Retiree Solutions & Advocacy

GE Retiree Benefit Solutions—Let us Help You!

Solutions Leadership Team Meeting Minutes

Date: 8/26/2021

Attendees: John Phelps, Connie Vick, Bob Dayhuff, Betsy Ervin, Rodney Ira, Brian Demo, Stanley Rice, Ed Stone, Don Trudeau, Glen Anderson, Mike Roberts, Nancy King. Called to Order – about 11:05 am

I. **Minutes, Financial Report & Review of Old Business** – A motion was made by Rodney to not review the minutes of the 6/10/2021 meeting, the July Financial summary in the agenda and old business summarized in the minutes. Connie seconded and all in favor.

II. **New Business – Benistar Group Health Plan**

John: All right, let me just start- we're going to get into the initiative here. Obviously, our big initiative is Benistar and the update and all that stuff, but I want to make kind of an opening statement here, and then I would like to hear an opening statement or response from Benistar and then we'll move forward to the specific details.

it's been a long time, as I've said, and I sent an email and you all appreciated that and Benistar my timeline and exchanges. About two years really if you take off six months that were from like July to December, that I was moving, trying to sell my house, moved to Florida, moved three times. That kind of knocked out six months' worth of progress. But we continued to have many, many meetings changes and revisions and updates and then revisions again and then miss deadlines four times. You know, again, I was partly to blame some of that Benistar, I believe it was blaming that and my opinion after listening to, you know, all the talk between us and Benistar. So a lot of it had to do with Anthem. Listen, they're good, they're dealing with big projects: New York's Don Cena thing about New York City and big project down there, 250,000 people. They're big fish to fry. And so they had big things to deal with and other things. And I'm just probably jumping to a conclusion here, but we were too small fish to fry get this done. So that was, I think, a big part of the delay.

Today there's going to be a lot of paperwork to digest I sent it out to the whole board for review. Hopefully you guys got a chance to look through it. And I know it can be confusing and we've gone over this time and again, but everybody needs a reminder, we need to refresh ourselves on what is being offered how we're going to get there, how we're going to complete this and finalize the damn thing. So that's all important to us as an organization, we want to bring this thing to completion, finish this up and kick it off.

One of the worst things for me has been kind of a credibility with our membership that constantly kinds number of times as we set dates. Foolishly I guess I put it out there to our membership and told them we're going to kick this off in January, we're going to kick this off in March, we're going to kick this off in June. And each time that kind of affects your credibility that you don't complete that with the membership. *They* say 'What's this guy talking about? He keeps telling us this thing's going to go and it's not going.' And I'm sure they're waiting for us to do this. So we need to get this done and I think, from what I've received so far, some of the sideline conversations, I think we're moving in the right direction and I'm hoping to get there. Timely as soon as possible, we can get there and get this thing, going. So that's my statement and Don or Glen and like anybody, Mike, want to make a statement from the Benistar side?

Don: I mean, I would keep mine very simple. We're happy to continue to participate and we're steadfastly focused on completing the task getting and then, I don't really have much to add to the history of it. It has been a longer than usual road but here we all are today so let's do what we can to make most of it.

John invited Glen or Mike to speak.

Mike: I just want to thank everybody for their patience., you know, it's been a long road, but Don and Glen are the best at what they do, which is why Nancy came to me and why I brought them to you and our part. And our partner, Paul, has built out an absolutely fantastic beautiful website. We're ready to go finish it up once we get through today's call. We're all very excited about this, and just thank everybody for their patience. That's all I got.

John: Okay, I think everybody's aware that the timeline that I put out there, many exchanges and documents and emails. It's pretty intensive, the work and the amount of work we've done over this past, again taking that six months out at least, that year and a half. We certainly have done a lot of work and it's time to finish, it is time to do it, to get it done. As Don said in his email, get it done.

Alright, so Don, where do you want to start, you know, our expectations are the things that I listed in that email of things that we need to get done. We got the agreement; I know you don't want to get into a bunch of conversation. You said limit discussion, but that plan that's out there now the new plan from Anthem, that looks very nice. There's some things that Ed and I need to talk about. Legally or legalistic, stuff that we need to expand on or enhance or do something with; but basically everything that you said in your email, was discussed in previous discussions and emails and Benistar responded. You try to include as much as possible and where you couldn't, you said you know, you kind of gave a short explanation of why you couldn't fulfill something to the degree that we want. But I want to kind of turn it over to you. Do you want me to put that up there, that agreement up there? Do you want to go over it, do you want to go from your email and discuss.

Don elected to bring up a document called "GERBS Group MAPD vs. Individual Medicare Overview 8.21.pdf" (it took a few minutes to bring it up). He started: I'm just going to say a couple words and I'm not going to really go through this, but you share this with the board obviously. So when we started this journey, back in the1700 s or whatever was, we considered a couple of different value propositions, one of which was whether we should directly compete with individual products in the

market. And we wanted to think through that at some point we spent some time talking about more of the Med Sup. sort of market and a little bit talking about zero premium plans and some other things related to that and kind of where we alighted, maybe we didn't say it explicitly, but I think we made it pretty clear was that we wanted to be able to offer something to people that would resonate with them and that they could not otherwise achieve themselves by going to Medicare. gov or to going to the individual market. And therefore, this is sort of the approach that we've taken and building out these two plans, and so what are those things? And they basically fall into two categories. Category one is cost and category two is level of benefits, so taking category one, which is the easy one, the cost part of it. As I started in this this opening remark there are plenty of zero premium plans if you're willing to accept the local market tight network and you'll have very little out of pockets, if you if you follow those rules. There's some Medicare Advantage plans that have that but in comparing this to, you know, folks who probably want a more robust and more flexible and more complete set of assets, we've picked some, we had Anthem pick them. But we pick some just, you know, some comparative stuff that shows kind of our high-level plan. We wanted one that was kind around that $200 mark. Another one is around that $100 mark. Keep it easy and there's nothing magic about it, but it feels about right for the market, and if you compare it to the individual Med Sup. market, for example, it compares pretty favorably. If you're age 65 in some markets, you can get a cheaper,, you know, plan G, which is a popular plan now. Obviously, Plan f was a very popular plan, but still under offered in the market. But you still have to go out and get prescription drug coverage and so that in almost all circumstances would push those premiums significantly above where we are today with a less robust set of benefits. I think, in part, we can say that you've achieved at least in, you know, the benefits and affordability aspect of it, what we had outlined previously in terms of in terms of our mission.

And then the rest of what we're going to go through, which is not reflected here, what's the particular mix of these benefits. Where's the right kind of inflection point about a doctor or a copay level, the differences between the plans, the level of benefits and prescription drug area, etc.? This this little piece is just intended to highlight a couple of the biggest factors. So the plan that we've put together in this group environment, has the benefits that are only available in the group environment. Those include the ability to go to any provider who accepts Medicare assignment, whether they are a Blue Cross contract provider or not It's in all 50 states and in fact, anywhere that that Medicare provides services, territories, Puerto Rico, etc.. And if you move about the country if you're in California, one day, and then Arizona, the next etc., you don't have to get, you know, referrals you go wherever you like, however, you like etc.. So that's a big advantage versus the individual market where these are not available. And the reason they're available in the group market, but not the individual market, is they are available through an exception provided to the to the group market.

The second thing is we've highlighted prescription drugs. It's something that we think will motivate a number of retirees when they when they think through how they purchase coverage. it's the number one, you know, question that we get. 'Hey is my drug covered and, if so, at what copay level?' And so without doing a deep dive on that … you'll see it a little bit further some details in terms of the structure which we hopefully simplified a little bit in the benefit plans. But they'll have access to very low cost of most of the generic drugs, most of the preferred brand drugs and they will have robust coverage for the most expensive drugs, especially pharmacy drugs etc., through what

we ended up doing is putting piecing together the broadest network. But then there's a preferred network, where you can get some further benefit if you if you still stay within that preferred network, and there the network is important. We will be able to support folks who are contemplating making a change, but who want this answered more specifically on a one-on-one basis, we'll do that beforehand and that that'll be the number one question by far, you know. We'll get 10 of those questions for one of every single other question.

The second most popular question will be ‘is my doctor in the network?’, despite the fact that we're indicating go wherever you want! People just want to know! And so we'll be able to do that as well. Blue Cross has over 800,000 in their Medicare network nationally, so if it's highly likely that they are. But even if they are not a contract provider, we don't care. We don't track it, it doesn't change the benefit level as long as they take Medicare assignment, you know, for those services that are being delivered. Where do you find that those don't happen? Well you're seeking dental or podiatric or something that's not a traditional Medicare benefit. You're going to run into people who are not going to take that sort of assignment and those are where things fall out a little bit, but those additional benefits are generally otherwise not available. Hopefully they're not a burden, but a positive.

And then the last thing I’ll say and highlighting this is that we have we've endeavored to add what we view, and you may view it differently, we view as Medicare Advantage additional benefits, non-Medicare benefits. And these include some of these extra programs that we will touch on when we go through the more detailed piece, but they certainly include things like the wellness program, which is the silver sneakers you can go to the gym and health club memberships for free and then there's a bunch of things around healthy eating. One of my favorites is something which is a transportation benefit. It's something that, as we move forward, if it gains the visibility and traction, that it has other places, we’ll look to make it even more robust. This is a benefit that delivers mobility to this population, so one of the biggest challenges that parties face is that they can't drive themselves to places. And we're not talking about, you know, an emergency or medical event driven transportation, but we're talking to the grocery store or to, you know, go someplace in the community so we've included a very base benefit here. It's 12 rides, but that's something that I feel is going to be a growing benefit as people move forward. It's not quite in the area of something if you're if you're following Medicare emphasis. There's something called the social endurance of health. So there's an emphasis on providing benefits through Medicare that support sort of an overall sense of wellbeing and transportation is not directly one of those, but it is part of it if you can move and be in contact with people and deliver services don't feel that you're at, you know, that you have to burden your neighbor or child or whatever, in order to do something. It can certainly have an impact in your life.

There's some other things that are mixed and I’m not going to go through every one of them, but those additional benefits is something that's been included, mostly with a with a larger focus on richer plan and the richer plan has robust brand drug coverage, so it is complete drug coverage through the donut hole. All those things are included and this is just a summary piece, kind of explaining it so that when you're thinking about it and reflecting on it, saying why the heck did we do this, why does it matter, this may resonate better with, you know, kind of your own mission, or maybe not and if it doesn't, then certainly provide us feedback. But I think that that was what we

thought was the goal and the mission, and I know there's often mission creep or changes or people do it differently, but I'll pause there if you think that's consistent with the with the goal of the board, then I think we can move to just review some of these particulars.

John: There's also, in that, some dental vision and hearing coverage, right. (Don concurred) I just wanted, because that was important, and of course it's a big political issue right now and expansion of Medicare and having those coverages. I certainly hope we get to that I'm looking for the document.

After a few minutes, Dan brought up the proposal (GE Retiree Group Healthcare Proposal-Anthem - July 2021.pdf) and moved through the first pages with some jokes about some of the figures. Don said: Okay, so can you see this I'm on page 19, but this is the *what* I'll call the financial exhibit. So I'm not going to spend a lot of time here, you've seen something similar to this previously. But I'm going to highlight a couple things. So where you see this blue box on the left that says medical, and if you keep going to the right, it says members 111. So this is an amalgam of data that you provided to us. Through some diligent effort, we kind of put into a census, and so they did the pricing and it did fairly reflect a diversity in geography and, you know, gender and age that sort of stuff so that that's all what this was based off. Does it dramatically change things? Not really, but in any case that that's if you're curious.

John: About that, that was to kick us off, right? I mean, we're expecting many more?

Don: Well, we certainly hope so, yes, so. And then the second thing I'm going to point out is there's two columns: *the* one that's highlighted, one it's blue and the other one's kind of a green going into gray. The blue one is the more expensive, but more robust benefit plan and the other one is the lower more affordable *plan*, but with a lower level of benefits as well, or higher out of pockets.

John: Don, can I ask you a question here on this? You know, many times we've tried to revise those top two bars, you know, whether it's Anthem. I don't care how they titled their part of it: Anthem Medicare Advantage but to say higher premiums, lower copays, lower deductibles and the other ones will say lower premiums, higher co pays and deductibles.

Don: That will be the case for member facing communications, you won't see any of this gobbledygook.

John concurred and Don continued: This rate in the middle, where it says Total PMPM rates - (blue column) it says $200.02. The other says $100.04. The way that those rates are developed is there is a rate for medical and above it, it says $56.76 and a rate for pharmacy $143.26. And the only reason I'm going to point this out is that what I want to emphasize is that even if we change around benefits in the medical sense, like we put in a $500 deductible or something like that, we could probably drive a medical component of this too close to zero, right? What is dropped is what drives the costs and what our core value proposition here is basically invested in the pharmacy benefits. The pharmacy benefits are the biggest driver of cost here and so you'll see comparatively one's $143 vs. $105. That by far drives it in fact, you know, the medical component on the base plans for $4.

John asked Don to repeat that Don: the medical component of that $110 on the lower level of benefits is only $4.09. Basically all the prescription drugs are driving the overall costs and I'm just making you aware of that That is consistent with our core value proposition, the same time, we are trying to achieve a robust level of health benefits. But the reason I want you to bear that in mind, is when I say something later, like it costs seven bucks to do this and you go 'That's nothing let's just throw that in there', that would that'd be 150% increase on the base rate of the medical, because it's only four bucks, right? So really in the design world, you know, just thinking this through, a lot of it has to do with where we are trying to achieve our price point, where we think we can get value in terms of building something out. And, as I say to folks 'you should feel comfortable, you know, enrolling in this yourself …, encouraging your spouse or, you know, whomever. This is intended to be a valuable benefit for them, at both medical and pharmacy side, so I don't have any questions about the rate part of it. But obviously if we decide to make a couple of adjustments and it might impact the rate a little bit, but in general we're trying to achieve those two rates targets, that we discussed.

John: The specifics of the tiers, and the pharmacy, that's covered in here too?

Don: Yep we're going to get to that next, benefit levels.

Mike: I have a question. On the rates presented, does that incorporate some type of feedback to GERS, so there has to be built in on top?

Don: It will, it will have to be built in on top and it's a minor legal point, but we have to work through it with them. Since they're not a licensed agency, it has to be a under shared services arrangement and it's something I'll discuss with Ed, also council for Anthem. But it's a fair point, Mike.

John: Yeah that's right, that is a concern. this is one of the points I had down, but Mike brought it up. And I was going to bring it up the fees that were mentioned in that John started looking through the document for something about shared fees.

Don: it's just in my cover email note and it's not it's not shared fees, it's shared services. And the reason for it is there's basically only a couple of ways, under which you could be *eligible*. One is the fulfillment of certain services or duties that would be under covered under an administrative shared service agreement or the other is producer compensation, which would require a licensure for it. And I don't think you want to go in that in that room for a couple of reasons, it would involve additional scrutiny. There was some more discussion between John and Don.

Don continued: So anyway, it'll be appropriately covered in whatever it is, but it doesn't mean you're going to define what that is. It doesn't impact any benefit costs or anything like that It'll be just if you would be where the fee is.

John: Well, Ed will make sure we're on this.

Ed: I will go over that with Don later and we'll figure out how to make it work. He's right, you can't share producer fees with non-licensed folk. John concurred.

Glen: Alright so John, before we go on this is Glenn. Has anything changed in the structure of the stipend? *Do* retirees still have to take a product from VIA in order to be eligible for the stipend?

John: That's a good point on those two options. I'm thankful for bringing that up for those two options. Yeah the people that are in the RRA, I'm assuming, and I think we discussed this before with you, Don and Glen. The second option would fill that without drug coverage. Is that it, or do we need a third option?

Don: *We* could have a third option, which would include filling it with, as you say, basically similar level of benefit, but without that component. Let's table that discussion though for right now, only because this sort of messaging is a little bit different than the messaging that you're talking about in terms of how you position it to the RRA group. I don't and we need to get into the weeds a little bit on that in terms of what would qualify for them. So, in other words, I think I remember this correctly and you'll correct me if I'm wrong, but I think the subsidy is $100 per month, as long as you take either an individual product through the exchange or you elect … I think they had like sort of a standardized prescription drug benefit, at least they did at one point. I don't know if that's still true that they can either do one or the other.

John: Well yeah you got to choose one: the medigap or the prescription to keep the RRA if you're going to go outside for one of the other. It's $1000, a year coverage for our RRA.

Don: So it was $1000, a year, and if they are a couple, it could be $2000? John and Don talked some more on this subject, clarifying details.

Don continued: What you're indicating is you must take in order to get that thousand dollars, you must take either medical through VIA or prescription through VIA, so the point I'm making is let's suppose that what we say, is you need to take or you're electing. We make available based medical and you're elected take prescription through VIA. Because, if you don't take prescription through VIA, this point of I'm getting. if you don't take prescriptions … and you elect to our medical only then you have no prescription and you don't get the $100. So that's like … someone was giving you a hundred dollars doesn't. … but what I'm saying is, if the point of what you're doing is you don't elect that prescription drug through them, in terms of what we looked at last time we looked at it and I'll grant you, it's been a year, but was generic only coverage. For any of those benefits, the point I'm making is even on that base benefit there's more robust benefits on prescription drug at $105 a month. So yes, you could get this this base benefit for $4 and you go into the individual market for zero dollars, but the point is, if you don't like the prescription drugs and it's going to cost you. If you don't get any subsidy and you don't have any prescription drug coverage, if you do elect it, then you don't have, the more robust prescription drug coverage. And you're back in sort of the individual market. All we're offering you is either this $4 or even if you do it in the richer base this $56 plan. Anyway, so we just have to figure out what would actually make sense and the point I'm making is you might be better off not taking the subsidy and just saying: 'Who cares, it doesn't matter, it doesn't help, it doesn't help me because, if I care about prescription drug coverage then these are both better plans that are available to me.' And these other pieces are as robust or more robust as you can get in the individual market,

John: What you're saying, basically, is it'll cancel out the $1000, not making it a concern.

Don: Exactly it's irrelevant. So anyway, we can talk a little bit more about that, but I just wanted to highlight that Don added a little more to the discussion while moving to slide 22, the proposed benefits and description of covered services. He stated: Moving on to the benefits for these two pieces, and again don't worry about this kind of labeling. (There was some more discussion and joking.) I think it's actually just descriptive: PPO is preferred provider organization, 10P is $10 primary care copay, high is high option. So what we did, and I'll just do this pretty quickly but in the in the prior version of this, if you saw it there was no deductible on the high plan, and there was no deductible on the base plan. For affordability we added a $200 deductible in network. And to make some difference, these were both $3000, out of pocket maximums. We reduced the one on the high options to $2750 and increased the one on the other *to* $3750. Unless you were hospitalized on the lower option plan for five days, those are unlikely to matter to you irrespective, because the copays are so low. In terms of inpatient benefits, this had been on the low option plan, a $240 copay for days one through six. We reduced it here from $240 to $200 copay and reduced the days from six to five. We made the outpatient hospital care just the event driven thing, the same as the hospital copay. It was previously either zero or $100. So that is a slight increase. This is incorporating comments that were shared by you, John. The primary care visit is reduced to $15, we actually reduced *by* $10. Just if you're going to have it be impactful, it might also make a meaningful difference, so this is $10 kept with this $25 kept especially at $25 on the richer plan, and then kept this at $40 for the specialty on the base plan So you'll see later that we kind of mirror that same thing in the diagnostic testing, when we get to that So any questions so far? These are the major benefits, right? These are the core major benefits, any questions on this, comments?

John: Anybody on the board on the comparison of the high low plan here, anybody?

Don: And you can save them all up and ask them at the end, if you want. … So the rest of these things are, I don't say they are lesser benefits but they're more particular, more specialized. It does include unlimited telemedicine and zero-dollar copay. It's an Anthem owned access point so you can call up and do either video like we're doing or you can do it on your mobile device. I don't know how you do on a mobile, … but it is possible. Or you can do it the old-fashioned way and just dial in. So that's available, unlimited live health doctors visit online. All the friendly care services.

John: You're going to say something, you said in your email that *you will* explain more on preventive care. I'm assuming that's like annual physicals, testing diabetic tests or whatever, screenings, stuff like that, is that right?

Don: Yeah what I was going to say, and I purposely didn't send this back, but if you'll recall that sort of hundred-page document, EOC? All of these are the Medicare coverage, so they're just the mandated preventative care benefits and there's a suite of them, there's 20 of them. It's certain vaccinations and certain screenings. It's a once-a-year health screening, there's some additional benefits women's health based. And there's diagnostic stuff, they're all covered at zero again. It's not like we're designing it in there, it's required by law. So I mean just some I've spent time talking about that but it will be for each member, they will be able to look it up and see it for themselves, so it will be in that 80- or 100-page document, whatever it is.

So, in terms of Inpatient mental health benefits, they're just mirroring the inpatient essentially, so mental health is treated the same as regular hospitalization. So $200 copay on the lower option plan mirrors that above for just regular hospitalization, no difference. Skilled nursing is, so remember Medicare doesn't cover custodial nursing, but if you are hospitalized or have some other accident or illness or certainly surgical related event, it will pay for skilled nursing facility, for your stay in a skilled nursing facility during those first hundred days. And so this is just outlining the copays for those.

John: I didn't ever think there was a hospice care copay. I don't know where I got that from but I'm surprised. Is that per day?

Don: No, you just enter hospice, you'll remember hospice is end-of-life care, and it's just a single copay. I mean this is like a free benefit, we could probably just make this price zero.

John: At our age, sometimes, some people have to deal with that

Don: Understood.

Mike: Don, you know Steve Cohen's organization down in DC? They're part of a national hospice nonprofit and again they're national and all their services are free. So if we need, we can just plug them in.

Don: Yeah, so hospice is defined as end-of-life care. it's when you have a life expectancy of less than 180 days. So that's the defining event and so hospice care is mostly palliative, it's not restorative. So, but anyway it's a Medicare mandated, so that's good as such. In terms of emergency care access, these are just the copays of your emergency room, it's waived if admitted. Same thing on the urgent care, $30. The emergency care is the same in both instances, urgent care is kind of a walk-in clinic or urgent care clinic. There are some hospitals that have urgent care. If you know how to navigate going to those, in Stanford, for example, they have a separate campus and they have an urgent care facility attached, but that's a lower level of care, much less costly and again available just through a copay. Ambulance rides again, these are these are emerging sort of care needs, these are not the routine which we'll hit on in just a minute. They are $70 to $100, same as they've been previously.

So here in this diagnostic area, this is something else I'll talk about just a little bit. There are two types of diagnostic categories. There's simple basic, so it's basically the diagnostic lab services, it's x-rays, and there's a few other tests that are just considered basic testing. Those are available, with a $25 copay in the richer plan and a $40 copay in the lower, the less rich plan. They had previously been $35, we changed them. These actually have sort of a meaningful pricing impact. And again I'm happy to spend more dollars if that's what we want to do, but these are generally at or better than what is available in the individual market. And complex ones, certainly are better than what are available in the individual market. This had been $25 but it costs, I think it's like $6.48 or some number like that to keep it $25. So I'm going to pause here, you can reflect on that That's the most significant change we made there because that's a bunch of dollars we could grab and spend someplace else and still not lose where we were relative to what's in the individual market. So

anyway $25 basic, $50 complex, so MRI's, cat scans that sort of thing and on the base plan $40 and $100.

John: Let me ask the board since you brought that up, and it could have been $25 but it costs $6 or whatever more on the premium. Anybody on the board have to deal with any kind of diagnostic services in your plans?

Bob: I had an MRI, didn't cost me anything.

John: What plan were you? Were you plan n?

Bob: Medigap. Plan n blend plan, g, plan f, plan something.

John: Okay, anybody else that had a copay for the bigger diagnostic there, the bigger category, Rodney or Connie?

Rodney: I'm looking right now trying to find it.

Connie: Ray had a lot of lab work done; I mean like per year.

John: But that's in the lower category, right? That's not *the description*. This one they were talking about like the MRI, CT's.

Connie: Yeah, he had all that stuff: CT scans, MRIs, all that

John: You remember the copay, Connie? Connie thought it was $25 or $50 but went to look for the paperwork.

Rodney: Something like an MRI you know, a copay, if it's for $50 or $100, is not going to be that big compared to what you would *how* many times you would have it done. It's just something you don't do that often.

John joked about getting his brain scanned and others joined.

Connie: A bill that I had that I just received, and it was for an ECG. I don't know if that would be the same thing and the charge was $21. But I wanted to pay $19 and so I guess I got a dollar knocked off. I don't know what that is but that's what I had to pay with $19, because the total charge was $152 and then I paid my $19.

Rodney: I had a $100 copay and that looks like on both different types of plans and Medigap coverage through Anthem for complex diagnostic and our radiology visit.

John: That would fit that category.

Rodney: If he's getting that done all the time, it might be a big deal but people don't get them that that many, that often. So hundred-dollar copay, most people aren't going to jump on that

Connie: I know I could not with all the stuff he was having done ..

John: I know. Basically I think everybody's saying that looks reasonable, and it's not going to raise any hair on anybody's neck.

Don: Okay, well, if you change your mind the next day or so, certainly advise. So these next suite of benefits are not all Medicare, they're not all supplemental to Medicare but they're kind of these ancillary ones that we are talking about. This first one is in fact for Medicare covered diagnostic hearing and evaluation so there's just doctor visit copays for that this the one that follows it is for non-Medicare routine exams and the benefit's a $70 benefit, single visit once a year, so. It's a modest benefit, but it's for non-Medicare covered benefits and then the final part on the hearing is there's a once every 12 months $500 hearing benefit that, again is available on both benefits, so these last two the exam and the hearing aid are supplemental to what you can receive from Medicare. The first one is just reflecting the Medicare copay to do a doctor visit for something that would be covered by Medicare.

John: If that changes in the Medicare expansion, if the legislation goes through, and has both house and the President of signs it, … will this change to match whatever? The legislation is the final coverage, right?

Don: Absolutely. I think what you're going to find is when they get down to the small strokes, that it's going to be a little bit of a battle. Because this way that it's structured right now, at least the House proposed bill, has them incorporating these additional benefits, the three that we were discussing: hearing, vision and some level dental. *This is* without increasing the reimbursement to the private sector providers so as you might imagine, they're not terribly thrilled with that So lots of advertising against it in trade rags, but we'll see how it comes out. Probably something will happen. … And when that change happens, absolutely it'll be incorporated.

So, similar to the hearing the next set is the vision. First is the Medicare coverage: it basically just mirrors the hearing. If it's a Medicare covered visit. there's a copay. …If it's following cataract, it's a slightly different benefit, and then the non-Medicare cover is the third piece here. So there's a zero copay once every 12 months and then $100 for materials, and this is where I think Ed's comment was: 'Like, is that a discount?' It is actually a payment but, you know, if you're paying $400, it will feel like basically just a discount, but it's a hundred bucks every 24 months for materials, that can be either eyewear or the frames. Again, supplemental to Medicare. Then mental, this is the outpatient mental nervous, the same as it had been previously. Same thing with the rehab 25$ copay in the richer plan, $40 in the lower plan.

Medicare Part B drugs, these are drugs that are not delivered through the outpatient prescription drug benefit that we'll get to that a little bit here. These typically are more expensive drugs and they're delivered in an expensive environment. So they're either delivered in a hospital or other healthcare institutions setting or they are injected or delivered by a physician in in some sort of. professional setting. So this is the copay for them *(20$ but 20% Coinsurance for the base plan)*, these drugs tend to be fairly expensive., you know, $1500 per injection or some something like that So that's why there's two things one, even if you could do this in a pharmacy benefit, outpatient sort of, you know, where you go to the pharmacy and fulfill it. And there are a couple of drugs where it is

the choice of the individual. Typically, we would recommend, you know, do you want an 80-year-old, self-injecting herself with a $1500 drug, perhaps not so.

Anyway, Medicare Part B drugs which is part of the standard benefits. chiropractic services covered at 20$ same as it was in both of these. Medicare has expanded and allows coverage for both acupuncture and chiropractic services. I will highlight that, in the prior thing, it was because no one paid any attention to it, we had a 5$ copay on it. And it's now 10$ and 15$. … I don't think there's a reason to have it as a 5$ copay to do acupuncture. it's not that it costs anything, it's just a strange to have it so dissimilar to just regular services.

Thia is all diabetic management. Again, this is Medicare mandated, so it's not like we're doing crazy beneficial here but this is everything. There are packages that you get that include the test strips, lance, etc.. This is a highly used benefit and, obviously, probably highly highly-utilized in your population as well. And it's zero if it's in their preferred and it's 10$ if it's not in a preferred, which is basically anywhere. And you can also get it through a DME provider, that would be that would be the durable medical equipment provider who provides … monitors and other sorts of control equipment. All that's, you know, pretty standard for Medicare.

And again, this is just more on that same topic: glucose monitor, itself. So if you get a preferred versus non-preferred for $10 difference. DME can provide it for zero. Therapeutic shoes are covered again. Those are all related to diabetes self-management training. This is something that's provided by Anthem, I think it's mandated actually by Medicare that they have to do so. So it's no copay, *it'*s just about how, you know, how often to test, how to inject yourself, etc. This is a big deal now. I don't know if anyone on the phone, please don't disclose, but the continuous glucose monitors, these are the ones that are connected. And either they're live connected in some cases where they're just recorded and you downloaded or attached to an app. So this is becoming more popular.

John: That's like the things they put on their arms, they're in the commercials and they scan it with their phone and the doctor just worked with that

Don: Yep, and it's a lot more efficient, a lot better in being able to. identify an issue before it becomes an emerging issue. DME on the on the higher plan, DME can be fairly expensive but it's all available, zero copay as long as Medicare necessary 20 co-insurance on the base.

Brian: Is that going to include CPAP and BIPAP?

Don: Probably it does, I'm just not familiar with BIPAP as much, but it does include CPAP, and it includes a pretty much wide variety of anything. I mean you can look it up anything, that's covered by Medicare a little, is covered in zero copay.

Bob: It covers both those things. They cover both those things

Don: Do you know that or you're asking?

Bob: My brother uses them

Don: Okay, and then yes.

Brian: I use the CPAP as well and go through Medicare first and the secondary is it hitting us because I'm still under GE insurance. Medicare won't pay for any of it. Medicare won't pay for the BIPAP.

Don clarified and added: Sometimes where they don't pay for it is if you don't have a diagnosis that would support its need. There's a medical need that that goes with it. But if it's Sleep Apnea or anything, there's a whole range of them in that category, it would be covered.

Bob: You are correct, because I gave my brother, a new one. Because the other one quit. And then they refused to pay on it, because the doctor didn't put the right paperwork in. And then they had a hearing about it, and what a big to-do. They end saying it was the fault of the company by not getting it documented from the doctor so my brother had to pay nothing

Don: Well that's good but he still had the paperwork.

Bob: Yeah, it is. That's what I wanted to add. It is complicated and you do have to make sure all that stuff is done right.

Don: Yeah, so again, if it's part of a cover diagnosis it should be fine, but I'm not saying mistakes don't happen. In fact, oddly enough, not for Medicare circumstance but we had the same thing, and they denied it because it was Sleep Apnea … So I said 'what would you cover for? … Give me an example.' It was like the thing is designed pretty much for Sleep Apnea and related conditions

Connie: I was going to say *that* a lot of raised DMEs were covered by Medicare and we didn't pay any copays. We had to earn some of those things, but not all.

Brian: I'm just going to have to get a new prescription from the doctor. I've had it for like years and apparently they've lost the sleep test results and the order from the doctor.

John: But does your Aetna plan, Brian, cover part of the cost. I wonder if because you're still getting the GE plan, plus the Medicare disability, right yeah, that might be the complication, is it?

Connie: I had a supplemental plan, but Medicare paid for all of it, so …

Don: I don't know what the particular challenge was in his case but here it should be covered and you know as long as it's a supporting diagnosis. Yeah, it's not it's the sort of thing that we're in place to help correct. Same thing here with some of these other ones: podiatric services are limited under Medicare but there's their benefits both for Medicare approved and for non-Medicare approved. These are just mostly doctor's visit type things. I've been doing this for 26 years and never really understood why podiatric services are limited, but I'm sure it was. Some community committee vote, you know, in the 60s, or something. But in any case, both are covered both Medicare and non-Medicare approved.

Moving to some of these supplemental benefit items: foreign travel, this is more mandated the emergency part of it. Remember Medicare only provide services within the Medicare service area, which is the US and its territories. But this provides coverage, both on an emergency basis, and I think it's a pretty big deal if we eventually get back to traveling internationally. This provides 60 full lifetime days with a zero-dollar copay or $200 copay, which is pretty meaningful. I mean this is inpatient coverage which is beyond Medicare.

There is a nurse line available, the nurse line is different. Going all the way back to the telemedicine line the nurse line is more of what you call up as a patient *and* say 'Hey, my neck is hurting me, you know, what can I do' or, you know, 'I'm eating this food and it's creating this issue'. So it's access to someone that you can talk to about medical stuff and they have some insights or they can help direct you to where you can get additional resources. So this is available 24/7. It doesn't cost anything.

Routine dental services, emphasis on routine. So this is not drilling a cavity, … putting in a crown, putting in false teeth, etc.. Those are not covered. But a routine coverage could be an x-ray, teeth cleaning, whatever they call the office visit, etc.. Those things will be covered, and those are non-Medicare benefits. If on the other hand you had jaw cancer or something that would be a medical benefit, reconstructive surgery, all that'd be Medicare covered and that would just flow through the other stuff. This is routine dental services that are not covered by Medicare so these are available under growth plans with no copay.

John: Now that provider right there, Liberty Dental, that's Well Care. My experience so far with them has not been good. You know, they fight between the provider. My point is this, Well Care approves a benefit, Liberty denies the benefit or denies the claim, I should say, and that drives me absolutely insane. I have to fight with both of them. So when I see the Liberty Dental on your sheet with the Anthem … I'm saying 'here we go', you know? As far as getting zero copay, you understand what I'm saying?

Don: I understand and you have my sympathies in advance. I don't have deep experience with them, so I can't comment. This is what we talked about: Silver Sneakers. It's a very popular benefit. Essentially they have a roster of health. We call it gyms and health club memberships that you can access fitness centers, etc.. It's a pretty popular benefit. People swim a lot, people walk and use, you know, basic equipment. And if you're an active retiree it's a meaningful benefit. If you're not, that's you know, obviously something you probably gloss over. So all of these are additional services:

Healthy meals. This is just a follow up thing where they'll provide up to 56 meals, 14 per qualifying event and it's basically post discharge, if you're coming out of the hospital or other Inpatient setting. I think there are some other things like if you're coming out of chemo etc.. They'll arrange meals for you, so it's a nice it's a nice benefit in that setting. It's not the world's biggest benefit but again, something about it. Adult day care is the same thing. I don't know if you're familiar with this. But this is if you essentially are in need of, I'm trying to use a word other than custodial here but it's kind of in that category. It's technically not custodial care but it's a professional who will be available one day per week and, you know, in a supervisory capacity. So that can be helpful. In order to qualify, you essentially have to demonstrate some level of disability so that could be, you know, grooming, continence, mobility etc.. I don't remember what the 6 ADLs are, but you need to have two of them in order to qualify. Because of that, I'll say it's a pretty minor benefit in terms of utilization.

Healthy Pantry is actually pretty good. This is a bigger deal and you think pretty much anyone as a cancer patient will utilize this. It's all of the supplemental nutritional stuff that you need, if you're going through chemo or there's some other dread disease. So this is pretty good it's telephonic counseling and then delivery of necessary nutritional supplements or food. This is the next one, the routine transportation thing I talked about. This is non-emergency, so this is 'I want to go the grocery store. I got to go pick up prescriptions', … They can get delivered and some grocery stores you can, but if you want to go someplace 'I need to go to the fitness center', whatever it is. It's just 12 trips a year. … It's one of my favorite things. Mobility is one of the biggest challenges we have as we get older and this is an easy one. It's kind of like having a free uber.

This last thing *(Special Discounts)* is something that I actually don't know a ton about but they have a bunch. You can go online to the Anthem site, there's a bunch of discount things that are in addition to not a substitute but an addition to any of the actual insured benefits. They have some discount stuff.

John: You know, just out of curiosity here, because welfare did have that and they had a 200, I think, a month and if you didn't use it, you could accumulate it towards any of those ordering vitamins, other type of care products, like blood pressure machine, you know? I'm wondering how that thing is set up. Not that I want to spend a lot of time on that, but I'm just wondering is that set up through Blue Cross, *do* they manage it? Or is it set up through an outside company?

Don: So it's available on their site, but I think that most of them have a third party involved. So the vision and hearing have third parties involved. … Do you know, things like vitamins and nutritional vitamins and nutritional stuff. Yeah, I don't think that there's anything where you accumulate like a rewards related thing at least that I've seen. But I'm not going to profess to have deep knowledge about it. I'm just curious. All right, yeah, but it is available on their site. I think it's delivered through a third party.

That's it on the medical benefits and we're about to move to the prescription drug benefits. Don opened it up to questions.

John: Is Rodney still here?

Rodney: Yeah I'm still here I'm just looking through parent plans.

John: Is Ed still on or did *he* leave?

Ed: I'm still here, just put it on mute.

There was some joking around and then Don continued: So, moving into the prescription drug area, just again, talking about this generically but or generally let's say. I'm not generally going to be confusing, talking to us generally obviously much richer benefits in the preferred, the high option, the richer benefit plan, than in the lower benefit plan. They use essentially the same network setup, they have essentially the same formulary setup, not essentially, they have the same formulary. So many of those things are similar. It's just there's more robust benefits and lower co pays in the richer category. So individual plans don't have coverage in the donut hole which happens after that initial coverage limit. After that 4430 has been expended, and in in the individual market, all you have are what's available through the discounts and there are pretty meaningful discounts that are offered in part-d-based programs. Now because they've been forced through law, the combination of the drug manufacturers and other, the PBM itself, have contributed to those discounts. But most of that is delivered for, you know, generic value etc.. So there's full gap coverage even for prescription drugs, even for brand prescription drugs on the richer plan and just the full generic in the lower plan. So that's the among the biggest drivers.

In the prior version of this, you saw that there were there were five tiers (now there are four). Basically the additional tier was just something related to how they broke apart generic between some preferred generics and some just broader generics. Here, they're just bundled together, but what is different about this is that, where you'll see at the bottom of the page, where it says Retail 30 is, that's the full on 64 000, you know, retail pharmacy network. The preferred Retail 30 is a preferred network of pharmacies. Among the biggest, the biggest chain, that is not a participant in that preferred Retail 30 is Walgreens at, this juncture. But it's significantly smaller it's about t's about 28 000 as opposed to 64 000, but it has a lot of the bigger chains. And if you're able to do it, and *there* should be at least one in most significant communities, not every community, but it certainly in most urban areas and most suburbs as well, centers in rural settings. … There will be some gaps, but if you if you're able just to go to that preferred retail, you essentially get, you know, your generics for free and you get 10 bucks off of your preferred, non-preferred, brands and you get

about a 5% discount on preferred specialty. So it's worth taking advantage of and, you know, if you don't want to bother, you know, you're willing to spend X bucks and don't even look at it, doesn't matter, but that's the incentive. There's a little bit of an incentive to go to that preferred area. So all generics essentially covered it with zero copay and it's a pretty broad category of preferred brands that are available with either $5 or $15, depending whether you're in the preferred network or not, on the richer plan, and then the balance of them are at that $35 or $50, I forget, a 45$ level in the non-preferred network.

And then there is mail order available. … Ingenico is the name of their PBM and it's their mail-order facility that will do the mail order. And obviously, if you're taking a medication for a chronic 90-day prescription, let me have it filled there.

John: I'll go up to the Retail 30, preferred Retail 30. Yeah, is the preferred Retail 30 more the pharmacy chains and the Retail 30 like the groceries that offer pharmacy, is that the split between the two or the distinction?

Don: No, it's whether you've accepted the lower reimbursement level and you're in the network. And so, not picking on them, but Walgreens did not accept it so they're not part of the preferred network. But there are a bunch of *chains* that have accepted it, and I can send that to you. … And some are groceries like Albertsons, etc., but some, you know, big national funds big national pharmacies like CVS.

Connie: But any pharmacy will accept these rights, not just like the chain ones. Don asked her to repeat and she did: So you can take these prescriptions *to* a regular pharmacy, not to a chain place?

Don: Yeah, your local neighborhood pharmacy is fine as well.

Connie: Because i know that the wealth care dropped the pharmacy I was using and they just went with the chain, so I had to change.

John asked Don if he heard Connie and he concurred and added: The answer is in the in the broader network in the Retail 30 network just about anyone you can imagine is in there. I think there's 65,000 and change licensed unique pharmacies in the U.S. or some number like that, maybe it's *64K to 66K* are in. And it's not just Anthem, pretty much everyone has like the generic contract like that. I don't know if you you're dropping a specific one-off mom-and-pop type thing. I don't know what the reason would be for that. Maybe it's because they rejected a contract or something but typically they should be there.

Connie: Okay, thank you.

Don: No worries. He turned to talking about extra covered drugs: *They are a* drug and we did not include this. This is a non-prescription sort of drug or drugs that have very specific use. I'll say it that way, lifestyle drugs for example.

John: So blood pressure, diabetes, are you saying that?

Don: No, I think more like hair growth, vitamin supplements like anti-aging, that sort of stuff.

John: They don't work, I've been using them for years. That led to some more joking.

Don: We're doing 30-day limits for retail, 90 days for mail. Especially the supplies have their own limits. That's all it was anyway, that's the prescription drugs. And what I want to emphasize, something here …

John: Vision or hearing what's the difference between true out of pocket, regular out of pocket expense?

Don: There isn't any difference. True out of pocket means that you have spent out of your pocket $7,050. and that's just the level at which catastrophic coverage kicks in from Medicare and you continue to pay co-pays beyond that anyway so it's all integrated. it's actually more of a carrier effect, it's where they start getting reimbursed by Medicare.

John: All right, anybody got any questions on the medical or the prescription plans at this point? Certainly if we have them later, we can consolidate them or whatever and present them to Benistar for answers. I do have one, Don. When you get down to the bottom I mean in the small print, I call it. When you look at it in the original, it's really small, and there's some things that Ed and I or Ed will be explaining to you. There's some things that we want a more descriptive or separate sheet like evidence of coverage or indemnity statements or stuff that are kind of squashed into this thing. in certain ways, that we have brought up before and that is brought up from a legal standpoint that we want in the finished product.

Ed: Yeah, that's exactly right, and I mean the coverage bits, I think are fine. There's a little bit of the language we have to go over. I am going to circle back with both of you, with Don and with you, John, just to nail everything down and make sure that we're clear. I think some of this is written down from the standpoint of GERBS paying for certain members which was not the way that we understood this was going to work. But I'll point those out to you and we'll take care *it* from there.

John: … We need to understand how that's going to work out.

Ed: And is there going to be a separate evidence of coverage document that's going to be an addendum to the final agreement?

Don: Yes, and each person will get one, it's part of fulfillment as well.

Ed: Right, but there'll be like a sample that we'll see along with the execute agreement, okay? That's what I expect.

Don: It'll be like exhibit B or whatever. And there's actually one for each, not to be confusing. There's a separate pre-enrollment document, which we try not to mail but, you know, distribute electronically, which we'll share with you. It'll get built as soon as we're final on this. That's a beast, it's like everything you could possibly want to know about. It's like 160 pages.

Ed: Yeah, I can't wait to see it.

Don: It's just a Medicare required thing.

Ed: I know, I I've looked at them before. They are beasts and they're a pain in the neck to read.

Don: I think I remember what I wanted to say. There are two things I want to say about the prescription drug thing. The first is, and I had started this at the very beginning, talking about the fact that it will be the number one concern for almost all people as they consider whether they want to join: 'Is my drug covered and where is it covered?' And so I sent to Ed, but he can certainly share it with you. Just like a 2021 regular formulary that is available electronically and will be available to them to look up but can also be supported. They can call it the service center and if they have specific drugs, they can look them up. Tell them exactly what the copay is, how they can how they can get them. They can also offer them some support services in terms of what it might cost at a pharmacy and whether there's an alternative available. And the thing that I had forgotten, that I

wanted to emphasize is that because preferred specialty drugs, the average I think special, well, I think the base in order to be in the specialty category. I think it has to cost like $600 and I forget what the number is: $680 per month. So there's $680 and above. So, if you have a thousand-dollar drug, just as an example, per month, 28% of that's still 280 bucks. It's a lot a lot of money, so in areas like that, what's become more and more popular are a couple of things: first programs that help you get those drugs that are supported, not entirely, but in large part by manufacturers and they're means tested. So, for households under a hundred thousand dollars in income, oftentimes there are very robust programs for that. And so people before, they go and just write checks for that, should, you know, I should explore those sort of things. And the second thing is: there's a growing sort of group of bioequivalents that are driving down some of the costs for some of these more expensive preferred specialties but these are all the drugs that are that are run non-stop at like 10 o'clock at night if you're watching television, you know, it's like whatever is two generations after Humira … and they are three times the cost and for whatever reason, they figured out ways to, and I'm not saying that they aren't beneficial, of course, they are most cases, but they figured out how to get them in front of the buying public. So that even 75-year-olds walk in and go like: "Yeah, I'd like Loprexa.' Doctor's like how about we find out what's what the condition is first, before you go spending two thousand dollars a month. Anyway, so those sort of drugs that their support for that and I just wanted to highlight that as, well that'll be one of the biggest drivers I think in terms of decision making.

John: All right, so there's the document that I sent on to the board, we just reviewed it on the medical and the prescription and there's some legalities involved. One of those pages had a signature form or some sort, a small signature form. I assume this is once Ed and I review it and the board approves it, that we sign this thing and we're good to go, that'd be good. So I would expect just off the top of my head I would expect Ed, would you say a week we should have that done, to be able to have any reason?

Ed: For sure, within a week.

John: Okay, so that takes care of that piece on the agenda of things that we've got expectations timeline so we're saying in a week.

Mike: I have a question and a statement to make and I just want to make sure that you saw that in Don's email, right? He frequently stated that we're probably realistically looking at a January one start date because there's so much disruption trying to go off cycle to enroll people and break into the middle of their contract. *This* doesn't mean we can't start talking about it, marketing and getting the word out, right Don?

Don: Yes, I mean that's exactly it. We will in fact want to get the word out and whenever, but I think for 99% of people, they're not going to make any change until 1-1 and they'll make that decision because AEP starts whatever, October 15, …

John: The open enrollment you talking about?

Don: Yeah the annual election period start yes.

John: So you kind of jumped ahead and that's good, Mike, that, you know, again, the webinar. Whether you guys are going to pre-record or live. The specific of the marketing plan, which I think are pretty well set. Glen can speak to a lot of this and Mike, I think, all this is pretty well set for but when we're looking at it, we're talking about maybe getting into it a more intensive marketing-based website webinar middle of September, and then push that through a number of months, and

then move to kick off, actual kickoff or open enrollment, if you will, or enrollment period on January 1st. Does that sound right to Benistar, everybody? I mean I'm following Don and Glen's lead on that.

Mike: Once you give us full approval to go and we have the verbiage, we can add it onto the website. Paul is sitting waiting for us.

John: Yeah well, I understood in an email here that you guys have those pieces in place.

Mike: Pieces are in place, the final rates that we just went through with you and the verbiage didn't have that until you saw it we weren't going to share it with anyone else.

John: So you're saying none of this can happen? Well I understand it we have to review this legally approve it board approve it send it back signing agreement and then we move forward but I'm saying moving forward in this timeline these things that we all have discussed the webinar the marketing plan the actual kickoff date and you know I know we did this four times already and I don't want to do it again and then collapse again so you did say in the email you're looking you just said it Mike that we're looking at starting maybe and Don kind confirmed it started marketing in let's say the middle of September but no actual kickoff until January which gives us time to breathe and not interrupt other open enrollments or other concerns. But to your point, when can we start? Marketing, create webinars and create videos?

Mike: ASAP, you give us the green light, we can engage. Glen and I will interface with Paul. the balls in your court.

John: Oh yeah, okay.

Glen: Anyways, that timeframe is accurate and

Rodney: People will actually be enrolling prior to January 1st … they're all going to be behind the eight ball. They're all going to be already have enrolled so I'm trying to switch in January or whatnot. I don't know how that's going to work out.

Don: I don't know they'll make elections under this plan or under AEP and you can make, you know, in the individual market under AEP, you can make as many changes as you want prior to 1231. So this stuff will be out to them and they'll be able to make an election. And what happens is, if you make an election, let's say that you make an election on, I'm just making this up, on the seventh of October. Well, not so, let's say the 15th of October and it gets processed it goes into CMS. They pump it up against their file. It'll be a change of coverage or new coverage and it's your first time enrolling but I suspect that most of you change your coverage. they'll then send you out a confirmation of that change, so you as an individual benefit history will get a confirmation back saying you have enrolled in the MAPD Anthem, plan blah blah blah. And it will outline all of your rights and then, if you wake up, you know, and thanksgiving dinner and go like 'I lost my mind, what am I doing? I don't want this.' Just enrolled, no harm, no foul. And you can enroll in another plan and let's say you do that on the 27th of November, you get the same process and on the seventh of December, you wake up and you go 'Nah, it was just momentary madness, I want to go back in the plan.' You can do it and they'll enroll you back into the Anthem plan up until 1231. You know, for one, effective date thereafter you're correct, if you want to make a change there after there are some people that have some special rights to do that and for our purposes it's a little bit different than the individual market, you could allow someone to enroll on February 1 if you wanted. So in a group plan, you are not you're not constricted by the AEP election period. And anytime someone disenrolls so if they wake up in March and go like 'I'm sick of this those knuckleheads over at

Anthem are horrible I'm going to, you know X Y Z plan.' They're allowed to do that, they disenroll from Anthem it automatically opens a special enrollment period. That's one of the beautiful things about coming out of group automatically opens it for them. They can enroll in any individual plan at that juncture for the following …

John: One right we thought that was one of the, Rodney, the saleable points about this being a group versus individual market that you could move back and forth or enroll or at different dates, not just during the open enrollment. We thought that was absolutely one of the better benefits, because … Okay you know I hate us, I understand your concern. I hate us missing the open enrollment period and let people get out then and then they say 'I don't want to change', I understand that, you know?

Don: But underscoring what Rodney was saying, it is better that they enroll during AEP if they can, I mean they make an election during that period. It's how they're trained to think, you know? You might as well emphasize and be ready for them to enroll during that period.

Glen: Okay, so to be clear, that's what we're saying that people will enroll during the CMS enrollment period this fall into our plans. It's just that they become effective January 1.

Ed: Okay, that's what I understood okay now. That makes sense, yes.

Glen: We're in the middle of everything going on in the Medicare world right now to have them be edited, ask questions, learn all about it and actually make an election this fall as they would in the individual market so we're playing right to the normalcy of the seasonality of what the traditional cycle is, okay?

John: That sounds good then, yeah, and I think Rodney's right about that concern and I think that was a good answer that we can have him come in previous to January 1st, obviously.

Mike excused himself, about 12:40, promising to follow up with the paperwork. There was a transition time before the meeting started up again.

John: All right, so anybody got any questions? I think we've fulfilled our expectations and our timeline and expectations of where we want to be, and where we're going. You and I got work to do and then final revisions. And then we whatever we end up in Benistar and Anthem in agreement, then we, ask the board for approval and we sign off, okay? And then we launch the marketing efforts and all the other stuff, right? Okay that makes sense, all right, very good everybody. Thank you, thanks guys. Rodney made motion to end the meeting and Connie seconded, all in favor. The meeting was an hour and 43 minutes.