

PROPOSED BARGAINED DESIGN

BYO Medical (In-Network)

		Individual		Individual +1		Family	
Option	Provision	Current	Proposed	Current	Proposed	Current	Proposed
BYO 1	Deductible	250	325	500	650	625	825
	OOP Limit	1,500	1,950	3,000	3,900	3,750	4,950
BYO 2	Deductible	500	650	1,000	1,300	1,250	1,625
	OOP Limit	2,000	2,400	3,300	3,960	4,000	4,700
BYO 3	Deductible	1,000	1,200	2,000	2,400	2,500	2,750
	OOP Limit	2,500	2,750	3,800	4,180	4,500	4,950

PCP office visit copay change from \$20 to \$25, specialist office visit copay change from \$30 to \$35

Coinsurance - all options - plan pays 80%, you pay 20%

BYO out-of-area plan will change in accordance with In-Network Deductible & Out-of-Pocket Maximum levels shown above

PROPOSED BARGAINED DESIGN BYO Medical (Out-of-Network)

		Individual		Individual +1		Family	
Option	Provision	Current	Proposed	Current	Proposed	Current	Proposed
BYO 1	Deductible	1,200	1,400	2,400	2,800	3,600	4,200
	OOP Limit	6,000	7,000	12,000	14,000	14,000	16,800
BYO 2	Deductible	2,500	\$2,800	5,000	\$5,600	7,500	\$8,400
	OOP Limit	8,000	\$8,960	12,000	\$15,000	16,000	\$16,800
BYO 3	Deductible	5,000	no change	10,000	no change	15,000	no change
	OOP Limit	10,000	no change	15,500	no change	18,000	no change

Coinurance - all options - plan pays 60%, you pay 40% after deductible is met

PROPOSED BARGAINED DESIGN

BYO Pharmacy Changes

	Option 1	Option 2
Retail Coinsurance (up to 30-day supply when you shop at a pharmacy)		
For Generic Drugs Plan pays / You pay	80% / 20% Subject to \$8 min and \$16 max	65% / 35% Subject to \$12 min and \$24 max
Preferred Brand Name Drugs Plan pays / You pay	80% / 20% Subject to \$19 min and \$48 max	65% / 35% Subject to \$28 min and \$70 max
Non-Preferred Brand Name Drugs Plan pays / You pay	80% / 20% Subject to \$38 min and \$105 max	65% / 35% subject to \$53 min and \$135 max
Mail-Order Coinsurance (up to 90-day supply)		
For Generic Drugs Plan pays / You pay	80% / 20% Subject to \$15 min and \$40 max	65% / 35% Subject to \$24 min and \$75 max
Preferred Brand Name Drugs Plan pays / You pay	80% / 20% Subject to \$48 min and \$120 max	65% / 35% Subject to \$70 min and \$210 max
Non-Preferred Brand Name Drugs Plan pays / You pay	80% / 20% Subject to \$98 min and \$263 max	65% / 35% Subject to \$144 min and \$375 max

Maintenance Medications — mail order encouraged after 90 days

Maintenance Choice — 90 day supply available through local CVS at mail order pricing

PROPOSED BARGAINED DESIGN

Alternate Plan— Anthem HMO Design

	Current	Proposed
Medical		
Primary/Specialist Office Visit	\$20/\$30	\$25/\$35
Physical Therapy	\$0	\$35
Emergency Room	\$100	\$150
Hospital Inpatient	\$500	\$500
Hospital Outpatient	\$250	\$250
Out of Pocket Cap	\$1,500/\$3,000	\$2,000/\$4,000
Lifetime Maximum	Unlimited	Unlimited
Pharmacy		
Retail	\$10/\$20/\$40	\$10/\$20/\$40
Mail Order	\$20/\$40/\$70	\$25/\$50/\$100

HDHP with HSA

Design

		Current HDHP Option 1	New HDHP Option 1	New HDHP Option 2
Main Design Provisions				
Deductible	Employee-only; Family ⁽¹⁾	\$1,500 \$3,000	\$1,600 \$3,200	\$2,600 \$5,200
Coinsurance & Copays (you pay)	Preventive	0% (no deductible)	0% (no deductible)	0% (no deductible)
	Office Visits	20% (after deductible)	20% (after deductible)	20% (after deductible)
	Other Medical	20% (after deductible)	20% (after deductible)	20% (after deductible)
	Pharmacy	20% (after deductible)	20% (after deductible)	20% (after deductible)
Out-of-Pocket Maximum	Individual; Family	\$1,500 \$3,000	\$1,600 \$2,500	\$2,600 \$5,200
Maximum Out-of-Pocket Exposure				
Deductible + Out-of-Pocket Maximum ⁽²⁾	Individual; Family	\$3,000 \$6,000	\$3,200 \$5,700	\$5,200 \$10,400
2011 HSA Contribution Limits (subject to annual change by IRS)				
Maximum out-of-pocket exposure	Individual; Family		\$3,050 \$6,150 (+ \$1,000 catch-up; 55 and older)	

⁽¹⁾ Family deductible must be met for any member in the family to meet deductible requirement.

⁽²⁾ Excludes deductible; proposed designs require family out-of-pocket to be met before plan pays 100% for any individual within family.

HDHP WITH HSA

Lower Payroll Contributions

Preventive Care

100% covered



All Other Services (Including Prescription Drugs)

You pay for services
up to annual deductible

Then, you share the costs with the plan:

You pay

In-Network
20%

Out-of-Network
40%

Plan pays

In-Network
80%

Out-of-Network
60%



When you reach your out-of-pocket maximum,
the plan pays 100% of covered expenses for
the rest of the year

Option 1 Summary

No charge for in-network
preventive care

Annual Deductible

In-Network

- Single \$1,600
- Family \$3,200

Out-of-Network

- Single \$6,000
- Family \$13,600

Annual Out-of-Pocket Maximum (not including deductible)

In-Network

- Single \$1,600
- Family \$2,500

Out-of-Network

- Single \$6,600
- Family \$13,600

HDHP WITH HSA

Comparing the Options: Proposed Plan Design

		In-Network Features		
		HDHP w/HSA Option 1	BYO 1+1	Anthem HMO
Employee Contribution Annual	Individual Family	\$250 \$1,134	\$1,357 \$4,571	\$1,755 \$5,866
Coinsurance & Copays	Preventive Office visit Other** Rx	100% 80% 80% 80%	100% \$25/\$35 80% \$8/\$19/\$38*	100% \$25/\$35 \$150/\$250/\$500 \$10/\$20/\$40*
Deductible	Individual Family	\$1,600 \$3,200	\$325 \$825	\$0 \$0
Out-of-Pocket Maximum	Individual Family	\$1,600 \$2,500	\$1,950 \$4,950	\$2,000 \$4,000
Total Deductible and OOP	Individual Family	\$3,200 \$5,700	\$2,275 \$5,775	\$2,000 \$4,000

*Minimum retail copays

** Copays for Emergency room / Outpatient surgery/ Inpatient confinement