

2014 Benefit Changes—Effective April 1, 2014

Tufts Health Plan will implement the following benefit changes April 1, 2014. In addition to these changes, there are many other changes related to the Affordable Care Act outlined in this newsletter.

HMO Basic 25:

- The inpatient and outpatient hospital copay has been reduced from \$600 to \$500 per visit

- The high-tech imaging copay has been reduced from \$150 per visit to \$100 per visit

Advantage PPO:

- The plan will have a separate deductible and out of pocket maximum for in-network services and out-of-network services. This is a change from our current benefit where there is just one deductible and one out of pocket maximum for in-network and out-of network services.

IMPORTANT:

Please share the information in this benefit change document with all benefit-eligible employees. Rates will be available in February.

Plan Changes

Effective upon your renewal, April 1, 2014, some Tufts Health Plan offerings will be discontinued, because of one or both of these reasons:

- 1) The plan currently has very little or no membership.
- 2) The plan does not meet Affordable Care Act plan design requirements for actuarial values (AV) for small groups.

Important Information

Please know that there will be no disruption in your coverage. Please read on to learn your options.

- If you are currently on a plan from the left column, effective April 1, 2014, your coverage will automatically be carried over to the plan from the right column because it is closest in rates and benefits to your current plan.
- You are welcome to select a different plan of your choice. You may work with Health Services Administrators to select any new plan for 2014 from the list of available plans. They can provide benefit information and answer other questions you might have. You don't need to take any action right now. More information on renewal rates and plan options will be sent to you in late February.

| Current Plan that will change on April 1, 2014 | New Plan Effective April 1, 2014 |
|--|--|
| HMO Premium, HMO Value Option 1 and 2, HMO Basic 25 Option 1 and 2, HMO Basic 20 | HMO Basic 25 Platinum |
| Advantage HMO 500, HMO Basic 35, HMO Basic 50 | Advantage HMO 500 Platinum |
| Advantage HMO 1000 Option 1 | Advantage HMO 1000 Gold |
| Advantage HMO 1500, Advantage HMO 1000 (80%) | Advantage HMO 1500 Gold |
| Advantage HMO 1000 Option 2, Advantage HMO 2000 Option 2 | NEW! Advantage HMO 1500 Low Rx Gold |
| Advantage HMO 2000 Option 1 | Advantage HMO 2000 Gold |
| Advantage PPO 1000 | NEW! Advantage PPO 1500 Gold |
| Advantage HMO Saver 2500 | NEW! Advantage HMO Saver 2000 Silver |
| HMO Select 20, Select Advantage HMO 1000, Advantage HMO Select 750 | Select Advantage HMO 1000 Gold |
| Select Advantage HMO 2000, Advantage HMO Select 2000 | Select Advantage HMO 2000 Gold |
| Steward Community Choice Copay | Steward Community Choice Copay Platinum |
| Steward Community Choice 1000 | Steward Community Choice 1000 Gold |
| Commonwealth HMO 250 w/ Coinsurance | NEW! Commonwealth Advantage HMO 400 with Coinsurance (Gold A) Gold |
| Commonwealth HMO 25, Commonwealth Advantage HMO 2000 v.2 | NEW! Commonwealth Advantage HMO 1000 v.2 (Gold B) Gold |

Guaranteed Availability—Live Work Reside Rule

On Feb. 22, 2013, the U.S. Department of Health and Human Services (HHS) issued a final rule to implement several provisions of the Affordable Care Act, including guaranteed availability (issue) of coverage.

The provisions apply upon your renewal effective April 1, 2014. Part of the guaranteed availability of coverage is that health plans that offer insurance through a network plan may “limit the employers that may apply for the coverage to those with eligible individuals in the group market who live, work, or reside in the service area for the network plan.” (45 C.F.R. 147.104(c))

This means that eligible members must meet at least one of the criteria: live, work, or reside within Tufts Health Plan’s provider service area.

Fitness Reimbursement Changes

Effective April 1, 2014, the Fitness reimbursement will be expanded as follows:

- The \$150 reimbursement limit will be replaced with a reimbursement of up to three months’ membership at a qualified fitness center.
- The reimbursement will now include certain organized group exercise classes. These classes include, but are not limited to: yoga, pilates, aerobics, Zumba, and kickboxing. Classes held in a residential setting or dance classes are not included.

To qualify for the reimbursement, fitness services must be received at a fitness center offering cardio and strength-training machines and other programs for improved physical fitness. The reimbursement does not include martial arts centers, gymnastics centers, country clubs, aerobics-only or pool-only centers, sports teams and leagues, social clubs and tennis clubs, personal trainers, sports coaches, or the purchase of personal or at-home exercise machines.

No Cost Sharing for Prenatal and Postpartum Outpatient Maternity Visits

Effective April 1, 2014, Tufts Health Plan will implement a coverage change with respect to prenatal and postpartum outpatient maternity visits. All in-network outpatient, routine maternity prenatal and postpartum office visits will be covered in full with no member cost sharing.

Coverage for Contraceptives

Tufts Health Plan has made a coverage change for certain contraceptives for women. The following are covered without member cost sharing:

- Multi-source brand contraceptives
- Over-the-Counter (OTC) female contraceptives when the member has a written prescription

Previously, only generic and single-source brand contraceptives (those with no generic equivalent) were available to members with no cost sharing.

Prescription Drug Formulary Changes

Effective April 1, 2014, as part of the implementation of Essential Health Benefits (EHB), all Tufts Health Plan options that include prescription drug coverage will follow a formulary (drug coverage list) based on state and group size.

You can review the new formulary at tuftshealthplan.com by clicking Pharmacy on the *I’m a Member* tab. Then click **Massachusetts Individual and Small Group Drug List**.

Coverage for Individuals Participating in Clinical Trials

Routine patient costs associated with qualified clinical trials are currently covered for cancer diagnoses. Effective April 1, 2014, plans will also include coverage for routine patient costs for individuals participating in an approved phase I, II, III or IV clinical trial conducted to prevent, detect, or treat a life-threatening disease or condition.

Effective for your plan April 1, 2014, the ACA requires health plans to cover routine patient costs when a "qualified individual" is in an "approved clinical trial." Routine costs for a qualified individual of an approved clinical trial include all items and services consistent with coverage that a Tufts Health Plan member would be eligible for if he or she is not enrolled in a clinical trial. A "qualified individual" is someone who meets the criteria to participate in an approved clinical trial. In addition,

either the individual's doctor has concluded that participation is appropriate, or the participant provides medical and scientific information establishing that his or her participation is appropriate.

Under the federal provision, the clinical trial must be approved or funded by specified entities, conducted under an investigational new drug application reviewed by the FDA, or conducted as a drug trial that is exempt from the requirement of an investigational new drug application. As defined by federal law, a life-threatening condition or disease means "any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted."



Essential Health Benefits: Pediatric Dental Coverage

Upon renewal in 2014, all Tufts Health Plan Small Group plan designs will include required essential health benefits, including pediatric dental coverage, unless specific requirements with respect to alternative pediatric dental coverage are met. Annually upon renewal, rates will include pediatric dental coverage administered by Altus Dental Insurance Company by default.

HMO plans will receive the Altus pediatric dental HMO plan and PPO plans will receive the Altus pediatric dental PPO plan.

If you would like a quote for a medical rate that does not include pediatric dental coverage, please contact Health Services Administrators. In order to qualify for coverage without pediatric dental, you will be required to submit an annual attestation form confirming that each employee and his or her qualified dependents have coverage through another carrier that meets federal requirements for pediatric dental care and is certified by the State Health Exchange.

The following types of services will be included in the 2014 pediatric dental benefit:

- **Type I Services: Preventive & Diagnostic**
Examples of services include oral exams, teeth cleaning, and x-rays
- **Type II Services: Basic Covered Services**
Examples of services include root canals on permanent teeth and amalgam restorations
- **Type III Services: Major Restorative Services**
Examples of services include porcelain/ceramic crowns and partial or complete dentures
- **Type IV Services: Orthodontia**
Services are covered when medically necessary and require prior authorization.

To view benefit summaries with a detailed description of the coverage offered, please visit our website:

- **HMO pediatric dental benefits**
http://www.tuftshealthplan.com/brokerlink/pdfs/altus_dental_HMO_pedi_summary_MA.pdf
- **PPO pediatric dental benefits**
http://www.tuftshealthplan.com/brokerlink/pdfs/altus_dental_PPO_pedi_summary_MA.pdf



Waiting Period for Coverage Cannot Exceed 90 Days

Under the Affordable Care Act, a group health plan or health insurance issuer offering group health insurance coverage shall not apply any waiting period that exceeds 90 days. This applies to your plan upon renewal on April 1, 2014.

A waiting period is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan can become effective. For this purpose, being eligible for coverage means having met the plan's substantive eligibility conditions (such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's terms).

This provision does not require the employer to offer coverage to any particular employee or class of employees, including part-time employees. It merely prevents an otherwise eligible employee (or dependent) from having to wait more than 90 days before coverage becomes effective.

Allowed waiting periods:

- Date of hire
- 30 days following date of hire
- 1st of the month following 30 days
- 60 days following date of hire
- 1st of the month following 60 days
- 90 days following date of hire

Please contact Health Services Administrators with questions or to change your group's waiting period.

Patient Centered Outcomes Research Institute (PCORI)

The Patient Centered Outcomes Research Institute (PCORI) was established by the Patient Protection and Affordable Care Act (PPACA). Insurers will be responsible for paying a fee to fund the federal Patient Centered Outcomes Research Institute. The fee will be equal to:

- \$1 for each of the average number of covered lives under the plan for the first plan year ending on or after October 1, 2012, and
- \$2 per life for each plan year ending on or after October 1, 2013, subject to an inflationary increase each year, and ending in 2019.

This fee does not apply to government programs. The federal government issued a final rule on December 6, 2012, which includes methods for calculating the fee. Plans must submit an IRS filing (Form 720) with the fee for the previous year each year by July 31st.

Tufts Health Plan is responsible for paying the fees for its covered insured lives. For more information, see the PCORI Fee Frequently Asked Questions at tuftshealthplan.com/healthcarereform.

Summary of ACA Fees

| | Who pays | | |
|--|---|----------------------------|----------------------|
| | Health Plan Issuer | Self Insured Employer pays | Grandfathered Groups |
| <p>Patient-Centered Outcomes Research Institute (Comparative Effectiveness) Fee (PCORI)</p> | <p>Yes</p> <p>Health insurance issuers and self-funded groups must file an excise tax return form 720 by July 31 of the year after the plan/policy year ends.</p> | Yes | Yes |
| <p>Annual Health Insurance Industry Fee (includes Medicare, Medicaid and Dental issuers)—Referred to as Health Insurer Fee*</p> <p>*Nonprofit insurers that receive more than 80% of their premium revenue from Medicare, Medicaid, CHIP, and Dual Eligible plans are excluded.</p> | <p>Yes – fee is divided proportionally between all issuers (for-profit insurers pay 2x as much as not-for-profits)</p> | No | Yes |
| <p>Transitional Reinsurance Program Assessment Fee</p> <p>States may establish their reinsurance program and if not, HHS will operate the program on behalf of the state</p> | Yes | Yes | Yes |
| <p>Risk Adjustment Program and Fee</p> <p>Spreads the financial risk of the issuers in the individual and small group markets evenly</p> | <p>Yes</p> <p>N/A to large group plans</p> | No | No |
| <p>Marketplace (i.e., Exchange) User Fees</p> | Yes | No | No |
| <p>Cadillac Excise Tax -40 % tax on premiums that exceed defined thresholds for single and family coverage.</p> | Yes | Yes | Yes |

| What the money is used for | What is the fee and when does payment begin? | |
|--|---|--|
| | Amount | Schedule |
| Provide evidence-based research intended to help people make informed health care decisions | <p>\$1 per covered life (.08 PMPM) \$2 per covered life (.17 PMPM)</p> <p>Fee = the sum of the fee in the prior year + an adjustment by the Treasury based on medical inflation. The dollar amount is indexed based on the projected per capita increase in National Health Expenditures</p> | <p>For Plan Years ending between: 9/30/12 -9/30/13 10/1/13-9/30/14 10/1/14 – 9/30/19</p> <p>FEE IS PHASED OUT AFTER 9/30/19</p> |
| Funds some of the provisions of ACA – including the individual premium subsidiaries or cost share reductions | <p>Total collection = 8 billion annually Increases to 14.3 billion, then indexed to rate of premium growth</p> | <p>2014 2018</p> <p>Fee is annual and permanent</p> |
| Used to stabilize individual premiums | <p>\$20 billion + \$5 billion contributed from the US Treasury</p> <p>Contribution rate of 5.25 per covered life per month which is equal to \$63 per individual enrolled (estimated by HHS) plus a small administrative fee</p> | <p>For Plan Years ending between: 2014 – 2016 Quarterly collections beginning in January, 2015 and phased out in 2016</p> <p>In 2014 (headcounts will be required by 11/15/14 with bills issued 12/15/14)</p> |
| Payments will be transferred from issuers with lower risk members to those issuers with higher risk populations. | Costs TBD | Begins in 2014 and is permanent |
| | Initial proposed was 3.5% of premium | For 2014, MA Health Connector deferred the charge. |
| Dollars to help finance health reform | <p>Thresholds estimated (may vary based on inflation): 10,200 for single coverage 27,500 for family coverage</p> <p>(increases for high-risk professions and retirees 55+)</p> | <p>2018 permanent</p> |

New Plan Options Available April 1, 2014

Please review the new coverage options available. If you'd like to change to one of these plans, please work with Health Services Administrators.

Advantage HMO 2000 (80%)

A deductible plan that applies coinsurance after the deductible has been met.

Advantage Saver

Our only Health Savings Account (HSA) qualified plan offering. The plan year is April 1 to March 31 of each year regardless of when it's purchased, and it has one combined out-of-pocket maximum of \$5,350 individual/\$10,700 family for medical, pharmacy, and pediatric dental. The deductible is \$2,000 individual/\$4,000 family.

Advantage HMO 1500 with Low Rx

Same plan design as the Advantage HMO 1500, but with higher Rx copays and a deductible for pharmacy.

Commonwealth Advantage HMO 1000 v.2

A standard network deductible plan that offers lower PCP copays and higher specialist visit copays.

Commonwealth Advantage HMO 400 with Coinsurance

A standard network plan with a low deductible to satisfy; coinsurance applies after the deductible has been met. Offers lower PCP copays and higher specialist visit copays.

Advantage PPO 1500

A deductible plan that allows you to see providers outside of the Tufts Health Plan network.

Small Group Metallic Tier Classifications

Effective upon your renewal on April 1, 2014, non-grandfathered fully insured small group plans will be classified according to how the plans compare in actuarial value (AV). AV is the percentage of covered benefits paid by the health insurer. The Affordable Care Act has established metallic tiers to represent the actuarial value of health plans.

Small group plans must be classified into the following metallic tiers, within +/- 2 percentage points:

- 60% = Bronze
- 70% = Silver
- 80% = Gold
- 90% = Platinum

The Department of Health and Human Services has provided an AV Calculator for insurers to determine the metallic tier, and upon renewal, a plan's tier will be indicated on Summary of Benefits and Coverage documents (SBCs).

Member ID Card Changes

Tufts Health Plan is working with a new vendor, Clarity, for our member ID cards. Newly issued cards will include a QR code on the back side that allows members to use their smartphones to connect to our mobile website and check benefits, view claims, and more.

In addition, our pharmacy benefits manager, CVS Caremark, had a systems upgrade which was seamless to members. As a result of the upgrade, the Caremark RXBIN number has changed (this number appears at the bottom of members' ID cards). Although this number changed, old Caremark RXBIN numbers will continue to operate at network pharmacies with no interruption.

Members of new groups and renewing groups with benefit changes that affect cards will receive new ID cards that contain the QR code and the new Caremark RXBIN number.

Members of groups renewing without changes that affect member ID cards will not receive new cards. However, any member who requests a replacement ID card will receive a card that has a QR code as well as the new Caremark RXBIN number.

To request a new ID card, please call Member Services at 800-462-0224.

How the Supreme Court's DOMA Decision Impacts Employer Groups

The Supreme Court's ruling on June 26, 2013, that Section 3 of the Defense of Marriage Act (DOMA) is unconstitutional means that the federal government will now recognize same-sex marriages that are valid under state law. With this ruling, the federal tax code, ERISA, COBRA, and other federal laws must recognize as married those same-sex spouses who live in a state where same-sex marriages are recognized.

Tufts Health Plan already allows coverage for same-sex spouses. Prior to the Supreme Court's decision invalidating DOMA, an employer group offering such coverage would have to report the value of the same-sex spouse's coverage as taxable income to the subscriber for federal tax purposes. As of June 26, 2013, employers no longer have to impute income to employees for the value of the health insurance coverage for same-sex spouses.

If you have any questions, please contact your tax advisor.



Plans for Retirees

Tufts Health Plan can meet the needs of your Medicare-eligible employees with options for affordable, quality coverage.

Tufts Health Plan Medicare Preferred HMO

This is the largest local Medicare Advantage Plan in Massachusetts. The group plan includes unlimited prescription drug coverage and offers coverage for hearing aids and eyeglasses. There is also a fitness center reimbursement available.

Tufts Medicare Complement

This plan covers Medicare deductibles, coinsurance, and additional benefits. Members receive care in our broad commercial Tufts Health Plan network. This option can be purchased with or without unlimited prescription drug coverage.

Retiree products can be purchased with or without a financial contribution from the employer group. For more information, please contact Health Services Administrators.

Tufts Health Plan Medicare Preferred is offered through Tufts Associated Health Maintenance Organization, Inc. Tufts Medicare Preferred is a Medicare Advantage organization with a Medicare contract. The Medicare Advantage contract between Tufts Health Plan Medicare Preferred and the Centers for Medicare and Medicaid Services (CMS) is renewed annually. The benefits, premiums, copayments, and service area offered by Tufts Medicare Preferred HMO plans are subject to change on an annual basis. The availability of coverage beyond the current contract year is not guaranteed.

Tufts Medicare Complement is offered through Tufts Associated Health Maintenance Organization, Inc.

Essential Health Benefits for Small Groups

The U.S. Department of Health and Human Services (HHS) has defined 10 categories of Essential Health Benefits (EHB) that health plans must cover for fully insured small group plans. This applies upon your renewal on April 1, 2014.

It is important to note that for the most part the health care services in these 10 categories have already been part of Tufts Health Plan's coverage. The 10 categories are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Laboratory services
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Pediatric services, including oral and vision care
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices

Each state was required to select a benchmark plan—one held up as a point of reference for comparison—to define the scope and limits of EHB within the 10 broad categories. Health plans must offer coverage in which the benefits in each of the categories are actuarially equivalent to those in the benchmark plans selected by Massachusetts.

For more information on EHB and each state's benchmark plans, please visit cms.gov/CCIIO/Resources/Data-Resources/ehb.html.

Key Changes

Tufts Health Plan has evaluated the EHB coverage in the benchmark plans and has determined that there are several changes needed in order for the coverage offered to small groups to be actuarially equivalent to the benchmark plan and meet the ACA requirements.

In addition, health plans may not impose annual or lifetime dollar limits on EHB.

Changes affecting Massachusetts Fully Insured Small Group Plans

- Chiropractic services—Add coverage for up to 2 modalities (therapeutic exercise and attended electrical stimulation) per visit, in addition to current coverage for spinal manipulation
- Wigs/scalp hair prosthesis—Remove \$350 annual limit and apply 30% coinsurance to be covered as durable medical equipment (DME)
- Pharmacy coverage—Apply Massachusetts Individual and Small Group Drug List (see article on p. 2)
- Weight Loss Reimbursement—Reimbursement for up to 3 months (12 weeks) for certain Jenny Craig and Weight Watchers programs; or reimbursement of 50% of initial evaluation fee for certain medical facility-based weight loss programs
- Fitness Reimbursement—Remove \$150 limit, replace with reimbursement of up to 3 months (12 weeks)
- Pediatric Dental—Offer coverage as standard (see article on p. 4)
- Federal Mental Health Parity—Remove visit and day limits from outpatient and inpatient mental health and substance abuse services
- Therapeutic Lenses—Remove \$69 dollar limit for frames. (Only standard frames are covered.)

Massachusetts Small Group Out-of-Pocket Maximums

Effective upon your renewal on April 1, 2014, small group plans will need to comply with the ACA out-of-pocket maximum requirement, which is that the out-of-pocket maximum cannot be greater than the high deductible health plan (HDHP) limits set by the IRS. For 2014, the out-of-pocket maximum limit is set at \$6,350 (individual)/\$12,700 (family). As a result, Tufts Health Plan will be incorporating out-of-pocket maximums on all plan designs in 2014.

For 2014, Tufts Health Plan will have separate out-of-pocket maximums for medical, pharmacy, and pediatric dental services, when pediatric dental is included in the medical plan, which in total cannot exceed the limit of \$6,350 for individual and \$12,700 for family.

| Plan | Out-of-Pocket Maximum | | |
|---|-----------------------|-----------------|------------------|
| | Medical | Pharmacy | Pediatric Dental |
| HMO Basic 25 Platinum | \$2,500/\$5,000 | \$2,400/\$4,800 | \$1,000/\$2,000 |
| Advantage HMO 500 Platinum | \$1,000/\$2,000 | \$2,400/\$4,800 | \$1,000/\$2,000 |
| Advantage HMO 1000 Gold | \$2,950/\$5,900 | \$2,400/\$4,800 | \$1,000/\$2,000 |
| Advantage HMO 1500 Gold | \$2,950/\$5,900 | \$2,400/\$4,800 | \$1,000/\$2,000 |
| Advantage HMO 1500 Low Rx Gold | \$2,950/\$5,900 | \$2,400/\$4,800 | \$1,000/\$2,000 |
| Advantage HMO 2000 Gold | \$2,950/\$5,900 | \$2,400/\$4,800 | \$1,000/\$2,000 |
| Advantage HMO 2000 (80%) Silver | \$2,950/\$5,900 | \$2,400/\$4,800 | \$1,000/\$2,000 |
| Advantage PPO 1500 Gold | \$2,950/\$5,900 | \$2,400/\$4,800 | \$1,000/\$2,000 |
| Advantage HMO Saver 2000 Silver | \$5,350/\$10,700 | | |
| Select Advantage HMO 1000 Gold | \$2,950/\$5,900 | \$2,400/\$4,800 | \$1,000/\$2,000 |
| Select Advantage HMO 2000 Gold | \$2,950/\$5,900 | \$2,400/\$4,800 | \$1,000/\$2,000 |
| Steward Community Choice Copay Platinum | \$2,950/\$5,900 | \$2,400/\$4,800 | \$1,000/\$2,000 |
| Steward Community Choice 1000 Gold | \$2,950/\$5,900 | \$2,400/\$4,800 | \$1,000/\$2,000 |
| Commonwealth Advantage HMO 400 with Coinsurance (Gold A) Gold | \$2,000/\$4,000 | \$1,000/\$2,000 | \$1,000/\$2,000 |
| Commonwealth Advantage HMO 1000 v.2 (Gold B) Gold | \$3,000/\$6,000 | \$2,000/\$4,000 | \$1,000/\$2,000 |

Deductible Limits

Effective upon your renewal on April 1, 2014, deductibles for small group plans can not exceed \$2,000 (individual)/\$4,000 (family).

The information in this newsletter regarding health care reform requirements is being provided for informational purposes only. While we aim to ensure that content is current, accurate, and complete, Tufts Health Plan makes no representations or warranties regarding its accuracy or completeness and the information provided should not be construed as legal or tax advice or as a recommendation of any kind. Please consult your own legal counsel and/or tax and benefit plan advisors with respect to your individual circumstances and needs.



**Health Services
 Administrators**

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WHAT'S INSIDE ...

2014 Benefit Changes—Effective April 1, 20141
 Plan Changes1
 Coverage for Individuals Participating in Clinical Trials3
 Essential Health Coverage: Pediatric Dental Coverage4
 Waiting Period Cannot Exceed 90 Days5
 Summary of ACA Fees6
 New Plan Options Available April 1, 20148
 How the Supreme Court's DOMA Decision Impacts Employer Groups9
 Essential Health Benefits for Small Groups 10
 Massachusetts Small Group Out-of-Pocket Maximums 11