EAST END HEALTH PLAN BULLETIN

March 2005 A Periodic Publication from the East End Health Plan

EAST END HEALTH PLAN SETS NEW PREMIUMS EFFECTIVE JULY 2005

The East End Health Plan (EEHP) Board of Trustees met on March 1st to approve new rates for the 2005/06 School Year. A priority of the Plan has always been to provide comprehensive benefits at a cost effective price

These rates, which will remain in place until June 2006, are $445 for an Individual Policy and $1,010 for a Family Policy.

These rates represent an overall increase from the 2004/05 Rates of about 13.6%. The rate of increase for the East End Health Plan for the last four years has remained well below national averages of 15%.

Please note that if you pay your premiums directly, such as retirees and COBRA enrollees, or if your district requires that you pay a percentage contribution to your premiums, the amount that you actually pay may be different from the above rates. This is due to the fact that the portion of the rates that you pay is based on the agreement in place with your district. If you have questions regarding what your specific payment will be, please contact the Health Plan Coordinator at your District.

It is important to note that the Plan's Board of Trustees will continue to study ways to help limit future cost increases as well as limit the effect that cost increases will have on the enrollees of the Plan.

BENEFIT CHANGES THAT WILL GO INTO EFFECT IN THE 2005/06 PLAN YEAR

In an effort to keep the Plan's premiums as competitive as possible, the Plan's Board of Trustees also enacted several benefit changes.

The two changes that will go into effect **on January 1, 2006** are:

- The Out-of-Network Deductible will be $350 for the enrollee, $350 for the enrollee's spouse, and $350 for all of the enrollee's dependent children combined. The current deductible, which will stay in place until December 31, 2005, is $250 for an individual and $750 for a family.

- The Out-of-Network Out-of–Pocket Maximum will be $1,500. The current out-of-pocket maximum, which will remain in effect until December 31, 2005, is $900.

The following changes will go into effect **on July 1, 2005**:

- The basic co-payment for the Plan will increase from $10 to $15. This means that all of the services that were subject to the $10 co-payment, will be increased to $15.

- There will be a co-payment for in-network hospital out-patient services, including ambulatory surgical centers of $35. This co-payment will be waived if the patient is admitted to the hospital for an overnight inpatient stay.

- There will be a co-payment for emergency room visits, regardless of whether they are in-network or out-of-network, of $50. This co-payment will be waived if the patient is admitted to the hospital for an overnight inpatient stay.

- Routine Physical Exams that are available to those enrollees above the age of 50 will now be subject to the $15 co-payment, but will no longer be subject to the $100 maximum benefit per year.

- The non-preferred prescription drug co-payment for drugs received at a retail pharmacy will change to $30. The other retail co-payments of $5 for generic drugs and $15 for preferred brand name drugs will not change.

- The co-payments for the mail order prescription drug plan will be changing. They will be $5 for generic drugs, $20 for preferred brand name drugs, and $40 for non-preferred brand name drugs.

- The hearing aid benefit will now be subject to a $1,200 maximum benefit ***per ear*** for every four years. The children's benefit will also change to $1,200 maximum benefit ***per ear*** every two years.

The Board of Trustees is very cognizant of the effect that some of these new benefit levels may have on those individuals enrolled in the Plan. They have taken every step possible to minimize the impact of these changes. However, it is important that the Plan remain financially stable and comparable with other Plans.