PERIODONTIC (Gum Disease)	
Covered at 80%, subject to the deductible.	
Includes:	
<ul style="list-style-type: none"> • Periodontic exams twice each 12 months. • Removal of diseased gum tissue and reconstructing gums. • Removal of diseased bone. • Reconstruction of gums and mucous membranes by surgery. • Removing plaque and calculus below the gum line for periodontal disease. 	

Payments are based on the Dental Network Fee Schedule or the "Allowed Amount", depending on which provider you choose to use.
This is not a contract. Benefits are subject to the terms, limitations and conditions of the group contract.

ClearWater Solutions, LLC

Rates effective December 1, 2011 through November 30, 2013

Open your eyes to high-quality vision care! The average family spends close to **\$600 each year** on routine eye health care. Using Humana/Compbenefits' VisionCare Plan, you will receive your routine eye health care with just a small co-payment.

Humana/Compbenefits' VisionCare Plan provides coverage for:

- **Eye examinations**
- **Frames**
- **Eyeglass Lenses**
- **Contact Lenses**
- **Discount on LASIK surgery**

Plus, when ordering from one of our network eye doctors, you will also receive in the year of your eye exam:

- **A 20% discount on a second pair of eyeglasses**
- **A 15% discount on fees for elective contact lenses**

MONTHLY RATES		SERVICE FREQUENCY		CO-PAYMENTS	
Employee only	\$ 9.34	Vision exam	Once every 12 months	Exam	\$15.00
Employee + family	\$22.68	Lenses	Once every 12 months	Materials	\$15.00
		Frame	Once every 24 months		

SEE THE DIFFERENCE

You can save money two ways with VisionCare. First, the cost of plan services and materials is discounted and prepaid. So **except for any co-payments**, you have **no out-of-pocket expenses** for covered services and supplies when you use one of our network doctors. Second, your coverage costs are deducted from your pay *before* any federal income or FICA taxes are taken out. This makes your taxable wage base lower, so you would pay less tax.

Here's an example of how the plan helps you save over the course of a year:

<u>If You Get:</u>	<u>You Pay:</u>	
	VisionCare Doctor	Typical Retail
Eye exam	.00	\$65.00
Frame (designer style)	.00	\$100.00
Lenses: Bifocal	.00	\$75.00
Option (pink tint #1 or #2)	.00	\$15.00
Co-payments:		
\$15 exam/\$15 materials	\$ 30.00	N/A
Premium (\$9.34 monthly X 12)	\$112.08	N/A
	\$142.08	\$255.00
Pre-tax savings) assuming 18% tax bracket & 7.65% FICA)	-28.75	.00
Total Cost	\$113.33	\$255.00

YOUR TOTAL SAVINGS THROUGH VISIONCARE: 65% OFF RETAIL

In this example, you would have saved **\$206.67** in vision care costs with VisionCare Plan. Keep in mind, however, that your actual savings will depend on your plan allowances, your actual premium, the doctors and materials you select, and your own tax situation.

HOW DOES VISIONCARE PLAN WORK?

Members simply select any in-network optometrist or ophthalmologist and schedule an appointment. You can locate a provider in your area by accessing the current directory online at www.mycompbenefits.com

The Plan is simple to use. Select a doctor from our provider directory and call for an appointment. At the time of your appointment, present your ID Card to the participating provider. Members will pay only their co-payments and for any extra cosmetic options selected. There are no additional forms to complete or claims to file.

Members can also choose an out-of-network provider. In this case, pay the doctor at the time of the visit and submit receipts to Humana/CompBenefits for reimbursement. Benefits are paid according to a reimbursement schedule listed below.

Maximum Allowances	Network Doctor (After co-payments/ Up to plan limits)	Non-network Reimbursement Amount (Co-payments apply)	
Eye Exam	Paid in full	\$35	* If you prefer contact lenses, the plan provides an allowance for your contacts instead of lenses and frames. ** Medically necessary (prior authorization required) is defined as 1) following cataract surgery w/o intraocular lens; 2) correction of extreme visual acuity problems not correctable with glasses; 3) anisometropia greater than 5.00 diopters and asthenopia or diplopia, with spectacles; 4) Keratoconus; or 5) monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life. *** Plan members must first contact Humana/CompBenefits for a list of providers and to receive a Refractive Care ID card. This schedule shows only a few of the covered procedures. Please see your Benefit Administrator for a complete schedule. This schedule is intended for comparison purposes only. The benefits of each plan will be determined by the contract. For a complete listing of benefits and exclusions and limitations, please reference your certificate of coverage.
Lenses (per pair)			
Single	Paid in full	\$25	
Bifocal	Paid in full	\$40	
Trifocal	Paid in full	\$60	
Lenticular	Paid in full	\$100	
Contact Lenses			
Elective (fitting, follow-up & lenses)	\$150*	\$150*	
Medically necessary**	Paid in full	\$210	
Frame	\$45 wholesale	\$45 retail	
Lasik*** Members receive benefits when services are received from a TLC Truvision network provider with the following preferred rates: <ul style="list-style-type: none"> • Silver Package: \$895/eye for Conventional LASIK • Gold Package: \$1,295/eye for CustomLASIK • Platinum Package: \$1,895/eye for CustomLASIK plus Bladeless LASIK (using IntraLase technology). <p>Members will also receive a 10% discount off UCR charges at other preferred LASIK provider locations, and pay no more than \$1,800 per eye for the Conventional LASIK procedure and \$2,300 per eye for CustomLASIK.</p>			

CAN I GET CONTACTS INSTEAD OF LENSES?

Yes. If you prefer contacts instead of glasses, your vision exam is covered-in-full with your exam co-payment and VisionCare Plan provides a generous allowance of \$150.00 to be applied towards your fitting and follow-up fees as well as materials costs. The Contact Lens allowance is in LIEU OF THE LENS / FRAME BENEFIT and is provided with the same frequency as your lens benefit.

CAN I GO ONLINE TO FIND OUT MORE ABOUT MY PLAN OR GET ASSISTANCE?

We are located online at www.humanavisioncare.com where you can learn more about your plan, check your benefits, use our Provider Locator, send us an email, and more.

HOW DO I GET FURTHER QUESTIONS ANSWERED?

You may contact Humana/CompBenefits Member Services Department with any questions or concerns at: 1-866-537-0229, Monday – Thursday 8am-8pm; and Friday 8am-6pm EST or locate us on the web at www.humanavisioncare.com