Q & A

Anthem Blue Cross medical www.anthem.com/ca/sisc

1. **What is a PPO Plan?** PPO is Preferred Provider Organization. PPO plans allows member to see any **In-Network** provider of your choice. Member can self-refer. Typically member will have office visit copay, deductible and co-insurance expenses.

2. **What is an HSA Plan?** This is a very high deductible plan with a Health Savings Account component. The plan allows member to set up a Health Savings Account. Money put into the account is tax deferred. Member is to pay the full cost of medical and pharmacy until the deductible has been met. Once the deductible has been met the member will pay copays until the out of pocket max has been met. The Anchor Bronze plan is HSA compatible.

   There will be more detailed information on the HSA plans on the HSA presentation pages.

3. **What is an HMO Plan?** An HMO plan is a Health Maintenance Organization Plan. Members are required to select a Primary Care Provider or Medical Group. Member will use assigned facilities and providers. Provider will refer member to Specialists. Member will usually experience lower out of pocket expenses.

4. **What is monthly premium?** Premium is the cost to purchase the plan.

5. **What is my deductible?** SISC offers medical plans that have individual and family deductible. The deductible is the member's cost share responsibility. If the individual deductible has been met it will be applied towards the family deductible and will also be applied towards the member's out-of-pocket max.

6. **When does my deductible apply?** When you seek services and there is a diagnosis and treatment, lab work done, tests run etc.

7. **What is Co-insurance?** Co-insurance is when the plan now shares in the cost of treatment. Once the deductible has been met the plan will pay 90% or 80% (depending on plan) of allowed charges and the member will be responsible for the other 10% or20% (depending in plan) until the out-of-pocket max has been met.

8. **What is Out-of-Pocket Maximum (OOPM)?** OOPM is the most a member will pay in a calendar year for services while using In-Network providers. Consider this a safety net. Once the OOPM has been met the plan becomes 100% through the end of the calendar year. The office visit copays, deductible and the 10% or20% (depending on plan) coinsurance all go toward the OOPM.

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9. **What is 4th quarter carryover?** When a member pays towards their deductible in the months of Oct, Nov or Dec that dollar amount is carried over to January to help satisfy the next year's deductible. ONLY the deductible is carried over not the copays or coinsurance.

10. **What does In-Network mean?** - This means a provider or facility has contracted with Anthem. This gives the member a safety net and the provider/facility cannot 'balance bill' the member. They accept the fee paid to them from Anthem for their services.

11. **What does Out-Of-Network mean?** This means the provider or facility has NOT contracted with Anthem. The provider or facility can 'balance bill' members for the cost difference between what was billed and what the insurance paid. There is no safety net for the member. The amount the member pays will not go towards their OOP Max. There is no limit, the safety net is gone.

12. **What if I go OON during an emergency?** There is a "No Surprises Act" bill that was passed into law and becomes effective in 2022. In the meantime since ER doctors, Anesthesiologists and Radiologists do not contract they will typically accept Anthem's payment as 'payment in full'. If they don't the member has the option to negotiate a lower fee with the provider. If the provider still insists on their full fee the member has the option to file an Appeal.

13. **What do I do if there are no In-Network Providers in area?** If you need to see a specialist and there isn't one in the area, you can call Anthem Customer Service and let them know your situation. Anthem will work with the member to find an In-Network provider, if they cannot, Anthem can approve an Out-of-Network Authorization. This will allow the member to see an OON Provider and the plan will pay as if In-Network. These authorizations may have an expiration date and will need to be reviewed to extend. Important: do not seek services prior to that authorization as you will be responsible for the cost of treatment, authorizations are not back dated.

14. **Why was my claim denied or not paid?** There could be several reasons
    - Procedure is considered cosmetic
    - Provider has not submitted the claim
    - Provider did not submit the claim timely
    - Provider submitted the claim with incorrect information. Such as ID# and/or incorrect diagnosis code. Sometimes they submit using the wrong provider TIN# on the claim.
    - Provider submitted the claim with incomplete information. Not enough information was provided to Anthem for payment consideration
    - Anything with the words "experimental' and/or 'investigative' will not be covered
    - Coordination of Benefits questionnaire was not returned to Anthem **Important, do not ignore.**

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15. **Who do I contact with questions about my insurance?**
    - You will first want to call Anthem Blue Cross Customer Service if they cannot help; you can call SISC to help answer questions.

16. **Why am I required to enroll in benefits if I have other coverage?** SISC policy requires all Full Time employees enroll in benefits offered through SISC. Since SISC is not an insurance company and districts joining are in a Pool this helps SISC meet our fiduciary responsibility to ALL districts in the Pool. By being a part of the Pool helps district stabilize rates and are not on the 'hook' for any large catastrophic claims. Claims are spread throughout all of the districts in the Pool.

17. **How to select a plan and what is the best plan for me?** You will want to look at how you currently use your insurance. Do you have more medical or pharmacy claims? Don't just look at the monthly premium also look at the Office co-pay, deductible and out of pocket max amounts. Review the pharmacy benefit.

18. **How does Coordination of Benefits work with dual coverage?**
    - With dual SISC PPO coverage, the member would have to satisfy the lowest deductible of the two plans before at least one of the plans begins to pay.
    - Eligible charges are applied to both plan deductibles at the same time. In other words the same eligible charges work to satisfy both deductibles. Member and plan continues to pay their share until the out of pocket max has been met.
    - Most couples will have a high and low plan.
    - Members will need to show both medical cards to the provider so both insurance plans can be billed.
    - If adding children to both plans you will want to put the kids on plan whose parent has the earliest birthday in the year as this will be primary for the children.

19. **Is there coordination of benefits with pharmacy?** SISC pharmacy plans do not have coordination of benefits. Whatever plan the employee is enrolled under is primary for the employee.

Navitus Pharmacy

1. **Who is Navitus Health Solutions?** Navitus is the Pharmacy Benefit Manager for the SISC medical plans.

2. **How do I find out if my medication is covered?** You can call Navitus Customer Care or you can register at www.navitus.com and you will have access to the formulary.

3. **What if my medication is not covered?** Navitus will be able to tell you what alternative medication is covered in that therapeutic category. You may want to have a conversation with your prescribing physician to discuss your options.

4. **What is a Prior Authorization (PA)?** A PA is attached to certain category of medications. The prescribing physician will need to call Navitus to show it is medically necessary to take this particular medication. If approved the PA is valid for a time period and must be reviewed periodically for effectiveness, and if it is still needed.

5. **What is Step Therapy (ST)?** Step Therapy is a program where the member is required to try a generic version of the medication before a brand version can be prescribed. The prescribing physician will need to call Navitus to show it is medically necessary to take one medication over another in the same therapeutic category.

6. **Why was my prescription denied?** There could be several reasons
   - Medication is not covered under the plan
   - Medication may be in a category that requires a prior authorization
   - Prior Authorization has expired
   - Prescription may be written for a higher dosage than what is approved by the plan or FDA
   - Member trying to fill too soon (prior to refill date)
   - Medication may be in a category that requires step therapy. Generics are to be tried first before the brand medication. This will require a call from the prescribing physician to Navitus.

For both Medical and Pharmacy: What if I am told I do not have coverage?

- Is the provider looking up the subscriber? All dependents are found under the subscriber.
- Is the provider confirming with the carrier or are they looking up online?
- Is the member using the current ID card?
- If a new hire did you complete the enrollment form and submit to your district?
- If adding dependents did you provide dependent documentation to your district?

Delta Dental

1. **How do I find a provider?** You can go to www.deltadentalins.com to find a provider

2. **What network can I use?** Delta Dental plans have two different networks.
   a) **DD Incentive:** you can use the Premier network or the PPO network.
   b) **PPO:** you need to use the PPO network. If you don't the plan will only pay 50% and the member will be responsible for the other 50%.
   c) **Orthodontists** just need to be contracting with Delta.

3. **Why didn't my insurance cover my treatment?** It is highly recommended that before any serious dental work is to be done the member should ask for a 'predetermination'. The provider will call Delta with a treatment plan and Delta will let the provider know (a) if it is covered (b) how much of your annual max is left to pay for it (c) potential member cost.

VSP Vision

1. **How do I find a provider?** You can go to www.vsp.com to find a provider.

2. **Can I use Costco?** Yes, you can use Costco, it is recommended to call VSP first. The eye doctors at Costco are independent and may not know the SISC/VSP benefit. **Reminder:** The frame allowance is lower than if you went to an optometrist's office but the quality of frames is the same.

The benefits of an HSA

Available only for SISC members enrolling in an HSA Compatible Plan

Planning for health care expenses is not only about money. It is about you. A health savings account (HSA) can help you meet your personal goals and help you reach them on your own terms.

What is an HSA?

An HSA offers tax-free savings for the qualified medical expenses of "eligible individuals" and their dependents. An "eligible individual" or HSA owner is someone covered under an HSA-compatible, High-Deductible Health Plan (HDHP) who is not covered under a non-HDHP or Medicare plan and not claimed as a dependent on another's tax return. To see a list of qualified medical expenses go to **www.irs.gov/publications/p502**.

HSA advantages

- HSA contributions are tax-deductible.
- Interest on an HSA is tax-deferred.
- HSAs are portable and owned by the individual, meaning, you can take any money left in the account with you if you leave your employer and continue to use the HSAs.
- HSA holders 55 and older can save an extra $1,000, which means $4,600 for an individual and $8,200 for a family for 2021.
- Unspent balances from one year roll over to the following year and can accumulate over a lifetime to help pay for uncovered Medicare expenses after retirement.
- In the event of the HSA holder's death, HSA balances pass on free of tax to their spouse, if the spouse is the named beneficiary.

We are here to support you

For guidance about your health benefits, programs, and services, visit sisc.kern.org/hw/member-resources.

SISC
Self-Insured Schools of California
Schools Helping Schools

Frequently asked questions

Q: Who can contribute to an HSA?
A: The HSA is funded by contributions from the employee, employer, or both.

Q: What is the maximum amount that can be contributed to an HSA?
A: $3,600 for an individual and $7,200 for a family for 2021.

Q: How does the HSA plan work?
A: Money in the HSA can be used to pay for covered qualified medical expenses and prescriptions not paid by the HDHP. The HSA dollars used apply toward the plan's annual deductible. If all of the dollars are not spent, the money remaining in the account will roll over to the following year.

Q: Can I enroll in an HSA if I currently have a general purpose medical FSA?
A: If you or your spouse participates in a general purpose flexible spending account (FSA), you would not be eligible for an HSA. According to the Internal Revenue Service (IRS), a general purpose FSA is considered "other insurance." You may be eligible for an HSA the following year, assuming you or your spouse are no longer participating in a general purpose FSA.

Q: Who do I contact to set up an HSA?
A: SISC does not handle HSAs so if you would like to set one up, contact any insured bank, credit union, or other entity that meets the IRS standards for being a trustee or custodian for an individual retirement account (IRA) or Archer Medical Savings Accounts (MSA).

Q: Are there any minimum yearly deductibles required by law?
A: Yes. Minimum yearly deductibles required by law are $1,400 for individual coverage and $2,800 for family coverage.

Q: Are there yearly out-of-pocket expense limits?
A: Yes. Yearly out-of-pocket expenses (deductibles, copays, and other amounts, but not premiums) cannot exceed $7,000 for individual coverage and $14,000 for family coverage in 2021.

HSA eligibility and contribution limits

How these limits are determined for married individuals

This table assumes that all other HSA eligibility requirements have been established and neither spouse has any other accident and health type coverage.

	Employee: No coverage of any kind	Employee: Self-only non-HDHP coverage	Employee: Self-only HDHP coverage	Employee: Family non-HDHP coverage	Employee: Family HDHP coverage
Legal spouse: No coverage of any kind	Cannot establish an HSA.	Cannot establish an HSA.	Employee is an eligible individual and can establish an HSA. The maximum contribution is the self-only contribution amount. Legal spouse cannot establish an HSA.	Cannot establish an HSA.	Employee is an eligible individual and can establish an HSA. The maximum contribution is the family contribution amount. Legal spouse cannot establish an HSA.
Legal spouse: Self-only non-HDHP coverage	Cannot establish an HSA.	Cannot establish an HSA.	Employee is an eligible individual and can establish an HSA. The maximum contribution is the self-only contribution amount. Legal spouse cannot establish an HSA.	Cannot establish an HSA.	Employee is an eligible individual and can establish an HSA. The maximum contribution is the family contribution amount. Legal spouse cannot establish an HSA.
Legal spouse: Self-only HDHP coverage	Legal spouse is an eligible individual and can establish an HSA. The maximum contribution is the self-only contribution amount. The employee cannot establish an HSA.	Legal spouse is an eligible individual and can establish an HSA. The maximum contribution is the self-only contribution amount. The employee cannot establish an HSA.	The employee and legal spouse are both eligible individuals and each can establish an HSA. The maximum contribution for each is the self-only contribution amount.	If legal spouse is not covered by employee's coverage, legal spouse is eligible to establish an HSA. The maximum contribution is the self-only contribution amount. If legal spouse is covered by the employee's benefits, the legal spouse cannot establish an HSA. The employee cannot an HSA.	Employee and legal spouse are both eligible individuals and can establish HSAs. They are treated as having only family coverage. The maximum contribution is the family contribution amount, to be divided between them by agreement.
Legal spouse: Family non-HDHP coverage	Cannot establish an HSA.	Cannot establish an HSA.	If employee is not covered by legal spouse's coverage, employee is eligible to establish an HSA. The maximum contribution is the self-only contribution amount. If the employee is covered by the legal spouse's coverage, the employee cannot establish an HSA. Legal spouse cannot establish an HSA.	Cannot establish an HSA.	If the employee is not covered by the legal spouse's coverage, the employee is eligible to establish an HSA. The maximum contribution is the family contribution amount. If the employee is covered by the legal spouse's coverage, the employee cannot establish an HSA. The legal spouse may not establish an HSA.
Legal spouse: Family HDHP coverage	Legal spouse is an eligible individual and may establish an HSA. The maximum contribution is the family contribution amount. The employee cannot establish an HSA.	Legal spouse is an eligible individual and may establish an HSA. The maximum contribution is the family contribution amount. Employee cannot establish an HSA.	Employee and legal spouse are both eligible individuals and may establish HSAs. They are treated as having only family coverage. The maximum combined contribution by employee and legal spouse is the family contribution amount, to be divided between them by agreement.	If legal spouse is not covered by the employee's benefits, the legal spouse is eligible to establish an HSA. The maximum contribution is the family contribution amount.If legal spouse is covered by employee's coverage, the legal spouse cannot establish an HSA. Employee cannot establish an HSA.	Employee and legal spouse are both eligible individuals and can establish HSAs. The maximum combined contribution by employee and legal spouse the family contribution amount, to be divided between them by agreement.