Local 812 Health Fund

Health Plan Changes Effective May 1, 2024

Participant Meeting

February 15, 2024

Agenda

Health

- Healthcare Trends
- Cost Management
- Plan Changes Effective May 1, 2024
- Relinquishing Grandfathered Status
- No Cost Sharing for Most Preventive Services
- Cost Sharing Limits that Protect You and Your Family
- Examples of New Plan Design
- Summary and Looking Ahead

Q&A

Health Fund
Healthcare Cost Trends

What Is Trend?

Health plan cost trend is the measure of **increases in** allowed **per capita claims cost**. Allowed per capita claims cost is eligible billed charges (before participant cost sharing) less provider discounts.

What factors influence trend?

Trend takes into account various factors, including:

- New treatments, therapies and technologies
- Greater emphasis on detection and diagnoses
- Medical inflation, which impacts the cost of delivering care
- Provider price increases
- Increased treatment burden due to the aging population and rise in obesity
- Social and economic factors, which can influence utilization or care decisions
- Regulatory changes (e.g., No Surprises Act regulations)
- Provider cost shifting from reduced payment by Medicare and Medicai
- Erosion effect of fixed-dollar deductibles and copayments*

For our reporting purposes, trend does not include the impact of PBM rebates.**

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Healthcare Cost Trends – Medical/Hospital

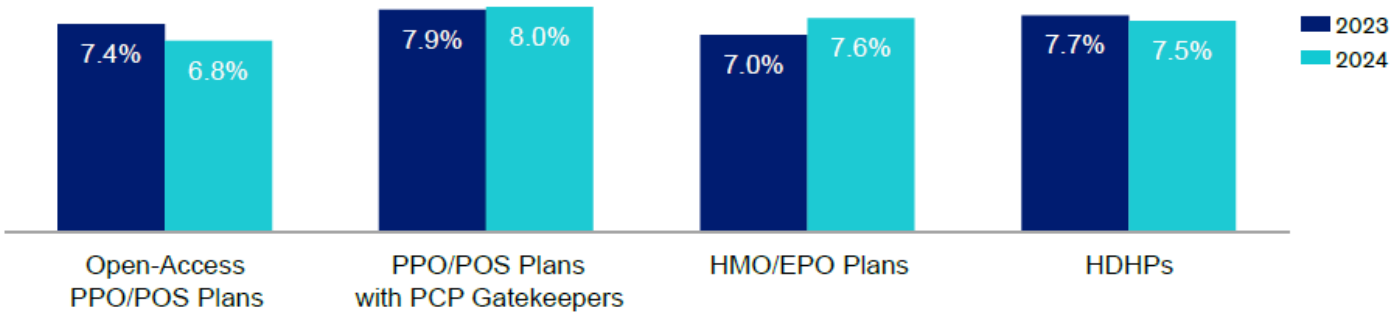
Medical Plan Trend and Cost Drivers

Several factors are pointing to higher medical trend projections during the next few years, such as:

- Declining population health
- Increased demand for mental health and substance use disorder services
- Impact of economic inflation related to provider contract renewals
- Shortages in supplies
- Healthcare staffing challenges
- Provider consolidation
- New treatments and technologies

Significant deflators of trend partially offsetting these increases include shifting of utilization to lower-cost sites acute-care services, more effective or lower-cost treatment alternatives and alternative payment contracting arrangements.

Medical Trend Projections* for 2024 Are Expected to be Similar to Prior Levels: Slightly Higher than 2023 for PPO/POS Plans with Gatekeepers and HMO/EPO Plans, Slightly Lower for All Other Medical Plan Types



* Projections are for actives and early retirees and exclude Rx.

Source: 2024 *Segal Health Plan Cost Trend Survey*

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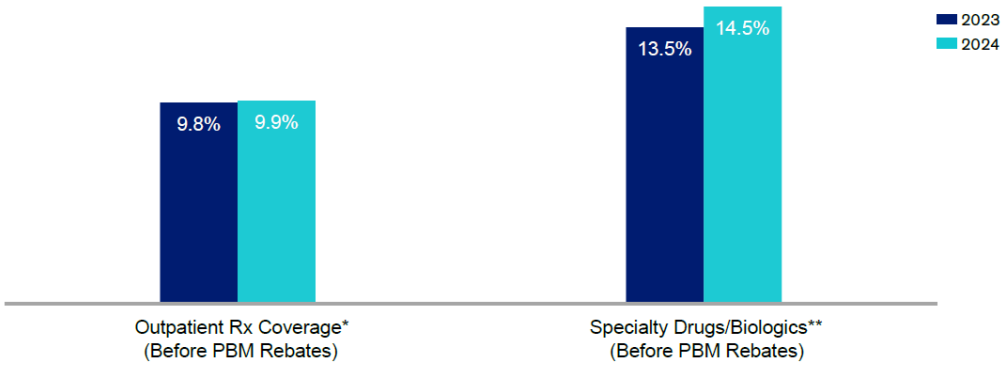
Healthcare Cost Trends – Prescription Drug

Prescription Drug Plan Trends and Cost Drivers

Rx plan cost trends continue to exceed all other health benefit cost trend estimates. Projected cost trend for outpatient Rx plans for 2024 is approaching double digits. Outpatient prescription drug coverage, which is typically administered by PBMs, include brand-name drugs, generics, biosimilars and specialty drugs dispensed though retail, mail-order and specialty-management pharmacy channels. Generally, there's an exclusion for drugs administered in an inpatient facility or physician office setting because a medical benefit program covers those drugs. However, increasingly, plan sponsors are carving out drugs that can be administered in a physician office or at home. Coverage of these drugs under outpatient Rx programs can achieve deeper discounts and reduce plan costs.

Projected Prescription Drug Trend Approaches Double Digits for Outpatient Rx Coverage and Nearly 15% for Specialty Drugs



* Outpatient Rx trend is for all prescription drugs (non-specialty and specialty drugs combined) for employer-sponsored plans for actives and retirees under age 65.

** Specialty drug/biologics trend is for outpatient specialty coverage. This data is for all coverage of specialty drugs for actives and retirees under age 65.

Source: 2024 *Segal Health Plan Cost Trend Survey*

What Are Specialty Drugs?

Specialty drugs are generally high-cost drugs or those that require special handling. Often, they're given by injection or infusion.

Most specialty drugs are biologics, which are derived from viruses or living organisms and are significantly more complex and challenging to develop and manufacture compared to non-biologic drugs, resulting in their higher cost.

A biosimilar is a biologic drug that is "highly similar" to another biologic medication (commonly known as the reference or innovator product), which is already licensed by the FDA.

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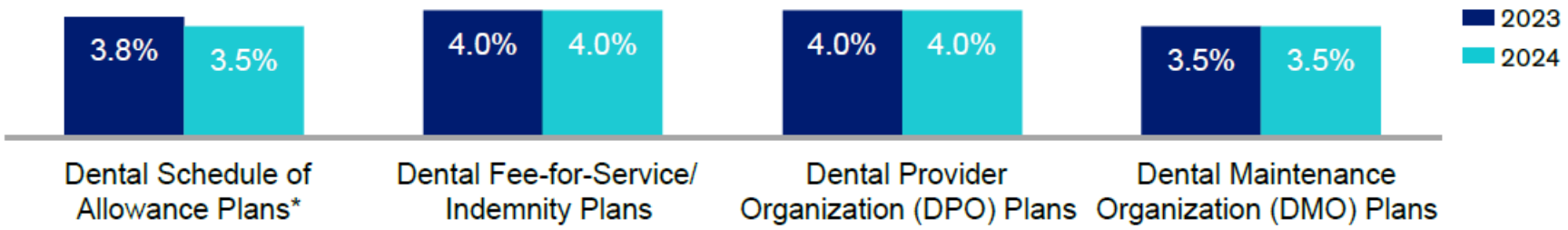
Healthcare Cost Trends - Dental

Dental Trends

Dental trends are consistent with prior year levels. The pandemic and economic environment contributed to increases in stress-related dental conditions, such as tooth-grinding, a condition that leads to broken teeth and temporomandibular joint disorder. Additionally, many have forgone the regular dental cleanings that promote good oral health. While this may result in minor cost savings in the short term, it could result in need for more expensive treatment longer term. It is important for plan sponsors to monitor their plan design and claims experience for insights to ensure their dental plan is operating optimally.

Trend Projections for Most Dental Coverages Are Similar to 2024 Levels



* A schedule of allowance plan is a plan with a list of covered services with a fixed-dollar amount that represents the total obligation of the plan with respect to payment for services, but does not necessarily represent the provider's entire fee for the service.

Source: 2024 *Segal Health Plan Cost Trend Survey*

Health Fund
Healthcare Cost Trends - Vision

Vision Trends

Vision plan cost trends for R&C plans increased by 0.8 of a percentage point over 2023.

Vision benefits have become increasingly popular and can help save on medical claim costs. Eye exams continue to play a role in the early warning of medical-related issues, such as detection of diabetes and hypertension, in addition to common eye diseases, such as glaucoma and cataracts. Factors contributing to the growing demand for vision care include an aging population and increased prevalence of nearsightedness due to screen time on digital devices. The increase of virtual work and sitting in front of screens for long periods require more use of blue-light glasses which reduce eye strain and eye damage as well as promote better sleep.

Vision benefits are an important component of a total rewards package to attract and retain employees. Vision should be seen as a preventive benefit, which could contribute to positive outcomes for employee's eye health and overall health. Plan sponsors should consider reevaluating their vision offerings and explore the current landscape, which accelerated use of online access for purchase of eyewear, communicating the value of this benefit to their participants.

Trend Projections for Vision R&C Plans Higher for 2024

Source: 2024 *Segal Health Plan Cost Trend Survey*

Health Fund
Healthcare Cost Trends- Medicare Eligible Retirees

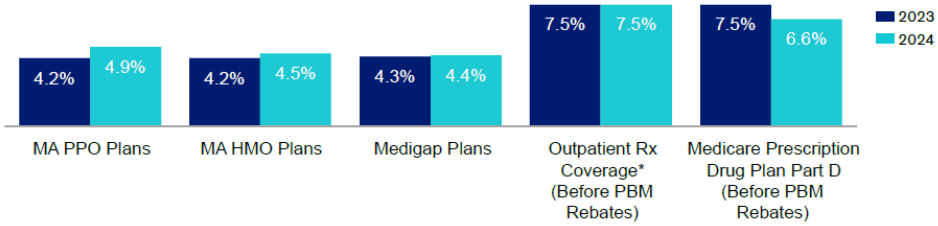
Medical Trends for Medicare-Eligible Retirees

Coverage for Medicare-eligible retirees generally falls into one of three categories: MA PPO plans, MA HMO plans and Medicare supplemental insurance coverage known as Medigap. While trend projections for each of these categories are considerably lower than trends for active and early retirees, they are expected to be higher than 2023 except for Medicare Prescription Drug Part D plans.

While trend increases between MA plans are comparable to traditional Medicare, a study published in *Health Affairs* found MA plans experienced lower overall healthcare utilization than fee-for-service Medicare enrollees. MA plans receive fixed monthly income which creates financial incentives to limit discretionary care. MA plans also receive additional rebate dollars when providing high-quality care through the Start Rating System. Based on the current Centers for Medicare & Medicaid Services dataset, half of Medicare eligible beneficiaries are enrolled in MA programs.

A *JAMA* study found high-risk medication use was lower among MA beneficiaries compared to those enrolled in traditional Medicare. Some medications are called "high-risk" because they can cause harmful side effects including falls, confusion, drowsiness and weakness. Limiting use of high-risk medications is an important aspect of providing high-quality of care for older patients. This is due to age-related changes in pharmacodynamics and chronic illness burden that may increase these patients' risk of avoidable hospitalization, healthcare spending and death. Since MA plans are mandated to report their high-risk medication rates under the HEDIS Drugs to Avoid in Elderly (DAE) measure, they utilize more effective UM strategies to manage medication use and outcomes.

2024 Projected Medical Trends for Medicare-Eligible Retirees Higher than 2023



* Outpatient Rx trend is for all prescription drugs (non-specialty and specialty drugs combined) for employer-sponsored plans. See page 13 for specialty drug trend projections.

Health Fund
Healthcare Cost Trends – Historical Summary

Selected Medical,[1] Outpatient Rx[2] and Dental Trends: 2010–2022 Actual and 2023 and 2024 Projected[3]

	Year	Open-Access PPOs/POS Plans	PPO/POS Plans with PCP Gatekeepers	HMO/EPO Plans	MA HMO Plans	Outpatient Rx Plans	DPO Plans
Actual	2010	7.6%	8.3%	8.7%	3.6%	6.4%	3.0%
	2011	7.5%	7.8%	8.0%	4.5%	5.0%	3.1%
	2012	7.3%	8.4%	6.7%	3.0%	5.5%	2.6%
	2013	5.7%	6.7%	6.1%	3.1%	5.5%	2.8%
	2014	6.5%	7.6%	6.3%	1.9%	10.7%	2.9%
	2015	6.8%	6.9%	6.4%	4.2%	11.1%	3.0%
	2016	7.1%	7.4%	6.3%	5.3%	8.1%	2.9%
	2017	5.7%	5.8%	6.6%	1.8%	5.2%	2.3%
	2018	6.3%	6.1%	6.0%	4.1%	5.3%	2.5%
	2019	6.8%	6.8%	6.6%	2.2%	5.6%	2.5%
	2020	-2.1%	1.5%	0.8%	-4.1%	8.5%	-3.5%
	2021	14.0%	12.0%	13.3%	9.1%	8.9%	4.5%
	2022	2.5%	5.5%	3.2%	3.0%	10.3%	4.0%
Projected	**2023**	**7.4%**	**7.9%**	**7.0%**	**4.2%**	**9.8%**	**4.0%**
	2024	**6.8%**	**8.0%**	**7.6%**	**4.5%**	**9.9%**	**4.0%**

[1] Medical trends exclude prescription drug coverage.

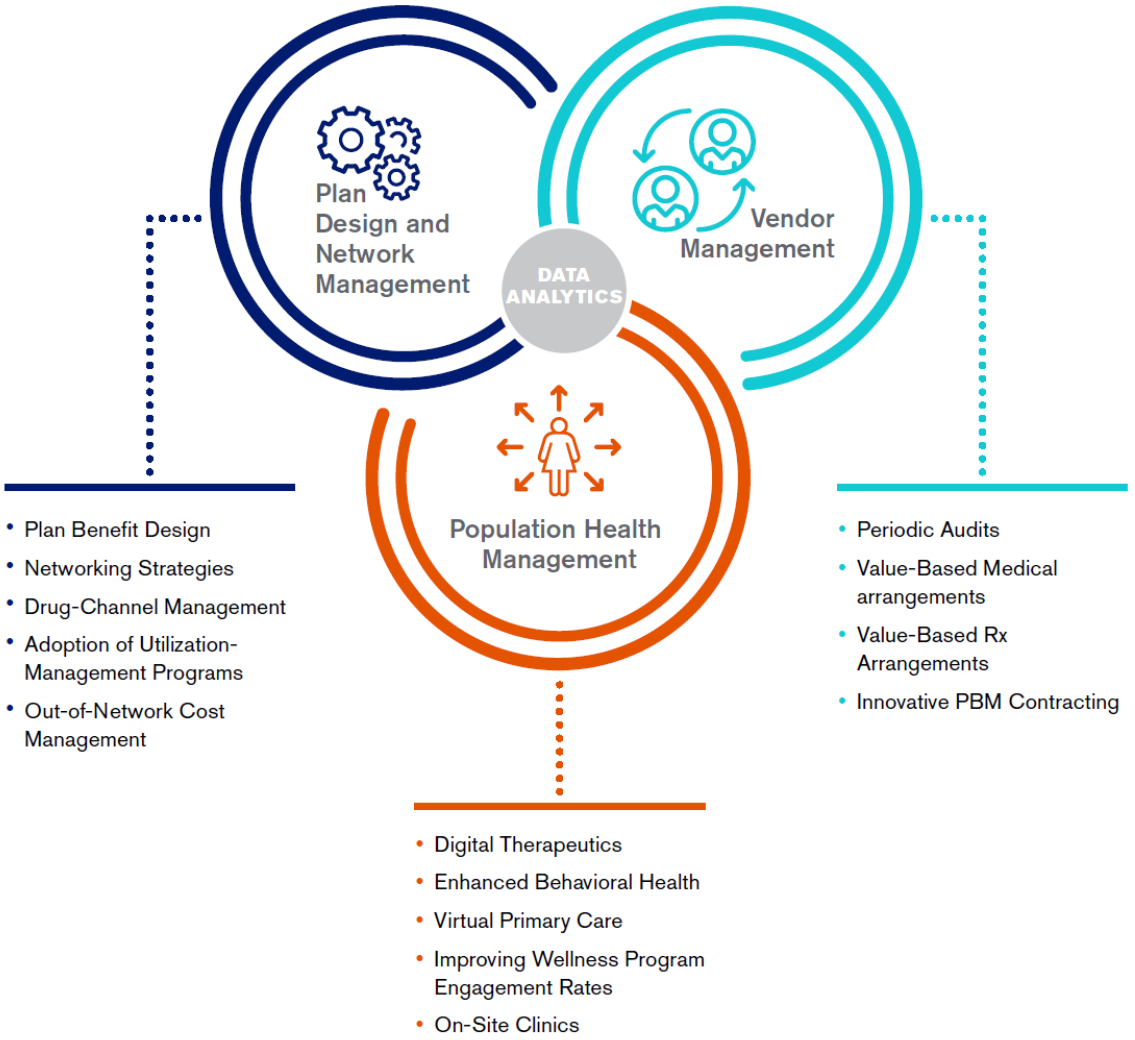
[2] Prescription drugs trends combine non-specialty and specialty drugs. These results do not include the impact of rebates from PBMs.

[3] All trends are illustrated for actives and retirees under age 65, except for the MA HMOs. (Graphs comparing 15 years of survey data — 2010 through 2022 actual trends and 2023 and 2024 projected trends — and showing actual annual trend by coverage type for the last five years are available.)

Source: 2012–2024 *Segal Health Plan Cost Trend Survey*

Health Fund
Cost Management

Our Approach to Effective Healthcare Cost Management



Health Fund
The Plan Has NOT Changed Since 1990

There have been **no increases** in participant copayments in the Health Plan **since 1990**.

Medical, Hospital, and Rx costs have continued to increase in the United States faster than inflation.

Changes are necessary to **BALANCE** income and expenses in the Health Fund.

Health Fund
Plan Changes Effective May 1, 2024

Medical and Hospital Benefit Changes

- **In-Network Deductible** of **$750 per person** (maximum of $1,500 per family).
- **Out of Network deductible** of **$1,500 per person** (maximum of $3,000 per family)
- **Emergency Room Copay** increased to **$100***
- **Urgent Care Copay** increased from $25 to **$40***
- **Physician and Specialist Copay** increased from $25 to **$40***

➢ *Copayments apply **AFTER** Annual Deductible is met

Our Provider Partners are NOT changing. You will continue to have access to high-quality Medical and Hospital benefits through MagnaCare.

Health Fund
Plan Changes Effective May 1, 2024

Prescription Drug Benefit Changes

- **Prescription Drug Coinsurance** increases from 20% to **30%** for all **Brand Drugs.**
- **Generic Drugs** will have a **$0 copayment** for **mail OR retail.**

Use of Generic Drugs is encouraged and is the most effective way to minimize out-of-pocket costs.

Our Provider Partners are NOT changing. You will continue to have the same extensive access to Prescription Drugs through the OptumRx network.

Relinquishing Grandfathered Status Effective May 1, 2024

- Plans are required to cover 100% of out-of-pocket costs (no copays, coinsurance, deductibles) for certain in-network preventive services.
- The deductible will **not** apply for preventive services.
- Lists of covered Preventive Care Services can be found at:

https://www.healthcare.gov/coverage/preventive-care-benefits/

Annual Physicals, many immunizations and age-specific screenings (colonoscopies, mammograms) will be **fully covered** in-network at **NO CHARGE** to you.

Cost-Sharing Limits That PROTECT You and Your Family

Effective May 1, 2024, an out-of-pocket cost limit will be established as follows:

Individual: $2,000 for Medical/Hospital and $2,000 for Rx

Family: $4,000 for Medical/Hospital and $4,000 for Rx

- The out-of-pocket cost limit is the most you can pay for in-network services during the calendar year before the Health Fund pays 100%.
- Out-of-pocket costs includes **deductibles, coinsurance and copayments.**
- Cost sharing **does not include balance billing** (generally from out-of-network services) **or spending on services NOT covered by the plan** (cosmetic procedures, for example).
- You are unlikely to have out-of-pocket costs that reach the maximum if you stay in network. However, if your out-of-pocket costs exceed the limits above, then the Fund will cover 100% of out-of-pocket costs for the rest of the year.

Coverage Example 1 – Individual

Steve goes for an **annual physical** in January.

Cost of physical to Steve (preventive) is $0.

Steve goes to a **chiropractor 5 times** between February and May.

Steve's out of pocket for the first three specialist visits ($250/visit) is $750.

Steve's individual annual medical deductible of $750 is met.

Steve pays the Specialist copayment of $40 for the 4th and 5th visit for a total of $80.

Steve **gets the flu** in October.

Urgent care is $40 copay.

Doctor copay is $40 copay.

Generic Rx for 7 days at a local in-network pharmacy is $0.

Coverage Example 1 – Individual Summary

Steve's Out-of-Pocket Costs

Physical:	$ 0
Individual Deductible:	$750
Chiropractor Copayments:	$ 80
Flu Visit to Urgent Care:	$ 40
Flu Visit to Doctor:	$ 40
Generic Rx for Flu:	$ 0
Total Out-of-Pocket Costs:	**$910**

Steve did not spend more than $2,000 out of pocket, therefore the out-of-pocket cost limit did not apply.

Coverage Example 2 - Family

Peter has type 2 diabetes and takes a brand medication for his diabetes that costs $3,000 per month.

For the first two months, Peter pays 30% coinsurance – which is $900 per monthly medication. This totals $1800.

For the 3rd month, Peter only pays $200 because his *Rx maximum out-of-pocket cost limit of $2,000 has been met*.

Peter's Rx for the remaining year is 100% covered by the 812 Health Fund and he will not have any out-of-pocket costs for any medications for the rest of the calendar year.

Brand medications require a 30% coinsurance. The use of generic medications is encouraged whenever possible for the best cost savings.

The Rx out-of-pocket cost limit is $2,000 for individual and $4,000 for family.

Coverage Example 2 - Family

Peter has Type 2 diabetes.

Peter needs to see his doctor once a month to manage his diabetes. Each doctor's visit is $250. The first three visits will cost Peter a total of $750 out of pocket.

Peter meets his $750 individual medical deductible after his third doctor visit.

Because Peter has met his individual deductible, other visits (even visits for other than his diabetes management) will require a $40 copayment per visit.

The annual individual medical deductible is $750.

Coverage Example 2 - Family

Peter's son Antonio breaks his leg.

The Emergency Room costs $2,000. Peter pays $750 for the Emergency Room visit, and *this meets Antonio's individual deductible of $750*. Because Peter also met his individual deductible previously, *the family deductible of $1,500 is also met at this time*.

Antonio's Rx for generic pain medication at his local pharmacy costs $0 out of pocket.

Generic medications are covered 100% by the 812 Health Fund. Copayments are not required.

The annual family medical deductible is $1,500.

Coverage Example 2 - Family

Peter's son Antonio needs physical therapy 3 times per week for 6 months (78 sessions total).

Each Physical Therapy session requires a $40 copayment.

For the *first 31 sessions*, Antonio's family pays $40 per visit for a total of $1,240. (31 visits x $40 = $1,240)

On his *32nd session*, the family will only pay $10 because *the annual individual medical out-of-pocket limit of $2,000 is met*. ($750 ER visit + $1,250 PT Copays = $2,000)

All other visits going forward will be covered by the plan at 100% with no further copayments required.

Copays are a fixed out-of-pocket amount for covered services. Deductible is the amount paid before the plan covers costs. Out-of-pocket cost limit is the most you pay for covered services in a plan year.

Coverage Example 2 - Family

Peter's spouse Rachel has tennis elbow and needs physical therapy 2 times per week for 20 weeks (40 sessions total).

Each Physical Therapy session requires a $40 copayment.

For the *first 31 sessions*, Rachel pays $40 per visit for a total of $1,240. (31 visits x $40 = $1,240)

On her *32nd visit*, Rachel will only pay $10 because *the annual family medical out-of-pocket limit of $4,000 is met*.

Visits going forward will be covered by the plan at 100% with no further copayments required.

The medical out-of-pocket cost limit is $2,000 for individual and $4,000 for family.

Coverage Example 2 – Family Summary

Peter's Family Medical Out-of-Pocket Costs

Peter's Initial Doctor Visits:	$750
Antonio's ER Visit:	$750
Antonio's PT Visits:	$1,250
Rachel's PT Visits:	$1,250
Family Medical Out of Pocket Costs:	**$4,000**

Any other medical costs are covered 100% by the 812 Health Fund and no further out of pocket costs are required for the rest of the calendar year.

Peter's Family Rx Out of Pocket Costs

Peter's Brand Rx:	$2,000
Total Rx Out of Pocket Costs:	**$2,000**

Any other individual Rx costs for Peter are 100% covered by the 812 Health Fund for the rest of the calendar year.

Cost sharing limits protect you and your family.

Summary and Next Steps

- You will receive a mailing from the Health Fund detailing the changes being made as of May 1, 2024
- New Plan Changes Take Effect
- The in-network annual deductible resets annually at the beginning of each year.
- The Trustees will continue to review the plan design to balance income and expenses.

Health Fund

Swift MD – Telehealth visits has $0 copay

Questions