

## **Finance Committee Meeting**

## **AGENDA**

# **February 1, 2011**

- I. <u>CALL TO ORDER</u>
- II. MATTERS BEFORE COMMITTEE
  - 1. <u>Discussion Insurance Renewal</u>
- III. ADJOURN



## **Finance Committee Meeting**

## **AGENDA**

## **February 1, 2011**

Item:
Discussion - Insurance Renewal  Department:
Additional Information:
Financial Impact:
Budgeted Item:
Recommendation / Request:

Viewing Attachments Requires Adobe Acrobat. Click here to download.

Attachments / click to download

Insurance Spreadsheet

PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
\$1,00	00,000
DEDUCTIBLE, PER CALENDAR YEAR	
\$200	\$400
\$600	\$1,200
COPAYMENTS	
\$10 copay then 100% up to \$100 per visit, then deductible and 80%	60% after deductible
80% after deductible	60% after deductible
80% after deductible	60% after deductible
The Emergency room copayment is waived if the emergency basis. The utilization review admini	· ·

5663 within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.

### MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR

\$1,200	\$600
\$2,400	\$1,200

The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.

The following charges do not apply toward the out-of-pocket maximum and are never paid at

Outpatient substance abuse treatment charges

Cost containment penalties

Copayments

Pre-existing Conditions Limitations and reductions to Reasonable and Customary

COVERED CHARGES		
Hospital Services		
80% after deductible	60% after deductible	
the semiprivate room rate	the semiprivate room rate	
80% after deductible	60% after deductible	
Hospital's ICU Charge	Hospital's ICU Charge	
80% after deductible the facility's semiprivate room rate 120 days Calendar Year Maximum	60% after deductible the facility's semiprivate room rate 120 days Calendar Year Maximum	

### NON-GRANDFATHERED Plan Design with Suggested Changes

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDI	ERS
MAXIMUM ANNUAL BENEFIT	AMOUNT		
VIII III VII VOILE BEIVEI II	Middle	\$750,000	
DEDUCTIBLE, PER CALENDAF	R YEAR		
Per Covered Person		\$200	\$1,0
Per Family Unit		\$600	\$3,0
COPAYMENTS	•		
Physician visits	\$20 copay then 100% up to \$100 per vis deductible and 80%	60% after deductible	
Outpatient services	80% after deductible	60% after deductible	
Emergency room	80% after deductible	80% after deductible	
Per Covered Person		\$600	\$3,0
MAXIMUM OUT-OF-POCKET A	AMOUNT, PER CALENDAR YEAR		
Per Covered Person		\$600	\$3,0
Per Family Unit		\$1,200	\$6,0
Γhe Plan will pay the designated per	centage of Covered Charges until out-of-pocket amount the rest of the Calendar Year unless stated otherwise	nts are reached, at which time the Plan will pay	\$6,0 y 100% c
the remainder of Covered Charges for The following charges do not apply to Outpatient substance abuse treatment	or the rest of the Calendar Year unless stated otherwise coward the out-of-pocket maximum and are never paid	nts are reached, at which time the Plan will pay e.	
The Plan will pay the designated perche remainder of Covered Charges for The following charges do not apply to	or the rest of the Calendar Year unless stated otherwise coward the out-of-pocket maximum and are never paid	nts are reached, at which time the Plan will pay e.	
The Plan will pay the designated perche remainder of Covered Charges for The following charges do not apply to Outpatient substance abuse treatment Cost containment penalties Copayments	or the rest of the Calendar Year unless stated otherwise coward the out-of-pocket maximum and are never paid	nts are reached, at which time the Plan will pay e.	
The Plan will pay the designated perche remainder of Covered Charges for the following charges do not apply to the Outpatient substance abuse treatment Cost containment penalties Copayments  Pre-existing Conditions Limitation	or the rest of the Calendar Year unless stated otherwise coward the out-of-pocket maximum and are never paid ent charges	nts are reached, at which time the Plan will pay e.	
The Plan will pay the designated perche remainder of Covered Charges for The following charges do not apply to Outpatient substance abuse treatment Cost containment penalties Copayments  Pre-existing Conditions Limitation COVERED CHARGES	or the rest of the Calendar Year unless stated otherwise coward the out-of-pocket maximum and are never paid ent charges as and reductions to Reasonable and Customary	nts are reached, at which time the Plan will paye.	
The Plan will pay the designated perche remainder of Covered Charges for The following charges do not apply to Outpatient substance abuse treatment Cost containment penalties Copayments  Pre-existing Conditions Limitation COVERED CHARGES	or the rest of the Calendar Year unless stated otherwise toward the out-of-pocket maximum and are never paid ent charges as and reductions to Reasonable and Customary  80% after deductible	nts are reached, at which time the Plan will paye.  I at 100%.	
The Plan will pay the designated perche remainder of Covered Charges for The following charges do not apply to Outpatient substance abuse treatment Cost containment penalties Copayments  Pre-existing Conditions Limitation COVERED CHARGES  Hospital Services	toward the out-of-pocket maximum and are never paid ent charges as and reductions to Reasonable and Customary  80% after deductible the semiprivate room rate	nts are reached, at which time the Plan will paye.  I at 100%.  60% after deductible the semiprivate room rate	
The Plan will pay the designated perche remainder of Covered Charges for The following charges do not apply to Outpatient substance abuse treatment Cost containment penalties Copayments  Pre-existing Conditions Limitation COVERED CHARGES  Hospital Services	or the rest of the Calendar Year unless stated otherwise toward the out-of-pocket maximum and are never paid ent charges  as and reductions to Reasonable and Customary  80% after deductible the semiprivate room rate  80% after deductible	nts are reached, at which time the Plan will paye.  If at 100%.  60% after deductible the semiprivate room rate 60% after deductible	
The Plan will pay the designated perether remainder of Covered Charges for The following charges do not apply to Outpatient substance abuse treatment Cost containment penalties Copayments  Pre-existing Conditions Limitation  COVERED CHARGES  Hospital Services  Room and Board	or the rest of the Calendar Year unless stated otherwise toward the out-of-pocket maximum and are never paid ent charges  as and reductions to Reasonable and Customary  80% after deductible the semiprivate room rate  80% after deductible Hospital's ICU Charge	of the semiprivate room rate  60% after deductible the semiprivate room rate  60% after deductible  Hospital's ICU Charge	
The Plan will pay the designated perche remainder of Covered Charges for The following charges do not apply to Outpatient substance abuse treatment Cost containment penalties Copayments  Pre-existing Conditions Limitation  COVERED CHARGES  Hospital Services  Room and Board	soward the out-of-pocket maximum and are never paid ent charges  80% after deductible the semiprivate room rate 80% after deductible Hospital's ICU Charge 80% after deductible	at 100%.  60% after deductible the semiprivate room rate 60% after deductible Hospital's ICU Charge 60% after deductible	
The Plan will pay the designated perche remainder of Covered Charges for the following charges do not apply to Outpatient substance abuse treatment Cost containment penalties Copayments  Pre-existing Conditions Limitation COVERED CHARGES  Hospital Services  Room and Board	or the rest of the Calendar Year unless stated otherwise toward the out-of-pocket maximum and are never paid ent charges  as and reductions to Reasonable and Customary  80% after deductible the semiprivate room rate  80% after deductible Hospital's ICU Charge	of the semiprivate room rate  60% after deductible the semiprivate room rate  60% after deductible  Hospital's ICU Charge	

#### PARTICIPATING PROVIDERS NON-PARTICIPATING PROVIDERS Physician Services 60% after deductible 80% after deductible \$10 copay then 100% up to \$100 per visit, then 60% after deductible deductible and 80% 80% after deductible 60% after deductible 60% after deductible 80% after deductible 80% after deductible 60% after deductible 80% after deductible 60% after deductible 100% deductible waived up to \$150 Lifetime 100% deductible waived up to \$150 Lifetime maximum for physician certified program maximum for physician certified program 100% deductible waived up to \$400 Lifetime 100% deductible waived up to \$400 Lifetime maximum for certified program maximum for certified program 60% after deductible 80% after deductible 120 days Calendar Year maximum 120 days Calendar Year maximum 60% after deductible 80% after deductible 120 days Calendar Year maximum 120 days CalendarYear maximum 80% after deductible 60% after deductible 180 days or \$3,000 inpatient and outpatient 180 days or \$3,000 inpatient and outpatient Lifetime maximum Lifetime maximum 80% after deductible 60% after deductible 80% after deductible 80% after deductible \$250 per period of disability per trip maximum \$250 per period of disability per trip maximum 80% after deductible 60% after deductible \$1,000 Lifetime maximum \$1,000 Lifetime maximum 60% after deductible 80% after deductible 80% after deductible 60% after deductible 60% after deductible 80% after deductible 80% after deductible 60% after deductible \$150 Calendar Year maximum \$150 Calendar Year maximum

#### **NON-GRANDFATHERED Plan Design with Suggested Changes**

	PARTICIPATING PROVIDERS	NON•PARTICIPATING PROVIDERS
Physician Services		
Inpatient visits	80% after deductible	60% after deductible
Office visits – includes office surgery	\$20 copay then 100% up to \$100 per visit, then deductible and 80%	60% after deductible
Surgery – except office surgery	80% after deductible	60% after deductible
Allergy testing	80% after deductible	60% after deductible
Allergy serum and injections	80% after deductible	60% after deductible
Hyperkinetic & ADD Syndromes	80% after deductible	60% after deductible
Obesity/Weight Loss (see note below)	100%	60% after deductible
Smoking Cessation (see note below)	100%	60% after deductible
Home Health Care	80% after deductible	60% after deductible
Home Heath Care	120 days Calendar Year maximum	120 days Calendar Year maximum
Outpatient Private Duty Nursing	80% after deductible	60% after deductible
	120 days Calendar Year maximum 80% after deductible	120 days CalendarYear maximum 60% after deductible
Hospice Care	180 days inpatient and outpatient Calendar year	180 days inpatient and outpatient Calendar year
	maximum	maximum
Bereavement Counseling	80% after deductible	60% after deductible
	80% after deductible	80% after deductible
Ambulance Service		
I. I. A. PANI	80% after deductible	60% after deductible
Jaw Joint/TMJ		
Wig After Chemotherapy	80% after deductible	60% after deductible
Occupational Therapy	80% after deductible	60% after deductible
Speech Therapy	80% after deductible	60% after deductible
Physical Therapy	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Prosthetics	80% after deductible	60% after deductible
Spinal Manipulation Chivappastic	80% after deductible	60% after deductible
Spinal Manipulation Chiropractic	10 visits per Calendar year	10 visits per Calendar year

## PARTICIPATING PROVIDERS NON-PARTICIPATING PROVIDERS Mental Disorders and Treatment of Substance Abuse \$10 Copay then 100% up to \$100 per visit; then 60% after deductible 80% after deductible 80% after deductible 60% after deductible 80% after deductible 60% after deductible **Preventive Care** 100% not covered \$400 Calendar Year maximum Includes but not limited to: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination and office visit. Frequency limits for mammogram Ages 40 and over . . . . . . . . annually 80% after deductible 60% after deductible 100% not covered \$400 Calendar Year maximum Includes but not limited to: office visits, routine physical examination and immunizations through age 1. 80% after deductible\* 60% after deductible\* \*Refer to the separate Organ Transplant policy \*Refer to the separate Organ Transplant policy indicating transplant reimbursement indicating transplant reimbursement 80% after deductible 60% after deductible Routine Colonoscopy only for Age 50 and over – limited to 1 every 5 years 60% after deductible 80% after deductible Dependent daughters not covered.

#### NON-GRANDFATHERED Plan Design with Suggested Changes

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Mental Disorders and Treatment of Substan	ce Abuse	
Office Visits	\$20 Copay then 100% up to \$100 per visit; then 80% after deductible	60% after deductible
Inpatient	80% after deductible	60% after deductible
All other covered services	80% after deductible	60% after deductible
reventive Care	•	
Routine Well Person Care	100%	not covered
office visit. Services/Tests that are covered b Frequency limits for mammogram	mear, mammogram, prostate screening, gynecolog yy Federal Mandate will be covered with no copay	
Ages 40 and over annually		
Routine Well Newborn Care	80% after deductible	not covered
	1000/	
Routine Well Child Care	100%	not covered
	ne physical examination and immunizations throug	
Includes but not limited to: office visits, routin Federal Mandate will be covered with no copa	ne physical examination and immunizations throug	
Includes but not limited to: office visits, routing Federal Mandate will be covered with no coparage of Transplants*  See page 20, section (I) Organ Transplant	ne physical examination and immunizations throughy or coinsurance for Network Providers.	gh age 1. Services/Tests that are covered by 60% after deductible*
Includes but not limited to: office visits, routing	ne physical examination and immunizations throughy or coinsurance for Network Providers.  80% after deductible*  *Refer to the separate Organ Transplant policy	gh age 1. Services/Tests that are covered by  60% after deductible*  *Refer to the separate Organ Transplant policy
Includes but not limited to: office visits, routing Federal Mandate will be covered with no coparant Transplants*  See page 20, section (I) Organ Transplant for limitations  Diagnostic Colonoscopy and associated	ne physical examination and immunizations throughy or coinsurance for Network Providers.  80% after deductible*  *Refer to the separate Organ Transplant policy indicating transplant reimbursement	gh age 1. Services/Tests that are covered by  60% after deductible*  *Refer to the separate Organ Transplant policy indicating transplant reimbursement

### NON-GRANDFATHERED Plan Design with Suggested Changes

PARTICIPATING PROVIDERS NON-PARTICIPATING PROVIDERS PARTICIPATING PROVIDERS	OVIDERS NON-PARTICIPATING PROVIDERS
---	-------------------------------------

Suggestions & Comments

Obesity/Weight Loss and Smoking Cessation - Lifetime maximums are no longer allowed, however these items are covered under the recommended Preventive Services list - so moving these items under the Preventive section would still allow you to pay them at 100% as required by Healthcare Reform but not cover them at all if OON. Another option would be to change the Out of Network percentage from 100% to 60% after deductible like most other items are paid

Non-Grandfathered groups are not allowed to ask whether or not dependents up to age 26 have coverage elsewhere

Non-Grandfathered groups must provide employees with the option of an external appeals process after the normal appeals process has been exhausted

No lifetime or annual maximums are allowed on any "essential health benefits"

A 30 day enrollment period must be offered to all employees to allow for addition of dependents up to age 26

No rescissions allowed