ABSTRACT

REPORT ON A TECHNICAL COMMUNICATION INTERNSHIP WITH TOWERS PERRIN

by Katie Knost

This report describes my technical communication internship at Towers Perrin in Cincinnati, Ohio, as a writer/communicator. To complete the Master of Technical and Scientific Communication (MTSC) degree from Miami University (Oxford, Ohio), I interned for 14 weeks at Towers Perrin, a global professional services firm that helps organizations optimize performance through effective people, risk, and financial management.

The first chapter of this report introduces Towers Perrin, describes my role in the organization, and outlines my goals for the internship. The second chapter is an account of my learning experience about health care, which was essential to complete my project tasks. The third chapter summarizes the major projects I completed, including summary plan descriptions, communication strategy documents, meeting presentations, project work plans, and training materials. The concluding chapter of my internship evaluates the strategies of project management, audience analysis, and document design as they related to my internship experience.
REPORT ON A TECHNICAL COMMUNICATION INTERNSHIP WITH TOWERS PERRIN

An Internship Report

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Department of English

by

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Miami University

Oxford, Ohio

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## GLOSSARY OF ACRONYMS

The following acronyms appear at least once within this text:

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>CDHP</td>
<td>Consumer-driven Health care Plan – a medical plan that fosters consumerism; plan participants generally pay more out-of-pocket for the cost of health care services</td>
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<td>CI</td>
<td>Change Implementation – a line of business within Towers Perrin’s HR Services</td>
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<td>EOB</td>
<td>Explanation of Benefits – a document that provides a detailed breakdown of who pays each portion of a medical bill from the medical provider</td>
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<td>FSA</td>
<td>Flexible Spending Account – an account that allows an individual to set aside tax-free money to pay for eligible medical expenses that are not covered under a medical plan</td>
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<td>HDHP</td>
<td>High-Deductible Health Plan – a specific type of consumer-driven health care plan that is tied to either a health reimbursement account or a health savings account</td>
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<td>HRA</td>
<td>Health Risk Assessment – provides personalized results, identifying an individual’s top health risks based on a health history and lifestyle questionnaire</td>
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<tr>
<td>HR</td>
<td>Human Resources – (as used in the context of this report) a group or department within an organization that is associated with employee relations, resource planning, and benefits strategy and administration</td>
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<tr>
<td>HSA</td>
<td>Health Savings Account – an account to save and pay for qualified expenses for current and future years; account is tax-advantaged and only available to individuals enrolled in a high-deductible health plan</td>
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<tr>
<td>LOB</td>
<td>Line of Business – a specific services line within Towers Perrin’s organizational structure</td>
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<td>SOW</td>
<td>Scope of Work – defines the terms and services of a project, including fees</td>
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<tr>
<td>SPD</td>
<td>Summary Plan Document/Description – a document that describes a benefit plan’s provisions in detail</td>
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<tr>
<td>TP</td>
<td>Towers Perrin – global professional services consulting firm</td>
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ACKNOWLEDGEMENTS

I would like to begin by thanking my parents, Rita and Jim Knost, for encouraging me to pursue a graduate degree. Their support throughout my academic career kept me motivated to reach my goals. I would also like to thank Dr. Jean Lutz, Director of the BATSC and MTSC programs, for being my committee chair, trusted advisor, and friend over the years. Her endless dedication and personal investment in her students is one-of-a-kind. I would also like to thank Dr. Michele Simmons and Dr. Marjorie Nadler for serving as readers on my internship committee. Both have been great resources and mentors for me.

My internship would not have been possible without the consultants of Towers Perrin (TP). I would like to thank them for providing me the opportunity to be a part of their organization. The experiences I gained as a writer and technical communicator with TP are invaluable. I would like to extend a special thanks to Rita Perkins, senior consultant, for being a wonderful mentor throughout my internship.

Finally, I would also like to thank Mike Frey. He always believes in my abilities, and for that, I am very grateful.
Chapter 1 – An Introduction to Towers Perrin

The purpose of this internship report is to present a detailed description of the context and activities that occurred during my 14-week internship at Towers Perrin (TP) in the Cincinnati, Ohio, office. I worked at TP from May 16, 2006, through August 18, 2006. In this first chapter, I introduce Towers Perrin, describe my role in the organization, and outline my goals for the internship. The second chapter is a detailed account of my learning experience about health care and consumerism. The third chapter of this report summarizes the major projects I completed during my internship. Finally, in the fourth chapter, I reflect on technical communication strategies, specifically those of project management, audience analysis, and document design to evaluate their application in my internship experience. Please note that throughout this report, I will refer to client organizations by fictitious names when discussing any client-related projects to maintain my client confidentiality agreement with Towers Perrin.

Towers Perrin is headquartered in Stamford, Connecticut, with 33 office locations in the United States and offices located in 25 countries around the world. The Company is a privately-held, global professional services firm that helps organizations around the world through effective people, risk, and financial management. The firm has served large organizations in both the private and public sectors for 70 years. TP’s clients include three-quarters of the world’s 500 largest companies and three-quarters of the Fortune 1000 U.S. companies. The firm provides innovative solutions to client issues in the areas of human resource consulting and administration services; management and actuarial consulting to the financial services industry; and reinsurance intermediary services.

The organization holds three core values — professionalism, integrity, and respect. Any representative of TP is expected to reflect these core values with clients, colleagues, vendors, or other professionals. Towers Perrin encourages personal initiative and drive toward self-development to best contribute to the firm and its success. The environment fosters a culture of entrepreneurship.
As an intern, I worked in the HR Services division — one of two primary operating units. The table below provides a high-level look (using the standardized naming conventions) at the service offerings for each operating unit.

<table>
<thead>
<tr>
<th>HR Services (Human Capital Services)</th>
<th>Risk and Financial Services</th>
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<td>Actuarial consulting</td>
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<tr>
<td>Executive compensation consulting</td>
<td>Enterprise risk and capital management</td>
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<tr>
<td>Health and welfare consulting</td>
<td>Financial modeling solutions</td>
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<tr>
<td>HR function effectiveness</td>
<td>— Reinsurance</td>
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<tr>
<td>Mergers, acquisitions, and restructuring</td>
<td>— Retirement risk solutions</td>
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<tr>
<td>Research and surveys</td>
<td>— Tillinghast insurance consulting</td>
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<tr>
<td>Retirement consulting</td>
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<td>Total rewards effectiveness</td>
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<td>Workforce effectiveness</td>
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My experience is limited to the HR Services business (also known as the Human Capital Services) of Towers Perrin, which provides global human resource consulting and administration services that help organizations effectively manage their investment in people (i.e., the organization’s employees). Within HR Services, the firm offers services in areas such as employee benefits, compensation, communication, change management, employee research, and the delivery of HR services. Overall, the service offerings reside in the three broad categories of HR strategy, HR function design, and HR function implementation.

The HR service offerings within the three broad categories include change implementation; executive compensation and rewards; health and welfare; and retirement. Although communication resides within the change implementation line of business (LOB), communication services are an integral component for all lines of business because it is how corporate leaders articulate their vision and direction for the business, explain how the company will meet its objectives, and inspire employees to execute the strategy. For a complete breakdown of the HR Service offerings, see Appendix A – HR Services and Lines of Business on page 54.
Each line of business within HR Services abides by the same internal, organizational hierarchy. From the top down, TP’s hierarchy includes: Board of Directors, Business Leader, Regional Leader, Market Leader/Managing Principal, Group Leader, Principal, Senior Consultant, Consultant, Associate, Intern, and Administrative Assistant. A consultant is elected a principal by the Board of Directors. Principals can represent any part of the firm’s businesses and operations; they may also be broad practitioners or deep specialists serving internal and/or external clients. The spectrum for the consultant and associate levels is broad and based on pay grades. Regardless of one’s position and level, consultants must have or pursue the following competencies:

- Leadership and vision
- Professional development
- Communication skills
- New business development acumen
- Problem solving abilities
- Project management expertise
- Interpersonal and team skills
- Business acumen
- Effective client relationships

I interned as a technical writer/communicator in the HR Services Change Implementation (CI) (and Communications) LOB. My involvement included working with a wide variety of clients (from small to large organizations) and all types of projects. My overall responsibilities changed depending on the nature of the project, but throughout my internship, I worked as a writer, editor, document designer, and communications consultant. On a daily basis, I coordinated with mostly three consultants — Rita (senior communications consultant), Lisa (communications consultant), and Eileen (communications consultant) — each working in the CI LOB. Although each of these consultants frequently worked individually on different projects, I interacted with all three consultants, which provided a greater opportunity to experience different consulting styles and practices.
With Rita as my primary mentor, I set the following goals at the start of my internship:

**Overall Goals**
- Understand the business’ structure – TP, general HR services, and consulting practices
- Learn the logistics – TP’s organizational structure and how it affects client relations and interactions
- Practice and use technical communication skills – applying knowledge gained through coursework and previous work experiences

**Personal Goals**
- Explore my role as a technical communicator in a consulting organization and TP’s CI LOB
- Experience and participate in CI proposal presentations, client negotiations and meetings, and conference calls
- Learn about opportunities for growth and personal development; assess the potential for a full-time position with the firm

During the internship, my responsibilities to Rita included:
- initiating weekly update meetings to discuss my progress and topics, such as consulting practices, TP’s organizational structure, and my work goals and objectives;
- participating in client conference calls and/or meetings;
- reviewing and editing client presentations and documents (such as proposals); and
- sharing document drafts when working on client projects.

My responsibilities to Lisa and Eileen were typically more collaborative than my interaction with Rita. For example, Eileen and I researched and wrote different sections of a client’s preliminary communication strategy, and then we met to brainstorm and write the remaining sections together. With Lisa, I typically drafted a specific communications piece for a project; she reviewed the draft; we discussed the edits; and I revised for another draft.

Since my specialty area in my undergraduate and graduate studies was medical/health, I was hired to primarily work on health and welfare-related projects for CI. One of the most significant
needs of TP’s clients is health care management and how to manage health care costs while sustaining a benefits program that attracts and retains talented employees in a challenging business environment. In today’s global marketplace, U.S. employers are faced with a growing dilemma — ongoing double-digit increases in health care costs. Organizations nationwide continue to look for new approaches to slow the growth of health care costs. (I discuss these issues in greater depth in chapters two and three.)

Towers Perrin is hired by organizations to configure health program strategies, design, and pricing; participate in health care vendor evaluation, selection, and monitoring; be involved in care and disease management consulting; create funding strategies; and advise on legal compliance.

When Towers Perrin is hired to develop communications for a client, it is generally for the following main reasons: 1) the client organization does not staff a full-time communicator; 2) the client HR staff is not equipped to create and implement a communications strategy (i.e., they are benefits experts, not professional communicators); or 3) the client organization tried to implement a change in the organization before and failed. As it related to the projects, the nature of the work I was hired to perform included:

- identifying audience/client needs
- developing and writing communication strategy documents, which includes the project’s goals and objectives, audience analysis, challenges, schedule, and media plan
- researching and writing communication pieces determined in the strategy document
- sending document drafts to consultants to send to the client for revisions, feedback, and approval
- editing presentations and proposals
- preparing for and participating in client calls and meetings
- logging billable hours spent researching, developing, and writing communication pieces for clients

While interning, I found that current and future project work was often unstable and changing. At the same time, ongoing or renewal work revolved around established client relationships. In
my capacity as an intern, I needed to be flexible and patient while Rita, Lisa, and Eileen handled more of the sales aspects involved with consulting. Fortunately for my internship experience, I had the opportunity to work on different stages in a project’s cycle. The next chapter highlights how and what I learned about the U.S. health care system. To successfully complete the project tasks assigned to me, I needed to learn about the United States health care system as well as current trends in health care.
Chapter 2 – Detailed Description of Learning About Health Care

My internship agreement with Towers Perrin (TP) stated that I would work on health and welfare-related projects (as part of the Change Implementation (CI) line of business) because health was my specialty area in the graduate program, and I needed to specialize to meet the program’s requirements.

In this chapter, I provide my process for 1) learning about health care and its cost trends; 2) studying health care plans, specifically consumer-driven health care plans (CDHPs); 3) gaining an understanding of what health care and consumerism means for employers (TP’s clients) and what it means for the client’s employees (generally, the end users); and 4) developing strategies for successfully implementing CDHPs for clients using effective technical communication. Because employees are often resistant to change and/or misunderstand their medical benefit options, employers are looking to outside organizations, like Towers Perrin, to help them develop strategies and communications that explain these systems and to earn buy-in from current employees and willing participation from potential new hires. To effectively complete my project tasks, I needed to first understand health care issues, the importance of the deliverables TP creates to the users (employees), and the criticality of successful plans to organizations that are trying to maintain competitive benefit programs.

The processes that I used for each of these activities were ongoing throughout my 14 weeks at TP and occupied a significant portion of my time. Working through the complexities of the health care system contributed to my development as a technical communicator and strengthened my skills in my specialty area.

Background: Learning about health care basics

Health care — and its related topics of cost, supply, trends, responsibilities, government regulations, dependency, pharmaceuticals, and Medicare & Medicaid — is a “hot topic” and an important discussion in our society today. In HR services consulting, health care is an increasing topic of interest, posing both a dilemma and an opportunity. Employers are looking to manage costs while also trying to keep the best employee talent in a challenging business environment. The charge for consultants is to make health care consumerism work — driving health care costs
down for an organization through plan design and wellness initiatives while aligning employer and employee interests. The overarching goals for health and welfare consultants are to advise clients to implement a benefits philosophy that:

- provides a range of choices for a variety of needs at affordable costs over the long-term for both employees and the company;
- ensures a competitive benefits package for current and potential employees;
- manages costs to be competitive as a business and as an employer;
- offers coverage that provides financial protection in the event of significant health care needs;
- provides a way to save for future health care costs; and
- designs benefit programs that encourage employee participation in health and benefit decisions.

Additionally, consultants must consider the employees’ health care needs by analyzing the employee demographic data and the health claims made through the respective medical plan provider.

**The Health Care Dilemma: What it means for employers**

The double-digit increases in health care costs, according to Towers Perrin’s 2006 *Health Care Cost Survey*, are ongoing and pose a growing threat for U.S. employers in today’s global marketplace. Most employers simply cannot afford or sustain the magnitude of these cost increases. At the same time, employers cannot abandon their current commitments to employees because they must offer some level of health care benefits to compete in the job market for talent and maintain the positive work environment that is needed to run a successful business.

Competitive health care benefits ranked near the top of the list of what U.S. employees look for in choosing to work for an organization, with retirement benefits also in the top 10 (according to Towers Perrin 2005 *Global Workforce Study*). With the current health care and competitive business environment, companies nationwide are looking for new approaches to slow the growth of health care costs. There is no single solution to approach the health care dilemma. In the 1990s, the “single solution” savings offered by managed care were long gone, and vendor management approaches (to maximize health care discounts in different networks), on their own, have had limited impact. As a result of these eventual failed attempts to address the rising cost
concerns, many health care specialists and employers alike have begun moving toward health care “consumerism” strategies.

A New Approach to Health Care: Consumerism
Consumerism strategies are designed to encourage individuals to take more responsibility and accountability for their health care and the cost of that care — with more control over the health care dollars spent. Consumerism is often used too loosely and in a variety of contexts, but the term (in a business context) is generally used to describe a new kind of partnership between employers and employees with regard to how employees use and pay for needed health care services.

Historically, under the managed care model, employers paid all or most of the cost of covered health care services typically leaving employees responsible only for premium payments and small out-of-pocket copayments when they used specific services. As a result, employees had little incentive to be vigilant consumers of health care. They did not seek the most appropriate services at the best price because their health plans paid for almost everything and effectively shielded them from understanding the total cost of their choices. Thus, managed care set the scene for unprecedented consumption of health care services by employees (and/or the general public).

In contrast, the primary principle of consumerism strategies is typically focused on managing the demand for services by providing employees with the knowledge, tools, and resources they need to understand health care and costs, and by ensuring that employees pay a more meaningful portion of the cost of care. The education piece of any consumerism health care strategy is pivotal to its success, which is why effective communication to the employee population is so important. When employees are educated about the true cost of health care, the idea is that they will put more thought into making a decision when there is significant cost to them, likening the whole idea of health care consumerism to other markets — such as buying a car or a home, for example. Consumerism drives a shift in mindset when it comes to health care services.
One of the primary goals of consumerism is to get people to think of health care as a long-term investment rather than as an immediate fix to a specific ailment. The philosophy is that paying more or sharing more of the cost for health care encourages people to make more informed decisions about a broad range of health-related issues from lifestyle choices (e.g., diet, exercise, smoking), to the type of medical plan they select, to how (and how often) they use health care services, and which health care providers they choose. Successful consumerism strategies must engage employees and, ultimately, motivate employees to change their behavior — making healthy lifestyle choices both today and tomorrow. If employees become healthier today, they are more likely to avoid costly health problems in the future. Additionally, companies that have lower than average costs are actively managing their vendor relations (i.e., with their sponsored health plan administrators and providers), taking measures that encourage employees to take responsibility for their decisions at the point of care, communicating more effectively about wellness and health care costs, and providing employees with the resources they need to make the “right” health care decisions.

Consumerism: What it means for employees

Towers Perrin conducts surveys to gauge employer and employee responses to current trends in the health care market. In January 2004, TP hosted an online employee survey among U.S. employees working for midsize and large companies in a wide range of industries. Over 1,000 people responded to the survey, representing a statistically valid sample of workers in corporate America who participate in company-sponsored health care plans today. The results of the survey provided a look at how employee views on health care have changed. In April 2004, TP conducted an online employer survey among executives and managers who participate in the TP Track research program, an ongoing series of employer surveys on a range of key business and human resource management issues. This survey elicited responses from managers in more than 120 midsize and large U.S. companies across all industries. All of the survey respondents are involved in the design, management, or communication of corporate health benefit programs.

A summary of two important key findings from the employee and employer surveys include:

- Employees are far from engaged in consumerism today, and in fact, are becoming increasingly resistant to their employers’ cost-management efforts. While most employees
express a willingness to assume more responsibility for their benefits, relatively few are taking the steps needed to effectively manage their health and financial risks. Also, not surprisingly, employees are clearly focused on their self-interest and the impact on their personal financial well-being, whereas employers have been focusing largely on the company’s interests, creating a significant disconnect.

- Still, many corporate managers and executives view consumerism as a potential solution to their health care cost problem and are moving quickly to introduce a range of plan design and employee education strategies to promote consumer behaviors.

Taken together, TP’s data suggest that for consumerism strategies to be effective, employers will need to address the fundamental disconnects that have emerged between employee and employer views on health care today.

**Consumerism: The challenge for employers**

The business challenge for employers is summarized by the fact that senior managers in the majority of organizations recognize that the double-digit increases in cost of health care are a serious business concern they must address. Beyond increasing the amount employees share in the cost for health care, some organizations are instilling consumerism as part of their health benefit strategy. Some employers offer a consumer-driven health plan that combines high-deductible coverage with account-based mechanisms, such as a Health Savings Account (HSA), to help employees pay for care. Overall, employers recognize that employee understanding and behavior change are the keys to success in consumerism strategies to control cost while supporting talent management goals.

**Consumerism: The challenge for employees**

The majority of employees remain focused largely on the increase in their own costs in recent years — and why would they not? Just as the rising costs in health care are negatively impacting a company’s bottom line, the increase in shared costs is impacting employees’ budgets and how they spend their money. For the same reason that an organization’s senior leadership recognize the need to offer competitive health benefits to keep and attract talented employees, the
availability of good health care coverage is one of the top reasons for an employee to choose one similar job over another.

Based on the *Understanding Employee Engagement: The 2003 Towers Perrin Talent Report*, employees’ views on whether their health benefits are competitive or meet their needs have deteriorated significantly in the last several years. Overall, few employees believe a company’s line about how health care costs are affecting the business, and similarly, employees do not trust what their employers communicate about health care costs — put simply, communication viewed as “spin” (*i.e.*, employers tell employees about rising health care costs only as a means to justify the cost increases for employees). This finding is consistent with other Towers Perrin research which suggests that the credibility of employee communications is low in many organizations (*Enhancing Corporate Credibility — Is it Time to Take the “Spin” Out of Employee Communication?*, Towers Perrin, 2003). This viewpoint presents a challenge for employers to convince an increasingly skeptical employee audience that the business threat posed by rising health care costs is real. Also, most employees believe they are already effective health care consumers, and they may not see a need to change their behavior. In short, often employees do not readily see the link between unhealthy lifestyle choice/behaviors and costly health care services. That’s why a communication strategy needs to be built-in with the company’s health and welfare strategy to, at the most basic level, educate and inform employees. Making changes to benefit levels is not enough to make a significant difference for the organization. The diverging views — between employers and employees — on employees’ effectiveness as health care consumers is one of the most significant disconnects identified by the TP surveys.

**Developing Strategies for a Successful Approach to Consumerism: The role of communication**

A lack of a shared vision between employers and employees about what it means to be a good health care consumer may be the central issue determining whether consumerism strategies will work. Reaching a shared understanding of the behaviors implicit in being a “good consumer” is a necessary first step in making a consumerism strategy successful. Technical communicators and communication strategists play an important role in this health care dilemma because part of the
reason for the growing divergence in views about health care boils down to communication. Interestingly, most CI/Communication practitioners, through survey results and individual analysis, found that the communication problem is generally not frequency, but content and tone. The missing link is communication that builds a shared understanding between employers and employees. An overriding focus on costs may explain why employees have a growing resistance to company messages about health care overall and consumerism in particular.

*Consumerism Strategies: An opportunity for change?*

Overall, employees understand that health care costs are a problem — at the business level and at the individual level, and they appear open to behavior and program changes that could reduce costs both for them and their employers. However, employees are not motivated to change only to save their employers money. From the employer perspective, the change is necessary because they cannot afford to continue to pay at the level they have been paying without consequence to the overall business.

Employers have an opportunity to influence employee understanding and behavior, but they also need to recognize that health care is an emotional issue for employees, not just a cost issue. When an employee or an employee’s loved one is in need of care, that employee is going to be most concerned about getting the best care, not about the cost. Again, for consumerism to be truly effective, employees need to believe it is in their interest to receive the right care, at the right time, and at the right cost. Additionally, employees need to be convinced that they need to help pay for the cost of their health care — that economic times might be tight for everyone, including their employers.

Employees who believe the company cares about their well-being and communicates clearly about the financial risks they are assuming are more likely to have positive views of benefit changes and are more likely to make appropriate behavior adjustments in response to those changes. One solution is strategic, targeted communication and engaged leaders at all levels combined with information and effective decision-support tools. These strategies are helping TP’s clients/employers make connections and motivate employees to actively manage their health care responsibilities and risks so both the employee and the company fare better. Once a
company establishes consumerism as the company’s health care strategy, the benefit design needs to be transparent to employees. Employees need to easily understand what they receive for what they pay/contribute.

Generally, successful consumerism strategies require long-term and sustained communication efforts with a range of educational tools and information that respond directly to employees’ health information needs, concerns, and preferences, allowing for easy comparison about how to choose a medical plan. TP consultants advise employers to craft messages and change processes that acknowledge the emotional aspects of health care and appeal to employees’ self-interest, rather than positioning health care issues exclusively in the context of the company’s business interests.

When employers are able to beat average cost trends and gain employee support in the process, they are, in effect, building a “culture of health” — where employers and employees together manage the money, manage the vendors and providers, and share a commitment to the value of employee health and wellness. In an effort to engage employees, build strong brands, and improve company performance, few business processes are as important as organizational communication. The communication needs to come from the employer, not the health care provider, for employees to be invested in building a culture of health.

Consumerism Strategies: Using organizational communication as a vehicle for change
Organizational communication is how corporate leaders articulate their vision and direction for the business, explain how the company will get there, and inspire employees to execute the strategy. The success of organizational communication is determined by employees and whether or not they believe what they are being told. In 2003, Towers Perrin conducted an online survey of 1,000 working Americans in U.S.-based organizations with at least 1,000 employees. The sample cut across a broad range of industries and included a statistically valid range of ages, education levels, genders, and incomes. This survey is relevant to evaluating the importance of organizational communication because the responses indicated that companies may be trying too hard to “spin” their internal communications and, as a result, may be undermining their
credibility with many employees. Equally important, employees generally believed their companies are more honest with shareholders and customers than they are with employees.

The results of the survey suggest that leaders would do well to be more forthcoming with employees — about the company’s prospects, about what it expects from and offers employees, and even about the future of their jobs. Often described as fundamental to good public relations practices, the use of two-way, symmetrical communication supports the results of the survey. As a planned effort to influence publics through good character and good will based on mutual satisfactory two-way communication, this type of communication includes a concern for the consumers — in this case, the employees are acting as the consumers.

Towers Perrin’s experience working with employers to improve organizational communications points to a number of approaches that over time can help enhance the effectiveness of employee communication processes and increase the credibility of leaders and managers. At a high-level, the list below outlines the steps Towers Perrin uses for a general strategy to improve organizational communications. I used these major points as guidelines for the projects I worked on, and I developed add-ons as appropriate for a specific project.

- **Take it from the top.** Senior leadership needs to be visible, accessible, and open with employees. Top leaders should serve as an example of clear, candid communication for employees and for other managers to follow and display their own health care choices as examples.
- **Understand the audience.** Frequently, company leaders assume they know what employees are thinking and anticipate employee reactions based on instinct more than fact. Using objective measurement techniques such as surveys, focus groups, and other feedback channels to take the ongoing pulse of the workforce, evaluating communication effectiveness, and developing communication strategies and programs that directly respond to changing employee needs, concerns, and perceptions are essential.
- **Align company messages and information channels.** Companies need to periodically audit their communication processes and media to manage and control the key messages and information delivered to employees. With the amount of possible communication channels (e.g., print, electronic, face-to-face), there’s a growing opportunity for organizational
communications to become out-of-sync and even contradictory while also overwhelming employees with too many messages.

- **Train leaders and managers.** Communication is a learned skill and one that is often neglected when managers are promoted in an organization.

- **Remember to tell the whole story.** Communication is often confused with information. Management focuses on disseminating the facts rather than providing the context and business rationale for company decisions and actions. Including the “why and how” makes information relevant and meaningful for employees, making it more personal to their specific situation.

- **Ensure a two-way dialogue.** Providing frequent opportunities for two-way communication demonstrates leadership’s interest in employees’ opinions and well-being.

- **Expect the unexpected.** Having an effective crisis communication plan in place is essential for managing employee actions, reactions, and perceptions of the organization during emergencies.

Change management as part of organizational communication also involves leadership support, decision support tools, and employee accountability. Building an effective change strategy involves:

- **Research.** Where is the target audience “now?”

- **A Plan.** Employer context, strategic objectives, effective change/communications

- **Measurements.** For reasonable progress goals

Ongoing communication is an integral part of change management for an organization. Communications that clearly describe the impact of change and provide employees with decision support tools, allowing employees to model the costs of their different health care options, enhance program effectiveness. Aside from the impact on employee engagement and a sense of greater comfort with benefit change, there is a significant financial rationale for ensuring a comprehensive well-thought-out communication experience for employees through the benefit (or other organizational) change process.

To demonstrate the previous consumerism strategies discussed in a real-life context, the next chapter describes some of my project work during my internship where I, along with other TP
consultants, developed work plans to successfully implement strategies for consumer-driven health plans for clients.
Chapter 3 – An Overview of Major Projects

This chapter describes the context and communications I prepared for various consultants during my 14 weeks with Towers Perrin. While I did work on large-scale, long-term projects, I also worked on smaller, one-day projects such as editing a client PowerPoint presentation or reviewing a client proposal. However, the majority of client projects I worked on required more than eight weeks of consulting and work. Please note that the detailed timeline (included as Appendix B on page 56) for each project does not necessarily reflect consecutive days. During any given day, I completed tasks for more than one project. I worked on multiple client projects simultaneously because project schedules and timelines often overlapped. For a snapshot example of project deliverables for one month, see Appendix C – Calendar Example on page 65. Switching between projects throughout the day forced me to be efficient with my time and well-organized. I kept a daily log of my tasks to bill my hours to clients appropriately and to remember project details for compiling my fifth- and 10th-week internship progress reports.

For each project, I worked alone or with colleagues to understand what were the communication needs; helped develop a communication strategy, including the different types of documents and media; and in most cases, prepared the documents. On an as-needed basis, I handled drafts, presented to clients, and conducted research and writing to meet client needs so, in turn, clients could better serve their employees.

Project A – Retiree Medical

For the Retiree Medical project, I created a summary plan description (SPD) template specifically for retiree medical SPDs. TP frequently works with clients to produce SPDs, which include current regulations for a specific benefit plan — whether it is for a medical, disability, or retirement and savings plan. Creating a template could minimize the amount of discretionary time a consultant needs to complete the project. To provide a useful document for employees, TP writes the SPDs with user-centered language, avoiding any unnecessary legal or governmental jargon.
The tasks
TP’s retiree medical SPD needed revisions to include the most current regulations and government plan options. My charge included writing about how the Medicare plan (Parts A and B), insurance carried coordination Part D, and Advantage Plans work. I needed to focus on a traditional indemnity plan, which could include possible coordination between a company’s plan and Medicare’s Parts A & B.

Challenges and strategies
To research the information, I reviewed technical memorandums posted by TP’s Technical Services division to keep consultants up-to-date with regulations from the Department of Labor (DOL). I also read and reviewed TP’s SPD (summary plan descriptions) Content Requirements memorandum, the Department of Health & Human Services Centers for Medicare & Medicaid Services’ booklet for *Medicare and Other Health Benefits: Your Guide to Who Pays First*, health vendor providers’ communications (such as United HealthCare and Aetna), and government sponsored websites (such as [www.medicare.gov](http://www.medicare.gov)).

The key challenges with writing the described sections included:
- providing enough information to explain some of the more complicated concepts without providing an overwhelming amount of information;
- understanding the different options for a company in its decisions concerning coordination with Parts A, B, and D;
- including the creditable coverage notice in the appropriate location within the document; and
- determining how detailed each section needed to be.

To overcome these challenges, I became as knowledgeable as I could on the approaches to Medicare integration through research and question-and-answer sessions with Lisa. I also narrowed the scope for Medicare overall to include: 1) original Medicare — how Medicare works, Parts A & B; 2) insurance carried coordination Part D; 3) Advantage Plans; and 4) a focus on traditional indemnity plans — possible coordination with Parts A & B.

Actions Taken
After writing the first draft, I sent it to Lisa with a list of questions. We met to discuss my questions and the strategy for integrating my sections in the retiree medical SPD and for re-
organizing sections. After a second draft and meeting, Lisa sent the SPD for review to Technical Services. The planned implementation for the new retiree medical SPD was scheduled for TP internal release in mid-August 2006. To read a draft of the Medicare Research project, see *Appendix D – Medicare Research Draft* on page 67.

**Analysis**

The importance of working on this project was personal because it marked the beginning of my research to gain the best understanding that I could of our current health care system. I also knew that when it was completed, this SPD would be used not only by consultants in the Cincinnati office, but also by consultants firm-wide. As a user advocate, I also understood its greater importance for those who would eventually use this type of document — our clients’ retired employees. The document needs to easily answer users’ Medicare questions, provide information free of legalese and jargon, and serve as a guide to best use their medical benefits. The Medicare system is complex, and retirees deserve a document that allows them to navigate the system to receive the coverage they need.

**Timeline**

The retiree medical project took five weeks from the initial internal request to the delivery of draft materials to Lisa. The project occurred in about the third week of my internship.

**Project B – Company Doe Pension Plan SPD**

Company Doe (referred to as ‘Company’) approached TP to revise and update its pension plan SPDs for different employee groups (*i.e.*, salary/manager and office employees, commissary employees, and hourly employees). Each pension plan SPD needed to include all of the regulatory information and hypothetical examples for employees to read and understand their pension benefit. The back-up copy, or the original SPD, was written by the Company’s attorney using legal phrases and jargon with an ‘imposing’ manner toward the employee reading the document. TP’s charge was to provide employees with an updated and easy-to-understand document that accurately described their pension benefit.

**The tasks**

Eileen gave me the SPD’s back-up copy (the original version) to begin drafting a revised version of the first SPD for managers and office employees. I would need to familiarize myself with the
language used in the original and learn how each benefit worked, including any regulations for receiving the pension benefit.

Challenges and strategies

I started this project by reviewing previous pension SPDs done by TP to familiarize myself with the content — terminology, organization, and tone — of course, every company’s pension plan is different, but the plans provided a foundation for me to start working on the document. My strategy involved a high-level approach that included an outline for a preliminary table of contents to get an overall picture for the document’s structure and the organization of the sections/topics. Then, I reviewed the back-up copy to determine how the document might need to be rearranged based on the preliminary table of contents. After evaluating the document’s organization and structure, I edited the document by making sentences more concise and user-centered. I also removed unnecessary legal jargon and grammatical inconsistencies. For a simple example, a sentence in the back-up copy read: “Each employee’s Continuous Service is counted beginning with the day on which the employee first performed an Hour of Service.” I revised the sentence to read: “Your Continuous Service begins after you complete one Hour of Service with the Company.”

Although we did not have direct access to Doe’s employee population to test the document, we asked for two TP internal reviews of the document. These individuals did not work in the Retirement line of business, which was important because that meant they were not technical experts on the subject matter covered in the document, providing a perspective that was as close to those of Doe’s employees. We used the internal reviews as a means to test the readability and usability of the document. The input the reviewers provided helped Eileen and me to revise sections of the document with clarifying statements.

The key challenges I experienced while working on this project included:

- determining appropriate language use (personalizing the information to make it more informal for the employee reader while not losing any of the plan’s necessary technical details and government mandated information);
- designing the look and feel of the document (slightly altering TP’s ‘usual’ formatting; e.g., adjusting the proximity between headings and text, aligning textboxes with other visuals on the page, abiding by basic document design principles as described in Chapter Four);
- organizing the information in a way that would make sense for the employee reader; and
- getting through the dense (and unfamiliar) material.

The challenges Eileen and I faced during the final stage of this project included:
- incorporating client edits consistently in all three versions (client edits were faxed to us);
- accidentally losing tables in redlined versions of the documents; and
- keeping the most up-to-date document active in our shared office computer drive while making edits simultaneously.

To overcome some of these challenges, Eileen and I printed hard copies of the most current drafts of each SPD variation. Then, we sat down together with the client edits and the peer review edits we had received from all of the drafts, ensuring the edits were applied to all three versions (when appropriate). This way, we could easily see which SPD variation still needed a specific edit.

**Actions Taken**

I designed the document in Microsoft Word in a 2/3 page layout with sidebar definitions and additional information in the left-hand column. I initiated sans serif fonts for the headings and appropriate proximity, allowing for more white space between the end of the previous section and the next section heading. I provided Eileen with a style guide that I created for the document review process. This SPD went through several drafts, and it also underwent a technical peer review by one of the actuaries in the TP office to check the accuracy of the calculations and hypothetical examples. To view a draft, see *Appendix E – Pension SPD for Managers* on page 70. The last draft was faxed to the client for the Company personnel to provide any edits and feedback. Eileen and I had a conference call with the client reviewers to discuss their edits. After receiving their edits, we finished the manager and office employees’ version and started drafts for the other SPD versions.

After three drafts for each of the three different SPD versions, the project was complete. We provided the Doe Company with an SPD for their manager/salary and office employees,
commissary employees, and unit hourly employees. The variations around these versions were primarily in the description of the audience (i.e., who is eligible to receive the benefit as described in the plan) and the pension formula used for the plan. The final drafts for each SPD version were delivered to the client electronically as email attachments. Due to cost constraints in our fixed-fee arrangement with the client, it was the Company’s responsibility to print, copy, and distribute the SPDs to its different employee groups.

Analysis
This project provided a valuable learning experience in seeing a project through from start to finish. The project’s volume was considered small by comparison to the majority of TP projects, but nonetheless, it was a stepping stone for TP to provide future communication services to this client. Previously, Doe only used TP for retirement and actuarial services, not communication services. The client seemed pleased with the deliverables and excited to distribute the updated documents to employees. Additionally, the true success of the project lies with the employees — having a usable document that explained their pension benefit and its provisions. This document could be a helpful tool for employees while planning for their financial future and retirement savings.

Timeline
The Pension Plan SPD project took eight weeks from the initial client request to the delivery of final drafts, including all versions of the SPD. The drafting of materials for this project started the first week of my internship.

Project C – Smith Company Communication Strategy and Implementation for HDHP and Wellness Initiatives
The Smith Company hired TP to restructure its health care strategy — including a high-deductible health plan (HDHP) implementation — and to introduce a wellness program. With a consumer-driven plan such as an HDHP, it is essential to provide adequate communications to describe the benefit changes, reasons for the changes, and how the changes impact each employee. The communication is essential because an HDHP is designed and functions significantly different than most traditional health plans, such as Preferred Provider Organization (PPO). We needed to develop a communication strategy that served as a guide for implementing
the proposed medical plan changes. The communication strategy document identified the project’s audience, needs, and methods for implementing the strategy.

The tasks
Eileen and I were charged with designing and writing a preliminary communication strategy document to show the client. To provide an effective communication campaign for the new medical plan and wellness initiatives, we needed to learn as much about the company as possible — its employee base, culture, technology preferences, prior employee communications, and employee preferences for receiving information. As such, we were creating an overall profile for the employee population. We gathered this information through dialog with other consultants who previously worked with this Company and from dialog with the client’s HR staff, providing us with different demographics and data. Overall, the Company has a paternal culture and has a relatively small employee base (around 3,000 employees).

Challenges and strategies
The initial key challenge was trying to draft a document before meeting with the client for the kick-off meeting. We wanted to be able to go to the meeting with a plan prepared, an effort to sell the work and strategy efficiently because it was a small client (by Towers Perrin’s standards). For the first draft of the strategy document, we did not want to include all of the details for incentives if an employee elects to participate in a health risk assessment (HRA), for example, but we still needed to include a placeholder for incentives in our media plan. As a result, the challenges surrounding this phase of the project included:

- allowing time for proper edits and revisions for three drafts (as requested by the client) for each communication piece;
- relating health care information employees might see in the media with the health care changes occurring at Smith Company;
- encouraging associates to consider joining the HDHP (note: Smith’s Company refers to employees as ‘associates’);
- preventing confusion about how an HDHP and health savings account (HSA) work; and
- helping associates to choose the best plan for their personal situation and health care needs.
To avoid any roadblocks in our communication, we identified key messages early in the process so that the communication strategy and program could reinforce the messages and help build associates’ understanding of the program.

**Actions taken**

Eileen and I decided what topics needed to be included in the strategy document. We separately wrote a couple of sections each to see if we were both writing from the same perspective. We worked collaboratively to revise our sections and write the document’s remaining sections. Then, we had a brainstorming session to come up with ideas for the media plan (e.g., how many newsletters will we write?). After we received client feedback, we revised the document with the client’s changes.

Once the scope of work and the budget were finalized, we needed to scale back on the number of drafts for each communication piece included in the plan because of the client’s limited budget. To review the scope of work, see *Appendix F – Scope of Work Document* on page 99. Based on the media plan that we included in the communication strategy, we prioritized the work, and I drafted a work plan and timeline for the project team to use. Following our timeline, I drafted a PowerPoint presentation for the Smith Company Human Resources (HR) Generalist Briefing meeting scheduled for July 27, 2006. Eileen and Rita peer reviewed the presentation, and I sent it to the project’s lead consultants in TP’s Cleveland office for review. The client used the presentation to provide a preview of changes for 2007 to the organization’s HR staff. The presentation’s key messages included:

- Here’s what we anticipate will change for 2007
- Here’s a look at our communication strategy
- Details will follow

As an example, the following page includes one slide from the presentation with the presenter’s talking points.
Medical Plans for 2007

We will continue to offer 4 plans:

- Elite
- Gold
- Kaiser
- HDHP (can open an HSA)

• Silver Plan will no longer be offered
• HDHP will be a new option for associates

Speaker notes for slide 1:

“The Medical Plans for 2007 are the Elite Plan, Gold Plan, Kaiser, and a new High Deductible Health Plan. We’re really excited to offer the High Deductible Health Plan as an option for our associates because it gives them the opportunity to participate in a Health Savings Account so that they may begin to save for their future retiree health care costs. In just a moment, we’ll go over how the new HDHP works.

The Silver Plan will no longer be offered in 2007. Approximately five percent of associates were in the Silver Plan. This plan was eliminated because of the low enrollment. We believe that a high deductible health plan (HDHP) enables us to offer a more competitive product that will be more attractive to our associates.

Each of the four plans has varying premiums and out-of-pocket costs based on the level of coverage it provides – just like before. We want everyone to clearly understand how the plans differ and the steps they need to take to choose the plan that is right for them and their families. This enrollment period, we will provide a great deal of education to help associates understand how each plan is different so that they can make the best choice for their personal situation.

Let’s spend a little time going over how the new HDHP works.”

To read the complete presentation, see Appendix G – Smith HR Generalist Briefing Presentation on page 107.
After completing the drafts and edits for the HR presentation, I drafted the introductory letter that is included in newsletter #1 — *Your Health, Your Retirement: Putting It Together*. To read the introductory letter and newsletter, see *Appendix H* on page 116.

**Analysis**

This project provided the opportunity for me to experience changes in a project’s scope. When the consultants first delivered the communication strategy document along with the scope of work document including our fees, the client experienced “sticker shock.” In response to the higher-than-expected fees, the client scaled back on the scope of work that TP would perform. In this specific case, the consultants misjudged what the client would be willing to pay for the design elements — creating a new brand, new logo, and new graphics. As a result, we lost time on our end re-drafting the scope of work and re-calculating fees. Clients are the obvious necessary factor to consulting, and this project is a prime example of the importance of maintaining a client relationship even when something unexpected happens.

**Timeline**

The Smith Company project took 18 weeks from the initial client request to the delivery of the print materials. The project occurred in about the ninth week of my internship. To view the entire work plan, see *Appendix I* on page 130. The employee feedback sessions to discuss the communications they had received to date were scheduled to take place one week after I completed my internship. These sessions would help the TP team to gauge if adjustments would be necessary to the communication strategy going forward.

**Project D – Miller Company Communication Strategy**

Similar to the Smith Company project, Miller Company is another client who sought Towers Perrin’s services to implement a high-deductible health plan (HDHP). This Company differs from Smith Company, however, because Miller is introducing the HDHP to drive health care costs down to stay competitive in the market; Smith eliminated only one of its health care plans when it introduced the HDHP option strictly as another choice for its employees. If costs go down for Smith Company with the implementation, it would be an added bonus, but it was not a key objective for the business at that time like it was for Miller.
Miller is a significantly smaller company by comparison to Smith, including some remote sites with only one or two employees at each location. To meet the client’s primary objective to drive health care costs down, our communication strategy for this project needed to focus on encouraging employees, if they could benefit from the new HDHP option, to elect the HDHP over the other health care plan option at enrollment.

The tasks
Since this project was on a smaller budget in comparison to most TP projects, the physical deliverables we provided the client were limited. The communication strategy included the following sections:

- Introduction and Background
- Objectives
- Challenges
- Key Messages
- Audience Analysis
- Media Plan

Challenges and strategies
The primary challenge with this project was working within the limited budget. To successfully introduce a new health care plan, specifically an HDHP, a strong communication strategy that uses different media and pieces (such as intranet postings, newsletters, postcards, and more is desirable) leading up to the client’s enrollment time is essential, but Miller did not have the budget for an aggressive communication campaign. Since the Company was more concerned about driving health care costs down for the long-term versus within one year, we used this objective to our advantage in the strategy. Instead of an expensive first-year campaign, we devised a strategic media plan that extended the campaign over a two- to three-year period. With this plan, the Company could use our expertise to help guide them through the enrollment period with a written plan of how to proceed in the upcoming years to increase employee enrollment in the new health plan.

Actions taken
To aid us in developing the communication strategy, we held a communication strategy kick-off meeting; I co-facilitated the meeting with Eileen. The meeting was collaborative between the TP
team (two Health & Welfare consultants, Eileen, and me) and the client team. We wanted the client to be an active participant in the meeting to help us develop the eventual strategy. Our agenda for the meeting included:

- **Introductions and Miller Company background** – This discussion helped the project team understand the issues and challenges Miller Company wanted to solve with this new program. This discussion also helped to identify the key information for the strategy.

- **“I Wish” statements** – This activity allowed the client team members to be interactive with each other and with the TP team. We had the client team members write ideas on post-it notes and stick them to a board at the front of the room so everyone could see where there were commonalities. An example statement was, “I wish that our employees would compare our medical coverage to their spouse’s coverage.” This activity helped to clarify the Company’s objectives, which are critical to developing a communication strategy that supports and meets the organization’s needs.

- **“All the people who might be impacted by this change are…” (audience analysis)** – This information ensured the communication strategy identified any unique employee groups that might have special information needs.

- **“Things that might get in the way of our success are…”** – This is another activity that allowed the client team to write ideas on post-it notes. The information we gained from this activity allowed us to develop ideas/approaches to counter the identified challenges.

- **“At the end of the day, I want employees to remember…”** – This discussion helped us to develop key messages in our communication strategy. We wanted the client to think in concepts such as ‘use the plan well,’ ‘make informed health care decisions.’

- **Media** – This discussion centered on the client’s current media use and where they wanted to be (at the end of 2007 and 2008). We learned what communication pieces needed to be included in this campaign to increase its effectiveness.

All of the work involved prior to the meeting and during the meeting was driven by the desire to develop sound plans, ensure the plans meet employees’ needs, and to communicate the plans to employees so they would understand them. The end user was always in mind.
From the feedback we received during the meeting and our analysis of audience and client needs, I drafted the communication strategy document for the Company. The document underwent more than one review by Eileen, and I had direct contact with the client via email or telephone for any questions. One week after our kick-off meeting, Eileen and I presented the communication strategy document to the client team and discussed it with them. To review the strategy document, see Appendix J – Miller Enrollment and Consumerism Education Strategy on page 135.

**Timeline**

The Miller project took 10 weeks from the initial client request to the delivery of the final print materials, including a benefits annual enrollment guide, which Eileen developed after my 14-week internship was complete. The project started in about the fourth week of my internship.

**Project E – Change Implementation (CI) Training Materials**

Eileen and I were charged with an internal project to prepare a CI training guide for one of the senior Health & Welfare consultants in the office. As a recent new hire to Towers Perrin, the senior consultant, Eric, requested help from CI consultants to better understand the line of business’ (LOB) service offerings and, in turn, help to sell our services when an opportunity presented itself in client meetings.

**Strategies**

To start this project, I reviewed information provided via TP’s intranet about the CI LOB. From this information, I created a high-level look at the consulting topics included in our LOB. I created the visual below to illustrate my findings.
I used this visual to organize the information for each topic in the completed training binder. Some of the topics in the binder include:

- **Communication Rewards** – Employers seeking better information on compensation and benefits
- **Strategic Change & Communication** – Culture assessment and transformation; Overview of rapid engagement diagnostic, which determines employees’ drivers of engagement in the workplace
- **HR Technology** – HR Software/Technology Consulting Services

Eileen and I explained the training materials to Eric and provided demonstrations of a few tools for him to actually see the technology as we explained it.

**Analysis**

Since I took on the responsibility of researching materials for Eric, I gained a deeper understanding of TP’s HR Services overall and specifically CI’s practices. While the training materials were prepared for one consultant, the training binder we compiled could be a great educational tool for any new consultant starting at TP. The success of the firm rests largely on consultants’ ability, regardless of their LOB, to recognize client needs and the opportunity to sell new services to clients.
Timeline

The CI Training Materials project took three weeks from the initial internal request to our meeting with the consultant. The project occurred in about the third week of my internship.

Project F – Jones Company Communication and Implementation Plan for Integrated Disability Management (IDM) Vendor Change

In years past, the Jones Company previously worked with TP to implement significant benefits changes. TP’s relationship with this Company gave us the opportunity for a project that involved communication around a change in the Company’s disability vendors. UnumProvident replaced MetLife as the claims administrator for both the Short-Term Disability (STD) and Long-Term Disability (LTD) Plans. The Jones employees would not experience any plan design changes (i.e., changes in benefit coverage levels).

Disability was only one of many other vendor changes the Jones Company would undergo in 2007. The client also changed dental, wellness, health, Flexible Spending Account (FSA), and expatriate administrators, but TP was not hired to communicate these changes. The primary goal for the Company’s benefits enrollment event was for Jones employees to focus on the different health care choices so they could make an informed decision at enrollment. Because the focus of this year’s enrollment was health care, we decided to provide limited communication to employees about the disability claims administrative change. Employees would receive limited information in the enrollment materials and would have more detailed information online as an additional resource when they experienced a disability and needed to use the plan. We made this decision based on the feedback the Company’s Claims Benefits Services (a call center) was receiving.

The tasks

The communication for the change in the disability vendor was limited because there were not any plan design changes. In our audience analysis, we discovered that Jones employees were confused about whom to call for what information regarding their benefit plans. As a solution, we provided in-depth training to line HR (general HR practitioners) not only about the change in administrator but about how the disability coverage works. During our analysis, we also
identified the need for HR to become more informed about how the disability plans work and used the vendor change as an opportunity to do so.

The following list includes key points the Jones Company provided for the STD and LTD vendor change communications.

- State the change in vendor for STD and LTD (from MetLife to UNUM effective January 1, 2007).
- Provide an explanation for why the vendor is changing.
  - Vendor change is based on employees’ requests and feedback.
- Explain that benefit levels are not changing.
- Support Line HR and Claims Benefits Service (CBS) with in-depth training not only on the change but on how the plans work.
  - Line HR needs a tool kit to give employees information for when they ask questions.
- Provide additional communication to DWU, a union organization (and OCU, the other union group).
- Produce targeted communication to current employees on disability about how their benefits are changing in the future.
- Provide employees with access to resources when making a claim.
- Embed the following key messages in employee communication: We listened to your feedback. Now, you’ll get faster claims processing and get your benefit payments faster. You’ll have more accessibility to UNUM with longer claims hours and faster phone responses. And, you can submit your claims on the Internet.

Challenges and strategies
Before we started drafting materials, the client identified the main employee audience groups to receive the information we would produce. The descriptions of each audience group helped us to determine what type of communication deliverable each group should receive. Below is a description of each identified audience.

- Jones employees: All employees would need to be made aware of the vendor change for STD and LTD. Employees would receive updated information specific to the coverage available to them when they needed it on the intranet.
• **Line HR:** This group would need to understand how the change in administrators also changes the process for submitting claims. They also needed to be educated on how the disability program works.

• **Claims Benefits Services (CBS):** Since CBS would be taking calls from employees, they needed to understand the changes so they would communicate them to employees appropriately.

• **Union Group DWU:** These employees would get the same communication as all other employees and Line HR, but they would receive an additional letter as part of their union contract.

• **Union Group OCU:** This group would have the option of receiving the additional communication that DWU union employees receive.

• **Employees currently on disability:** The date upon which an employee became disabled would affect whether he or she would remain covered by MetLife or would move to UnumProvident on January 1, 2007. They needed communication in a personalized letter.

To create connections for employees to something they were already familiar with, we decided to package the integrated disability management changes within the Health Span framework, the Company’s branded health care program. At open enrollment, employees would receive a small amount of information on IDM in the open enrollment guide so they could focus on the health care changes. The information provided an overview of the employee benefit since we identified that many employees did not know or understand the benefit. Although we did not have direct access to the various employee groups, we were able to identify this overall need based on data provided by the Company’s call center where employees make inquiries about their benefits.

**Actions taken**

I started drafting the deliverables we outlined in our scope of work to the client. I drafted a union letter announcing the vendor change, explaining that the benefit coverage level would not change, and described the claims procedure for employees to follow until January 1, 2007. The letter was mailed to union employees signed by the union leader. I also drafted PowerPoint slides with talking points for the client’s HR manager to use in discussions with the union leader. The slides highlighted information similar to what was included in the letter.
Timeline

The Jones Company project took seven weeks from the initial client request to the delivery of the final print materials. The project occurred in about the eighth week of my internship.

Project G – Jacobs Company Change in Retiree Medical Plan

The Jacobs Company is one of TP’s Cleveland office clients. Jacobs requested Towers Perrin’s assistance to facilitate a series of focus groups in June 2006. The purpose of the focus groups was to gather retiree (the Company’s retired employees) input on a potential administrative change to some of the retiree medical programs. A total of 33 retirees and 11 guests participated in focus groups held at the following locations:

- Marshall, Michigan, where one focus group was conducted with 13 retirees and nine guests.
- Milwaukee, Wisconsin, where one focus group was conducted with 20 retirees and two guests.

It is important to note that the focus group participants represented a cross section of numerous retiree groups and retiree medical plans.

Retirees in each group were educated through a short presentation on the potential changes to the Company’s retiree medical program. After the presentation, they were asked a series of questions to gather their thoughts and opinions on the potential administrative changes to their medical plan. In addition, participants’ input was solicited on the best way to communicate these potential changes to other retirees.

Based on the retirees’ feedback, the communications needed to promote the value of the new process — less paperwork, less coordination, and fewer ID cards. The communication strategy should also include a provider communication piece, such as a letter, that retirees could take with them to their doctors that explained the new billing process.

The tasks

From the focus group report (compiled by TP consultants after the focus group sessions were complete), I learned that the communication strategy for the retirees needed to:

- minimize any concerns retirees might have about the potential administrative change;
develop communications that were simple, clear, and direct; and
focus retirees on the change in billing process and what that means to them.

It was important to reassure retirees that everything else about the Company’s medical program would remain the same. To test this theory, Towers Perrin changed the focus group approach in Milwaukee to talk about a change in billing process. Overall, this approach was easier for retirees to understand.

The communications campaign also needed to address Jacobs’ cost savings (that would result from this administration/process change) and savings that allowed Jacobs to continue to provide the same level of medical coverage to retirees. There was a need to explain why the cost savings would not be shared with retirees.

Strategies and challenges

Focus group participants recommended a combination of print and face-to-face meetings to communicate the changes to retirees. Due to the “snowbird” factor (retirees living in a secondary location during the winter months), participants said that mailing materials to homes was the best way to contact retirees. Several participants suggested calling retirees a week before the mail was expected to arrive to alert them that important information from the Company would arrive soon.

Both locations recommended face-to-face meetings so retirees would have the opportunity to ask questions. Union retirees suggested using their monthly scheduled meetings to explain the program changes. Retirees also recommended sending out the print materials in late October/early November 2006 prior to the start of the holiday season. Done this way, the materials were not sent out too far in advance so that retirees would forget about the changes by the effective date (January 1, 2007). Participants recommended the communications focus on the billing process change and reinforce nothing else was changing. Participants suggested that the communications should avoid the term “administration” and instead, explain it as a change in the billing process.

In conclusion, both focus groups said the communications needed to tell retirees that nothing was changing with the retiree medical program, except the billing process. This approach would minimize any concerns retirees might have about the retiree medical program changes.
**Actions taken**

Our consultation and recommendations included Jacobs Company conducting face-to-face meetings with retirees and providing accompanying print materials. We also asked them to consider sending advance communications — via postcard or voice recording via the phone — to retirees to alert them to the fact that they would receive important information in the mail from the Company. TP also recommended sending print materials to retirees and conducting meetings in late-October and early-November 2006.

We also advised Jacobs to work with FirstHealth/Coventry to be able to provide retirees an explanation of benefits (EOBs) that gave a detailed breakdown of who pays each portion of their medical bill. In addition, we told the client to consider having a dedicated phone line for retirees during the enrollment process so retirees could have access to a customer service representative. Another important piece of the communication materials was to include a letter in the packet that retirees could take to their health care providers that explained the new billing process.

Rita included me on the Jacobs project to work with her and the other consultants out of the Cleveland office. My role on the project included participating in conference calls — both internal calls with the TP team and calls with Jacobs and the new vendor provider (FirstHealth/Coventry). My priority was to write and edit drafts for the retiree medical brochure that would be mailed to the Company’s retiree population. To view Rita’s redlined edits on my second draft, see Appendix K – Jacobs Retiree Medical Brochure on page 156.

**Timeline**

The Jacobs project took 14+ weeks (continued after I completed my internship) from the initial client request to the delivery of final materials. The project occurred in about the ninth week of my internship.

Each project that I worked on during my internship provided me with a different learning experience. The diversity of the project tasks allowed me to use and test all of the skills I acquired during my graduate studies. Because of the exposure I had working at Towers Perrin, I think consulting provides a unique and rewarding environment for technical communicators to add value and to be more than a writer. This type of environment also adds an experience in
balancing several interests at once — Towers Perrin, Towers Perrin’s clients, and client’s employees.
Chapter 4 – Application of Technical Communication Strategies

Overall, my internship experience at Towers Perrin reaffirmed that the strategies, processes, and applications from my academic courses in technical and scientific communication are directly applicable in the workforce.

The talents and value-add of writers and technical communicators in consulting organizations are not well understood — perhaps, by some writers themselves, by their colleagues, and especially by clients. However, I found that reflecting on strategies that I learned in the Masters program and their application in the Towers Perrin environment that technical communication practices are essential to this particular organization — and probably to others as well.

I reflect on the technical communication strategies in this chapter to acknowledge those strategies that were particularly applicable in the TP environment. I end with a call for technical communicators to help employees and clients see that “good communication is good business” and that technical communicators have the necessary skills to deliver good communication.

Application of Project Management

Project management is especially critical in a consulting environment because the majority of the work, if not all work, is project-based with a set timeline to achieve the project’s goals and objectives. My analysis of project management during my internship is based on theory presented in Dr. Robert K. Wysocki’s book, *Effective Project Management: Traditional, Adaptive, Extreme*, which includes contributions by Rudd McGary, Ph.D., PMP. I selected this essay as my reference because Wysocki, as the primary author, is knowledgeable about various client methodologies and owns a consulting practice.

*Traditional Project Management*

Wysocki identifies five phases in the traditional project management life cycle:

1. Scope the project
2. Develop the project plan
3. Launch the plan
4. Monitor/control project progress
5 Close out the project

Within each phase, there are five steps to complete before the project progresses to the next phase. Although Towers Perrin does not use the exact same names for each phase of the traditional project management life cycle, there are several similarities, which I describe below.

1 **Scope the project.** In consulting, the scoping phase begins with an exchange of information between a potential client, or the “requestor,” and a TP consultant/team, or the “provider.” This exchange of information may take place when TP responds to a request for a proposal (RFP), or in a less formal situation, an exchange may occur through networking or discussing a client’s additional needs after a project ends. After the information exchange takes place and the potential client expresses an interest in TP’s services, a formal scope of work (SOW) is written and delivered, such as Appendix F. The SOW includes some standardized, legal language that is included in every TP scope, but a more detailed SOW also includes the following sections: background, services, key deliverables and assumptions, TP team members and roles, fees and expenses, invoicing and payment, and out-of-scope services.

2 **Develop the project plan.** Differing slightly from TP’s standard order, Wysocki suggests that the project plan is a deliverable that comes from the formal planning session, which is part of developing the project plan phase. From my observation, the planning session does occur during the project plan phase at TP, but at that point, a proposal does not follow because the client accepted the fees and terms of agreement outlined in the precursor proposal and the formal scope of work (SOW) document. Additionally, the planning session is scoped in the project’s budget because the firm wants to be paid for that service.

The project plan is developed to describe the necessary steps to complete the key deliverables as agreed upon in the SOW. Wysocki suggests that a project plan is “a description of the events to come” and acts as a “model of the project” (26). The model is expected to change as the project’s future events occur. Using computer-based project modelers and supporting tools, such as Microsoft Project, is the most feasible way to model the different interdependent project variables (27). In the CI LOB, project plans are generally created using Microsoft Word and Excel, and they are shared with the client.
TP’s primary purpose for developing a project plan is timing — to best ensure client deadlines are met. For example, during annual enrollment season (when employees enroll for company-sponsored benefits), a client’s enrollment dates are pre-determined and the deliverables must back-up from and be completed before those dates. Production is a critical factor when developing a project plan, often requiring coordination among several vendors. A consultant may be able to rush the drafting process, however unwise, but it’s less likely that the printing can be rushed. For this reason, TP relies heavily on a project schedule, but that’s not to say that it is not adaptable.

A client’s needs are expected to come first but not if it means sacrificing the quality of work the TP team produces. In the end, a client will be more satisfied if all of their needs are met and the work succeeds/exceeds the project’s goals and objectives, rather than sacrificing quality for the sake of meeting the project plan’s deadlines. The project plan is shared between the TP team and the client, but it does not require the client’s approval. In the ideal working relationship, TP consultants are hired by clients to be trusted advisors, managing the variables and delivering the project pieces as scheduled. If a problem occurs on either the client- or TP-end, it’s TP’s practice to initiate an open discussion with the client to determine how the plan should be adjusted. Often times, the client misses the deadline to provide feedback on a document draft, as an example, but the project plan is usually not adjusted as a result. More than likely, the TP team absorbs the lost time by creating the next draft in less time, while keeping the next draft’s delivery date. Although such a situation is not always in the best interest of the TP team, I would argue that it often seems necessary or is intrinsically part of the consulting environment to accommodate a client’s lack of responsiveness.

3 **Launch the plan.** Wysocki defines ‘launch the plan’ as the third phase of the traditional project management life cycle. According to Wysocki, this phase includes specifying the project team (27). At Towers Perrin, the project team is usually selected when the Scope of Work (SOW) is written because the team members and their roles are described in that document, (which typically occurs in the first phase). Additional members might join the team or other members might need to leave the team after the project plan is launched. When
the TP team changes, the client is notified and the project manager or senior consultant explains how the change might affect the team.

The project team members are selected for numerous reasons, including geographic location, time availability, previous experience, skills/expertise, professional development, and established client relationships. Depending on the size, length, and magnitude of the project, services from more than one line of business might be required, which necessitates a cross-functional team. An example of a project that would require a TP cross-functional team is one that is working with a client to design and implement a new medical plan option, such as the Smith Company projected described in Chapter Three. For such a project, the TP team would include:

- health & welfare consultants to analyze the client’s employee population, use of current medical plans, and solicitation of medical plan administrators;
- communication consultants to develop a communication strategy and create the deliverables; and
- change management consultants to develop the roll-out and implementation of the benefit changes, connecting all of the project’s various pieces together.

Cross-functional teams are a common practice at TP, but the team members may not all be working together simultaneously on the project.

4 **Monitor/control Project Progress.** Based on traditional project management, the project enters the monitoring phase as soon as the project work begins. Wysocki explains that change management is a significant part of this phase and procedures for change requests are determined during the launch phase (28). In general, TP does not provide formal progress reports to clients. Instead, TP establishes a set time and day for status calls to review and update the project plan, discuss feedback on current drafts, and resolve problems with internal team members and external and/or client members.

5 **Close Out the Project.** Ideally, Wysocki states that a project closes when all of the deliverables and criteria defined in the project plan (or SOW) are completed to the client’s satisfaction. To officially close out a project, Towers Perrin uses an assignment management
model to maintain professional excellence, which is implemented at the onset of a project versus the final phase. The model consists of a series of steps, blending some of the phases of traditional project management together, leading to a final review of client and staff satisfaction.

The outcomes of a client project must be measurable for several reasons: 1) to demonstrate the impact on the client’s bottom line; 2) to measure the success of the project (i.e., the end user’s satisfaction level); 3) to provide prospective clients with examples of past client work, establishing credibility for TP’s strategies and consulting experience; 4) to offer best practices within the firm for future client work; and 5) to develop and market TP’s human capital and intellectual property. Once a project is complete, all back-up files, client confidential materials, and final printed deliverables are stored in the office’s central files. Other consultants use central files as a reference for future projects.

In summary, the following list outlines Towers Perrin’s methodology for advancing through the phases of traditional project management, and above all, ensures accurate delivery of a client’s employee materials. These processes include:

- On-site project kick-off meeting resulting in a detailed project plan
- Standing project management conference calls between the client and TP throughout implementation
- Weekly monitoring of project process (dates and deliverables) against project plan
- Interim face-to-face meetings with the client members
- TP internal project management calls/meetings
- Seamless management of third-party vendor
- Client relationship management process (allowing the client to provide feedback to someone directly on the project team)
- Post-project debriefing session
- Rigorous quality review process

Consultants will also guide a client through exercises to best determine the ‘needs’ from the ‘wants.’ From the information gathered during the session, the consultants develop what Wysocki calls the ‘conditions of satisfaction’ (COS). These conditions are the goals and
objectives TP defines in a SOW and in the strategy document. The conditions are defined to successfully meet the client’s needs as well as the client’s wants (51).

**Client-Focused and Client-Driven Operating Model**

Towers Perrin’s mission is to make significant contributions to improving clients’ business performance through a unique combination of talent, expertise, and commitment. This mission epitomizes the firm’s operating model which puts the client first (within good reason) and this principle filters down to their overall approach to project management. Wysocki seems to agree with such an approach because he views client-focus as the most important of the core values in the adaptive project framework. The author states that, “the needs of the client must always come first, as long as they are within bounds of ethical business practices” (276). TP practices the client-focused approach and maintains the clients’ best interests, even if that involves challenging the client. In my experience, TP consultants took the right actions for the right reasons and with integrity for their clients.

Being client-driven does not involve the client dictating the direction of a project. Instead, consultants must act as trusted advisors while engaging the client in the decision-making process. The most successful arrangements I observed were the ones that included a primary project manager for the TP team as well as a primary project manager for the client team, creating co-project managers. As Wysocki describes, with co-project managers, both individuals share equally in the success and failure of the project because there is a sense of ownership (276). With this type of arrangement, the teams are more likely to see the project through to successful implementation.

**Managing Client Expectations**

Managing client expectations is essential for a consulting team to be successful. At the end of the day in the consulting business, it is irrelevant that the consulting team agrees on the work they delivered if the client does not. Wysocki explains this type of “expectation gap” to be the result of a failure to communicate, and the lack of communications starts at the beginning of the project and can extend until the end (50). The Smith Company project, as described in Chapter Three, is an example of a project where an expectation gap occurred. In this example, the client scaled
back on the scope of the project in response to Towers Perrin’s fees. As a result, some of the work the TP consultants completed before the formal scope of work was signed by the client could not be billed to client because they removed it from the scope.

To avoid an expectation gap, TP almost identically follows Wysocki’s three primary ways to manage client expectations at the onset of the project, including:

- Sorting wants versus needs;
- Developing conditions of satisfaction; and
- Conducting milestone reviews.

Problems often occur during a project’s cycle because there is not a direct connection between what the client says he/she wants and what he/she really needs (51). For this reason, technical communicators are a valuable asset to a consulting team, especially where audience analysis and user testing are paramount to a project’s success. The client’s disconnect is often unknown to the client because they are too involved in the minutia to see the larger picture. Often times, clients think they know what their employees need without directly asking them. To avoid a disconnect between what the client wants and what the client needs, TP conducts interviews and facilitates planning sessions, as described in the next section, Application of Audience Analysis.

**Application of Audience Analysis**

In theory, audience and user task analysis are processes that occur prior to and throughout the development of a project’s lifecycle with documentation. In the best-case scenario, the writers, strategists, and developers need to learn about the audience by understanding the users’ needs for information, ways of thinking about and organizing information, expectations, levels of knowledge on the subject matter, and levels of experience. During my internship, I needed to consider multiple audiences, including Towers Perrin’s client, the client’s primary audience, and the “real” audience/end user. If I (and the larger TP project team) did not meet the needs of the real audience, then, in turn, we were not serving our client well either.

The Change Implementation (CI) line of business uses a thorough process to conduct audience analyses and to ensure CI delivers measurable outcomes to the client. This process includes three
methods — interviews, focus groups, and custom engagement surveys. After talking with potential clients to learn more about their needs, TP consultants decide on the measurement tool(s) to use for the project.

**Interviews:**
- Interviews are typically one-hour sessions conducted by a senior consultant or principal that provides input for project direction and/or research design.
- Interviews are conducted with client senior leaders, other key leaders, division or line managers, human resources professionals, and others as appropriate.
- Interviews help consultants to explore the organization’s business and people strategies while gathering data needed to link the project to these strategies.
- Interviews also provide a way to inform managers about the purpose and timing of the research effort, how to use the data, and how to assess readiness and buy-in for the project.

**Focus Groups:**
- Focus groups are typically 90 minutes to two hours and are conducted with 8-12 employees who provide input for survey design or additional insight regarding company-specific issues.
- Key segments of the population are involved in focus groups, including employees in various job groups, levels, and tenure.
- Focus groups are a helpful tool for measuring the level of organizational readiness for the survey or for testing plans/changes in the design process.

**Custom Surveys:**
- Surveys are designed based on the input from the client team and/or interviews and focus groups.
- Items are selected and/or are developed specifically to meet the client’s needs.
Unfortunately, not every client project, when applicable and appropriate, is equipped to support focus groups/custom surveys prior to developing a communications strategy or a change management plan because of the constraints previously mentioned (time, budget, and geography). In the majority of TP case studies I read, and during my internship, the client projects that conducted focus groups at the onset of a project launch resulted in an efficient and effective strategy, producing better than expected end results for the client. The Jacobs project described in Chapter Three is a prime example of such success.

Aside from creating a project strategy, it was also important for consultants to have a dialogue with the client’s leadership team. The success of a project is largely based on the support and buy-in from leadership. As a result, the value of meeting with senior leadership is to:

- Educate them on the processes involved to develop a communication or change management strategy that can be used to support the organization’s other business strategies.
- Determine the executives’ information needs (i.e., what do they need to learn to manage their business more effectively, what are the business priorities, what are employee skills/capability needs?).
- Understand the messages they want to convey to employees through the process, understand that any research intervention (e.g., surveys, focus groups) is a communication process as much as it is a data-gathering and change-enabling process.

If time, budget, and geography are not barriers, the ideal scenario for a project is to ask the end users the same questions the TP project team might ask the HR leaders, senior managers, and project sponsors.

Although some consulting projects are unable to implement methods of audience analysis (and/or user testing), it is still the consultant’s/project team’s responsibility to meet the users’ needs while also meeting the project sponsor’s (client) communication needs — delivering communications that meet the project’s goals and objectives. Consultants are trained to ask the necessary questions to gather as much information as possible, conducting as thorough of an audience analysis as possible without direct access to any members of the audience groups. In situations without direct access to the audience, consultants rely on previous experiences with
clients in similar industries. While the consulting business thrives or perishes on its ability to create customized client work, a tried and true practice in industry is equally important for understanding audiences.

A successful client example of audience analysis is the Jacobs retiree medical project, as described in Chapter Three, where focus groups provided valuable insight for the strategy and end communication pieces. Without the focus group findings, TP consultants might have “missed the mark” for the client and the employees, developing an approach and message platform that would be strategic, but might not apply to the retirees, as the information “users.” For example, prior to conducting the focus groups, the consulting team planned to include a return form for retirees to submit, verifying they received and read the informational brochure. After meeting with retirees, the consulting team learned that submitting a form would only confuse retirees because the upcoming benefit change did not require the retiree to take any action.

Because Towers Perrin’s projects are typically more than eight weeks in length from start to finish, the Jacobs project is the only example I have of a project that facilitated focus groups as part of the development process for the communication and change management strategy. On the other hand, for nearly every project I touched, interviews were used as a means to create profiles for each significant audience group.

Integrating writers with strategists and other project team members demonstrates an effort to create a collaborative working environment to deliver the best product, including effective and useful documentation. Unfortunately, time and budget limitations can hinder the ability to perform the testing that user-centered documentation requires. If a client does not “purchase” user testing, then the consulting team must find other ways to gather the audience analysis information and to test deliverables to ensure the same end result. As user-advocates in the business world, technical writers and communicators should strive to test as often and as frequently as possible.
Two barriers exist when attempting to integrate communications into client projects. First, the need to communicate a change or to educate an audience through communications is sometimes viewed as a “nice to have” or an add-on to the project near the end of a project’s life cycle. If this situation occurs, the other consultants are at fault because it is their responsibility to learn about all of the client’s needs, regardless of whether or not communication is within his/her expertise; he/she needs to recruit the appropriate consultants to join the team. Second, the clients must have buy-in and approval from their senior leadership for the communications and understand the true value for the cost.

Application of Document Design
Throughout my technical and scientific communication coursework, I learned about the principles and relationship of product and visual design, which are related for more than one reason. The most important relation between the two includes the user. In Karen Schriver’s book, *Dynamics in Document Design*, she states that “good document design enables people to use the text in ways that serve their interests and needs” (11). While documents should meet the clients’ requirements, the reader’s needs must drive design.

The purpose of visual design is to provide viewers with an immediate understanding. Often, the point of visual design is to eliminate the amount of effort a user needs in order to understand any given piece of information. Readers often rely on documents to help them make important decisions, such as choosing health benefits, so the highest ethical standards are used to make textual choices — when deciding what to include and what not to include, what to picture and what not to picture in a document (Schriver, 11).

Document design theory is relevant and applicable for CI consultants’ work. More specifically, TP communication consultants work closely with TP designer consultants. Often times, an organization’s communications, regardless of their sponsorship or point-of-origin, are haphazard without a consistent look and feel. CI consultants are frequently hired by clients to create a brand/identity for an organization’s communications.
Creating a brand/identity is one element for a large communication strategy, whether it is an HR communication strategy or an overarching organizational communication strategy. For example, an organization’s name and logo is a means of conveying a particular image to a public. Ideally, the name and logo will appropriately reflect back upon the organization. Publics today are overwhelmed by different media. For this reason, an organization needs to present an impressionable and memorable image — one that catches the eye and keeps users’ attention. The name and logo become synonymous with the company itself. If each communication that an employee receives looks and feels different, it may be difficult for the employee to make connections within the business and to readily recognize a communication piece as coming from the company/leadership.

**Balancing Needs**

The primary challenge for a document designer — to balance the reader’s needs and the organization’s needs — is the same challenge a CI consultant faces when creating employee communications for a client. The challenge is to negotiate among the needs of multiple real audiences, “juggling allegiances, mindsets, and agendas of competing stakeholders” (Schriver, 167). To be an expert in document design, one must be able to write and design a single document that meets the needs of multiple audiences.

As evident by the projects I completed, the balance for employee communications is to meet the client’s/organization’s needs and reflect their identity as well as those of the employees. This balancing act presents a rhetorical situation where document designers take into account the readers’ knowledge and values while at the same time furthering the goals of an organization (Schriver, 167). During my internship, I did not observe a “tried and true” practice used to balance the reader’s and the organization’s needs. Each client project is unique; therefore, it requires an evaluation of how to best achieve the appropriate balance. As a result, the process is not the same for every project. Occasionally, a client will disagree with the consulting team’s recommendations to best meet the needs of both the organization and employees. In the end, the client’s needs trump the needs of the employees, as reader/user, because the client is sponsoring the project. Consultants may advise, but the client’s opinion takes precedence. At times, the nature of the consulting business is a disservice to the user.
Closing Thoughts

The practices of communication consulting are engrained with the basic principles that technical communicators and public relations specialists strive to uphold. I felt well-equipped to complete the tasks given to me, and I was able to contribute new ideas for projects. My input was respected because of my educational background and the consultants’ appreciation for any new insight into the field.

The following quote summarizes my overall experience as a technical communicator in Towers Perrin’s workplace.

Because the talent and knowledge that writers possess are not well understood, managers tend to believe that the key to being a good communicator is being a subject-matter expert. Studies tell us, however, that knowing a lot about a subject does not mean one can communicate clearly about it (Schriver, 76).

An acknowledgment of what technical communication can offer is evident among industry practitioners, but a limitation also appears to exist in terms of practitioners’ understanding of technical communication breadth and depth. In fairness to the TP workforce (and others), some of the responsibility rests with the technical communicator to explain and educate, but at times, I found it challenging to define all that the field encompasses.

Based on interviews I held with CI/Communication consultants, Towers Perrin has made a firm-wide effort over the past few years to better educate consultants in other lines of business about the importance of communication and the value-add for clients. From their experience, senior consultants attest that the communication line item in a client’s budget is often the first to be eliminated when budget constraints exist. Not only do communication consultants need to educate their colleagues on the value of communication, but they also need to educate their clients too.

Most notably, I learned that I want to use technical communication as a means to build connections for people. It will be important for me to transform my appreciation and passion for the field into communications that are value-added for others. I also learned that communication
is a powerful tool to drive behavior change. My internship provided real-world experience by allowing me to manage multiple projects, adapt to tight project deadlines, select vendors, and synthesize unfamiliar technical information quickly. These skills will be applicable in any industry that is willing to invest in technical communicators as practitioners of effective project management and well-executed communication.
REFERENCES


Towers Perrin (2003). Enhancing Corporate Credibility — Is it Time to Take the “Spin” Out of Employee Communication?


Appendix A – HR Services and Lines of Business
## Towers Perrin - HR Services & Change Implementation/Communications

**HR Services**
- Retirement
- Health & Welfare
- Change Implementation
- Executive Compensation & Rewards

**HR Effectiveness**
- HR Effectiveness
- HR Strategy
- HR Structure
- HR Business Process Outsourcing
  (HR Outsourcing Overview)

**Strategic Change**
(Change Implementation & Communication)
- Communication Overview
- Research and Measurement
- Organization Communication Effectiveness
- Communication Strategy Process
  - Global Workforce Study
  - PeopleSoft
  - SAP HCM Consulting Services
  - Onboarding
  - Personalized Total Compensation Statements
  - Professional Development Training
  - Group Consulting/Communication

**Research & Measurement**
- Research and Measurement
- Total Rewards Optimization

**Communicating Rewards**
- Compensation
- Health & Welfare
- Retirement
- Web
- Other
- Our Methodology
- Compensation and Benefits
- Rewards Communication
- Summary Plan Descriptions
  (SPD Proposal)
- Organization Communications
Appendix B – Chapter 3 Detailed Project Timelines
Project A – Retiree Medical

Day 1  ▪ Introduced to retiree medical templates project
Day 2  ▪ Read materials from Lisa on retiree medical SPD for 65+ retirees/employees
Day 3  ▪ Finished reading packet of information for retiree medical; met with Lisa to discuss my first step — to draft for Medicare overall: how Medicare works (Parts A & B), insurance carried coordination Part D, and Advantage Plans
         ▪ Focused on traditional indemnity plan (possible coordination with Parts A & B)
Day 4  ▪ Drafted for retiree medical SPD
         ▪ Sent draft to Lisa with a list of questions that surfaced when writing the draft; made plans to discuss the following week
Day 5  ▪ Met with Lisa to discuss the sections I wrote
         ▪ (Next steps:) make edits in full document (concise and clear); remove unnecessary section; re-write sections that need to be included
Day 6  ▪ Completed read through and high-level edit for retiree medical SPD
Day 7  ▪ Read retiree medical updated guidelines
Day 8  ▪ Met with Lisa to discuss retiree medical draft
         ▪ Incorporated Lisa’s edits and re-organization
         ▪ Drafted a section on coordination with Medicare Part A & B with examples of various coordination methods; coordination with Medicare Part D
Day 9  ▪ Finished draft of retiree medical SPD; sent to Lisa for final edits prior to last-round of review

Project B – Company Doe Pension Plan SPD

Day 1  ▪ Introduced to pension SPD project
         ▪ Researched TP samples of pension plans
         ▪ Drafted table of contents
Day 2  ▪ Started drafting re-write of SPD
Day 3
- Printed hard copy of draft to make a comparison to the original – checked to ensure all legal technicalities transferred
- Created a brief style guide for the SPD document and made a list of open questions to resolve
- Drafted calculations to include in document
- Finished first draft of managers’ SPD version

Day 4
- Sent SPD draft to Eileen for review

Day 5
- Reviewed SPD draft with Eileen; comments included: simplify terminology further, change word choice, change sentence structure, examples, and plan details

Day 6
- Discussed more revisions to the SPD

Day 7
- Completed third draft of SPD; emailed to Eileen for detailed review

Day 8
- Incorporated edits from Eileen’s review; re-submitted to Eileen

Day 9
- Reviewed format edit for SPD

Day 10
- Submitted SPD to TP actuary in Retirement LOB for technical peer review

Day 11
- Reviewed edits with Eileen
- Accepted document design changes and made edits

Day 12
- Made edits, page numbering, and formatting for SPD; sent to client (given one week for review)

Day 13
- Reviewed edits and feedback received from the client

Day 14
- Completed edits for commissary employees’ SPD

Day 15
- Reviewed client edits; made edits electronically for managers’ version; compared mark-up on hard copy for commissary version

Day 16
- Sent draft to client

Day 17
- Made electronic edits to unit hourly and final draft of managers’ version

Day 18
- Completed edits for commissary version

Day 19
- Reviewed all client edits received for each version and prepared filing

Day 20
- Made final client edits to commissary version

Day 21
- Compiled all drafts and emails sent to client for TP filing/archiving purposes
Project C – Smith Company Communication Strategy and Implementation for HDHP and Wellness Initiatives

Day 1  ▪ Introduced to Smith Company project
         ▪ Read Smith materials and prepared for conference call with project staff
Day 2  ▪ Read and reviewed HDHP case studies
Day 3  ▪ Followed-up with conference call
         ▪ Drafted a plan outline for Eileen and I to use while working on the two phases of the communication strategy
Day 4  ▪ Reviewed Smith materials from Rita
         ▪ Started drafting the introduction, client needs, and challenges sections
Day 5  ▪ Finished read through of Smith materials
         ▪ Drafted introduction and background, client needs, and expectations for communication strategy document
         ▪ Met with Eileen and reviewed her sections, combined sections, and continued writing the draft
Day 6  ▪ Completed draft of preliminary communication strategy document; handed-off to Eileen for any other edits and to flush-out some details
Day 7  ▪ Participated on internal conference call with project team and discussed preliminary communication strategy document edits and scheduled kick-off meeting with the client
Day 8  ▪ Reviewed and made edits to Smith’s preliminary communication strategy to send to Cleveland office
Day 9  ▪ Met with Eileen to learn the software called Assignment Planning and Monitoring Tool (APM) for the Smith project
Day 10 ▪ Set-up assumptions, activities, hours, and fees in Excel and APM
Day 11 ▪ Made hour adjustments with activities in APM
Day 12 ▪ Generated query reports in APM for Smith hours spent in May and June to run Actuals versus Budget (the hours billed by consultant versus the estimated project budget)
Day 13 ▪ Reviewed communication strategy document
         ▪ Participated on a conference call with TP designer/consultant in Detroit office to gather information for quotes to include in pricing plan
Day 14  ▪ Edited and gathered all materials and emailed to project team for client meeting

Day 15  ▪ Participated on internal conference call to discuss Smith strategy, fees, scope of work, and next steps
         ▪ Designed a grid to display phases in the communication document with consulting and design fees
         ▪ Started draft for the scope of work document

Day 16  ▪ Started draft for the HR Generalist Briefing presentation

Day 17  ▪ Finished drafting HR Briefing presentation; sent to Eileen for peer review
         ▪ Participated on conference call with Encore Productions to get a DVD quote (as part of our communication strategy)

Day 18  ▪ Edited, with Eileen, on the HR presentation

Day 19  ▪ Received edits from Rita for Smith HR Generalist Briefing presentation

Day 20  ▪ Drafted Smith’s work plan
         ▪ Made edits to HR Generalist Briefing and sent to two consultants in Cleveland for a technical review

Day 21  ▪ Completed edits to the work plan, timeline, and HR Generalist PowerPoint presentation

Day 22  ▪ Drafted introductory for Smith’s Newsletter #1 and article, *Retirement and Health care: May have More in Common Than You Think*

Day 23  ▪ Sent introductory letter and article for Newsletter #1 to Eileen for review

Day 24  ▪ Met with Eileen and Rita to discuss changes in scope of work for the project
         ▪ Made edits and updated costs for Smith’s scope of work (SOW)

Day 25  ▪ Discussed outline for Smith’s Newsletter #2
         ▪ Started the newsletter draft

Day 26  ▪ Finished newsletter draft and sent to Eileen for review

Day 27  ▪ Incorporated Eileen’s edits in the newsletter and sent to Rita for review

Day 28  ▪ Made edits to newsletter based on Rita’s feedback

Day 29  ▪ Met with Rita to plan Smith’s open enrollment guide revisions
         ▪ Started drafting the text insert for new sections in open enrollment guide

Day 30  ▪ Finished redline edits and text inserts for open enrollment guide; sent to Rita for review
Day 31  ▪ Reviewed Smith’s updated scope of work for postcards

**Project D – Miller Company Communication Strategy**

**Day 1**
▪ Introduced enrollment and consumerism education project
▪ Attended planning meeting with Joe (Health & Welfare consultant) and discussed strategy and agenda for initial meeting with Miller

**Day 2**
▪ Researched Miller’s company website
▪ Read through guidelines for creditable coverage

**Day 3**
▪ Participated in initial client meeting with Miller to discuss goals, next steps, and vision for the Company

**Day 4**
▪ Participated in internal planning meeting to prepare for the communication kick-off meeting with Miller

**Day 5**
▪ Reviewed agenda for communication strategy meeting

**Day 6**
▪ Discussed of more revisions to the SPD

**Day 7**
▪ Determined roles for the kick-off meeting; who would introduce and lead discussion for each section
▪ Researched and reviewed UnitedHealth Care’s (UHC) tools and free offerings as options for Miller to use; printed samples for meeting

**Day 8**
▪ Participated in communication kick-off meeting with client team and our project team
▪ Typed and organized our flip chart notes from the meeting to begin the strategy document

**Day 9**
▪ Met with Eileen and discussed the results of kick-off meeting and plans for drafting the communication strategy document
▪ Continued researching UHC’s tools – focused on disease management, 24-hour nurse helpline, and myUHC.com
▪ Started drafting the Miller communication strategy

**Day 10**
▪ Drafted the introduction and background, audience analysis, and challenges sections
▪ Met with Eileen to discuss UHC tools to include in the strategy

**Day 11**
▪ Performed an editorial review of communication strategy document

**Day 12**
▪ Met with Anna, Health & Welfare consultant on the project team, to clarify
the new health plan’s technical details

Day 13
- Finished final edits on the communication strategy document and brainstormed theme ideas for the strategy – such as “Invest in Your Health”
- Printed the suggested tools for Miller to use from UHCtools.com

Day 14
- Participated in client meeting to discuss and review the communication strategy document; reviewed our proposed media plan and theme ideas

Day 15
- Drafted outline for Miller web meeting and PowerPoint slides

Day 16
- Drafted Miller CEO’s email (sent on his behalf to the Miller management team)

Day 17
- Participated in conference call with Eileen and client team to discuss timeline and next steps
- Started draft for managers’ training on 2007 benefits changes

Day 18
- Finished drafting manager training presentation; sent to Eileen for review
- Updated dates to the work plan

Day 19
- Made edits to Miller manager training session
- Finalized draft CEO letter; sent to Eileen

Day 20
- Incorporated edits and charts/visuals for manager training session
- Drafted an enrollment form to include in the enrollment guide

Project E – Change Implementation (CI) Training Materials

Day 1
- Introduced CI training materials project
- Researched and gathered information on CI and HR Services on TP World

Day 2
- Prepared plan document for meeting with Eileen and Rita to discuss presentation points to Eric

Day 3
- Met with Eileen to gather and prepare materials for second meeting with Rita to discuss HR tools with Eric

Day 4
- Participated on conference call with expert on eValuator tool

Day 5
- Created visual hierarchy and organization of CI

Day 6
- Met with Eileen to prepare materials for Eric’s training session

Day 7
- Read through CI training packet

Day 8
- Met with Rita and Eileen to solidify all documents to be included in Eric’s training binder
Day 9  
- Prepared hard copies of CI training packet
- Met with Eric; Eileen and I co-facilitated the information/training session

**Project F – Jones Company Communication and Implementation Plan for Integrated Disability Management (IDM) Vendor Change**

Day 1  
- Introduced to Jones project

Day 2  
- Participated on conference call with client to discuss roles and next steps
- Started first draft of letter re: STD and LTD vendor change for Jones DWU employees; sent to Eileen for review
- Divided sections with Eileen to start drafting the communication strategy document

Day 3  
- Received Eileen’s edits and made updates
- Sent DWU letter and DWU presentation slides (after Eileen’s edits) to Rita for review

Day 4  
- Began writing work plan to include in the strategy document

Day 5  
- Continued drafting work plan

Day 6  
- Made revisions to DWU letter and PowerPoint presentation; sent to Laura, TP Health and Welfare consultant, for technical peer review
- Drafted Jones IDM information to include in enrollment materials

Day 7  
- Made edits to DWU letter and presentation per Laura’s review; sent to client with the scope of work document

Day 8  
- Participated in internal strategy meeting with Lisa, Rita, and Eileen
- Reviewed Jones’ intranet site

Day 9  
- Met with Rita to discuss Jones’ different employee groups

Day 10  
- Finished drafting presentation outline; sent to Eileen and Rita for review

Day 11  
- Read through presentation outline draft sent to client

**Project G – Jacobs Company Change in Retiree Medical Plan**

Day 1  
- Introduced to Jacobs project

Day 2  
- Participated in internal conference call to discuss roles, next steps, and potential for communication work
- Reviewed Jacobs focus group information to prepare for next conference call and to be familiarized with Jacobs Retiree Medical and Medicare coordination

Day 3
- Participated on conference call with TP team and FirstHealth Coventry team to kick-off the Jacobs project

Day 4
- Updated Rita on the conference call; prepared materials for Retiree Medical brochure

Day 5
- Started drafting Retiree Medical brochure

Day 6
- Continued drafting brochure

Day 7
- Completed first draft of Jacobs’ Retiree Medical brochure; sent to Rita for review

Day 8
- Met with Rita to discuss new direction for Jacobs’ Retiree Medical brochure

Day 9
- Drafted second version of brochure

Day 10
- Reviewed brochure; sent to Rita

Day 11
- Reviewed edits with Rita
- (Project continued after I left my internship)
Appendix C – Calendar Example
<table>
<thead>
<tr>
<th>Sun</th>
<th>Mon</th>
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<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
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<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Client 2: 1&lt;sup&gt;st&lt;/sup&gt; draft of paragraph included in enrollment guide</td>
<td>Client 2: 2&lt;sup&gt;nd&lt;/sup&gt; draft of Employee OE Guide paragraph</td>
<td>Client 3: 1&lt;sup&gt;st&lt;/sup&gt; draft leadership presentation</td>
<td>Client 1: Final draft HR meeting materials</td>
<td>Client 5: 1&lt;sup&gt;st&lt;/sup&gt; draft email from Tom to management</td>
<td>Client 2: Final draft employee OE Guide paragraph</td>
<td></td>
</tr>
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<td>16</td>
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<td>18</td>
<td>19</td>
</tr>
<tr>
<td>Client 1: Second drafts of consumerism wrap and cover letter</td>
<td>Client 4: 1&lt;sup&gt;st&lt;/sup&gt; draft of newsletter</td>
<td>Client 1: Final draft HR meeting materials</td>
<td>Client 5: 1&lt;sup&gt;st&lt;/sup&gt; draft Web meeting for Management Team</td>
<td>Client 3: 1&lt;sup&gt;st&lt;/sup&gt; draft introductory letter</td>
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<td>20</td>
<td>21</td>
<td>22</td>
<td>23</td>
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<td>26</td>
</tr>
<tr>
<td>Client 1: final draft of consumerism wrap and cover letter</td>
<td>Client 3: 2&lt;sup&gt;nd&lt;/sup&gt; draft leadership presentation</td>
<td>Client 1: 2&lt;sup&gt;nd&lt;/sup&gt; draft of enrollment materials</td>
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<td>28</td>
<td>29</td>
<td>30</td>
<td>31</td>
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</tr>
<tr>
<td>Client 1: Print consumerism wrap and cover letter</td>
<td>Client 3: 1&lt;sup&gt;st&lt;/sup&gt; draft enrollment guide, cover letter and tip sheet</td>
<td></td>
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<td>2006</td>
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</tbody>
</table>
Appendix D – Medicare Research Draft
Understanding Medicare

Medicare is a health plan provider to help pay for your health care coverage. You are eligible for Medicare health care coverage if you are:

- Age 65 or older;
- Under age 65 with [certain?] disabilities; or
- Have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

You choose the Medicare health plan that is best for you. Your choice affects many factors such as cost, benefits, doctor choice, convenience, and quality. Medicare offers more than one health plan to provide you with the most appropriate coverage for your specific circumstances.

You may have more than one type of insurance or coverage that will pay before, or along with, Medicare. If you have a question about who should pay, or who should pay first, check your insurance policy or coverage.

Original Medicare: Parts A and B

The Original Medicare Plan is available nationwide. The Original Medicare Plan pays for many health care services and supplies, but it is unable to pay for all of your health care costs. The costs you need to pay include coinsurance, co-payments, and deductibles. The costs that are not covered in the Plan are called “gaps” in Medicare coverage.

Part A (Hospital Insurance)
Medicare Part A provides coverage if you are hospitalized. This coverage pays for inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). In addition, Medicare Part A also helps cover hospice care and some home health care. Most people do not need to pay a premium for Part A because you (or a spouse) already paid for it through payroll taxes while working.

Part B (Medical Insurance)
Medicare Part B provides coverage for medical care including doctors’ services (office visits) outpatient hospital care, and some other medical services that Medicare Part A does not cover. Part B also covers some other medical services that Part A does not cover such as services for physical and occupational therapists and some home health care. Most people pay a monthly premium to receive Part B coverage.

Medicare Part D: Prescription Drug Coverage

Medicare Part D provides prescription drug coverage. Part D coverage is to help you pay for both brand-name and generic drugs that you need. To get Medicare prescription drug coverage, you need to choose and join a Medicare drug plan.
There is more than one type of Medicare drug plan offered to you:
- Medicare Prescription Drug Plans that add coverage to the Original Medicare Plan;
- Medicare Private Fee-for Service Plans that do not offer Medicare prescription drug coverage;
- Medicare Cost Plans [needs a description?]; and
- Prescription drug coverage as part of the Medicare Advantage Plans. (See section below called “Advantaged Plans” for more details.)

Your costs are dependent on your financial situation and the Medicare drug plan you choose. Regardless of your choice, all Medicare drug plans offer at least the standard level of coverage.

**Joining a Medicare Drug Plan**

Joining a Medicare drug plan is your personal choice. If your company retiree drug coverage is as good as Medicare coverage, you can stay with your current coverage now, and you will not pay a penalty if you later decide to switch to Medicare drug coverage. For clarification, Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage.

In some cases, if you do decide to enroll in a Medicare prescription drug plan and drop your company-sponsored prescription drug coverage, you may be unable to enroll in the company coverage later.

**Medicare Advantage Plans and Other Medicare Health Plans**

Medicare Advantage Plans combine Medicare Parts A, B, and D into one plan. To join a Medicare Advantage Plan, you must first have Medicare Part A and Part B. Medicare Advantage Plans include:
- Medicare Health Maintenance Organization (HMO) Plans
- Medicare Preferred Provider Organization (PPO) Plans
- Medicare Private Fee-for-Service (PFFS) Plans
- Medicare Special Needs Plans

These plans may cover more services and have lower out-of-pocket costs than the Original Medicare Plan. Although costs may be lower, in some plans like HMOs, you may only be able to see certain doctors or go to certain hospitals (often referred to as networks.)
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About This Booklet

This booklet provides you with information about your Doe’s Pension Plan. This Summary Plan Description (SPD) applies to managers and office employees of Doe’s Restaurants, Inc. (Doe’s) or its subsidiaries. Commissary employees also participate in this Plan and have a separate SPD. This SPD is separated into two sections:

■ How the Plan Works

■ Plan Details

This SPD is intended to help you understand how the Plan works. Please read through this booklet and share it with your family. If you have questions after reading it, please contact Doe’s Benefits Hot Line at 1-800-879-8338 or 513-559-5199.

How the Plan Works
Determining Your Eligibility

You are eligible to participate in this Plan if you are a manager or an office employee of Doe’s. See the sidebar to the left for a more detailed description of “manager or an office employee.” If your employment status changes and you become ineligible, you will stop earning benefits in the Plan.

Newly eligible employees may enter the Plan at one of two “entry dates” during the year – either June 1 or December 1. If you are an eligible employee and at least age 21, you may begin participating in the Plan on the first entry date after you have completed at least one year of Continuous Service with the Company and have worked for at least 12 months before your entry date. A year of Continuous Service is earned for each calendar year you work 1,000 hours.

Let’s look at an example:
Tom is age 24 and his first day of work at Doe’s was April 1, 2006. On December 31, 2006, Tom will complete one full year of Continuous Service. On April 1, 2007, he will have worked for 12 months. Tom’s entry date into the Plan will be June 1, 2007.

Vesting in the Plan

To “vest” in the Plan means that you earn a right to receive a benefit when you retire. You are vested in the Plan after you complete five years of Continuous Service with the Company. You are also vested if you work one hour after your normal retirement date. If you are not vested when you leave the Company (for whatever reason, including death), neither you nor your beneficiaries may receive a benefit from the Plan.

When You Can Retire

You can retire early, late, or at a “normal” time. Here’s how those terms are defined:

- **Normal retirement**: Your 65th birthday. However, you may not retire earlier than the June 1 before the 5th anniversary of your entry date in the Plan.

- **Early retirement**: Your 55th birthday. However, you may not retire earlier than completing five years of Continuous Service.

- **Late retirement**: Any time after your normal retirement date. If you are not working for Doe’s on the April 1 of the calendar year following the calendar year when you reach age 70 ½, you must begin receiving your benefits at that time. If you are working for Doe’s at that time and are not a 5% shareholder, you may choose whether you want to begin receiving your benefits then or wait until later.
How Your Benefit Is Calculated

Assuming you take a normal retirement, here’s how your monthly retirement benefit is calculated:

Your normal retirement benefit will be the larger of Box A or Box B.

<table>
<thead>
<tr>
<th>Box A</th>
<th>Box B</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10 x Years of Credited Service up to 40 years</td>
<td>([51% x Monthly Plan Compensation) Minus (50% x Social Security Benefit]) Times [1/28 x Years of Credited Service up to 28 years]</td>
</tr>
</tbody>
</table>

Pension Calculation Definitions

**Monthly Plan Compensation:** The average of your monthly pay during the five consecutive calendar years that your average pay was the highest. If you have fewer than five consecutive calendar years, your compensation will be based on the average pay during the time you worked. Pay refers to your W-2 earnings plus your before-tax contributions to the 401(k) plan and your before-tax premiums for other benefits. Your pay is essentially equal to your base salary plus any overtime pay you receive plus any incentive/bonus payments you receive. This excludes automobile allowances or reimbursements, moving expenses, or stock options.

**Social Security Benefit:** The monthly benefit you would be entitled to receive from the government at your normal retirement date (or late retirement) based on the Social Security Act in effect when you left the Company, or when you begin to receive your benefit, whichever is earlier.

**Years of Credited Service:** The number of years in which you worked at least 1,000 hours per calendar year. See the section titled “All About Service” for special situations.
Benefit Calculation Example
Assume the following about Pam, who plans to take a normal retirement benefit:

- Retirement date: June 1, 2023
- Years of Credited Service: 30
- Monthly Plan Compensation: $3,000
- Social Security benefit: $1,200

Pam's benefit is the larger of Box A or Box B.

<table>
<thead>
<tr>
<th>Box A</th>
<th>Box B</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10 x 30 = $300</td>
<td>$\left[(51% \times 3,000) - (50% \times $1,200)\right] \times \frac{1}{28} = 28 \times (1,530 - 600) = 930$</td>
</tr>
</tbody>
</table>

Since $930$ is greater than $300$, Pam's monthly benefit is $930.$
Taking Your Retirement Early

You may retire early if you are at least age 55 and have completed five years of Continuous Service with the Company. To determine your early retirement benefit, the first step is to calculate your normal retirement benefit as if you continued to work to age 65.

Your normal retirement benefit is multiplied by the service fraction to provide the “Prorated Accrued Benefit,” as follows:

\[
\text{Prorated Accrued Benefit} = \text{Normal Retirement Benefit} \times \frac{\text{Actual Continuous Service}}{\text{Projected Continuous Service at Normal Retirement Date}}
\]

Your Prorated Accrued Benefit will be reduced for each year that you start payments before age 65 because you are expected to receive benefits over a longer period of time.

The Prorated Accrued Benefit is reduced by the early retirement factor assigned to the age when you start payments, as shown in the chart below:

<table>
<thead>
<tr>
<th>Age when you start payments</th>
<th>Early retirement factor %</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
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<tr>
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</table>

<table>
<thead>
<tr>
<th>Prorated Accrued Benefit</th>
<th>Early Retirement Factor at Benefit Start Date</th>
<th>Early Retirement Benefit</th>
</tr>
</thead>
</table>
**Benefit Calculation Example**

Assume the following about John, who decides to retire early (at age 60):

- Continuous service at age 60: 25 years
- Normal retirement benefit based on Credited Service to age 65 (with five or more years of service): $900 per month

First, we multiply John’s normal retirement benefit by the service fraction to come up with the Prorated Accrued Benefit.

**Prorated Accrued Benefit**

\[ \text{Prorated Accrued Benefit} = 900 \times \frac{25}{30} = 750 \text{ per month} \]

If John elects to start his payments when he retires at age 60, we refer to the chart to determine the early retirement factor at age 60, which is 66.67%. Using the formula above, here’s how John’s early retirement benefit is calculated:

**Early Retirement Benefit**

\[ \text{Early Retirement Benefit} = 750 \times 66.67 \% = 500 \text{ per month} \]

So, John’s early retirement benefit is $500 per month.

John may decide to retire early, but wait to receive his benefit until he reaches age 65. In that case, his benefit will be larger than it would be if he took it now, but not as large as it would be if he continued to work until age 65.

In this case, his benefit would not be multiplied by the 66.67% early retirement factor. So, it would equal the Prorated Accrued Benefit of $750 per month.

**Taking Your Retirement Late**

If you decide to work beyond your normal retirement date, you will receive a monthly pension at retirement. If you are not working for Doe’s on the April 1 of the calendar year following the calendar year when you reach age 70 ½, you must begin receiving your benefits at that time. If you are working for Doe’s at that time, you may choose whether you want to begin receiving your benefits then or wait until later.
If You Leave Before You Retire

If you leave Doe’s before you retire and are not vested when you leave, you will not receive a pension benefit.

If you leave Doe’s before you retire and you are vested when you leave, you have a right to receive a pension benefit. When you can receive your benefit depends on the amount of your benefit as shown below:

<table>
<thead>
<tr>
<th>If the total lump sum value of your benefit is:</th>
<th>Then you:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $1,000</td>
<td>Are required to receive it in a lump sum form after you leave the Company (before retirement)</td>
</tr>
<tr>
<td>$1,000 - $3,500</td>
<td>Can choose to receive it in a lump sum form any time (before or at retirement)</td>
</tr>
<tr>
<td>More than $3,500</td>
<td>May not receive your benefit until you retire (as early as age 55 for a reduced benefit, but no later than age 65 for a full benefit)</td>
</tr>
</tbody>
</table>

If you will receive your benefit in a lump sum form before age 59 ½, it will be subject to penalty taxes unless you roll it over into an eligible retirement plan. See the section titled “Tax Consequences” for more information.

Understanding Forms of Payment

There are two forms of payment under the Plan – automatic and alternative. You will receive the automatic form of payment if you do not elect otherwise. Benefit payments made in a form other than the 5-Year Certain Form will be actuarially adjusted to provide an equivalent value.

**Automatic Form of Payment**

The automatic payment differs depending on whether you are unmarried or married at retirement. (If you are married for less than a year at retirement, your spouse is not eligible for a benefit and the unmarried form of payment applies to you.)

- **Unmarried**: If you are unmarried when you retire, the automatic form of payment is called the 5-Year Certain Form. This form pays a benefit to you each month until you die with 60 monthly payments guaranteed whether you are living or not.
That means if you die before the 60 payments are made, the remaining guaranteed payments go to your designated beneficiary.

- **Married**: If you’re married for more than a year when you retire, the automatic form of payment is called the **Qualified Joint and 50% Survivor Annuity**. This form provides a monthly benefit to you for the rest of your life. When you die, 50% of the amount that was paid to you each month will be paid monthly to your surviving spouse. (Note: If you marry after your pension benefit begins, your spouse is not entitled to receive benefits when you die.)

### Alternative Forms of Payment

You may choose one of the following payment options instead of the automatic forms of payment described in the section above. All of the alternatives are equal in value based on assumptions about life expectancies. If you choose an alternative form, you must elect it in writing within 90 days of starting payment.

- **Life Only Form**: Pays a monthly pension benefit to you for your lifetime. When you die, payments stop.

- **10-Year Certain Form**: Pays a monthly pension benefit to you each month until you die with 120 monthly payments guaranteed. If you die before 120 monthly payments are made, the remaining payments go to your beneficiary.*

- **15-Year Certain Form**: Pays a monthly pension benefit to you each month until you die with 180 monthly payments guaranteed. If you die before 180 monthly payments are made, the remaining payments go to your beneficiary.*

- **20-Year Certain Form**: Pays a monthly pension benefit to you each month until you die with 240 monthly payments guaranteed. If you die before 240 monthly payments are made, the remaining payments go to your beneficiary.*

- **Qualified Joint and Survivor Annuity**: There are two Qualified Joint and Survivor Annuities:

  - Qualified Joint and 50% Survivor Annuity: Pays a monthly benefit to you for the rest of your life. When you die, 50% of the amount that was paid to you each month will be paid monthly to your surviving spouse. (Note: If you marry after your pension benefit begins, your spouse is not entitled to receive benefits when you die.)

  - Qualified Joint and 100% Survivor Annuity: Pays a monthly benefit to you for the rest of your life. When you die, 100% of the amount that was paid to you each month will be paid monthly to your surviving spouse. (Note: If you marry after your pension benefit begins, your spouse is not entitled to receive benefits when you die.)

- **Lump-Sum Payment**: Pays a one-time single sum amount at retirement. Payment in excess of $3,500 may not be made before age 55.
*In some instances, these payment forms may be restricted by federal law. If You Have a Small Benefit

If you leave Doe's before retiring and the lump sum payment value of your benefit is less than $1,000, the Advisory Committee may require you to receive that amount in a lump sum.

**Tax Consequences**

In general, benefit payments from the Plan will be subject to federal income taxes and may be subject to state and local income taxes as well. If you elect a single sum payment, the Company is required to withhold federal income taxes equal to 20% of the taxable portion of your payment, unless you roll over your distribution directly into a traditional IRA or eligible employer Plan. Unless you are at least age 55 at the time you leave the company, or you are at least age 59½ at the time payment is made to you, or another exception applies, your distribution may be subject to a 10% early payment penalty tax in addition to regular income taxes if it is not rolled over. Your distribution may be rolled over to the extent it is an “eligible rollover distribution.” Generally, a distribution is an eligible rollover distribution if it is paid in the form of a single lump sum payment, or in the form of installment payments made over a period of less than 10 years. For more information on the additional 10% tax, please see IRS Form 5329. Note that nonspousal beneficiaries cannot roll over any payments from this Plan.

You are responsible for complying with applicable federal, state, and local tax laws and regulations when you receive the distribution. You will receive more information about the applicable rules when you request a distribution. Because taxes are complicated and subject to change, you may wish to consult a tax advisor before receiving benefits from the Plan.

**Understanding Death Benefits**

If you die after your pension benefits have been paid, any pension benefits to your beneficiary will be determined by the payment election you made when you retired.

If you die after completing five years of service with the Company, and before any benefits have been paid, a death benefit will be paid to your beneficiary equal to 100% of the present value of your accrued benefit under the Plan. In general, a death benefit will not be paid until you would have reached retirement age.

If you have been married for more than a year when you die, your spouse is eligible to receive a benefit from the Plan. By law, your surviving spouse will be the recipient of 50% of the present value of your accrued benefit. The beneficiary you designate, which may also be your spouse, will be the recipient of the other 50%. If you are not married when you die, all of the benefit will be paid to your designated beneficiary. Your spouse’s or beneficiary’s benefit will be calculated as follows:
First, the benefit will be calculated as shown in the section titled “How Your Benefit Is Calculated.”

Next, the present value of this benefit is determined.

After that, it will be adjusted for the Qualified Joint and 50% Survivor Annuity Form.

Next, the 50% survivor annuity portion of the benefit is calculated for your surviving spouse. This is calculated assuming that payments start at the earliest date after your death that you could have elected payments to begin if you had not died. This amount is paid to your spouse for life.

Then, the present value of this benefit is determined.

Finally, the difference between the present value in (2) above and (5) above is paid to your designated beneficiary in the 5-Year Certain Form.

Note: If you are not married, steps (3) and (4) above are not applicable and the present value in step (5) is zero.

It is important that you keep your designated beneficiary current. If you die without a spouse or a designated beneficiary, your estate will receive a lump sum of your death benefit.
Plan Details
All About Service

There are several different forms of service. The definitions below for each type of service give a detailed description.

**Continuous Service**

This service is used to determine your eligibility and vesting rights. Your Continuous Service begins the day you complete an hour of service for the Company. You need to have 1,000 hours in each calendar year (January 1 – December 31) for it to qualify as a year of Continuous Service.

A couple of exceptions apply:

- If you do not have 1,000 hours in your first or second calendar year (January 1 – December 31) of employment but you do have 1,000 hours in your first anniversary year (hire date to the same date the following year), you will receive one year of Continuous Service for that time. For example:
  - Assume you started in October 1998 and did not complete 1,000 hours from October 1998 to December 31, 1998, or in calendar year 1999, but did complete 1,000 hours from October 1998 to the anniversary of your hire date in October 1999.
  - Because you completed 1,000 hours from October 1998 through October 1999, you will earn a year of Continuous Service for your time working from October 1998 to December 31, 1998.

- If you were employed before 1993, your service is counted a little differently because of a change in rules. See the section on the next page titled “Employed Before 1993?” for more information.

**Credited Service**

Your credited service is used to calculate your benefits under the Plan. You receive one year of credited service for each year of Continuous Service when you reach 1,000 hours of service. (Note: After 1999, no credited service accrues for highly compensated employees. See the sidebar to the left for a definition of highly compensated employees.)

**Employed before June 2, 1986?** Your service before June 2, 1986, is counted if you elected to participate in the Plan at that time.
**Hours of Service**

If you are a salaried employee, you are credited with 10 hours of service each day that you work, up to a maximum of 45 hours per week. Your hours of service are credited not only for working time, but also paid time off, including vacation time, paid holidays, paid jury or military duty, paid sick leave, and paid leave of absence.

Some non-paid leaves of absence will count toward your hours of service, but with the following limitations:

- If you take a child care leave, your hours will be counted according to your normal work schedule. Your hours of service may not exceed 501 hours per year.
- If you take any other non-paid leave, 10 hours of service will count each week. Your hours of service may not exceed 501 hours per year.

**Break in Service**

If you worked for the Company, left for an extended period of time and then rejoined, you may have a “break in service.” Having a “break in service” will affect the way your pension benefit is calculated. It depends on whether you were vested or not when you left and how long were away, as follows:

- If you **were vested before you left**, you will not have a “break in service” and your service before your break will count toward your pension benefit. If you already began receiving benefits when you left, your benefits will continue to be paid while you are working.
- If you **were not vested before you left**, and were gone for five consecutive years (calendar years that you worked less than 501 hours), you have a “break in service.” That means that all the continuous and credited service before you left will not count in calculating your pension benefit. **Exception:** Any service you had before 1993 while participating in this Plan will count toward your pension benefit.

**Employed Before 1993?**

In 1992, the Company changed the Continuous Service definition from “anniversary year” (hire date to the same date the following year) to “calendar year” (January 1 to December 31). This means that:

- If you completed **1,000 hours of service between your anniversary date and December 31, 1992**, you earned an additional year of Continuous Service. Assume you started working on May 1, 1980. In 1992, you would earn your regular anniversary year of service from May 1, 1991, through May 1, 1992, and then, because you worked 1,000 hours from May 1, 1992, through December 31, 1992, you would also earn a year of Continuous Service for that time.
- If you **did not complete 1,000 hours of service between your anniversary date and December 31, 1992**, you will receive an additional 1/6 of a year of credited service for each month during that period (up to a maximum of 6 months) when you performed at least 83 hours of service.
Leaves of Absence
You may be able to continue your participation during leaves of absence under this Plan under certain circumstances.

*Continuation of Participation While on Approved Leaves of Absence*
If you take an approved **paid** leave of absence (including short-term disability leave), you will continue to participate in the Plan as if you were an active employee. That means you may continue to accrue benefits and work toward becoming vested, if you are not vested already. While on your leave, you cannot begin to receive your benefit.

If you take an approved **unpaid** leave of absence other than a long-term disability leave, you will not continue to receive service for purposes of vesting and benefit accrual. While on your leave, you cannot begin to receive your benefit. However, while on an unpaid leave of absence, you do not incur a break in service.

*Continuation of Participation for Employees in the Uniformed Services (USERRA)*
The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. The terms “Uniformed Services” or “Military Service” mean the Armed Forces (i.e., Army, Navy, Air Force, Marines Corps, Coast Guard), the reserve components of the Armed Services, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted. These rights include service credit under the Plan for purposes of calculating a benefit and becoming vested. Such leave will not constitute a break in service.

If you think you may be eligible for these special rights under USERRA, please contact the Doe’s Benefits Hot Line at 1-800-879-8338 or 513-559-5199.
Continuation of Participation While on a Family and Medical Leave (FMLA)

Under the federal Family and Medical Leave Act (FMLA), if you meet eligible service requirements, you are entitled to take up to 12 weeks of leave for certain family and medical situations. An absence under the Family and Medical Leave Act will not constitute a break in service for purposes of this Plan. In general, your FMLA leave is treated like any other paid or unpaid leave under the Pension Plan. If your FMLA leave is paid, your leave will be treated like other paid leaves; if your FMLA leave is unpaid, it will be treated like other unpaid leaves.

Funding for the Plan

The Pension Plan is a defined benefit plan. The Plan is funded by Company contributions. Employees are not permitted to contribute to this Plan. Contributions are calculated by an actuary who estimates the amount needed based on the amount of benefits that need to be paid.

Plan Limits

Federal law limits the amount of benefits that may be received from a qualified Pension Plan. In particular, for 2006 no more than $220,000 of annual compensation may be taken into account in determining your benefit. Also, in 2006 your annual benefit will be limited to the lesser of $175,000 or 100% of your average compensation during your highest three years. These limits may be adjusted periodically for changes in the cost of living, and may be adjusted depending on the form of benefit you select and your benefit commencement date.

Non-Duplication of Benefits

If for the same period of service more than one benefit is payable under this Plan alone, or under this Plan and another qualified defined benefit Pension Plan or agreement that Doe’s contributes or has contributed, benefits under this Plan will be adjusted to eliminate that duplication.
Administrative Information

- **Name of the Plan**
  (Plan Number 001)
  Doe’s Restaurants, Inc. Pension Plan for Managers, Office, and Commissary Employees

- **Plan Sponsor**
  Doe’s Restaurants, Inc.
  2800 Gilbert Avenue
  Cincinnati, Ohio 45206
  (513) 961-2660

- **Employer Identification Number**
  31-0523213

- **Plan Type**
  Defined Benefit Pension Plan

- **Administration Type**
  The Pension Plan is administered through a trust.

- **Plan Administrator**
  Advisory Committee
  c/o DOE’S RESTAURANTS, INC.
  2800 Gilbert Avenue
  Cincinnati, Ohio 45206
  (513) 961-2660

- **Trustee**
  Craig F. Maier
  Donald H. Walker
  Michael E. Conner
  c/o Doe’s Restaurants, Inc.
  2800 Gilbert Avenue
  Cincinnati, Ohio 45206
  (513) 961-2660

- **Service of Process**
  Notices, forms, and legal process concerning the Plan may be served on and delivered to Doe’s Restaurants, Inc., the Pension Advisory Committee, or the Trustee.

- **Plan Year**
  The Plan Year is the 12-month period ending May 31.
Plan Records
Plan records are kept on a Plan-year basis (June 1 – May 31).

Effective Date
The original effective date of the merged Plan was May 31, 1995.

Right to Change or End the Plan
The Plan may change from time to time for any reason. However, the change may not:

- Increase the duties or liabilities of the Trustee without the Trustee’s consent.
- Cause Plan assets to be reverted to or to be used by the Company for any purpose besides one that benefits the participants and beneficiaries of the Plan, unless otherwise allowed by law.
- Decrease the benefits of a participant or beneficiary who earned benefits before the change.
- Eliminate or reduce the early retirement benefit or optional payment form, unless otherwise allowed by law.

We reserve the right to discontinue the contributions or end the Plan for any reason.

If the Plan ends:

- You will become fully vested in the benefits you have earned to that point (to the extent your benefits are funded).
- Benefits will not increase and no further contributions will be made. However, the amount of funds in the Pension Plan will remain and will be invested until they are distributed.
- Distributions will be made in any matter permitted by the Pension Plan as soon as possible and any excess funds will revert to the Company.
- The Pension Benefit Guaranty Corporation (PBGC) will insure vested benefits up to a certain level. See the section titled Pension Benefit Guaranty Corporation for more information.
- You may not require the Company to pay a benefit or to make additional contributions to the Plan. The Pension Plan or its investments are not guaranteed by Doe’s, the Advisory Committee or the Trustee.
**Limitation on Assignment/QDRO**

Your rights and benefits under this Plan cannot be assigned, sold, transferred, or pledged by you or reached by your creditors or anyone else except under limited circumstances. However, the law does permit the assignment of all or a portion of your interest in the Plan to your former spouse or children as part of a Qualified Domestic Relations Order (QDRO).

A QDRO is a legal judgment, decree or order that recognizes the rights of an alternate payee under the Pension Plan with respect to a child’s or other dependent’s support, alimony or marital property rights. The company is legally required to recognize QDROs.

If you are in the process of a divorce, check with your attorney about a portion or all of your benefit under the Pension Plan being assigned to someone else to satisfy a legal obligation you may have to a spouse, former spouse, child or other dependent.

You may obtain, without charge, a copy of the procedures governing QDRO determinations under the Plan from the Plan Administrator by contacting the Advisory Committee.

**Plan Interpretation**

To the fullest extent permitted by law, the Advisory Committee will have the exclusive discretion to determine all matters relating to eligibility, coverage and benefits under the Plan. The Advisory Committee will also have the exclusive discretion to determine all matters relating to interpretation and operation of the Plan. Decisions by the Advisory Committee will be conclusive and binding.

**Pension Benefit Guaranty Corporation**

Your pension benefits under the Pension Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits
- Certain benefits for your survivors.

The PBGC guarantee generally does not cover:
- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates

- Some or all of benefit increases and new benefits based on Plan provisions that have been in place for fewer than five years at the time the Plan terminates

- Benefits that are not vested because you have not worked long enough for the Company

- Benefits for which you have not met all the requirements at the time the Plan terminates

- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan’s normal retirement age

- Nonpension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your Plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask your Plan Administrator or contact the PBGC’s Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, DC 20005-4026 or call 1-202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 1-202-326-4000. Additional information about the PBGC’s pension insurance program is available through the PBGC’s web site on the Internet at http://www.pbgc.gov.

Your Right to Appeal

If you have any questions about the Pension Plan or if you wish to make a claim for benefits, you should contact the Advisory Committee at 2800 Gilbert Avenue, Cincinnati, Ohio 45206.

If you feel you have a right to a benefit under the Plan that you have not received, you may file a claim for the benefit with the Plan Administrator.

Time Frame for Claim Determinations

If you receive an adverse benefit determination (i.e., any denial, reduction or termination of a benefit, or a failure to provide or make a payment), the Advisory Committee will notify you of the adverse determination within a reasonable period of time, but not later than 90 days after receiving the claim. This 90-day period may be
extended for up to an additional 90 days, if the Advisory Committee both determines that special circumstances require an extension of time for processing the claim, and notifies you, before the initial 90-day period expires, of the special circumstances requiring the extension of time and the date by which the Plan expects to render a determination.

In the event an extension is necessary due to your failure to submit necessary information, the Plan’s time frame for making a benefit determination on review is stopped from the date the Advisory Committee sends you an extension notification until the date you respond to the request for additional information.

**If You Receive an Adverse Benefit Determination**

The Advisory Committee will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the benefit determination is based
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why that material or information is necessary
- A description of the Plan’s appeal procedures and time limits applicable to these procedures, including a statement of your right to bring a civil action under ERISA after an adverse determination on appeal.

** Procedures for Appealing an Adverse Benefit Determination**

You or your authorized representative has 60 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination. You should submit this to the Advisory Committee by certified or registered mail.

You have the right to:

- Submit written comments, documents, records, and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as “relevant” to your claim if it:
— Was relied upon in making the benefit determination;

— Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;

— Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or

A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination.

The Advisory Committee will notify you of the Plan’s benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review by the Plan. This 60-day period may be extended for up to an additional 60 days, if the Advisory Committee both determines that special circumstances require an extension of time for processing the claim, and notifies you, before the initial 60-day period expires, of the special circumstances requiring the extension of time and the date by which the Plan expects to render a determination on review.

In the event an extension is necessary due to your failure to submit necessary information, the Plan’s time frame for making a benefit determination on review is stopped from the date the Plan Administrator sends you notification of the extension until the date you respond to the request for additional information.

The Advisory Committee’s notice of an adverse benefit determination on appeal will contain all of the following information:

— The specific reason(s) for the adverse benefit determination;

— References to the specific Plan provisions on which the benefit determination is based;

— A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim; and

— A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.

If the Advisory Committee determines that you are not entitled to the benefits claimed, you or your representative may personally present your claim to the Advisory Committee. The Advisory Committee needs to provide its final decision,
giving specific reasons for the decision in writing to you through certified mail within 60 days.

**Note:** You must use and exhaust the Pension Plan’s administrative claims and appeals procedure before bringing a suit in either state or Federal court. Similarly, failure to follow the Plan’s prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.
Your Rights Under ERISA

As a participant in the Pension Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

**Receive Information About Your Plan and Benefits**

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as work sites, all documents governing the Plan including a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including copies of the latest annual report (Form 5500 Series), and updated SPD. The administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- Obtain a statement telling you whether you have a right to receive a pension at your normal retirement age (age 65) and if so, what your pension benefits would be at normal retirement age under the Plan if you stop working now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

**Enforce Your Rights**

If your claim for a pension benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or federal court, but only after you have exhausted the Pension Plan’s claims and appeals procedures as described in the section titled “Your Right to Appeal.” In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in a Federal court.

If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance With Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
Your Employment

This SPD provides detailed information about the Pension Plan and how it works. This SPD does not constitute an implied or express contract or guarantee of employment. Similarly, your eligibility or your right to benefits under the Pension Plan should not be interpreted as an implied or express contract or guarantee of employment. Doe’s employment decisions are made without regard to benefits to which you are entitled upon employment.
Appendix F – Scope of Work Document
July 24, 2006

Mr. John Doe
Vice President, Human Resources
Smith
29500 Solon Road
Solon, Ohio 44139

Dear John:

ENGAGEMENT OF TOWERS PERRIN FOR CONSULTING SERVICES

Following up on our recent discussions, this letter confirms the terms under which Smith ("Smith" or "you") has engaged Towers, Perrin, Forster & Crosby, Inc., trading as Towers Perrin ("Towers Perrin," "we" or "us"), to perform consulting services. Please review the letter and, unless you have questions or concerns we need to address, indicate your acceptance by signing the enclosed copy and return it promptly to me. The terms on which we are undertaking this assignment are as follows:

1. **Services and Fees** — In connection with Smith’s consumerism and open enrollment initiatives for 2007, Towers Perrin agrees to provide the consulting and graphic design services described in the table below (more detail on the services is provided in the attached communication strategy). The associated fees for each service are also outlined.

<table>
<thead>
<tr>
<th>Phase I – Education:</th>
<th>Consulting Fees</th>
<th>Graphic Design Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication strategy and initial planning meeting</td>
<td>$13,500</td>
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</tr>
<tr>
<td>Newsletter</td>
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<td>$4,950</td>
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<td>Phase II – Enrollment:</td>
<td>Consulting Fees</td>
<td>Graphic Design Fees</td>
</tr>
<tr>
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</tr>
<tr>
<td>HRA promotion</td>
<td>$29,700</td>
<td>$12,260</td>
</tr>
<tr>
<td>Enrollment kit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postcards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: If Smith would like to refresh the brand, the cost would be $8,200. This includes the refreshed design, as well as any work required in the layout of existing pieces (enrollment guide, postcards, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DVD</td>
<td>$29,300</td>
<td>$2,480</td>
</tr>
<tr>
<td>Note: production costs for the DVD are estimated to be $20,000 - $25,000. Quotes will be obtained and shared with Smith.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Management*</td>
<td>$17,700</td>
<td>N/A</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>$106,200</td>
<td>$19,690</td>
</tr>
</tbody>
</table>

*Our project management fees are 20% of all costs. If services are decreased, the project management cost decreases accordingly.

These fees above do not include printing estimates. Once we receive your confirmation on services, we will provide estimates to you.

2. **Approach** — For each deliverable, we will provide three drafts for your review before releasing the final. If you have multiple reviewers commenting on your materials, please provide one set of consolidated edits to us. To help us keep the project moving smoothly, we will conduct weekly status calls with you.
3. **Timeliness** — The time frames set forth in the Scope of Work represent our good faith estimate of the periods required to perform the Services, and we will diligently seek to meet them. Our estimate assumes that you will take, in a timely fashion, whatever actions you need to take to support our work.

4. **Standards of Performance** — Towers Perrin will perform the Services in accordance with the following standards:

   — We will assign to our project team members of our staff who, in our judgment, have adequate education, training or experience to perform the tasks assigned to them.

   — Our Services will be performed in a professional manner.

   — When working “on-site” at your premises, members of our project team will conduct themselves in accordance with your policies respecting the conduct of your own associates, provided that you communicate those policies in advance to our project manager.

   — The work product we deliver to you in connection with the performance of the Services will not infringe any intellectual property right of any third party.

   — For the duration of this project, Towers Perrin: (a) will comply with all material federal, state and local laws applicable to, and (b) will obtain from the appropriate public authorities all material registrations, permits and licenses required for, the conduct of our business operations in connection with this project.

5. **Fixed Fee** — Your payment will be on a fixed fee basis. Our charges will consist of the following components:

   — A fixed fee, for the items you agree to receive as shown in the Services section of this document. The fees in the Services section include an administrative component to offset non-itemized expenses related to our performance of the services, such as routine black and white copying/printing, telephone and facsimile services. This administrative fee is equal to six and one-half percent (6-1/2%) of our hourly time charges.
— Reimbursement, at cost, of direct expenses reasonably incurred by us in connection with the performance of our Services, such as travel and other vendor expenses

— The amount of any tax or similar assessments levied or based upon our charges or the provision of the Services.

6. **Invoicing and Payment** — We will bill you for the services each month as they become due, with all other charges shown separately (such as travel and vendor expenses). At your request, we will submit reasonable documentation to verify any reimbursable direct expense that exceeds $100. If you have any questions about any of our invoices, you must notify us within 30 days from the date of the invoice.

Invoices are due upon receipt. Any charge or portion of a charge outstanding 30 days after the date of the invoice will be subject to a late charge, which you agree to pay, equal to the lesser of 1.0 percent or the maximum allowed by law for each month that payment remains outstanding, beginning from the date of the invoice.

6. **Out-of-Scope Services** — If you would like us to perform the Services differently than contemplated in the Scope of Work, or to perform additional consulting services that are not contained within the Scope of Work, we would be happy to consider your request. If the scope of the different or additional services can be clearly defined, such services will be done on a fixed fee basis. Otherwise, we will charge for the different or additional work scope based on our hourly rates. Prior to commencing any such work, we will promptly notify you that we consider the requested services to be out-of-scope. If the additional fee is estimated to be $3,000 or less, we will proceed without providing a fee quote. If the additional fee is estimated to exceed $3,000, we will provide a fee estimate. We will make all reasonable efforts to provide you with this estimate within 72 hours of our determination that the work is out-of-scope, and we will commence work on your approval.

7. **Client Information** — To enable us to perform our Services, you will promptly provide us with such direction, materials, information and access to your representatives as we reasonably request. Please note that we do not take responsibility for verifying the accuracy or completeness of information supplied to us by you or your representatives. If we receive inaccurate, incomplete or improperly formatted information, any additional time and expenses required to correct the information will be billed to you as additional services outside the Scope of Work.

8. **Nondisclosure** — Each of us (“Recipient”) agrees to take reasonable precautions to ensure that it does not disclose to any third party any information that the other
9. **Limitation of Liability** — The liability of Towers Perrin, our affiliates, employees, actuaries, agents, and brokers, whether arising in contract, tort (including negligence) or otherwise, in connection with any of the Services provided to you under this agreement, shall in no event exceed the total amount of the fees paid to us for those Services.

In no event shall Towers Perrin, our affiliates, employees, actuaries, agents, and brokers be liable to you for any incidental, special, punitive, or consequential damages of any kind (including, without limitation, loss of income, loss of profits, or other pecuniary loss); or for any losses or expenses resulting from any inaccuracy in or omission from any information or data supplied to us in connection with the Services provided under this agreement.

10. **Work Product** — The Services we perform, together with the work product we deliver to you, are provided for your internal use, solely for the intended purpose, and may not be referenced or distributed to any other party without our prior written consent. You will own the copies of the work product delivered to you and have the right to use, reproduce and adapt it for internal purposes within your organization, once your obligations under this letter have been met. You will retain ownership of any information specific to your employees or business operations contained in our work product. We will retain all intellectual property rights (including patents, trade secrets and copyrights) in our work product, including derivative works of it, and may use it for any purpose consistent with the terms of this agreement.

11. **Termination** — Either of us may terminate this agreement at any time by providing at least 30 days prior written notice to the other. Upon termination, we will determine in consultation with you the portion of any fixed fee or retainer earned to that date. Any amount determined to be due to either party will be paid within 30 days. For work performed on an hourly rate basis, you agree to pay us for all direct expenses and charges accrued for Services performed up to the effective date of termination. The provisions entitled “Nondisclosure,” “Limitation of Liability,” “Work Product,” and “Disputes/Waiver of Jury Trial” will survive termination.
12. **Insurance** — During this engagement, Towers Perrin will maintain insurance policies relating to professional liability, worker’s compensation and general liability in such amounts as we determine to be appropriate for our business activities.

13. **Independent Contractor** — All of the Services provided by Towers Perrin will be rendered in our capacity as an independent contractor. None of the terms set forth in this letter agreement will be interpreted to create any agency, master-servant, employment or any other relationship between you and Towers Perrin or any of our employees. Towers Perrin will determine the time, place and manner in which the Services are performed. We do not accept any fiduciary or trust responsibilities in connection with the performance of the Services.

14. **Disputes/Waiver of Jury Trial** — The parties agree that they will work in good faith to resolve any disputes arising under this agreement. If a dispute cannot be resolved by the parties, the matter will be submitted to nonbinding mediation before the parties pursue any other remedies.

   The parties hereby waive their respective rights to trial by jury of any claim or cause of action arising out of or in any way connected with this agreement or the Services performed thereunder.

15. **General** — This letter sets forth the entire agreement between you and Towers Perrin concerning this engagement and replaces and supersedes all other agreements of any kind in relation to the Services. Any amendment of it must be in writing and signed by both parties. If any provision set forth in this agreement is invalid or unenforceable under any law, the provision will be enforced to the extent permitted by law. Neither party will be responsible for any delay or failure in the performance of its duties caused by forces or events beyond its reasonable control. Neither party may assign any rights set forth in this agreement to any third party without the other’s written consent. The validity and interpretation of the provisions of this agreement will be governed by the laws of Ohio, without regard to any provisions governing conflict of laws, and both parties agree that the exclusive jurisdiction and the proper venue for any action brought hereunder will be the courts of that state or the federal courts sitting there.

We look forward to your approval so we can commence work on the project.

**TOWERS, PERRIN, FORSTER & CROSBY, INC.**
(TRADING AS TOWERS PERRIN)
By: ____________________________  ____________________________

[Name], Principal         [Name], Senior Consultant

Accepted and agreed:

SMITH

By: ____________________________

Print Name: ____________________________

Print Title: ____________________________

Date: ____________________________

DVR: sem

cc: Mr. John J. Doe — Towers Perrin
    Mr. Erik S. Doe — Towers Perrin
    Ms. Kathryn Knost — Towers Perrin
    Ms. Rita M. Perkins — Towers Perrin
    Ms. Eileen M. Speidel — Towers Perrin
Appendix G – Smith HR Generalist Briefing Presentation
The purpose of this presentation is to provide a high-level overview of the health care changes for 2007. We’d like to share our communication strategy with you. Please know that more details will follow this preview at a later date.
Medical Plans for 2007

We will continue to offer 4 plans:

- Elite
- Gold
- Kaiser (can open an HSA)
- HDHP

• Silver Plan will no longer be offered
• HDHP will be a new option for associates

The Medical Plans for 2007 are the Elite Plan, Gold Plan, Kaiser, and a new High Deductible Health Plan. We’re really excited to offer the High Deductible Health Plan as an option for our associates because it gives them the opportunity to participate in a Health Savings Account so that they may begin to save for their future retiree health care costs. In just a moment we’ll go over how the new HDHP works.

The Silver Plan will no longer be offered in 2007. Approximately five percent of associates were in the Silver Plan. This plan was eliminated because of the low enrollment. We believe that a high deductible plan (HDHP) enables us to offer a more competitive product that will be more attractive to our associates.

Each of the four plans has varying premiums and out-of-pocket costs based on the level of coverage it provides – just like before. We want everyone to clearly understand how the plans differ and the steps they need to take to choose the plan that is right for them and their families. This enrollment we will provide a great deal of education helping associates understand how each plan is different so that they can make the best choice for their personal situation.

Let’s spend a little time going over how the new HDHP works.
The HDHP is a consumer driven health care option with a low premium but a higher cost at the point of care. Its monthly premium will be the lowest of all of the four options. Its deductible will be $1,500 for associate only coverage, $3,000 for associate and spouse or associate and children and $4,500 for full family coverage. This plan would likely appeal to a person who wants lower fixed costs (premiums), is willing to pay more when they actually need care, and wants to save money for future health care expenses – such as expenses in retirement. This may be an attractive plan for many of our associates if they look at the financial impact of a health care plan.

Once you satisfy the deductible, the plan pays 100% of the cost of an in-network covered service. Once you reach the deductible, the plan pays the remaining qualifying expenses for the year.

As I mentioned, those who join the HDHP are eligible to open a Health Savings Account (HSA). A Health Savings Account (HSA) is an account that lets you save toward your health care expenses on a tax-free basis. You fund the HSA with your own money and it is invested and earns interest. You can draw upon your HSA savings throughout the year to help satisfy your deductible, or to help pay for your other out-of-pocket costs. Alternatively, you can save your HSA money to take advantage of the tax-free growth and build your health care savings for retiree expenses.

You will get in-depth training on how the HDHP and HSA work at the end of August.
Over the last year, we have made a number of changes to our retirement benefits, which stress personal responsibility. The introduction of the HSA actually fits as part of that strategy. An HSA allows associates to save for their health care needs for today and for retirement. It offers associates a tax-free method to save for health care in retirement – and is a more tax effective method for saving than a 401(k) because HSA savings are never taxed as long as the money is used for health care expenses.

As we communicate the health care changes for 2007, we will do so as part of an education process that encourages associates to look at their total situation – their health care needs as well as other financial needs today and when they retire.

We want to educate associates that their total income can be broken down into their health care costs for today, health care savings for retirement, retirement income savings through vehicles like the 401(k), and then their general living expenses. By taking advantage of the HSA, associates who do not need to spend much in health care now, will have a tax-free way to build their future savings.
We believe in helping our associates stay healthy. As a first step, we introduced a Health Risk Assessment in 2005, but we did not receive the desired response and participation from associates.

In response to associate feedback about the Assessment, we are introducing a new Health Risk Assessment that will be easier to use. We want to promote the assessment, and we are looking to you to help us encourage associates to participate. At the same time, we will educate them on how participating is not only important to their health, but it could also save their life. To encourage participation, associates will get a chance to receive a free airline ticket.

By participating in the Health Risk Assessment, associates can lower their monthly premium for the medical plan. The reduction is $7 per month if the associate takes the Health Risk Assessment and $14 if the associate and spouse take it. Likewise, if only the spouse takes the Health Risk Assessment, the reduction is $7 per month.
### Communication Timeline & Next Steps

<table>
<thead>
<tr>
<th>Date</th>
<th>Communication Piece</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug. 14</td>
<td>Senior Mgt Briefing</td>
</tr>
<tr>
<td>Aug. 29</td>
<td>Mailing to homes: Associate Newsletter #1: Your Health, Your Retirement, Putting It Together</td>
</tr>
<tr>
<td>Aug. 29</td>
<td>HR Generalist Training</td>
</tr>
<tr>
<td>Sept. 15</td>
<td>Mailing to homes: Associate Newsletter #2: Choosing the Right Plan</td>
</tr>
<tr>
<td>Sept. 25</td>
<td>Lunch &amp; Learn Presentation on HSA (Given by HR Generalists)</td>
</tr>
<tr>
<td>Sept. 15 – Oct. 31</td>
<td>Health Risk Assessment Promotions</td>
</tr>
<tr>
<td>Oct. 12</td>
<td>Mailing to homes: Associate Enrollment Kit</td>
</tr>
<tr>
<td>Week of Oct. 16 &amp; Oct. 23</td>
<td>Associate Enrollment Meetings</td>
</tr>
</tbody>
</table>

As you can see, we have developed a comprehensive communication plan to help educate everyone on the new program. (Review timing and communication pieces.)
For this open enrollment, we are asking that you understand the changes so that you can, in turn, educate associates and answer their questions. You will also need to support the changes.

We’re looking to you to help associates link their benefits today with the future (health care and retirement). We’re hoping that you can be as pleased with this new health plan offer as we are and are willing to support the changes being made. Also, the more familiar you are with the high deductible health plan, the HSA, and our other plans, the easier it will be for you to answer any associates’ questions. The lunch & learn presentations, lead by you, will be an opportunity to provide associates with details about how the new HDHP and the HSA work. This will also provide associates with an opportunity to get answers to their questions.
Questions? Comments?

We’ll be addressing more of the change details in the August training – stay tuned!
Appendix H – Smith Introductory Letter and Newsletter
Dear Fellow Associates:

Smith is proud of its history of providing competitive benefits to associates, and we are committed to continuing that tradition. As you look at our benefits program for 2007, you will find a blend of both familiar and new programs. Together, our plans continue to provide you and your family with important, competitive coverages.

The benefit changes we’re making for 2007 are designed to further our commitment to helping associates take charge of their health:

- **A new medical plan option** in 2007 will provide you and your family with coverage at a very low monthly contribution.

- The **ability to save for your health care needs** both today and in retirement through the introduction of a new account call a Health Savings Account (HSA). The HSA is only available if you elect our new medical plan.

- **A new Health Risk Assessment program** (administered by a new company) can help you understand how healthy you are today – and simple steps you can take to improve it.

- The opportunity to **reduce your monthly contributions** for medical coverage if you take the Health Risk Assessment by November 1. And, if your spouse takes it – you can save even more!

These changes make it easier for each of us to take more personal responsibility for our health and our health care. And, these changes are designed to work with other benefit changes effective January 1, 2007. Earlier this year, we introduced our new Retirement Savings Plan, which blends your personal responsibility to save for retirement with Smith’s company contributions to your account. Our new Health Savings Account, which is paired with our new medical option, gives you a tax-efficient way to save for your health care expenses in your active and retirement years. This means your Retirement Savings Plan and the Health Savings Account can actually work together to help you plan for your retirement needs.
We recognize that having a choice in benefits is important to everyone, That is why we will continue to offer our offer the Elite Plan, the Gold Plan, and the Kaiser Plan along with our new medical plan. I encourage each of you to take some time to think about how you use your health care benefits in a year and determine the plan that is best for your needs. No matter what your health care situation is, Smith is pleased to provide you with the tools and education to enable you to buy the right plan, use your plan wisely, and lead a healthy lifestyle.

The enclosed newsletter describes some of the important changes we are making to our health care program for 2007. Because these changes require you to think carefully about your health care needs, we are sending this newsletter in advance of Open Enrollment to give you extra time.

I am excited about the changes we are making to our benefits for 2007 and the positive directions we are taking to help our associates stay healthy. I encourage you to read this newsletter carefully so you will understand the changes and what they may mean to you and your family.

Sincerely,

[John Doe
Vice President, Human Resources]
Your Health Care Needs Today and Tomorrow

Your health care needs today are probably very different from what they’ll be tomorrow. Are you prepared for the future? Many times we think of health care as something we need today and retirement income as what’s needed tomorrow. But, money that may not be needed for health care immediately can be put away for health care needs in retirement.

It’s important that you have enough money saved to help cover your out-of-pocket health care costs in retirement. The choices you make now can impact the amount you have later.

One way Smith is helping you plan for your long-term needs is through our new Health Savings Account (HSA). This new account lets you save money each year on a tax-free basis toward your current health care expenses. And, any money you don’t use rolls over for you to spend in the future – even in retirement. To be eligible for this new account, you must enroll in our new plan, the Healthy Plus Plan.

How do you know if the new Healthy Plus Plan and the HSA are right for you? Take some time and think about how you use your health care coverage each year – and how much you spend in monthly contributions, the deductible, and other out-of-pocket expenses each year. Are you buying a more expensive level of coverage and yet rarely using the plan in a year? If so, you may save money by selecting the new Healthy Plus Plan and putting the difference in a Health Savings Account to help cover your out-of-pocket expenses. And any left over money in your HSA rolls over to be used in the future, including retirement.

As you make your health care enrollment decision for 2007, think not only about the upcoming year, but about your health care needs down the road and into retirement. Money that you don’t need for health care now might be better used to save for your health care and retirement income needs for the future.
Your Medical Plan Options for 2007 [head 1]

Your medical options include:
- Elite Plan
- Gold Plan
- Healthy Plus Plan
- The Kaiser Plan (available to people in [Ohio])

With the **Elite Plan**, you will pay the highest amount in monthly contributions. When you enroll, you’ll choose a primary care physician (PCP) from the [Anthem] network. With this plan, you can see any network provider at any time without a referral from your PCP and receive in-network benefits. When you get care, you’ll pay the least of the plan offerings.

With the **Gold Plan**, your monthly contributions are between the Elite Plan and the new Healthy Plus Plan. You can choose to receive care from a provider in the [Anthem] network or a provider outside the network. If you enroll in this plan, you do not need to select a PCP. When you get care, you’ll pay less than the Healthy Plus Plan, but more than the Elite Plan.

The **Healthy Plus Plan** offers you the lowest monthly contributions – and the coverage is free to you and your spouse if you take the Health Risk Assessment by November 1! You must meet your deductible before you and the plan share expenses. With this plan, you will pay more out of your pocket (compared to the other plans) before the plan begins to pay benefits. If you enroll in this plan, you are eligible to open a Health Savings Account (HSA). The HSA is a way for you to save money to cover your deductible and to save toward future health care costs tax-free.

With the **Kaiser Plan**, you’ll choose a primary care physician (PCP) from the [Anthem] network when you enroll.

[Callout: **Save On Your 2007 Monthly Contributions**
*Take the Health Risk Assessment by November 1*]

That’s right, you can **save $7 each month** on your medical contributions by simply taking the Health Risk Assessment by November 1.

Want to save more? Have your spouse take the Health Risk Assessment by November 1 and save another $7 off the monthly medical contribution for your spouse’s coverage through Smith.

[Callout: **Buy Well, Use Well, Live Well.**]

**Become a Better Health Care Consumer** [head 1]

No matter which plan you choose, it’s to your advantage to become a better consumer of health care. Here’s how to do it:
- Buy well: Choose the right coverage for you and your family by carefully considering your health care needs.
- Use well: Get the right care at the right time in the right setting for the right cost.
- Live well: Make healthy lifestyle choices to avoid costly health problems.

**Buy Well: Weighing Contributions and Out-of-Pocket Costs**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Payment Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elite Plan</td>
<td>Requires the least payment when you get care</td>
</tr>
<tr>
<td>Gold Plan</td>
<td>Requires less out of your pocket than the Healthy Plus Plan but more than the Elite Plan when you get care</td>
</tr>
<tr>
<td>Healthy Plus Plan</td>
<td>Requires the highest payment when you get care</td>
</tr>
</tbody>
</table>

The Kaiser Plan is also available to associates in [Ohio]. Its cost is [$xx] and requires [$xx] in payment when you get care.

Please take the time to consider the total cost you will spend through each plan before selecting the one that is best for you and your family.

**[Callout: Did You Know?]**

As you think about which plan is right for you, consider these Smith 2005 [confirm] statistics:

- XX% of our associates and their covered families had no health care claims
- XX% of our associates and their covered families had health care claims of $500 or less
- XX% of our associates and their covered families had health care claims of $1,000 or less

Typically, 20% of people covered in our plans account for about 80% of our total costs, due to a major illness or injury. The remaining 80% use much less of our health care dollars. Knowing your typical health care claims in a year can help you select the appropriate amount of coverage for your needs – without overpaying (buying too much) for coverage.

**How the New Healthy Plus Plan Works** [head 1]
The Healthy Plus Plan offers you the lowest monthly contribution but with a higher deductible. Let’s take a closer look at the features of this new plan:

<table>
<thead>
<tr>
<th>Your Monthly Contributions</th>
<th>How the Plan Works</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Associate Only:</strong> $7/$0 if you take the Health Risk Assessment</td>
<td><strong>Your Deductible</strong> (what you must pay in expenses before the plan pays benefits)</td>
</tr>
<tr>
<td><strong>Associate + spouse:</strong> $14/$0 if you take the Health Risk Assessment</td>
<td>$1,500 single</td>
</tr>
<tr>
<td><strong>Associate + children:</strong> $XX/$XX if you take the Health Risk Assessment</td>
<td>$3,000 family</td>
</tr>
<tr>
<td><strong>Family:</strong> $XX/$XX if you take the Health Risk Assessment</td>
<td><strong>Coinsurance</strong> (What the plan pays once you meet your deductible)</td>
</tr>
<tr>
<td><strong>Family:</strong> $XX/$XX if you take the Health Risk Assessment</td>
<td>Plan: 80%</td>
</tr>
<tr>
<td></td>
<td>You: 20%</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-pocket maximum</strong> (Once you pay this amount out of your pocket in a year, the plan pays 100% of covered expenses)</td>
</tr>
<tr>
<td></td>
<td>$5,000 single</td>
</tr>
<tr>
<td></td>
<td>$10,000 family</td>
</tr>
</tbody>
</table>

Is this plan right for you? It may be if you are willing to shift your costs from fixed monthly premiums to paying costs when you actually use the plan. Why would this make sense?

- **Lower monthly contributions** – Your monthly contributions for any of our medical plans are fixed, no matter how much you use a plan in a year. And if you don’t use your medical plan much, paying a high monthly contribution may not make sense.

Instead, consider enrolling in the Healthy Plus Plan and saving the difference in monthly contributions to help cover your out-of-pocket costs.

And, if you take the Health Risk Assessment (HRA) by November 1, coverage for you is free under this plan. Have your spouse take the HRA too and his/her coverage through Smith is free under this plan.

- **Ability to save tax free for your medical expenses for today and tomorrow** – If you enroll in the Healthy Plus Plan, you can sign up for a Health Savings Account (HSA), which allows you to save money on a tax-free basis to help you cover your health care expenses.

Only you know if the new Healthy Plus Plan is right for you. Think about how you use the plan, then make the decision that is right for you.
How the New Health Savings Account Works

A Health Savings Account (HSA) is an account you use to pay for current health care costs and/or save for your health care costs in retirement. The account allows you to:

- Save for your current and future health care costs – tax free
- Earn tax-free interest on your savings
- Withdraw money for health care expenses on a tax-free basis
- Rollover any money you don’t use in any year – and you can use that money for future health care expenses – including health care expenses in retirement

The chart below shows how the Health Saving Account works with the Healthy Plus Plan to help you manage for your out-of-pocket expenses.
With an HSA, you’re in control of how your health care dollars are spent. The chart below outlines how the HSA works and the features it offers you.

**[graphic option #1]**

<table>
<thead>
<tr>
<th>Set Up An HSA</th>
<th>Contribute To Your HSA</th>
<th>Use Your HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open a [vendor] HSA by completing the [vendor] application in your enrollment kit.</td>
<td>Contribute up to the Healthy Plus Plan deductible amount ($1,500 per person, $3,000 per family) in your HSA each year.</td>
<td>Simply use your debit card to pay qualified medical expenses for you and your family – the money is automatically withdrawn from your account. Details will be in your enrollment kit.</td>
</tr>
</tbody>
</table>

**Receive the Benefits of an HSA**

- Your HSA deposits are tax-free, saving you money.
  - Payroll deductions are deposited before taxes [confirm].
  - You indicate other deposits when you file your taxes.
- You earn tax-free interest on your account – allowing it to grow faster.
- Any money left over at year-end rolls over to the next year – allowing you to build your HSA account for future health care expenses.
- When you die, your account stays in your estate and is passed on to your beneficiaries.

**[Sidebar/Callout] – Needs a head???
Instead of spending more money in the form of higher monthly medical contributions, you can keep your savings in an account that belongs to you to be used now or in the future.**

**Examples**

It’s up to you when you use your HSA; you don’t need to use it during the year. In fact, you’ll earn more money in the long run if you keep the money in the HSA and save if for use in retirement.
The example and corresponding graph below shows the growth of an HSA account over time. For this example, the assumptions are:

- Every year Mary contributes the maximum in her HSA, which is $1,500.
- She never takes any money out of the HSA. So, in year two, her balance is $3,000.
- In year 3, Mary deposits $1,500.
- She continues to deposit another $1,500 each year and earns a 4% interest rate. 
  [We've used 4% as a conservative interest assumption. She would have even more if the interest rate is higher.] See how her HSA grows over the years. [John: Please confirm the numbers for the 4% rate (numbers are rounded).]

<table>
<thead>
<tr>
<th>Year</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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</tr>
<tr>
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<tr>
<td>5</td>
<td>$9,130</td>
</tr>
<tr>
<td>6</td>
<td>$11,060</td>
</tr>
</tbody>
</table>

Since money in your HSA can grow with interest on a tax-free basis, it’s to your advantage to save as much money in your HSA as you can.

[Callout: Why is the Healthy Plus Plan Deductible So High?]

You may be wondering why the Healthy Plus Plan deductible is so high. To qualify for a Health Savings Account (HSA), a person must participate in what the government calls a “high deductible health plan” and they define the deductible and out-of-pocket limit required for the plan to qualify.

Our plan is designed to qualify under government regulations as a high deductible health plan – allowing you to participate in a Health Savings Account.
What Is the Health Risk Assessment (HRA) [head 1]

We want to help you stay healthy! A great way for you to learn more about your personal health situation is to take a Health Risk Assessment. The HRA is a screening that helps you identify health risks and prevent illness down the road, which could save your life.

Our HRA partner this year is WellCorp, a company known for its excellent, easy-to-use program and great associate service.

During the HRA, you will:

■ [Receive a clinical screening and complete an online questionnaire (only takes [xx] minutes)]
■ [Get a personal health report providing lab results and information on your health risks and ways to avoid them]
■ [Receive (a possible) call from a nurse who reviews your results and provides information to help you improve your health]

The results from your questionnaire and any conversations you have with nurses are kept strictly confidential; they will not be shared with Smith.

Be sure to sign up for your HRA today! [It is scheduled for [dates] at [location/or website address]. If you and/or your spouse complete the HRA by November 1, you will reduce your medical premium by $7 per month!]

How You Can Buy Well [head 1]

To choose the best health care plan for you and your family, consider how much health care you will need in 2007. Consider the following questions to help you estimate your costs:

■ Are you a low user of health care services (meaning you have an annual check up and maybe one or two other services)?
■ Do you have a few ongoing health care problems?
■ Do you require frequent care for chronic conditions?
■ How much do you expect to spend on health care in 2007 for your annual deductible, coinsurance, and other health care benefits?

We encourage you to take the time to evaluate all four of our medical plan options. Consider the total cost you will spend through each plan before selecting the one that is best for you and your family. Often times we select a health care plan based on the most expensive plan rather than selecting the plan that best meets our needs and is the best “buy” based on how much we use the plan.

The following examples may help you to see where you might fit best: Erin is single and healthy. She doesn’t anticipate needing to go to the doctor at all in 2007, except for an annual checkup. Erin would like a plan that offers a low monthly contribution. She is also interested in saving up money for health care expenses she
may have down the road. Erin chooses the Health Plus Plan because it has the lowest monthly contribution and offers the Health Savings Account.

Mark has two young children and a wife with a chronic medical condition. He knows how much his health care expenses are each year and has looked at what his “total cost” will be for each of the plans – including his monthly contributions, deductibles, coinsurance and copays. Based on how much he typically spends, Mark decides to join the Elite Plan because it provides him with the lowest total cost – even when he factors in the higher monthly contributions.

Julie has a husband and one child. They expect to have only minimal medical expenses and a few prescription drug expenses in 2007. She has looked at how much they typically have in health care claims in a year – including her monthly contributions. While her lowest cost would be with the Healthy Plus Plan, she isn’t quite ready to take on the higher deductible amount. Therefore, she decided to go with the Gold Plan for 2007.

[Include if we want a description for Kaiser Plan.] Ben is a single parent with one child. Usually, they’re both healthy, but they tend to go to the doctor for a lot of minor illnesses, such as colds and flu. They also make routine visits for preventive care. Ben chooses the Kaiser Plan because their family doctor is in the Kaiser network, and he’s comfortable with using only Kaiser providers. The plan’s no deductible and low out-of-pocket costs fits his budget well, and for what’s not covered by the plan, he will be reimbursed from the money he contributes to the Health Care Reimbursement Account.

[Question for John Fazio: Since not using eValuator, is there another cost estimator tool they can use?] How You Can Use Well [head 1]

Once you select a medical plan, it is up to you to use the plan well. In other words, get the right care, at the right time, in the right setting, for the right cost. When you do these things, you get appropriate care and help curb rising health care costs.

Here are a few quick tips for using the plan well:

- **Save the emergency room for emergencies.** Using the emergency room is very costly. Before getting in your car to go, think about whether the problem might be handled through an urgent care center, by your primary doctor or even over the phone from a registered nurse (the 24-hour NurseLine is completely free and confidential).

- **Use a primary doctor for more.** Many times primary doctors perform the same services as specialists – for less. Ask your primary doctor if he or she performs Pap smears, dermatology services and podiatry services.

- **Buy generics.** When it comes to drugs, just because something costs less doesn’t mean it’s any less effective. Generic drugs contain the same active ingredients as their brand-name counterparts.
Use the mail-order drug program. If you have a chronic condition, using the mail-order drug program makes good sense. Not only is the mail-order drug program more convenient since drugs are delivered to your door, the overall cost you pay is significantly lower than if you bought the same drugs at the pharmacy.

Seek out the best doctor or hospital for your needs. Be educated about the experience that doctors and hospitals have in treating conditions that you or your family members have. By using a quality provider, you will receive the care you need the first time and avoid unnecessary or problematic treatment.

Ask questions of your doctor. Be informed about your condition. When your doctor recommends a test, drug or service, be sure you ask if there are any equally effective but less expensive alternatives.

Stay in-network. Always make sure that the doctor, hospital or facility you go to is inside the plan’s network. That way, you’ll take advantage of negotiated rates.

How You Can Live Well [head 1]

Your level of commitment to live a healthy lifestyle significantly weighs on your willingness to be a health care consumer. There are many simple things that you can do to live a healthier lifestyle. It starts with good nutrition and exercise, but it also involves preventive care, understanding current health risks, and preventing and treating health conditions.

Preventive Care [head 2]

By using preventive care today, you could avoid expensive treatments and health services down the road. Smith recognizes the value in preventive care and that’s why all of our medical options include preventive care coverage. Be sure to ask your doctor about recommended preventive care for your age, gender, and family history.

Understanding Health Risks [head 2]

You are highly encouraged to complete a Health Risk Assessment – which is a completely confidential questionnaire about your health can family history. The assessment identifies your health risks and advises you on how to decrease those risks. To take the Health Risk Assessment, simply [do what.] Results will not be shared with Smith.

[Callout: What to get a lower medical premium? Don’t forget to participate in the Health Risk Assessment! It’s easy to do so just take the Health Risk Assessment and you’ll save $7 per month on your medical premium!]

Treating Health Conditions [head 2]

No matter which medical plan you choose, you have access to these helpful wellness programs to help you get the care you need and treat health conditions:

- [24-hour Nurse Line]
- [Care Management]
- [Smoking Cessation Program]
- [Others?]
Appendix I – Smith Work Plan
## Smith

### Consumerism Education and Open Enrollment Work Plan

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Activity</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newsletter</td>
<td>Towers Perrin provides draft 1 to Smith</td>
<td>August 15, 2006</td>
</tr>
<tr>
<td></td>
<td>Smith provides edits on draft 1 to Towers Perrin</td>
<td>August 22</td>
</tr>
<tr>
<td></td>
<td>Towers Perrin sends Newsletter to layout</td>
<td>August 25</td>
</tr>
<tr>
<td></td>
<td>Towers Perrin provides draft 2 in layout to Smith</td>
<td>September 1</td>
</tr>
<tr>
<td></td>
<td>Smith provides edits on draft 2 to Towers Perrin</td>
<td>September 7</td>
</tr>
<tr>
<td></td>
<td>Towers Perrin provides draft 3 to Smith</td>
<td>September 12</td>
</tr>
<tr>
<td></td>
<td>Smith provides edits on draft 3 to Towers Perrin</td>
<td>September 14</td>
</tr>
<tr>
<td></td>
<td>Towers Perrin sends final to Smith</td>
<td>September 15</td>
</tr>
<tr>
<td></td>
<td>Smith provides sign-off</td>
<td>September 18</td>
</tr>
<tr>
<td></td>
<td>Towers Perrin sends to printer</td>
<td>September 19</td>
</tr>
<tr>
<td></td>
<td>Newsletter is mailed to homes</td>
<td>September 25</td>
</tr>
<tr>
<td>Deliverable</td>
<td>Activity</td>
<td>Timing</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Health Risk Assessment/</td>
<td>Towers Perrin provides draft 1 of HRA tri-fold [or wrap] and all poster</td>
<td>TBD</td>
</tr>
<tr>
<td>Promotion</td>
<td>and table tents to Smith</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Smith provides edits on draft 1 to Towers Perrin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Towers Perrin sends all to layout</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Towers Perrin provides draft 2 to Smith</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Smith provides edits on draft 2 to Towers Perrin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Towers Perrin provides draft 1 of ad on intranet and trinket with</td>
<td></td>
</tr>
<tr>
<td></td>
<td>advertisement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Smith provides edits on draft 1 to Towers Perrin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Towers Perrin provides draft 3 to Smith (HRA tri-fold, etc.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Towers Perrin provides draft 2 to Smith (ads)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Smith provides edits on draft 3 to Towers Perrin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Smith provides edits on draft 2 to Towers Perrin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Towers Perrin provides final to Smith</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Towers Perrin provides draft 3 to Smith (ads)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Smith provides sign-off (HRA tri-fold)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Smith provides edits on draft 3 to Towers Perrin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Towers Perrin provides final to Smith (ads)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Smith provides sign-off</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Towers Perrin sends poster/table tents to printer; ads to Smith</td>
<td></td>
</tr>
<tr>
<td></td>
<td>intranet coordinator</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Towers Perrin sends HRA tri-fold to printer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Towers Perrin order trinkets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Towers Perrin provides poster/table tents to Smith HR coordinator</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HRA tri-fold is mailed to homes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Poster/table tents are posted</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ad on intranet is posted</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trinkets are mailed</td>
<td></td>
</tr>
<tr>
<td>Deliverable</td>
<td>Activity</td>
<td>Timing</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------------------------</td>
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<td>August 31, 2006</td>
</tr>
<tr>
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<td>Smith provides edits on draft 1 to Towers Perrin</td>
<td>September 7</td>
</tr>
<tr>
<td></td>
<td>Towers Perrin sends kit to layout</td>
<td>September 12</td>
</tr>
<tr>
<td></td>
<td>Towers Perrin provides draft 2 of kit (in layout) and letter to Smith</td>
<td>September 19</td>
</tr>
<tr>
<td></td>
<td>Smith provides edits on draft 2 to Towers Perrin</td>
<td>September 22</td>
</tr>
<tr>
<td></td>
<td>Towers Perrin provides draft 3 to Smith</td>
<td>September 27</td>
</tr>
<tr>
<td></td>
<td>Smith provides edits on draft 3 to Towers Perrin</td>
<td>September 29</td>
</tr>
<tr>
<td></td>
<td>Towers Perrin sends final to Smith</td>
<td>October 3</td>
</tr>
<tr>
<td></td>
<td>Smith provides sign-off</td>
<td>October 4</td>
</tr>
<tr>
<td></td>
<td>Towers Perrin sends to printer</td>
<td>October 5</td>
</tr>
<tr>
<td></td>
<td>Kit and letter are collaged with other materials and mailed to homes</td>
<td>October 12</td>
</tr>
<tr>
<td><strong>DVD</strong></td>
<td>Towers Perrin provides draft 1 to Smith</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td>Smith provides edits on draft 1 to Towers Perrin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Towers Perrin provides draft 2 of script to Smith</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Smith provides edits on draft 2 to Towers Perrin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Towers Perrin provides draft 3 of script to Smith</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Smith provides sign-off</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Towers Perrin provides script to DVD producer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Towers Perrin and DVD producer shoot in Cincinnati</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Towers Perrin and DVD producer shoot in Cleveland</td>
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<tr>
<td></td>
<td>DVD is sent for duplication</td>
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</tr>
<tr>
<td></td>
<td>DVD is mailed with enrollment kit</td>
<td></td>
</tr>
<tr>
<td>Deliverable</td>
<td>Activity</td>
<td>Timing</td>
</tr>
<tr>
<td>-------------</td>
<td>----------</td>
<td>--------------</td>
</tr>
<tr>
<td>Post Card</td>
<td>Towers Perrin provides draft 1 of all post cards to Smith</td>
<td>September 14, 2006</td>
</tr>
<tr>
<td></td>
<td>Smith provides edits on draft 1 to Towers Perrin</td>
<td>September 20</td>
</tr>
<tr>
<td></td>
<td>Towers Perrin sends post card to layout</td>
<td>September 25</td>
</tr>
<tr>
<td></td>
<td>Towers Perrin provides draft 2 of post card (in layout) to Smith</td>
<td>October 2</td>
</tr>
<tr>
<td></td>
<td>Smith provides edits on draft 2 of post card to Towers Perrin</td>
<td>October 5</td>
</tr>
<tr>
<td></td>
<td>Towers Perrin sends final draft to Smith</td>
<td>October 10</td>
</tr>
<tr>
<td></td>
<td>Smith provides sign-off</td>
<td>October 11</td>
</tr>
<tr>
<td></td>
<td>Towers Perrin sends post card to printer</td>
<td>October 12</td>
</tr>
<tr>
<td></td>
<td>Post card is mailed to homes</td>
<td>October 19</td>
</tr>
</tbody>
</table>

OPEN ENROLLMENT PERIOD: October 16 – October 31
Appendix J – Miller Enrollment and Consumerism Education Strategy
Miller

Enrollment and Consumerism Education Strategy

July 25, 2006
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INTRODUCTION AND BACKGROUND

Miller has a strong interest in increasing the level of education its employees have when it comes to making health care buying decisions. In general, many employees do not seem to understand how their current programs work. Many also do not take personal responsibility for their health care – and because of that, are not making smart buying decisions.

Beginning with this enrollment season, Miller will begin providing consumerism education both to its employees and to its management team. As part of the move to consumerism, Miller will offer a new high deductible health plan (HDHP) option in addition to its current medical plan. The new HDHP will encourage employees to be more responsible consumers and make educated decisions when it is time to use the plan. The HDHP will provide employees with an excellent opportunity to save toward their future health care costs on a tax-free basis through a Health Savings Account (HSA).

In addition to the new HDHP, employees will experience the following changes beginning January 1, 2007:

- A new opportunity to choose the health care plan that’s right for them
- A new contribution structure
- Introduction of a spousal surcharge
- Earlier enrollment to coincide with a January 1 effective date for benefits
- A new process for returning enrollment forms (must be submitted directly by the employee instead of through a local administrative assistant)
- Introduction of confirmation statements
These changes will help to move Miller employees into a culture of taking greater responsibility for their health and their health care. Our communication strategy will encourage employees to choose the right coverage for their needs, make smart decisions when it is time to buy health care, and to lead a healthy lifestyle.

In this document, Towers Perrin outlines how we will assist Miller in providing a communication strategy for implementing a HDHP with an HSA as part of the benefits enrollment for 2007 which will include significant HR training materials. Our communication strategy for this project is divided into the following sections:

- Objectives
- Audience Analysis
- Challenges
- Themes
- Media Plan
OBJECTIVES

Our communication plan will support the following long-term objectives that you have identified:

- To raise the level of understanding among employees about how the plans work.

- To get employees to make an informed decision when choosing their health care plan and when they need care.

- To encourage employees to take more ownership and responsibility for their health care (includes taking advantage of self-service options, like myUHC.com).

- To get employees to keep an open mind about change and not “run away” from the HDHP without taking the time to understand it and the advantages that the HSA has to offer (begin with the selling points of the HSA and then provide HDHP details).

- To encourage employees to make decisions based on their situation over the long-run, not just for the upcoming year.

- To decrease the entitlement attitude that is prevalent among employees and for employees to appreciate the great benefits Miller offers.

- To view all benefits as a part of a package – not just health care as a separate plan.

- To raise the level of knowledge about free consumerism programs available to employees (for example, the NurseLine).

- To help employees understand the true cost of health care (not just the employee’s cost).

- To encourage employees to ask questions of their doctor about the services they need to receive.
To get more employees (and spouses) to attend health care meetings.

To gain support from the management team for health care initiatives and for the team to follow-through with the recommended health care communication strategy.

To encourage employees to keep themselves as healthy as possible and be proactive about doing so.

To increase enrollment in the Flexible Spending Accounts and get employees to use the FSAs more appropriately.

Moving employees from being a passive participant in health care buying decisions to being an engaged consumer is a process that takes longer than one enrollment season. It typically takes several years of education. However, this enrollment season, we will begin the consumerism education process and will make significant progress toward achieving the objectives outlined above.

Before and during enrollment season, our efforts will focus mainly on educating employees about how their health care plan options work so that they can choose the best plan for their personal situation. Then, in 2007, we recommend that Miller take advantage of the communication materials that UnitedHealthcare offers to you at no additional charge. These materials will promote consumerism and wellness programs that employees can take advantage of to become better consumers of health care.
AUDIENCE ANALYSIS

Reaching the right people with messages about Miller’s new health plan is critical to the communication program’s success. The first step in this process is identifying the critical audiences who need to understand the new program. The critical audiences for this communication program include:

- **Employees** — Miller is unique because of its different employee groups by location (Home Office, LW, CinAir, Atlanta, Dallas/Minneapolis, Florida, and B & J). In general, employees have little knowledge about their health care plan. Consumerism concepts will be new to most employees.

- **Management Teams** — The regional managing partners, partners, and VP of finance are an extremely important audience for us to reach with our communication plan. The entrepreneurial spirit of each office makes commonality for initiatives like the health care program communication challenging. We run the risk of the management teams at some offices going their own direction instead of following the communication strategy that we set for Miller as a whole. Since employees will follow the lead of the management team at their respective location, it is imperative that we gain support from the management team and get a commitment that they will follow through with our communication strategy.

- **Gatekeepers at LW and CinAir** — These individuals are responsible for the flow of information to and from employees at their locations. We will need to involve these individuals with our communication strategy so that they can help support it and therefore encourage employees at their locations to make educated decisions this enrollment and throughout the year.

- **Spouses** — Many times spouses, not employees, are making the health care decisions for their families. For that reason, communication about choosing the right plan, using the plan wisely, and living a healthy lifestyle needs to involve both the
employee and the spouse. To reach family members, materials will be sent to the home and any face-to-face or web meetings should involve spouses.

- **Tom Williams** — As CEO of Miller and the person that the management team reports to, Tom is the key person to stimulate change among the management team. We will ask Tom to communicate with the management team about the importance of supporting our communication strategy. We recommend that an introductory letter to employees about the program come from Tom so that they will read the letter and understand the significance of this change.

- **Providers** — Providers can be an excellent partner to employees in helping them navigate through the health care system in order to make smart health care buying decisions. We will provide employees with pre-developed provider materials to educate them about the new HDHP so that they may assist their patients with questions they may have about the plan.

- **The Williams Family** — These individuals are owners of Miller and the dependents of those owners, not employees. We may want to provide this group with a courtesy advance preview of materials that we send out to employees so they may be kept in the loop about key changes in the organization.

- **Over-Age Dependents** — These are dependents that are out of high school but still may be covered under the plan. We will not communicate directly to these dependents but we will make sure that the employees understand the coverage rules for this group (e.g., eligibility for coverage and the point at which coverage ends).
CHALLENGES

Identifying the challenges associated with introducing a new program allows Miller to develop and implement strategies to overcome or reduce the effect these issues can have on the success of the project. The challenges we have identified for each phase are detailed below:

- **Working within the Company’s ‘entrepreneurship’ attitude.** Miller’s organization structure promotes the ideals of individuality and entrepreneurship. As a result, each office location acts according to its own set of “rules.” This type of operational management may work effectively for business ventures but could jeopardize the success of our health care communication program. We will need to gain commitment from the management team to carry out the roles required of them to support the overall strategy.

- **Overcoming adversity to change.** Employees may at first reject the idea of a new type of plan that requires them to pay more at the point of care. And, the concept of thinking of health care as their responsibility may also be new to them. We need to continue to explain the positive benefits offered with the new plan and continue to reinforce messages about taking ownership in their health care needs.

- **Gaining an understanding from employees about how the plan works.** The HDHP and HSA are brand-new concepts for Miller employees. The communication vehicles will provide explanations in simple, everyday language, using several examples to illustrate how employees can use the plan. We will want to help people understand the difference between the current plan and the HDHP with an HSA option. Since Miller identified an education need around health care even before the introduction of the HDHP, we will be sure to provide a base-level understanding of how health care plans work before digging deeper into the plan features of the HDHP.
Helping people to choose the right plan for their health care needs. Until this year, employees had one health care option. Introducing the HDHP gives employees the option to choose which plan works best for their needs and their families. We want to educate employees on factors to consider in selecting a plan, which should help people take a closer look at the HDHP option or their spouse’s options.

Getting people to make the time to understand the health care changes. People need to make the time to attend meetings, read their enrollment materials, and really care about their health care coverage.

Getting to the family member who really makes the health care buying decisions. If the spouse of an employee is the primary decision maker when it comes to health care, we will need to make sure that person receives the education about the changes and about being an improved health care consumer.

Employees comparing the plan to that of friends/family and neighbors. People often have false information about the coverage that their friends and family have. Miller’s program is very competitive in the marketplace. We will set the record straight by providing information about the competitiveness of our new program in our communication.
THEMES

A few possible themes for the consumerism education program are:

- Be smart, be involved, be well
- Buy well, use well, live well
- Take charge of your health
- Be educated and be in charge
- Invest in your health
# MEDIA PLAN – ENROLLMENT COMMUNICATION

<table>
<thead>
<tr>
<th>Timing</th>
<th>Media</th>
<th>Audience</th>
<th>Purpose</th>
<th>Key Messages</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/21</td>
<td>Email from Tom to Management Team (Towers Perrin provides first draft; Miller finalizes)</td>
<td>Management Team</td>
<td>To ensure that the management team supports this change, attends management training, and follows through on their role in the communication strategy</td>
<td></td>
</tr>
</tbody>
</table>
  - We are making important changes to our benefits program that will require your employees to make educated decisions about their healthcare.
  - Your support for the change and ability to help educate employees is critical to the success of this program.
  - I need for each of you to attend a Web meeting on 8/30 to go over the changes and understand the important role you will play. Please make every effort to attend and inform me personally if you are unable to do so.
  - [Contact person] will send a follow-up message with logistics for the meeting. |
<table>
<thead>
<tr>
<th>Timing</th>
<th>Media</th>
<th>Audience</th>
<th>Purpose</th>
<th>Key Messages</th>
</tr>
</thead>
</table>
| 8/30   | Web meeting for Management Team | Management Team | To educate the management team about the changes and get their commitment to support the program and serve as an important resource for employees to go to with questions | - We are offering a new consumer-driven health plan option which will give employees a unique opportunity to save for retiree health care expenses on a tax-free basis. Miller is one of many organizations who have moved to this type of plan. Here's how the new program works...  
- For the first time, employees will have a choice between health care options. They will need to carefully think about the health care needs of their family before choosing the right plan for them.  
- Here are the other significant changes that will occur for 2007 and the rationale behind them  
  — January 1 effective date (allows employees to compare coverage to that offered by the spouse's employer)  
  — Contribution structure change and introduction of spousal surcharge (much of our cost is for spouse coverage and our first responsibility is to our employees)  
  — New process for returning enrollment forms (ensures privacy and reinforces the idea of taking personal responsibility)  
  — Introduction of confirmation forms (gives employee the peace of mind that the correct selection was submitted)  
- We are working to provide education about the health care programs to our employees as well as to encourage employees to take on more responsibility for their health  
- You have a very important role in helping employees understand these changes  
  — Make sure you study the changes so that you can answer employee questions with confidence  
  — When employees ask about the changes, be sure you show support and refer to Q&As for questions you aren't sure about. |
<p>|        | 30 minute presentation about the changes, your role, and communication strategy |               |                                                                         |                                                                                                                                            |
|        | Q&amp;A (distributed by email) |                |                                                                         |                                                                                                                                            |
|        | Miller presents (with Towers Perrin support, if desired) |                |                                                                         |                                                                                                                                            |
|        | (Towers Perrin provides first draft; Miller finalizes) |                |                                                                         |                                                                                                                                            |</p>
<table>
<thead>
<tr>
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<th>Key Messages</th>
</tr>
</thead>
</table>
| 9/7    | Introductory Letter from Tom (Towers Perrin provides first draft; Miller finalizes) | Employees and Spouses | To show that health care is a very important priority to Miller and to be sure that employees make smart health care decisions at enrollment and throughout the years. | ■ We're proud of our tradition of providing very competitive health care benefits to you.  
■ We are pleased to provide you with a new health care option that is very popular in the marketplace. It gives you the chance to open a Health Savings Account so that you can save for your retiree health care on a tax-free basis. The plan has a low contribution and requires you to pay more at the point of care.  
■ We are committed to helping you make the right plan choice for your personal situation this enrollment. We will also give you the tools to help you get the most out of the plan when it’s time for you to receive care. And, we’re glad to offer two good plans that provide you with the opportunity to prevent illness and stay healthy throughout the year.  
■ Look for education sessions about the new HSA as well as enrollment materials that will provide details on each of your benefit options.  
■ Beginning this year, enrollment will occur earlier from Oct. 30 - Nov. 10. This will enable you, if you have a working spouse, to adequately compare Miller’s coverage to that of your spouse’s employer. |
| 9/13   | HSA Lunch and Learn Promotional Email and/or bulletin board notice if feasible (Miller drafts and finalizes with consultation from Towers Perrin) |        |        | ■ Have you heard the buzz about HSAs? Learn all about them!  
■ Don’t miss this chance to learn about how to save money!  
■ Attend the HSA Lunch and Learn at [date], [time]. [Miller: Do you want to provide an incentive to attend?]  
■ Be sure to invite your spouse to attend. Many times spouses make the enrollment decisions. |
<table>
<thead>
<tr>
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<th>Audience</th>
<th>Purpose</th>
<th>Key Messages</th>
</tr>
</thead>
</table>
| Week of 9/18    | HSA Lunch and Learn Sessions               | Employees and Spouses | To educate employees on what an HSA is, how it works, and its advantages | - An HSA is like a 401(k) for your health care. You can put away money on a tax-free basis. The account grows with interest over time. You can use the money in your account for your health care needs now or in retirement!  
- You need to be a participant in the HDHP in order to open an HSA. Here's how the HDHP works and how the HSA coordinates.  
- Here's an example of showing account growth over time  
- Here's how to enroll in the HSA; here's how to put money in the HSA; here's how to get money out of the HSA |
<p>|                 | Presentation                               |                     |                                        |                                                                              |
|                 | HSA Pocket Guide (from UHC)                |                     |                                        |                                                                              |
|                 | Manager kicks off meeting, Sandra presents, Towers Perrin is in attendance, if Miller desires |                     |                                        |                                                                              |
|                 | (Towers Perrin provides two drafts and finalizes) |                     |                                        |                                                                              |</p>
<table>
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</tr>
</thead>
</table>
| Mailed to homes on 10/25      | Enrollment Packet            | Employees and Spouses | To provide the deepest level of detail about all the changes happening this enrollment with particular focus on the choosing the right medical plan for an employee’s needs. | - Take responsibility for your health – make the right choice for you and your family [provide details about plan choices]  
- All About the HSA  
- Tips to save money in the plan  
- Tools to help you be a wise consumer of health  
  — myUHC.com  
  — NurseLine  
  — Disease Management Program  
- About the new contribution structure and spousal surcharge  
- Take charge of your enrollment  
  — Don’t miss the date  
  — Be sure to provide your form to HR directly (not through a local administrative assistant)  
  — Look for your confirmation form to make sure your elections were submitted correctly  
- What’s the FSA and how do you use it?  
  — Take advantage of FSA direct deposit (where to go to get a form)  
- Don’t forget about your other benefits  
  — Complete a beneficiary designation form  
  — Enroll or increase your contribution to the 401(k) |
<table>
<thead>
<tr>
<th>Timing</th>
<th>Media</th>
<th>Audience</th>
<th>Purpose</th>
<th>Key Messages</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/26</td>
<td>Enrollment Meeting</td>
<td>Employees and Spouses</td>
<td></td>
<td>Don’t forget: Enrollment is earlier this year, corresponding with enrollment of many other employers. This will allow you to adequately compare Miller’s coverage to that of your spouse’s employer.</td>
</tr>
<tr>
<td></td>
<td>Email or Letter</td>
<td></td>
<td></td>
<td>Make the right enrollment decision for you and your family</td>
</tr>
<tr>
<td></td>
<td>(Miller develops and finalizes)</td>
<td></td>
<td></td>
<td>Attend the enrollment meetings on [date] and [time]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Be sure to invite your spouse to attend. Many times spouses make the enrollment decisions.</td>
</tr>
<tr>
<td>Week of 10/30</td>
<td>Enrollment Meetings</td>
<td>Employees and Spouses</td>
<td></td>
<td>Overview of the changes and rationale</td>
</tr>
<tr>
<td></td>
<td>Sandra leads enrollment meetings with support from UHC if needed</td>
<td></td>
<td></td>
<td>How the new HDHP and HSA work</td>
</tr>
<tr>
<td></td>
<td>(Miller develops materials for presentations with consultation on key messages from Towers Perrin)</td>
<td></td>
<td></td>
<td>Things you can do to make smart health care decisions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Steps you need to take to enroll</td>
</tr>
</tbody>
</table>

Open Enrollment Period: October 30-November 10
<table>
<thead>
<tr>
<th>Timing</th>
<th>Media</th>
<th>Audience</th>
<th>Purpose</th>
<th>Key Messages</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/8</td>
<td>Don't Forget to Enroll Email</td>
<td>Employees</td>
<td></td>
<td>▪ Don't miss the deadline to enroll. If you do, you will receive no medical coverage.</td>
</tr>
<tr>
<td></td>
<td>(Miller drafts and finalizes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mailed to homes on 10/17</td>
<td>Employees and Spouses</td>
<td></td>
<td>▪ Your enrollment elections are...</td>
</tr>
<tr>
<td></td>
<td>Confirmation Statement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Miller drafts and finalizes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/18</td>
<td>Letter to providers (will be contained in an email sent to employees in HDHP)</td>
<td>Providers</td>
<td>To help doctors understand the new plan so they might help employees use the plan in the best manner</td>
<td>▪ Your patient is a participant in a consumer driven plan called the High Deductible Health Plan. Here’s how the plan works.</td>
</tr>
<tr>
<td></td>
<td>(Miller drafts and finalizes with consultation from Towers Perrin)</td>
<td></td>
<td></td>
<td>▪ Because your patient will be responsible for significant out-of-pocket costs, it is in their best interest to purchase health care in the most cost-effective way possible, without compromising the quality of care they receive.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>▪ We would appreciate your being a resource to your Miller patient in providing helpful information on how to purchase health care services most cost-effectively.</td>
</tr>
</tbody>
</table>
MEDIA PLAN – CONSUMERISM EDUCATION IN 2007

To keep employees educated about the resources available to them to make the right health care buying decisions, we recommend taking advantage of several communication vehicles offered through UnitedHealthcare beginning in 2007. It’s important to provide steady communication, but not to overwhelm employees with too much – especially since they are not accustomed to receiving this type of material. For year one, we recommend a strategy that focuses on educating employees about the advantage of enrolling in myUHC.com and in taking advantage of the NurseLine. Suggested deliverables and their recommended timing are shown below:

<table>
<thead>
<tr>
<th>Month</th>
<th>Deliverable</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>myUHC.com Flyer</td>
</tr>
<tr>
<td>March</td>
<td>Nurse Line postcard</td>
</tr>
<tr>
<td>May</td>
<td>myUHC.com payroll stuffer</td>
</tr>
<tr>
<td>July</td>
<td>Nurse Line flyer/email</td>
</tr>
</tbody>
</table>

If you identify certain disease states that you are interested in helping to manage, we can help you identify materials from UnitedHealthcare that will be appropriate to send to employees and the suggested timeframe for doing so.

For enrollment in 2008, you might consider doing a campaign around getting employees to take the Health Risk Assessment on myUHC.com. Enrollment time is usually a good time to get employees interested in taking the Health Risk Assessment. You
could provide an incentive to participate in the Health Risk Assessment such as an iPod, free vacation day, or a decrease in their medical contribution.
Same Great Benefits – With A New Process

Beginning January 1, 2007, Jacobs is making an important change to the billing process – that is how your medical claims will be processed. While the billing process is changing, the amount you receive in benefits will not change. And, you can continue to use the same doctors, hospitals, and other facilities that you do today.

Beginning January 1, 2007, all your claims for medical benefits will be processed by Coventry (who owns FirstHealth). They will process your claims for Medicare Parts A and B, as well as for your Jacobs benefits. Don’t worry, your Medicare coverage continues, but where those claims are processed is changing to Coventry. Your prescriptions drug benefits will continue to be processed by Express Scripts.

Be sure to read this brochure carefully to fully understand what this new process means to you.

Coventry…a Name You Trust

Jacobs has used Coventry (who owns FirstHealth) to process your claims for several years and they provide first-class service for our retirees. When Jacobs was looking to make changes to the billing process for our retirees, we asked Coventry to help us. Jacobs also looked at several other organizations, just to assure we were making a good choice. After a careful comparison, we were convinced that Coventry was the best choice for this new billing process.

A Closer Look At The Program Today and Tomorrow

Let’s take a look at the process for how your medical bills are currently paid versus how they will be paid beginning January 1, 2007.

Today, when you have a medical plan claim, your bills are first sent to Medicare, and they pay their portion of the cost. Then, the remaining balance is sent to Coventry to be paid under Jacobs’s retiree medical plan.

Beginning January 1, 2007, your doctor or other health care provider will send your claim to Coventry. Then, Coventry, under their agreement with Medicare and Jacobs, will process your entire claim – all in one step. The result is that you will receive the same amount in benefits – but all in one easy step.

Medicare ensures that Coventry will pay the same benefit amount as Medicare A and B. And Jacobs ensures that you will receive the same amount that you currently do under the
Jacobs plan. So, under this new process, you receive the same benefits as you receive now.

[Graph option] I like this one

**Paying Your Claims [Note: May need to be an insert due to different versions.]**

Under the new billing process with Coventry, your medical benefits combine Medicare A and B with Jacobs’s supplemental benefits into one plan.

The example below shows how your claims are paid today and how they would be paid with the new process. This example assumes a hospital stay (under Part A) and prescription drug expenses.

As you can see from this example, you will receive the same benefit amount under the new billing process that you currently receive. Your out-of-pocket costs will not change as a result of this new billing process.

**[Need a new example from George?]**

<table>
<thead>
<tr>
<th>Today's Payment Program</th>
<th>Tomorrow's Payment Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total claim = $3,000</strong></td>
<td><strong>Total claim = $3,000</strong></td>
</tr>
<tr>
<td>Medicare Part A pays = $2,048</td>
<td>Coventry will process the claim with the total benefits paid equaling the same amount you would receive under Medicare A, B and Jacobs’s plan.</td>
</tr>
<tr>
<td>Medicare Part B pays = $0</td>
<td></td>
</tr>
<tr>
<td>Jacobs’s Plan pays = $856.80</td>
<td></td>
</tr>
<tr>
<td><strong>Total Amount Paid By Medicare and Jacobs: $2,904.80</strong></td>
<td><strong>Total Amount paid by First Health/Coventry: $2,904.80</strong></td>
</tr>
<tr>
<td>You pay = $95.20</td>
<td>You pay = $95.20</td>
</tr>
<tr>
<td>Total Rx Claim = $500</td>
<td>Total Rx Claim = $500</td>
</tr>
</tbody>
</table>
Jacobs pays = $450

Your Rx portion to pay = $50

It is important to note that because your claim will be processed in one step with Coventry (vs. the current two-step process with Medicare and Coventry), they will process the claim differently than before. However, the end result will be the same benefit payment as before.

Coventry will pay your medical claims and Express Scripts, our current prescription drug administrator, will continue to pay your prescription drug benefits. Your claims will no longer need to go through Medicare first and then go through Coventry. This new process reduces paperwork and minimizes coordination between administrators.

Why this change…and why now? Quite simply, recent Medicare Legislation (the same piece of legislation that approved Medicare Part D prescription drug coverage) contained a provision that allows individual insurance companies – such as Coventry – to pay Medicare claims for Medicare. Medicare pays Coventry for the cost of the claims, as well as an administrative fee. Medicare is allowing insurance companies to pay these claims with the expectation that insurance companies can be more efficient in the administrative process, and, over time, help Medicare save money on these costs.

Understanding the Program

To help you better understand how the process is changing, the chart below shows different features of your medical program and how they will work beginning January 1, 2007.

<table>
<thead>
<tr>
<th>Feature</th>
<th>Today’s Program</th>
<th>Tomorrow’s Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Coverage</td>
<td>■ Medicare Benefits – Paid as defined by Medicare</td>
<td>■ New process will pay the same claim amount as you receive under the current plan</td>
</tr>
<tr>
<td></td>
<td>■ Jacobs Benefits – Paid as described and defined in current plan materials</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>■ Benefit Amount – Paid as described and defined in current plan materials</td>
<td>■ Benefit amount remains the same and claims will be paid by Express Scripts</td>
</tr>
<tr>
<td></td>
<td>■ Claims paid by Express Scripts</td>
<td></td>
</tr>
<tr>
<td>Medical Administrator</td>
<td>■ Coventry for Jacobs’s benefit</td>
<td>■ Coventry will pay your claims under Medicare A and B, as well as the benefits provided by Jacobs</td>
</tr>
<tr>
<td></td>
<td>■ Medicare for Medicare A and B</td>
<td></td>
</tr>
<tr>
<td>Providers</td>
<td>■ Any doctor or hospital that accepts Medicare</td>
<td>■ Any doctor or hospital that accepts Medicare</td>
</tr>
<tr>
<td>ID Cards</td>
<td>■ Medicare</td>
<td>■ Express Scripts</td>
</tr>
<tr>
<td></td>
<td>■ Coventry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Express Scripts</td>
<td></td>
</tr>
<tr>
<td>Nurse Line and Illness</td>
<td>■ Not available</td>
<td>■ Available</td>
</tr>
</tbody>
</table>
Watch for Information from Coventry

Coventry will assume responsibility for your medical claims through their medical produce called Adventura® Freedom. You will receive information from Coventry with this name – so be sure to watch your mail.

[Sidebar]

Less paperwork –

Less paper, less hassle! You (or your doctor and/or hospital) will need to submit claims to only two insurance companies – Coventry for medical benefits and Express Scripts for prescription drugs. Right now, you are submitting your claims to three companies (Medicare, Coventry, and Express Scripts.)

Fewer medical ID cards –

You'll need only two cards with the new program – a Coventry card for medical and an Express Scripts card for prescription drugs. You won't need your Medicare card because Coventry is taking care of your Medicare claims for you. You will receive a new, combined Medicare/Coventry card (shown below) in December – well before the new effective date of January 1, 2007.]

[Place picture of ID card here.]

[End sidebar]

What if Medicare Changes?

If Medicare changes the rules in the future and does not allow private insurance companies, such as Coventry, to pay Medicare claims, Jacobs intends to revert back to the current program’s process where your claims under Parts A and B are processed by Medicare.

[Sidebar]

Same Benefits, New Process

Here’s the bottom line – a new process for paying claims with the same great medical benefits. Beginning January 1, 2007, your claims for Medicare and Jacobs medical benefits will be processed by Coventry. Your prescription drug claims will continue to be processed by Express Scripts. While Medicare is paying the cost of the claim, nothing will pass through Medicare anymore for claims administration.

[End Sidebar]
Enhancing Your Benefits

Coventry will also offer you two new features beginning January 1, 2007:

- **24-hour Nurse Line** – Coventry offers you the opportunity to call a toll-free phone number and talk with a Registered Nurse (RN) at any time of the day or night. The Nurse Line can help if you have a health care question, a question about your care, or if you need help determining where to go for appropriate care (a doctor’s office or an ER, for example).

- **Care Management** – If you have a long-term medical condition (currently defined as diabetes, congestive heart failure, end stage renal disease, coronary artery disease or COPD). Coventry offers a voluntary program – called care management – that provides you with the tips and advice to help you manage your health condition. If you agree to participate in this program, you will receive information on managing your condition, as well as the opportunity to talk with a Health Coach who can answer questions and provide helpful tips.

Callout: The 24-hour Nurse Line and the Care Management program do not replace the advice of your doctors. Rather, they are designed to provide you with additional information and an opportunity to ask questions.

Why Is Jacobs Changing?

Medicare can now pay insurance companies, such as Coventry, to administer their claims. The payment amount that Medicare will give Coventry to administer their claims is enough to reduce what Coventry is charging Jacobs to administer the Company’s portion of the medical claims. This is resulting in a savings estimated to be several million dollars for Jacobs. It is important to know that Jacobs’s savings are not being generated by reducing your retiree benefits – the amount of your benefit coverage remains the same.

As you already know, health care costs continue to increase each year. Today, Jacobs spends approximately $90 million to provide medical benefits for our retirees. This cost increases by about 10% each year – so next year Jacobs would face an additional $9 million to provide the same benefits. These increasing costs make it difficult for the Company to compete in the marketplace. Therefore, Jacobs continually looks for ways to save money without reducing retiree medical benefits.

Having Coventry process all our retiree medical claims (both Medicare and Jacobs’s benefits) is the perfect solution. Coventry can provide the right service at the right cost.

How To Enroll

You will be automatically enrolled in this new process, avoiding any unnecessary paperwork for you. It is that simple.

You will receive a new medical ID card from Coventry during December. This new card will direct your doctors/hospitals to send your claims for medical care to Coventry. You will no
longer need to show your Medicare card. For prescription drugs, continue to use your Express Scripts ID card. There’s no need for you to switch doctors or hospitals – if your doctor/hospital accepts Medicare, they are required to accept Coventry.

If you choose not to participate in the program, you will need to call Coventry at XXX-XXX-XXXX and request to be removed from this program. You should be aware that this new program with Coventry is Jacobs’s new health care program for retirees. Therefore, if you choose not to participate, you will remain in Medicare Parts A and B, but you will no longer be covered by Jacobs’s medical or prescription drug plan.

**If You Have Under Age 65 Dependents**

If you are covering anyone under age 65 through Jacobs’s medical plan, you will not move to this new billing process until the January 1 after the date all your covered dependents reach age 65. You will remain under the current billing process until that date. Jacobs is doing this for administrative ease.

**Attend a Retiree Meeting**

**Find Out More**

Jacobs will be sponsoring special meetings for our retirees who are moving to this new billing process. The meetings will be conducted in areas where we have a large concentration of retirees.

You will find included in this packet a listing of the cities and dates where these meetings will be conducted. To RSVP for a meeting, call.

These meetings will provide you with an opportunity to learn about this billing change and ask questions.

**About this Brochure**

This brochure describes the key features of the medical benefits provided through Coventry/FirstHealth. Every effort has been made to provide an accurate summary of the plan. However, a complete description will be provided through Coventry. If there is a conflict between these materials and the documents or contracts, the documents or contracts will govern. Jacobs reserves the right to amend, change or terminate its benefit plans at any time.