HealthTrust

September 3, 2015

Dear HealthTrust Member:

The HealthTrust Board of Directors and staff review plans, products and services annually to ensure we always offer you and all of our Members the benefits and programs that best meet your needs. We would like to tell you about some of the important updates to our medical and prescription plan options that will begin in 2016. These changes will:

- Help to contain your healthcare costs;
- Lower your risk of incurring additional costs when the "Cadillac Tax" under the Patient Protection Affordable Care Act becomes effective in 2018;
- Streamline our benefit plan options to make them easier for you and your employees to understand; and
- Offer your employees a key network enhancement to the HMO (Matthew Thornton Blue) plan, which expands in-network benefits to include the entire New England network of Blue Cross and Blue Shield providers.

HealthTrust is also excited to share with you that in partnership with Anthem, we will be moving to a new computer platform with Anthem on January 1, 2017. This transition will allow HealthTrust to:

- Track deductibles and out-of-pocket maximums on a Plan Year instead of calendar year basis for HealthTrust's July renewal groups
- Integrate medical and pharmacy deductibles and out-of-pocket limits
- Administer the pharmacy benefits for the Lumenos consumer driven health plan through CVS/caremark

HealthTrust expects that this change in platform will allow greater flexibility in designing future plans to meet the ever-changing needs of our Members.

As discussed above, over the next two years HealthTrust is implementing several changes that may impact your group. The enclosed document provides a summary of the changes and respective effective dates. Below are some additional details regarding the changes.

NETWORK ENHANCEMENT FOR ALL HMO (MATTHEW THORNTON BLUE) COVERAGES

Healthcare is a dynamic, ever-changing system and New England as a whole has some of the most skilled and respected medical resources. Access to only a single state network may no longer meet the needs and/or expectations of enrollees. Having access to a New England-wide network will provide greater value to our Members and their enrollees. With the Access Blue New England network, enrollees can choose and use any Blue Cross and Blue Shield Access Blue New England network doctor or hospital in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island or Vermont. This will allow access to in-network primary care, specialist care, and urgent care anywhere in New England **without a referral.**

This change takes effect January 1, 2016 for January renewal groups and July 1, 2016 for July renewal groups.

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DISCONTINUING AND CONSOLIDATING MEDICAL AND RX PLANS

At last year's Board retreat, the Board directed staff to review the medical and pharmacy plans currently offered to determine if there are any that could be discontinued or consolidated, provided that HealthTrust give sufficient advance notice of any changes. As a result, the Board voted to discontinue or consolidate the following medical plans effective July 1, 2016 for July renewal groups and January 1, 2017 for January renewal groups:

Medical Plan Changes	
Discontinue:	**Consolidate**:
Indemnity (JY, JW and Comp) plans	BC2T10+ (move to BC2T10)
PPO plans	BC3T5 (move to BC3T5RDR)
	BC2T20IPDED (move to BC2T20)

Additionally, the Board voted to discontinue the $1 and $3/7 mail order plans (as well as some other, non-standard plans) effective January 1, 2018 for January renewal groups and July 1, 2018 for July renewal groups. The RX10/20/30 plan would be changed to an RX10/20/35 plan in order to receive maximum discounts at retail pharmacies and through the mail order program. The RX10/20/45 and the 6-tier R10/25/40/M10/40/70 plans continue to be HealthTrust preferred options.

50 AND UNDER POOL PLAN OPTIONS

The Board voted to limit the offerings within the 50 and under pool to eight plans (excluding Medicomp), with no more than three options per Member group. Additionally, these plans may only be offered with the RX10/20/45 and 6-tier pharmacy plan (R10/25/40/M10/40/70).

The Board is limiting offerings for the 50 and under pool because this population is community rated and the chosen options will promote effective and fair management of costs among all the 50 and under pool participating Member groups through thoughtful plan designs that maximize network discounts. This should mitigate future rate increases by lowering claims and administrative costs. For example, due to differing network discounts, the same prescription under the $1 prescription drug option costs the 50 and under pool more than if processed under the RX10/20/45 option.

DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS ON PLAN YEAR INSTEAD OF CALENDAR YEAR

HealthTrust has historically applied deductibles and out-of-pocket maximums to its medical and pharmacy plans on a calendar year basis. In other words, a covered individual's deductibles and out-of-pocket responsibilities would start anew on January 1, for both the January and July groups. In 2014, the Affordable Care Act ("ACA") set out-of-pocket limits on all non-grandfathered health plans (with the exception of retiree-only Medicomp plans). According to the language of the law and its implementing regulations, it appeared that the out-of-pocket limits would need to be applied on a Plan Year basis, e.g. the out-of-pocket amounts would have to reset on July 1 for all July groups, and January 1 for January groups. In response to comments received by Centers for Medicare & Medicaid Services ("CMS") relative to the administrative difficulties of this change, the final ACA implementing regulations for 2016 provide that for the time being, non-calendar year plans may apply the out-of-pocket limits on either a plan or calendar year basis.

Nonetheless, HealthTrust believes it is in the best interest of our July Member groups and their employees to transition all medical and pharmacy plans (with the exception of the Medicomp plans) to a Plan Year deductible and out-of-pocket limit because (a) it would eliminate conflicts that exist by having different years for plan renewals and out-of-pocket responsibilities, (b) it would be more understandable to and preferred by our July groups and covered individuals when changing plan options, (c) new Member groups would have a seamless transition to a HealthTrust plan relative to deductibles and out-of-pocket limits, and (d) it would allow HealthTrust to track medical and pharmacy deductibles and out-of pocket amounts on an integrated basis.

The transition from a calendar year deductible and out-of-pocket limit to a Plan Year basis for medical expenses will begin with the July 1, 2017 through June 30, 2018 Plan Year. To accomplish this transition in compliance with the ACA maximum out-of-pocket requirements and without adversely impacting the covered individuals, deductibles and out-of-pocket expenses incurred from January 1, 2017 through June 30, 2017 would be credited toward the individual/family's deductible and out-of-pocket responsibilities for the July 2017 through June 2018 Plan Year.

Again, this transition will not be implemented for Medicomp enrollees (retirees age 65 and older). It is necessary for Medicomp enrollees to remain on a calendar year plan to coordinate with Medicare's calendar year administration.

INTEGRATED MEDICAL AND PHARMACY OUT-OF-POCKET MAXIMUMS

While the ACA regulations allow the establishment and tracking of out-of pocket limits separately for medical and pharmacy benefits, the maximums of both combined cannot exceed the ACA single maximum. Integrating these out-of-pocket limits would reduce the overall costs of the plan. Thus, the Board voted to establish and track out-of-pocket limits for medical and pharmacy benefits on an integrated basis.

Given the Anthem platform transition for January 1, 2017, it is believed the best time to integrate the medical and pharmacy out-of-pocket maximums is January 1, 2018 for January renewal groups and July 1, 2018 for July renewal groups. The Lumenos plan, however, will integrate effective January 1, 2017. This allows CVS/caremark to provide the pharmacy benefits for this plan for the first time, which will result in lower plan costs.

In the coming weeks our benefits team will reach out to your group to explain these changes and the impact to your group specifically. If you need assistance in the meantime, please feel free to contact your HealthTrust Benefits Advisor.

Yours in good health,

Peter Curro
Chairman, Board of Directors

Peter Bragdon
Executive Director

cc: [Union Representatives]