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October 1, 2019

Dear Christian Brothers Employee Benefit Trust Plan Administrators:

The Trustees of the Christian Brothers Employee Benefit Trust (CBEBT) have approved the following Plan changes, which become effective January 1, 2020.

One of these changes is the introduction of a new optional prescription drug program, **Smart90 Prescriptions**, which allows Trust participants the option to fill a 90-day prescription at a Walgreens pharmacy (or its affiliates) as an alternative to filling their maintenance prescriptions through Express Scripts mail order delivery program.

Additional plan changes include coverage being added for Habilitative services; coverage for Video and Virtual Visits with a member's physician; hypertension monitoring from Livongo; separate application of In-Network & Out-of-Network Deductible & Out-of-Pockets, combining Medical and Prescription Drug Out-of-Pockets, Allergy Copay Indexing, and the inclusion of a compulsory Generic Drug Provision called "Member Pays the Difference." Please take the time to review these plan enhancements/changes carefully. These are described in more detail below.

Furthermore, please also find attached applicable participant notices regarding the Women's Cancer Care Rights, CHIP (Children's Health Insurance Program), our updated HIPAA Privacy Policy, and other employer notices. Participant annual notices will be emailed or mailed directly to CBEBT participants. These notices can also be found under Required Notices under the Health Resources & Tools at cbservices.org.

As a reminder, we have also included the notice of semiannual update to the Express Scripts' formulary drug list, and the SaveonSP specialty drug list, as well as the Affordable Care Act (ACA) and Health Savings Account (HSA) Qualified Plan Guidelines for 2020. To remain in compliance with IRS regulations, we have indexed HSA plans to the required updated level.

The Summary of Benefits and Coverages (SBCs) for 2020 will reference the new programs. The SBCs and other plan documents are accessible on the administrator website under *Coverage Summaries* and by your participants at mycbs.org/health under *My Coverage Summary*.

Should you have any questions regarding the changes, please do not hesitate to contact your Benefit Consultant.

Separate Application of In-Network & Out-of-Network Deductible & Out-Of-Pockets

As of January 1, 2020, Deductibles and Out-of-Pockets for all Plans will be applied separately for In-Network and Out-of-Network.

Medical & Prescription Drug Out-Of-Pockets Combined

Medical and Prescription Drug Out-of-Pockets for all Plans will be combined on January, 1, 2020. Check your Summary of Benefits & Coverage (SBC) to see your combined Out-of-Pocket levels.

Allergy Copay Indexing

Effective January 1, 2020, all member copay plans will be set to $10 for the allergy copay.

Coverage for Video and Virtual Visits

Video and On-Line visits, also known as Virtual Visits, will be covered under all EBT plans if offered by the physician. Under the plan, participants will be subject to the office visit copay or plan of benefits that would normally apply.

Smart90 Prescriptions—90-day prescription fills at Walgreens Retail Network Pharmacies

Nearly all Rx plans offered by EBT have a Retail Refill Allowance that allows the participant to have an initial fill and two subsequent refills at a retail pharmacy before the participant is enticed to utilize the mail-order pharmacy. The participant may continue to fill at the retail pharmacy after the two refills but will pay the corresponding mail order copay and be limited to a 30-day supply of medication.

Smart90 Prescriptions gives the participant the option to either fill a 90-day prescription at a Walgreens (or its affiliates). This option applies to no other retail pharmacies for the 90-day fill option. The program provides the participant flexibility if they prefer not to have their 90 days of medication delivered to their home.

Essential Health Benefits Habilitative Coverage

EBT has always included rehabilitative services when deemed medically necessary. These services are defined as the treatment of disease, injury, developmental delay, or other cause by physical agents and methods to assist in the rehabilitation of normal physical bodily function, that is goal-oriented and where the person has the potential for physical improvement and ability to progress.

Until now, EBT did not cover Habilitative services, which are defined as health care services that help a person maintain, learn, or improve skills and functioning for daily living. Such services may include physical therapy, occupational therapy, speech-language pathology and other services.

Beginning January 1, 2020, EBT will offer participants Habilitative benefits limited to 20 visits, when medical necessity is shown, not to be combined with any service provided under Rehabilitative benefits. EBT will continue to provide Rehabilitative services as it has in the past provided medical necessity has been met.

Expansion of Livongo—Hypertension

Beginning January 1, 2020, EBT participants with hypertension can enroll in the Livongo for Hypertension Program at no cost to them. The Livongo for Hypertension program offers real-time recommendations tailored to each person's unique health experience. Participants enrolled in the program receive a connected high blood pressure monitor and access to the Livongo App through which they send their blood pressure readings. After each reading, a specialist provides them with personalized content based on the current reading and past trends. Participants also receive feedback if their blood pressure is elevated and can schedule a session with Livongo's trained coaches. If participants with hypertension are also currently enrolled in the Livongo for Diabetes program, they can now manage both conditions with one easy point of contact.

Brand to Generic—Member Pays the Difference

Currently, Trust plans include a Member Pays the Difference generic provision, which requires the participant to pay the brand copay and the difference between the brand and generic cost when the participant requests the brand name and the physician indicates that it was acceptable to dispense the generic. If the physician indicates to dispense as written with no generic substitution, then the participant may fill the brand medication at the brand copay.

Beginning January 1, 2020, all Trust plans will include a more comprehensive Member Pays the Difference provision. If a generic is available and the brand medication is filled, regardless of how the prescription is written, the participant will pay the brand copay and the difference between the brand and generic cost.

A physician appeal protocol through Express Scripts is in place that will allow participants to fill the brand name at the brand copay if they cannot take a generic due to reasons supported by the prescribing physician.

*Participants who may be affected will be notified in advance.

2020 Prescription Formulary Changes

Periodically Express Scripts, the Trust's Pharmacy Benefits Manager, announces changes to their formulary drug list. Some prescription drugs currently covered will be excluded from coverage while other prescription drugs will move from a Preferred Brand status to a Non-Preferred Brand status.

The formulary is a list of drugs—generic and brand name—that offer the greatest overall value to Plan participants. Formulary management enables participants and their physicians to choose clinically appropriate and cost-effective drugs for specific conditions.

The exclusion list is for medications not covered on the Express Scripts drug list. For each one of those excluded drugs, there are clinically equivalent, lower-cost options available. The Formulary Exclusion List includes preferred alternatives for those medications that are not covered.

Express Scripts also has made available a list of name-brand drugs that will be classified as Non-Preferred effective January 1, 2020, and the Preferred Alternatives for each drug.

*Participants who may be affected will be notified in advance.

Out-of-Pocket Limits on Health Savings Account (HSA) Qualified High Deductible Health Plans

The Department of Health and Human Services has indexed the 2020 Out-of-Pocket Requirements and Minimum Deductible levels as follows.

	2020	**2019**	**Change**
HDHP Minimum Deductibles	Individual: $1,400 Family: $2,800	Individual: $1,350 Family: $2,700	Individual: $50 Family: $100
HDHP Maximum Out-of-Pocket Limits	Individual: $6,900 Family: $13,800	Individual: $6,750 Family: $13,500	Individual: $150 Family: $300

Out-of-Pocket Limits on non-Grandfathered Plans under Affordable Care Act (ACA)

The Department of Health and Human Services has indexed the 2020 Out-of-Pocket Requirements to a maximum of $8,150 for self-only coverage and $16,300 for family coverage. In addition, the self-only Out-of-Pocket maximum is applied to each covered individual, whether the individual is enrolled in self-only coverage or family coverage.

	2020	**2019**	**Change**
ACA Maximum Out-of-Pocket Limits	Individual: $8,150 Family: $16,300	Individual: $7,900 Family: $15,800	Individual: $250 Family: $500

High Limit Claimants & Pooling Levels

Member Employers who receive experience-underwritten renewals are moving to a minimum pooling level of $125,000. Member Employers with less than 100 enrolled lives in the medical plan will have the minimum pooling level, while those 100 and over will be gradually increased over the next two renewal cycles to a pooling level of $150,000.
As a way to be lockstep in the marketplace, during the underwriting review process individuals that are considered exceptionally high claimants over multiple time periods will be reviewed independently from other high claimants. This allows the Trust to reflect the potential exposure of these ongoing higher claimants in formulating the renewal rates. This review, which includes clinical and financial analytics, provides not only a basis for a solid renewal but spreads risk more equitably among all Member Employers. Your Benefits Consultant can provide further clarity when discussing your renewal especially if you have high claimants among your membership.
Notice of Patient Protections

The CBEBT does not require the designation of a primary care physician. Plan participants do not need prior authorization from CBEBT or from any other person, including a primary care provider, to obtain access to obstetrical or gynecological care from an In-Network health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

A list of participating health care professionals who specialize in obstetrics or gynecology can be located under "Resources" / "Find a Provider" link at myCBS.org/health. We encourage participants to log in to be directed to their specific PPO.

Notice of HIPAA Special Enrollment Rights

At, or prior to the time of enrollment, a group health plan must provide each eligible employee with a notice of his or her special enrollment rights as required by the Health Insurance Portability and Accountability Act (HIPAA). These enrollment rights are outlined in the Summary Plan Document "Eligibility" section, listed under "Special Enrollment Provisions." Participants can access the Summary Plan Document by logging in at myCBS.org/health and clicking the "Coverage Summary" link, then under Medical Plan Summary, clicking the link "My Current Plan Booklet."

HIPAA Privacy Notice

The plan administrator or issuer must provide the Notice of Privacy Practices to new health plan enrollees at the time of enrollment. Furthermore, at least once every three years, participants must be notified about the availability of the Notice of Privacy Practices. Christian Brothers Services' HIPAA privacy policy and authorization forms provide notice annually.

Women's Health and Cancer Rights Act (WHCRA) Notice

Plans and issuers must provide notice of participants' rights to mastectomy-related benefits under the Women's Health and Cancer Rights Act (WHCRA) at the time of enrollment and on an annual basis.

Newborns' and Mothers' Health Protection Act (NMHPA)

The plan administrator or issuer must provide notice of protections under the Newborn's Act for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Annual Children's Health Insurance Program Reauthorization Act (CHIPRA) Notice

Group health plans covering residents in a state that provides a premium subsidy to low-income children and their families to help pay for employer-sponsored coverage must send an annual notice about the available assistance to all employees residing in that state. Christian Brothers Services sends out these notices each year on or before January 1.

Medicare Part D Notices

Group health plan sponsors must provide a notice of creditable or non-creditable prescription drug coverage to Medicare Part D eligible individuals who are covered by, or who apply for, prescription drug coverage under the health plan. This creditable coverage notice alerts the individuals whether their prescription drug coverage is at least as good as the Medicare Part D coverage. The notice generally must be provided at various times, including when an individual enrolls in the plan and each year before October 15 (when the Medicare annual open enrollment period begins). Christian Brothers Services sends out these notices each year on or before October 15 and as needed.

Wellness Program Notices

If you offer the CBEBT Wellness Program through Health as We Age (HAWA), Empower Health, or through your own wellness vendor, which includes a health risk assessment (HRA) or medical examination or covers spouses, you should consider your compliance requirements under new rules issued by the Equal Employment Opportunity Commission (EEOC) under the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA).

For example, under these rules:

- Incentive limits that are tied to the wellness program cannot exceed 30 percent of the total cost of self-only coverage. If spouses participate in the wellness program, their maximum incentive also cannot exceed 30 percent of the self-only coverage.
- Information from the wellness program may be disclosed to employers only in aggregate terms.
- Employers must give participating employees a notice that tells them what information they will collect as part of the wellness program, with whom they will share it and for what purpose, the limits on disclosure and the way information will be kept confidential. The EEOC has provided a sample notice to help employers comply with this ADA requirement.

As a reminder, the CBEBT is committed to providing access to wellness benefits at no cost to you or your participants. CBEBT has agreements with a variety of wellness vendors to provide on-site wellness screenings or flu shots, or your organization may choose its own wellness vendor. Please reach out to your Benefit Consultant for more information on how to arrange a wellness event. In addition to these services be sure to keep apprised of the Trust's other value-added services, such as Teladoc, Smoking Cessation, Diabetes Care Management, and other Preventive Care services.

On behalf of Christian Brothers Services, thank you for your continued participation in the Trust and the privilege to serve you and your employees.

Sincerely,

John M. Airola
Managing Director
Christian Brothers Health Benefit Services