Employee Benefit Changes – Health Care
For Nonrepresented (Management) 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 Stacks Up

Annual Health Care Premiums

- **Single Coverage**
  - Total $7,398
  - Employee Share: $1,132
  - Employer Share: $6,066

- **Family Coverage**
  - Total $20,101
  - Employee Share: $5,712
  - Employer Share: $14,389

To Other Employer Plans

- **Single Coverage**
  - Total $7,260
  - Employee Share: $1,071
  - Employer Share: $5,179

- **Family Coverage**
  - Total $18,960
  - Employee Share: $4,655
  - Employer Share: $14,305

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. Assumest all services occur in-network
Examples of How Costs may Work

Example: Having a Baby (Assumes all services received are in-network.)

<table>
<thead>
<tr>
<th>Medical Service</th>
<th>Negotiated Rate</th>
<th>Plan Pays</th>
<th>Member Pays Deductible</th>
<th>Member Pays Coinsurance</th>
<th>Member Pays Copay</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial office visit</td>
<td>$100</td>
<td>$100</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>Covered under preventive services</td>
</tr>
<tr>
<td>Initial preventive lab work (e.g. HIV screening, RH typing)</td>
<td>150</td>
<td>150</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Covered under preventive services</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>500</td>
<td>250</td>
<td>250</td>
<td>0</td>
<td>0</td>
<td>Services subject to $250 deductible</td>
</tr>
<tr>
<td>Additional nonpreventive lab work</td>
<td>600</td>
<td>540</td>
<td>0</td>
<td>60</td>
<td>0</td>
<td>Services subject to the 10% coinsurance</td>
</tr>
<tr>
<td>Inpatient vaginal delivery—facility</td>
<td>6,200</td>
<td>5,580</td>
<td>0</td>
<td>620</td>
<td>0</td>
<td>Services subject to 10% coinsurance</td>
</tr>
<tr>
<td>Inpatient vaginal delivery—professional</td>
<td>2,750</td>
<td>2,475</td>
<td>0</td>
<td>275</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Breast pump – durable medical equipment</td>
<td>150</td>
<td>150</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Covered under preventive services</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$10,450</strong></td>
<td><strong>$9,245</strong></td>
<td><strong>$250</strong></td>
<td><strong>$955</strong></td>
<td><strong>$0</strong></td>
<td></td>
</tr>
</tbody>
</table>

Illustrative purposes only; individual situations may differ.
## Examples of How Costs may Work

**Example: Knee Replacement (Assumes all services are received in-network.)**

<table>
<thead>
<tr>
<th>Medical Service</th>
<th>Negotiated Rate</th>
<th>Plan Pays</th>
<th>Member Pays Deductible</th>
<th>Member Pays Coinsurance</th>
<th>Member Pays Copay</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial office visit</td>
<td>$200</td>
<td>$175</td>
<td>$0</td>
<td>$0</td>
<td>$25</td>
<td>Office visit copay – specialist</td>
</tr>
<tr>
<td>MRI</td>
<td>2,000</td>
<td>1,575</td>
<td>250</td>
<td>175</td>
<td>0</td>
<td>Services subject to $250 deductible, followed by 10% coinsurance</td>
</tr>
<tr>
<td>Additional pre-surgical office visits (2 visits)</td>
<td>400</td>
<td>350</td>
<td>0</td>
<td>0</td>
<td>50</td>
<td>$25 copay for each office visit</td>
</tr>
<tr>
<td>Pre-surgical lab work</td>
<td>100</td>
<td>90</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>Inpatient knee replacement surgery</td>
<td>30,000</td>
<td>29,185</td>
<td>0</td>
<td>815</td>
<td>0</td>
<td>10% coinsurance to meet $1,000 coinsurance maximum for year</td>
</tr>
<tr>
<td>Out-patient physical therapy</td>
<td>2,700</td>
<td>2,250</td>
<td>0</td>
<td>0</td>
<td>450</td>
<td>$25 copay for each office visit (18 visits)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$35,400</strong></td>
<td><strong>$33,625</strong></td>
<td><strong>$250</strong></td>
<td><strong>$1,000</strong></td>
<td><strong>$525</strong></td>
<td></td>
</tr>
</tbody>
</table>

*Plan Total: $33,625  Member Total: $1,775*

Illustrative purposes only; individual situations may differ.
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

• 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 ON DEMAND]</th>
<th>[amwell]</th>
</tr>
</thead>
</table>
| **Type of Care** | Primary Care  
Behavioral Health | Primary Care  
Behavioral Health |
| **Available States** | 46 states & DC  
Not available in Alabama, Alaska,  
Arkansas & Louisiana | 46 states & DC  
Not available in Alabama, Alaska,  
Arkansas & Texas |
| **Capabilities** | Video consult only | Video & phone consults |
| **Accessing a Provider** | Acute Care for  
Minor Illnesses: On-demand  
appointments  
2-minute average wait time | Behavioral Health:  
Scheduled appointments |
| **Provider Selection** | Doctor is assigned | Patient may select doctor |
| **Website**     | doctorondemand.com | amwell.com |
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>
</tr>
<tr>
<td>Brand Drugs, Nonformulary</td>
<td>$50</td>
</tr>
</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>
</tr>
<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
### FSA Example

<table>
<thead>
<tr>
<th></th>
<th>With FSA</th>
<th>Without FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual pay</td>
<td>$50,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>FSA pre-tax contribution</td>
<td>($2,000)</td>
<td>$0</td>
</tr>
<tr>
<td>Taxable income</td>
<td>$48,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Federal income, Social</td>
<td>($10,966)</td>
<td>($11,616)</td>
</tr>
<tr>
<td>Security and Medicare taxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After-tax dollars spent</td>
<td>$0</td>
<td>($2,000)</td>
</tr>
<tr>
<td>on eligible expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Real spendable income</td>
<td>$37,034</td>
<td>$36,384</td>
</tr>
<tr>
<td><strong>Savings with an FSA</strong></td>
<td><strong>$650</strong></td>
<td></td>
</tr>
</tbody>
</table>

*Sample 2012 tax savings for a single taxpayer with no dependents. Actual savings will vary based on your individual tax situation. Please consult a tax professional for more information.*
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>
</tr>
<tr>
<td>Two-Party</td>
<td>$113.55</td>
<td>$176.64</td>
</tr>
<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>
</tr>
</tbody>
</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
Other Benefits

• Dental and Vision
  • Provided at no cost to you.
  • Dental and Vision Benefits are NOT changing.

• 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