CITY OF MANITOWOC
PERSONNEL COMMITTEE MEETING

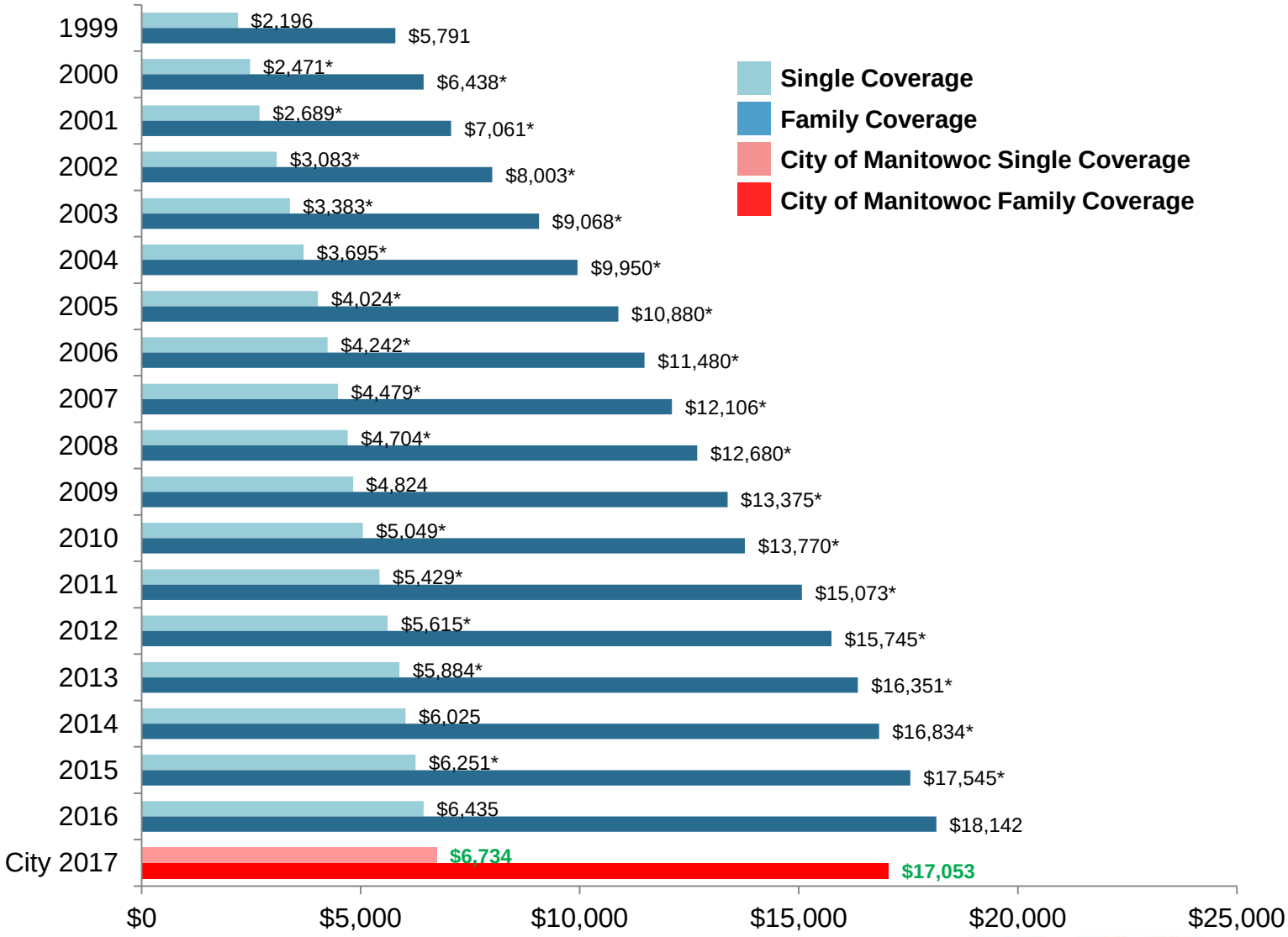
PRESENTED BY:

Jay Scott, CHC
Senior Vice President,
Employee Benefits Group Practice Leader

October 2, 2017

Associated
Benefits and Risk Consulting

Average Annual Premiums for Single and Family Coverage, 1999-2016



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2015

*Estimate is statistically different from estimate for the previous year shown (p>.05).

2018 HEALTH PLAN RECOMMENDATIONS

- Renew with **Anthem BlueCross BlueShield** to provide 2018 health plan administrative services including these related partners in health:
  - Well Priority Provider Network
  - Anthem Pharmacy, in partnership with Express Scripts and Accredo Pharmacy

- Current and Renewal monthly medical and dental plan funding rates are provided below.
  - **Medical Plan** (single/family)
    - 2017: $561.15 / $1,421.09
    - 2018: $606.53 / $1,538.94 (+8.26% to funding)

  - **Dental Plan** (single/family): **E** = Enhanced Plan, **P** = Preventive Only Plan
    - 2017: **E** $45.54 / $110. 51 **P** $15.10 / $34.61
    - 2018: **E** $48.97 / $119.14 **P** $16.09 / $37.16
      (a total of +7.75% to funding)

MANITOWOC
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2018 VOLUNTARY VISION PLAN RECOMMENDATION

 Service / Material	VSP "Plan B" Current / Renewal		NVA Option 2	
	In-Network Coverage	Out-of-Network Reimbursement Allowance	In-Network Coverage	Out-of-Network Reimbursement Allowance
Standard Copays	$10 exam; $25 materials		$10 exam; $25 materials	
Examination	100% after copay	Up to $45	100% after copay	Up to $45
Frames				
Allowance (Up to $$$)	Up to $130	Up to $70	Up to $130	Up to $70
Discount after Allowance is Met	N/A	N/A	20%	N/A
Lenses *(Standard Glass or Plastic)*		*Copay applies*		*Copay applies*
Single Vision	100% after copay	Up to $30	100% after copay	Up to $30
Lined Bifocal		Up to $50		Up to $50
Lined Trifocal		Up to $65		Up to $65
Lenticular		Up to $100		Up to $75
Lens Extras	*Separate "Lens Extra" benefits not indicated for this plan*			
Standard Polycarbonate Single-Vision (SV)			$25 copay	N/A
Standard Polycarbonate - Dependents < Age 19			$25 SV copay	N/A
UV Coating			$12 copay	N/A
Tint (solid & gradient)			$10 to $12 copay	N/A
Standard Anti-Reflective Coating			$40 copay	N/A
Standard Progressive Lenses			$50 copay and up	N/A
Standard Scratch Resistant Coating			$10 copay	N/A
Other Add-ons and Services			20% discount	N/A
Contact Lenses *(In lieu of Frames & Lenses)*	*15% Exam Discount In-network*		*In-Network Fitting & Evaluation Services:*	
Standard Fitting & Evaluation Services	Max copay $60	N/A	*Daily Wear $20 copay, Extended Wear $30 copay, then 100%*	
Conventional Contact Lens Allowance *	Up to $130	Up to $105	Up to $130	Up to $105
Discount after Allowance Met	N/A	N/A	15%	N/A
Disposable Contact Lens Allowance *	Up to $130	Up to $105	Up to $130	Up to $105
Discount after Allowance Met	N/A	N/A	10%	N/A
Medically Necessary	100%	Up to $210	100%	Up to $210
Frequency				
Eye Exam	Once every 12 months		Once every 12 months	
Frames	Once every 24 months		Once every 24 months	
Lenses or Contact Lenses	Once every 12 months		Once every 12 months	
Participation	51+ Employees		Minimum of 10 enrollees	
Rates	**Current**	**Renewal**	**Option 2**	
Single 52	$4.91	$5.47	$4.68	
Employee / Spouse OR Ltd Family 49	$7.12	$7.92	$6.79	
Employee / Children 0	$12.77	$14.21	$12.17	
Family 59	$12.77	$14.21	$12.17	
Monthly Premium	**$1,357.63**	**$1,510.91**	**$1,294.10**	
Annual Premium	$16,291.56	$18,130.92	$15,529.20	
Annual Increase / (Decrease)	11.29%		-4.68%	
Annual Increase / (Savings)	$1,839.36		-$762.36	
Rate Guarantee	2 years		***4 years***	

Move from VSP to National Vision Administrators (NVA)

- Reduced premium (-4.68%)
- 4 year rate guarantee
- Similar provider network
- Similar benefit design, plus *Essential Eye Program* *(new benefit - liked by members who buy more than one set of frames/ contacts in a 12 month period)*

2018 MEDICAL PLAN OPTION

Service	Current Plan Design	2018 – Plan Option
Annual Deductible Limit In-Network (Single/Family) *Out-of-Network (Single/Family)	 $1500 / $3000 $3000 / $6000	 $1750 / $3500 $3500 / $7000
Coinsurance In-Network *Out-of-Network	 90% 70%	 80% 60%
Annual Medical Plan Out-of-Pocket Maximum In-Network (Single/Family) *Out-of-Network (Single/Family) *Prescription drugs also subject to Separate Pharmacy Out of Max. Out of Pocket Maximum*	 $3600 / $7200 $7200 / $14400 *Includes Deductible*	 $4000 / $8000 $8000 / $16000 *Includes Deductible*
Preventive Care In-Network *Out-of-Network	100%, no deductible 70%, after deductible	100%, no deductible 60%, after deductible
Primary Care Office Visits In- Network *Out-of-Network	$30 copay, 100% 70% after deductible	$40 copay, 100% 60%, after deductible
Specialist Office Visits In-Network *Out-of-Network	$50 copay, 100% 70% after deductible	$65 copay, 100% 60%, after deductible
Urgent Care Office Visits In- Network *Out-of-Network	$75 copay, 100% 70% after deductible	$90 copay, 100% 60%, after deductible

*Out-of-network services subject to reasonable and customary charges as defined in the Medical Summary Plan Description.

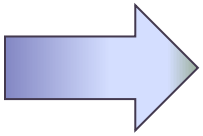
2018 MEDICAL PLAN OPTION…

Service	Current Plan Design	2018 - Plan Option
Outpatient Hospital Services		
(Includes Labs and X-rays) In-Network	90%, after deductible	80%, after deductible
*Out-of-Network	70%, after deductible	60%, after deductible
Inpatient Hospital Services *(Includes Labs and X-rays)*		
In-Network	90% after deductible	80% after deductible
*Out-of-Network	70% after deductible	60% after deductible
Emergency Treatment in Emergency Room *(Includes Labs and X-rays)*	$200 co-pay, 90%	$200 co-pay, 80%
Prescription drugs – **Retail Pharmacy (30 days)** Generic/Brand/Non-formulary brand/ Specialty Medications-Injectables	$10/$40/$60/ 20% to $125 max. ($75 min.)	$10/$40/$60/ 20% to $125 max. ($75 min.)
Prescription drugs – Mail Order (90 days) Generic/Brand/Non-formulary brand/ Specialty Medications-Injectables	$20/$80/$120/ 20% to $125 max. ($75 min.)	$20/$80/$120/ 20% to $125 max. ($75 min.)
Annual Pharmacy Out-of-Pocket Maximum	$2500/$5000	$2500/$5000

*Out-of-network services subject to reasonable and customary charges as defined in the Medical Summary Plan Description.

COST DRIVERS YEAR OVER YEAR

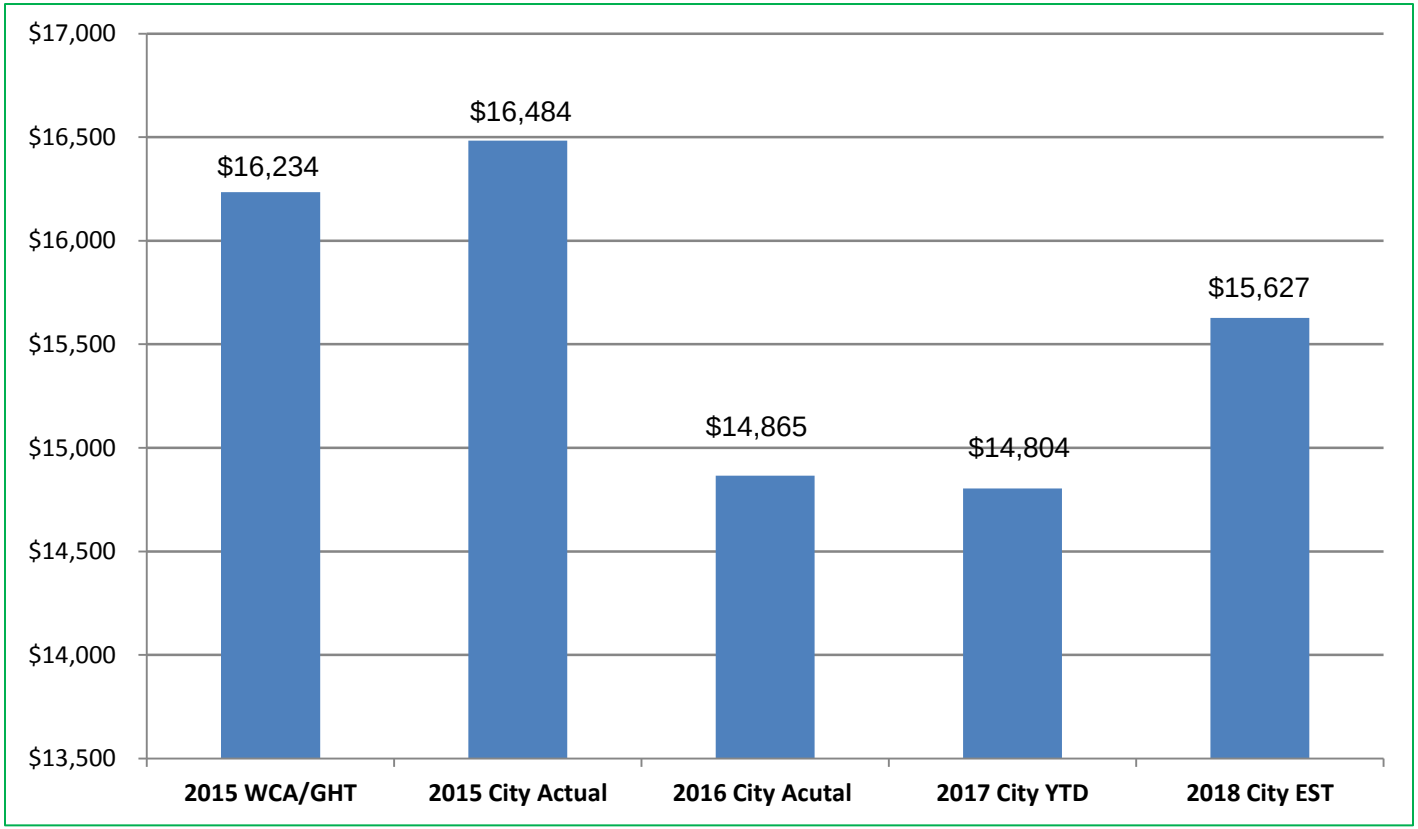
- Inpatient Admissions . . . 28% increase
- Outpatient Visits . . . . . 26% increase
- Physician Visits . . . . . 32% increase



8% increase
Covered Members

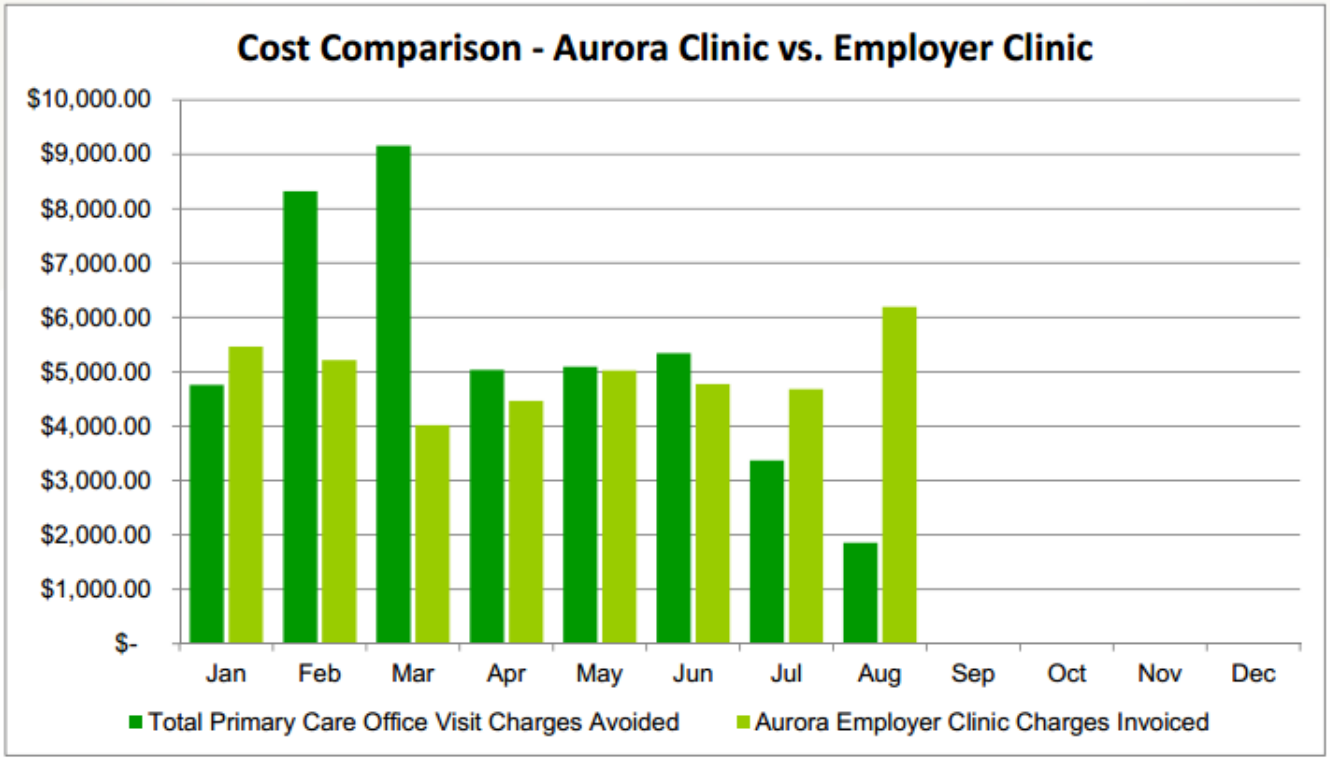
- High Cost Claims . . . . . 9% increase
- Drug Claims . . . . . 18% decrease

CITY HISTORICAL ANNUAL MEDICAL PLAN COST PER EMPLOYEE COMPARED TO WI PUBLIC SECTOR NORM



Note: 1/1/2016 changed from Auxiant/HPS Network to Anthem/Well Priority Network

Utilization of Clinic



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD Dec 2017
Customary Clinic Charges	$4,760.51	$ 8,320.51	$ 9,158.09	$ 5,032.17	$5,094.31	$ 5,342.37	$ 3,368.47	$ 1,853.93					$ 42,930.36
Employer Clinic Charges	$5,463.31	$ 5,214.16	$ 4,016.91	$ 4,466.16	$5,021.98	$ 4,773.58	$ 4,680.84	$ 6,194.68					$ 39,831.62
Estimated Savings	$ (702.80)	$ 3,106.35	$ 5,141.18	$ 566.01	$ 72.33	$ 568.79	$ (1,312.37)	$ (4,340.75)					$ 3,098.74

QUESTIONS?