Valdez City & School District
2017-2018 Renewal

Attached please find the renewal exhibits for the 2017-2018 Plan Year.

Exhibit I A-C shows the Claims Experience in the most recent 12 months for the group combined as well as the City and the School District separately. Combined the claims are slightly higher in the most recent 12 months than the prior 12 months with the overall claims cost for Medical and RX increasing from $1195 PEPM to $1360.30 PEPM. Dental claims also went up from $ $108.69 PEPM to 120.00. Vision Claims decreased slightly from $44.48 PEPM to $39.65 PEPM. This is to be expected with a slight increase in population from an average of 218 to 221 employees.

Even with the increase in claims the group's overall loss ratio is 72% of Expected Costs and 58% of Maximum Costs in the first 10 months of the plan year. There are currently 4 claims which have exceeded $62,500 or 50% of the Specific Deductible and no claims have exceeded the Individual Stop Loss Deductible of $125,000.

Group	Status	Total Paid	Over Stop Loss
127	Complete	$94,531.57	$0.00
127	Slowing	$113,160.88	$0.00
127	Ongoing	$63,764.93	$0.00
27	Ongoing	$70,987.84	$0.00
	Totals	**$342,445.22**	**$0.00**

With this combination of low claims over the past 2 years we were able to negotiate very favorable renewal rates with the Stop Loss Carrier, HCC Life,

HCC Life came down to a 2.53% overall increase as shown in **Exhibits II A&B**.

The Specific Stop Loss Premium is only increased by 6.4% from $244.09 to $259.71 for an increase of $15.62 PEPM. This increase is well below the current trend rates of 12% to 15%.

The Aggregate premium was originally quoted with a 9.38% increase which we were able to negotiate down to a 4.8% increase or $0.37 PEPM.

By leveraging the past history of the group we were able to keep the claim factor increase at a minimal 1.7% or 34.77 PEPM.

The only additional increases are reflected in the administrative costs.

- ✓ BridgeHealth has increased their administrative fee from $.05 PEPM to $1.50 PEPM.
- ✓ The City of Valdez has stepped up their wellness plan from Jog to Run, for an additional $1.65 PEPM.

Based on this we have spread the renewal offer at $125,000 Specific Stop Loss Deductible for the experience of both the City and the School District.

The final rates for the City are $2,399.58 PEPM compared to the prior year of $2300.84 PEPM, an overall rate change of 4.29%, as shown in **Exhibits II C&D**.

The final rates for the School District are $2,716.89 PEPM compared to the prior year of $2,691.54 PEPM, an overall rate change of .94%, as shown in **Exhibits II E&F**.

Exhibit III provides a history of the plans Stop Loss Ratio by comparing claims in excess of the Stop Loss Deductible to Stop Loss Premium. Although there have been a few years with high loss ratios, above 75%, overall the loss ratio for the last 9 years is favorable at 48.39%

Exhibits IV-A &B show plan changes allowable within the ACA guidelines for Grandfathered Plans. Deductibles and coinsurance limits may be increased based on "Medical Inflation" from March 2010. This allowable increase is cumulative, and not on an annual basis.

Employer Contributions can also be adjusted so long as the ***Employer Contribution is not reduced more than 5% from what it was in March 2010***, when the Affordable Care Act took effect.

Included is a list of items that would trigger the loss of Grandfather Status and a listing of the items that must be included in a Non-Grandfathered Plan.

We have had discussions with both the City and School District this year regarding alternative plan models and other cost saving measures. Please let us know if you have any additional questions

We look forward to continuing to serve both the City of Valdez and the Valdez City School District.

Craig Kestran
Employee Benefit Manager
Insurance Brokers of Alaska
907-564-6143

Diana Stewart, RHU, CEBS
Executive Benefits Consultant
Digital Insurance
907-564-6140

AUIB Renewal Projection for City of Valdez and Schools Effective 4/1/17

Current Plan

Aggregate Factor Calculation

Months	Latest 12 Months February 2016 - January 2017				Previous 12 Months February 2015 - January 2016			
	Employees	Claims			Employees	Claims		
	Total	Med & Rx	Dental	Vision	Total	Med & Rx	Dental	Vision
February	218	261,459	33,412	5,775	224	187,380	25,120	7,828
March	221	770,607	28,152	23,603	222	272,842	26,387	13,066
April	222	175,047	24,975	3,336	220	257,050	25,683	8,162
May	222	331,380	19,861	10,682	219	141,869	30,173	10,451
June	221	553,826	26,051	11,005	217	500,923	26,565	15,013
July	217	108,562	25,843	4,024	210	176,232	23,010	3,684
August	214	412,202	33,603	5,775	210	187,634	16,348	8,620
September	223	241,472	20,832	7,837	216	335,697	18,965	11,458
October	221	153,437	26,434	4,336	218	207,527	20,791	5,939
November	220	260,231	34,895	12,572	219	195,769	26,625	6,051
December	221	170,210	21,886	11,092	219	412,002	22,341	5,557
January	226	160,909	21,567	4,869	218	248,520	21,894	20,361
Total	**2,646**	**3,599,342**	**317,511**	**104,906**	**2612**	**3,123,445**	**283,902**	**116,190**
Monthly Average*	**221**	**299,945**	**26,459**	**8,742**	**218**	**260,287**	**23,659**	**9,683**

	Med & Rx	Dental	Vision	Med & Rx	Dental	Vision
Average Claims Per EE Per Month	**1,360.30**	**120.00**	**39.65**	**1,195.81**	**108.69**	**44.48**

Weighted Average (Med & Rx)	1360.30 (.75) + 1195.81 (.25) =	1,319.17
Trend 11% per year @ 14 Months	x	1.1283
Monthly Expected Claim Factor (Med & Rx)		**1,501.22**
Weighted Average (Dental)	120.00 (.75) + 108.69 (.25) =	117.17
Trend 4% per year @ 14 Months	×	1.0467
Monthly Expected Claim Factor (Dental)		**123.03**
Weighted Average (Vision)	39.56 (.75) + 44.48 (.25) =	40.86
Trend 1% per year @ 14 Months	×	1.0117
Monthly Expected Claim Factor (Vision)		**41.39**

* Eligibility Lagged 1 Month

Projection for 2017- 2018

Expected Claims	Medical & Rx	1,501.22
	Dental	123.03
	Vision	41.39
	Total	**1,665.64**
Maximum Claims	Medical & Rx	1876.52
	Dental	123.03
	Vision	41.39
	Total	**2040.94**

EXHIBIT I-A

AUIB Renewal Projection for the City of Valdez Effective 4/1/17

Current Plan

Aggregate Factor Calculation

Months	Latest 12 Months February 2016 - January 2017				Previous 12 Months February 2015 - January 2016			
	Employees	Claims			Employees	Claims		
	Total	Med & Rx	Dental	Vision	Total	Med & Rx	Dental	Vision
February	107	86325	18755	2033	112	53200	8691	3259
March	109	447666	11569	7229	110	113789	10517	4066
April	110	92705	10198	1658	108	171362	9333	3060
May	109	126427	8471	1566	106	54817	14161	6029
June	109	205285	6344	3662	104	264493	9905	3392
July	109	55895	9737	1293	106	73325	9608	2574
August	109	175308	18264	816	106	76679	6313	2874
September	109	118068	14201	4137	105	152098	12251	3327
October	107	58230	10843	2025	106	104107	9054	2477
November	106	94766	18748	4607	106	107897	16928	1185
December	105	70867	13314	2443	106	184650	11563	2857
January	107	71226	9623	2577	107	113024	12321	13514
Total	**1296**	**1,602,768**	**150,067**	**34,046**	**1282**	**1,469,441**	**130,645**	**48,614**
Monthly Average*	**108**	**133,564**	**12,506**	**2,837**	**107**	**122,453**	**10,887**	**4,051**

	Med & Rx	Dental	Vision	Med & Rx	Dental	Vision
Average Claims Per EE Per Month	**1,236.70**	**115.79**	**26.27**	**1,146.21**	**101.91**	**37.92**

Weighted Average (Med & Rx)	1236.70 (.75) + 1146.21 (.25) =	1,214.08
Trend 11% per year @ 14 Months	x	1.1283
Monthly Expected Claim Factor (Med & Rx)		**1,381.62**
Weighted Average (Dental)	115.79 (.75) + 101.91 (.25) =	112.32
Trend 4% per year @ 14 Months	×	1.0467
Monthly Expected Claim Factor (Dental)		**117.94**
Weighted Average (Vision)	26.27 (.75) + 37.92 (.25) =	29.18
Trend 1% per year @ 14 Months	×	1.0117
Monthly Expected Claim Factor (Vision)		**29.56**

* Eligibility Lagged 1 Month

Projection for 2017- 2018

Expected Claims	Medical & Rx	1,381.62
	Dental	117.94
	Vision	29.56
	Total	**1,529.12**
Maximum Claims	Medical & Rx	1727.03
	Dental	117.94
	Vision	29.56
	Total	**1874.53**

EXHIBIT I-B

AUIB Renewal Projection for Valdez City Schools Effective 4/1/17

Current Plan

Aggregate Factor Calculation

Months	Latest 12 Months February 2016 - January 2017				Previous 12 Months February 2015 - January 2016			
	Employees	Claims			Employees	Claims		
	Total	Med & Rx	Dental	Vision	Total	Med & Rx	Dental	Vision
February	111	175,134	14,657	3,742	112	134,180	16,429	4,569
March	112	322,941	16,583	16,374	112	159,053	15,870	9,000
April	112	82,342	14,777	1,678	112	85,688	16,350	5,102
May	113	204,953	11,390	9,116	113	87,052	16,012	4,422
June	112	348,541	19,707	7,343	113	236,430	16,660	11,621
July	108	52,667	16,106	2,731	104	102,907	13,402	1,110
August	105	236,894	15,339	4,959	104	110,955	10,035	5,746
September	114	123,404	6,631	3,700	111	183,599	6,714	8,131
October	114	95,207	15,591	2,311	112	103,420	11,737	3,462
November	114	165,465	16,147	7,965	113	87,872	9,697	4,866
December	116	99,343	8,573	8,650	113	227,352	10,778	2,700
January	119	89,683	11,944	2,292	111	135,496	9,573	6,847
Total	**1,350**	**1,996,574**	**167,445**	**70,861**	**1330**	**1,654,004**	**153,257**	**67,576**
Monthly Average*	**113**	**166,381**	**13,954**	**5,905**	**111**	**137,834**	**12,771**	**5,631**

	Med & Rx	Dental	Vision	Med & Rx	Dental	Vision
Average Claims Per EE Per Month	**1,478.94**	**124.03**	**52.49**	**1,243.61**	**115.23**	**50.81**

Weighted Average (Med & Rx)	1478.94 (.75) + 1243.61 (.25) =	1,420.11
Trend 11% per year @ 14 Months	x	1.1283
Monthly Expected Claim Factor (Med & Rx)		**1,616.09**
Weighted Average (Dental)	124.03 (.75) + 115.23 (.25) =	121.83
Trend 4% per year @ 14 Months	×	1.0467
Monthly Expected Claim Factor (Dental)		**127.92**
Weighted Average (Vision)	52.49 (.75) +50.81 (.25) =	52.07
Trend 1% per year @ 14 Months	×	1.0117
Monthly Expected Claim Factor (Vision)		**52.75**

* Eligibility Lagged 1 Month

Projection for 2017 - 2018

Expected Claims	Medical & Rx	1,616.09
	Dental	127.92
	Vision	52.75
	Total	**1,796.76**
Maximum Claims	Medical & Rx	2020.11
	Dental	127.92
	Vision	52.75
	Total	**2200.78**

EXHIBIT I-C

City of Valdez and Valdez City Schools Combined
2017 - 2018 Renewal Summary

Renewal Options

	2016-2017	2017-2018	
	Costs	**Costs**	**Percent Change**
Specific Deductible	**125,000**	**125,000**	
Administration / Meritain Inc BH	29.95	31.40	4.84%
Consult & Doc/Healthy Merits (city only)	5.90	7.55	N/A
Utilization Review / MRC	2.45	2.45	0.00%
Broker / AUIB	10.25	10.25	0.00%
Specific Premium / HCC Life	244.09	259.71	6.40%
Aggregate Premium / HCC Life	9.06	9.43	4.08%
Total Fixed Costs	**301.70**	**320.79**	**6.33%**
Expected Claims			
Medical & Rx	1,636.30	1,664.12	1.70%
Dental Expected Claims	113.50	123.03	8.40%
Vision Expected Claims	41.53	41.39	-0.34%
Total Expected Cost	**2,093.03**	**2,149.33**	**2.69%**
Maximum Claims			
Medical & Rx	2,045.38	2,080.15	1.70%
Dental Maximum Claims*	113.50	123.03	8.40%
Vision Maximum Claims*	41.53	41.39	-0.34%
Total Maximum Cost	**2,502.11**	**2,565.36**	**2.53%**

*** Because of the ability to accurately predict the amount of dental and vision claims, expected figures have been used here. Actual claim volume for the dental and vision plans may be slightly higher or lower than these figures.**

EXHIBIT II-A

City of Valdez and Valdez City Schools Combined
2017 - 2018 Renewal Summary
OVERALL RENEWAL
HCC / Meritain $125,000 Specific SL

	2016-2017	2017-2018	
	Costs	Costs	Percent Change
Specific Deductible	125,000	125,000	N/A
Fixed Costs	**301.70**	**320.79**	**6.33%**
Expected Claims			
Medical & Rx	1,636.30	1,664.12	1.70%
Dental Expected Claims	113.50	123.03	8.40%
Vision Expected Claims	41.53	41.39	-0.34%
Total Expected Cost	**2,093.03**	**2,149.33**	**2.69%**
Maximum Claims			
Medical & Rx	2,045.38	2,080.15	1.70%
Dental Maximum Claims*	113.50	123.03	8.40%
Vision Maximum Claims*	41.53	41.39	-0.34%
Total Maximum Cost	**2,502.11**	**2,565.36**	**2.53%**
Total Monthly Expected Cost (238 Empls)	**498,142.09**	**511,540.54**	**2.69%**
Total Monthly Maximum Cost (238 Empls)	**595,502.18**	**610,555.68**	**2.53%**
Total Annual Expected Cost (238 Empls)	**5,977,705.10**	**6,138,486.48**	**2.69%**
Total Annual Maximum Cost (238 Empls)	**7,146,026.16**	**7,326,668.16**	**2.53%**

*** Because of the ability to accurately predict the amount of dental and vision claims, expected figures have been used here. Actual claim volume for the dental and vision plans may be slightly higher or lower than these figures.**

EXHIBIT II-B

City of Valdez
2017 - 2018 Renewal Summary

Renewal Options

	2016-2017	2017-2018	
	Costs	**Costs**	**Percent Change**
Specific Deductible	125,000	**125,000**	
Administration / Meritain Inc BH	29.95	31.40	4.84%
Consult & Doc/Healthy Merits (city only)	5.90	7.55	N/A
Utilization Review / MRC	2.45	2.45	0.00%
Broker / AUIB	10.25	10.25	0.00%
Specific Premium / HCC Life	244.09	259.71	6.40%
Aggregate Premium / HCC Life	9.06	9.43	4.08%
Total Fixed Costs	**301.70**	**320.79**	**6.33%**
Expected Claims			
Medical & Rx	1,475.29	1,531.50	3.81%
Dental Expected Claims	113.50	123.03	8.40%
Vision Expected Claims	41.53	41.39	-0.34%
Total Expected Cost	**1,932.02**	**2,016.71**	**4.38%**
Maximum Claims			
Medical & Rx	1,844.11	1,914.37	3.81%
Dental Maximum Claims*	113.50	123.03	8.40%
Vision Maximum Claims*	41.53	41.39	-0.34%
Total Maximum Cost	**2,300.84**	**2,399.58**	**4.29%**

*** Because of the ability to accurately predict the amount of dental and vision claims, expected figures have been used here. Actual claim volume for the dental and vision plans may be slightly higher or lower than these figures.**

EXHIBIT II-C

City of Valdez
2017 - 2018 Renewal Summary
CITY RENEWAL
HCC / Meritain $125,000 Specific SL

	2016-2017	2017-2018	
	Costs	Costs	Percent Change
Specific Deductible	125,000	125,000	N/A
Fixed Costs	**301.70**	**320.79**	**6.33%**
Expected Claims			
Medical & Rx	1,475.29	1,531.50	3.81%
Dental Expected Claims	113.50	123.03	8.40%
Vision Expected Claims	41.53	41.39	-0.34%
Total Expected Cost	**1,932.02**	**2,016.71**	**4.38%**
Maximum Claims			
Medical & Rx	1,844.11	1,914.37	3.81%
Dental Maximum Claims*	113.50	123.03	8.40%
Vision Maximum Claims*	41.53	41.39	-0.34%
Total Maximum Cost	**2,300.84**	**2,399.58**	**4.29%**
Total Monthly Expected Cost (125 Empls)	**241,502.25**	**252,088.25**	**4.38%**
Total Monthly Maximum Cost (125 Empls)	**287,605.00**	**299,947.50**	**4.29%**
Total Annual Expected Cost (125 Empls)	**2,898,027.00**	**3,025,059.00**	**4.38%**
Total Annual Maximum Cost (125 Empls)	**3,451,260.00**	**3,599,370.00**	**4.29%**

*** Because of the ability to accurately predict the amount of dental and vision claims, expected figures have been used here. Actual claim volume for the dental and vision plans may be slightly higher or lower than these figures.**

EXHIBIT II-D

Valdez City Schools
2017 - 2018 Renewal Summary

Renewal Options

	2016-2017	2017-2018	
	Costs	**Costs**	**Percent Change**
Specific Deductible	125,000	**125,000**	
Administration / Meritain Inc BH	29.95	31.40	4.84%
Consult & Doc/Healthy Merits (city only)	0.00	0.00	N/A
Utilization Review / MRC	2.45	2.45	0.00%
Broker / AUIB	10.25	10.25	0.00%
Specific Premium / HCC Life	244.09	259.71	6.40%
Aggregate Premium / HCC Life	9.06	9.43	4.08%
Total Fixed Costs	**295.80**	**313.24**	**5.90%**
Expected Claims			
Medical & Rx	1,792.57	1,791.42	-0.06%
Dental Expected Claims	113.50	123.03	8.40%
Vision Expected Claims	41.53	41.39	-0.34%
Total Expected Cost	**2,243.40**	**2,269.08**	**1.14%**
Maximum Claims			
Medical & Rx	2,240.71	2,239.28	-0.06%
Dental Maximum Claims*	113.50	123.03	8.40%
Vision Maximum Claims*	41.53	41.39	-0.34%
Total Maximum Cost	**2,691.54**	**2,716.94**	**0.94%**

*** Because of the ability to accurately predict the amount of dental and vision claims, expected figures have been used here. Actual claim volume for the dental and vision plans may be slightly higher or lower than these figures.**

EXHIBIT II-E

Valdez City Schools
2017 - 2018 Renewal Summary
SCHOOL DISTRICT RENEWAL
HCC / Meritain $125,000 Specific SL

	2016-2017	2017-2018	
	Costs	Costs	Percent Change
Specific Deductible	125,000	125,000	N/A
Fixed Costs	**295.80**	**313.24**	**5.90%**
Expected Claims			
Medical & Rx	1,792.57	1,791.42	-0.06%
Dental Expected Claims	113.50	123.03	8.40%
Vision Expected Claims	41.53	41.39	-0.34%
Total Expected Cost	**2,243.40**	**2,269.08**	**1.14%**
Maximum Claims			
Medical & Rx	2,240.71	2,239.28	-0.06%
Dental Maximum Claims*	113.50	123.03	8.40%
Vision Maximum Claims*	41.53	41.39	-0.34%
Total Maximum Cost	**2,691.54**	**2,716.94**	**0.94%**
Total Monthly Expected Cost (113 Empls)	**253,503.97**	**256,406.49**	**1.14%**
Total Monthly Maximum Cost (113 Empls)	**304,144.02**	**307,014.22**	**0.94%**
Total Annual Expected Cost (113 Empls)	**3,042,047.69**	**3,076,877.90**	**1.14%**
Total Annual Maximum Cost (113 Empls)	**3,649,728.24**	**3,684,170.64**	**0.94%**

*** Because of the ability to accurately predict the amount of dental and vision claims, expected figures have been used here. Actual claim volume for the dental and vision plans may be slightly higher or lower than these figures.**

EXHIBIT II-F

Valdez City & School District
Claims in Excess of Stop Loss
2008 Through 2017

	# of Claims	Claims in Excess of Stop Loss	Specific & Aggregate Stop Loss Premium	Annual Loss Ratio
Symetra Financial				
2008-2009	0	**$0.00**	**$314,527.00**	**0.00%**
2009-2010	0	**$0.00**	**$385,381.00**	**0.00%**
2010-2011	5	**$235,428.45**	**$446,959.00**	**52.67%**
2011-2012	3	**$184,596.59**	**$509,606.00**	**36.22%**
2012-2013	3	**$154,502.20**	**$526,541.00**	**29.34%**
2013-2014	6	**$558,078.73**	**$588,748.00**	**94.79%**
Move to HCC Life				
2014-2015	4	**$415,237.98**	**$509,702.00**	**81.47%**
2015-2016 YTD 10 Mo	2	**$327,260.00**	**$593,736.00**	**55.12%**
2016-2017 YTD 10 Mo	0	**$0.00**	**$506,894.00**	**0.00%**
HCC Life Experience		**742,497.98**	**1,610,332.00**	**46.11%**
COMBINED 9 YEAR TOTAL		**$1,875,103.95**	**$3,875,200.00**	
Loss Ratio				**48.39%**

AS OF 1/31/2017

EXHIBIT III

City of Valdez

1/1/2017

Grandfathered Plan - Areas of Allowable Benefit Changes

Deductible & Out of Pocket Increase

Allowed increase 15% + medical inflation		Base 15%	Medical Inflation 3/31/10 to 1/1/17	Total % Increase	Max Increase at %	New Amount	
Medical							
Deductible							GF PLAN INCREASES
Individual	$100.00	15.0%	20.8%	35.8%	35.80	$135.80	
Family X 3	$300.00	15.0%	2.1%	17.1%	51.24	$351.24	
Out-of-Pocket							
Individual PPO	$448.00	15.0%	20.8%	35.8%	160.38	$608.38	
Dental							
Deductible							GF PLAN INCREASES
Individual	$25.00	15.0%	20.8%	35.8%	8.95	$33.95	
Family X 3	$75.00	15.0%	20.8%	35.8%	26.85	$101.85	

Co Payment Changes

Allowed Co-pay increase is limited to the GREATER of:

-OR- **Medical inflation +15%**

$5 (adjusted for medical inflation since March 2010) or medical

($5 *1.208) = $6.04 **(Dec 2015)**

					Max Increase at %	Max Allowable Increase	New Amount	
Prescription Drug - Retail								
Generic	$5.00	15.0%	20.8%	35.8%	**1.79**	$6.04	$11.04	GF PLAN INCREASES
Preferre	$10.00	15.0%	20.8%	35.8%	**3.58**	$6.04	$16.04	
Prescription Drug - Mail Order								
Generic	$5.00	15.0%	20.8%	35.8%	**1.79**	$6.04	$11.04	
Preferre	$10.00	15.0%	20.8%	35.8%	**3.58**	$6.04	$16.04	

Employer Contribution Change (Cumulative since March 2010)

Employer contribution -(calculated as a % of total cost of coverage) may not decrease more than 5%

This is applied individuall to each tier of coverage depending on how you are allocating employee contributions

Examples:

Compoiste Rate - all employees contribute the same amount towards coverage

Tiered by coverage - Employee only, Employee & Spouse, Employee & Children, Family

By Employement Category - Classified, Certified, Administration

EHIBIT IV-A

Valdez City Schools

1/1/2017

Grandfathered Plan - Areas of Allowable Benefit Changes

Deductible & Out of Pocket Increase

Allowed increase 15% + medical inflation		Base 15%	Medical Inflation 3/31/10 to 1/1/17	Total % Increase	Max Increase at %	New Amount	
Medical Deductible							GF PLAN INCREASES
Individual	$100.00	15.0%	20.8%	35.8%	35.80	$135.80	
Family X 3	$300.00	15.0%	20.8%	35.8%	107.40	$407.40	
Out-of-Pocket							
Individual PPO	$448.00	15.0%	20.8%	35.8%	160.38	$608.38	
Dental Deductible							GF PLAN INCREASES
Individual	$25.00	15.0%	20.8%	35.8%	8.95	$33.95	
Family X 3	$75.00	15.0%	20.8%	35.8%	26.85	$101.85	

Co Payment Changes

Allowed Co-pay increase is limited to the GREATER of:

-OR- **Medical inflation +15%**

$5 (adjusted for medical inflation since March 2010) or medical

($5 *1.208) = $6.04 **(Dec 2015)**

					Max Increase at %	Max Allowable Increase	New Amount	
Prescription Drug - Retail								
Generic	$5.00	15.0%	20.8%	35.8%	**1.79**	$6.04	$11.04	GF PLAN INCREASES
Preferre	$10.00	15.0%	20.8%	35.8%	**3.58**	$6.04	$16.04	
Prescription Drug - Mail Order								
Generic	$5.00	15.0%	20.8%	35.8%	**1.79**	$6.04	$11.04	
Preferre	$10.00	15.0%	20.8%	35.8%	**3.58**	$6.04	$16.04	

Employer Contribution Change (Cumulative since March 2010)

Employer contribution -(calculated as a % of total cost of coverage) may not decrease more than 5%

This is applied individuall to each tier of coverage depending on how you are allocating employee contributions

Examples:

Compoiste Rate - all employees contribute the same amount towards coverage

Tiered by coverage - Employee only, Employee & Spouse, Employee & Children, Family

By Employement Category - Classified, Certified, Administration

EXHIBIT IV-B

PLAN CHANGES WHICH COULD TRIGER THE LOSS OF GRANDFATHER STATUS: "THE SLIPPERY SEVEN"

Elimination of Benefits

A Plan will cease to be grandfathered if it eliminates all or substantially all benefits to diagnose or treat a particular condition. This is applicable to any benefit, not just "Essential Benefits".

Increase of Percentage Cost Sharing Requirements

ANY increase in the percentage cost sharing requirement will cause a plan to lose its grandfather status. (Changing plan from 80/20 coinsurance to 70/30 coinsurance)

Increase in Fixed Amount Cost Sharing – Other than Co-Pays

Changes in Deductibles or Out of Pocket Maximums by more than the "Maximum Percentage Increase". **"Maximum Percentage Increase" is defined as Medical Inflation (as of March 23, 2010) + 15%).** ***March 23, 2010 will always be your reference point.***

Increase in Fixed Amount – Co-Pays

A plan will cease to be grandfathered if it increases any co-pay by more than the greater of (a) the Maximum Percentage Increase, or (b) Five Dollars ($5), increased by medical inflation.

Decreased Employer Contributions

A plan will lose its grandfather status if it decreases its "contribution rate" toward the total cost of coverage for any tier of coverage by more than 5% below their March 23rd contribution rate. The term "Contribution Rate" means the amount of contribution made by an employer compared to the total cost of coverage, which is expressed as a percentage.

Changes in Annual Limits

A plan my not impose a **new** annual or lifetime limit if there was not an annual or lifetime limit in effect on March 23, 2010 . A plan with a lifetime limit but not annual limit, **can not add** an annual limit that is lower than the lifetime limit in effect on March 23, 2010. (There is a graduated scale of annual plan limits available till 2014, starting at your current $1,000,000 lifetime maximum.)

Changes in Fully Insured Carriers/Allowed as of 11/15/2010 for similar benefits

Any change in fully insured carriers will cause a plan to lose its grandfather status. As a self funded plan you are allowed to change Third Party Administrators.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

BENEFITS APPLICABLE TO NON GRANDFATHERED PLANS

Coverage of immunizations & preventative care at 100% - No deductible (See attached listing of Preventative care)

Coverage of Women's Health Care at 100% - No deductible (See attached listing of Women's Health Coverage)

Abide by Deductible & out of pocket limits (updated 2016 Limits

Specific Deductible limits have been removed, but can not exceed Out of Pocket Maximums.
Family deducible can not exceed 2 x Individual Deductible
Out of pocket limits $6,850 Individual & $13,700 Family

Allow Free Choice among participating primary care physicians. – No referral for OB/GYN services

Routine patient cost in connection with Clinical Trials must be covered

Cover Emergency services without preauthorization at same coinsurance level both in and out of network

Provide internal and external review process for certain denied claims.

Brought to you by Alaska USA Insurance Brokers

Preventive Care Coverage Guidelines

The Affordable Care Act (ACA) requires non-grandfathered health plans to cover certain preventive health services without imposing cost-sharing requirements for the services. This requirement generally became effective for plan years beginning on or after Sept. 23, 2010. It does not apply to grandfathered health plans.

On July 19, 2010, the Departments of Health and Human Services (HHS), Labor and the Treasury issued interim final rules relating to coverage of preventive care services.

In August 2011, HHS issued additional preventive care guidelines for women. These additional guidelines, which are generally effective for plan years beginning on or after Aug. 1, 2012, require non-grandfathered health plans to cover women's preventive health services (such as well-woman visits, breastfeeding support, domestic violence screening and contraceptives) without charging a copayment, a deductible or coinsurance.

Special rules regarding contraceptive coverage apply to religious employers, including churches and other religious-based institutions, such as schools, hospitals, charities and universities.

COVERAGE OF PREVENTIVE CARE SERVICES

For plan years beginning on or after Sept. 23, 2010, non-grandfathered group health plans must cover certain preventive care services and may not charge copayments, coinsurance or deductibles for these services when delivered by a network provider.

The recommended preventive care services covered by these requirements are:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents and adults that are currently recommended by the Centers for Disease Control and Prevention (CDC) and included on the CDC's immunization schedules;
- For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration (HRSA) guidelines; and
- For women, evidence-informed preventive care and screening provided in guidelines supported by HRSA (for plan years beginning on or after Aug. 1, 2012).

These recommended preventive services include screening for a number of conditions, as well as counseling for various health-related issues. The complete list of recommended preventive services that must be covered can be found at www.HealthCare.gov/center/regulations/prevention.html.

Office Visits

The interim final rules clarify the cost-sharing requirements when a recommended preventive care service is provided during an office visit. Whether cost-sharing requirements may be imposed will depend on: (a) whether the preventive care service is billed or tracked separately, and (b) whether the preventive care service is the primary purpose of the office visit. Cost-sharing is permitted only if:

- The recommended preventive care service is billed separately (or is tracked as individual encounter data separately) from an office visit; or

- The recommended preventive care service is not billed separately from the office visit and the primary purpose of the office visit is not to obtain the recommended preventive care service.

Cost-sharing requirements are not allowed in cases where the recommended preventive care service is not billed separately, but it is the primary purpose of the office visit.

Example - An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is given a cholesterol screening (a recommended preventive care service). The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test. The plan may not impose any cost-sharing requirements with respect to the laboratory work. Because the office visit is billed separately from the cholesterol test, the plan may impose cost-sharing requirements for the office visit.

Example - An individual covered by a group health plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening (a recommended preventive care service). The provider bills the plan for an office visit. The blood pressure screening was not the primary purpose of the visit. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

Example - A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam (a recommended preventive care service). During the office visit, the child receives additional items and services that are not recommended preventive services. The provider bills the plan for an office visit. The recommended preventive care service was not billed as a separate charge and was the primary purpose of the visit. Therefore, the plan may not impose a cost-sharing requirement for the office visit.

Additional Clarifications

The interim final rules make clear that plans may continue to impose cost-sharing requirements on preventive care services that employees receive from out-of-network providers.

Also, plans may use reasonable medical management techniques to determine the frequency, method, treatment or setting for preventive care services, as long as they are not specified in the recommendation or guideline.

WOMEN'S PREVENTIVE CARE SERVICES

On Aug. 1, 2011, HHS issued the HRSA-supported preventive care guidelines for women to fill the gaps in the current preventive health services guidelines for women. According to HHS, these new guidelines will help ensure that women receive a comprehensive set of preventive health services without having to pay a copayment, a deductible or coinsurance.

Non-grandfathered health plans will need to include these services without cost-sharing for plan years beginning on or after Aug. 1, 2012 (Jan. 1, 2013, for calendar year plans), subject to the special provisions described below for religious employers.

Covered Health Services

The preventive care guidelines for women cover the following health services:

Type of Preventive Service	HHS Guideline	Frequency
Well-woman visits	Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should,	Annual, although several visits may be needed to obtain all necessary recommended preventive care services, depending on a woman's health status, health needs and other risk factors

8/11, BK 2/13

Preventive Care Coverage Guidelines

	where appropriate, include other preventive care services covered under ACA.	
Screening for gestational diabetes	Screening for gestational diabetes	In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes
Human papillomavirus (HPV) testing	High-risk HPV DNA testing in women with normal cytology results	Screening should begin at 30 years of age and should occur no more frequently than every three years.
Counseling for sexually transmitted infections	Counseling on sexually transmitted infections for all sexually active women	Annual
Counseling and screening for human immunodeficiency virus (HIV)	HIV counseling and screening for all sexually active women	Annual
Contraceptive methods and counseling	All FDA-approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity Special provisions apply to religious employers.	As prescribed
Breastfeeding support, supplies and counseling	Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period and costs for renting breastfeeding equipment	In conjunction with each birth
Screening and counseling for interpersonal and domestic violence	Screening and counseling for interpersonal and domestic violence	Annual

According to HHS, health plans may use reasonable medical management techniques for women's preventive care to help define the nature of the covered service, consistent with guidance provided in the interim final rules. For example, health plans may control costs and promote efficient delivery of care by continuing to charge cost-sharing for brand-name drugs if a safe and effective generic version is available. In addition, the interim final rules confirmed that plans may continue to impose cost-sharing requirements on preventive services that employees receive from out-of-network providers.

8/11, BK 2/13

Preventive Care Coverage Guidelines

Contraceptive Coverage and Religious Employers

Exemption

On Aug. 3, 2011, HHS issued an amendment to the interim final rules to allow certain non-profit religious employers offering health coverage, such as churches, to decide whether or not to cover contraceptive services, consistent with their beliefs. A non-profit religious employer, for this purpose, is an employer that:

- Has the inculcation of religious values as its purpose;
- Primarily employs persons who share its religious beliefs; and
- Primarily serves persons who share its religious beliefs.

HHS finalized this amendment on Feb. 15, 2012.

Temporary Safe Harbor

On Jan. 20, 2012, HHS announced that it would amend the interim final rules to allow non-profit employers that, based on religious beliefs do not currently provide contraceptive coverage to their employees, an additional year to comply with the new requirements. The amendment would allow these employers to delay covering contraceptive services until the first plan year beginning on or after Aug. 1, 2013 (Jan. 1, 2014 for calendar year plans). This extension covers church-affiliated organizations that do not qualify for the exception for non-profit religious employers, such schools, hospitals, charities and universities.

On Aug. 15, 2012, HHS released a bulletin describing the temporary enforcement safe harbor for nonprofit organizations that do not provide some or all of the required contraceptive coverage based on their religious beliefs.

Accommodation Approach

On March 21, 2012, the Departments issued an advance notice of proposed rulemaking to outline draft proposals and seek input on the contraceptive coverage requirement for religious employers. This proposal would not require religious organizations, such as schools, charities, hospitals and universities, to provide contraceptive coverage, refer their employees to organizations that provide contraception or subsidize the cost of contraception. However, contraceptive coverage would be provided to female employees by an independent third party, such as an insurance company or third-party administrator (TPA), directly and free of charge.

On Feb. 1, 2013, the Departments issued a proposed rule that would exempt additional religious employers from the requirement to cover contraceptive services. Under the proposed accommodations, the eligible organizations would not have to contract, arrange, pay or refer for any contraceptive coverage to which they object on religious grounds. Plan participants would receive contraceptive coverage through separate individual health insurance policies, without cost sharing or additional premiums.

For insured group health plans, the religious organization would provide the self-certification to the health insurance issuer, which would be required to automatically provide separate, individual market contraceptive coverage at no cost for plan participants. For self-insured group health plans, the religious organization would notify its third-party administrator (TPA), which would be required to automatically work with a health insurance issuer to provide separate, individual health insurance policies at no cost for participants.

The Departments also proposed rules for religious non-profit organizations that are institutions of higher education. If this type of organization arranges for student health insurance coverage, it is eligible for an accommodation comparable to the type available for a religious organization with an insured group health plan.

8/11, BK 2/13

Health Care Reform: Women's Preventive Care

Additional guidelines expand coverage

The health care reform law requires health plans to cover certain preventive care services for participants without any cost-sharing, such as deductibles, copayments or coinsurance. This requirement includes additional preventive care for women. Read on to learn about these additional benefits.

Additional Coverage for Women

The health care reform law requires that more types of preventive care are provided at no cost to women than to men. The reasoning behind this is that women have unique health needs and higher rates of chronic disease, such as diabetes, heart disease and stroke.

What Is Covered?

Health plans must cover certain additional preventive services with no copay, coinsurance or deductible for the patient. The following items are included in this coverage:

- Well-woman visits (annual preventive care visit in which adult women obtain recommended preventive services)
- Gestational diabetes screening for women 24 to 28 weeks pregnant, and women at high risk
- Human papillomavirus (HPV) testing for women 30 and older, once every three years
- Annual counseling for HIV and sexually transmitted infections, plus annual HIV testing for all sexually active women
- Contraceptives and contraceptive counseling. (Certain religious employers, such as churches, are not required to cover contraceptives)
- Breastfeeding support, supplies and counseling
- Domestic violence screening and counseling

Coverage of additional preventive services for women at no cost to the patient is effective for plan years beginning on or after Aug. 1, 2012.

Be sure to check your plan's specific rules before receiving care. The preventive care rules do not apply to health plans that have "grandfathered" status under the health care reform law.

Though plans are required to provide these services free of charge, they do have the option of using cost-control measures, such as requiring you pay for a brand name drug if a comparable generic drug is available, or charging a copayment for preventive services received at out-of-network facilities.

When Does This Take Effect?

The additional preventive care guidelines for women are effective for plan years beginning on or after Aug. 1, 2012. If your plan operates on a calendar year basis, the new rules will not be effective until Jan. 1, 2013.

Also, if you work for a church-affiliated organization, your employer may have an additional year to comply with the contraceptive coverage requirement, and may choose not to cover contraceptives at all. If this applies to you, keep in mind that a new rule is underway that will allow you to obtain contraceptive coverage directly from your insurance company.

Health Care Reform: Women's Preventive Care

Additional guidelines expand coverage

The health care reform law requires health plans to cover certain preventive care services for participants without any cost-sharing, such as deductibles, copayments or coinsurance. This requirement includes additional preventive care for women. Read on to learn about these additional benefits.

Additional Coverage for Women

The health care reform law requires that more types of preventive care are provided at no cost to women than to men. The reasoning behind this is that women have unique health needs and higher rates of chronic disease, such as diabetes, heart disease and stroke.

What Is Covered?

Health plans must cover certain additional preventive services with no copay, coinsurance or deductible for the patient. The following items are included in this coverage:

- Well-woman visits (annual preventive care visit in which adult women obtain recommended preventive services)
- Gestational diabetes screening for women 24 to 28 weeks pregnant, and women at high risk
- Human papillomavirus (HPV) testing for women 30 and older, once every three years
- Annual counseling for HIV and sexually transmitted infections, plus annual HIV testing for all sexually active women
- Contraceptives and contraceptive counseling. (Certain religious employers, such as churches, are not required to cover contraceptives)
- Breastfeeding support, supplies and counseling
- Domestic violence screening and counseling

Coverage of additional preventive services for women at no cost to the patient is effective for plan years beginning on or after Aug. 1, 2012.

Be sure to check your plan's specific rules before receiving care. The preventive care rules do not apply to health plans that have "grandfathered" status under the health care reform law.

Though plans are required to provide these services free of charge, they do have the option of using cost-control measures, such as requiring you pay for a brand name drug if a comparable generic drug is available, or charging a copayment for preventive services received at out-of-network facilities.

When Does This Take Effect?

The additional preventive care guidelines for women are effective for plan years beginning on or after Aug. 1, 2012. If your plan operates on a calendar year basis, the new rules will not be effective until Jan. 1, 2013.

Also, if you work for a church-affiliated organization, your employer may have an additional year to comply with the contraceptive coverage requirement, and may choose not to cover contraceptives at all. If this applies to you, keep in mind that a new rule is underway that will allow you to obtain contraceptive coverage directly from your insurance company.