

Olympia CUSD #16 Health Benefit Plan Frequently Asked Questions

Last Updated: October 2011

Medical Insurance Questions

Wellness:

1. Does every employee on the Insurance Plan receive the \$400 wellness, regardless of what option they selected (like Dental and Vision)?

No...only employees covered under the Major Medical or Supplemental Plans receive the wellness benefits. However, when the Olympia Health Plan sponsors and pays for benefit events, all those who are participating in the Plan may attend.

2. If an employee has spent \$350 of their wellness dollars and they go to have routine blood work. They only have \$50 left and the bill is \$125. Wellness will cover \$50 and the employee will cover the remaining \$75. Does the remaining \$75 go toward their deductible that year?

Yes. Due to changes for Federal Health Care Reform, effective September 1, 2011, the additional amounts over the wellness dollars will apply the deductible and then the applicable co-insurance.

3. The blood draw the District is sponsoring says that "Available to all Employees on the Insurance Plan and those members covered under the Family Plan 18 years and older". Does this mean my son, daughter and spouse over 18 can attend the draw even if I am on Dental and Vision? What if I am on single coverage and I purchased the Add On Family Dental/Vision?

No, the District only offers the blood draw to those eligible medical plan member 18 year or older, to attend. If you are not covered by the medical plan, you are not eligible. (For example, the screening would not pertain to the spouse of a teacher who is on single coverage. The screening would pertain to the spouse if the teacher was on family coverage).

4. My doctor and I have discussed routine colonoscopies. What are the steps to determine if I am eligible for the benefit?

As always, the discussion needs to begin with your physician. If the member is under the age of 50, the member would need to have their physician send in information as to why the member would need a routine

colonoscopy. This information would need to be sent to HCH (to the attention of Medical Affairs). The HCH Medical Affairs Department would then do a pre-determination to see if the member would qualify for a routine colonoscopy. Once the decision is made by the HCH Medical Affairs Department, the information would be sent back to the member's physician for review.

If the member is age 50 or older, the plan will cover one routine colonoscopy every 10 years.

If a member needs a colonoscopy due to symptoms they are having, the colonoscopy would be considered diagnostic and paid under the Plan accordingly.

If there is ever any question about how a colonoscopy service would be covered (routine or diagnostic), please contact HCH Administration PRIOR to having the procedure performed.

5. How do the new Federal Health Care Reform Mandates affect the Wellness Coverage?

1. *Effective September 1, 2011, the plan will cover wellness at the following:*
 - i. *The first \$400 for 16 and older or the first \$200 for members under 16 will be paid at 100%. Any amounts over the 100% coverage will apply to the member's deductible and then applicable co-insurance.*

6. What can be applied to the \$400 wellness benefit for members 16 and older?

For members 16 and older, the Wellness benefit covers physician examinations and related testing except as limited by the plan. One routine pap smear, clinical breast exam at least every year, prostate specific antigen testing, digital rectal exam and expenses incurred for bone mass measurement and the diagnosis and treatment of osteoporosis. The wellness benefit is per calendar year.

7. Are routine hearing exams covered under the major medical plan?

Effective September 1, 2009, routine hearing exams are now covered under the Major Medical plan. The plan will cover one routine hearing exam per calendar year at the same level as an office visit (\$20 co-pay) for members under the major medical plan ages 19 and older. This is for in-network audiologists only. To find an audiologist in the network, please go to www.hchadmin.com or call HCH at (800) 447-3227.

Deductibles and Out of Pocket Maximums:

1. What are the deductible levels?
 - a. Single Deductible for PPO and Non PPO: \$500 per calendar year
 - b. Employee + 1 for PPO and Non PPO: \$1,000 per calendar year
 - c. Family for PPO and Non PPO: \$1,500 per calendar year
2. Do I have to satisfy my deductible before the plan pays on my claims?

Yes, unless otherwise stated as the deductible being waived, the member must satisfy the deductible before the plan will pay any portion of the medical claims. If a member ever has questions about how much of their deductible has been satisfied or needs to be satisfied, please call HCH Customer Service at (800) 447-3227.

3. When does the deductible begin and end?

The deductible runs on a calendar year basis. It begins January 1st and ends December 31st.

4. What are the out of pocket maximum levels per calendar year?

Please note—the below dollar amounts INCLUDE the deductible

- a. Single
PPO: \$1,000 Non PPO: \$2,000
- b. Employee + 1
PPO: \$2,000 Non PPO: \$6,000
- c. Family-
PPO: \$3,000 Non PPO: \$6,000

5. When the plan says \$1,000 out of pocket, is that \$1,000 total for the whole year or is that \$1,000 per incident?

Per Calendar Year, the plan has a \$1,000 out of pocket maximum for single (including the deductible), \$2,000 for employee + 1 (including the deductible) and 3,000 for family (including the deductible). Each person must meet the deductible and out of pocket. It is not a combination of amounts from the individuals in the family.

6. When does the plan pay my claims at 100%?

The plan pays a member's claims at 100% when the member meets their deductible and out of pocket maximum. In the case of a member with single coverage, the member would need to meet the \$500 deductible and then an additional \$500 to satisfy the out of pocket maximum.

Dental/Orthodontic Benefits:

1. What Dentists are in the network? Can we go to any?

Members may go to any dentist they wish. Dentists are not part of the PPO network.

2. What are the Dental and Orthodontic Benefits?

- a. Dental
- b. Orthodontia

3. Why are dental benefits paid at 70/30, 80/20 or 90/10? Shouldn't they be paid at 100% until I exceed the benefit level?

The benefit level and the amount that is paid on the specific dental benefits, is determined by the plan. These levels and benefits available are listed in the plan document.

4. What is my out of pocket limit on dental? Does it depend on which plan? What is it for each plan?

There is no out of pocket maximum on the dental benefits. There is a calendar year maximum of benefits paid by the plan. That maximum is \$1,500 per calendar year.

5. What is considered preventative for dental?

Routine oral exams, cleanings, bitewing x-rays, and fluoride treatments (to age 19) twice in a calendar year. Full moth x-rays once in a consecutive twenty four month (24) period.

6. If a child covered under the Dental/Vision Family Plan has x-rays and it's determined that orthodontic braces are needed, what would be covered under the Dental/Vision plan?

X-rays as part of the normal exam from the dentist will be covered as specified in the plan. Brace work would be covered as specified in the plan, but x-rays performed by an orthodontist would not be covered.

Vision Benefits:

1. What optometrists are in the network? Can we go to any?

For routine eye care, member may go to any optometrist they wish. There is not a network for routine eye care.

For a medical condition of the eye (conjunctivitis, cataracts, etc.) members must contact their PPO network to find out which ophthalmologists are in the network.

Prescription Drugs:

1. How do we know what drugs are generic and which drugs are not? Is there a list that can be published?

Members can go to the Catalyst Rx Website www.catalystrx.com and look up all the generic drugs. We also have small handouts of the formulary lists that can be sent to members.

2. If I have questions about Catalyst and co-pays, who do I contact?

Members can contact Catalyst Customer Service at (800) 997-3784.

3. Please outline the process (steps) for prescriptions from beginning to end, including communication with Catalyst.

An employee should present their ID card to the pharmacist when filling a prescription.

The pharmacist will then process the prescription through Catalyst.

The employee will pay the co-pay depending on the type of prescription filled (i.e., generic or brand).

If questions arise, the member can call Catalyst Customer Service at (800) 997-3784. The member will need to have their ID card available when they call.

Members can also go to the Catalyst web-site www.catalystrx.com and register for an account. This will allow members to see the set up of their benefits plan, co-pays, pharmacies and mail order information. Members can also set up a personal account, which will allow them to view prescriptions filled.

PPO Network:

1. How do I find a doctor or facility in our PPO?

All members covered under the Major Medical and Supplemental Plan will use the Health Alliance Network. To find a physician, please visit www.hchadmin.com, select PPO Networks and Providers, then select Health Alliance.

2. If my child is in college and attends college far away from our coverage area (and on the Olympia Insurance Plan), how do they get medical coverage from in-network doctors?

Health Alliance does have providers throughout Illinois and in parts of Iowa. The plan does cover Non-PPO doctors at the PPO rate if no PPO doctor is available. Members also have access to the HealthLink Network when they are outside of Illinois or in the Chicago area for Emergency Care.

3. If Bromenn is considered in-network, why are some doctors in the facility out of network? How can we ensure that our employees that go to Bromenn Healthpoint to get in-network discounts get the doctors that are actually in the network?

Not all doctors that have privileges at Bromenn have contracts with the PPO network. If a person doesn't have a choice (say ER visit), the plan does cover those situations at the PPO rate, if necessary.

4. If I go to an out of network doctor, how much does the insurance plan cover?

After the member's deductible has been satisfied, the plan will pay 70% of the allowed charges. Out of network is 70/30 with 70% being paid by the plan (after deductible) and 30% being the employee responsibility.

5. If I am at a PPO Facility and I need a procedure they can't do, can I go to a Non-PPO facility and have it covered?

Situations such as this that are non-emergency would need to be reviewed by the HCH Medical Affairs Department. If the procedure truly isn't available at any PPO facility in the area, HCH Medical Affairs will determine whether or not the procedure should be paid at the in-network rate. Any emergency situation should be handled as need at the time. Any questions on coverage should be directed to HCH Administration.

Miscellaneous Questions:

1. If there are questions on the plan, who should be called?

Members can call HCH Administration at (800) 447-3227. Members can also contact Andrew Wise (Business Manager) at extension 1114 or any Insurance Committee member.

2. When will new sign-ups receive their insurance card and HCH On-line passwords?

Usually 7-10 business days.

3. If I did not receive my insurance or Rx card, who should I contact? If I did not receive or misplaced my cards, who should I contact? If I need a new card, who should I contact?

Please contact Kathy Kendrick at extension 1129 or HCH Customer Service at (800) 447-3227.

4. When I lose my login and password for HCH On-line, who should I contact?

Please contact HCH Customer Service at (800) 447-3227.

5. Can teachers not interested in any of the insurance plans opt out of enrollment?

No, teachers have to participate in one of the four insurance plans offered as per their negotiated agreement.

6. At age 65, does the district have to offer a supplemental plan for those that are Medicare qualified?

No. There are over 300 private carriers' available offering supplemental plans.

7. If a dependent child in our health plan turns 26 (or 30 if military vet) or married before turning 26 (or 30 if military vet) is coverage terminated at the end of the month?

No, termination from the plan is on the day of the 26th (or 30th if military vet) birthday. Coverage can be continued under COBRA if no other insurance is available for 18 months. Contact HCH Administration if you have a dependent approaching one of these events.

8. What is the \$1,000 reduction in benefits?

The \$1,000 reduction in benefits is for non-notification of a non-emergency, hospital inpatient admission or emergency admission. You must notify HCH Administration prior to a non-emergency, hospital in-patient admission or within 2 days after an emergency admission to avoid the \$1,000 reduction of benefits.

9. What is the deadline for filing claims?

Claims must be filed within 180 days after the end of the calendar year in which they are incurred.

10. Are there claim forms that need to be filled out to get a bill paid?

No, there are not claim forms that need to be filled out. Send the bill with your name, social security number and OLY16 on it to the address on your enrollment card.

Health Care Reform:

1. When do the changes that were passed in the Health Care Reform Bill go into effect for Olympia's Health Plan?

Changes for Federal Health Care Reform went into effect on September 1, 2011.

2. What are the changes we will see next year?

Please note that some of the parts of the Health Care Reform Bill are still being defined. Many of the plan changes for Health Care Reform have already been implemented due to Illinois Mandated Coverage.

3. Where can I find more information on Health Care Reform?

*Members can get more information by going to the following web-site:
www.healthcare.gov*