General Insurance FAQ's

If there are only two people on the health insurance, does each person only have to meet the single deductible? Or do they have to meet the full family deductible?

If you are enrolled in the Low Deductible or the High Deductible Wellness plans, and have only two people, then only two "single" portions of the family deductible would have to be met with the remaining amount being waived. For example, effective July 1, 2012, the High Deductible Wellness family deductible is increasing to \$2,750 while the single deductible amount is increasing to \$1,100. If a "family" in this plan only had two members then \$2,200 would have to be met (with no more than \$1,100 being met by one person) to satisfy the family deductible.

For the High Deductible/HSA Qualified plan, the full family deductible (which increases to \$5,000 effective July 1, 2012) would have to be met to satisfy the deductible. In this plan the deductible can be met by only one family member or split among them.

Why do I have to have family insurance if there is only my spouse and myself? Shouldn't there be a lower price just for two people?

The family premium is charged any time there is more than one adult. The reason for this is because one adult always costs more to insure than multiple children (unless a child has a serious illness). This is why we added the Employee + Child (ren) coverage level a few years ago and charge less premium, because there is only one adult.

Can I still have my FSA if I open a HSA?

Only if it is a "Limited Purpose" Flexible Spending Account (FSA). A Limited Purpose FSA can only be used for optical and dental expenses (no medical or prescription). Remember that you should not need an FSA if you are able to contribute to an HSA because you can use HSA dollars for anything you could use FSA dollars for and more! Plus, the HSA dollars will roll over from year to year whereas the FSA dollars are "use it or lose it" funds.

What if I still have money in my FSA in July?

You actually have a grace period for incurring claims against your Flexible Spending Account (FSA) funds that lasts until September 15th. You then have 90 days from then to submit claims.

If you are planning on switching to the High Deductible/HSA Qualified Plan (and contributing to a Health Savings Account (HSA)), then you must have your FSA spent down to \$0 by June 30, 2012 in order to be eligible to open up an HSA effective July 1, 2012. If you do not have it spent down to \$0 at that time you will have to wait until October 1, 2012 to open your HSA (the first of the month following the end of the FSA grace period).



What is the difference between a general flex account and a limited purpose flex?

A Limited Purpose Flexible Spending Account (FSA) can only be used for optical and dental expenses (no medical or prescription). It is generally opened by an individual who is also contributing to a Health Savings Account (HSA) because a General Purpose FSA can be used to pay for first dollar (before deductible) medical and prescription expenses, which would make the individual ineligible to open and/or contribute to an HSA. A General Purpose can be used for optical and dental expenses as well.

Can you please tell me what percentage BSU pays of the HSA/HDHP premium for the upcoming year (starting July 1, 2012)? I know that in the past BSU paid 90% and the employee 10%. Do those numbers still hold?

Yes, the University is still subsidizing 90% of the premium for the High Deductible/HSA Qualified Health Plan.

Can I cover my spouse on my HDHSA (High Deductible/HSA Qualified) plan as secondary coverage?

Yes. If your spouse picks up coverage with his or her employer that is not HSA-qualified, it will not affect your eligibility to contribute to an HSA <u>UNLESS</u> he or she also adds you to their employer's plan (as secondary coverage). The key to eligibility is the accountholder's (your) status – as long as you are not covered by a non-qualified plan you can still contribute to an HSA. Additionally, even though your spouse will be covered by a non-qualified plan you can still pay for his out of pocket expenses with your HSA funds.

If I decide to go with the High deductible HSA plan, do I open my account with HSA Bank first or switch my plan here and then open my account with the bank?

You can actually begin the process of setting up the account with HSA Bank at anytime, but the account cannot be officially opened until the first day of the month following your effective date in the HSA Qualified health plan.

I forgot to open my HSA Bank account; can I still get the contributions from earlier this year?

No, the contributions are pro-rated and will begin on the next available pay period. Multiple communications regarding the process for opening a Health Savings Account (HSA) with HSA Bank were sent out over the 6-month period between June and December of 2011. It was well-communicated that the account had to be opened in order to receive the University contributions (seed).



When do the new seed amounts begin/change? How are the per pay contributions calculated and when are the deposits made?

The seed amounts will actually change beginning in July as part of the approved 2012 contribution schedule. In January of 2013 the seed amounts will change again per the Board approved 2013 amounts. The contributions are made on a pro-rated monthly basis, 12 times for 12-month employees and 10 times for 10-month employees. Please see the charts below for details:

2012 HSA Seed Contribution Schedule:

HSA Qualified Plan	Monthly Contribution 12-Pays	Monthly Contribution 10-Pays	Maximum 2012 CY University Contribution	
Individual Coverage Jan. 1 – June 30	\$63.83	\$76.60	\$574.50 (\$191.52 left in 2012)	
Individual Coverage July 1 – Dec. 31	\$31.92	\$38.30		
Employee & Child(ren)/Family Coverage Jan. 1 – June 30	\$160	\$192	\$1440	
Employee & Child(ren)/Family Coverage July 1 – Dec. 31	\$80	\$96	(\$480 left in 2012)	

2013 HSA Seed Contribution Schedule:

HSA Qualified Plan	Monthly Contribution 12-Pays	Monthly Contribution 10-Pays	Maximum 2012 CY University Contribution
Individual Coverage Jan. 1 – Dec. 31	\$36	\$43.20	\$432
Employee & Child(ren)/Family Coverage Jan. 1 – Dec. 31	\$90	\$108	\$1,080



I am currently enrolled in the HSA qualified plan. Currently, I believe the OOP maximum is \$5,750 for family coverage. It appears that the OOP maximum will be raised substantially beginning in the coming plan year, to \$8,000. My question: will I be responsible for an additional \$2,250 OOP expense beginning on July 1? Or does this new OOP maximum come into play beginning on January 1?

You will be responsible for meeting the additional amount of Out-of-Pocket (OOP) maximum beginning on July 1, 2012. In other words, if you have already met your \$5,750 OOP maximum and are receiving 100% coverage, you will have to go back to paying coinsurance until the additional \$2,250 is met. (These numbers are assuming all innetwork/Endorsed/Encircle providers and facilities.)

Given all the changes that have been made, it may be that staying in the HSA qualified plan no longer makes sense for me. If I switch to one of the other plans, will the funds currently accumulating against our deductible and OOP maximum <u>carry over</u> to one of the other plans? Or will the deductible and OOP be reset to zero if I change plans?

Yes, all of our plans are fully integrated. In other words, you will have "credit" from your current plan (for claims incurred January 1 – June 30) applied to the deductible and/or Out-of-Pocket (OOP) maximum of your new plan. The deductible and OOP maximums will not be reset to zero (\$0) until January 1, 2013.

If the funds in our deductible and Out Of Pocket (OOP) maximum do in fact carry over, will that carry-over be accomplished as of July 1?

Yes. We will work with Medco and KBA (Key Benefit Administrators) to transfer the accumulators during the month of June so that they are ready to be switched over as of July 1, 2012. Please contact the PEB office right away if you do not believe your OOP and/or deductibles have transferred over correctly. Please remember that prescriptions bought at retail WILL NOT transfer to your new prescription OOP because it is a mail-order only OOP.

If, I would switch plans, what happens to the HSA seed money?

It is pro-rated so the contributions would stop effective with the August payroll (the seed money you have received thus far would remain yours).

Do payments for vision and dental appointments count against my Out of Pocket Maximum on the High Deductible/HSA Qualified Plan?

No, only medical and prescription.

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Can I use my HSA account for medical e	expenses for my husband if	I do not add him to my l	nealthcare plan /
enroll as single coverage?			

Yes.

I am considering changing to the HSA Qualified High Deductible plan. My only concern relates to my dependents. My husband is self-employed so I carry our only insurance. We have two sons ages 24 and 22. One is in school, one is not but they both qualify as dependents for Ball State health insurance. Will they still be covered and will I be able to use HSA funds for their medical expenses?

Per PPACA rules (healthcare reform), your two sons can remain on your health plan until they turn age 26 - so yes, they still qualify for coverage under BSU's health plan(s). However, the actual HSA (account) that is tied to the HSA Qualified health plan is governed by the IRS, not PPACA, so they would have to be actual IRS dependents in order for you to use your HSA (account) to pay for their out-of-pocket expenses with the HSA funds. The IRS' definition of a dependent can be found at www.irs.gov.

Is pre-natal care considered a preventive service under the High Deductible/HSA Qualified plan, and thus would not be subject to the deductible (i.e. covered at 100%)?

Prenatal visits will not be covered under preventive this year. So at this time you would be subject to the deductible for any prenatal care.

Do well baby exams include immunizations?

Yes, routine childhood immunizations are included in the 100% benefit for preventive care.

Are there other adult immunizations included in preventive? If so, where can I find a list of all that are included?

Yes, routine adult immunizations are also included. Please visit www.healthcare.gov and click on the Prevention and Wellness tab for guidance on covered preventive services.

Will the spouse still be able to use the BSU Quick Clinic with 100% coverage in the Low Deductible PPO and High Deductible Wellness plan if our coverage is secondary?

Yes.

I have major concerns about the new emergency room policy. This past year, 2011-2012, I opted for the HD Wellness, in part because ER visits were not subject to deductible. Fortunately, no one in my family needed to go to the ER this year, so I did not take advantage of this benefit. However, with the new policy, I am being punished for those who do abuse the ER. Furthermore:

1. Where else do you go with a sick child at 2am? _None_ of the other options are available at that time.

If an event that occurs at 2:00a.m. requires medical attention you will have to go to the ER and anticipate a \$100 co-pay unless the patient is admitted to the hospital. This new policy is in no way meant to deter employees with real emergencies (or with sick children in the middle of the night) from seeking treatment at an Emergency Room. Surprisingly, though, our data showed that the majority of our group's ER visits occurred on Thursdays (and not on the weekends when other options for care may not be available). Although we could not pinpoint the exact time of day for the visits, given the fact that the majority of our ER users were Medicare users, it is unlikely that they occurred in the middle of the night. Additionally, the data supports that the ER was consistently used for non-emergency services.

2. Often, an ER is able to treat an accident/illness without a hospital admittance, where an Urgent Care clinic cannot. Why should someone who has already suffered a serious injury/illness that is NOT TREATABLE in another Urgent Care setting be punished with \$100 co-pay just because it wasn't quite serious enough for them to be admitted to the hospital? At this point, we are already being hit by high deductibles and will have to pay for most of the ER visit ourselves anyway.

Our consultants indicated we were an outlier in not applying emergency room visits to the deductible – in essence we were financially incentivizing our employees to choose this option over other, much less costly, options. Our claims history shows emergency room utilization of almost twice the national averages – and many of the visits were for non-emergency care during normal business hours.

Additionally, to put the actual cost of an ER visit into perspective, in 2011 a member covered by the High Deductible Wellness Plan went into the ER complaining of abdominal pain. The attending physician ordered 2 CT scans and some blood work to determine the cause, and two Tylenol were administered by the nurse during the visit for pain. After all the tests came back negative, with no cause of the pain identified, the member was released and told to follow up with their family doctor. The billed cost of that visit was close to \$6,300, and after network discounts the charges came down to just over \$5,000. In 2011, that equated to the member paying 20% of that charge, or \$1,000. If this same scenario were to happen after July 1, 2012, the member would have to first meet his or her deductible (a maximum of \$1,100, but could be less if other family members had already met a portion of the family deductible). Add the \$100 co-pay because of not being admitted, and then 20% of the \$3,900 balance left after deductible. The total owed would be \$1,880 (\$100 co-pay, plus \$1,100 in deductible, plus \$780 in coinsurance). Yes, this is \$880 more than in the previous year, but the plan had to pay \$3,120! As you can see, even in the second scenario the plan is paying much more for the ER visit than the member would. The patient did follow up with his family doctor and the problem turned out to be a pulled muscle, which was treated with a prescription for Flexerill, a muscle relaxer, along with some rest and stretching. As you can imagine, the cost of the follow-up treatment was thousands of dollars cheaper than the ER visit.

Again, this benefit change may not be popular with every employee, but in the context of raising everyone's premiums even higher it seemed like a rational choice.



Is urgent care treated the same way as the ER?

No, effective July 2, 2012, you will be charged a \$100 flat co-pay for Emergency Room (ER) services. If you are admitted then the co-pay will be waived. Both urgent care and ER services will be subject to the deductible. For a listing of Encircle urgent care facilities, please visit the PEB website at www.bsu.edu/benefits. There is a document entitled Urgent Care Resources located under the Open Enrollment 2012 tab – just click on the Emergency Room Benefits tab.

What does being admitted to the hospital mean relative to the ER additional co-pay of \$100? Does admit mean only if you go into a regular room and spend the night?

That's correct; being admitted would actually be going into an "inpatient" setting where you are not released after treatment in the Emergency Room (ER).

Lab charges for employees on both the Ball State Low and High Deductible Wellness PPO plans are covered 100% when performed through LabCorp, Quest Diagnostic/LabCard, or American Health Network. Otherwise, they are subject to 20% co-pay after deductible. Question, does the 100% coverage applied to High Deductible HSA Qualified plan if the out of pocket maximum (OOPM) has not yet been met for the year? Or are we charged the lab fee until we meet our OOPM?

If the labs are diagnostic then you must first meet the High Deductible/HSA Qualified plan's <u>deductible</u>, not OOPM, before you qualify for 100% coverage at the contracted labs.

Can we get discounts on the gym or classes to encourage us to exercise?

Please visit www.bsu.edu/workingwell for information on Wellness Incentives. Currently a \$90 voucher that can be used toward the Wellness & Recreation Center fees is available.

Why do we have to pay full price for gym memberships?

When the new recreation center was opened in August of 2010, the decision was made that employees would pay the same membership fees to use this facility that the students were being charged as part of our dedicated fees. The other University facilities like the Ball Gym continue to be free for employees but with rising tuition costs the University felt that it was inappropriate that University subsidize employee's membership to the facility when we were requiring the students to pay the fee. To help with the cost of the membership, employees can elect to have the fees deducted from their paychecks. See the recreation center staff to get information on setting up payroll deductions for the membership fees.



Why do we have a self-funded insurance plan? Why not a commercial plan? Wouldn't it be cheaper to change that?

Ball State University self-funds all our benefits plans with the exception of Long Term Disability. For all the self-funded plans, we utilize third party administrators, KBA (Medical), MEDCO (prescription), and Cigna (Group Life, AD&D and Short Term Disability) to administer the plans as defined by the University. In self-funded insurance plans, the University assumes the liability and risk associated with uncertain healthcare costs in exchange for a number of significant financial benefits. While not without risks, self-funded insurance plans can give organizations better cash flow, a greater degree of flexibility over the plan's design and reduced administration costs. The University sets the premium rates based on our claims history and adjust the plan in other ways to control costs. If claims are lower than anticipated, the University can invest the savings and earn interest, help fund the VEBA trust that is used to cover retiree health insurance and/or help fund the claims reserves established to fund years of unusually high claims.

In a commercial or insured health plan, the employer, insurance provider, and employees have fairly fixed roles. An organization will pay premiums based on its projected claims, but won't get reimbursement if the claims come in lower than projected. With these insurance plans, employers pay an insurance provider in advance to cover projected claims, in addition to the insurer's overhead and administrative costs and other regulatory fees imposed by State laws.

In self-funded plans, there is greater flexibility in plan design and administration. An employer can choose what coverage it wants and avoid paying for what it doesn't. Then, the employer essentially pays claims out-of-pocket from collected premiums rather than using predetermined premiums to compensate an insurance provider for assuming financial risk. In addition, if claims during a particular month are lower than anticipated, that money adds to the reserve and earns additional interest, creating a long-term financial benefit.

The fact that employers are directly paying for health insurance claims also makes wellness programs and other incentive programs more relevant. With fully insured plans, wellness initiatives generally do not result in significantly lower health insurance costs. However, in a self-funding scenario, an overall improvement in employee health can lead to an immediate reduction in claims, which feeds back into the organization's reserve fund. If those trends continue, there may be a reduction in the necessary contributions made by both employers and workers.

When is the dependent audit? Will it be during the summer?

The audit will most likely begin in the early summer. Once the University has chosen a vendor the audit will begin. If you currently have dependents (including your spouse and/or same-sex domestic partner) covered on your plan, you will receive a request for information that will require you to provide documentation proving the eligibility of your dependents.

I am concerned about identity fraud. How will I know the dependent audit company is legitimate and from BSU?

Security of employee information is very important to the University and will be one of, if not the most important, factor evaluated when we choose the vendor to conduct the audit. Any communication you receive from the vendor will be endorsed clearly by the University so you will know that it is a legitimate and confidential request for information.



Where would I find a listing of the physicians that are In-Network/Endorsed/Encircle?

You can search for them on the Encore website at www.encoreconnect.com.

What is Encircle vs. Encore? I don't understand the difference.

Encore is a network of physicians and hospitals/facilities where the level of discount negotiated results in a coinsurance of 70% paid by the University. Encircle is a <u>hospital/facility only</u> network that contracts with hospitals and facilities at a deeper level of discount that results in an increased coinsurance of 80% paid by the University.

Will the 3 year rule apply next year?

At this time, we do not know. The decision to waive the 3-year rule for switching health plans typically is made when a high number of changes are made for the upcoming plan year. It is possible that the rule will not be waived so when making your health plan decision you should make it knowing that you may have to stay in the plan you choose for 3-years (unless you experience a Qualifying Event like a birth, death, marriage, divorce, etc.).

What is the website we go to for our EOBs from Key Benefits?

The website is <u>www.kbasolution.com</u>. KBA has recently updated their systems so if you have registered since the upgrade, you will need to register again.

In checking my past KBA statements, all of my providers but one were paid at 80%, so I believe that all of my providers (but the one) are in-network. The one that wasn't paid at 80% was paid at 70%, so would going to this doctor result in penalties?

No penalties, just less coinsurance – most likely the 70% provider is not endorsed, but is in-network. Endorsed providers are paid at 80%. You can find your provider's endorsed/non-endorsed status by looking them up at www.ahdi.com.

What is meant by flat dollar penalties relative to the health plans?

There is a \$2,000 flat penalty per out-of-network inpatient hospital admittance – this type of penalty would not apply to your deductible or OOP.

I am reviewing the last couple of years of claims to see if I should switch my health care plan from low deductible. Please let me know how the year is calculated – by calendar year or a fiscal year. If I do switch during this open enrollment time, when does it change for filing claims?

Deductibles and Out-of-Pocket maximums for each plan reset at \$0 on January 1 (calendar year). However, if you make a plan change it would go into effect on our plan year which starts on July 1 and that is when you claims would start processing under the new plan. (You would get credit for any deductible/OOP met from Jan. 1 to June 30).

What lab charges are considered preventive and which are considered diagnostic?

Preventive labs are those ordered as part of a routine check-up or procedure (yearly physicals and the associated blood work, etc.). The opposite of preventive is diagnostic – so any tests ordered because you are exhibiting symptoms of an illness, or because you have had a past history of a particular illness, would not be considered preventive.

I remember when I was doing new hire paperwork a place that employees and their families could go to have blood drawn and it was at no cost to the employee. Did I not understand this correctly, or is there a place to go to get blood drawn that it is cheaper? My doctor's office seems pretty expensive and I need two more blood draws done very soon.

Yes, employees in the Wellness plan can go to LabCorp, American Health Network, or Quest Diagnostic/LabCard and have labs done at \$0 coinsurance (100% covered). LabCorp was formerly known as Pathologists Associated or PA Labs.