FAQ on AP's proposed benefits changes for 2014-16 for bargaining unit employees

Revised 11.13.13

The AP has revised its medical benefits proposal for 2014-2016 in response to the News Media Guild's counterproposal. This revised proposal offers alternatives and some flexibility in the requirements for spouse coverage and wellness participation while also aligning AP's medical benefits program for union employees with the program already in place for administrative employees.

The AP has deferred its proposal for a consumer-driven health plan (CDHP) with a Health Savings Account (HSA) for 2015. Instead, we propose to continue the Premium and Basic plans - with the plan design changes initially proposed for 2014 – and revised premium increases.

This FAQ is designed to help you understand AP's proposals and how the changes would affect you. This document does not cover every detail of the plans; if you have additional questions, please send them to benefits@ap.org so that concerns may be delivered and resolved during the bargaining process with the guild.

PLAN DESIGN & CONTRIBUTIONS

What are the proposed plan changes for 2014 for union-covered employees?
There are changes to monthly premiums, deductibles, copays, out-of-pocket maximums, prescription costs and the vision benefit. The Premium plan design also includes coinsurance for in-network care, which means that you'll be responsible for a portion of your medical expenses beyond copays and deductibles until you meet your out-of-pocket maximum. The current union Basic plan and out-of-network Premium include coinsurance; the coinsurance percentages will increase in 2014 under AP's proposal.

Why is AP proposing these changes?
The current trajectory of AP's health care expense is untenable. What was once an affordable benefit to offer is now an extraordinary expense. As AP's medical benefits costs grew significantly over the past five years, union employees saw no increase to their monthly contributions and no substantial changes to their plan designs.

Our proposal aims to make the plans and contributions for bargaining unit employees consistent with their administrative colleagues, and manage expenses in a way that will allow AP to continue to offer competitive health coverage options to our employees.

How would the vision benefit change?

The AP proposes to end the $200 annual reimbursement vision benefit for employees and replace it with a benefit that is part of the medical plan and available to everyone covered on the plan. Under the proposal, you must be enrolled in the medical plan in order to get vision benefits in 2014. All covered family members will be included; the plan will be subject to copays, coinsurance and annual maximums.

How does coinsurance work?
Coinsurance is the percentage of covered expenses you must pay in addition to the deductible. For example, our policy may pay 85 percent of covered charges after you pay the deductible. You would then pay the remaining 15 percent as coinsurance until a maximum out-of-pocket expense is reached. If you go to an out-of-network doctor, the coinsurance is based on reasonable and customary charges. For example:

On Jan. 8 you go for labwork to an in-network lab and you are in the **Premium Plan**.
Assume this is the first time you are using the health plan in 2014.

The cost of the lab work is $700

Deductible:	$400	
Coinsurance:	85%	
Cost of in-network lab work:	$700	
You pay:	$400	
Balance:	$300	
Your coinsurance is:	15%	
You pay:	$45	(15% * $300)

Plan pays:	$255
You pay:	$445
Total lab work charges	$700

SPOUSAL COVERAGE

Why is AP proposing this change to spousal/same-sex domestic partner coverage?
The change is part of AP's plan to manage costs in the face of rising health care expenses. We think it's appropriate that other employers pay for their employees' primary medical coverage. AP is among a growing number of employers making changes regarding spousal coverage.

When can my spouse/same-sex domestic partner be enrolled in the AP plan for primary coverage?
Spouses can be enrolled in the AP plan for primary coverage if one or more of the following applies:

- They are not employed.
- They work for an employer that does not offer coverage.
- They work for an employer that doesn't subsidize employees' coverage.
- They do not meet the eligibility requirements of their employer's plan.
- Their employer plan doesn't meet the minimum value standard under the Affordable Care Act.

What proof would AP need that my spouse qualifies for primary coverage on AP's plan?

To enroll your spouse in any AP medical plan, you would complete the spousal certification form in the Benefits section of MySAP.

In addition, spouses would be required to provide to AP written proof that the employer's coverage is not expected to meet the minimum value standard under the Affordable Care Act or that the coverage isn't subsidized. The acknowledgment must be on the spouse's employer's company letterhead or in a written communication from the employer to the employee. An annual exchange notice from the spouse's employer will state if the coverage does not meet minimum value.

If my spouse is covered on his/her employer's plan and also covered on the AP plan, how does secondary coverage work?

First of all, it's important to understand that secondary coverage is only available if your spouse has primary coverage elsewhere. All expenses must be submitted to the spouse's employer's plan prior to being submitted to AP's plan. For example:

Your spouse's employer's plan is primary, assume:	AP's plan is secondary, assume:
Deductible is met, coinsurance is 80% Bill = $100 Primary plan pays: $80 Balance: $20	Deductible is met, coinsurance is 85% Primary plan paid $80, balance is $20 AP's plan will pay: $17 (85% of $20) You will pay $3 ($20 - $17)

What do I need to do during open enrollment if my spouse is currently on AP's plan, or if I want to add my spouse in 2014?

If your spouse is currently enrolled in AP's medical and/or dental plans and for 2014 you want to:

- Keep primary or secondary coverage: You must complete the spousal certification in the Benefits section of MySAP. Based on your answers, your spouse will be moved to either primary or secondary coverage.* If your spouse has employer coverage that isn't subsidized and/or doesn't meet the minimum value standard under the Affordable Care Act, you also will be required to provide written proof to AP in order for your spouse to be primary on AP's plan.
- Drop coverage: If you want your spouse to be covered only by their own employer's plan and not AP's, you need to remove your spouse during open enrollment.

If your spouse is not enrolled in AP's plan this year and for 2014 you want to:

- Add primary or secondary coverage for medical and/or dental: You must enroll your spouse in coverage via Benefits > Open Enrollment section on MySAP and complete the online spousal certification form. Based on your answers, your spouse will be placed in either primary or secondary coverage.*

***IMPORTANT NOTE:** AP's secondary coverage plan is only for spouses who are enrolled in another plan with primary coverage. **You may not have secondary coverage only.** If your spouse has access to his/her own employer-sponsored plan and doesn't enroll in that plan (or doesn't have other primary coverage in place), you shouldn't enroll your spouse in AP's secondary coverage plan.

What about our children who are on AP's plan?
Your dependent(s) may remain on AP's plan as long as they meet eligibility requirements, even if your spouse moves to his/her employer's plan. If your working spouse's plan also covers dependents, you can decide which option is best for your family.

What should my working spouse do to prepare for this change?
An important first step is to gather information about your spouse's employer's plan, including premium costs, covered medical expenses, the amount the plan will pay for covered expenses, whether there's a network of preferred providers, etc. You'll also want to find out about the company's annual enrollment period, which can differ from company to company and may not be the same as AP's.

WELLNESS

What changes is AP proposing for the wellness program in 2014?
AP proposes that employees who participate in the wellness program will pay $50/month less for their medical premiums. These three participation steps must be completed by March 31, 2014:

- complete a biometric screening (or have physician submit the 2014 Health Advocate physician form with required biometrics);
- complete the personal health profile; and
- talk with a health coach.

AP's initial proposal required both the employee and covered spouse/same-sex domestic partner to complete the three steps in order to avoid the $50/month surcharge. Under our revised proposal, spouses/same-sex domestic partners will be dropped from the requirement; only employees must complete the three steps.

What changes is AP proposing for the wellness program in 2015?
In 2015, AP proposes an outcomes-based program. Employees will be required to meet at least three health targets to avoid the $50 premium surcharge. The targets we use are provided by Health Advocate, our wellness administrator, based on guidelines set by the National Institutes of Health/American Heart Association and Diabetes Association.

In accordance with the Affordable Care Act, AP's wellness program will provide for alternative options for employees who are unable to meet three of the targets. This will provide all plan participants an opportunity to work toward alternative goals and avoid the surcharge.

What are the health targets?

Body Mass Index (BMI)	29.9 or below if BMI is above 30, then waist circumference must be less than 40 for men and less than 35 for women
HDL cholesterol (healthy cholesterol)	50 mg/dl or higher for women 40 mg/dl or higher for men
Glucose	non-fasting glucose at 140 or below if non-fasting is 141 or above, then HbA1c equal or less than 5.7 percent
Blood pressure	systolic BP under 140 mm/Hg and/or diastolic under 90hmm/Hg

How will biometrics for the wellness program be collected?
Biometric screenings can be completed at your doctor's office. The doctor will complete the physician's form and fax it directly to Health Advocate (formerly WellCall), our wellness program administrator. If you had your biometrics completed after April 1, 2013, there is no need to have them done again; your doctor can fill out the physician form and fax it to Health Advocate. The contact information is on InsideAP > Benefits > Wellness 2014.

In addition to the biometrics, will I be interviewed about my health practices (such as, "How often do you exercise?") as part of the assessment?
Those questions will be asked on your personal health profile. The health profile will generate a report for you, and both your health coach and you can refer to the report when developing your wellness goals.

How frequently will my progress in meeting wellness goals be measured, and when can I benefit from meeting them?
Annually. In compliance with the Affordable Care Act, we will remove the monthly payment surcharge if the employee/doctor provides proof of significant progress toward the defined goals or an alternative goal - to be tweaked as needed as the regulations become definitive.

Will AP have access to my biometric screening results?
No, screening results are sent directly to WellCall and are not shared with AP.

Are mitigating factors (such as pregnancy or other medical conditions) considered when assessing the biometrics?
Yes, we will follow up with more information on this topic and provide guidelines. Pregnant women automatically meet the requirements.

DEFINITIONS

What is a deductible?

A deductible is a specific dollar amount the plan requires you pay out-of-pocket each calendar year before any benefits are paid by the plan.

A deductible is not applied for in-network preventative services for a routine annual physical exam. These services include screenings, immunizations and well-child care exams.

What is coinsurance?

Coinsurance is the percentage of covered expenses you must pay in addition to the deductible. For example, our plan may pay 80 percent of covered charges after you pay the deductible. You would then pay the remaining 20 percent as coinsurance until a maximum out-of-pocket expense is reached. If you go to an out-of-network doctor, the plan's payment is based on reasonable and customary charges.

What are copayments or copays?

Copayments are pre-determined, fixed fees for certain services (e.g. in-network office visits) paid by the covered person at the time of service. Services subject to copayments are **not** subject to deductible or coinsurance.

What is an out-of-pocket maximum?

An out-of-pocket maximum is an amount set by the benefit plan beyond which you no longer must pay for covered services. First you have an annual deductible to meet, after which the plan begins paying a portion of covered expenses (e.g. 85 percent). You must pay the balance (e.g. 15 percent) until the amount you have paid over the course of the year reaches the out-of-pocket maximum. Once you reach this maximum, the plan pays 100 percent for covered services for the remainder of the year. (For out-of-network services, the plan participant will continue to be responsible for charges that exceed reasonable and customary limits, if applicable). Beginning in 2014, copays count toward out-of-pocket maximum.

Out-of-Pocket

An out of pocket expense can refer to how much the copayment, coinsurance or deductible is. Also, when the term annual out-of-pocket maximum is used, that is referring to how much the insured would have to pay for the whole year out of their pocket, excluding premiums, non-covered services and amounts over reasonable and customary for out-of-network services.

PROPOSED DEDUCTIBLES, COINSURANCE AND OFFICE VISIT COPAYS

MEDICAL PLAN

2014 - 2016

		Premium Plan	Basic Plan
Deductible	In-Network Deductible (Individual/Family)	$400/$800	$800/$1,600
	Out-of-Network Deductible (Individual/Family)*	$900/$1,800	$2,000/$4,000
Office visit copays	Primary Care Physician (PCP)	$30/visit	$30/visit
	Specialist	$45/visit	$45/visit
Coinsurance	In-Network (plan pays)	85%	75%
	Out-of-Network (plan pays)	60%	60%
Out-of-pocket max	In-Network OOP (incl. deductible & copays)	$2,400/$4,800	$3,400/$6,800
	Out -of-Network OOP (incl. deductible & copays)	$4, 000/$8,000	$6,800/$13,600

*Reasonable and customary charges for out-of-network services will apply toward a deductible; coinsurance applies after the deductible is met.

PRESCRIPTION AND VISION PLAN

2014 - 2016

Prescription	Retail (30-day supply)	Mail (90-day supply)
Generic	$10 copay	$20 copay
Brand	20% (minimum $30, maximum $100)	20% (minimum $60, maximum $200)
Brand - NP	30% (minimum $50, maximum $120)	30% (minimum $100, maximum $240)
Rx OOP Max*	$1,500	
Limited Retail Network	Walgreens, Wal-Mart, Duane Reade: excluded from the retail network	
Mandatory	Mail and Generic	Mail and Generic

* Once an individual pays $1,500 in a year for covered prescriptions, remaining covered prescriptions are paid in full. If the Affordable Care Act requirement does not change, prescription drug copayments will apply to the medical plan out-of-pocket maximum in 2015.

Vision		
Exam/Lenses*/Frames	In-Network	$20/$20/up to $175
Exam/Lenses*/Frames	Out-of-Network	Up to $40/$40 - $80/up to $45

* Contacts in lieu of lenses