



BENEFIT *Advisor*

In This Issue

In this ninth issue of the McGrawWentworth Benefit Advisor for 2008, we discuss Medicare. Medicare seems simple enough, it is a government sponsored health plan for the aged or disabled. Unfortunately, Medicare is much more complicated than it seems.

This Advisor will dissect the different sections of Medicare, including Part A, B and D. It also discusses the plans that supplement Medicare and plans that can replace Medicare. Finally, we address administrative issues related to Medicare, including eligibility, enrollment and claims processing. Even if you are not close to becoming Medicare-eligible, you may have parents or employees impacted by Medicare that may need guidance.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGrawWentworth web site at www.mcgrawwentworth.com.

“Navigating Medicare”

Most people know that Medicare provides health benefits for anyone over age 65, the disabled and people suffering from end stage renal disease. Medicare seems simple enough when you hear about the benefits, but if you have ever had to help a parent or an employee with Medicare related issues, you realize Medicare is much more complicated.

In Michigan, the popularity of employer-sponsored retiree health care has meant many employees have been insulated from the growing number of complex retiree health care options. This growth in options is both good news and bad news. The good news is that seniors have more health coverage options available; the bad news is that the large number of choices available is confusing.

Now that many employers, including the Big Three, are eliminating or reducing retiree health care coverage for salaried retirees, retirees are asking about Medicare coverage and supplemental Medicare options.

This Advisor discusses the complexities of Medicare including:

- Traditional Medicare Benefits (Medicare Parts A and B)
- Medicare Part D Benefits (Outpatient Prescription Drugs)
- Supplementing Medicare

- Replacing Medicare (Medicare Advantage Plans)
- Eligibility
- Enrollment Process
- Premium Cost
- Claims Process



It would make sense that a plan providing health benefits to the elderly should be fairly straightforward; unfortunately, the Medicare program is difficult to navigate, but knowledge is power. Understanding the program details, requirements and enrollment process will enable you to explain Medicare issues to your current employees and your retirees.

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Traditional Medicare Benefits (Medicare Parts A & B)

Medicare Part A

In general, Medicare Part A covers inpatient hospital services including:

- Inpatient hospital care, in both critical care hospitals and inpatient rehabilitation facilities.
- Inpatient stays in a skilled nursing facility (for medically necessary reasons, not custodial

care) – with limits on the number of days covered.

- Hospice care services.
- Home health care services.

These services are not covered in full. Medicare beneficiaries pay a sizable deductible along with copayments for a host of services. What’s more, these amounts increase every year to keep pace with inflationary increases in medical costs. The 2008 and 2009 cost share amounts are shown in the table to the right.

The Medicare Part A benefit period begins with the first day of an inpatient stay and continues through the stay. The benefit period ends when the patient is able to go 60 days without an inpatient admission. If a patient is readmitted within 60 days, the second admission is considered part of the first benefit period. If a patient is readmitted after 60 days of no inpatient activity, a new benefit period begins and a new Part A deductible applies. There is no limit on the number of benefit periods Medicare will cover for a beneficiary.

Some additional information on Medicare Part A benefits follows:

- Durable medical equipment is covered with a 20% copayment.
- Medicare does limit coverage for stays in a psychiatric hospital to 190 days in a lifetime.
- The first 20 days of a stay in a skilled nursing care facility during a benefit period is not subject to any copayments.

For people in poor health, the cost sharing associated with Part A can be significant.

Medicare Cost Share Provisions		
	2008	2009
Part A Deductible for first 60 days of hospitalization in a benefit period	\$1,024	\$1,068
Daily copay for the 61st through 90th day of hospitalization in a benefit period	\$256	\$267
Daily copay for inpatient hospital stays beyond 90 days in a benefit period. The beneficiary has up to 60 lifetime reserve days	\$512	\$534
Copay for the 21st to the 100th day of inpatient skilled nursing home care in a benefit period	\$128	\$133.50

Medicare Part B

Medicare Part B covers medically necessary doctor and outpatient hospital services as well as a specific, not particularly comprehensive, list of preventive services. The annual deductible for the 2008 and 2009 calendar year is \$135. This amount also increases annually. Once the deductible is met, most services are subject to 20% coinsurance. The 20% coinsurance **does not** have an annual limit like many group health plans.

The coverage for preventive services is relatively new (many services were added in 2005). **The preventive services have limits in certain medical situations and certain timing requirements.** Some of the covered preventive services may include:

- Colorectal cancer screenings
- Diabetes screening and glaucoma tests
- Bone mass measurements
- Cardiovascular screenings
- Diabetes self-management training
- Flu shots and hepatitis B shots
- Welcome to Medicare physical (must be completed within first 6 months of coverage)

- Mammograms, pelvic exams and pap tests
- Prostate cancer screenings
- Smoking cessation counseling

Before seeking preventive care, a Medicare beneficiary should verify whether the specific services will be covered.

Medicare beneficiaries with chronic conditions could end up with sizable out-of-pocket costs even though they have Medicare Part B coverage.

Medicare Part D Benefits (Outpatient Prescription Drugs)

Medicare Part D is the newest portion of Medicare. It was launched in January 2006 and provides valuable benefits for outpatient prescription drugs. The decision to add outpatient coverage for prescription drugs was a long, hotly contested battle that lasted over a decade in Congress. Seniors needed coverage without a doubt, but prescription expenses are a sizable portion of most benefit budgets. The primary concern was the overall cost of the benefits now and in the future.

The Part D benefit plan is very complicated. The government does not directly administer the Part D benefits; instead it outsources the delivery of these benefits to private insurance carriers and administrators across the country. These private plans receive a stipend from the government and premiums from Medicare beneficiaries to fund the various plans.

The government designed a “standard” benefit plan. It begins with an upfront deductible, followed by a period of cost sharing and then a coverage gap, where the plan pays none of the cost and finally comprehensive coverage for catastrophic prescription drug expenses. The amounts are indexed annually to adjust for inflation. The standard plan design for 2008 and 2009 is shown in the table at the bottom of the page.

The difficult aspect of Part D is that the government allows private plans to create actuarial equivalent plans to deliver these Medicare benefits. Most Part D plans offer actuarial equivalent plans, usually using the tiered copay structure so familiar to employees. Even plans with a copay structure may still offer little or no coverage during the gap, or they may cover only generic drugs.

Most plans require Medicare beneficiaries to pay a premium for coverage. The premiums will vary from

carrier to carrier and plan to plan. In general, the more comprehensive the plan design, the higher the premium. The result is that many areas in this country have between 40 and 70 Part D plans to choose from – all with different plan designs, covered drugs and pharmacy management programs.

With so many options, how can seniors choose which option is best? When these plans were first introduced, this simple question posed a very big challenge. Today, however, the government’s Medicare website has a very useful search engine. Seniors can enter the specific prescription drugs they take and the pharmacies they use. The search engine then analyzes the drug cost and matches the beneficiary with the plan that has the lowest out-of-pocket cost.

The cost calculations take into account the monthly premium, the deductible, copays or any other cost sharing amounts and any expected costs the beneficiary may have to pay in the coverage gap. Medicare eligible married couples should run the search separately; in many cases, they may need to enroll in separate plans to maximize benefits.



The Part D plans all have annual open enrollment periods that run from November 15 to December 31. Open enrollment allows Medicare beneficiaries to switch to different plans. Beneficiaries may want to change plans when their prescriptions change during the year or their out-of-pocket cost seems too high.

The government also helps low income participants. This help ranges from paying the premium for a Medicare Part D plan to coordinating with Medicaid. Medicaid covers prescription drugs through special state-negotiated Medicare Part D plans offering comprehensive coverage and low out-of-pocket costs.

Although Medicare Part D provides much needed benefits, many Medicare beneficiaries struggle to understand these complex plans.

Supplementing Medicare

Because Medicare beneficiaries could be responsible for considerable out-of-pocket costs, many seniors purchase individual insurance plans to supplement Medicare benefits.

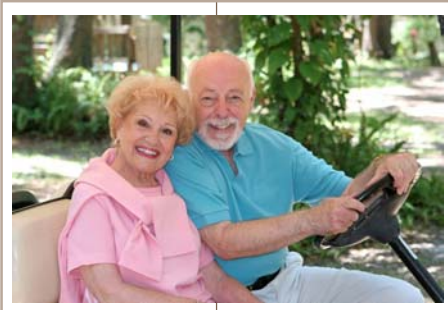
Policies that supplement Medicare are sometimes called Medigap plans. Private insurance carriers offer these plans and the federal government strictly regulates them. Most Medicare beneficiaries can choose from 12 different plan options. The plans differ depending on the expenses reimbursed under the plan. Some carriers will offer only one or two plan designs, but others may offer more options.

	2008	2009
Deductible	\$275	\$295
Initial Coverage Limit	\$2,510	\$2,700
Out-of-Pocket Cost Threshold	\$5,726.25	\$6,153.75
True Out-of-Pocket Limit	\$4,050	\$4,350
Generic and Brand copay after true out-of-pocket cost is met (greater of 5% of cost or copay amount)	\$2.25 generic/ \$5.60 brand	\$2.40 generic/ \$6.00 brand

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To be eligible for a Medicare supplement plan, you must be enrolled in Medicare Part B. The best time to enroll is either three months before or three months following your 65th birthday. During this time, an insurance company can't medically underwrite an applicant. Insurance carriers:

- Cannot refuse to sell you any Medicare supplement policy they offer.
- Cannot delay the date your coverage starts.
- Cannot charge you more for a Medigap policy because of your health or a pre-existing medical condition.



Medicare supplement policies can have pre-existing condition limitations. However, if you maintain creditable coverage through an employer's plan or another source and you do not have more than a 63-day break in creditable coverage, the plan must offset the pre-existing condition limitation by the length of your creditable coverage.

If you do not enroll in a Medicare supplement plan when you are initially eligible, you will have limited opportunities to do so. In the following situations, if you apply for the supplement policy within 63 days after you lose creditable coverage,

the carrier must sell you a Medigap plan (the carrier cannot refuse to cover you):

- If you enrolled in a Medicare Advantage plan and that plan discontinues coverage in your area or you move out of the plan's service area.
- If you are covered by an employer group health plan (as an active employee, as a COBRA continuant or as a retiree) and you lose that coverage.
- If you are enrolled in a Medicare Advantage plan or another Medicare supplement plan and you lose that coverage because the insurer hasn't followed the rules or has misled you

about coverage.

- If you are enrolled in a Medicare supplement plan and the insurance carrier goes bankrupt or if you lose coverage through no fault of your own.

The following are trial rights that Medicare supplement plans are temporarily offering:

- If you enroll in a Medicare Advantage plan when you are initially eligible for coverage and within your first year you

decide to switch back to traditional Medicare.

- If you drop a Medicare supplement policy to enroll in a Medicare Advantage plan and within your first year you decide to switch back to traditional Medicare.

The best time to enroll in a Medicare supplement plan is right after you enroll in traditional Medicare. There is not much opportunity to switch among various Medicare supplement policies. The state insurance law and the insurer carriers' policies determine when you can change Medicare supplement policies.

Medicare supplement policies can be rated in different ways:

- **Community-Rated:** Premiums are the same for everyone. The rate does not depend on age or health. Instead, the rate depends on the experience of the pool and participants are charged equally for the coverage.
- **Issue-Age Rated:** Premiums depend on the age you are when you buy the Medicare Supplement policy. Premiums can be increased annually, but they cannot be influenced by the age or health of an individual.
- **Attained-Age Rated:** Premiums depend on your current age; thus they are adjusted annually for age changes.

NOTABLE THOUGHTS

YOU MAY HAVE TO FIGHT A BATTLE MORE THAN ONCE TO WIN IT.

MARGARET THATCHER

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Many Medicare beneficiaries use Medicare supplement policies to help pay some of the out-of-pocket costs not covered by traditional Medicare. However, these policies cannot supplement Medicare Part D plans. Beneficiaries can search for Medigap plans available in their area on the Medicare website.

Replacing Medicare (Medicare Advantage Plans)

Medicare supplement policies are not the only way to help with Medicare expenses. A Medicare beneficiary can select a Medicare Advantage plan. Medicare Advantage plans replace Medicare. The plan can be an HMO, PPO or traditional fee for service arrangement. These plans look much more like the plans employees have available to them through their employers.

Since these plans replace Medicare, beneficiaries must first enroll in Medicare Part A and Part B. Beneficiaries continue to pay Part B premiums and those premiums are used to fund these plans. Medicare Advantage plans are funded through government subsidies, Part B premiums and health plan premiums. Plans covering prescription drugs are usually considered Part D prescription drug plans. Premium amounts may also depend on the prescription drug plan.

These plans offer comprehensive benefits that are more in line with the coverage Medicare beneficiaries received from their employers. Medicare Advantage plans offer clear benefits to members and employers. The following features may be very attractive:

- These plans offer a coordinated approach to Medicare Parts A, B and D. Traditional Medicare has many different compo-

nents that when combined provide comprehensive coverage. Most Medicare coverage beneficiaries work with different carriers for their Medicare supplement and the Medicare Part D coverage. Working with CMS and various carriers can be confusing.

Medicare Advantage vendors are responsible for administering Part A, Part B, Part D and supplemental coverage in one

comprehensive medical plan.

- In most cases, Medicare Advantage plan premiums and out-of-pocket costs for care can be significantly less. From a premium perspective, Medicare Advantage plans use government subsidies to deliver benefits. In addition, wrap benefits can be less expensive because the plan is managing all aspects of Medicare. In general, these plans cost less.
- These plans also offer care management and disease management programs to help people manage their health effectively. In addition, many of these plans offer more comprehensive wellness benefits.

While these plans offer many advantages over traditional Medicare, they do have potential drawbacks as well:

- Depending on the plan design, a beneficiary's provider choice may be limited. In an HMO, the beneficiary must typically choose a primary care physician and that physician must render any necessary care or refer the

beneficiary to another provider. In some of the HMO Medicare Advantage products, the network is even more restrictive than the network for group health plans. Many seniors may have established relationships with their various specialists, and the HMO plan

design may be too limiting in provider choice. The PPO plan design will have more freedom of choice, but seniors will need to make sure the

providers they choose are in the PPO network. Traditional plans offer the greatest freedom of choice in providers, but the services will be subject to reasonable and customary fees.

- The plan may require the beneficiary to enroll in a medical management or care management program.
- The opportunity to re-enroll in traditional Medicare is limited.

Most Medicare beneficiaries feel these minor drawbacks are definitely offset by the cost and benefit improvements Medicare Advantage plans offer.



Medicare beneficiaries have limited opportunities to enroll in these plans:

- **Initial Coverage Election Period:** The initial coverage election period is the period a newly eligible Medicare beneficiary can elect Medicare Advantage plans. The initial enrollment period is the same as the initial enrollment period for Part B. Beneficiaries can enroll 3 months before and 3 months after the date they are eligible for Part B. For example, if a person is eligible for Parts A and B of Medicare on September 15, the initial election period for Medicare Advantage plans would be during the 3 months before September, the month of September and the 3 months after September.
- **Annual Coordinated Election Period:** The annual coordinated election period is the annual period where a Medicare beneficiary can choose either a Medicare Advantage plan or traditional Medicare. The beneficiary can change Medicare Advantage plan options during this period as well. The annual coordinated election period runs from November 15 to December 31 each year with changes effective on January 1.
- **Special Enrollment Period:** A special enrollment period is allowed when circumstances change. For example, special

election is allowed when a plan withdraws from the market or a beneficiary moves out of the service area. The Medicare Advantage plans must promptly notify their members of any changes to their programs. In addition, members must promptly notify the plan of any status changes.

The enrollment rules under Medicare Advantage are more restrictive than many beneficiaries expect. Beneficiaries should review these plans carefully before they decide to enroll. Although Congress has reexamined these restrictive enrollment rules, the government has not yet acted to make the rules more flexible for anyone enrolling in or disenrolling from these plans.



Medicare Advantage plans have grown significantly since their launch in 2006 and Congress has hotly debated funding them. The stipends Medicare Advantage

plans receive are estimated to be almost 13% higher than the cost for providing coverage under traditional Medicare. The funding will be cut back in the future based on legislation passed this last July. How much the funding cut will impact these plans has yet to be seen. However, if their explosive growth continues, these plans will likely receive adequate funding and remain a viable private alternative to Medicare.

Eligibility

People become Medicare eligible in three ways:

- When they turn age 65 (coverage is effective the first day of the month in which they turn 65).
- Disabled people receiving social security disability income become eligible for Medicare after 24 months. In order to qualify for those disability income benefits, a person must first have been disabled and unable to work for at least 5 months. In reality, therefore, a disabled person becomes Medicare eligible 29 months after the date of disability. The 29 month period is made up of an initial 5-month waiting period for disability income and 24 months receiving income benefits.
- People with certain medical conditions are also eligible for Medicare. For example, people diagnosed with end stage renal disease are Medicare eligible but the effective date of coverage depends on their treatment. Details on end stage renal disease qualifications can be found at http://www.cms.hhs.gov/employerservices/04_endstagerenaldisease.asp.

People with ALS (amyotrophic lateral sclerosis or Lou Gehrig's disease) automatically become eligible for Medicare the month their disability income benefits begin.

Once a person becomes eligible, in many cases the individual must also enroll in certain parts of Medicare within a specific time frame. Enrolling in some parts of Medicare after that time frame may result in late enrollment penalties. The enrollment process can be complicated and it varies depending on an individual's situation. The next section describes the enrollment process in detail.

Enrollment Process

Anyone eligible for Medicare must actively enroll in order to receive coverage. Anyone enrolling after the deadline may have to pay late enrollment penalties.

The Medicare deadline for enrolling depends on many different factors. See tables on the right for more details.

In all situations, people need to enroll on time or they will face two problems:

1. Late enrollment penalties.
2. Limited ability to enroll in Medicare in the future.

Part B and Part D both have late enrollment penalties. For Part B employees must pay a 10% penalty for each 12-month period they do not have Part B coverage. If an individual is covered by an employer group health plan by virtue of current employment status, the late enrollment penalty is waived.

For Part D, Medicare beneficiaries must pay a 1% penalty as an additional premium for each month they do not maintain creditable prescription drug coverage.

Enrollment can be limited, too. Anyone enrolling late may need to wait:

- **Medicare Part B:** If you fail to enroll when you are initially eligible or within the 8-month special enrollment period after you lose employer group health plan coverage, you can enroll late only in the first 3 months of the year and coverage will

not go into effect until July 1 of that year.

- **Medicare Part D:** If you fail to enroll when you are initially eligible or within the 63-day special enrollment period after you lose creditable prescription

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Beneficiary Achieves Age 65	
Part A	A person is automatically enrolled in Part A of Medicare when he or she applies for income benefits with social security. Anyone choosing not to apply for income benefits can enroll in Part A at the local social security office.
Part B	A person is also automatically enrolled in Part B when he or she applies for income benefits. Beneficiaries can decide to disenroll from Part B.
Part D	A beneficiary must actively enroll in a Part D plan. The individual should choose the plan best suited to his or her situation. Most Part D plans allow people to enroll in writing, over the phone or via the Internet.
Beneficiary Works Past 65; Retires at Age 66	
Part A	An individual is automatically enrolled in Part A of Medicare when he or she applies for social security income benefits. Anyone choosing not to apply for income benefits can either enroll in Part A at the local social security office upon turning 65 or enroll in Part A when he or she retires.
Part B	Anyone automatically enrolled in Part B (after applying for income benefits) should disenroll if he or she is already covered through an employer. It makes sense to disenroll; the monthly Part B premium is sizable and the benefit will be minimal, with the employer's plan paying primary. A retiree has 8 months after losing coverage through an employer plan to enroll in Part B without having to pay a late enrollment penalty. The 8 months is measured from the time the person loses active group health plan coverage, not COBRA coverage.
Part D	Employees with creditable prescription drug coverage from an employer do not need to enroll in Medicare Part D plan. Again, most plans require a premium and the benefit is minimal because the group health plan pays primary. Retiring employees do not have to pay a late enrollment penalty if they enroll in a Part D plan within 63 days from the date they lose creditable coverage.
Disabled Beneficiary	
Part A	An individual is automatically enrolled in Medicare Part A after receiving the 23rd month of social security disability income.
Part B	The individual is also automatically enrolled in Medicare Part B after receiving the 23rd month of social security disability income.
Part D	The individual becomes eligible under the same terms as Parts A and B. The beneficiary, however, must actively enroll in a plan. If the disabled individual is eligible for Medicaid, the Medicaid plan will refer the individual to the Medicaid/Medicare Part D plan the state uses.

drug coverage, you will be able to enroll in Medicare Part D plans only during the annual open enrollment period, November 15 through December 31. Your coverage then becomes effective on January 1.

Enrollment deadlines are confusing and the consequences for not enrolling on time can be serious. The [Medicare.gov](http://www.Medicare.gov) website includes a tool to help potential Medicare beneficiaries determine their eligibility date.

Premium Cost

Medicare is not free and in many cases, beneficiaries are required to pay a premium:

- Part A is typically paid for through payroll taxes during an individual's working years. Once an individual contributes to Medicare program for 40 quarters, which is roughly 10 years, the individual and their spouse will generally be eligible for Part A premium free. If an individual does not meet the premium-free requirements, Part A coverage may be available for a cost:



- If you are 65 or older and did not work or did not work enough quarters.
- If you are disabled and are unable to return to work to meet your work quarter requirements.

The cost is not cheap. For 2008, the monthly premium is \$423. In 2009, Part A premiums will be \$443.

- Part B is a voluntary and requires monthly premium to participate. The monthly premium is increased annually. The Part B premium for 2008 is \$96.40. The premiums will not change in 2009. Part B premiums are also income based. If an individual reports more than \$82,000 in income or more than \$164,000 if reporting income jointly, the Part B premium will be higher. The higher premium can range from \$122.20 per month up to \$238.40 per month depending on income. In 2009, the income threshold for individuals will increase to \$85,000 or for couples filing jointly \$170,000. The income rated premiums will range from \$139.90 to \$308.30.
- Part D premiums depend on the private prescription drug plan the Medicare beneficiary

selects. The premium varies depending on the state and the benefits the plan offers. In Michigan plan premiums range from \$17.90 to \$97.50.

- Medicare Advantage plans typically charge premiums and the beneficiary still must pay the Medicare Part B premium. The premiums for all types of Medicare Advantage plans in Michigan range from \$0 to \$266 a month.

Beneficiaries have several options to consider for paying Medicare premiums. For Part B premiums, Medicare Part D options and Medicare Advantage plans premiums may be:

- Deducted through electronic fund transfer from a checking or savings account.
- Charged to a credit or debit card.
- Billed directly to the beneficiary (may require bi-monthly or quarterly billing).
- Deducted from the Social Security check.

Paying premiums can be confusing; in many cases, it may make sense to have the premiums deducted directly from the social security check.

Claims Process

The Medicare claims process has become much more sophisticated and automated over the last decade. Most claims are submitted electronically to Part A, Part B or the Medicare Advantage plan. Anyone covered by a Medicare supplement plan can authorize Medicare to submit claims directly to the Medicare

NOTABLE THOUGHTS

**IF YOU TELL THE TRUTH, YOU DON'T HAVE
TO REMEMBER ANYTHING.**

MARK TWAIN

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supplement carrier. This means, for the most part, seniors are not as involved with the claim process because it is handled automatically.

To streamline the process, Medicare sends beneficiaries an explanation of benefit letter once every quarter instead of sending out an explanation of benefits letter for every claim it processes. Also, Medicare's online system allows beneficiaries to view any current claims.

In addition, Medicare treats participating physicians differently from those that are non-participating. Medicare refers to these physicians as those accepting Medicare assignment or those not accepting Medicare assignment. The category affects how claims are processed:

Accepts Assignment or Participates with Medicare

- Physician will be paid directly by Medicare.
- Physician accepts the Medicare approved amount as payment in full for Medicare covered services.
- Physician may only charge a beneficiary the applicable deductible or copay amounts.

Does Not Accept Assignment or Does Not Participate with Medicare

- Physician collects payment from the Medicare beneficiary (Medicare sends payments to the beneficiary directly).
- Physician is not obligated to accept the Medicare approved amount as payment in full; the



provider is only permitted to charge 115% of the Medicare approved amount – this is referred to as the limiting charge.

Most health care providers participate with the Medicare program. Medicare has a search tool on its website to help people find participating providers.

Concluding Thoughts

The Medicare program is complicated. Seniors must understand the enrollment process, because failing to enroll in any part of Medicare on time can result in costly premium penalties.

With the state of retiree health benefits in Michigan in flux, many employers are discontinuing retiree health coverage. It is important to understand how Medicare works so that we can help our parents and our relatives understand and find workable coverage to supplement Medicare.

The good news is the government has many resources to help seniors understand Medicare and shop for coverage. The website, www.medicare.gov, provides a host of tools seniors can use to navigate search engines for Medicare Part D, Medicare Advantage and Medicare supplement plans.

If you have any questions about Medicare, please contact your McGraw Wentworth Account Manager. **MW**

ACCOUNT DIRECTORS	ASSISTANT PLAN ANALYST MANAGER
	PRINCIPAL PLAN ANALYST
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McGraw Wentworth, Inc.

3331 West Big Beaver Road, Suite 200
 Troy, MI 48084
 Telephone: 248-822-8000 Fax: 248-822-4131
www.mcgrawwentworth.com

250 Monroe Ave. NW, Suite 400
 Grand Rapids, MI 49503
 Telephone: 616-717-5647 Fax: 248-822-1278
www.mcgrawwentworth.com