Empire BlueCross BlueShield

# Good employee health is good for your business

## Renewal Kit
## VERATEX INC

**Master Group #: 243400**
**Renewal Month: December 2013**
**Your Broker: TOBIN LUSTGARTEN**

# Your renewal financial exhibit

Empire BlueCross BlueShield

Company Name: VERATEX INC
Region: DOWNSTATE 2

Group #: 243400 - 1
Benefit Package Number: 001

| Your group has Calendar Year benefits | Renewal Effective Date: 12/01/2013 | |
|---|---|---|
| | **Current Plan** | **As Is Renewal** |
| | **Empire PPO Option 1** | **Empire PPO Option 1** |
| **Cost Share In-Network** | | |
| **Office Visit** | $45/$60 | $45/$60 |
| **Emergency Room** | $150 | $150 |
| **Inpatient** | Deductible & Coinsurance | Deductible & Coinsurance |
| **Outpatient** | Deductible & Coinsurance | Deductible & Coinsurance |
| **Deductible** | | |
| **In-Network** | $1000/$2500 | $1000/$2500 |
| **Out-of-Network** | $2500/$6250 | $2500/$6250 |
| **Coinsurance** | | |
| **In-Network** | 90%/10% | 90%/10% |
| **Out-of-Network** | 70%/30% | 70%/30% |
| **Total Maximum Out-of-Pocket** | | |
| **In-Network** | $3000/$7500 | $3000/$7500 |
| **Out-of-Network** | $7500/$18750 | $7500/$18750 |
| **Rx** | | |
| **Rx: RX Retail Copay** | Copay $10/$35/35% Ded. $50 | Copay $10/35%/50% Ded. $100 |
| **Dental Plan: Progressive Dental** *In-Network Benefits Only* | | |
| **Diagnostic & Preventive** | Benefit Payment | Benefit Payment |
| **Basic Services** | Benefit Payment | Benefit Payment |
| **Major Restorative** | Benefit Payment | Benefit Payment |

**Other Available Riders** (Listed below are your current purchased riders. These riders will be applied to your "as is renewal" if available)

Gym Membership Reimbursement

# Your renewal financial exhibit
## (continued)

Company Name: VERATEX INC
Region: DOWNSTATE 2

Group #: 243400 - 1
Benefit Package Number: 001

| | Renewal Effective Date: 12/01/2013 | |
|---|---|---|
| | Current Plan | As Is Renewal |
| | Empire PPO Option 1 | Empire PPO Option 1 |
| **Enrollment Information*** | **Rates: 4-Tier Structure** | |
| Basic Rates | | |
| Individual 1 | $839.26 | $857.13 |
| Employee/Spouse 0 | $1,697.16 | $1,732.90 |
| Employee/Child(ren) 1 | $1,533.02 | $1,565.18 |
| Employee/Family 0 | $2,517.91 | $2,571.52 |
| Monthly Total Premium 2 | $2,372.28 | $2,422.31 |
| Annual Total Premium | $28,467.36 | $29,067.72 |

The instructions for submitting your renewal decision are on the prior page "What to do next" page of the package.

*Note: All quotes are based on the number of enrolled subscribers at time of publication. Approval of coverage and final quotes will be based on actual enrollment. Other options may be available for your group. For more information, please talk to your broker or Empire sales representative.

Per the Affordable Care Act (or health care reform law), Summary of Benefits and Coverage (SBCs) can be accesed through our internet posting site at www.find-sbc.com.

# Important information

## Regulatory updates:

We also want you to be aware of state and federal laws that may impact your group health benefits, including:

- The Federal Mental Health Parity and Addiction Equity Act requires "parity" between the financial requirements and treatment limitations applied to medical and/or surgical benefits and mental health and substance use disorder benefits for all fully insured and administrative services only (ASO) plans covering 51 or more total employees. Small groups are required to provide parity benefits if they have 51 or more total employees regardless of the number of enrolled or eligible employees. If your group meets this definition, please contact your broker to discuss your new plan options.
- Implications of the New York State Timothy's Law require that – upon inception or renewal of your Empire Small Group health insurance policy, you have the right to purchase optional coverage for biologically-based mental Illness (for covered dependent children and covered adults) and children with "serious emotional disorders" (for covered dependents under the age of 18) through a rider that is available at an additional cost. Please note that Empire's base benefits do not cover these conditions.

For more information, call your broker, Empire representative or the GBA Contact Center at 866-422-2583.

- If you currently have a grandfathered benefit plan under the provisions of the Patient Protection and Affordable Care Act, please be aware that changing your benefit plan, employer premium contribution or insurance carrier may cause your plan offering to no longer be considered grandfathered.

## Affordable Care Act (ACA or Health Care Reform Law)

- Effective January 1, 2014, the Affordable Care Act (ACA or health care reform law) imposes a new annual fee on health insurance providers based on their market share of net premiums written, or the sum of premiums earned from all policies, during the previous year. The total fee amount to be collected across all health insurers is set at $8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017 and $14.38 billion in 2018. After 2018, it increases annually based on premium growth. The fee is anticipated to raise $101.7 billion and is not tax deductible.

- Section 1341 of the Affordable Care Act provides that a transitional reinsurance program be established in each State to help stabilize premiums for coverage in the individual market during the years 2014 through 2016. All health insurance issuers, and third-party administrators (TPAs) on behalf of self-insured group health plans, will submit contributions to support reinsurance payments to issuers that cover high-cost individuals in non-grandfathered individual market plans.

- This quotation includes amounts for the ACA Insurer Fee and ACA Reinsurance Fee. Since the fees become effective in January 2014 for all business regardless of renewal date, we have calculated the amounts applicable starting with January 2014 through the end of your coverage period, and those amounts have been prorated across your full coverage period. The amounts to be effective in January 2014 are equal to 2.46% of premium for the ACA Insurer Fee and $5.25 per member per month for the ACA Reinsurance Fee.

# Important information (continued)

## Benefit Updates:
## New York Autism law takes effect in November

A new law in New York calls for health insurers to cover "the screening, diagnosis and treatment" of autism spectrum disorder (ASD) when prescribed by a licensed doctor or psychologist. The new law affects most health insurance policies that cover physician services, major medical or similar comprehensive coverage. The law takes effect November 1, 2012, starting on an employer group's renewal date (or date of issuance). The New York Autism Mandate includes the following important conditions:
o It requires coverage of certain services for people with "autism spectrum disorder" (ASD), as defined by the law.

o Covered service categories for treating ASD include:

- Psychiatric and psychological care provided by a psychiatrist, psychologist or licensed clinical social worker for direct or consultative services.
- Behavioral health treatment provided by a licensed provider, and consisting of counseling and treatment programs as necessary to develop, maintain or restore a person's functioning.
- Applied behavior analysis (ABA), as defined in the law. ABA must be provided (i) by a certified behavior analyst or by an individual who is certified and subject to supervision by a certified behavior analyst and to standards set forth by the New York Department of Financial Services and New York Department of Health and Education; and (ii) per a treatment program that gives measurable goals addressing the member's condition and functional difficulties. The treatment program must include goals from an initial assessment and later interim assessments over the course of the treatment.
- Therapeutic services necessary to develop, maintain or restore a person's functioning, and provided by licensed or certified speech therapists, occupational therapists, physical therapists and social workers – provided the services are covered by the policy.
- Assistive communication devices (ACDs), when ordered or prescribed by a physician or psychologist based on formal evaluation by a speech-language pathologist, to improve communication for members unable to communicate through normal means. (May be limited to dedicated devices only.)

o The law contains important limits. Prior authorization, utilization review, case management and other managed care provisions may apply.

- Coverage is subject to medical necessity review, with external appeal rights under the NY Insurance law.
- Coverage may be subject to annual deductibles, copayments and coinsurance consistent with cost sharing for other benefits. Annual maximum caps may apply.
- Services may have to be given by network providers credentialed by the plan.
- When ABA services are covered, they must be provided or supervised by a behavior analyst certified by the Behavior Analyst Certification Board (BACB). BACB is a professional credentialing body.

The mandate does not affect obligations under existing programs for services provided per an individualized family service plan or individualized education plan or under the Early Intervention Program.

o The Autism Mandate does not apply to Hospital-only, Healthy NY, standardized Direct Pay (individual) HMO and HMO/POS plans, or Medicaid/FHP health plans. It also does not apply to ASO benefit plans.

NOTE: This is for informational purposes only and is a summary. Specific coverage terms will be set forth by policy rider and are subject to existing policy terms and governing law. In the event of a conflict between this information and benefit plan terms, the terms of the policy form hold.

# Important information (continued)

## Benefit changes to full service Blue View Vision℠ plans:

Great news! When you renew your vision plan this year, you'll be upgraded to our newest vision coverage.You'll get enhanced in-network benefits that include:

- Transitions® lenses for kids up to age 19 at no extra cost because it's important that kids have protection from harmful UV rays. Transitions block 100% of UVA and UVB harmful rays, so they help keep eyes protected.
- Factory scratch coating included at no extra cost on standard lenses
- Additional savings on new lens upgrade options

Refer to your benefit booklet for complete details regarding your vision benefits.

## Women's Preventive Care Services

Your plan has new and newly expanded benefits for women's preventive care. The following services, drugs and supplies will now be paid at 100% in-network in keeping with the comprehensive guidelines of the Health Resources and Services Administration (HRSA). Coverage for these services is included in this renewal.

- Well woman visits
- Breastfeeding support, supplies and counseling*
- Prescription contraceptives (birth control) and counseling for women**
- Permanent surgical contraception (sterilization) for women
- Counseling for sexually transmitted infections
- Counseling and screening for HIV
- Screening and counseling for interpersonal and domestic violence
- Screening for gestational diabetes
- HPV testing

*Breast pumps must be purchased/rented from an in-network medical or DME provider, per the terms of your policy, to get 100% coverage. Breast pumps obtained from non-network providers may be covered, but may result in a cost share or balance billing. Limited to the purchase of one breast pump per year, although exceptions may be approved through the appeal/authorization process.

** Your drug plan formulary determines which specific drugs are covered under your plan. To get 100% coverage for a covered prescription contraceptive, it must be a generic drug or a brand-name drug that doesn't have a generic equivalent and be obtained from an in-network pharmacy. A cost-share may apply for other prescription contraceptives, based on your drug benefits.

Coverage of the services, drugs and supplies listed above are also subject to the terms and conditions contained in the governing benefit policy. Full details regarding these benefits will be contained in a rider(s) to your policy and will be effective on your renewal. A new member ID card and benefit booklet will be sent to all enrolled employees to advise them of the details of these benefits. Please share this information with your employees so that they are aware of the upcoming added benefits to their policies.

# Important information (continued)

## Product Update:

Starting April 1, 2013, upon a group's renewal date, Rx Drug Cost Share Option $10/$35/35% will be withdrawn from the Small Group Market for PPO Plans. This means that your current drug option will no longer be available with PPO plans upon your renewal on or after April 1, 2013.

If you do not choose a new drug option, you will be automatically transferred to coverage with a $10 co-pay for Tier 1 formulary drugs, 35% coinsurance for Tier 2 drugs and 50% coinsurance for Tier 3 drugs.

You may select the $10 Generic drug plan that Empire offers in the small group market. You may also choose not to have drug coverage at all.

Visit our Empire Rx e-tutorials:
http://www.empireblue.com/10/35/50
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