

## FAQ

**Q. Will co-pays now roll into my deductible?**

A. No, co-pays will roll into out-of-pocket maximums. They do not apply to the deductible.

**Q. What happens if I've met my current deductible? Will I have to start over beginning April 1? A.**

No. Any amount of your deductible that you've satisfied before April 1 will roll into your new deductible requirement. Any out-of-pocket maximums that have been reached before April 1 will also roll into the new plan year.

**Q. What happens with my deductible if I see mostly in-network doctors and just one out-of-network doctor?**

A. In- and out-of-network deductibles do not cross over. If you are seeing an out-of-network provider, the out-of-network deductible will be assessed separately from your in-network deductible.

**Q. What if I go to an in-network emergency room and an out-of-network doctor is on duty?**

A. If you are at an in-network facility, your claim will be adjusted to reflect as an in-network claim up to usual, reasonable and customary charges.

**Q. What if I'm having surgery at an in-network facility by an in-network surgeon and the anesthesiologist is out-of-network?**

A. Your claim will be adjusted to reflect an in-network claim up to usual, reasonable and customary charges.

**Q. What are access fees and how do they apply to out-of-pocket maximums?**

A. Access fees are associated with ER visits. They do not roll up to out-of-pocket maximums. If you are admitted to the hospital from the ER, your access fee will be applied to your deductible and coinsurance. If you go to the ER for an issue that is not considered a true emergency (non-life or limb threatening emergency), you will be charged the \$200 access fee and the charges incurred in the ER will apply to your deductible and coinsurance.

**Q. If I go to the ER and I'm admitted, what happens to my \$200 access fee?**

A. If you are admitted into the hospital, your access fee payment will roll into your deductible and cost share (coinsurance) amount of your hospital stay.

**Q. What/Who determines if my ER visit is a true emergency or not?**

A. Medical emergencies have specific diagnostic codes associated with them. When the provider bills the plan, the codes on the claim will indicate the appropriate code related to your circumstance which will determine how the claim is paid.

**Q. What happens if my doctor or Teladoc provider tells me to go to the ER and my visit is not coded as an emergency?**

A. If a Teladoc provider or other physician elevates your situation to an ER visit, there will be documentation on file with that physician. That information may be required for the claim to be processed correctly, at which point assistance can be provided by TML or the City's Human Resources Benefits team.

**Q. Are biometric screenings required for all employees?**

A. Employees are encouraged to participate in biometric screenings. Employees who participate will qualify for the reduced WellLife rate. To be eligible, the biometric screening must be completed by September 1, 2014. Employees not completing the screening will pay the non-participation rate effective October 1, 2014.

**Q. Are covered spouses required to participate in biometric screenings to receive the discounted premium?**

A. Covered spouses are encouraged to have an annual physical or biometric screening, however, it is not required to be eligible for the WellLife Rate.

**Q. Does the City receive individual employee biometric screening results?**

A. No, the City does not receive individual results from screenings. To protect your privacy, the City is engaging an independent third party firm to conduct onsite screenings. The City will receive the following information:

1. A list detailing which employees participated in the screening and are eligible to continue on the WellLife Rate and
2. The aggregated results for the entire city employee group.

NO INDIVIDUAL RESULTS WILL BE SHARED WITH THE CITY. The screening company will do nothing more with this information. This is protected health information subject to the HIPAA privacy regulations. This information will be used by the City to identify appropriate education, programs, tools and resources based on the health risks of our population and to support and encourage employees to be better engaged in their health.

**Q. Will the mobile screenings be available to all shifts and locations?**

A. No. While every effort will be made to accommodate as many shifts and locations as possible with mobile assessment screenings, not every shift, location or employee will necessarily be reached with mobile opportunities. Personal physicians may become a more viable option for these unique circumstances.

**Q. Will participation in Health Check be enough to get the WellLife benefit?**

A. No. Health Check through CTMC is still available to employees who want to participate. However, Health Check participation will not satisfy the requirement for the WellLife reduced premium. Only biometric screenings provided by the medical screening services firm or obtained from your personal physician with completion of provided forms will qualify you for the WellLife rate.

**Q. Will the medical screening services form adhere to privacy rules and regulations?**

A. Yes, it's the law. HIPAA laws prohibit disclosure of an individual's protected health information (PHI). Individual results are not disclosed to the City due to patient confidentiality.

**Q. Will we be doing biometric screenings each year?**

A. Yes. An annual screening is a benchmark on the day it is done. Our health changes and must be re-evaluated on an ongoing basis.

**Q. Can my health screening results stay with my doctor instead of being forwarded to the medical screening firm?**

A. No, not if you want to receive the WellLife reduced premium.

**Q. Can the results of my biometric screenings be shared with my personal doctor?**

A. Yes. You will receive an individualized printed report of your results that you can forward to your doctor.

**Q. When can we begin doing our biometric screenings?**

A. More information on the biometric screenings and the specific medical screening firm will be provided during open enrollment. Employee communication will be provided as onsite screening opportunities are scheduled.

**Q. Will there be one big biometric screening or will there be opportunity for multiple site screenings?**

A. Yes. There will be more than one opportunity to participate in onsite biometric screenings. Information on screening opportunities including locations, dates and times will be provided to employees in advance.

**Q. Will there be a standardized form to take to my physician? What do I do with the completed form?**

A. Yes. There will be a standardized form provided through the medical health screening firm. If you choose to have your biometrics done with your physician, he/she will need to complete the provided form. You will then need to forward your completed form to the health screening firm within the required timeframe.

**Q. Can my specialist provider complete the biometric screening?**

A. Yes. If you are receiving ongoing care from a specialist, the forms that will be provided by the medical screening firm can be completed by your in-network specialist.

**Q. What impact does National Health Care have on our cost increases and plan designs?**

A. Changes to our plan resulting from National Healthcare have been extensive. Your benefits have been expanded in a variety of ways such as wellness benefits, removing dollar caps on benefits including lifetime maximums and expansion of coverage to children up to age 26. These changes have increased claims costs for the plan, as well as the cost of excess or stop loss insurance. This year the Health Care Act removes pre-existing condition limitations for new employees or newly enrolled dependents. Additionally, this year we will be subject to two mandated fees which will apply to each individual covered by our plan. The first is a Transitional Reinsurance fee of \$63.00 and the second is a fee to fund the Patient Centered Outcome Research Initiative (PCORI) of \$2.00. Based on our current enrollment, the increased cost to our plan will be \$80,000 next plan year.

**Q. Is our plan in jeopardy of not meeting government requirements under Health Care Reform Health?**

A. No. Since its inception, our plan has responded to the mandates required by National Health Care by changing benefit designs, plan language and provisions required in the Act. Each plan year we evaluate new requirements and receive guidance from Health Care Reform experts that enable us to continue offering a viable health plan to employees.

**Q. Can I shop on Health Care Reform's marketplace website to possibly find a different plan and get a subsidy?**

A. While you are certainly able to shop the market at the government's website, under Health Care Reform rules, you and your eligible dependents are not eligible for a subsidy if you have access to an employer's health plan.

**Q. What future changes can we expect with increases and benefit design changes?**

A. Healthcare is constantly changing, and more so now than ever with National Healthcare. As a result, it is not possible to know what the future looks like. However, every effort will be made to minimize changes and to maximize communication when changes are necessary.

**Q. Are there different rate tiers now for families with more or less children?**

A. No, rate tier structures are not changing this plan year. The Employee/Child(ren) and Employee/Family Tier provides coverage for all eligible children.

**Q. What amount of funding is the City chipping in on the increased Plan cost?**

A. The City is funding an additional \$85 per employee for the new plan year, while employees are contributing an additional \$22.50 each month.

**Q. Is there a fee to the employee to use the concierge service?**

A. No. The employee using the service will not incur an expense. The service will provide more information than we've had available in the past on both the quality of a provider and the cost of services which will allow you to make informed decisions. We anticipate that the savings will far exceed the cost of the service and provide additional services to you.

**Q. If I am not making any changes to my benefits this year will I need to do online enrollment?**

A. Yes. All employees are required to not only complete online enrollment, but attend Open Enrollment education sessions as a part of the open enrollment process this year. A complete schedule of education sessions will be made available to all employees, as well as instructions and a link to the online enrollment system. This year's online enrollment will also contain eligibility information and require an acknowledgment that every covered dependent is eligible for coverage.

**Q. Will I be required to provide my marriage license during open enrollment to provide that my wife is eligible to be on my plan?**

A. No, not this year. During open enrollment, employees will be required to acknowledge and verify the eligibility of their covered dependents in the process of online enrollment. Next year, the City anticipates a complete eligibility audit that will require marriage licenses, birth certificates and other legal documents related to the coverage of your eligible dependents so it is a good idea to begin gathering the information now in preparation for this process. New hires will be required to provide documentation of eligibility at initial enrollment moving forward.

**Q. Will the new concierge service be able to provide information on the best places to buy prescriptions?**

A. Yes. In addition, you can currently access Restat's website through a link found on [www.tmliebp.org](http://www.tmliebp.org). Using this tool you can see the cost of a prescription to you, to the City, the availability of the drug at specific pharmacies, generic alternatives, etc.

**Q. Where can I locate information about benefit changes and open enrollment to share with my spouse?**

A. All benefit change information and open enrollment material will be housed on the City's internet site at [www.sanmarcostx.gov](http://www.sanmarcostx.gov) under the Human Resources department tab. Spouses are also welcome to attend open enrollment education sessions and/or City Manager employee meetings that are currently being conducted to share information on the upcoming changes.

**Q. How can I tell if I'm going to an urgent care clinic or an emergency care facility and what co-pay you'll be paying?**

A. When a claim is submitted by a provider, the claim includes the provider identification number that associates the type of facility and services provided. It is this number that drives the co-pay. You can do a provider lookup on TML's website to identify urgent care, and convenience care clinics (extended hours and minor emergency care). You can also call TML at 800-282-5385 to verify status. As a rule of thumb, if an "urgent care" facility is associated with a hospital, it is likely considered a "stand alone" emergency room with an emergency room code/co-pay.

**Q. Does out-of-pocket max include prescriptions?**

A. No, just deductibles, co-pays, and co-insurance accumulate to out-of-pocket maximums beginning April 1.

**Q. Will my out-of-pocket maximums that I've reached before April 1 roll into the new plan year?**

A. Yes, any out-of-pocket amounts that you've satisfied before April 1 will roll forward to the new plan year. Deductibles and co-pays incurred before April 1 will not be included in the out-of-pocket maximums, only deductibles and co-pays incurred after April 1 will apply to out-of-pocket maximums.

**Q. Are these changes going to discourage people from going to the doctor until they are very sick?**

A. The changes do not affect primary care co-pays, pharmacy co-pays or wellness benefits. Providing affordable care for employees was a key consideration in benefit decisions. There are many aspects to improving the health of our group. Routine care, early identification and treatment including taking routine medications contribute to our health and ultimately the lowest costs to both employees and the plan. Wellness visits are still provided to participants at no out-of-pocket costs. It's these visits that help identify problems early and allow for lowest cost treatment options.

**Q. How much are biometric screenings costing the City?**

A. Approximately \$120 per participant including lab work which includes a consultation with a nurse practitioner and a customized personal wellness guide for participants.

**Q. So I can get a reduced premium as long as I do biometric screenings each year and never make any changes? How is that beneficial to the City?**

A. Knowledge is power. When you are aware of your health status you'll be better able to address any changes that you may want to make. Additionally, the City will be able to design programs and opportunities targeting the health needs of our employees.

**Q. Why did the family deductibles not increase in proportion to individual deductibles?**

A. Family deductibles are two times the individual deductible and are competitive with the market.

**Q. Can I cover my same sex spouse on the City's plan if I have a marriage certificate from another state?**

A. No, the City's plan recognizes spouses as defined by applicable Texas state law. Further details can be found in the Plan book under "Spouse Eligibility."

**Q. Is it better to continue our Plan as a self-funded plan or to move to a fully insured plan with an insurance company?**

A. That's a good question. In selecting a benefits consultant we asked each of the firms that question. All had the same response that we should self-fund. An insurance company is going to estimate costs at the highest level and include a profit. Through self-funding, we are able to retain any amounts that aren't used to pay claims and plan costs. Additionally, a self-funded plan has more flexibility to design a plan that works best for its participants while controlling costs.

**Q. Can I opt out?**

A. Yes. Beginning this open enrollment, employees will have the ability to opt out of medical and/or dental coverage. THIS IS AN IMPORTANT DECISION THAT SHOULD BE GIVEN CAREFUL CONSIDERATION. IT IS IMPORTANT TO NOTE THAT ONCE YOU DECLINE COVERAGE, YOU WILL NOT BE ABLE TO RE-ENROLL UNTIL NEXT YEAR UNLESS YOU HAVE A CHANGE IN FAMILY STATUS WHICH RESULTS IN A QUALIFYING EVENT AS DEFINED IN THE PLAN BOOK. The following acknowledgement will be required to opt out:

**EMPLOYEE ELECTION TO OPT OUT OF MEDICAL AND/OR DENTAL COVERAGE**

I acknowledge and affirm that I am voluntarily declining medical and/or dental coverage provided by the City of San Marcos effective April 1, 2014.

I understand that:

- I am declining coverage that is available to me for \$22.14 a month for employee coverage. I understand that the City also contributes to the cost of coverage for my dependents (if applicable).
- I cannot re-enroll in the plan unless I have a change in family status or other qualifying event (defined in the plan book) until April, 2015.
- The Affordable Care Act and the Marketplace:
  - ✓ Coverage is available to individuals through the Marketplace, [www.healthcare.gov](http://www.healthcare.gov).
  - ✓ Individuals who are eligible for coverage through an employer based plan, such as the City's plan, are not eligible for a subsidy and must pay the full cost of coverage.
  - ✓ Beginning in 2014, people without health coverage will be required to pay a penalty AND assume responsibility for the cost of their medical care. These costs can be catastrophic. If you do not have other coverage, you won't have financial protection from the very high cost of medical care. The penalty in 2014 is \$95 for an individual and \$285 for a family and will increase in 2015 and 2016.

**PLEASE GIVE CAREFUL CONSIDERATION TO THIS DECISION TO OPT OUT OF THIS IMPORTANT EMPLOYEE BENEFIT. IF YOU HAVE QUESTIONS, PLEASE CONTACT THE HUMAN RESOURCES STAFF PRIOR TO OPTING OUT OF THE CITY'S COVERAGE.**