Employee Benefit Changes – Health Care
For Nonrepresented Employees, Nurses (OPEIU) and Security/Police (SPFPA)

Changes Effective January 1, 2016
Health Care Benefit Changes

• Our mission – a high-quality, high-value educational experience
  Committed to keeping tuition as affordable as possible

• Employee-related costs – 75% of our educational & general budget
  Annual increases in employee benefit costs are far outpacing normal inflationary trends

• Selected changes in the way healthcare costs are shared between the plan and the members
  The plan changes will impact employees differently, depending upon the types of medical services used by employees and their covered family members

• The State System healthcare benefit program – comprehensive and competitive
  Even after the changes, the plan continues to provide excellent healthcare benefits
How the State System STAKES UP To Other Employer Plans

Annual Health Care Premiums

- **Single Coverage**
  - Employee Share: $1,332
  - Employer Share: $6,066
  - Total: $7,398

- **Family Coverage**
  - Employee Share: $1,368
  - Employer Share: $5,832
  - Total: $7,200

- **National Employers**
  - Employee Share: $1,071
  - Employer Share: $5,179
  - Total: $6,251

- **Total**
  - $17,545

Health Care Benefit Changes - Overview

Applicable to nonrepresented employees, campus security/police (SPFPA) and nurses (OPEIU)

• Remove HMO plan options
• Modify the PPO plan design for active employees (and future non-Medicare eligible retirees)
  • $250 in-network individual annual deductible applicable to certain services
  • 10% in-network member co-insurance, up to an out-of-pocket individual max of $1,000/calendar year
• Prescription drug plan changes
  • RX member copay change - $10/$30/$50 retail (mail-order copays = 2x retail copays)
  • RX cost management programs for select drug classes
• Increase FT employee premium contributions from 15% to 18% for Healthy U participants (from 25% to 28% for non-participants)
• No new same-sex domestic partners may be enrolled (existing domestic partners are grandfathered)
Health Care Benefit Changes – Key Dates

• Plan design changes are effective for 1/1/2016
• Employee premium contributions are effective for 1/22/16 pay date
• Special open enrollment for impacted employees:
  • Open enrollment dates – 11/9 – 11/20
  • All employees – given opportunity to make changes (add or drop dependents, waive or enroll in coverage)
  • HMO members – will be moved to the PPO, can remain in the PPO or waive coverage
• Non-Medicare eligible employees who retire on/before 12/30/15 will enroll in the existing PPO plan design – those who retire 12/31/15 and later will be enrolled in the new PPO plan design
  • When retirees turn 65, they are all enrolled in the same Signature 65 plan that supplements Medicare
Eliminate HMO Plan Options

• The four HMO plan options (Geisinger, Keystone East, Keystone Central, UPMC) will be eliminated.

• Employees and their covered dependents who are currently enrolled in an HMO plan will be enrolled in the PPO plan effective 1/1/2016 and will receive Highmark member ID cards in the mail in late December.

• If impacted employees wish to make changes to their enrollment (waive coverage, add or remove dependents) they will have the opportunity to do so during open enrollment.

• New enrollees to the PPO will initially pay the lower, Healthy U participant rates.
  • Employees and covered spouses will need to complete the Healthy U participation requirements by the program deadline of 5/31/16 in order to continue paying the lower contributions for the plan year beginning 7/1/2016.
PPO Plan Modifications - Deductible

Deductible –
The amount a member will pay for the applicable health care services before the health plan begins to pay

- Implement an in-network annual deductible of $250 individual ($500 family) on certain services
  - Out-of-network deductible will be $500 individual ($1,000 family)
  - Over 95% of the current PPO claims are in-network
- The deductible does **not** apply to in-network preventive care – this continues to be covered at 100% (no member cost)
- The deductible applies to all medical services that a copay does **not** apply
PPO Plan Modifications – Coinsurance

Coinsurance –
The member’s share of the cost of the applicable health care services, after the deductible has been met

- Implement in-network member coinsurance of 10% on certain services, subject to an annual maximum of $1,000/individual ($2,000/family)
  - Out-of-network coinsurance will be 30%, annual maximum of $2,000/individual ($4,000/family)
- After the maximum amount of coinsurance has been paid, the plan will cover the remaining applicable costs at 100% for the remainder of the calendar year

- The coinsurance applies to all medical services that are subject to the deductible
  - The coinsurance does not apply to preventive care – this continues to be covered at 100% (no member cost)
  - Coinsurance applies to all medical services that a copay does not apply
In-Network Deductible/Coinsurance – How Does It Work?

- Deductible/Coinsurance **not applicable to preventive care**
  - Preventive care continues to be provided at no member cost (100% paid by the health plan)

- Deductible/Coinsurance **not applicable to any service that is currently covered by a copay** – some examples include:
  - Office visits (primary care and specialist)
  - Urgent care visits
  - Emergency room visits
  - Physical therapy
  - Chiropractic visits
  - Outpatient mental health visits
  - Prescription drugs
In-Network Deductible/Coinsurance – How Does It Work?

- The following types of services would be subject to the deductible/coinsurance (not a comprehensive list)

- Diagnostic/Imaging Services (x-ray, MRI, non-preventive lab work)
- Surgery (inpatient and outpatient)
- Hospitalization
- Durable Medical Equipment
- Chemotherapy, dialysis, infusion therapy
- Home health care, skilled nursing facility care, hospice
In-Network Deductible/Coinsurance – Annual Maximums

Single Coverage –

- Member pays the first $250 of applicable costs (deductible)
- Then member is responsible for 10% of the subsequent costs (coinsurance), up to an annual maximum of $1,000 in coinsurance payments
- Total member expenses for these types of services are capped at $1,250 for the year ($250 in deductible + $1,000 in coinsurance)
- All applicable costs for the remainder of the calendar year after reaching this cap will be paid 100% by the plan*

*Assumes all services occur in-network

*Members may incur other medical costs in the form of office visit and prescription drug copays
In-Network Deductible/Coinsurance – Annual Maximums

Two-Party Coverage –

• Each member pays the first $250 of applicable costs, for a total of $500 (family deductible)

• Then each member is responsible for 10% of the subsequent costs (coinsurance), up to an annual maximum of $1,000/person ($2,000 family maximum) in coinsurance payments

• Total member expenses for these types of services are capped at $1,250/person for the year ($2,500 total for family) in deductible and coinsurance

• All applicable costs for the remainder of the calendar year after reaching this cap will be paid 100% by the plan*

Assumes all services occur in-network

*Members may incur other medical costs in the form of office visit and prescription drug copays
In-Network Deductible/Coinsurance – Annual Maximums

Multi-Party Coverage (family of 3+ people)

- Maximum annual in-network deductible for the family is $500, which may be satisfied in a number of different ways
  - Two members of the family could each meet the $250 individual deductible maximum, for a total of $500
  - Or together as a family, they could meet the $500 family maximum deductible on an aggregate basis.

For example, in a 4-person family, each person could incur $125 of applicable medical services in a year, and satisfy the $500 family deductible in that manner ($125 X 4 people). In that example, any applicable medical services incurred by any member of the family after that point would be subject to the 10% co-insurance payments (with the remaining 90% of costs paid by the plan).

- The coinsurance annual out-of-pocket maximum works in the same manner – it could be satisfied individually by two members of the family, or on an aggregate basis by three or more family members.

- No one person in the family will ever pay more than $250 in deductible, or more than $1,000 in coinsurance payments.

- Total family expenses for these types of services are capped at $2,500 for the year, at which point the plan will pay 100% of subsequent expenses.*

*Members may incur other medical costs in the form of office visit and prescription drug copays. Assumes all services occur in-network.
A New Benefit – Telemedicine, A “Virtual” Doctor Visit

• For minor illnesses
  • Colds, flu, sinus infections, sore throat, headache, pink eye, etc.
  • Staffed 24/7
  • No appointment needed
  • Save a little money - $10 office visit copay for telemedicine acute care (versus a $15 primary care office visit copay, or a $25 urgent care visit)

• For behavioral health appointments (scheduled)
  • $25 office visit copay for behavioral health (same as a specialist office visit copay)

• Save time – no need to leave the house or office
• All transactions occur over a secure video/phone platform
• Register online, payment via credit card
# Telemedicine – Two Vendors Available

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Dr. Doctor On Demand</th>
<th>Amwell</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Care</td>
<td>Primary Care Behavioral Health</td>
<td>Primary Care Behavioral Health</td>
</tr>
<tr>
<td>Available States</td>
<td>46 states &amp; DC Not available in Alabama, Alaska, Arkansas &amp; Louisiana</td>
<td>46 states &amp; DC Not available in Alabama, Alaska, Arkansas &amp; Texas</td>
</tr>
<tr>
<td>Capabilities</td>
<td>Video consult only</td>
<td>Video &amp; phone consults</td>
</tr>
<tr>
<td>Accessing a Provider</td>
<td>Acute Care for Minor Illnesses: On-demand appointments 2-minute average wait time</td>
<td>Behavioral Health: Scheduled appointments</td>
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<td></td>
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<td>Acute Care for Minor Illnesses: On-demand appointments 2-minute average wait time</td>
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<tr>
<td></td>
<td></td>
<td>Behavioral Health: Scheduled video appointments</td>
</tr>
<tr>
<td>Provider Selection</td>
<td>Doctor is assigned</td>
<td>Patient may select doctor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient may select doctor</td>
</tr>
<tr>
<td>Website</td>
<td>doctorondemand.com</td>
<td>amwell.com</td>
</tr>
</tbody>
</table>
Another New “Virtual Health” Benefit – Dermatologist On Call

- Quality care for many common problems – including:
  - Acne
  - Athlete’s Foot
  - Eczema
  - Rosacea
  - Poison Ivy
- $25 copay
- Eliminates the long wait for an appointment
- Convenient, no need to miss work, school or activities
- Board-certified dermatologists
- Secure on-line platform
- Three easy steps – www.dermatologistoncall.com
  1. Create an online account and choose a dermatologist
  2. Take and upload photos
  3. Within three business days, receive a diagnosis, care plan and prescription (if needed)
Prescription Drug Plan – Copay Changes

Member RX copays will adjust as follows:

<table>
<thead>
<tr>
<th>Drug Tier</th>
<th>Retail Copay (30-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$10</td>
</tr>
<tr>
<td>Brand Drugs, Formulary</td>
<td>$30</td>
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<tr>
<td>Brand Drugs, Nonformulary</td>
<td>$50</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug Tier</th>
<th>Mail-Order Copay (90-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$ 20</td>
</tr>
<tr>
<td>Brand Drugs, Formulary</td>
<td>$ 60</td>
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<tr>
<td>Brand Drugs, Nonformulary</td>
<td>$100</td>
</tr>
</tbody>
</table>
Prescription Drug Plan – Other “Behind the Scenes” Changes

- Managed RX drug program
  - Clinical edits – Appropriateness of use
  - Step therapy
    - Cholesterol, depression, acid reflux
- Prior authorization – certain drug classes
  - Includes many specialty medications, anabolic steroids, fertility agents, etc.
- Quantity level limits – certain drug classes
  - Includes some contraceptives, pain treatment, Acetaminophen, etc.
- Specialty Drug – Exclusive vendor
  - Walgreens Specialty Pharmacy
  - Mail delivery
  - Focused patient support

- Targeted communications from Highmark to members utilizing these drugs will occur
Managing Cost Impact – Healthcare FSA

- Employees can enroll in a Healthcare FSA or increase their election to mitigate the impact of these changes
- Maximum Healthcare FSA election - $2,500
- FSA Open Enrollment – October 19 through November 20
- Save money - Pay for qualifying expenses with pre-tax dollars
- Budgeting for expenses – Healthcare FSA dollars are available immediately in plan year, FSA deductions occur pro-rata throughout the year
- Use of the Healthcare FSA debit card can minimize cash flow issues
- Up to $500 in unused Healthcare FSA funds can be carried over to the following plan year, any unused amounts over $500 will be forfeited
Employee Premium Contribution Changes

- Increase for full-time employees from 15% to 18% premium contribution (from 25% to 28% for Healthy U non-participants)
- Impact of the increase is partially offset by the reduction in plan costs resulting from benefit changes
- Biweekly premium contributions effective with the 1/22/16 pay are below:

<table>
<thead>
<tr>
<th>Coverage Tier</th>
<th>Full-Time Healthy U Participant</th>
<th>Full-Time Healthy U Nonparticipant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$ 51.22</td>
<td>$ 79.67</td>
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<tr>
<td>Two-Party</td>
<td>$113.55</td>
<td>$176.64</td>
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<tr>
<td>Multi-Party</td>
<td>$139.16</td>
<td>$216.47</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage Tier</th>
<th>Part-Time Healthy U Participant</th>
<th>Part-Time Healthy U Nonparticipant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$163.61</td>
<td>$177.84</td>
</tr>
<tr>
<td>Two-Party</td>
<td>$362.74</td>
<td>$394.28</td>
</tr>
<tr>
<td>Multi-Party</td>
<td>$444.55</td>
<td>$483.20</td>
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</table>
Prospective Elimination of Same-Sex Domestic Partner Health Benefits

• Existing same-sex domestic partners/children enrolled in the plan remain eligible for benefits, but no new domestic partners will be added after 1/1/2016

• With the federal and PA changes in marriage laws, the philosophical reason for offering this benefit no longer exists. Same-sex couples now have the same legal ability as opposite-sex couples have to marry.
Thinking about retirement?

• Impact of premium increase from 15% to 18%
  • This change by itself should not be a factor – regardless of date of retirement (pre- or post-1/1/16), both groups of retirees will be paying 18%
  • The employee who retires prior to 12/31/15 will actually be paying more (as plan premiums in 2015 are higher than plan premiums in 2016)

• Impact of PPO plan design changes
  • Only impacts retirees/dependents who are not Medicare eligible, and only for the number of years before they become Medicare eligible
  • “Worse case” scenario – Each member spends $1,250 more/year in deductible/co-insurance, plus additional $ in RX co-pays
  • Employee must weigh this potential added annual cost against the lost income/benefits of retiring earlier than planned
Final Thoughts

• The State System health plan
  • Protecting your health
  • Protecting you financially
  • Modest changes for most employees
• Health benefits - only one component of a comprehensive benefits program
  • Retirement benefits, tuition benefits, paid time off, employer-paid dental, vision and life insurance
  • A valuable package – can be worth an additional 70%+ of salary