Alliance Alert

2016 Calendar Year
Pre/Post Sixty-five Retiree Benefits

The Public Employee Benefits Alliance (PEBA) was created by a group of Texas Government leaders working together for over a year to develop strategies to manage the rising costs of healthcare benefits. PEBA was established in January 2006 and was created pursuant to Chapter 791 of the Texas Local Government Code, the Purchasing Program Chapter 271 of the Texas Local Government Code and all other applicable provisions of Texas Law. PEBA membership is open to all Texas Local Governments who pay an annual membership fee and execute a PEBA Participating Interlocal Agreement. However, Local Governments who are members of one of the political subdivision Pools will obtain automatic annual PEBA membership through the participating Pool. An additional per proposal fee is established for proposal participants for all non-Pool members.

PEBA's mission is to support the individual members by providing: negotiation services to manage the spiraling cost of healthcare and related benefits, work through the alliance procurement model to purchase healthcare and related benefits a competitive price, and contractual negotiations which will include vendor service accountability requirements. In order to accomplish this mission, PEBA makes a commitment to negotiate on behalf of the membership affordable, high-quality healthcare and related benefits and services.

The PEBA Board met September 11, 2015 and made the decision to approve the PEBA Administrative Services staff recommendation to approve the TML MultiState IEBP (IEBP) and UnitedHealthcare for pre/post sixty-five retiree benefits for calendar year 2016.

The PEBA membership will be required to sign a Letter of Intent if they are interested in accessing the 2016 pre/post sixty-five retiree benefits.

The following Retiree Experience Timeline schedule has been developed.

Function	IEBP Pre Sixty-five Retiree Benefits	UnitedHealthcare Pre Sixty-five Retiree Benefits	UnitedHealthcare Post Sixty-five Retiree Benefits
Employer Webcast: PEBA 2016 Pre/Post 65 Options	September 11, 2015 September 18, 2015, 10:00 AM September 29, 2015, 10:00 AM	September 11, 2015 September 18, 2015, 10:00 AM September 29, 2015, 10:00 AM	September 11, 2015 September 18, 2015, 10:00 AM September 29, 2015, 10:00 AM
Call Center Opens	Open	October 19, 2015 (Note: This is two weeks before Open enrollment begins on 11.1.15. No rates will be provided until 11.1.15)	November 3, 2015
Submit Roster File	N/A	October 14, 2015	October 14, 2015
Reminder Postcard #1		November	November
Reminder Postcard #2		December	December
Online Resources	October 1, 2015	November 1, 2015	Week of November 9, 2015
Employer Retiree Election Decision	October 23, 2015	October 23, 2015	October 23, 2015
Announcement Letter	November 1, 2015	Week of October 20, 2015	Week of October 20, 2015
Retiree Enrollment Begins	October 26, 2015	November 1, 2015	November 16, 2015
Pre 65 Retiree Enrollment Begins	October 26, 2015	November 6, 2015	November 3, 2015
IEBP Retiree Enrollee Webcast (Pool Members)	September 29, 2015	September 29, 2015	September 29, 2015
Retiree Enrollment Date Deadline	December 4, 2015	December 15, 2015	December 4, 2015
Enrollment Kits Mailed	November 1, 2015	November 1, 2015	November 1, 2015
Welcome Kit to Retirees	N/A	Mailed within a few days of the policy being effectuated. This means the first month that the premium is received.	Mailed within a few days of the policy being effectuated. This means the first month that the premium is received.

Function	IEBP Pre Sixty-five Retiree Benefits	UnitedHealthcare Pre Sixty-five Retiree Benefits	UnitedHealthcare Post Sixty-five Retiree Benefits
ID Cards	Prior to December 23, 2015	Mailed within a few days of the policy being effectuated. This means the first month that the premium is received.	Mailed within a few days of the policy being effectuated. This means the first month that the premium is received.

Texas Legal Update

1. Chapter 175 of the Local Government Code-applies to a person who retires from municipal employment with a population of 25,000 or more
   a. The level of coverage provided under this chapter at any given time is the same level of coverage provided to current employees of the municipality at that time
   b. The person may elect to continue coverage at a reduced level, if offered by the municipality
2. Rate may be at the same rate available to active employees or a reasonable or actual utilization rate established for retirees that may be greater than the rate offered to active employee
   a. Manual Rate with Retirees and Actives
   b. Manual Rates Active only
   c. Manual Rates for Retirees only
   d. Utilization Review/Loss Ratio for Actives and Retirees
   e. Utilization Review/Loss Ratio for Actives only
   f. Utilization Review/Loss Ratio for Retirees only
3. THE TEXAS CONSTITUTION, ARTICLE 3. LEGISLATIVE DEPARTMENT
   a. Sec. 53. COUNTY OR MUNICIPAL AUTHORITIES; EXTRA COMPENSATION; UNAUTHORIZED CLAIMS. The Legislature shall have no power to grant, or to authorize any county or municipal authority to grant, any extra compensation, fee or allowance to a public officer, agent, servant or contractor, after service has been rendered, or a contract has been entered into, and performed in whole or in part; nor pay, nor authorize the payment of, any claim created against any county or municipality of the State, under any agreement or contract, made without authority of law
4. 1625.10/EEOC Costs and benefits under employee benefit plans
   a. Possible discrimination against the older employee by making compensation in the form of employee and denying that compensation altogether to an older employee unwilling or unable to meet the less favorable terms. Such discrimination is not authorized by Section 4(f)(2).
   b. Awaiting final written regulations on EEOC costs and benefits

Employer Plan Guidelines

Pre Sixty-five (65) Employer Benefit Plan Options		Post Sixty-five (65) Employer Benefit Plan Options	
IEBP Pre Sixty-five (65) Employer Benefit Plan Options	**UnitedHealthcare Pre Sixty-five (65) Employer Benefit Plan Options**	**UnitedHealthcare Post Sixty-five (65)** Employer Benefit Plan Options	
Employers may choose to have the pre sixty-five retirees access the active employee benefits at the active employee cost.	Employers may offer their pre sixty-five retirees the employer's affordable (less than 9.5% of Box 1 of the employees W-2 form) minimum essential coverage employer plan or the UnitedHealthcare's Off Exchange Pre Sixty-five Connector Model benefit plans.	UHC is offering the employers two Medicare Supplement Plans, two stand-alone Medicare Part D Plans and two Medicare Advantage HMO Plans that are available in designated geographic areas.	The Individual Connector Model is available to employers who have fifty (50) or more retirees. The Post 65 Individual Connector model has Tier 1 generic only prescription coverage in the gap for Part D.

Pre Sixty-five (65) Employer Benefit Plan Options		Post Sixty-five (65) Employer Benefit Plan Options	
IEBP Pre Sixty-five (65) Employer Benefit Plan Options	**UnitedHealthcare Pre Sixty-five (65) Employer Benefit Plan Options**	**UnitedHealthcare Post Sixty-five (65)** Employer Benefit Plan Options	
Employers may choose to have the pre sixty-five retirees access the active employee benefit plan at 195% of the active employee rate.	Employers may offer their pre sixty-five retirees the employer's non-affordable (more than 9.5% of Box 1 of the employees W-2 form) minimum essential coverage plan or the UnitedHealthcare's On or Off Exchange Pre Sixty-five Connector Model benefit plans.	1. The employer will have the option to choose one HMO Advantage Plan One Supplemental Plan and One Part D Prescription Plan. 2. The retiree will have the option to choose one medical plan (if supplemental plan, retiree can choose medical only or Medicare Advantage must be Medical and Prescription benefits).	
Employers may offer their pre sixty-five retirees the active employee benefit plan or the Pool pre sixty-five metal benefit plan options. Once a pre sixty-five retiree transfers to a Pool metal plan they cannot transition back to the employer plan.		The HMO Advantage Plan will only be available to retirees who reside in the county specific area. The HMO Advantage Plans **must be** bundled with the prescription plan of the employer's choice. If emergency room copay added $75.00 - the pricing impact of changing the ER Copay from $50 to $75 would be $.50 pmpm. This would apply to each of the current HMO rates. Pool level or independent PEBA employer level. 1. UHC will offer the employer one option of two Medicare Advantage HMO Plans. a. Austin Counties: Bell, Travis, Williamson b. Houston Counties: Austin, Brazoria, Fort Bend, Hardin, Harris, Jefferson, Liberty, Montgomery c. Corpus Christi Counties: San Patricio d. Dallas/Fort Worth: Collin, Dallas, Denton, Ellis, Johnson, Kaufman, Rockwall, Tarrant e. San Antonio Counties: Atascosa, Bexar, Comal Guadalupe, Kendall, Wilson	
		1. Part D Options: Option I is coverage in the gap. The coverage in the gap option requires 35% employer subsidy except for IEBP membership. UHC is offering the employer one option out of two Part D Benefit Plans. a. Option I i. Formulary H (Full Gap Coverage) - Group Select b. Option II i. Formulary G (Generic in the Gap) - Group Choice	

IEBP Pre Sixty-five Retiree Medical Options

The Pool member employer may offer their retirees a choice of one of the four plan options. Pool membership not currently accessing the pre sixty-five Pool will require individual underwriting and may not receive the below rates.

Pre Sixty-five Retire Pool Rates			2014	Jun'13-May'14 Loss Ratio (126.24% Overall LR)	% Increase	2015	% Increase	2016
Platinum	PA95-100-50-MAC A	Retiree	$840.70	104.26%	25.00%	$1,050.88	20%	$1,261.06
Platinum	PA95-100-50-MAC A	Composite	$1,002.22		25.00%	$1,252.78	20%	$1,503.34
Gold	PA85-125-50-MAC A	Retiree	$811.38	37.63%	25.00%	$1,014.24	20%	$1,217.10
Gold	PA85-125-50-MAC A	Composite	$967.00		25.00%	$1,208.76	20%	$1,450.52
Silver	*PA75-150-50-MAC A*	*Retiree*	*$784.60*	*132.14%*	*25.00%*	*$980.76*	20%	$1,176.92
Silver	*PA75-150-50-MAC A*	*Composite*	*$934.84*		*25.00%*	*$1,168.56*	20%	$1,402.28
Bronze	PA64-175-50-MAC A	Retiree	$754.22	171.51%	25.00%	$942.78	20%	$1,131.34
Bronze	PA64-175-50-MAC A	Composite	$898.38		25.00%	$1,122.98	20%	$1,347.58

Plan Designs	Platinum Plan	Gold Plan	Silver Plan	Bronze Plan
Benefit Percentage	90% / 50%	80% / 50%	70% / 50%	60% / 40%
Network Deductible: Individual/Family	$1,000.00 / $2,000.00	$1,250.00 / $2,500.00	$1,500.00 / $3,000.00	$1,750.00 / $3,500.00
Non-Network Deductible: Individual/Family	$1,250.00 / $2,500.00	$1,500.00 / $3,000.00	$1,750.00 / $3,500.00	$2,000.00 / $4,000.00
Network Out of Pocket Max: Individual/Family	$5,000.00 / $10,000.00	$5,000.00 / $10,000.00	$5,000.00 / $10,000.00	$5,000.00 / $10,000.00
Healthy Initiatives Program	▪ Biometric Screenings and Health Power Assessment paid 100% for Choice Plus network providers. ▪ Completion of Biometric Screenings and Health Power Assessment per Calendar Year = $150.00 Incentive payment			

Medication Therapy Management Program

The Prescription plan offered by IEBP is a Medication Therapy Management Program (MTMP) that promotes Evidence Based Prescription Utilization, Consumer Education, Cost Effective Alternate Prescription Options, and Coverage for prescriptions and biotech prescriptions that are available through the Pharmacy Benefit Manager will be paid per the Medication Therapy Management Guide. Eligible injectable, biotech, and biosimilar prescriptions may be purchased from network providers per the Medication Therapy Management Guide.

For eligible prescriptions purchased outside of the Pharmacy Benefit Manager or the Network Providers, the plan will pay at the out of network benefit percentage and will not, at any time, pay at 100% for any prescription services under the out of pocket provision of the Plan.

This plan requires Prior Authorization and Step Therapy compliance.

MAC A Plan: If a brand name drug is dispensed and a generic alternate drug exists, the **Covered Individual pays the difference between the brand name and generic** price in addition to the appropriate copayment for the brand name. The **cost difference between the brand name and generic price does not apply to any individual deductibles or out of pocket amounts**. The MAC differential applies to all prescriptions purchased through this program when a generic alternate is available.

MAC C Plan: If a brand name drug is dispensed and a generic alternate drug exists, the Covered Individual pays the appropriate brand copay.

Covered Individual Out of Pocket (OOP)			
Prescribed (Doctor Ordered) Over the Counter Alternates and Prescription Networks	**Retail:** (up to 34 day supply max unless noted otherwise)	**Mail/Maintenance:** (up to 90 day dispensement)	**SpecialtyRx/Biotech/ Biosimilar:** (up to 34 day dispensement)
• Smoking Cessation (Nicorette Gum), Quantity Limit - 3 months per plan year • Aspirin, Folic Acid, Fluoride Chemoprevention Supplements, Iron Deficiency Supplements, and Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at an increased risk for falls; per prescription	$0.00	N/A	N/A
Network Retail: 34 day Non-Cost Share most Generic Dispensement	$0.00 (up to 34 day supply)	N/A	N/A
Network Retail: 90 day Non-Cost Share most Generic Dispensement	$9.00 (35 up to 90 day supply)	$25.00	
OptumRx Network Non-Cost Share Best Brand/Formulary List	$38.00	$95.00	
OptumRx Network Non-Cost Share Non-Best Brand/Non-Formulary List	$60.00	$150.00	
OptumRx Network Cost Share	$120.00	$300.00	
OptumRx Specialty/Biotech Prescriptions	N/A	N/A	$100.00 (up to 34 day supply)
OptumRx Biosimilar Generic Prescriptions	N/A	N/A	$75.00 (up to 34 day supply)
Prescription Refill Control Standards	75%	70%	

Women's Preventive Health Services Covered Individual Out of Pocket (OOP)			
Benefit	**Retail Rx Medical Plan**	**Prescription Plan**	**Plan Ineligible**
Oral Contraceptives Generic *(no cost share)*		X	
IUD Device *(no cost share)*	X	X	
Implant Device *(no cost share)*	X	X	
Permanent Implantable Contraceptive Coil *(subject to the appropriate deductible and benefit percentages)*	X		
Insertion and/or Removal of Contraceptive Devices *(no cost share)*	X		
Urine Pregnancy Test, Urinalysis, Sonogram to Detect Placement of Device *(no cost share)*	X		
Injectable Contraceptives *(no cost share)*	X	X	
Injectable Administration Fee *(no cost share)*	X		
Diaphragm (cervical), Hormone Vaginal Ring, Hormone Patch, Cervical Cap, Spermicides, Sponges *(no cost share)*		X	
Diaphragm (cervical) Instruction and Fitting Fee *(no cost share)*	X		
Emergency Contraceptives		X	
Over-The-Counter (OTC) Contraceptives not otherwise listed as covered			X
Contraceptive Management *(no cost share)*	X		
Female Condoms *(no cost share)*		X	
Medications for risk reduction of breast cancer in women who are at increased risk for breast cancer and at low risk for adverse medication effects: Tamoxifen or Raloxifene		X	

Value Added Supplement Benefits Pre Sixty-five Dental and Vision Rates

Employers that offer one or more of the IEBP Pre Sixty-five retiree plans will also have the option of making available to their retirees fully funded Dental and Vision plan options.

2016 Dental II Plan 50% Increase	Mandatory*	Voluntary
Pre Sixty-five Retiree	$17.86	$24.10
Dependent		
Composite	$31.42	$42.46
OR		
Spouse	$25.02	$33.82
Child(ren)	$21.48	$29.02
Family	$36.78	$49.68

2016 Dental III Plan 50% Increase	Mandatory*
Pre Sixty-five Retiree	$62.28
Dependent	
Composite	$97.72
OR	
Spouse	$65.58
Child(ren)	$72.12
Family	$128.88

2016 Dental IV Plan 50% Increase	Mandatory*	Voluntary
Pre Sixty-five Retiree	$41.82	$64.74
Dependent		
Composite	$69.04	$106.92
OR		
Spouse	$56.50	$87.48
Child(ren)	$48.12	$74.50
Family	$83.64	$129.54

** 100% Employer subsidy required for Pre-65 Retiree participation*

2016 Vision A Plan 0% Increase	Mandatory*	Voluntary
Pre Sixty-five Retiree	$7.68	$10.66
Dependent		
Composite		
Family	$15.32	$21.28

2016 Vision B Plan 0% Increase	Mandatory*	Voluntary
Pre Sixty-five Retiree	$10.66	$10.66
Dependent		
Composite		
Family	$21.28	$21.28

** 100% Employer subsidy required for Pre-65 Retiree participation*

Retiree Reimbursement Arrangement (RRA) Option

To complement the Pre Sixty-five plans, the employers may also elect to purchase an RRA option for an administrative rate of $3.70 PRPM (per retiree per month). The Retiree Reimbursement Arrangement (RRA) must be executed annually. IEBP will request confirmation regarding the responsible party (Employer or retiree) for the $3.70 monthly administrative fee.

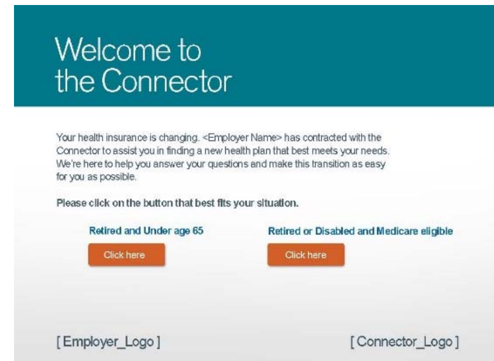
Medical/Rx Plan Rates

The IEBP Pre Sixty-five plans are group plans that provide guarantee issue for current covered individuals. Pre Sixty-five benefit coverage will continue until the end of the month of the covered retiree's 65th birthday. Coverage for early retirees under these plans will require that the early retiree enroll in the IEBP plan within 31 days of commencement of their Pre 65 retirement and meet the definition of retiree per the employer's Retiree Policy, Ordinance, or Resolution. In addition for eligibility under the plan, IEBP will require that the early retiree meet the employer's definition of a retiree and that the retiree receive all other applicable benefits provided to retiree population.

UnitedHealthcare Pre and Post Sixty-five Retiree Benefit Option Overview

I. Pre Sixty-five Plan Options
   - A. Advocacy Service Center is available for the lifetime of the retiree as long as the members entered into the plan through the connector exchange and chose a carrier that was and is still offered in the connector exchange. Once they transition to one of the carriers on the exchange they have this as a service. If the issue cannot be resolved by the carrier client service center identified on the back of the ID card, they can call to the toll free number for the Connector Exchange for assistance. This is available if the retiree has employer subsidy or not.
   - B. The Connector Exchange offers Product Advisors to assist in access to Multiple Carriers for individual plan options and selection. A sample of the carriers are: BC/BS, Coventry, Humana, Anthem, Empire, UnitedHealthcare, CIGNA, HSCS, Aetna, Kaiser Permanente
   - C. An individual selecting an "On Exchange Plan" may be Eligible for tax subsidies based on House Hold Income. (See definition below.)
     - 1. Connector Exchange Product Advisor Assistance
       - a. Federal Run Exchanges
       - b. State Run Exchanges

D. Internet Enrollment Process



- 1. Interactive Tools
  - a. Plan selector (needs assessment)
  - b. Plan results by area
  - c. Drug cost estimator
  - d. Provider search
  - e. Pharmacy locator
  - f. Federal tax credit estimator
- 2. URL Employer Co-Branded Site with UnitedHealthcare
- 3. Employer Eligibility Transfer
  - a. Pre Sixty-five Connector Model Pre-Populated Fields
    - i. First Name
    - ii. Last Name
    - iii. Social Security Number
- 4. Enrollment 10 minutes timeframe
  - a. Privacy
  - b. Application per Employer Eligibility File
  - c. Health Status ONLY Tobacco Use (Load)
  - d. Guarantee Issue
  - e. Every Page is toll free number 800 local time 7 days a week for access to enrollment advisor
  - f. Open Enrollment January Plan Year
  - g. Qualifying Event
  - h. Loss of Coverage if no other plan to access excluding COBRA

E. On Exchange/Off Exchange Multi-Carrier Plan Availability. Call center advisors use a “needs dialogue” approach to narrow the product portfolio to one product that On Exchange/Off Exchange Multi-Carrier Plan Availability. Call center advisors use a “needs dialogue” approach to narrow the product portfolio to one product that meets a retiree’s specific need

- 1. Enrollee Questions
  - a. Do you prefer on exchange or off exchange model.
  - b. Do you qualify for on exchange subsidy support because you household income is between 100-400% of Federal Poverty Level
  - c. If yes, the following household income questions will be required:
    - i. Household Income
      - ➤ Household Income
        - » **Who/What is defined as “household”?**
        - » Tax filers + tax dependents = household
        - » For the Model, your household generally includes the tax filers plus their tax dependents. If you claim someone as a tax dependent, include them on your application, even if they’re not applying for insurance.
        - » There are exceptions. Sometimes the model includes people you live with who aren’t in your tax household
        - » The Model counts income for each of these people and considers them part of your household depending on things like their age and relationship to you, the type and amount of income they have, and more.
      - ➤ Understanding Elements to Qualify for Federal Tax Credit, Individuals to include on the Application
        - » Yourself
        - » Your spouse

- Your Children living with you – even if they make enough money to file a tax return themselves
- Anyone you include on your tax return as a dependent even if they don't live with you
- Your unmarried partner; only if one or both of these apply:
  - They are your dependent for tax purposes
  - They are the parent of your child

- Understanding Elements to Qualify for Federal Tax Credit
  - **What is included as income?**
    - When you fill out a model application, you'll need to estimate what your household's income will be **in the next year**—the year you'll be covered. If you're not sure, make your best estimate:
    - COUNTED AS INCOME
      - Wages and salaries (W-2)
      - Tips
      - Net income from self-employment or business
      - Unemployment compensation
      - Social Security payments, including disability payments
      - Retirement of pension income, including IRA or 401(k) withdrawals
      - Investment income (dividends/interest)
      - Rental income
      - Other taxable income (prizes, awards, gambling winnings
    - NOT INCLUDED AS INCOME
      - Child Support
      - Gifts
      - Supplemental Security Income (SSI)
      - Veterans' disability payments
      - Workers' compensation
      - Proceeds from loans (like student loans, home equity or bank loans)

2. Tax Subsidy 100%-400%

a. **2016 Federal Poverty Level**

Every year, the perimeters of the Federal Poverty Level (FPL) increase based on the cost of living. Families need to understand where they fall on the FPL so they know whether they are eligible for **Medicaid** in their state or whether they are eligible for a federal Subsidy because they earn between 100 and 400 percent of the FPL, or whether they are eligible for a tax credit because they purchased a Silver plan and earn less than 250 percent of the FPL.

The following rates are updated for the 2016 calendar year. The 2016 Open Enrollment Period begins on **November 1st and closes on January 31, 2016.**

Family Size	100%	133%	138%	250%	400%
1	$11,770	$15,654	$16,242	$29,425	$47,080
2	$15,930	$21,186	$21,983	$39,825	$63,720
3	$20,090	$26,719	$27,724	$50,225	$80,360
4	$24,250	$32,252	$33,465	60,625	$97,000
5	$28,410	$37,785	$39,205	$71,025	$113,640
6	$32,570	$43,318	$44,946	$81,425	$130,280
7	$36,730	$48,850	$50,687	$91,825	$146,920
8	$40,890	$54,383	$56,428	$102,225	$160,360

b. With the above responses the UnitedHealthcare system will ping healthcare.gov for verification.

3. Do your prefer less premium or broader based of coverage
4. How often do you use the benefit plan
5. Which best describes you
   a. One physician coordinating care
   b. More flexibility
   c. Network Status via zip code provider name, specialty
   d. "Help Me" Functionality
6. Do you have ongoing prescriptions
   a. Medication
   b. Dose
   c. The RX coverage depends on the plan the individual selects. Every carrier has levels of plans to review with the participants. Some carriers are stronger in RX than others. The tool has a look up function to identify how the drug is covered by a carrier. There are options with the top rated plans in each. The advisor will guide the retiree through this dialogue.
7. View Best Plan
8. View Runner Up Plan
   a. Metal Plans
      i. Platinum
      ii. Gold
      iii. Silver
      iv. Bronze

II. "Off Exchange Plans" often broader Networks

A. Bronze Plan
   1. Lowest Premiums
   2. 60% Plan Cost Sharing
   3. Catastrophic Coverage

B. Silver Plan
   1. Low Premiums
   2. 70% Plan Cost Share
   3. Baseline plan for federal subsidy

C. Gold Plan
   1. Competitive Premiums
   2. 80% Plan Cost Share

D. Platinum Plans
   1. Highest Premiums
   2. 90% Plan Cost Share

State	Geographic Area	Bronze	Silver	Gold	Platinum
Texas Blue Cross	Harris County	$406-$609	$531-$772	$645-$955	N/A
Texas UHC	Harris County	$477-$526	$560-$583	$624-$636	$698
Texas Humana	Harris County	$530-$692	$624-$723	$750-$889	$951-$1139
Texas Other?	Harris County	$400-$627	$526-$809	$631-$899	N/A

State	Geographic Area	Bronze	Silver	Gold	Platinum
Texas Blue Cross	Travis County	$424-$623	$555-$790	$674-$977	N/A
Texas UHC	Travis County	$467-$515	$548-$571	$611-$623	$684
Texas Humana	Travis County	$412-$573	$486-$599	$583-$736	$740-$943
Texas Other?	Travis County	$429-$628	$511-$799	$635-$883	N/A

SAMPLE

State	Geographic Area	Bronze	Silver	Gold	Platinum
Texas Blue Cross	El Paso County	$361-$518	$472-$657	$574-$812	N/A
Texas UHC	El Paso County	$571-$630	$670-$699	$748-$762	$837
Texas Humana	El Paso County	N/A	N/A	N/A	N/A
Texas Other?	El Paso County	$404-$483	$495-$590	$637-$696	N/A

SAMPLE

E. Dental United PPO Network
   1. Two plans available
      a. Value
      b. Premier
   2. Network Benefits
      a. Preventive covered 100% no deductible, no waiting period
      b. Annual deductible of $50 per person for Basic/Major combined
      c. Basic covered 80/20 after deductible & 6 month waiting period
      d. Major covered 50/50 after deductible & 12 month waiting period
   3. Annual maximum of $1,000 per person
   4. Premiums are typically $30-50 PMPM

F. Optional Vision Rider (Potential rider to dental coverage)
   1. Easy copayments for network basic vision services, including exam and prescription eye wear
   2. Extensive vison care network includes over 31,000 private practice and retail chain providers.
   3. Benefit limitations to once every 12/24 months

Other

A. The state of Texas currently does not have a state run health exchange where you can get quotes direct. The Connector Exchange will assist you with Federal Exchange Options and off exchange Options.

B. For last year's Public Enrollment: Most people who sign up for insurance using the marketplace qualify for assistance. According to the Department of Health and Human Services, about 87 percent of people who used the federal exchange to enroll in 2015 qualified for subsidies. The average subsidy covered 72 percent of the premium price, which left many individuals paying just $101 per month for coverage this year.

C. If it's outside of open enrollment but you want to estimate how much of a subsidy you might be eligible for, then check out the subsidy calculator available from the Kaiser Family Foundation. This will give you some idea of what you might expect once open enrollment starts.

D. For marketplace and privately purchased plans, there's a set time when you can enroll called the annual open enrollment period. For coverage beginning in 2016, the open enrollment period will run from Nov. 1, 2015 through Jan. 31, 2016. Outside of these dates, you can only sign up for marketplace coverage if you qualify for a special enrollment period.

E. To qualify for special enrollment: A time outside of the open enrollment period during which you and your family have a right to sign up for health coverage. In the Marketplace, you qualify for a special enrollment period 60 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other health coverage. Job-based plans must provide a special enrollment period of 30 days.

F. If you forego health insurance entirely, then you'll pay a fee for non-compliance. When you file your 2016 taxes, you'll be charged the greater of $695 per adult in your household or 2.5 percent of your taxable household income.

G. If you decide not to take COBRA coverage, you can enroll in a Marketplace plan instead. Losing job-based coverage qualifies you for a Special Enrollment Period. This means you have 60 days to enroll in a health plan, even if it's outside the annual Open Enrollment Period.

Can you change from COBRA to a Marketplace plan?		
	If your COBRA is running out	If you're ending COBRA early
During Open Enrollment	Yes, you can change.	Yes, you can change.

Can you change from COBRA to a Marketplace plan?		
	If your COBRA is running out	**If you're ending COBRA early**
Outside Open Enrollment	Yes, you can change - you qualify for a Special Enrollment	No, you can't change until the next Open Enrollment Period, your COBRA runs out, or you qualify for a Special Enrollment Period another way.

H. Does COBRA count as minimum essential coverage?
   1. Yes. This means if you have COBRA coverage you don't have to pay the fee that people without coverage must pay
I. If an employee or family member is covered by a group plan and has a COBRA event (which causes a loss of coverage), can he or she qualify for coverage on the insurance exchange as a special enrollment?
   1. The answer to the question will be "yes," if COBRA is not elected.
   2. If a former employee is simply offered COBRA coverage but does not elect it, he or she should become exchange coverage eligible, presuming other qualification criteria are satisfied. Moreover, the subsidy could be available. (This is true because the individual will only be treated as "eligible for employer coverage through COBRA" -- and disqualified for subsidies -- for months when the person has elected COBRA coverage.) Without a COBRA election, the mere offer of COBRA will not preclude the individual's eligibility for exchange coverage enrollment, or the subsidy.
   3. By contrast, if COBRA is elected, the answer to the same question is "no." Moreover, the employee cannot later enroll in exchange coverage if he or she chooses to drop (voluntarily walk-away from) COBRA coverage.
   4. Electing COBRA immediately ends any special enrollment right. So, once the person takes COBRA coverage, there will be no special enrollment on the exchange until either COBRA is exhausted, or until the next exchange open enrollment season.
J. What about the impact of COBRA on eligibility for a federal subsidy which can be used to buy coverage on the exchange?
   1. Ironically, the subsidy remains available - regardless of whether COBRA is offered and even regardless of whether COBRA is actually elected. Under the technical rules governing how federal subsidies are extended, the mere COBRA offer does not affect an individual's ability to qualify for the subsidy, and neither does actually electing COBRA (since continuation is not technically employer-paid coverage). The seeming inconsistent application of the rule described above, inside the context of possible "subsidy" eligibility requires a closer look.
   2. Why is this ironic? Exchange marketplace eligibility immediately closes upon a COBRA election. So, even if the individual technically qualifies for a subsidy, that person cannot enter the exchange outside of the special enrollment or open enrollment, which is the only place where the person can spend the subsidy. It is as though the person is barefoot and has money, but the only shoe store in town is closed. In other words, unless the individual enrolls via an exchange, there is no way he or she can actually spend the government's subsidy dollars.
K. Can the former employee drop COBRA?
   1. If COBRA is elected and then dropped, the person is precluded from enrolling in exchange coverage at their convenience. This means that "voluntarily dropping" COBRA or, perhaps more commonly, failing to pay for COBRA, will not create a new right to enroll on the exchange. Although the subsidy may be available technically, for similar reasons as explained above, the subsidy cannot be used ("spent") without exchange access also being available.
L. What if the employer paid for COBRA for some period of time, such as for six months following severance from employment, then later for whatever reason that employer stops paying for the continuation coverage? This question has particular implications for employers planning to transition employees out of the workforce - both voluntary and involuntary terminations of employment.
   1. Again, once COBRA is elected, the failure of anyone, even a former employer, to pay the premium will not trigger an enrollment right. The insurance carriers on the exchange can require the former employee to wait until the next annual enrollment period, so the result is the same as above: Even if the former employee can qualify for the subsidy, the individual cannot access the exchange policies, so he cannot "spend" the subsidy. In order to

have health insurance, the former employee would need to either pay for the COBRA coverage until the earlier of the next open enrollment for the exchange, or wait until COBRA is exhausted. Due to this Catch-22, it would be preferable for the severance negotiation to be a cash amount, rather than payment for COBRA premiums. The former employee could then elect exchange coverage, possibly qualifying for a subsidy (a possibility the former employer should never guarantee or promise).

M. If someone voluntarily drops COBRA during an exchange open enrollment, are they eligible for subsidies in the individual marketplace?

1. Per federal agency guidance issued April 21, 2014, during the exchange open enrollment, a person can voluntarily drop his or her COBRA coverage and obtain an exchange plan instead, even if COBRA has not expired. The individual also may be determined eligible for a subsidy in this case. (This result is possible because the exchange is hosting its enrollment season, and subsidy money that an individual might qualify for is therefore available to use to fund purchases.)
2. Outside of Marketplace open enrollment, if a person's COBRA expires, he or she would qualify for a special enrollment period (and he or she may be eligible for a subsidy). This interpretation fits with the long-standing HIPAA portability special enrollment rule that allowed an individual access to "other coverage" upon COBRA exhaustion.) By contrast, if the COBRA person is voluntarily dropping coverage outside of open enrollment (the COBRA has not yet expired), he would not qualify for a special enrollment period. During the next open enrollment period or when COBRA expires, he could enroll in a policy and may be eligible for a subsidy

N. **Retiree Reimbursement Account Management** - Optional employer subsidy through a Retiree Reimbursement Arrangement (RRA) or members may pay premiums via electronic fund transfer:

1. If there is a Low Benefit PPO and NOT a HDHP that has excess HRA dollars can that be transferred to the RRA? **Yes**
2. The current RRA administrator funds and administration will be transferred to Optum and the fee per participant be **$3.75** per acct per month. Optum will use the standard industry tool called "Take Over". The balance will appear in the Optum account and be notional dollars. The claims history will not transfer.
3. Is there any additional transfer fees? **No**, unless there are special file issues required.

O. <u>**On and Off Exchange Connector Exchange Rules**</u>

1. Can the Employer Subsidize the value of the premium for the individual plan and the retiree still gain access to the Federal Subsidy?
   a. **No, it's either the Federal Subsidy or the Employer Subsidy the retiree has to take one versus the other.**
2. If the retiree moves from the HRA to the RRA and the monies are transferred to the RRA and there is no additional employer contribution, can the retiree then access the Federal Subsidy?
   a. **No**, our general opinion is that if the person is "double dipping" (i.e. getting the tax benefit of using HRA/RRA funds to pay for premiums, they cannot also qualify for a subsidy). In this case, no more money is going in, but if they can use those funds to pay premium, then they are, in essence double dipping.
3. If the plan is unaffordable, they can then go to the exchange and take a federal subsidy. Here are the general rules:
   a. A eligible retiree will qualify for federal premium tax credits so long as:
      i. Their income is between 100% and 400% of the FPL for their family size as shown below AND
      ii. The cost of employer provided retiree only coverage exceeds 9.5% of their MAGI (Modified Adjusted Gross Income – the income used for purposes of this test)

      So, for an individual earning $40,000 per year, as long as the cost of employer coverage exceeds $316.67 per month (9.5% x $40000 / 12), they would receive a premium tax credit.

      Since any single individual whose income is above $47,080 will not qualify anyway, we can say that if the employer coverage costs more than $372.72 per month (9.5% x $47080/12), any retirees who is single will qualify if their income is below 400% of FPL ($47,080).

Similarly, we can say anyone with a two person family will qualify if their income is below 400% FPL, if the employer plan costs more than $504.45 (see below for the corresponding figures for three to eight person families.)

The point of all of this is that there may be some individuals with larger families whose income is below 400% FPL (so they satisfy **i.** above) but the cost of the TML coverage is less than 9.5% of their income (so they fail **ii.** and are therefore NOT eligible for federal premium tax credits).

Affordability Table

400% FPL		9.5% of 400% FPL
1	47080	$ 372.72 monthly
2	63720	$ 504.45
3	80360	$ 636.18
4	97000	$ 767.92
5	113640	$ 899.65
6	130280	$ 1,031.38
7	146920	$ 1,163.12
8	163560	$ 1,294.85

Post Sixty-five Plan Options

1. Group Medicare Advantage National PPO NPPO
2. Group Medicare Supplemental Program
3. *AARP Supplemental Program*
4. Connector Model
5. Medicare HMO Advantage Plan

UnitedHealthcare (UHC) Post Sixty-five (65) Employer Benefit Plan Options

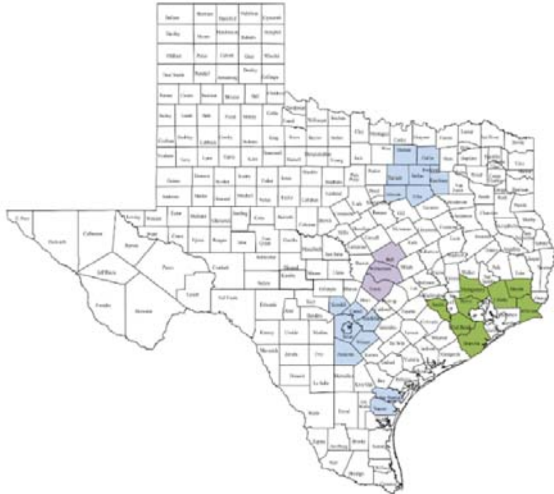
UHC Post Sixty-five Retiree Plan Options to PEBA

PEBA	2011	2012 Renewal	2012 Rate Relief	2012 Final	2013	2014	2015	2015 % Renewal	2016	2016 % Renewal
HMO Austin, full Rx**	$320.61	$341.45	$333.43	$320.92	$336.97	$336.97	$368.98	9.50%	$391.12	6.00%
HMO Houston, full Rx**	$288.32	$307.06	$299.85	$288.28	$302.69	$302.69	$331.45	9.50%	$351.33	6.00%
HMO Other, full Rx**	$245.49	$261.45	$255.31	$242.80	$254.94	$254.94	$279.17	9.50%	$295.82	5.96%
HMO Austin, tier 1 Rx**	$220.64	$234.98	$229.47	$229.47	$240.94	$240.94	$263.83	9.50%	$279.66	6.00%
HMO Houston, tier 1 Rx**	$183.50	$195.43	$190.84	$190.84	$200.38	$200.38	$219.42	9.50%	$232.58	6.00%
HMO Other, tier 1 Rx**	$143.30	$145.30	$141.89	$141.89	N/A	N/A	N/A	N/A		
Supp Plan F	$184.00	$197.80	$191.36	$191.36	$200.93	$200.93	$217.00	8.00%	$225.68	4.00%
Supp Plan K	$105.13	$113.01	$109.34	$109.34	$114.81	$114.81	$123.99	8.00%	$128.95	4.00%
Rx Plan 1 full Rx	$167.40	$200.40	$187.49	$179.99	$185.39	$185.39	$194.66	5.00%	$206.34	6.00%
Rx Plan 2, tier 1 Rx	$60.77	$75.96	$68.06	$68.06	$70.10	$70.10	$73.61	5.00%	$78.02	5.99%
TAC										
Senior Supp Plan F + Admin Fee	$194.00	$207.80	$201.36	$201.36	$210.93	$210.93	$227.00	8.00%	$235.68	3.82%
Rx Plan 1 full Rx	$167.40	$200.40	$187.49	$179.99	$185.39	$185.39	$194.66	5.00%	$206.34	6.00%

** If emergency room copay added $75.00 - the pricing impact of changing the ER Copay from $50 to $75 would be $.50 pmpm. This would apply to each of the current HMO rates.

Post Sixty-five Retiree Benefits

Medicare Advantage HMO with Integrated Medicare Part D Plan Options in Texas



2016 HMO SERVICE AREAS AND MONTHLY RATES

Option 1		Option 2	
Austin, TX:	**$391.12**	Austin, TX:	**$279.66**
Counties: Bell, Travis, Williamson			
Houston, TX:	**$351.33**	Houston, TX:	**$232.58**
Counties: Austin, Brazoria, Fort Bend, Hardin, Harris, Jefferson, Liberty, Montgomery			
Other:	**$295.82**	Other:	**N/A**
Counties: **Corpus Christi**: Nueces, San Patricio; **Dallas/Fort Worth**: Collin, Dallas, Denton, Ellis, Johnson, Kaufman, Rockwall, Tarrant counties; **San Antonio**: Atascosa, Bexar, Comal, Guadalupe, Kendall, Wilson			

Medical Plan with Prescription Plan	HMO Option 1 | 3A Custom Plan Full Gap Coverage (requires employer subsidy of 35% excluding IEBP)	HMO Option 2 | 3A Custom Plan Tier 1 Generic Gap Coverage
Service Area: **Monthly Rate***	**Austin TX:** Bell, Travis, Williamson counties **$391.12**	**Austin TX:** Bell, Travis, Williamson counties **$279.66**
Service Area: **Monthly Rate***	**Houston TX:** Austin, Brazoria, Fort Bend, Hardin, Harris, Jefferson, Liberty, Montgomery counties **$351.33**	**Houston TX:** Austin, Brazoria, Fort Bend, Hardin, Harris, Jefferson, Liberty, Montgomery counties **$232.58**
Service Area: **Monthly Rate***	**Other: Corpus Christi**: Nueces, San Patricio; **Dallas/Fort Worth**: Collin, Dallas, Denton, Ellis, Johnson, Kaufman, Rockwall, Tarrant counties; **San Antonio**: Atascosa, Bexar, Comal, Guadalupe, Kendall, Wilson counties **$295.82**	**Other: Corpus Christi**: Nueces, San Patricio; **Dallas/Fort Worth**: Collin, Dallas, Denton, Ellis, Johnson, Kaufman, Rockwall, Tarrant counties; **San Antonio**: Atascosa, Bexar, Comal, Guadalupe, Kendall, Wilson counties **N/A**

* *The monthly rate is per Retiree. The Retiree needs to be entitled to Medicare Parts A & B, and continue to pay the Part B premium.*

Medicare Advantage HMO with Integrated Medicare Part D Plan Options in Oklahoma

Retiree Medicare Advantage Counties

Medical Plan with Prescription Plan	2016 HMO Option 1 | 3A Custom Plan Full Gap Coverage (requires employer subsidy of 35% excluding IEBP)	2016 HMO Option 2 | 3A Custom Plan Tier 1 Generic Gap Coverage
Service Area:	**Oklahoma:** Canadian, Cleveland, Oklahoma, Pottawatomie	**Oklahoma:** Canadian, Cleveland, Oklahoma, Pottawatomie
Monthly Rate*	**Census Underwriting Required**	**Census Underwriting Required**

* *The monthly rate is per Retiree. The Retiree needs to be entitled to Medicare Parts A & B, and continue to pay the Part B premium. United will require underwriting approval for new employer membership.*

Medicare Supplement Plan (Texas and Oklahoma Benefit Options)

Supplement Plan: Plan F	**Supplement Plan: Plan K**
Prescription Plan: Not included in price Service Area: National Rate: Composite Employer Funding Requirement: None	Prescription Plan: Not included in price Service Area: National Rate: Composite Employer Funding Requirement: None
2016 Monthly Rate* $225.68	**2016 Monthly Rate* $128.95**
TAC Supplemental Plan F + Admin Fee $235.68	

** The monthly rate is per Retiree. The Retiree needs to be entitled to Medicare Parts A & B, and continue to pay the Part B premium.*

BENEFITS "Plan Pays"	**PLAN F**	**PLAN K**
Part A and Part B CALENDAR YEAR PLAN DEDUCTIBLE	N/A	N/A
Part A and Part B MOOP ANNUAL LIMIT (Medicare copayments, coinsurance and deductibles)	N/A	$4,620 per year (2010 amount shown)
LIFETIME POLICY MAXIMUM	N/A	N/A
Part A - Hospital (Part A Deductible) - Days 1-60	Covered 100% by Plan	Covered 50% by Plan
Part B - DURABLE MEDICAL EQUIPMENT		
Part B - Medicare Part B Deductible (Applicable to Part B DME)	Covered 100% by Plan	Not Covered
Part B - DME Remainder of Medicare Approved Amounts (After Part B Deductible Has Been Met)	Remainder After Medicare Payment Covered 100% by Plan.	Remainder After Medicare Payment Covered 50% by Plan.
Part B - Medicare Part B Deductible (Applicable to Part B Medical Services)	Covered 100% by Plan	Not Covered
Part B - Medical Services Remainder of Medicare Approved Amounts (After Part B Deductible Has Been Met)	Remainder After Medicare Payment Covered 100% by Plan.	Remainder After Medicare Payment Covered 50% by Plan.
PART B EXCESS CHARGES - (The Difference Between Medicare Allowable Amount and Up to 115% of Medicare Allowable Amount)	Covered 100% by Plan	Not Covered
FOREIGN TRAVEL: Medically Necessary Emergency Care Services, applicable only during the first six months of each trip outside of the United States.		

PDP Plan Option 1: Full Gap Coverage (requires employer subsidy of 35% excluding IEBP)	**PDP Plan Option 2: Generic Gap Coverage**
Service Area: National Rate: Composite Employer Funding Requirement: None	Service Area: National Rate: Composite Employer Funding Requirement: None
2016 Monthly Rate* $206.34	**2016 Monthly Rate* $78.02**
TAC Rx Plan 1 Full Rx $206.34	

** The monthly rate is per Retiree. The Retiree needs to be entitled to Medicare Parts A & B, and continue to pay the Part B premium. HMO Advantage requires prescription plan inclusion. Supplemental F or K may be accessed medical only or medical and Rx. Rx Plan option requires employer level decision.*

Prescription Creditable Coverage Part D Plans	**PDP Option 1**	**PDP Option 2**
Prescription Drug Plan Type	Custom	Custom
Part D Gap Coverage	**Full Gap Coverage**	**Tier 1 Generic Gap Coverage**
Formulary	Formulary H	Formulary G
Bonus Drug List	None	None
Rx Deductible	$0	$0
Rx Out-of-Pocket Maximum	None	None
Part D Retail (Member Cost Share Before Pharma Brand Discounts)		
Tier 1	$5	$5
Tier 2	$25	$25
Tier 3	$60	$60
Tier 4	33%	33%
Part D Mail Order (Member Cost Share Before Pharma Brand Discounts)		
Tier 1	$10	$10
Tier 2	$50	$50
Tier 3	$120	$120
Tier 4	33%	33%
Initial Coverage Limit	$3,310	$3,310
TrOOP Threshold	$4,850	$4,850
Catastrophic Coverage over TrOOP (greater amount of)		
Copay for generics	$2.95	$2.95
Copay for all other drugs	$7.40	$7.40
OR Coinsurance	5%	5%

Preferred Retail Pharmacy Network

1. Applies to Part D individual plans only
2. Provides lower copays at preferred retail pharmacies vs. other network pharmacies
3. Copays are consistent across all participating pharmacies
4. Copays may vary by plan or region
5. Thrifty White to join 1.1.12-15

Pharmacy Saver Program

1. Applies to MAPD and Group Part D EGWP plans only
2. Drug prices and quantities may vary between participating pharmacies
3. Pharmacy Saver has a list of drugs that are available through the program
4. Drug list, prices, quantities and participating pharmacies are subject to change during the plan year

UnitedHealthcare Retiree Member Rewards and Incentives

Advocate4Me Program

UnitedHealthcare Retiree Solutions introduced the Advocate4Me Program last year. This program incorporates claims and other clinical information to enhance the membership experience with the customer care professionals. In 2015 this was expanded to a member rewards program that provided members with gift cards once they completed specific health-related activities. In 2015, the gift card was distributed for the completion of an Annual Wellness visit.

Treatment Decision Support

Registered nurses with specialized training about targeted conditions and treatment options help retirees make care decisions that are informed, evidence-based and preference-sensitive.

Disease Manage Programs

- Congestive Heart Failure (CHF)*
- Coronary Artery Disease (CAD)
  - Advanced Illness - Case Management for those with life-limiting illness
- Diabetes

Catastrophic and Pre-Catastrophic Case management

Telephonic and face-to-face intervention to help retirees and their families effectively cope with multiple chronic conditions, frailty, disability or den of life issues. Nurses and social workers help individual and their families utilize community resources, understand the most effective ways to cope with their conditions, adhere to their doctor's treatment plan and prevent caregiver burn out

Transplant Resource Services

Help members identify a preferred provider based on quality and efficiency outcomes – this is not a network.

<u>Prevention and Wellness</u>

1. Health Risk Assessment
2. Preventive care reminders
3. Nurse Line: Our newly expanded Nurse Line program empowers retirees to make better health care designs. Nurse Line's registered nurses focus on our four basic value pillars to support retirees in making informed healthcare decisions: Right Care, Right Provider, right Medication, and Right Lifestyle Available 24/7/365
4. Treatment Decision and Access Support
5. Silver Sneakers: Retirees receive a basic health club membership at their choice of participating senior-friendly fitness centers, access to senior-focused fitness classes and social events, and advice from a senior fitness advisor
6. Solutions for Caregivers: Our comprehensive eldercare management program designed to support family caregivers in helping aging family members to stay healthy, to function as independently as possible and to live with dignity

7. Discounted Hearing Aid Program
    a. Get a hearing test
    b. Select a hearing aid from the Premium list offered by Health Innovations (HI)

Case Management for Members at Risk

1. Group Retiree Case Management
2. Disease Management
    a. Diabetes
    b. End Stage Renal
    c. Transplant, Specialized Network
    d. Congestive Heart Failure (CHF)

House Calls for Members at Risk (if applicable)

Post Sixty-five Retiree Value Added Supplemental Benefits

UnitedHealthOne: Dental and Vision Supplemental Benefit Option for Post Sixty-five Supplemental Benefits. Vision is only an option under the Dental Plan. The waiting period is extensive, and retirees were educated to obtain services under the IEBP Benefit Plan prior to the close of December so the transition would not be as difficult.

1. Dental Benefit Options
    a. The value added benefit options will be available as an individual choice per retiree.
        i. **Preventive services** have no waiting period and include routine dental exams, routine X-rays, cleaning, fluoride treatment for children, sealants, and space maintainers.
        ii. **Basic services** have a six-month waiting period and include dental exams, X-rays, routine extractions, treatment for children to ease dental pain, and simple fillings.
        iii. **Major services** have a 12-month waiting period and include treatment for diseases of the pulp (including root canals), bone and other tissues supporting the teeth, crowns, inlays, onlays, veneers, bridges, dentures (payable once every 5 years), and oral surgery for impactions
    b. Please contact UnitedHealthOne
    c. Call: (800) 321.1957 - Ask for "Dental Benefits"
    d. Online: www.uhone.com “get quote” (pink tab has sample brochures)
2. Vision Benefit Options
    a. The valued added vision benefit is available at an individual choice per retiree contingent on the retiree’s purchase of Dental Benefits
    b. Please contact UnitedHealthOne
    c. Call: (800) 321.1957 - Ask for "Vision Benefits"
    d. Online: www.uhone.com “get quote” (pink tab has sample brochures)

Development of the Medicare Plan for 2016

1. The Medicare Modernization Act (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to announce each year the Medicare Part D standard defined benefit and Retiree Drug Subsidy (RDS) amounts for the coming year.
2. ACMS announced the rates for 2016.

Benefit Parameter	2016	2015	2014
Deductible	$360.00 (100% paid by participant)	$320.00 (100% paid by participant)	$310.00
Initial Coverage Limit	$3,310.00 (25% paid by participant, 75% paid by plan)	$2,960.00 (25% paid by participant 75% paid by plan)	$2,850.00
Out of Pocket Threshold	$4,850.00 (Brands: 50% discount, 45% paid by participant, 5% paid by plan) (Generics: 58% paid by participant, 42% paid by plan)	$4,700.00 (Brands: 50% discount) 45% paid by participant 5% paid by plan; Generics: 65% paid by Participant 35% paid by plan)	$4,550.00

Benefit Parameter	2016	2015	2014
Total Covered Part D Spending before Catastrophic Coverage	$7,062.50 + 5% paid by plan, 80% paid by Medicare	$6,680.00 (15% paid by plan 80% paid by Medicare	$6,455.00
Generic Preferred Multi-Source Drug	$2.95	$2.65	$2.55
Other Drug	$7.40	$6.60	$6.35

3. Medicare Announced Premiums & Deductibles

Benefit	2016	2015	2014	2013	2012	2011	2010
Part A Premium >40 quarters of Medicare covered employment 30-39 quarters <39 quarters	awaiting Medicare release	$0.00 $224.00 $407.00	$0.00 $426.00	$0.00 $441.00	$0.00 $248.00 $451.00	$0.00 $248.00 $450.00	$0.00 $244.00 $443.00
Part A (1-60 day Deductible) (Inpatient hospital, skilled nursing, hospice, certain HHC services)	awaiting Medicare release	$1,260.00	$1,216.00	$1,184.00	$1,156.00	$1,132.00	$1,068.00
Inpatient Charges 61-90 days >90 days	awaiting Medicare release	$315.00/day $630.00/day	$304.00/day $608.00/day	$296.00/day $592.00/day	$289.00/day $578.00/day	$283.00/day $566.00/day	$267.00/day $534.00/day
Skilled Nursing 21-100 days	awaiting Medicare release	$157.50/day	$152.00/day	$148.00/day	$144.50/day	$141.50/day	$133.50/day
Part B Premium (Physician, outpatient, certain HHC, DME and other services)	awaiting Medicare release	$104.90	$104.90	$104.90	$99.00	$96.40 **or** $110.50	$96.40
Part B Deductible	awaiting Medicare release	$147.00	$147.00	$147.00	$140.00	$162.00	$135.00
Part D Beneficiary Premium	awaiting Medicare release	$33.13	$32.42	$31.17	$31.08	$32.34	$31.94

CMS allows 14 days for Carriers to process enrollments - receipt of following items is dependent on clean enrollments without necessity of additional information for processing (i.e. correct Medicare Claim Numbers).

4. Medicare Supplement Plans

Plan	A	B	C	D	F	F+1	G	K(2)	L(3)	M	N
Part A Deductible		X	X	X	X	X	X	50%	75%	50%	X
Part A Coinsurance (plus coverage for 365 addt'l days after Medicare benefits end)	X	X	X	X	X	X	X	X	X	X	X
Blood: First three pints of blood each	X	X	X	X	X	X	X	50%	75%	X	X
Skilled Nursing Co-insurance			X	X	X	X	X	50%	75%	X	X
Hospice	X	X	X	X	X	X	X	50%	75%	X	X
Part B Deductible			X		X	X					
Medical Expenses: Part B Coinsurance	X	X	X	X	X	X	X	50%	75%	X	Copay max: $20 OV $50 ER
Part B Preventive Care Coinsurance	X	X	X	X	X	X	X	X	X	X	X
Part B Excess Charges					X	X	X				
Foreign Travel Emergency			X	X	X	X	X			X	X

*Plan includes a $2,110 annual deductible *$2,400 maximum out of pocket, indexed to Medicare costs

* $4,800 maximum out of pocket, indexed to Medicare costs

*Not approved for sale to groups in Florida, Louisiana, Minnesota, Montana, New Hampshire, Vermont, Washington State

Medicare Part D Overview

Benefit	2016	2015	2014	2013	2012
Deductible	$360.00 (100% paid by participant)	$320.00 (100% paid by participant)	$310	$325	$320
Copay	see UHC Group Prescription Plan	see UHC Group Prescription Plan			See UHC Group Prescription Solutions Plan
Retail Mail Service	see UHC Group Prescription Plan	see UHC Group Prescription Plan			See UHC Group Prescription Solutions Plan
Drug Spend	$3,310.00 (25% paid by participant, 75% paid by plan)	$2,960 (25% paid by participant, 75% paid by plan)	$2,850.00	$2,970.00	$2,930.00
Individual Spend	$4,850.00 (Brands: 50% discount, 45% paid by participant, 5% paid by plan) (Generics: 58% paid by participant, 42% paid by plan)	$4,700 (Brands: 50% discount -45% paid by participant, 5% paid by plan) (Generics: 65% paid by participant, 35% paid by plan)	$4,550.00	$4,750.00; Total Covered Part D Drug Spending before Catastrophic Coverage $6,733.75	$4,700.00
Total Covered Part D Drug Spending before Catastrophic Coverage	Catastrophic Care $7,062.50 + 5% paid by plan, 80% paid by Medicare	$6,680.00	$6,455.00		
Catastrophic Copay Cost	Greater amount of 5% or $2.95, any other drugs $7.40 or 5%	Greater amount of 5% or $2.65, Any other drugs $6.60 or 5%	Greater amount of 5% or $2.55, Any other drugs $6.35 or 5%	Greater amount of 5% or $2.65, Any other drugs $6.60 or 5%	Greater amount of 5% or $2.60, Any other drugs $6.50 or 5%

Benefit	2011	2010	2009	2008
Deductible	No deductible	$310.00	$295.00	$275.00
Copay	See UHC Group Prescription Solutions Plan	See Aetna and CVS/Caremark SilverScript Plans	See Aetna and CVS/Caremark SilverScript Plans	See Aetna and CVS/Caremark SilverScript Plans
Retail Mail Service	See UHC Group Prescription Solutions Plan	See Aetna and CVS/Caremark SilverScript Plans	See Aetna and CVS/Caremark SilverScript Plans	See Aetna and CVS/Caremark SilverScript Plans
Drug Spend	$2,930.00	$2,830.00	$2,700.00	$2,510.00
Individual Spend	$4,700.00 Total Covered Part D Drug Spending before Catastrophic Coverage $6,657.50	$4,550.00	$4,350.00	$4,050.00 - Some plans have generic access in the gap
Catastrophic Copay Cost	Greater amount of 5% or $2.60, Any other drugs $6.50 or 5% after drug spend of $6,657.50	Maximum amount of 5% or $2.50; Any other drugs $6.30 or 5% after drug spend of $6,440.00	Maximum amount of 5% or $2.40; Any other drugs $6.00 or 5%.	Maximum amount of 5% or $2.25; Any other drugs $5.60 or 5%.

The "Donut Hole"/"Gap" continues to be an area of concern in Healthcare Reform discussions.

The Affordable Care Act made significant changes to the Medicare program, including for Medicare beneficiaries enrolled in a Part D plan. In 2013, seniors who hit the "donut hole" received improved coverage on their brand name drugs. Manufacturers began to cover 50% of the cost of the brand-name drugs and in 2013 and 2014, the plan paid another 2.5%, providing seniors with total coverage of 52.5% in the donut hole. Therefore, seniors pay 47.5% of the costs for brand-name drugs in the donut hole.

In 2015 manufacturers will continue to cover 50% of the cost of the brand-name drugs and the plan will pay another 5%, providing seniors with total coverage of 55% in the donut hole. Therefore, seniors will pay 45% of the costs for brand-name drugs in the donut hole.

Coverage of generic drugs in the gap will increase annually until it reaches 75% in 2020. By 2020, the cost sharing for both brand and generic prescription drugs will be the same during the "donut hole" as during the initial coverage period. Consequently, in 2020, individuals will pay 25% of drug costs, and the Part D plan will pay 75%. In 2015, Part D plans will pay 35% of the cost of generic drugs in the donut hole leaving seniors responsible for 65%.

Medicare Part D Cost Sharing in 2016

Generic/Preferred Multi-Source Drug* $2.95, Other Drug $7.40 [For Part D plans that charge copayments in the catastrophic portion of the benefit (instead of 5% coinsurance), the amount of the copayments for a generic drug or for a preferred multiple source drug (i.e., generally on for which there are two or more products that are therapeutically and pharmaceutically equivalent) is a set at a lower amount than the amount for any other drug].

- **Copayments in Catastrophic Coverage**
  - ✓ 15% Paid by Plan
  - ✓ 80% Paid by Medicare
  - ✓ 5% Paid by Participant
- **Catastrophic Coverage $7,062.50**
- **Brands**
  - ✓ 50% Discount
  - ✓ 45% Paid by Participant
  - ✓ 5% Paid by Plan
- **Generics**
  - ✓ 58% Paid by Participant
  - ✓ 42% Paid by Plan
- **Initial Coverage Limit $3,310.00**
  - ✓ 25% Paid by Participant
  - ✓ 75% Paid by Plan
- **Deductible $360.00**
  - ✓ 100% Paid by Participant

If the retiree has limited income and resources the retiree may request extra help for payment of the Medicare prescription drug coverage. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at (800) 772-1213 (TTY (800) 325-0778).

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-0778

Taking Action to Manage Post Employment Benefit Options

1. GASB Liability
   a. GASB 45
      i. Governmental Accounting Standards Board
         » Determine and recognize an actuarial value of promised (defined benefit) retiree medical and other benefits on an employer's balance sheet
         » Other Post Employment Benefits (OPEB) must be accounted for just like pension benefits
      ii. OPEB requires the cost be realized while the employee is active, not at the time of retirement
      iii. Could Impact Bond Rating
2. Timeline of GASB 45 Requirement
   a. Implementation in three phases:
      i. 1st - $100M or more in annual revenue for periods after 12/15/06
      ii. 2nd - $10M or more, but less than $100M, for periods after 12/15/07
      iii. 3rd - $10M or less for periods after 12/15/08
3. What is the Concern?
   a. Employers who provide post-employment medical benefits are realizing that they can no longer afford to provide a "defined benefit" solution.

i. With the Baby Boomer population entering retirement age, Political Subdivisions are faced with the liability of "defined benefit"

ii. Due to the financial requirements, the Political Subdivisions are transitioning from Defined Benefits to Defined Contribution.

4. Definition of Eligibility for Post Employment Benefits
   a. GASB 45
      i. Retiree Definition/Employer Decisions
         » Definition of Retiree
         » Age
         » Years of Service
         » Accordance with Existing Retirement Program (TMRS)
         » Available Benefits
         » Sample Policy/Ordinance/Resolution
         » Dependent Coverage Eligibility
         » Survivor Coverage Eligibility
      ii. Disclaimer of Benefit Effective Date and Review Date
5. Funding Option for Public Safety
   a. TMRS Annuity Fund Healthcare Premium Payment Access
      i. Annuity Benefit access for Public Safety Retirees
      ii. Annuity Benefit may apply to Premium payment for Health, Part D, Vision, Dental and/or Long Term Care
      iii. No Survivor Annuity Benefit
      iv. IRS Tax Return Requirement/Reduction of Pension 1099 Tax Return Completion
6. Defined Contribution Management Options
   a. Taking Action to Managing your OPEB Obligation
      i. Manage cost of current benefit offering, eligibility and caps on future promises
      ii. Migrate from a defined benefits to defined contribution approach
      iii. A Health Reimbursement Arrangement (HRA)/Retiree Reimbursement Arrangement (RRA) is an employer pre-taxed fund account for eligible medical expenses including premiums for eligible medical plans under the IRS Notice 2002-24.

PEBA Annual Membership Fee Schedule

Annual Membership Fees	2012	2012 Out of Texas	2013	2013 Out of Texas	2014	2014 Out of Texas	2015	2015 Out of Texas
Employer								
0-100 Lives	$150	$250	$150	$250	$150	$250	$150	$250
101-500 Lives	$300	$450	$300	$450	$300	$450	$300	$450
501-1000 Lives	$500	$750	$500	$750	$500	$750	$500	$750
1,001-5,000 Lives	$700	$900	$700	$900	$700	$900	$700	$900
5,001-15,000 Lives	$750	$1,250	$750	$1,250	$750	$1,250	$750	$1,250
15,001-25,000 Lives	$1,000	$3,000	$1,000	$3,000	$1,000	$3,000	$1,000	$3,000
>25,000	$1,750	$3,500	$1,750	$3,500	$1,750	$3,500	$1,750	$3,500

PEBA Proposal Fees

Benefit Product	2014 and 2015 Proposal Costs	2014 and 2015 Proposal Costs Out of Texas	Late Fee
Pre/Post 65 Retiree Benefits (combined)	▪ 0-100 Active EE Lives: $500 ▪ 101-500 Active EE Lives: $750 ▪ 501-1000 Active EE Lives: $1,250 ▪ 1001-5,000 Active EE Lives: $1,750 ▪ 5,001-15,000 Active EE Lives: $2,250 ▪ 15,001-25,000 Active EE Lives: $2,750 ▪ >25,000 Active EE Lives: **$3,250**	▪ 0-100 Active EE Lives: $550 ▪ 101-500 Active EE Lives: $800 ▪ 501-1000 Active EE Lives: $1,300 ▪ 1001-5,000 Active EE Lives: $1,800 ▪ 5,001-15,000 Active EE Lives: $2,300 ▪ 15,001-25,000 Active EE Lives: $2,800 ▪ >25,000 Active EE Lives: **$3,300**	▪ 0-100 Active EE Lives: $1,000 ▪ 101-500 Active EE Lives: $2,000 ▪ 500-1000 Active EE Lives: $3,700 ▪ >1000 Active EE Lives: $5,000

Benefit Product	2014 and 2015 Proposal Costs	2014 and 2015 Proposal Costs Out of Texas	Late Fee
Pre 65 Retiree Benefits (Pre only)	▪ 0-100 Active EE Lives: $450 ▪ 101-500 Active EE Lives: $700.00 ▪ 501-1000 Active EE Lives: $1,200 ▪ 1001-5,000 Active EE Lives: $1,700 ▪ 5,001-15,000 Active EE Lives: $2,200 ▪ 15,001-25,000 Active EE Lives: $2,700 ▪ >25,000 Active EE Lives: **$3,200**	▪ 0-100 Active EE Lives: $500 ▪ 101-500 Active EE Lives: $750.00 ▪ 501-1000 Active EE Lives: $1,250 ▪ 1001-5,000 Active EE Lives: $1,750 ▪ 5,001-15,000 Active EE Lives: $2,250 ▪ 15,001-25,000 Active EE Lives: $2,750 ▪ >25,000 Active EE Lives: **$3,250**	▪ 0-100 Active EE Lives: $700 ▪ 101-500 Active EE Lives: $1,200 ▪ 500-1000 Active EE Lives: $2,050 ▪ >1000 Active EE Lives: $2,700
Post 65 Retiree Benefits (Post only)	▪ 0-100 Active EE Lives: $450 ▪ 101-500 Active EE Lives: $700.00 ▪ 501-1000 Active EE Lives: $1,200 ▪ 1001-5,000 Active EE Lives: $1,700 ▪ 5,001-15,000 Active EE Lives: $2,200 ▪ 15,001-25,000 Active EE Lives: $2,700 ▪ >25,000 Active EE Lives: **$3,200**	▪ 0-100 Active EE Lives: $500 ▪ 101-500 Active EE Lives: $750.00 ▪ 501-1000 Active EE Lives: $1,250 ▪ 1001-5,000 Active EE Lives: $1,750 ▪ 5,001-15,000 Active EE Lives: $2,250 ▪ 15,001-25,000 Active EE Lives: $2,750 ▪ >25,000 Active EE Lives: **$3,250**	▪ 0-100 Active EE Lives: $500 ▪ 101-500 Active EE Lives: $1,000 ▪ 500-1000 Active EE Lives: $1,850 ▪ >1000 Active EE Lives: $2,500

To learn more about PEBA Membership or how to access Pre/Post Sixty-five Retiree services, contact PEBA:
Nickie Bischoff (512) 719-6768 or (800) 348-7879, ext 6768