

# HealthPlus PPO FAQ'S

## Transition from CBT to HealthPlus PPO

**1. What is the effective date of the HealthPlus PPO coverage?**

July 1, 2011.

**2. I've heard of HealthPlus HMO. What is the difference between an HMO and this PPO coverage?**

CBT and MESSA were both PPO Plans. PPO's do not require referrals from your doctor to see a specialist, as with an HMO. In addition, you are not required to identify one Primary Care Physician, as with an HMO.

**3. Can I make changes to my elections? (single, couple, family, cash in lieu, etc.) at this time?**

No. Everyone that is currently participating in CBT will be moved to the HealthPlus PPO with the same level of coverage. You will have the ability to make changes during our annual open enrollment, which occurs in November.

**4. Can I move to the HealthPlus HMO at this time?**

No. Because this is not an open enrollment, you will be moved to the HealthPlus PPO plan, which is equivalent the CBT PPO plan. You will have the ability to make changes during our annual open enrollment, which occurs in November.

**5. How do I find out if my doctor is in the HealthPlus PPO network?**

- Go to [www.healthplus.org](http://www.healthplus.org)
- On the top of the screen, click on the "Find a Doctor/Hospital"
- Under "Select Your Plan", select **HealthPlus PPO**
- Under "Select Your State", if you select any state other than Michigan, you will see an icon for a provider network in that state. Click on the icon to go to that online provider directory.
- Under "Select Your State", if you select Michigan, you will have the option of searching the HealthPlus PPO network or the **Cofinity network**. Click on the icon to go to that online provider directory.

Note: The Cofinity network is the same network used by CBT.

**6. What can I do if my doctor doesn't participate with HealthPlus PPO?**

Begin by calling HealthPlus at 888-212-1512 to notify them of the situation. Often times, HealthPlus can encourage providers to join the HealthPlus network. You can receive services from out of network providers. However, out of pocket costs which are the responsibility of the employee will be incurred. Refer to the Custom PPO Plan # LT (WRAP Plan) benefit summary and schedule of benefits for specific information. Both may be found at [http://www.mcc.edu/hr/hr\\_healthwellness.shtml](http://www.mcc.edu/hr/hr_healthwellness.shtml).

Note: If your doctor was in the CBT Cofinity network, they should be in the HealthPlus PPO Cofinity network.

**7. If my doctor is in the HMO network, will they automatically be in the PPO network?**

Not necessarily. However, there is a good likelihood that they are either directly contracted with HealthPlus or that they participate in the Cofinity network, and are therefore, an in-network provider.

**8. What do I need to do if I am currently under active treatment for an ongoing medical condition?**

HealthPlus understands the importance of continuity of care. Please talk with your healthcare provider to ensure they are a participating provider with the HealthPlus PPO or check for yourself by following the instructions above. If he/she is not a participating provider, you can continue to see that provider using your out-of-network benefits. You can also call HealthPlus at 888-212-1512 and discuss your condition with them to ensure a smooth transition to your new coverage.

**9. What do I need to do if I have a surgery or procedure scheduled close to the time of the transition to HealthPlus?**

If your surgery or procedure is scheduled prior to your effective date with HealthPlus, you should follow the guidelines established by your current carrier. If it is scheduled for on or after July 1, 2011, you should check with your provider to ensure appropriate prior authorization has been secured. A list of services and supplies which require authorization was provided during the recent series of employee meetings and is also available at [http://www.mcc.edu/hr/hr\\_healthwellness.shtml](http://www.mcc.edu/hr/hr_healthwellness.shtml). You can also call HealthPlus at 888-212-1512 and discuss your condition with them to ensure a smooth transition to your new coverage.

**10. What do I need to do to ensure I have coverage on July 1<sup>st</sup>, 2011?** Your coverage will be transferred from CBT to HealthPlus PPO seamlessly with no action required on your part. You should receive your HealthPlus PPO identification card no later than June 30th. Beginning July 1st, present your HealthPlus PPO identification card any time you receive medical or prescription drug services. If you have not received your HealthPlus PPO identification card by June 30th, contact a HealthPlus representative at 888-212-1512 and request your Member ID number. This ID number will allow you to receive medical and prescription drug services over the July 4th holiday even if you have not received your actual card. You will no longer use your Aetna or CareMark cards.

**11. Will my bi-weekly employee contribution to premium change?**

No. Your bi-weekly employee contributions will remain the same as they were with CBT.

Coverage (Employee Groups)	Per Pay Period Employee Contribution
Single (all employee groups)	\$0
Couple (PT, AS, M&O, Exempt grades 12-24)	\$10
Couple (S&M, Exempt grades 1-11)	\$20
Family (PT, AS, M&O, Exempt grades 12-24)	\$15
Family (S&M, Exempt grades 1-11)	\$30

**12. Who do I contact if I have a billing issue from a claim that occurred while I was still covered by CBT (service date prior to July 1, 2011)?** SET Employee Benefits (SET SEG) has agreed to work on your behalf answer any claim or billing issues associated with the CBT coverage and ensure issues are addressed in as timely a manner as possible. Call a SET SEG representative at 800-292-5421. In most cases, the SET SEG representative will ask for a summary of the issue and any supporting documentation (provider bills, etc.). Once this information is provided, the SET SEG representative will contact CBT, advocate on your behalf, ensure the matter is resolved, and then follow up with you a

report of the outcome. Turnaround time on these inquiries will depend upon the complexity of the matter.

**13. Will my dental and vision coverage change with the HealthPlus PPO plan?**

No. Your dental and vision coverage will remain unchanged.

**14. How many HealthPlus PPO identification cards will I receive?**

A family of 1-5 will get 2 cards, a family of 6 will get 4, a family of 8 will get 6 and so on. Additional cards, at no charge, can be requested by calling the HealthPlus Customer Service line at 888-212-1512.

## **HealthPlus PPO Plan**

**15. How will my medical coverage change?**

Your medical coverage will not change. The HealthPlus PPO coverage with third party administration services provided by Employee Health Insurance Management, Inc. (EHIM) is an exact match to the current CBT coverage. This includes not only what is covered, but the other “rules” such as dependent eligibility and effective dates of coverage.

**16. What does “in-network” vs. “out-of-network” mean?**

“In-network” providers have an agreement with HealthPlus to provide services for a set schedule of charges. These agreed upon charges are referred to as “Reasonable and Customary” (R&C). If you go to an “in-network” doctor, the R&C charges apply which help control the cost of healthcare and your out-of-pocket costs remain minimal. If you go to an “out-of-network” doctor, because there are no R&C agreements with HealthPlus, the charges for treatment can be much higher and therefore your out-of-pocket costs increase.

**17. Will I need referrals to see specialists?**

No. Unlike the HealthPlus HMO, you do not need a referral to see a specialist. You can choose to see any doctor within the HealthPlus PPO/Cofinity network. The network includes primary care physicians and specialists. You can make an appointment with a specialist just as you would with your primary care physician. To verify that your doctor and/or specialists are in the HealthPlus PPO network, refer to question #5.

**18. I did not have in-network deductibles with CBT. Why does the Benefit Summary indicate that I will now?**

There are in-network deductibles tied to the HealthPlus PPO Plan (\$1,250 per person/\$2,500 per family), however The College will be funding and paying for all in-network deductibles. You will not pay any out-of-pocket expenses related to your in-network medical coverage. (See EHIM section of this document for more information.)

**19. Will my copay for office, urgent care, and emergency room visits change?**

Yes. These copays have been eliminated for the remainder of the plan year (through 6/30/12).

**20. The handout regarding services and equipment needing prior authorization says that CPAP equipment must be recertified every 3 months. Do I need to do that?**

No, this is handled between the insurance company and the equipment provider. This handout was informational only.

**21. When my doctor is doing their pre-visit insurance verification, will HealthPlus know the status of my deductible?**

Yes.

**22. Am I covered by HealthPlus, Cofinity or EHIM?**

You are covered by HealthPlus. If your doctor asks what insurance you have, the answer is HealthPlus PPO. Cofinity is the network of participating doctors with the HealthPlus PPO plan. The HealthPlus PPO plan provides in-network access to providers that participate in the HealthPlus PPO or the Cofinity network. EHIM is the 3<sup>rd</sup> party administrator that will be processing and paying, on behalf of MCC, any In-Network deductibles (\$1,250 per person/\$2,500 per family). EHIM is explained in more detail later in this document.

**23. Is Prior-Authorization for procedures and/or surgeries required?** Some services and supplies require prior-authorization. Providers typically understand which services and supplies to which this requirement applies. However, it is advisable to ask your provider if a particular service or supply requires prior-authorization. The intent of prior-authorization is not to deny services or supplies but rather to ensure that the services and supplies are optimal for the given situation and in the best interest of the subscriber. A list of services and supplies which require prior-authorization was provided during the recent series of employee meetings and is also available at [http://www.mcc.edu/hr/hr\\_healthwellness.shtml](http://www.mcc.edu/hr/hr_healthwellness.shtml).

**24. Is Prior-Authorization required for High-Tech Radiological Services?** Yes, HealthPlus has partnered with CareCore, to ensure that our members are receiving the safest, most appropriate radiological testing. Your doctor will work with CareCore to determine whether radiology testing is appropriate for your condition. Using CareCore helps prevent repeated, unnecessary and possibly dangerous radiological tests and improves safety. The doctor managing your treatment must obtain prior authorization for the following tests from CareCore to prevent you from incurring additional out of pocket costs: Computed tomography (CT/CTA), Magnetic resonance (MRI/MRA), Positron emission tomography (PET), Nuclear medicine (e.g., bone and thyroid scans), Nuclear cardiology (e.g. cardiac stress tests).

**25. If a service (such as an MRI is denied), what can I do?**

You can appeal the decision. Services are usually only denied for a lack of documentation. Therefore, once HealthPlus receives the documentation they need, the service is typically approved.

**26. Can I get a flu shot in my physician's office?**

Yes.

**27. Can I get blood work done in my physician's office?**

Yes.

**28. What about chiropractic care? Is therapeutic massage covered?**

Like the CBT plan, the HealthPlus PPO plan allows for 38 chiropractic visits per year included therapeutic massage.

**29. Is HealthPlus PPO the primary coverage in an auto accident?**

Yes.

**30. Am I covered when traveling abroad?**

Yes. You are covered for emergency services. You may need to pay out of pocket at the time services are rendered, but you will be reimbursed.

**31. How can I find out more about what is covered under the HealthPlus PPO plan?**

Refer to the Custom PPO Plan # LT (WRAP Plan) benefit summary and schedule of benefits for specific information. Both may be found at [http://www.mcc.edu/hr/hr\\_healthwellness.shtml](http://www.mcc.edu/hr/hr_healthwellness.shtml).

**EHIM (3<sup>rd</sup> Party Administrator)**

**32. What is EHIM?**

EHIM stands for Employee Health Insurance Management (EHIM). EHIM is a 3<sup>rd</sup> party administrator that will be processing and paying, on behalf of MCC, the In-Network deductibles (\$1,250 per person/\$2,500 per family).

**33. What role will EHIM have with my HealthPlus PPO benefits?**

There are in-network deductibles tied to the HealthPlus PPO Plan (\$1,250 per person/\$2,500 per family), however The College will be funding and paying for all in-network deductibles. You will not pay any out-of-pocket expenses related to your in-network medical coverage. EHIM will be processing and paying the in-network deductibles on behalf of The College. After the deductible(s) have been met, claims will then be covered and paid by HealthPlus.

**34. If I don't use all of my deductible, who keeps the remaining amount?**

The College only pays for the portion of the deductible that is used. Lower deductible usage will typically result in lower rate increases during the following plan year.

**35. Will EHIM's Customer Service number be on my HealthPlus PPO ID card?**

No. However, you will receive a wallet-sized card showing EHIM's contact information. In addition, you will receive shortly a card "sleeve" that your HealthPlus PPO ID card will fit into. The sleeve will also have the EHIM Customer Service number printed on it.

**36. After I meet my deductible, will I have any contact with EHIM?**

Yes. EHIM will continue to receive the claims and send you a simplified Explanation of Benefits (EOB) noting that the deductible has been met and that the claim was paid by HealthPlus. Furthermore, EHIM will review any claims denied by HealthPlus to see if they should be paid under the enhanced benefit coverage as a match to the prior CBT coverage.

**37. If I have already paid towards my yearly out-of-network deductible with CBT, do I have to start all over in regards to HealthPlus' out-of-network deductible?**

Yes. Deductibles will reset July 1 of each benefit year.

**38. Does EHIM have an online system for reviewing Explanation of Benefits for things like flexible savings accounts?**

No. However, you shouldn't have a need to submit anything to your FSA for medical services unless you use an out of network provider. There are no office visit, urgent care, or emergency room copays

and the deductible is paid by the College. Your prescription co-pays (\$10-generic, \$20-brand) can be submitted to your FSA but the register receipt or mail order receipt will suffice.

**39. What kind of reporting will EHIM provide to the College?**

The College will only receive reports showing aggregate data. Aggregate data includes statistical data and total deductible dollars paid for the group. The College will not receive any of your Protected Health Information. Protected Health Information includes services provided for you by your healthcare provider(s), procedure codes, billing codes, diagnostic codes, date of service , etc. EHIM is subject to HIPAA regulations just as HealthPlus.

**Pharmacy Benefit (Including Transition Questions)**

**40. Which pharmacies are in the network?**

The HealthPlus Pharmacy network includes most major pharmacy chains and many smaller, independently owned pharmacies. A list of participating pharmacies is available at [www.healthplus.org](http://www.healthplus.org).

**41. Will I have a separate prescription benefit card?**

No, unlike with CBT, you will have one card to use for both your medical and prescription coverage.

**42. Will my prescription copay change?**

No, your prescription copays will not change. Generics, brand drugs without a generic available, and prescriptions that are indicated “Dispense as Written” (DAW) by your physician remain at \$10 per prescription. All others are \$20 per prescription.

**43. Is the list of medications requiring step therapy that was provided during the employee meetings all-inclusive?**

Yes. The list may change from time to time but for now is all-inclusive. You will be notified in advance of any changes.

**44. If I am already using the generic equivalent of one of the medications shown on the Prior Authorization or Step Therapy list, do I need to fill out the New Member Prior Authorization Rx History Form?**

No.

**45. If I send an email to Jennifer Szumowicz at HealthPlus regarding prescriptions I am currently taking, can I just send an email or does she need the New Member Prior Authorization Rx History Form?**

You can simply send an email to Jennifer.

**46. What if my doctor writes me a new prescription for one of the medicines on the Prior Authorization or Step Therapy list after July 1<sup>st</sup>?**

You can get the medicine for the generic copay amount if the doctor indicates “Dispense as Written” (DAW) on the prescription. If the doctor does not indicate DAW, you will be required to try the generic first.

**47. Does HealthPlus PPO offer a prescription mail order program?**

Yes. Mail service prescription information was provided in the welcome packs you received at the recent employee meetings. You also received information in your welcome pack on HealthPlus' Ask for 90 Rx Program which complements the mail service prescription program. You can find these handouts and additional information about both of these programs on Mott Community College's website here: [http://www.mcc.edu/hr/hr\\_healthwellness.shtml](http://www.mcc.edu/hr/hr_healthwellness.shtml) or on HealthPlus' website here: <http://www.healthplus.org/ProviderPharmacyCenter.aspx>.

**48. I currently participate in Caremark's mail order program. Can I get my prescriptions transferred to HealthPlus' mail order program?** No. You will need to set up a new prescription through HealthPlus' mail service prescription program. It is recommended that you have all prescriptions filled prior to July 1 and then enroll in HealthPlus' mail service prescription program by going to <http://www.healthplus.org/PharmacyMailServicePrescriptions.aspx>. You may need to have your provider write a new prescription for your medications to complete the enrollment process for HealthPlus' mail service prescription program.

## **Customer Service**

**49. Who do I contact if I have an issue or concern?**

You have a wealth of resources available to you including the following:

- For questions regarding your medical benefits, call EHIM at 248-204-6440 (in the Detroit area) or 855-396-1159.
- For questions regarding your prescription drug benefits, call HealthPlus at For questions regarding your prescription drug benefits, call HealthPlus at 877-710-0993 or 888-212-1512.
- If you need any further assistance, call SET SEG at 800-292-5421.

Additional resources include:

- HealthPlus online at [www.healthplus.org](http://www.healthplus.org)
- Employee benefit information clearinghouse on Mott Community College's website at [http://www.mcc.edu/hr/hr\\_healthwellness.shtml](http://www.mcc.edu/hr/hr_healthwellness.shtml)
- Access to live HealthPlus representatives on a walk in basis at both the Saginaw and Flint locations.

**50. If I receive a bill from my doctor and the doctor calls and says I must pay it, who do I call?**

EHIM at 248-204-6440 (in the Detroit area) or 855-396-1159. However, if you call HealthPlus, the HealthPlus customer service representative will call EHIM for you and transfer you over to an EHIM representative.