EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST
Actions of the Board of Managers

2015-16

A. *PREMIUMS – Effective September 1, 2015. The Board of Managers APPROVED a 5% rate increase.*

	Plan A		**Plan B**		**Plan C**		**High Deductible Health Plan**	
	Current	**2015-16**	Current	**2015-16**	Current	**2015-16**	Current	**2015-16**
Employee	$728	**$764**	$658	**$692**	$568	**$596**	$484	**$508**
EE + Spouse	$1,500	**$1,576**	$1,355	**$1,424**	$1,175	**$1,234**	$994	**$1,044**
EE + Children	$1,450	**$1,524**	$1,306	**$1,372**	$1,134	**$1,191**	$976	**$1,026**
Family	$1,615	**$1,696**	$1,456	**$1,530**	$1,265	**$1,328**	$1,072	**$1,126**

B. *NETWORK CHANGE – Effective September 1, 2015. The Board of Managers APPROVED moving to the Coventry / Aetna Choice POS II Network.*

Meritain will continue to process and pay benefit claims and Care Coordinators by Quantum Health will continue to serve as the central contact point for all customer and provider service, utilization review and care management. Therefore, the member service experience should remain very much the same.

To search for a network provider **in Illinois or Missouri** members should use the following link and instructions.

http://caremanagementresources.coventryhealthcare.com/services-and-support/members/locate-a-provider/index.htm

Click “Enter Provider Search” toward the center of the screen.
Select “CMR” when prompted.

If your provider does not participate in the CMR/Coventry network there are two ways to nominate a provider.

1. Ask your health care provider to self-nominate by clicking on the following link and completing the application.

   http://chcmissouri.coventryhealthcare.com/services-and-support/providers/provider-nomination/index.htm

2. Members may also request a provider is contacted to participate in the network by contacting the Care Coordinators at 855-452-9997. The Care Coordinators will contact the network and request the provider is contacted.

To search for a network provider **outside of Illinois or Missouri** members should used the following link and instructions.

www.aetna.com/docfind/custom/mymeritain

When prompted to select a plan choose: “Aetna Choice POS II (Open Access)”

Further detailed information will be included in the upcoming Summer newsletter and during the 15th Annual Administration meetings July 29th – July 31st.

C. *MEDICAL BENEFIT CHANGES – Effective September 1, 2015 (except as stated below).*

- **Network and Non-Network Benefit Levels.** An additional advantage of making the change to Coventry is that the plan design can be simplified to only two benefit tiers. The Coventry and Aetna networks have only one in-network tier instead of two. With the combined Coventry and Aetna networks, there will be excellent network access in all states. The Board of Managers APPROVED the following benefit changes as shown in the attached new ***Benefit Schedules*** with the new plan design for each Plan.
  - ***In Network Benefits***. The new Network benefit is identical in all respects to the current Tier 1 benefit for each Plan, with the same Tier 1 deductibles, out of pocket maximums and coinsurance levels.
  - ***Non-Network Benefits.*** The new Non-Network benefit is based on the current Tier 3 benefit level for each Plan, except with higher deductibles and out of pocket maximums. This change is intended to provide a greater incentive for members to use Network providers. As is the case now, charges made by Non-Network providers for services performed at Network hospital facilities will be paid at the Network benefit level when the member does not select the provider (for example, anesthesiology, radiology, pathology). This includes inpatient and outpatient hospital facilities and Emergency Room services.
  - ***Separate Accumulation.*** The Board of Managers APPROVED amending the Plan so that Network charges and Non-Network charges accumulate separately, as is common in other plans. Network charges will not count toward the Non-Network deductible and out-of-pocket maximum, and Non-Network charges will not count toward the Network deductible and out of pocket maximum. All ambulance charges will count toward the Network deductible, out of pocket maximum and ACA cost share maximum. Emergency Room coinsurance will count toward the Network out of pocket maximum and ACA cost share maximum, and ER copays will count toward the ACA cost share maximum. The deductible does not apply to ER charges. Members will receive credit for any deductible and out of pocket satisfied prior to September 1, 2015.
- **Temporary Moratorium on Plan E.** At present, a district is not permitted to offer any other Plan if the district chooses one of the Plan E options. Only two districts offer Plan E-1 at this time and there are no districts offering Plans E-2, E-3 or E-4. Some districts have expressed interest in these Plans but only if they can also offer other Plan choices to employees. Further analysis is required to determine whether premium rates for Plan E-1 and the other Plan E options are appropriate relative to the other Plans. The Board of Managers APROVED a temporary Moratorium on new districts offering Plan E. The Benefits Committee will meet in late May and early June to continue studying Plans E with the goal of again opening Plans E to districts which are interested in offering them. A special Board of Managers meeting would be required to approve any changes and may be scheduled over the summer to consider any changes recommended by the Benefits Committee.
- **Expand 100% Lab Benefit.** The Plan currently pays 100% benefit when members use LabCard providers for diagnostic lab services. With the network change, the Trust will have access to many other network lab providers with excellent discounts so there will no longer be a reason to favor LabCard over other Network providers. The Board of Managers APPROVED amending the Plan to pay the 100% benefit for lab services billed by any independent lab provider in the Network, including but not limited to Quest providers. The 100% benefit does not apply to outpatient lab services provided in a hospital or physician's office.
- **Eliminate Plan A. <u>Effective September 1, 2017</u>.** In recent years many districts ceased offering Plan A as an option and many members have chosen other Plans. At this time only about 25% of the membership is enrolled in Plan A. Plan A is a very rich plan compared to most employer plans today. For several years the Trust actuaries have warned that Plan A is at serious risk of triggering the "Cadillac tax" under the Affordable Care Act, if that tax is implemented in 2018 as scheduled. The Board of Managers APPROVED eliminating Plan A as an option effective September 1, 2017. Plan A will continue to be available through August 2017 but not thereafter.

- **Eliminate Annual Dollar Limit on Autism Benefits.** **Effective January 1, 2015.** Recent guidance indicates that school health plans in Illinois are no longer permitted to place dollar caps on autism benefits. This change has been implemented effective January 1, 2015.

D. PRESCRIPTION DRUG BENEFIT CHANGES.

- **Cover Nexium 24 Hour OTC with $0 Copay.** The Board of Managers APPROVED adding coverage for Nexium 24 hour OTC with no copay. Scrip World advises that the active ingredients are equivalent but the cost of the OTC is considerably less than prescription Nexium so will more than offset eliminating the copay for the OTC version. Scrip World will reach out to members currently taking Nexium to educate them about the benefits of making this change.
- **Specialty Drug Copays.** **Effective September 1, 2016.** For many years the copay for injectable specialty medications has been 3% of the ingredient cost of the drug in addition to the normal copay. The additional 3% charge was added at a time when virtually all specialty drugs were injected. Since that time, more and more specialty drugs have become available, many in oral form. All of these drugs are very high cost. There is no longer a good reason to charge different copays for injectable and oral specialty drugs. The Board of Managers APPROVED extending the 3% additional copay for injectable drugs to oral specialty drugs effective September 1, 2016. To mitigate the cost for all members taking specialty drugs, the Board of Managers APPROVED capping the member cost for any oral or injectable specialty drug at a maximum of $150 per month effective September 1, 2015.

E. CHANGES IN PLAN LANGUAGE AND TRUST RULES.

- **Workers Compensation Leaves.** The Plan provides that an employee may stay on regular plan coverage during a leave of absence approved by the employer for up to 12 months from the last day worked. After 12 months, the employee (and any family members) must be moved to COBRA status even if the employee is still on leave. Some districts have allowed employees to stay on regular coverage indefinitely until a workers' comp claim is resolved, which can sometimes take several years. The Board of Managers APPROVED adding language to clarify that the 12-month maximum leave rule applies to workers comp leave like all other leaves. Any employee on leave for more than 12 months must be converted to COBRA coverage. This is not a change in Plan rules, but simply a clarification to minimize further confusion.
- **Allow Participants to Change Plans when Adding a Dependent Mid-year.** The Plan currently provides that if a participant has an appropriate change in status event, the participant may add coverage for a dependent mid-year, but cannot change Plans and must add the dependent to the Plan in which the participant is enrolled. To comply with HIPAA regulations, the Board of Managers APPROVED amending the Plan to allow participants to change to a different Plan if they have any change in status event that allows them to add a dependent to the participant's existing coverage. This would be an exception to the rule that requires 12 months advance notice if a participant wants to move to a richer Plan. In all cases, all covered family members must be enrolled in the same Plan.
- **Allow Participants to Revoke Plan Coverage Due to Marketplace Special Enrollment.** The Plan already permits participants to elect or drop coverage during insurance marketplace annual open enrollment periods in order to move to or from marketplace coverage effective as of January 1 each year. IRS recently issued guidance stating that Section 125 plans may be amended to allow employees to revoke their elections for employer plan coverage if they have a special enrollment period for marketplace enrollment, such as birth, marriage, death, a spouse's loss of other coverage, etc., and enroll for marketplace coverage. This recognizes that if a new dependent is acquired or a family member loses other coverage, it may be more advantageous for the entire family to obtain private insurance than to enroll in the employer plan. The Board of Managers APPROVED amending the Plan to permit participants to revoke Plan coverage in order to move to private insurance, through the marketplace or otherwise, if they have a special enrollment event that would allow them to enroll for marketplace coverage. Districts with Section 125 plans should contact their advisors before allowing employees to revoke salary reduction elections mid-year in these circumstances.

- **Increase the Notice Period for District Withdrawals to 60 Days.** The Board of Managers APPROVED amending the Trust documents to increase the notice period districts must give before withdrawing from the Trust from 30 to 60 days. The current Trust rules are much more liberal than those of similar organizations which typically require much longer notice periods before an employer can withdraw.

F. DENTAL BENEFITS – Effective September 1, 2015.

The Board of Managers APPROVED moving the voluntary dental insurance program from Delta Dental to Ameritas. Ameritas is offering lower premium rates than the Delta Dental renewal quote along with eliminating the $50 deductible for preventive dental services. Ameritas also offers a rewards program that allows members to roll over some unused benefits to the following year. Members in the High Plan who use less than $750 of the dental benefit in a year may roll over $250 in benefits with no cap on the rollover amount. Members in the Low Plan who use less than $250 of the dental benefit in a year may roll over $125 in benefits up to a maximum rollover accumulation of $500. Ameritas has offered a guaranteed renewal rate for next year of not more than 8.5%. Ameritas will not require new applications and all enrollment files will be transferred. The premiums with Ameritas are as follows:

	Ameritas Dental Rewards – No Deductible for Preventive Care	
	Low Plan	**High Plan**
Employee	$14.26	$32.08
Employee + 1	$26.18	$58.96
Employee + 2	$49.70	$85.70

G. VISION BENEFITS – Effective September 1, 2015.

The Board of Managers APPROVED moving the voluntary vision plan from Uniview to Vision Service Plan (VSP) through Ameritas. VSP includes a Lasik benefit of $700 ($350 per eye) in either the first or second year of coverage. If the Lasik benefit is not used until the third year or after, the benefit is $1,400 ($700 per eye). The annual benefit of $700 or $1,400 is also the lifetime maximum for this procedure. The VSP provider network does not include the big box and national chain providers such as Lenscrafters and Pearle Vision, but includes a majority of independent providers and is expected to reduce member costs for vision services. The premiums with VSP are as follows:

	Ameritas VSP
Employee	$7.96
Employee + 1	$11.40
Employee + 2	$20.64

H. LIFE INSURANCE BENEFITS – Effective September 1, 2015.

The Board of Managers APPROVED moving the life insurance to Dearborn National. Lincoln Financial Group proposed a 50% renewal rate increase from the current rate of $1.20 to $1.80 per $1,000 of coverage. The Trust received a very competitive quote from Dearborn National at the rate of $1.00 with a four-year rate guarantee for the basic life insurance. The rates for additional voluntary coverage remain the same. The $1.00 rate applies only if the employer district pays the premium for basic life coverage. If the employer allows employees to buy basic coverage on a voluntary basis, the cost will be the age-rated premium rates for voluntary coverage. No underwriting will be required for existing enrollees. The guaranteed issue limit for new employees is $100,000.

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EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST
APPROVED BENEFIT SCHEDULES AS OF SEPTEMBER 1, 2015

Description of Services	Plan A		Plan B		Plan C		HDHP (HSA Qualified Plan)	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Deductible								
INDIVIDUAL	$300/$400**	$800	$500/$600**	$1,200	$1,000/$1,100**	$2,200	$1,300	$2,600
FAMILY	$900/$1,200**	$2,400	$1,500/$1,800**	$3,600	$3,000/$3,300**	$6,600	$2,600	$5,200
Out of Pocket Maximum								
INDIVIDUAL	$1,100/$1,200**	$3,700	$1,200/$1,300**	$4,100	$2,200/$2,300**	$6,900	$3,900	$7,750
FAMILY	$2,200/$2,400**	$11,100	$3,600/$3,900**	$12,300	$6,600/$6,900**	$20,700	$7,800	$15,500
Cost Share Maximum								
INDIVIDUAL	$6,600	N/A	$6,600	N/A	$6,600	N/A	$6,600	N/A
FAMILY	$13,200	N/A	$13,200	N/A	$13,200	N/A	$13,200	N/A
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Reimbursement	90%	70%	85%	65%	80%	60%	90% / 80%**	60%
Inpatient Hospital (Illness or Injury)	$250 Copay Then 90%	$550 Copay Then 70%	$250 Copay Then 85%	$550 Copay Then 65%	$250 Copay Then 80%	$550 Copay Then 60%	$250 Copay, Then 80%	$550 Copay Then 60%
Outpatient Surgery	$250 Copay Then 90%	$550 Copay Then 70%	$250 Copay Then 85%	$550 Copay Then 65%	$250 Copay Then 80%	$550 Copay Then 60%	$250 Copay, Then 80%	$550 Copay, Then 60%
Primary Doctor (PCP) Office Visit	$25 Copay Then 100% No deductible	70%	$25 Copay Then 100% No deductible	65%	$25 Copay Then 100% No deductible	60%	$25 Copay, Then 80%	60%
Specialist Office Visit with Primary Doctor (PCP) Referral/Notification	$30 Copay Then 100% No deductible	70%	$30 Copay Then 100% No deductible	65%	$30 Copay Then 100% No deductible	60%	$30 Copay Then 80%	60%
Specialist Office Visit without Primary Doctor (PCP) Referral/Notification	$40 Copay Then 100% No deductible	70%	$40 Copay Then 100% No deductible	65%	$40 Copay Then 100% No deductible	60%	$40 Copay Then 80%	60%
Emergency Room	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 80%	$300 Copay Then 80%
Urgent Care Facility	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 80%	$40 Copay Then 80%

Drug Card	Plan A Retail 30 days	Plan A Retail 90 day Maintenance Drug after first 2 fills	Plan A Home Delivery up to 90 days	Plan B Retail 30 days	Plan B Retail 90 day Maintenance Drug after first 2 fills	Plan B Home Delivery up to 90 days	Plan C Retail 30 days	Plan C Retail 90 day Maintenance Drug after first 2 fills	Plan C Home Delivery up to 90 days	HDHP Retail 30 days	HDHP Retail 90 day Maintenance Drug after first 2 fills	HDHP Home Delivery up to 90 days
GENERIC	$12	$36	$30	$12	$36	$30	$12	$36	$30	$12	$36	$30
FORMULARY	$25	$85	$55	$25	$85	$55	$25	$85	$55	$25	$85	$55
NON-FORMULARY	$40	$130	$100	$40	$130	$100	$40	$130	$100	$40	$130	$100

RATES (Includes $10,000 Basic Life)	Plan A	Plan B	Plan C	HDHP
Employee Only	**$764**	**$692**	**$596**	**$508**
Employee + Spouse	**$1,576**	**$1,424**	**$1,234**	**$1,044**
Employee+Child or Children	**$1,524**	**$1,372**	**$1,191**	**$1,026**
Family	**$1,696**	**$1,530**	**$1,328**	**$1,126**

Notes:

Network and Non-Network deductibles and out of pockets will accumulate separately

Ambulance charges will count toward the Network deductible, out of pocket maximum and ACA cost share maximum.

Emergency Room (ER) coinsurance will count toward the Network out of pocket maximum and ACA cost share maximum, and ER copays will count toward the ACA cost share maximum. The deductible does not apply to ER charges.

All Prescription Drug charges will apply toward the Network ACA Cost Share Maximum.

** Members may achieve a reduced individual and family deductible and out of pocket when completing the wellness requirements. Members who are enrolled in Plan HDHP may achieve a 10% increased benefit level when completing the wellness requirements.