**GROUP BENEFITS PLAN CHANGES**

As approved by the General Council Executive, the following changes will take effect on January 1, 2022:



## DECISION TO CLOSE OPTIONAL PLAN

**Why is the Optional plan being discontinued?**

It is estimated that in 2021, the plans will incur a $2.4 million deficit for which we are running out of reserve funds to cover. This deficit is primarily from the active member optional health and dental plans and from the retiree health and dental plans. The current deficit, and those in earlier years, fueled by drug inflation that is considerably higher than the general cost of living index, increased costs of health and dental service, and an aging membership in the plans, as well as a shrinking employer base, have been covered by draws from the reserves accumulated by the plans in much earlier times. **The reserve funds are projected to be depleted before 2024 in the absence of significant changes to the plan and/or its rates.**

Last year, members said further dramatic premium increases were unaffordable. Optional plan members (~40% of total membership) are currently covered for the Core benefits which are paid for by their employer. People who are using the Optional plan to the fullest extent is being subsidized by those who may not be able to afford it.

In 2020, the General Council Executive directed a full actuarial review of the active member plans. Benefits consultants and actuaries worked with staff for a year and an advisory group, made up of a member of the Executive, a retired UCC minister with a previous life in the insurance industry, and VP risk management and pricing with a large insurer, reviewed the options and refined the recommendations. The recommendation of the advisory group was that the Optional health and dental plan be discontinued effective January 1, 2022. Reluctantly, the Executive agreed with this recommendation to discontinue the Optional plan.

**Why weren't members consulted?**

A year ago, Nora Sanders, then the General Secretary, advised members in a letter that both active employee and ministry personnel and retiree group health and dental plans were under enormous pressure. Collectively they were reimbursing members $2.4 million more in benefits than the premiums were covering. The deficit was being covered by a quickly shrinking benefits reserve fund. Staff has been raising concern for years and this concern has been communicated to you.

The Executive of the General Council directed staff to undertake a thorough forensic review of the plans with the aid of professional benefits consultants and actuaries and to consider changes, including the

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prospect of discontinuing the Optional plan, that would lead to both sustainability and affordability while protecting you and your family from extraordinary economic loss because of medical, dental or disability expenses.

Currently all employees and ministers working 14 hours or more are covered by a core set of benefits paid for by the employer. About 40% of our plan members elected to supplement these benefits with the Optional health and dental plan. Last year the premium for this optional benefit increased 50%. This increase did not eliminate the deficit but only stemmed the draw on reserves. **You responded clearly that such continued increases are not affordable for you**.

**Since I won't have the Optional plan, can I buy secondary insurance to cover expenses not covered under the new Active Plan?**

Yes. With the move to a single **employer** paid plan, there are enhancements to the current core plan but there are, also, adjustments to the co-payments and maximums that those in the optional plan have been used to. Not paying the optional premium will free some financial resources for you to top up our service provision.

**How much will I have to pay per month for the new Active plan?**

Nothing. The new Active Plan is an **employer** paid plan. There will no longer be a premium charged to the insured member as the entire premium for the new Active Plan life, short term disability as well as for health and dental benefits will be **payable by the employer**. That being said, long-term disability premiums and optional life, optional spousal life, and optional AD&D will still be a responsibility of the insured member. The 2021 rates are posted on the Pension and Benefits Deduction page. The 2022 rates will be posted closer to the end of the year. For preliminary rates, please visit the United Church website and search "Budgeting Tools for Treasurers".

**Do I have to participate in the new Active Plan?**

Yes, enrollment in the new Active plan is mandatory for all employees and ministers working 14 hours or more a week as it is something your employer pays for. Upon retirement, if eligible, you will have the option of joining or not joining the Retiree health plan. Once you have joined**, you cannot opt out at a later date**. Qualifying "Life events" provide an opportunity to change status and add/remove dependants (family/single). For more information, please visit the FAQ page, under Group Benefits, Opting Out.

**I didn't receive the email about these changes.**

Please visit the Benefits Centre website and sign up for our mailing list to ensure we have your correct email address on file for future mailings. A sign-up pop up will appear when you first visit, and you can also sign up from the newsroom.

## DRUG PLAN

**What is a managed formulary?**

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To ensure value for dollars spent, all drugs newly approved in the Canadian market are evaluated by a GSC committee of pharmacy experts before being added to the formulary for reimbursement. Drugs are assigned to one of three categories: "covered," "not covered," or "prior authorization required."

- ***Covered*** drugs are full benefits of the plan.
    - Approved unconditionally as a covered benefit
    - Plan member has open access to benefits
- A small subset of drugs is assigned a ***not covered*** status when the drugs provide no additional value over those already listed in the formulary.
    - Does not present significant therapeutic or cost advantages when compared to existing alternatives
    - Plan member can pay the full drug cost or consult their prescribing physician regarding alternatives
- ***Prior authorization*** required is assigned to drugs for which "step therapy" can be applied and to non-high-cost drugs that offer value only when used for patients with certain clinical characteristics.
    - Considered a second-line therapy, with high potential for misuse and/or prescribed to treat unapproved conditions
    - Plan member must meet specific criteria to access benefits; first-line therapy must appear in claims history for auto-approval and/or the prescribing physician completes a special authorization form indicating therapeutic need.

And, as with the open formulary, a prior authorization required status is also assigned to high-cost and/or specialty drugs with potential for inappropriate prescribing and use. This type of formulary "management" balances the need of plan members to have access to medically necessary drug therapies with plan sustainability.

**Who manages the managed formulary?**

Green Shield Canada (GSC). Managed formularies are often used by provincial drug plans to manage costs effectively. For example, the Ontario Drug Benefit (ODB) Program, the plan for seniors over 65, is a managed formulary.

**I am currently taking "x" drug. Will it be covered under the new Active Plan?**

The new changes around drug claims **will not apply to your existing prescriptions**. Starting on January 1, 2022, any new drug you are prescribed will be subject to the "managed formulary" criteria.

**How do I know if a drug will be covered?**

Effective January 1, 2022, you will be able to check the Plan Member Online tool, offered by Green Shield Canada, to find out if your drug is covered, or will need prior authorization. It can be found under the "Your Health Benefits" heading, then select the "Drug" tile. You'll be able to find out:

- whether a drug is covered under your drug plan
- if you will need to pay a copayment (and if so, how much)
- if the drug needs a physician's authorization (and if so, whether your doctor can print the authorization form directly)

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Enter the name or DIN number of your drug, then select who the drug is for on your plan.

*A few tips*

- Drug Name: you must enter at least the first three letters of the drug name. For example, if you enter “Tyl” for Tylenol, then all drug names that begin with “Tyl” will be displayed.
- DIN: to search by DIN, the full DIN must be entered for the search tool to display the drug.
- Select Participant: some drugs have use restrictions based on things like your age. This is why the tool will ask who the drug is for under your plan.

To access the tool, you will have to register for an account with Green Shield Canada (GSC) everywhere. If you had an account on the previous site, you can log in with **exactly the same username and password you used**. If you haven’t registered, here is a video guide that can walk you through the registration process.

You can also call in to the call centre and check with an agent. 1-888-711-1119

**If there is no generic form, or the patient can't take the generic form, will the plan cover the cost of the non-generic, or at least a portion of the non-generic up to the cost of the generic?**

Under the managed formulary, it is possible for both the generic and brand name drugs to be listed. Assuming both the generic and the brand name drugs are on the formulary, the rules for generic substitution would apply as they do today, namely, if a brand-name drug is prescribed when there is a generic (or lower-cost) equivalent available, coverage will be based on the lower-cost drug unless your doctor specifies that the brand-name drug is required.

We encourage you to discuss generic alternatives with your doctor, as cost differences can be significant.

For a drug that is in the “prior authorization” category, the use of a recognized first-line drug is required before approval of a more complex second-line drug is given. Plan member must meet specific criteria to access benefits; first-line therapy must appear in claims history in order for the drug to be auto-approved. Otherwise, the prescribing physician must complete a special authorization form indicating therapeutic need.

**If a doctor prescribes a medication, could the insurance company reject it because they believe something else would work better?**

Yes, they may. A pharmacist always has the authority to review and substitute. This is not a new provision.

At Green Shield, drugs are reviewed by a committee of pharmacy experts to establish the overall value of each drug and determine where it should be placed on our formularies. Their criteria, based on objective medical evidence, evaluates the drug’s clinical efficacy, safety, and the unmet need it fulfills to establish the value it offers to plan sponsors and plan members. The committee reviews drug submissions from manufacturers including clinical trials and other available evidence. The six pharmacists on the committee cover a range of experience and expertise:

- Community pharmacy, including compounding
- Hospital pharmacy

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- Specialty care, including oncology and transplant
- Public payor
- Pharma industry
- Quebec market

Plus, there's a nurse with clinical and health care navigation experience on the committee, and a committee member with a PhD in health policy.

**What is out-of-pocket maximum?**

Out-of-pocket maximum is the most you have to pay for covered services in a plan year. Once a member has paid that amount in deductibles and co-insurance in a calendar year, eligible expenses will be reimbursed 100%, subject to plan maximums. Effective January 1, 2022, the out-of-pocket maximum would be set to $1,000 in a calendar year and would apply to drugs ONLY.

## VISION CARE

**What are the limitations on vision coverage?**

There is a division between optometry and ophthalmology, separate professions offer separate services, which led to the development of separate payment policies. For the vision coverage, which includes the services of an optometrist as well as glasses/corrective lenses, this plan provides a reasonable and adequate coverage based on the industry standards ($100 per person per 24 months).

If you are interested, please visit https://www.greenshield.ca/en-ca/getting-started/discounts for some discounts for Green Shield members that are applicable to our membership.

## PARAMEDICAL COVERAGE

**Why is the maximum combined for some paramedical practitioners?**

In order to contain costs, some paramedical practitioner services have been pooled for a single maximum. Highest paid paramedical practitioner claims include massage therapist, physiotherapist, and chiropractor.

**I use a lot of paramedical coverage, how am I affected?**

Effective January 1, 2022, you will be limited to an annual maximum of $500 combined for such practitioners as acupuncturist, chiropractor, massage therapist, naturopath, and osteopath. Furthermore, the out-of-pocket maximum provision currently applicable to drug and health claims combined, going forward will apply to drug claims only. As a result, any health expenses (such as paramedical services) in excess of coverage volumes would not factor into the "out of pocket" maximum calculation and would be at the member's expense.

**Will a doctor's note be needed for massage therapy/physiotherapy/chiropractor/etc.?**

No, it will not be required.

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**What mental health practitioners are covered?**

Prior to this change, the coverage was limited to the diagnosis, assessment, and treatment provided by a fully qualified, registered, legally practising Psychologist or Master of Social Work (MSW). Services of a "digital therapist", provided specifically through Mind Beacon for Internet-based Cognitive Behavioural Therapy were also covered. Effective January 1, 2022, in addition to the above-listed therapists, the coverage will be extended to Counsellor, Psychotherapist, and Psychoanalyst.

**Is the doctor's note required for mental health coverage?**

The doctor's note will no longer be required, effective January 1, 2022.

## DENTAL

**Is the $1,500 annual maximum per person or per family?**

The $1,500 annual maximum is for **each** eligible family member - Preventative Service, Basic Services, and Major Services combined.

**Are Orthodontic services covered?**

Orthodontics are not covered by the existing Core plan and will not be covered going forward, under the new Active plan.

However, Green Shield Canada members, even those without orthodontic coverage are eligible for a discounted rate with SmileDirectClub (SDC). SDC allows you to receive virtual orthodontic treatment from a licensed dentist or orthodontist from the comfort of home. If you are interested, please visit https://www.greenshield.ca/en-ca/the-digital-clinic/oral-health

## MEDICAL DURABLE DEVICES

**What about coverage for hearing aids, or CPAP machines? Will that still be covered under the new Active Plan?**

The changes to the new Active Plan are in the comparison chart on the Benefits Centre website on the Group Benefits page, under Life, Health & Dental, Disability Benefits. If it is **not** listed in the comparison chart (ex. hearing aids), then **coverage under the current Core plan will be what is covered under the new Active Plan**. Please refer to the Benefits for Active Members – Summary of Coverage booklet, in the Document Library, under Benefits Administration, for a list of all Health Benefits.

## EMPLOYER PREMIUM INCREASE / FUNDING

**When do the 19.5% increases for employers end?**

The current projection is a 19.5% increase in 2022 and approximately 15% in 2023. From that time onwards, only trend increases, estimated at approximately 6% going forward.

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**Would an equivalent plan in the private sector be more expensive?**

Yes. The market study done on pensioner plan indicated that any private coverage that provides similar value (level of co-pay and maximums) is more expensive than a group one. Also, under the private coverage, the premium rates grow based on the insurer's book of business, whereas in the group setting, the premium rates grow based on group's experience.

**Could the sale of church property be used to subsidize the fund? Or those most in need?**

Yes, but those funds are disbursed by the community of faith and Regional Council. The proceeds of sales **are not assets of the General Council to allocate** (other than property directly owned by the General Council, which is not much compared to what is held by congregational trustees). Local congregations, in cooperation with the Regional Council, decide on the disbursement of property proceeds. There are many requests on the proceeds, resulting in making it unlikely that a reserve, generating at least $1 million dollars a year, could be secured.

## OTHER CHANGES

**Does this impact optional life insurance and AD&D?**

No. This change does not impact these optional coverages.

**Does this impact members who are going through gender transition?**

No. It does not. There, however, changes to the administration of the benefit. Effective June 30, 2021, Green Shield has agreed to include a gender affirmation offering as a standard benefit in all Group plans that provide extended health services coverage in their book of business. We have transitioned over to their standard platform while maintaining our existing coverage. Administrative steps on how to apply and claim have changed (now entirely through Green Shield), but the coverage for members who are going through gender transition remains the same.

**What effect does this have on the Retiree Health and Dental benefits?**

The retiree plan is separate from the active member plans and is not affected by the closing of the Optional plan.

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