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Human Resources: Frequenty Asked Questions regarding the HDHP and HRA

Q. Does WHOI plan on continuing to pay 75% of the HDHP premium in future years?
A. As part of WHOI's long-term commitment to provide a balanced total compensation package, it is WHOI's intent to continue to cover 75% of the premium cost for this medical plan. However, due to uncertainty of annual medical renewals and budget constraints, we cannot make any guarantees. This will need to be evaluated on an annual basis.

Q. Does WHOI plan on continuing the employer-funded HRA in future years?
A. Again, it is WHOI's intent to continue to offer this benefit as part of the HDHP option but we will need to review it on an annual basis.

Q. It seems too good to be true! Why wouldn't someone enroll in the HDHP?
A. There is no catch to the HDHP. Because of the lower premium cost, greater WHOI cost-share, and availability of the HRA that covers 50% of the annual deductible, it is an attractive option for many employees. The HDHP is still a choice for employees and should be considered carefully before enrolling. Typically, a high deductible health plan is not desirable to those who are not comfortable with taking the upfront risk for paying out-of-pocket expenses, which can create a cash flow issue for some.

Q. Is there any situation where any employee would not save money under the HDHP compared to the other HMO or Access plans?
A. Under the employee scenarios that were illustrated in the HDHP presentation, we showed in each case there was opportunity for savings. Again, with the lower cost premium and WHOI-funded HRA, employees are at an advantage even when meeting their annual deductible under the plan. However, in these scenarios we assume the members are using "in-network" providers. On an individual basis, you must consider your own risk for using out-of-network benefits which could then result in a negative savings for some.

Q. What is considered in-network under the HDHP?
A. Any provider or hospital in the PPO Preferred Network which includes over 90% of all providers and hospitals in the United States. There are even some participating providers outside the U.S. in places like Puerto Rico and US Virgin Islands. All employees considering enrolling in the HDHP are encouraged to check if their current providers are in the PPO network. Use the following link to find a PPO Preferred network provider or hospital (use "XXP" for the 3-digit ID number):
http://www.bcbs.com/healthtravel/finder.html

Q. What is considered out-of-network under the HDHP?
A. Any provider or hospital who does not have a contract with BCBS. Remember, under the HDHP, members are allowed to use any provider (in or out-of-network) but understand there will be additional co-insurance charges for using an out-of-network provider up to the annual out-of-pocket maximum under the plan. So, employees should plan carefully when traveling, to locate an in-network provider or participating hospital. Of course, in an emergency situation, you should always go to the nearest hospital. See question #8 for additional explanation on the treatment of Emergency Room service charges.

Q. Although the PPO Preferred Network is a national network and provides for coverage outside of Massachusetts and across the United States, how will this affect employees working out of the country for a good portion of the year?
A. Coverage through a non-network provider will be covered under the 'out-of-network' level of benefits and will require a separate co-insurance (20% of charges) above and beyond the annual deductible but not to exceed the annual out-of-pocket maximum ($5,000 per member, capped at $10,000 per family). (NOTE: The out-of-pocket max is a combined amount of deductible and co-insurance charges.)

Q. How are Emergency Room visits covered for out-of-network hospitals?
A. An Emergency Room visit anywhere is covered at the in-network level for all BCBS medical plans, requiring the standard co-payment, or deductible under the HDHP. However, if a member is admitted to the out-of-network hospital as part of that ER visit, then under the HDHP that part of the visit will be covered as an out-of-network benefit and will require co-insurance above and beyond the deductible up to the calendar year out-of-pocket maximum. Once the out-of-pocket maximum is met, the remainder of the charges are covered in full by BCBS.

Q. The HRA will fund the first 50% of the annual deductible. Does this mean if a member is subject to a $500 deductible charge for a service, the HRA will fund ½ of that ($250)?
A. No, the HRA will fund upfront full reimbursement of charges up to 50% of the total annual deductible. So, in the example above, this employee would receive the full $500. For individual coverage, an employee can receive reimbursement for the first $1,000 incurred in deductible expenses for the year. For individual plus (employee + spouse/domestic partner or employee + children) or family coverage, the employee can receive up to the first $2,000. Once the HRA is exhausted, the employee is then responsible for the remainder of charges up to their applicable annual deductible, or out-of-pocket maximum if using out-of-network coverage.

NOTE: The HRA will reimburse for deductible expense for any member of the family who is covered under the HDHP, not just incurred expenses of the employee.

Q. What services are subject to the annual deductible?
A. Most services are subject to the annual deductible with the exception of your "routine annual exams" like your annual physical, annual GYN exam, annual vision, and other routine preventive tests like mammograms and colonoscopies. It is very important for employees to understand the difference between a preventive visit vs. a sick or medical visit. Although a procedure may seem preventive in nature to

you, it may not be covered as such under the medical plan. For a complete list of what is covered as routine preventive care (for adult and children), please refer to this link:
http://www.whoi.edu/cms/files/Preventive_Services_53965.pdf

Also, it is important to note that the covered routine preventive visits must be performed by an in-network provider, otherwise you will be subject to the deductible plus the additional out of pocket maximum for using out-of-network coverage. All other visits not noted on the list at the link above are subject to the upfront deductible.

Q. My doctor orders me to have routine tests each year in order to prevent a serious health problem. Will this be covered as a preventive service?
A. If the tests are performed as part of the annual routine preventive visit, then they are covered as part of that visit and included in the $15 office visit co-payment. But, if the tests are performed outside of the annual physical exam, then it would be subject to the annual deductible.

Q. What is my maximum exposure for out-of-pocket expenses?
A. If utilizing in-network benefits, you are subject to up to the annual deductible, less the WHOI HRA contribution. So, a net deductible of $1,000 for individual coverage or $2,000 for individual plus (employee + spouse/domestic partner or employee + children) coverage, plus any co-payments for office visits and prescription drugs*.

If using out-of-network coverage, you are subject to up to the annual out-of-pocket maximum, less the WHOI HRA contribution. So, a net maximum of $4,000 for individual coverage or $8,000 for individual plus (employee + spouse/domestic partner or employee + children) coverage, plus any co-payments for office visits and prescription drugs*.

* office visit and Rx co-payments are not subject to and do not count towards the deductible or out-of-pocket maximum and will always apply to the member.

Q. Is there a lifetime maximum for covered services under the HDHP? In other words, is there a limit to the maximum dollar amount BCBS will pay in medical claims per individual member?
A. No, there is no limit to covered medical claims under any of the BCBS plans.

Q. Are chiropractic visits covered? If so, are they covered as a preventive visit? Is there a maximum number of visits per year like the Access Blue plan?
A. Yes, chiropractic visits are covered and are subject to the annual deductible. They are not considered a preventive service and are covered under the $15 office visit co-payment only if and after the annual deductible has been met. There is no limit under the HDHP for the number of chiropractic visits per year.

Q. Are pediatric dental services covered under the HDHP?
A. Pediatric dental is not covered under the HDHP, and is only covered under the Access Blue plan.

Q. If I have surgery and later find out that the Anesthesiologist is not a contracted provider with BCBS, am I responsible for those charges under out-of-network coverage?
A. *If this does happen, BCBS will cover the charges at the in-network level as long as the services were performed at an in-network facility. If a member receives a separate bill for these charges, you should contact BCBS immediately so they can help resolve the matter.*

Q. If I incur claims in December but the provider does not submit the claim to BCBS until the next year, how will these claims be charged against my deductible?
A. All claims will be processed based on the actual date of service.

Q. I was told I should not pay for any deductible charges at the doctor's office, but what if I do?
A. Providers in the PPO Preferred Network are very familiar with these types of plans and should not be requesting payment at the point of service. The provider will send the claim to BCBS for appropriate adjustment to determine the 'allowable or discounted charges' and then the provider will bill you for that allowable amount. There may be a situation where you pay the $15 office visit charge for a deductible service and will you need to ensure that that amount is deducted from the bill or from your payment to the provider.

Q. Who do I pay for my deductible charges?
A. Your provider will bill you and you pay the provider directly. Under the HDHP, employees will receive a Claims Summary (also known as Explanation of Benefits) for all charges and the total amount that the member is responsible for. This information is also sent to the provider, so the provider should not be billing you for any amount over the BCBS summary amount. If there is a difference in the amount that your provider is billing you, you should report this immediately to BCBS as providers are not allowed to balance bill their patients for in-network benefits.

Q. I have a child that attends college out-of-state, how will the HDHP plan benefit me?
A. The HDHP might still be a good option for college students residing out of state. Under the HDHP, there is a very large provider network, which means there is a good chance you should be able to find an in-network doctor and/or hospital in the geographic area of

your child's school. Do some research and check to see if providers and hospitals near your child's school are in the BCBS PPO Preferred Network. Remember that, under the HDHP, your child can seek care anywhere – even at out-of network providers and hospitals. If out-of-network, those costs would just be subject to additional expenses up to the out-of-pocket maximum.

Q. Are the HRA funds taxable to the employee?
A. No, there are no tax consequences for HRA funds. The employee does not claim HRA reimbursements, nor does the employer claim it on the employee's payroll taxes.

Q. Can I use my Health Flexible Spending Account (FSA) for deductible expenses? How do the HRA and FSA work together?
A. You can have both a HRA and FSA account. However, you cannot receive reimbursement from your FSA for the same reimbursements you receive from your HRA (you can't double dip). Reimbursements are drawn from your HRA first. Once your HRA is exhausted, then you can request reimbursement from your FSA for the 2nd half of your deductible. You can always use your FSA for eligible out-of-pocket expenses, such as office visit and prescription co-pays.

Q. How will I receive my HRA reimbursement?
A. WHOI has contracted with Benefit Strategies to administer the HRA. This is the same vendor we have been using for our FSA administration. BCBS will notify Benefit Strategies on a weekly basis when an employee or member incurs any deductible charges. Benefit Strategies will automatically process the HRA reimbursement for whatever is available from the employee's HRA balance and cut a check directly to the employee (the employee can also elect to receive direct deposit payments). The employee will pay the provider directly.

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