

A man in a white shirt and red vest is tending to a large, shaggy brown bear. The bear is standing on its hind legs, and the man is holding its front paws. The background is dark with some blue light streaks.

# 8 Ways to Tame Your Employee Benefit Costs

How you can manage or control your costs without resorting to massive benefit cuts

Michele Bossi and Camille Coutu

Presented by **Michele Bossi** Practice Leader, Health and Productivity Consulting and **Camille Coutu** Health and Productivity Consultant in conjunction with the Toronto Board of Trade's Advanced Business Fundamentals education series

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# Why?

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## How you can manage or control your costs without resorting to massive benefit cuts.

As you know, health care costs are unlike most regular expenses that employers incur. Why? Because they are increasing annually at double-digit rates and have been for the past 5 years.

Buck publishes an annual Health Care Trend Survey. We poll the major benefits insurers and ask them what trend factors they are using in their pricing for the upcoming year. For the past five years, these trend factors have been between 13 and 15%. Compounded annually, that means that many employer health premiums have doubled in the past five years.

We're in a tough economy. Revenues have declined in almost all business sectors. This is increasing the pressure on employers to look at expenses and control or reduce them where possible.

How do you attempt to contain costs that are increasing that rapidly? Many employers feel that health costs are outside of their control. They are at the mercy of their benefit plans and continue to pay the increases until they can't anymore. What then? Slash and burn. Cut the program.

The eight tips we will discuss in this booklet are not necessarily solutions for every benefit plan, but ideas that you might want to explore with your consultant or benefits advisor.

You should keep in mind that benefits are part of an employer's total compensation package and are an important component of your Human Capital attraction and retention strategy. Any decisions on benefits should include consideration of the bigger picture of how this affects the company's talent pool.

Our theme as you may have guessed is "taming the beast". This is not about killing the beast because health care costs are always going to be an issue for employers. This is about finding ways to gain control over something that you may think is outside of your control today.

*Employer health and dental premiums increasing 15% per year - a doubling of costs every 5 years*

- *Buck's 2009 Canadian Health Care Trends Survey*

# 1 – Define your promise



## Where you can, define what you'll spend, not what you'll cover

Benefits by their very nature involve a promise from the provider of the benefits to the beneficiary. In most cases that promise is protection in the event that something bad happens. When employee benefits were first introduced, that's what they were all about. Protecting employees in the event of bad health. Certainly today, many of the benefits we provide are still all about protection. Life, disability and some health expenses require that the employer promise coverage in the event that something happens.

But think about health expenses today. Vision. Dental. Massage Therapy. Drugs. And on and on. Are these really events that are outside of the employee's control? Do they require blanket coverage or would it be more beneficial to both parties for the employer to simply provide funds to the employee to use toward these expenses?

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benefits insurers and ask them what trend factors they are using in their pricing for the upcoming year. For the past five years, these trend factors have been between 13 and 15%. Compounded annually, that means that many employer health premiums have doubled in the past five years.

### Scenario

- 1,000-life employee group
- 2009 average Health claims: \$1,500 per employee
- 2010 average Health claims: \$1,700 per employee

If you define the benefit, you're promising to cover all eligible expenses under the plan:

- 100% health care
- 2009 cost = \$1.5 million
- 2010 cost = \$1.7 million

However, by defining what you'll contribute - for example, to a Health Spending Account - you are promising funds towards the cost of eligible expenses, up to a maximum

- \$1,500 HSA per employee
- 2009 cost = \$1.5 million
- 2010 cost = \$1.5 million

### Scenario

This employer offers a traditional health plan covering 100% of health expenses. We show it as an umbrella because this is what health programs are like. The promise is of coverage. It doesn't matter how much rain hits the umbrella, the plan must protect the employee. 2009 plan cost is 1.5 million – 1000 employees at \$1,500 per head. 2010 cost is

\$1.7 million because the employer's cost is at the mercy of the plan.

What if the employer promised dollars instead of coverage? In this case, the employer is providing an HSA of \$1,500 per employee. 2009 cost is \$1.5 million, same as under the traditional

umbrella plan. 2010 cost? 1.5 million. The promise has not changed. What about the additional \$200 per employee? Well, maybe the employee would pay for it. Maybe the employee would shop more wisely knowing that there was a \$1,500 limit and manage his health costs within the \$1,500 budget.

There are certain features that must be in place in a HSA in order to comply with CRA requirements, but the HSA is a very effective way for an employer to control costs while giving the employee added flexibility as well as incentive to manage their own costs. The list of eligible expenses under an HSA is very broad, much broader than under most health and dental programs and the employee is free to use his/her HSA funds among any of his/her eligible family members.

#### **Health Spending Account (HSA)**

- Way for employer to give pre-tax dollars to employee to spend on health expenses
- Provides additional flexibility for employee
- Dollars, not coverage
- Appropriate for non-catastrophic, controllable expenses like vision, paramedical practitioners, routine dental services

A health spending account is essentially an allocation of funds to employees. It is not an insurance program. It is a way for an employer to give money to employees to spend on a pre-tax basis.

#### **Flex Plans**

- Fixed employer contribution
- Additional flexibility for employees who wish to purchase higher levels of coverage
- Company must be significant in size for flex to work well (over 500 employees)

Flex plans allow the employer to define or fix their contribution, yet maintain high coverage levels for those employees who wish to pay for them.

We caution you, however, that true flex plans are only effective for medium to large employers (typically over 500 employees).

*The Health Spending Account is a very effective way for an employer to control costs while giving employees added flexibility as well as incentive to manage their own costs.*

## 2 – Take on some of the risk

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### Consider alternate funding arrangements

Today, benefit plans not only have a component of insurance, but also of perk. A health plan, for instance, may cover emergency out-of-country coverage – insurance against harmful financial loss, but may also have coverage for eyeglasses – more in the nature of a perk as purchase of eye glasses is not catastrophic in nature and typically budgetable.

Given that more and more items under health and dental benefit plans are budgetable or there is a known maximum liability (i.e. annual maximums for dental plans) and that the larger your organization, the more predictable the health and dental claims can be year-over-year, exploring alternate funding arrangements for more of the budgetable and therefore predictable claims running through a plan is recommended.

#### **Why would you want to explore alternate funding?**

The more risk you take on versus the insurer, the less you pay in expenses.

The more risk you take, the less reserves you pay. Or the reserves can be eliminated altogether.

The more risk you take, the more flexibility you have in establishing what you pay and how you pay in order to release cash flow.

There are 3 ways to fund your plan:

#### **Insured Non-Refund**

The insurer accepts full risk in return for non-refundable premium. Premium rates can be set based on the insurer's block of business. This is commonly known as fully pooled programs. Often

Accidental Death & Dismemberment insurance is fully pooled.

Or, if your group is large enough, premium rates can be set based on a combination of the insurer's block of business and / or your own claims experience. This is referred to experience-rating the premium. For smaller and larger groups, Health and Dental insurances are often experience-rated. For larger groups, the insurer may experience-rate the Life and Long Term Disability insurances.

#### **Insured Refund**

The employer accepts partial risk in the financial performance of the insurance plan. At year-end, a calculation is completed to determine if there is a surplus or a deficit. If there is a surplus, the monies may go to funding a reserve, be deposited into an account or withdrawn as cash by the employer. If there is a deficit, the employer may pay it immediately or over time, as negotiated with the insurer.

While it seems that the employer holds the majority of the risk due to the annual surplus / deficit calculation, there is risk borne by the insurer in that the employer can terminate the insurance contract in a deficit position at any time.

The insurer may partially or fully experience-rate the premium. However, as the employer is assuming risk, there is more room to negotiate annual premiums.

In addition, the employer may be able to negotiate a reduction or an elimination of the typical reserves seen on an insured non-refund arrangement.

### **ASO (Administrative Services Only)**

The employer is fully liable for all claims under the plan. This arrangement is typical for Health and Dental benefits for medium to larger plans.

Why ASO? As there is no insurance, there is no risk for the insurer. The insurer simply adjudicates the claims on behalf of the employer. The employer assumes 100% of the risk and thus benefits from reduced expenses (as the insurer does not charge for holding the risk), and the elimination of insurer reserves.

### **Stop loss, health pooling**

When an employer assumes some or all of the risk, it is typically a decision made because the claims experience is somewhat predictable, year over year. However, there are areas in a Health benefit plan that are open to unpredictable, high and catastrophic claims in nature. For example, a member of the plan may travel and have a

medical emergency and incur \$200,000 in claims or a member of a plan could be diagnosed with an illness where the only drug available to treat the illness costs \$50,000 per year.

What is stop loss? Claims above a stop loss or pooling limit are removed from the employer's chargeable claims and become the liability of the carrier. The employer pays a premium for this protection.

Using the above example of the \$200,000 claim, the employer has a stop loss pooling limit of \$25,000 per person per year. In this case, the employer, if under an ASO financial arrangement, will be responsible for the claim up to \$25,000. The insurer will be responsible for paying the claim from \$25,000 to \$200,000.

When reviewing alternate funding where the employer is considering taking on some or all of the risk, a review of stop loss protection is necessary.

## 3 – Employee cost sharing

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### Employees contribute to claims or premiums

Most health and dental plans were initially set up to cover 100% of eligible expenses and the cost was paid by the employer. These employer-pay-all plans were affordable then.

Today, there are few plans that do not involve some form of cost sharing from employees.

It's important to know that there is more than one way for employees to contribute to the cost of their benefits, especially health and dental.

#### **Premium Contribution**

Premium contribution is the traditional, payroll deduction approach, where the employee contributes to the premium for the plan.

Let's say you have a plan that costs \$127.50 per month for employees with family coverage. Employees are required to contribute 20% to the cost of their health benefits. An employee with family coverage would pay \$25.50 per month for their benefits. This would typically be done via payroll deductions.

Each pay stub would show a deduction for that employee's health care costs.

Human nature dictates that when we pay money for something, we want to get value for that cost. When employees see a deduction each pay for the cost of their health and dental benefits, many will want to ensure that they claim at least that amount in order to get the value out of the plan. Keep in mind that many of these costs are within an employee's control. If every employee made sure that they claimed at least as much as they paid, the costs would necessarily increase.

This is a form of cost sharing that actually encourages spending and drives costs up.

*It's important to know that there is more than one way for employees to contribute to the cost of their benefits.*

#### **Co-pay**

Under co-pay arrangements, the employee pays a portion of the cost of the claim at the point of sale. This helps develop employee awareness of the cost of benefits, leads to them making wiser health decisions, and leads to improved plan management.

Under this arrangement, the employer pays 100% of the premium, but the plan only reimburses 80% of the eligible expense. The employee still pays 20%, but they pay their 20% at the point of purchase. They pay a portion of each claim, not of the premium.

We are seeing a shift toward co-pays rather than payroll deduction as a form of employee cost sharing.

Out-of-pocket maximums can be used to cap the employee's cost when there is co-pay. For example, the plan may reimburse 80% to a maximum out of pocket expense of \$1,000 or \$500, and then 100% thereafter.

Ultimately, this is about consumerism. Having employees share in the claims cost encourages wiser, more prudent decisions and ultimately engages employees to assist you in managing your health plan costs.

## 4 – See the big picture



### Understand how today's decisions impact tomorrow's costs

We live in a fast-paced society. However, there are times when we recommend looking beyond the quick yes-or-no answer, the transaction, or the desire to cross something off of your to-do list.

As consultants, there is a list of items that we deal with on a regular basis, typically after the decision has already been made. We expect that most of you have dealt with one or more of these issues and probably considered it as a quick item to respond to.

Here are some examples of not seeing the big picture or not seeking the advice of an expert before you make a decision – and while this decision may not cost you big dollars today, it does, in most cases, open the door of liability to potential future high costs, or a “promise of benefits” that cannot be taken away.

#### **Long Term Disability**

Does your plan have a written and explicit policy in place advising employees that should they be deemed disabled, their health and dental benefits will continue for X amount of years? For those that don't, do you intend to offer health and dental benefits until age 65 regardless of costs?

Remember that this can cost you, say, \$25,000 in claims each year for perhaps another 30 years? That's \$750,000.

We are not advising you to cut off benefits for your disabled employees. We want to encourage dialogue in your company about items that come up often with our clients. We have clients who come to us after the fact and say to us “What are my options to reduce costs associated with this

disabled person? He's been on the health and dental plan for 20 years.” and often we have to refer them to an employment lawyer for legal advice as changing benefits for a disabled employee is quite a contentious topic. Changing things after the fact always makes it difficult.

Why not be proactive? If it is your intent to terminate health and dental benefits for disabled employees after 10 years, for example, then implement a policy today for future disability claimants.

We recommend having the policy in writing in their employment contract and employee booklet; having the employees sign off that they understand the policy. We also recommend a reminder at the 8 or 9-year mark, to ensure that proper advance notice is provided of the upcoming termination of benefits.

*We have clients who come to us after the fact and say to us “What are my options to reduce costs associated with this disabled person?”*

#### **Severance**

How many organizations have a policy in place that severance packages must be approved by HR before they are offered to an employee? Insurers do not have to approve any extension of benefits beyond what is listed in the employment standards act as the minimum notice period. Will the insurer extend coverage beyond the minimum

notice period? Yes, but pre-approval needs to be sought from the insurer before offering the extension to the severed employee. Some insurers will limit the amount of coverage and / or length of the extension. Never promise a severed employee coverage before seeking approval from the insurer or you might place yourself in the position of insurer yourself if the insurer declines your request.

If you are a large company you can often have a negotiated arrangement with an insurer that you have automatic approval for extension of benefits for up to one year, for example. Always obtain this in writing from the insurer.

### **Salary updates**

It is important to remember to update your members' salaries with the insurer on a regular basis, especially because life and disability insurances are often based on a member's salary.

The insurer is within its right at the time of a life insurance claim to pay out only what they have listed on system as the salary. For example, a member's salary was \$50,000 in 2007. Your company has experienced a lot of turnover in the benefits administration department and as such, this member's salary has not been updated for two years. In this two years, the member has had two cost of living adjustments and a promotion. His current salary is \$62,000. His life insurance coverage under the plan is based on one times his annual salary.

If the member passes away, the insurer will see that premiums submitted by the plan sponsor were based on \$50,000. It is very difficult at time of claim to negotiate with the insurer to pay out \$62,000. If the insurer says that they are only paying out \$50,000, who will pay out the remaining \$12,000 to the beneficiary? Probably you.

### **Written documentation**

We always recommend making plan documents and booklets available electronically on the corporate intranet and avoid distribution of paper material as paper documentation is difficult to manage in the plan member's hands and over time may become outdated.

If you must distribute paper documentation, we recommend:

- Request outdated booklets from the plan members when providing updated booklets
- Have plan member's sign off that they understand that the new booklet overrides any previous documentation

It is also important for plan sponsors to ensure that all written documentation pertaining to benefit plans matches. We recommend cross-checking standard employment letters, member booklets, master contracts with the insurer, standard severance letters, company intranet, online enrolment tools, HR policies and other, as identified internally.

### **Special exceptions**

We do not live in a black or white world. We understand that there is a lot of grey. We understand that once in awhile there will be a need to make a special exception, however, we do recommend that you:

- Avoid making special exceptions if you don't have to
- Ensure the plan member you DO offer a special exception to understands that you are not setting a precedent or promise of future benefits
- Have the member sign off that this is a one-time exception and that it must remain confidential

## 5 – Examine retiree benefits



### Think carefully about offering benefits to retirees

The most recent Board of Trade Benefits and Employment Practices Survey showed that less than ¼ of employers offer benefits to retirees today.

Many employers have reduced or eliminated retiree benefits since that time.

*Courtesy Toronto Board Of Trade "2008 Benefits and Employment Practices Survey"*

	<u>Life</u>	<u>Health</u>	<u>Dental</u>
Yes	23%	21% - 24%	17% - 18%
No	77%	76% - 79%	82% - 83%

Benefits promised to retirees usually remain in effect for the life of the retiree.

### *The cost of offering benefits to your active population is valued very differently than the cost of offering benefits to retirees*

When we consider benefits costs, we typically look at the current cash costs. With retiree benefits, we need to look, not only at today's cash costs, but at the present value of the future benefits promise.

Let's look at an example to show the magnitude of this future cost.

We have a client for whom we did the actuarial calculation on their post-retirement benefits. This client had about 700 active employees and 70 retirees. The benefit costs for their retiree group are shown here for the past three years:

<b>2005</b>	<b>\$134,551</b>
<b>2006</b>	<b>\$174,544</b>
<b>2007</b>	<b>\$178,353</b>

But, the accumulated post-retirement benefit obligation for this group was \$18.9 million. Why?

This is because the valuation is done, not only on the future benefits for the current *retirees*, but it values that promise for the current *active population* as well.

#### **What should you do?**

- Rethink the benefit promise to retirees
- or
- If retiree benefits are a "must", explore alternate options to typical offering

#### **If you currently offer retiree benefits**

- Reduce or eliminate for future employees
- Review alternate funding of these benefits
- Investigate buyout packages for retirees

*Always seek legal advice before making any changes to a retiree program that is currently in place*

## 6 – Maximize economies of scale



### Investigate options for consolidation

#### **Umbrella plans**

With the merger and acquisition activity in recent years, it is not uncommon to see a large corporation have multiple plans with multiple providers. While it is not always feasible to consolidate the actual plans into one plan design, it is usually feasible to consolidate the various plans with one provider under an umbrella program. Maximizing on the economies-of-scale theory, having all plans with one provider can save on costs as:

- The larger the group with a provider, the less expense you'll pay
- The larger the group, the more stable the rating can be as fluctuations in year-over-year claims are minimized

#### **Association plans**

Many companies belong to various associations and many associations offer programs to their members, such as a low-cost group benefits program. A member of the association can, in some cases, save costs by having their benefit plan under an association plan. Some examples of associations that offer access to these sort of plans include the Toronto Board of Trade, the Retail Council of Canada and often many of the professional associations that we all belong to. There are pros and cons to being part of an association plan: you may pay lower costs, but your company may have to fit into the association's plan model.

#### **Placing all benefits with one provider**

It is not uncommon to see a smaller, standard plan have multiple insurers involved.

Why have multiple insurers? By placing those benefits with one insurer, you save on expenses, become a bigger client to the insurer, save yourself the administrative hassle, and facilitate the employee experience.

*The 'shared services' approach is now the trend in all sectors / industries*

*The larger you are, the more they hear you; the more you buy, the cheaper the price*

## 7 – Broaden your horizons

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### Know the players

When we think of benefit providers, we think of the big insurance companies.

The image of the insurance company is a big, solid financial institution. It makes sense that we would look for a secure, solid institution to provide us with protection from a catastrophic loss. But as we've stated a number of times, there are many aspects of benefit programs that do not involve catastrophic loss. Reimbursement of health and dental claims has become more of a transactional business than a risk-based business.

In the past couple of decades, many new providers have entered the marketplace. These providers are not looking to insure your benefits, but to merely provide a service. They may do this better and more efficiently than the insurance carrier. Then again, they may not.

It's important, however, to know that there are alternative providers that may be able to meet your needs at a lower cost.

#### Alternative and specialist providers

**Disability Managers** – Many of you probably have self-insured short term disability programs. Who manages your claims? Some of you use an insurance carrier to adjudicate and pay your disability claims. Do they do a good job of managing the claims and getting employees to return to work? Disability managers do just that. They work with the disabled employee to ensure they are receiving the appropriate treatment and are focused on returning to work. They also work with line managers to facilitate return to work programs. This not only helps save benefit costs, but saves costs through improved productivity.

#### Pharmacy Benefit

**Managers** – Did you know that most pay-direct drug claims are actually adjudicated and paid through Pharmacy Benefit Managers or PBMs? Most insurers are part of a PBM network that adjudicates and pays claims on its behalf. Some PBMs will work directly with employers to adjudicate their drug claims.

*Bottom line here is – Know what's available in the market place. Don't feel confined to the traditional benefit providers.*

**TPAs** – TPAs are Third Party Administrators. Some employers outsource the administration of their benefit programs (especially flex benefit programs) to a third party who has the expertise and systems to do it more efficiently than administering in house.

**Claims Adjudicators** – We talked about health and dental plans being self-insured and ASO. When a program is self-insured, you do not need to have it adjudicated by an insurance company. Claims Adjudicators (also sometimes called TPAs) are companies that do just that. They adjudicate and pay self-insured health and dental claims on behalf of employers.

**Special Risk Carriers** – There are actually insurers who specialize in high risk coverage such as Accidental Death and Dismemberment, Business Travel, Ex-Patriate coverage, etc. Because they specialize in providing this coverage, they can often provide it at a lower cost and with added features.

# 8 – Review current plan design and costs



## Slashing the plan to save costs is not the only option

Among administrators and sponsors, slashing the plan to save costs always seems to be top of mind. And while it's not the only option, it is something to consider. But before adopting any slash-and-burn tactics, consider your overall strategy and benefits philosophy and make very targeted cuts where needed.

### Philosophy

What is your benefits philosophy and is your plan aligned to that philosophy? Some employers may want to only cover medically necessary costs – so why do their plans cover birth control?

*Before adopting slash-and-burn tactics, consider your overall strategy and make very targeted changes.*

Other areas of coverage to review include lifestyle drugs (i.e. erectile dysfunction drugs), catastrophic coverage (emergency out-of-country insurance), preventative/wellness treatments (i.e. smoking cessation drugs), consumer-driven healthcare (i.e. co-pays or dispensing fee maximums).

Is your plan up-to-date with current trends in the industry? It may be paying claims for outdated services that today have cheaper alternatives. Does your plan have the appropriate fraud controls in place? For example, is your plan positively enrolled? Do you have a drug card to

process claims electronically but also apply proper controls, or is your drug plan still paper-based?

Plans have evolved. It is important to conduct regular plan design reviews every 3 to 5 years.

### Costs

It is important to manage costs, period. But to do that, you first need to set benchmarks of what is acceptable and what is not. These are typically based on internal objectives and external industry and market facts, including:

- Your benefit costs as a percentage of total payroll and your benefit costs per employee
- Your contributions to benefit costs as compared to the employees' contributions
- Your average claims costs compared to other organizations like yours?

Another area of increasing interest in managing costs is simply auditing what is happening under the plan. We work more and more on claims audits – auditing the claims adjudicator to ensure that they are adjudicating claims correctly. We also see more eligibility audits, ensuring that the dependent spouses and dependent children are eligible to be under the plan.

Many plan sponsors are conducting full-fledged funding reviews, which entails reviewing the cost, benefit, risk assessment of the financial arrangements behind their benefit plans.

And last but not least, we always recommend that a plan sponsor conduct a market review to ensure that the costs charged by their current provider are competitive as compared to the marketplace. A full marketing of the plan should be conducted at least every 3 to 5 years.

**Michele Bossi** is the leader of the Health & Productivity practice. She has spent several years in group underwriting and claims, sales and service, and benefits consulting. Michele has led and completed many initiatives to simplify, consolidate and create consistency in benefit programs and processes across the organizations she works with.

Michele served as Trustee for several joint employer/union benefit trusts and was a member of Blue Cross' Client Advisory Council. She was also chosen as one of the editors for The Handbook of Canadian Pension and Benefit Plans – 12th Edition.

Michele has been a long standing member of the Canadian Pension and Benefits Institute (CPBI) as well as the International Foundation of Employee Benefit Plans (IFEFP). She has also served as a guest lecturer for the Certificate of Proficiency in Employee Benefits (CEB) course, Humber College, as well as the Human Resources Management course, McMaster University.

**Camille Coutu** is a Consultant in the Health & Productivity practice in Buck's Toronto office. She provides a variety of consulting services to her clients, including market searches, education and training, plan redesigns, plan bench-markings and recommendations concerning funding arrangements.

Camille is experienced in corporate accounts practices, insurance sales, and third-party administration. Her expertise involves group insurance underwriting and plan administration as well as in reviewing renewals and financial

reports on both traditional benefit programs as well as flexible benefit programs.

Camille achieved her designation as a Certified Employee Benefit Specialist (CEBS) in 2003 and has sat, in various roles, on the board of the Toronto Area Chapter of the International Society of Certified Employee Benefits Specialists for a period of three years. She is also licensed by the Financial Services Commission of Ontario to deal with insurances relating to life, disability, health and travel.



### **Buck Consultants**

Organizations succeed when their people succeed. We love to find answers to tough problems in the areas of employee benefits,

human resource operations and talent strategy. Our expert consultants think ahead, react fast, and tailor real-world solutions to fit each client's unique needs and culture. Buck, established in 1916, is an independent subsidiary of Xerox.

Our main Canadian offices are located in Toronto, Montreal, and Ottawa, with a total of 236 employees. We also have an affiliation with Sinclair Billard + Weld, with offices in Nova Scotia and Newfoundland.

Contact us by email at [infocanada@buckconsultants.com](mailto:infocanada@buckconsultants.com)

or by phone at

TORONTO 416-865-0060

MONTREAL 514-987-1510

OTTAWA 613-798-2825

Find out more about us online at: [www.acsbuckcanada.com](http://www.acsbuckcanada.com).