

An Important Message to All PEEHIP Members:

Medical and pharmaceutical costs have increased at a much greater rate than expected this year due in part to new and expensive medical and drug treatments, an increase in drug prices and increased medical utilization. The PEEHIP Board and staff work hard to save money where possible. Because of your participation, the wellness program has and will continue to save the plan tens of millions of dollars annually and, more importantly, help our members stay healthier. The trend of increased costs, however, is a national one and beyond the control of the Board or staff. As a result, PEEHIP anticipates a \$140 million dollar shortfall in funding for FY 2016, despite the Legislature's appropriation to the plan of over \$900 million. This shortfall is more than the Board can obtain from any other funding source.

The PEEHIP Board and staff care deeply about the financial challenges members face. But it was confronted with difficult choices that had to be made to ensure the survival of your health care plan. After much thought and deliberation, the PEEHIP Board voted on May 28, 2015, to implement changes to the plan. **These changes, which are described below, were required to keep PEEHIP financially solvent so that our members can count on coverage when they need it.**

Please know that the PEEHIP Board and staff have adopted changes that will minimize the financial hardship on membership. Even taking these changes into account, the PEEHIP plan remains one of the most affordable health care plans in the country. The PEEHIP Board and staff will continue to work to find ways to keep your health care as affordable as possible while maintaining a high level of service and benefits.

Don Yancey
Deputy Director
RSA/PEEHIP

Sarah S. Swindle
PEEHIP Board Chair

PEEHIP Benefit and Premium Changes Effective October 1, 2015

Medical Plan Changes

- **Specialist office visit copay increases from \$30 to \$35.**
(This does not apply to Family/General Practice, Internal Medicine, Gynecology, Obstetrics, Pediatrics, Certified Nurse Practitioner, Physician Assistant, Clinic, and Midwives.)
- **Removal of 4th quarter major medical carryover deductible.** Effective 1/1/16, major medical claims in the 4th quarter of the calendar year will no longer be carried over and counted towards the deductible of the following year.
- **Removal of the accident rider.** The accident rider previously allowed first dollar coverage for accidents up to \$500. Members were not required to pay the Emergency Room (ER) copay of \$150 in the event of an accident. Removing this rider treats accidents like any other illness and all applicable copays will apply.

Premium Rate Changes

(These rate changes apply to active and retired members, members who are on leave of absence, COBRA, and surviving dependent accounts.)

- **Increase tobacco premium from \$28 to \$50 for the subscriber and an additional \$50 for the spouse per month if both are tobacco users.**
- **Increase family dental premium from \$45 to \$50 per month.**
(Note: The single dental rate remains \$38. The other optional plan premiums remain \$38 per month.)
- **Spousal Surcharge:** Add a **monthly** spousal surcharge of \$75 for spouses on active contracts and non-Medicare eligible spouses on retired contracts, and \$25 surcharge for Medicare primary spouses on retired contracts. The spousal surcharge will be phased in over 3 years. Note: The spousal surcharge will not apply to spouses who are independently eligible for PEEHIP. See 3 year phase-in details below.

3 Year Phase-In Schedule

- **Spouses on active contracts and non-Medicare eligible spouses on retired contracts**
 - **Year 1: \$25 (Effective 10/1/2015)**
 - **Year 2: \$50 (Effective 10/1/2016)**
 - **Year 3: \$75 (Effective 10/1/2017)**
- **Medicare primary spouses on retired contracts**
 - **Year 1: \$10 (Effective 10/1/2015)**
 - **Year 2: \$20 (Effective 10/1/2016)**
 - **Year 3: \$25 (Effective 10/1/2017)**

Pharmacy Plan Changes

- Various changes to the commercial plan formulary were made, including step therapy, prior authorization, quantity limits, and the exclusion of some drugs to drive utilization to lower cost alternative drugs.
(Note: This does not change the normal current three-tier drug copayments of \$6 for generics, \$40 for preferred brands, and \$60 for non-preferred brands.)
- Flu Vaccine to be allowed at participating retail pharmacies at no cost beginning August 1, 2015.

Viva Health Plan Benefit Changes

- Increase drug copay to \$60 for preferred brand and \$80 for non-preferred brand.
- Change in coverage for biological drugs, biotechnical drugs, and specialty drugs to 70%.
- Change in coverage to 90% for outpatient services performed in an outpatient hospital setting. \$150 copay remains for outpatient services performed at an ambulatory surgical center.
- Increase in copay per lab test at independent labs to \$7.50 and 90% coverage per test at hospital-based labs.
- Increase in inpatient copay to \$50 copay for days 2-5.
- Increase in Emergency Room copay to \$200 copay per visit.
- Change diagnostic services (e.g., CT scans, X-rays, etc.) from \$150 copay per service to 90% coverage.
- Change in coverage for genetic testing, dialysis, and allergy testing and treatment to 80%.
- Combine medical and prescription out of pocket maximums (currently separate). Set the combined member out of pocket maximum to \$6,600 for an individual, and \$13,200 for the family per calendar year.

Supplemental Hospital Medical Changes

The following additions and revisions were made to the **current** exclusion language for the Supplemental Hospital Medical plan.

- Members enrolled in the VIVA Health plan offered through PEEHIP cannot also be enrolled in the PEEHIP Supplemental Plan.
- Members are not eligible for the PEEHIP Supplemental Plan if they have a primary plan with a deductible greater than **\$1,450** for individual or **\$2,700** for family. (Was \$1,250 for individual and \$2,500 for family.)
- Annual maximum amount paid for the Supplemental Plan will be indexed to match the Hospital Medical overall maximum out of pocket (MOOP). Currently the MOOP is \$6,600 for single coverage, and \$13,200 for family coverage per calendar year.

Flex Plan Change:

- Effective October 1, 2015, the Flex Debit Card will no longer be available as a reimbursement method option under the PEEHIP Health Flex Spending Account. Note: Members will continue to have the automatic bump and the manual reimbursement method options.

These changes will also be published in the July 2015 PEEHIP Advisor.