Linda M. Hodge

First Selectman

Board of Selectmen Special Meeting Minutes
Monday, June 1, 2009
Colchester Town Hall
Suite 201 – at 8:00 a.m.

MEMBERS PRESENT: First Selectman Linda Hodge, Selectman John Malsbenden, Selectman Rosemary Coyle (via teleconference), Selectman Greg Cordova (via teleconference), Selectman Stan Soby (via teleconference)
MEMBERS ABSENT:
OTHERS PRESENT: Mike Caplet

1. **Call to Order:** First Selectman L. Hodge called the meeting to order at 8:06 p.m.

2. **Discussion and Possible Action on Non Union Employee Health Benefits:** J. Malsbenden moved to approve the proposed change for non union employee health benefits to the Century Preferred Plan as presented, and to authorize the First Selectman to sign all necessary documents, seconded by S. Soby. Following discussion, all members present voted in favor. MOTION CARRIED.

3. **Adjourn:** J. Malsbenden moved to adjourn at 8:08 a.m., seconded by G. Cordova. Unanimously approved. MOTION CARRIED.

Attachments

1. Proposed Town of Colchester Non-Union Insurance Benefits for FY 09-10 (subject to approval of Board of Selectmen)

Respectfully submitted,

Michael J. Caplet
Executive Assistant to the First Selectman

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TOWN OF COLCHESTER
PROPOSED NON-UNION INSURANCE BENEFITS FOR FY 09-10
(SUBJECT TO APPROVAL OF BOARD OF SELECTMEN)
Century Preferred $20/$200/$50/$100

Century Preferred is a preferred provider organization (PPO) plan.

COST SHARE PROVISIONS	**In-Network** *Member pays:*	**Out-of-Network** *Member pays:*
Office Visit (**OV**) Copayment	$20 per visit	Deductible & Coinsurance
Hospital (**HSP**) Copayment	$200 Copayment	Deductible & Coinsurance
Urgent Care (**UR**) Copayment	$25	Not Covered
Emergency Room (**ER**) Copayment – *waived if admitted*	$50	$50
Outpatient Surgery (**OS**) Copayment	$100 Copayment	Deductible & Coinsurance
Annual Deductible (*individual/2-member family/3+ member family*)	Not Applicable	$400/$800/$1200
Coinsurance		20% after deductible up to
Coinsurance Maximum (*individual/2-member family/3+ member family*)		$1,100/$2,200/$3,300
Cost Share Maximum *(individual/family)*		$1,500/$3,000/$4,500
Lifetime Maximum	Unlimited	$1,000,000
PREVENTIVE CARE		
Well child care	OV Copayment	Deductible & Coinsurance
Periodic, routine health examinations	OV Copayment	
Routine eye exams (Once every two years)	OV Copayment	
Routine OB/GYN visits	OV copayment	
Mammography	No Charge	
Hearing screening (One every two years)	OV Copayment	
MEDICAL CARE		
Office visits	OV Copayment	Deductible & Coinsurance
Outpatient mental health & substance abuse - *prior authorization required*	OV Copayment	
OB/GYN care	OV Copayment	
Maternity care – *initial visit subject to copayment, no charge thereafter*	OV Copayment	
Diagnostic lab and x-ray	No Charge	
High-cost outpatient diagnostic	No Charge	
Allergy services *Office visits/testing* *Injections—80 visits in 3 years*	 OV Copayment No Charge	
HOSPITAL CARE – *Prior authorization required*		
Semi-private room *(General/Medical/Surgical/Maternity)*	HSP Copayment	Deductible & Coinsurance
Inpatient mental health & substance abuse	HSP Copayment	
Skilled nursing facility – *up to 120 days per calendar year*	HSP Copayment	
Rehabilitative services – *up to 60 days per person per calendar year*	HSP Copayment	
Outpatient surgery – *in a hospital or surgi-center*	OS Copayment	
EMERGENCY CARE		
Walk-in centers	OV Copayment	Deductible & Coinsurance
Urgent care – *at participating centers only*	UR Copayment	Not Covered
Emergency care – *copayment waived if admitted*	ER Copayment	ER Copayment
Ambulance	No Charge	No Charge

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OTHER HEALTH CARE	In-Network *Member pays:*	Out-of-Network *Member pays:*
Outpatient rehabilitative services *50 combined visit maximum for PT, OT, ST and Chiro per year.*	No Charge	Deductible & Coinsurance
Durable medical equipment / Prosthetic devices *Unlimited maximum*	No Charge	
Diabetic supplies & equipment	No Charge	
Infertility services – *prior authorization required* *Some restrictions may apply*	Applicable Copayment	Deductible & Coinsurance
Home health care	No Charge	$50 Deductible & 20% Coinsurance

PREVENTIVE CARE SCHEDULES

Well Child Care (including immunizations)
- 6 exams, birth to age 1
- 6 exams, ages 1 - 5
- 1 exam every 2 years, ages 6 - 10
- 1 exam every year, ages 11 - 21

Adult Exams
- 1 exam every 5 years, ages 22 - 29
- 1 exam every 3 years, ages 30 - 39
- 1 exam every 2 years, ages 40 - 49
- 1 exam every year, ages 50+

Mammography
- 1 baseline screening, ages 35-39
- 1screening per year, ages 40+
- Additional exams when medically necessary

Vision Exams: 1 exam every 2 calendar years

Hearing Exams: 1 exam every 2 calendar years

OB/GYN Exams: 1 exam per calendar year

Notes To Benefit Descriptions

- In situations where the member is responsible for obtaining the necessary prior authorization and fails to do so, benefits may be reduced or denied.
- Inpatient Hospital Per Admission Copay is waived if readmitted within 30 days for same diagnosis. Maximum of 3 copays per person per year.
- Skilled Nursing Facility Copay is waived if admitted within 3 days of hospital discharge.
- Home Health Care services are covered when in lieu of hospitalization. Includes infusion (IV) therapy.
- Members must utilize participating Blue Quality Centers for Transplant hospitals to receive benefits for Human Organ & Tissue Transplant services. This network of the finest medical transplant programs in the nation is available to members who are candidates for an organ or bone marrow transplant. A nurse consultant trained in case management is dedicated to managing members who require organ and/or tissue transplants. Covered services are subject to a lifetime maximum of $1,000,000.
- Members are responsible for the balance of charges billed by out-of-network providers after payment for covered services has been made by Anthem Blue Cross and Blue Shield according to the Comprehensive Schedule of Professional Services.

Please refer to the *SpecialOffers@Anthem* brochure in your enrollment kit for information on the discounts we offer on health-related products and services.

This does not constitute your health plan or insurance policy. It is only a general description of the plan. The following are examples of services NOT covered by your Century Preferred Plan. Please refer to your Subscriber Agreement/Certificate of Coverage/Summary Booklet for more details: Cosmetic surgeries and services; custodial care; genetic testing; hearing aids; refractive eye surgery; services and supplies related to, as well as the performance of, sex change operations; surgical and non-surgical services related to TMJ syndrome; travel expenses; vision therapy; services rendered prior to your contract effective date or rendered after your contract termination date; and workers' compensation.

A product of Anthem Blue Cross and Blue Shield serving residents and businesses in the State of Connecticut.

TOWN OF COLCHESTER
PROPOSED NON-UNION INSURANCE BENEFITS FOR FY 09-10
(SUBJECT TO APPROVAL OF BOARD OF SELECTMEN)

CENTURY PREFERRED
MANAGED RX, 3 TIER
Benefits at a Glance

$5 COPAYMENT GENERIC DRUGS
$25 COPAYMENT LISTED BRAND-NAME DRUGS
$40 COPAYMENT NON-LISTED BRAND-NAME DRUGS
Unlimited Annual Maximum
Oral Contraceptives

How To Use 3-Tier Managed Rx

3-Tier Managed Rx has three different levels (or "tiers") of copayments, depending on the type of prescription drug you purchase (see the chart below for details). Your copayments will be lower when you use generic or brand-name medications that are on our list of preferred prescription drugs. The medications on this list are selected for their quality, safety and cost-effectiveness. You'll still have coverage brand-name drugs that are not on the list, but your copayment will be higher.

Talk to your provider about using generic drugs or listed brand-name drugs. It's a simple way to save out-of-pocket expenses.

Copayments and Day Supplies

- You will be responsible for **one** copayment when purchasing a **30-day supply** of prescription drugs from a retail pharmacy.
- You'll be responsible for the following:

Option 2. Two copayments when purchasing a **31-day to 100-day supply** of maintenance drugs through the voluntary mail-service program (see chart for details).

Generic Drugs Have the Lowest Copayment

		Your copayment:
Tier 1: Generic drugs	The term "generic" refers to a prescription drug that is not protected by a trademark. It is required to meet the same bioequivalency test as the original brand-name drug. Tier 1 copayment applies.	$5
Tier 2: Listed brand-name drugs	The term "listed brand-name" refers to a brand-name prescription drug that is on Anthem Blue Cross and Blue Shield's list of preferred prescription drugs. Tier 2 copayment applies.	$25
Tier 3: Non-listed brand-name drugs	The term "non-listed brand-name" refers to a brand-name prescription drug that is not on Anthem Blue Cross and Blue Shield's list of preferred prescription drugs. Tier 3 copayment applies.	$40
Mail Service	Two copayments per 31-100 day supply	$10 tier 1 $50 tier 2 $80 Tier 3
Annual Maximum	Per member per calendar year	Unlimited

Generic Substitution

Prescriptions will be filled with the generic equivalent when there is one available. Exception: If your doctor indicates "Dispense as Written." In this case you will receive the brand-name drug—and you will be responsible for the applicable listed brand or non-listed brand copayment. NOTE: If your doctor does *not* indicate **"Dispense as Written,"** you will be responsible for the applicable listed brand or non-listed brand-name copayment as well as the difference in cost between the generic and listed brand or non-listed brand name drug.

Voluntary Mail-Service Program

Anthem Rx, our voluntary mail-service drug program, can save you time and expense if you regularly take one or more types of maintenance drugs. You can order up to a **100-day supply** of these medications and have them delivered directly to your home.

Two **mail-service copayments** will apply as follows: When Rx drugs are dispensed for 31-100 days 2 copays are taken.

National Pharmacy Network

Members also have access to a network of more than 53,000 retail pharmacies throughout the country. Members may call 1-888-207-4214, or go to www.anthemprescription.com, to locate a participating pharmacy when traveling outside the state.

Non-Participating Pharmacies

Members who fill prescriptions at a non-participating pharmacy are responsible for payment at the time the prescription is filled. Members must submit claims to Anthem Blue Cross and Blue Shield for reimbursement, and payment will be sent to the member. Members who use non-participating pharmacies will pay 20% of the in-network allowance, plus the difference between Anthem Blue Cross and Blue Shield's payment and the pharmacist's actual charge.

Limits and Exclusions

Benefits are limited to no more than a **30-day supply** for covered drugs purchased at a retail pharmacy, and no more than a **100-day supply** for covered drugs purchased by mail service. All prescriptions are subject to the quantity limitations imposed by state and federal statutes.

Benefits for prescription birth control and Sexual Dysfunction medications are optional for groups such as yours. Check with your benefits administrator to find out whether or not you have such benefits.

This is not a legal contract. It is only a general description of the Managed Rx, 3 Tier version. Please consult the Evidence of Coverage or prescription drug rider for a complete description of benefits and exclusions applicable to your coverage.

7-08