Your Open Enrollment Questions Answered!

Thank you to those who joined the open enrollment meetings last week as we reviewed the City of Turlock's health plans commencing July 1, 2020.

The questions below came from the live Q&A held on 5/12/2020:

1. **How much money is the city saving by switching to these two plans?**

   Please contact your union representatives or Human Resources. These numbers were included in the materials provided during the union negotiation meetings.

2. **In our current plan therapy to treat Autism is not covered. Is preventive coverage for Autism covered under the Affordable Care Act? Such as ABA (Applied Behavioral Analysis).**

   Under the new preventive care guidelines which will be implemented July 1, 2020, screenings (diagnosis) for autism will be covered. At this time, treatment for autism such as ABA Therapy will continue to be excluded under the health plan.

3. **Can you please clarify if the HSA funds are immediately available like the FSA funds are?**

   Unlike a health flexible spending account (FSA) where funds are available immediately upon the start of the plan year, the health savings account (HSA) funding does not work the same way. The City of Turlock will be depositing half of the contribution on July 1, 2020; the additional contribution will be deposited per pay period from January 1, 2021 through the subsequent 12 payroll periods. The contributions vary by single and family coverage. The City of Turlock annual contribution for the 2020-21 Plan year is $1,250 for single coverage and $2,100 family. The HSA is a bank account and think of it like any other bank account; if there is no money in the account, you cannot spend it. The medical FSA is different inasmuch as the "account" is virtual and held with your employer, not in a bank account.

4. **How much is matched per year for the health savings account (HSA)?**

   Employees do not have to match the City of Turlock's contribution through payroll deductions in order to receive the contribution from the City. You will receive this amount regardless if you decide to contribute with your own pre-tax payroll deductions.

5. **Have we determined what is happening with the flex daycare fund balances during this COVID-19 time when daycare's have closed?**

   For dependent daycare, employees did have an opportunity to change elections if/when your daycare situation was changed. Human Resources reached out to every member to confirm what each person wanted to do, if their daycare situation was changing, etc.

For specific questions or help, contact the following:
Human Resources: 209.668.5150 or humanresources@turlock.ca.us
Winton-Ireland, 209.667.0995: Andrea ext 3101 (ahiykel@wisg.com), Gina ext 3053 (grogers@wisg.com), Lynn ext 3056 (lbull@wisg.com)

Just a side note for the medical FSA accounts, we continue to watch the IRS update notices and website for any announcements regarding changes related to COVID-19. As most of you know, benefits cannot change mid-year unless there is a qualified life event. Specific to medical flexible spending, these qualified life events are more restrictive than the medical plan qualified life events so review of each situation is key to confirm if your specific change is allowed by the IRS. At this time, the IRS is continuing "business as usual" and in absence of any other IRS guidance, the "use it or lose it" rule still applies. If this changes, Human Resources will notify you.

6. If you opt for an HSA can you have an AFLAC type of policy as well?

We would recommend you discuss this with your AFLAC representative. The IRS sets specific guidelines on having other coverage and still being able to qualify to participate in HSA contributions.

7. What is the difference between family plan deductible and family max out of pocket?

Specific to the High Deductible Health Plan, the family deductible of $2,800 must be met before the plan begins paying a portion of your healthcare costs. Either 1 person of the family can meet this deductible or a combination of family members. Once the deductible is met, you will be responsible for any copays associated with the service. The deductible and copays accumulate toward the out-of-pocket maximum of $6,000. Again, either 1 person of the family can meet the entire $6,000 out-of-pocket maximum or a combination of family members. Once the family out-of-pocket maximum is met, the plan will begin paying 100%.

Conversely, the Traditional PPO plan has a $500 family deductible. Under this plan, no one person will exceed $250 toward the deductible. Once an individual meets the deductible, the plan will pay 90% and you will be responsible for 10% coinsurance, or applicable copays, depending on the service provided. The coinsurance and copays accumulate toward the out-of-pocket maximum of $2,500. Again, no one person in the family will exceed a $2,500 out-of-pocket maximum. Once an individual meets $2,500, the plan will begin paying 100% for that person. The additional $2,500 to make up the $5,000 family out-of-pocket maximum can be met either by 1 person or a combination of family members.

8. Does the high deductible health plan begin to operate as a "normal" health plan once the deductible has been met?

Yes, once the deductible is met, the plan begins paying for covered medical care, subject to the schedule of benefits.

9. Can you tell us which is cheaper for the consumer out of pocket if we hit the max out of pocket?

This depends on the employee's health plan preference. Under the Traditional PPO plan, the individual out-of-pocket is $2,500 whereas it is $3,000 under the high deductible health plan. This alone is a $500 difference in out-of-pocket; however, the high deductible health plan allows you to contribute pre-tax

dollars to your health savings account which lessens your taxable income. This tax benefit may affect the employee and their family differently.

10. If an employee leaves to another city and we are on the HDHP with HSA plan, what happens to the money remaining in the HSA account?

Yes, like a regular bank account, this account is yours to take if you ever separate employment. There are IRS rules which must be followed if you would still like to *contribute* to your Health Savings Account. For example, you must be enrolled in another high deductible health plan in order to contribute. However, you can continue to "spend down" this money as it is your money. If you use the HSA funds for anything other than medical expenses or IRS qualified items, not only will you lose the tax advantage, you will pay tax and a penalty on the money.

11. Is the max out of pocket divided per person on the family plan? Or is it cumulative?

This depends on the plan you elect. The high deductible health plan is cumulative or, in healthcare industry terms, aggregate. The Traditional PPO plan is per person, where no one person will exceed $2,500 in out-of-pocket expenses.

12. Where did the $2,100 number come from, what is that amount based on? And will this be every year?

Please contact your union representatives. These numbers were included in the materials provided during the union negotiation meetings and in no way guarantees future amounts, as this is a negotiated benefit.

13. Under the Traditional PPO, the inpatient responsibility is 10% after deductible. So, we would be responsible for the $500 plus 10% of the entire hospital bill? Same question for emergency room visit. Would our responsibility be $150 plus 10% of the entire bill?

You are responsible for your deductible, copay, plus 10%, up to the out-of-pocket maximum of $2,500. This out of pocket limits is in the PPO network and runs plan year. If using an out of network provider, we could have "balance billing" (see question #f16).

14. What is the coverage for vacation/out of area/out of country coverage?

The UnitedHealthcare Select Plus network is a national network. We encourage you to pin the umr.com website to the home screen on your smart phone. They do not have a mobile app; however, their website is mobile-friendly. This will allow you to look up contracted providers if you are in another state. Regarding out-of-country services, only emergency services are covered, and are treated as an in-network service.

15. **There has been no mention of premiums. Do we know when they are coming? Is this going to be negotiated or imposed?**

    Currently, there are no premium contributions for either plan. Please contact your union representatives for more information on future contributions and effective dates.

16. **How does Sutter ER apply if that is the closest ER to our home? Does this mean you could potentially pay higher than the current deductibles if you go there?**

    Always visit the nearest emergency room or call 911 for life or limb threatening conditions. As all you know, Sutter Health providers and all affiliates are considered out-of-network providers under the City's health plan. The one exception is emergency services. Per healthcare reform, emergency services at an out-of-network provider must be paid at the same *benefit level* as if they were an in-network provider.

    The City of Turlock plan is generous with the reimbursement rate provided to these out-of-network providers. The plan will typically pay up to 300% of Medicare (or 3 times more than what the provider would receive if they were servicing a patient who had Medicare only). This does not mean the provider may not try to balance bill you. In this case, if you get a bill and the provider is billing you for these services, please contact UMR or Winton-Ireland Insurance Agency for assistance in negotiating these bills.

17. **Could you explain once more how the deductible and max out of pocket work differently for each plan in regard to families?**

    Please refer to the answer under question #7 above.

18. **Will the HSA balance roll over to the following year if it goes mostly unused?**

    Yes. Unlike the flexible spending account where you must "use it or lose it", the health savings account balances roll over from year to year and accumulate indefinitely. After $3,000, Optum Bank allows you to invest your HSA account (refer to the Optum website for more details, www.openenrollment123.com) as your money will be "at risk".

19. **Would you say that once the HSA deductible has been met, either single or family, the plan goes to a regular health plan. The difference between HSA and Traditional PPO is that, once deductible has been met, would be that HSA does not have the 10% requirement?**

    Correct. Once the high deductible health plan deductible has been met for the year, a copay then applies to the various services while in-network and the plan works like a "regular" health plan. You pay these copays until you satisfy the out-of-pocket maximum.

    Once the deductible under the Traditional PPO is met, either a copay or 10% coinsurance will apply until you reach the out-of-pocket maximum.

20. Can you please explain why this upcoming health plan does not cover therapies under SB 946-California State Regulated Insurance Coverage?

As the City of Turlock plan is a self-funded health plan, it is governed by Federal laws. State laws do not apply to self-funded plans since they are not governed by the California Department of Insurance.

21. Please clarify if one person can meet the $5,000 maximum within the family plan?

No. Under the Traditional PPO plan, no one person in a family will exceed the $2,500 out of pocket limit. Once a person in a family reaches $2,500, the plan will begin paying 100%. The additional $2,500 of the full $5,000 family out-of-pocket maximum can be met by one person or a combination of family members.

22. Based on previous numbers for the City of Turlock what is the average health care dollar amount use per person per year?

Please contact your union representative or Human Resources for more information.

23. To confirm the HSA money spent towards vision, chiropractor, or other FSA type spending does NOT go towards the max out of pocket?

Dental and vision services accumulate under their respective plan limits. Chiropractic care would count toward satisfying the deductible and out-of-pocket maximum under the high deductible health plan. Under the Traditional PPO plan, the copays for chiropractic care would assist in meeting the out-of-pocket maximum. Remember that only covered medical services will apply to your respective plan deductible.

If you enroll in the high deductible health plan, you cannot elect the medical FSA account.

24. If Johnny meets the $2,500 out of pocket, Jill will still need to meet $2,500 in order to be 100% covered through Traditional PPO?

This is correct. If Johnny meets $2,500, the plan will pay 100% for him. Jill would still have to meet $2,500 for the plan to pay 100% for her. This assumes services are in the PPO network.

25. Trying to figure out what my family will spend on average to determine which plan, any idea on average dollar use per person or per family?

We recommend registering on umr.com to review your claims history. This will provide amounts you have had to pay for services and may give you a better idea of what to expect.

26. For the Traditional PPO plan, to clarify if 1 person reaches the $2,500 out-of-pocket than all other family members out-of-pocket is met for that year and will be covered at 100%?

This is incorrect. If one person reaches the $2,500 out-of-pocket maximum, then the plan will begin paying 100% for only that one individual. The other members of the family would have to accumulate the additional $2,500 or one person of the family

27. To clarify for the Traditional PPO, if I meet the $5,000 max I won't pay anymore, but my family will each still need to meet the $5,000 individually? 3 people = $15,000

Once a family meets the $5,000, then the plan will pay 100% for all members of the family. No one person will exceed $2,500 toward the out-of-pocket maximum if you stay within the PPO network. Once one person meets $2,500, the plan pays 100% for that person only. The other members of the family would have to accumulate the additional $2,500 (or one additional person of the family meeting $2,500).

28. I think it would help if you use the compare medical plans chart and a medical issue (i.e. a broken arm) to walk us through how the costs work.

An example of how the deductible, copays, and coinsurance all interact with each other to reach the out-of-pocket maximum was provided in the "On-Demand Learning" presentation. We recommend you review this presentation for more information. In the packet being mailed to homes, claims examples are being included (pages 9 – 12 of the on-demand learning presentation).

29. Is there a chart that breaks down inpatient hospital type procedures and "other services"?

Let us answer this in two parts as it relates to the high deductible health plan – the IRS defines what is considered a qualifying expense in order to use your health savings account dollars. Please refer to IRS publication 502 or publication 969 for exhaustive lists.

Separately, any covered benefit under the plan would apply to the in-network deductible and out-of-pocket maximum. Please refer to the Summary Plan Description (SPD).

30. Is Teladoc still free of charge? Or do we need to meet the $6,000 out-of-pocket max first before it's free?

The IRS governs the high deductible health plan and the IRS rule is that there can be no first dollar coverage (i.e. copay) before the deductible is satisfied. The charge for a Teladoc visit under the high deductible plan is $59/visit until the $1,400 single/$2,800 family deductible is met. Once the deductible is met, there is no charge for Teladoc visits.

Under the Traditional PPO plan, it will continue to operate as it has in the past. The service will be free of charge and the $250 deductible does not apply.

31. So, HSA deductible of $1,400 must be met for Teladoc?

The $1,400 individual deductible does have to be met for Teladoc visits to be free of charge. You can still utilize the Teladoc services prior to satisfying the deductible; the consultation cost is $59/visit. This is the IRS requirement for no "first dollar services".

32. Under the Traditional PPO plan, are chiropractic visits at a copay or 10% after deductible?

Chiropractic care is NOT subject to the deductible while in-network under the Traditional PPO option; a $20 copay applies. For this plan, chiropractic visits are limited to 26 visits per year.

33. Is there a list for items that qualify for deductible on the high deductible health plan? And can I combine items – Teladoc and other items?

Yes, please refer to the Summary Plan Description (SPD), as covered services apply to your deductible. Any covered benefit under the high deductible health plan would apply to the deductible and out-of-pocket maximum. Depending on where you access care, in or out of network, will determine the applicable coverage levels.

34. Are we going to receive an EOB brochure for the new plan, or can it be found somewhere?

Yes, an example Explanation of Benefits (EOB) will be posted to the City internet site/intranet. This will walk you through how to read your UMR explanation of benefits.

35. What is the premium cost of the HDHP vs the traditional PPO cost to employee?

Currently, there are no premium contributions requirements for either plan. Please contact your union representatives for more information on anticipated amounts and effective dates of future changes.

36. Under these new plans can a family member have double coverage?

Yes, if you are enrolled in the Traditional PPO plan. Coordination of benefits rules still apply.

Regarding double coverage under the high deductible health plan, you may not have other primary coverage and contribute to a health savings account UNLESS that other coverage is also an HSA compatible high deductible health plan. The IRS governs these rules, not the City of Turlock. You have the option to enroll in the high deductible health plan through the City of Turlock if you have other coverage; however, neither you nor the City of Turlock would be able to contribute to the HSA account on your behalf. See question #83 on how qualified medical child support orders (QMSCO) or other primary child coverage interacts with this IRS rule.

37. But could you still have double coverage for dental and vision?

Correct. These operate outside of the medical plan and any coordination of benefit rules still apply.

38. **I understand there is no cost at this time but if the premiums were to come into play during the contract year, what impact would that be or are the no premium for this year locked into place until July 1, 2021.**

    Again, we are unable to provide an extensive response to this question. Currently, there are no premium contribution requirements in place. Please contact your union representatives or Human Resources for more information on anticipated amounts and effective dates.

39. **If there is premium imposed, can the medical FSA change mid-year?**

    Our insurance broker, Winton-Ireland Insurance Agency, is researching this question under the IRS Section 125 rules. The IRS is very We will provide an update once we have a response.

40. **Just to confirm, you still get the negotiated rate while you are meeting your deductible.**

    Absolutely! We always recommend seeing contracted (or in-network) providers for covered healthcare services, as you will only be responsible for paying that negotiated (discounted) rate. For example, if a primary care physician office visit is billed at $300 and discounted to $150, specific to the high deductible health plan, you will only be responsible for paying $150. The difference between the billed and allowed amounts, while in the PPO network, are contract write off amounts.

    If you choose to see out-of-network providers for healthcare services, please keep in mind you could be balance billed, as these providers are not under contract. Any balance billed amount does NOT apply to your out-of-network out-of-pocket maximum.

The questions below were added after the live Q&A held on 5/13/2020 and 5/14/2020:

41. **On the Traditional PPO plan, if each person in my family of 6 only had $1,000 each and no one met the $2,500, would the family out-of-pocket maximum still be $5,000?**

    Yes. A combination of family members can assist in meeting the full $5,000 out-of-pocket maximum. Once the out-of-pocket maximum is met, the plan will begin paying at 100% for everyone in the family. Keep in mind, no one person will exceed $2,500 toward the $5,000 family out-of-pocket maximum.

42. **Under the Traditional PPO, would I pay a $20 copay or 10% coinsurance after deductible?**

    Primary Care Physician and Specialist office visit copays are a $20 copay; deducible waived. Please review the benefit booklet to review the services where the 10% coinsurance applies. If the service reflects a 10% coinsurance, it will also be subject to the deductible (i.e. the deductible is met first then the 10% coinsurance applies).

43. How do prescription copays apply on the high deductible health plan?

As with medical healthcare services, prescription copays do *not* apply until the $1,400 single deductible or $2,800 deductible is satisfied. After the deductible is met, copays would apply. For example, if the retail cost of a generic medication is $300 and then discounted to $100, you would be responsible for $100 until the deductible is met. After the deductible is met, the generic prescription copay would be $10.

44. When and how long does it take to get reimbursed from the Health Savings Account?

We recommend registering online to access your OptumBank HSA account. There are a few options in order to reimburse yourself – 1) you can elect to have OptumBank pay your provider directly for the amount being billed, 2) you can use your OptumBank debit card to pay your provider, or 3) use the direct deposit option where OptumBank will deposit the requested funds directly into your bank account. The direct deposit option can take anywhere from 2 – 3 business days to process, depending on the timing of your reimbursement request.

45. Since the City of Turlock is contributing half of the HSA contribution on July 1, 2020, would I have to cover the additional cost and then be able to reimburse myself?

Yes. If the service is incurred July 1, 2020 or after, you could use the money in your HSA to pay for a portion of the expense. Once additional money is funded into the HSA by either yourself (through pre-tax payroll deductions) or the City of Turlock, you could request reimbursement.

46. Where can I look to estimate the cost of a service if I am enrolling the high deductible health plan?

There are two ways to obtain this information:

1) Please visit umr.com, register to establish an online account (if you don't already have one), and conduct a provider search under the UnitedHealthcare Select Plus network. We encourage you to register as a member; if you search the network as a member, the provider search list will *exclude* Sutter Health providers and all affiliates. If you choose to conduct a provider search on umr.com public website, without registering as a member, this will *include* Sutter Health providers and all affiliates. This will provide inaccurate results based on the City of Turlock excluding Sutter facilities.
2) Review past claims incurred by you and your family. The UMR Explanation of Benefits (EOB) will reflect total billed amount and total allowed amount. The allowed amount is the amount you would pay to the provider if you choose to enroll in the high deductible health plan, as the contracted (allowed) amount to the provider is the same regardless of which plan you have.

47. How does the management groups retiree savings account through ICMA work with any HSA funds acquired at time of retirement?

We would recommend you discuss this with the ICMA representative.

48. Can employee premium contributions be paid with HSA dollars?

Generally, you cannot use HSA funds to pay for health insurance premiums unless the premiums are for long-term care insurance (subject to IRS mandated limits based on age) or Medicare (if you are 65 or older).

49. I have an old health savings account from a previous employer, which I no longer utilize. Can I transfer the balance? Will the Optum Bank account have issues being set up?

You can transfer funds from an old HSA account to the Optum Bank account. You can contact Human Resources for the correct transfer form. Once you complete this form, you will need to contact the company who manages your *old account* in order to work with them to ensure funds are transferred.

50. If a service is incurred prior to July 1, 2020, can I utilize the health savings account to pay for these expenses?

No, as this is not a qualified expense since the service was incurred before the health savings account was established. In tandem with this, it is also not a qualified expense as it was incurred on a Traditional PPO plan.

51. Are the slides available for this presentation?

Yes, and we encourage you to review if you have additional questions. It can be located at https://vimeo.com/417280312. Please utilize the password referenced on the postcard in order to access the video.

Additionally, we encourage you to review the on-demand learning presentation for claims examples https://www.youtube.com/watch?v=yD7BQwZlHfE. This presentation does not require a password.

52. Are well-baby visits considered preventive? Does this also include vaccination shots for children?

Yes. The U.S. Preventive Services Task Force website identifies the type of immunizations covered and any respective age limits. Please visit https://uspreventiveservicestaskforce.org/uspstf/ for more information.

53. Are preventive well checks still available if you have a pre-existing medical condition, such as high blood pressure?

Yes. Please be aware, if you discuss any other medical condition during your preventive care visit, the provider's office may change the diagnosis from preventive to diagnostic. This means you will be responsible for any applicable deductible, copay, or coinsurance depending on the plan you enroll in.

54. Are supplemental vitamins covered?

No, supplemental vitamins do not qualify as a qualified expense on the high deductible health plan or under the health flexible spending account.

55. Will birth control pills be covered?

Yes, birth control is now covered under the women's health preventive care benefits. Generic birth control are covered with no cost share. If you choose to take a brand name medication for birth control, you would be subject to the brand prescription copay on the traditional PPO plan or pay the applicable discounted drug cost on the high deductible health plan.

56. Are the dental and vision plan benefits staying the same as they are now?

Yes. There are no changes to these plan benefits.

57. If a service is <u>not</u> covered by the health plan, regardless if you are enrolled in the Traditional PPO or high deductible plan, is the patient charged the fee scheduled rate or the billed amount?

Because the service is not covered, the provider would not be bound by their contract to limit their charges to the allowed fee (fee schedule amount). While we encourage you to seek care at contracted or in-network providers through the UnitedHealthcare Select Plus network, if this service is not covered by the Plan, our advice would be to negotiate with the provider in advance to see if there is a cash price, or a negotiated amount you can come to terms with that provider. Unfortunately, for non-covered services, you would be liable for the full cost on your own, without regard for the network contracted rate.

58. If your primary care doctor conducts a video visit, is that covered even after COVID-19?

Yes, telehealth services are covered. You will be responsible for any applicable deductible, copay, or coinsurance depending on the plan in which you enroll. Teladoc is also available and offers the telehealth services at a competitive rate.

59. I am allergic to bees, would my EpiPen be covered under preventive maintenance?

No. The U.S. Preventive Services Task Force identifies what qualifies as a preventive service. While you be using it to *<u>prevent</u>* a reaction, it is not considered a preventive service like a well-woman exam, mammogram, prostate check, etc.

60. I have a child who is turning 26 during the 2020-2021 plan year, when will coverage end for him/her?

Children are covered through the month of their birth. For example, if the child turns 26 on September 15th, they would be covered through September 30th. The dependent child would receive a COBRA election letter should they decide to continue their coverage at the listed rates.

The questions below apply specifically to those who are expecting babies:

61. On the high deductible health plan, should I expect to pay the family deductible of $2,800 or the $6,000 out-of-pocket maximum?

We would advise that you will most assuredly expect to pay the $2,800 deductible; however, once the deductible is met then copays apply to services. You would have to incur multiple services after the deductible is met for you to accumulate enough copays to meet the $6,000 family out-of-pocket.

62. If I am due to have a baby, is it still considered one patient or is the baby another charge on the high deductible health plan?

Yes, the baby would also incur their own set of charges after delivery. Unfortunately, we cannot tell you who would meet the deductible first (i.e. the mom or the baby). This depends on when the claims are received by UMR. It is important to keep in mind on this plan that either 1 person can meet the entire $2,800 family deductible or a combination of family members.

63. The high deductible health plan references a $150 copay after deductible for inpatient hospital so wouldn't we expect to pay that plus the deductible for the hospital fees? I am comparing this to the Traditional PPO plan which says I would be responsible for 10% of the bill after the deductible is met.

Yes, you could potentially be responsible for the $150 copay for inpatient hospital; however, this depends on when the claims are received by UMR. If the hospital claim is received first, then it would be subject to the deductible and, therefore, the $150 copay would not apply. If the physician's claim was received first, then it would be subject to deductible and then the $150 copay of inpatient hospital would *potentially* apply once it is received (if the deductible was fully satisfied on the physician's claim).

The questions below were added after the live Q&A held on 5/15/2020:

64. Who receives the FSA funds that are forfeited at the end of the plan year?

The IRS dictates who is to receive the forfeited funds. The IRS states the funds can be kept by the Plan Sponsor, in this case it is the City of Turlock, to assist in defraying administrative costs.

65. If we choose to enroll in the high deductible health plan with the health savings account and later change to the Traditional PPO plan, can we use health savings account funds for those PPO bills in the future?

Yes, you may use funds in a health savings account for any qualified expenses; however, the IRS states you *cannot* contribute to a health savings account *unless* you are enrolled in a high deductible health plan which is compatible with a health savings account.

66. If I have a health savings account, can I identify a beneficiary to receive the funds if I pass away? Can I do this "In Trust" to avoid probate?

Once your account is established by OptumBank, you can register online to add a beneficiary as well as manage other aspects of your account. We would encourage you to contact OptumBank directly to discuss alternative methods of adding beneficiaries such as an estate or trust.

67. Does the $2.75 per month fee only apply if your health savings account balance is less than $3,000?

The 2.75 per month fee is charged every month regardless of the balance in your account.

68. Can I use my health savings account funds for skilled nursing expenses?

Yes, any deductible or coinsurance incurred for services at a skilled nursing facility are considered a qualified expense.

69. With the health savings account, should I wait for the negotiated amount before paying the bill with debit card or pay at time of service?

We recommend you wait until the claim is received and processed by UMR to ensure you do not have to request a refund from the provider later. Sometimes it can be difficult to receive a refund from a provider as they may recommend you keep it on account as a credit for the next time you incur services. There may be a time where a provider will request a portion from you up front. In this case, we leave it to your discretion on how to work with the provider. If the provider would like you to pay if you have money left to incur toward your deductible, please ensure they have called UMR to verify the amount.

70. Aside from the high deductible health plan with an HSA being a "savings" account if not used, Is there any other value of the high deductible health plan? I could just save the money myself.

The biggest advantage of enrolling on an HSA compatible high deductible health plan is the ability to contribute *pre-tax* dollars to this account. While it is true you could simply save the money yourself, you benefit by paying less in taxes at the end of the year. Depending on your family situation, the tax benefit may be of more value to you at the time you file your taxes. Only a tax advisor can assist you in identifying the best option. Generally, the tax savings is more of a benefit than simply saving the money in the health savings account with after tax dollars.

71. Is the HSA account invested or does it accumulate any interest?

The health savings account is capable of both accumulating interest and being invested. Once your account is established with OptumBank, please fee free to contact them for more information on investment opportunities and interest rates. Information can also be found online by navigating to www.optumbank.com or www.openenrollment123.com.

72. On the high deductible health plan for family, once the family reaches the $2,800 deductible please explain the 40% coinsurance for healthcare costs that I saw on one of the slides. Can any out-of-network charge be applied to the annual deductible?

The 40% coinsurance only applies to out-of-network services. Each benefit tier, in-network and out-of-network have their own separate accumulators (i.e. deductibles and out-of-pocket maximums). The individual out-of-network deductible is $2,800 and the family deductible for out-of-network services is $5,600. Please reference the benefit booklet for more information.

A covered service under the plan would apply to the out-of-network deductible and out-of-pocket maximums.

73. What ambulance fees are under the Traditional PPO plan and the high deductible health plan?

On the Traditional PPO plan, ambulance services are subject to the $250 individual deductible first. Once the deductible is met, 10% coinsurance applies up to the $2,500 out-of-pocket maximum.

On the high deductible health plan, ambulance services are subject to the $1,400 individual deductible or $2,800 family deductible first then $50 copay per trip after deductible.

74. How do I find out how much my current medication costs?

Please register on umr.com to review your claims history which includes prescription claims. If you are going to be taking a new medication you have not previously taken, please visit OptumRx's website where you will be able to lookup the type of medication and its associated cost. You'll need to know the specific medication name as well as dosage (i.e. mg) and quantify (i.e. how many pills per day/month).

75. After you meet the deductible on the high deductible health plan it looks like it would be hard to get to the out of pocket max because the co-pays are very low after that.

Correct. It would take an individual or family multiple services to incur enough services to accumulate copays to meet the out-of-pocket maximums.

76. What is "first dollar coverage?"

This is insurance lingo which means the plan will pay the balance on a service once the applicable copay is paid by the patient **without** the patient having to meet the deductible first. Anytime you see a benefit listed with a copay and the words "deductible waived" means there is first dollar coverage.

77. Are there specific in-network hospitals? If you are out of the area and get seriously injured, are we expected to drive to an in-network hospital to receive the maximum plan benefits?

This is a 3-part answer:

A. Yes, there are specific in-network hospitals in the immediate area. Please familiarize yourself with these should you be hospitalized for a non-emergency service.

B. If you are out of the area and get sick, again non-emergency, while you are on vacation, you can log into your account on umr.com to search for contracted providers in the area. The United Healthcare Select Plus network is a national network and there may be contracted providers, such as urgent cares, in all areas of the United States.

C. If you are out of the area and have a life or limb threatening emergency, please go to the nearest emergency room. Per the Affordable Care Act, services incurred at an out-of-network facility for emergency services must be paid at the same *benefit level* as if you were seeing a contracted or in-network provider. Note the words "benefit level". Since an out-of-network provider is not contracted to accept discounts, they may try to balance bill you. If this happens (i.e. you receive an actual bill from the provider charging more than what is reflected on the Explanation of Benefits), please contact UMR first for assistance. UMR may be able to negotiate with the provider to greatly reduce the balance billed amount. If UMR is unsuccessful, please contact Winton-Ireland, Strom & Green Insurance Agency as they will try to advocate on your behalf as well. If they are unable to negotiate, we encourage the patient to work with provider to settle on a balance.

78. On the Traditional PPO plan, I took a child to the emergency room and we say it was going to cost $1,200 at the hospital, can you explain how that would work with the benefit listed?

In this example, we are going to use $1,200 as the allowed amount for simple math and benefit application. The allowed amount is *after* discounts are applied (i.e. total billed minus discounts equals allowed amount). Typically, the use of emergency room would be more costly.

First, emergency room services are subject to the deductible and the $250 would come right off the top as patient responsibility. This leaves a balance of $950. Once the deductible is met, the patient is responsible for $150 copay. This now brings the balance to $800 and the total patient responsibility to $400. The 10% is then calculated from the $800 balance; therefore, the patient would be responsible for an additional $80 ($800 X 10% = $80). Total patient responsibility on this bill would be $480 and the health plan would pay the additional $720.

79. If I retired today, what would it cost me to stay on this plan?

These rates are currently being developed and are subject to change each plan year. Please check with Human Resources in a few days for more information.

80. How much does the city budget for individual or family per month for health care coverage?

Please contact your union representation as this information was provided during negotiations. You may also contact Human Resources.

81. If I enroll on the high deductible health plan with the HSA, how many debit cards will I receive?

During the account vetting process, you willl receive an email with instructions to verify your identity. During the setup, you will be asked if you want debit card(s) issued and to whom. Additional cards can be ordered anytime in the future by using your member portal at www.optumbank.com, using the mobile application, or by calling customer service.

82. If I have a child that is in college, but still enrolled on the health plan, how does the health savings account work? Can I use the HSA to reimburse their expenses as well?

Family situations vary greatly so it's always best to check with your financial advisor for any tax advice. Generally, contribution limits to an HSA are determined by the type of coverage — individual or family. Even if your spouse or dependents are not covered by your high-deductible health plan, you may use your HSA dollars to pay for qualified medical expenses for them, if it is used for IRS dependents. ***However, if you have adult children covered under your health plan, you may not use your HSA to pay or reimburse yourself for their qualified medical expenses if they are not your tax dependents***. However, those children may be able to open their own HSAs and contribute up to the limit dictated by the type of health plan they are covered under — individual or family.

83. If I want to enroll on the high deductible health plan with the health savings account, and am required by my divorce (or court order) to cover my children on my health plan, and my kids have double coverage between the City of Turlock and my ex-spouse's plan (City of Turlock primary). Is this considered "other first-dollar coverage" by IRS definition that would exclude me from contributing to an HSA account?

The City of Turlock plan must comply with any custody and/or court orders. If you are considering the high deductible health plan with the HSA, and you have children who have other primary coverage that may pay as a traditional plan (non-HDHP), their coverage is not considered other primary coverage when applying this IRS rule. The IRS states that the primary tax filers can establish an HSA account. In addition, your tax dependents cannot establish their own account, therefore, because of this, their other coverage is not considered when applying this rule.

Please feel free to re-visit this list as often as you feel necessary in order to make the best health plan decision for you and your family. Also, please contact Human Resources or Winton-Ireland Insurance Agency directly for any questions you may have specific to your unique situation.

For specific questions or help, contact the following:
Human Resources: 209.668.5150 or humanresources@turlock.ca.us
Winton-Ireland, 209.667.0995: Andrea ext 3101 (ahiykel@wisg.com), Gina ext 3053 (grogers@wisg.com), Lynn ext 3056 (lbull@wisg.com)