

FAQ'S
(FREQUENTLY ASKED QUESTIONS)
Health, Pharmacy & Dental Plans – Active Employees

Q – How do I know what health plan I have?

A - Anthem sent you an **ID Card** when you enrolled. Please read the card. It will tell you the plan you enrolled in and whether or not you have dental coverage. You should have also kept a copy of the last enrollment form you completed and signed. This will also tell you the plan you elected.

Q – I have questions about what is covered under my medical, dental or pharmacy plan. How do I get my questions answered?

A – The best sources for information about your plans are the companies that pay the claims and perform administration. Anthem and Medco customer service units understand the details of the plans you are in. Although the Pension & Benefits office can be helpful with broad issues, we still have to call the carriers to get detailed answers. For prompt service, Anthem and Medco are a phone call away. **The phone numbers are on your ID cards.** You can also log onto www.myanthem.com, register and find information about claims, coverage and special programs. There are Anthem Summary Plan Descriptions available in hard copy or on online.

Q – Do I have “insurance” or is the City “self-insured?”

A - The City has hired Anthem and Medco to perform claim payment services under what is called an “Administrative Services Only” (ASO) arrangement. Although it looks and feels like we have “insurance”, we really pay fees to the vendors for services and the City “retains most of the risk”. There is “stop-loss” insurance to handle catastrophic losses, but, when claims are paid, the funds to pay the doctors, hospital, pharmacy and dental claims all come directly out of City funds. Anthem and Medco perform the plan administration and process claims on our behalf.

This ASO arrangement is an advantage because we do not have to pay premium taxes and certain other charges that would raise the total costs and your premium share associated with running these plans.

Q – My spouse has medical coverage through his/her company and I am covered under that medical plan. Can I pick up just the dental coverage from the City Plan?

A – The core part of the programs the City offers are the medical plans. If you elect a medical plan, you can also elect or decline dental, but **dental coverage cannot be selected as a stand alone part of the program.** We need to maintain a balance between the number of people covered by the medical and dental plans. Selecting dental alone creates a situation where people who have a higher likelihood of filing dental claims, will “select” just and only the program they need. By requiring

employees to select a broader spectrum of plans, the likelihood of “antiselection” diminishes as the claims then come from a larger, broad based population of covered individuals.

Q – I am a teacher. I am confused because my rates change in September and it appears that all the benefits run on a calendar year basis. Don't I get new plan maximums when I start the new school year?

A – No. The school year is different than the calendar year and so we have to tie your rates to when teachers receive paychecks. We collect your premium share starting each new school year, and ending in the spring of the following year. Benefit plan accumulators (deductibles, plan maximums) on the other hand, run on a calendar year basis. So for all employees in the City, the annual plan maximums reset each January 1, which ties to the tax year while the rates change mid-calendar year (July 1 for General Government – September 1 for Teachers and 10 month employees) so the *rates* tie to our fiscal year.

Q - Open enrollment is closed. What are the rules for adding dependents or a spouse later, outside of an open enrollment period?

A- The rules are different, depending upon the individual situation;

- **Newborn Baby or Adoption** – the baby is covered automatically for **31 days**, however, **YOU MUST ENROLL** the baby *before* the **31 days** expires in order for coverage to continue. Premium will be adjusted to reflect the addition of a dependent back to the date coverage began if you apply within **31 days of birth**. In the case of an adoption, we will need proof of the adoption within **31 days of the adoption**.
- **New Marriage** – You have **31 days** following a marriage to add a new spouse. You will need to provide a certified marriage certificate.
- **Job Loss - Spouse** – Sometimes a spouse loses their job and health coverage. You may enroll your spouse within **31 days** of job loss. The City and Anthem will require a certificate of creditable coverage to prove coverage was previously in place.
- **COBRA Ends for Spouse** – If COBRA has been in place and the COBRA period and coverage ends, the spouse can be added within **31 days** of the date his/her COBRA coverage ends. A certificate of creditable coverage should be presented.
- **Court Orders** – If a court orders a parent to cover children, the children should be added within **31 days** of the court order. If the court order is retroactive, any and all retroactive employee contributions must be paid. We will need to see a copy of the order.
- **Spouse's Plan Costs Increase** – If you have been covered under your spouse's plan and you go into “OPEN ENROLLMENT” with that plan, you may be able to “opt out” of that plan during their enrollment period and join the City's Plan. If the premium rates go up substantially or the plan design changes (co-pays go up, deductibles increase, etc.) and the spouse's plan would cause you to incur higher out-of-pocket expenses, you can enroll in the

City's plan within 31 days of the close of the spouse's open enrollment period. (Or anytime during their open enrollment period.) **We will require proof of the plan changes, close of the enrollment period and any premium increases.**

- **Since many companies conduct their open enrollment in the FALL and the City now holds open enrollment in the SPRING, please note that if you miss the 31 days in the FALL, you can always enroll during the City's SPRING enrollment.**
- **LATE – You are LATE if you request coverage outside of the 31 Day Period following the EARLIEST DATE that you could apply for coverage. You are also late following 31 Days after any of the above situations. You can add dependents or a spouse during any open enrollment period. You can add dependents or a spouse within 31 days of any of the events listed above. If you are LATE, you will need to wait until the next open enrollment period to add people to existing coverage or to increase your coverage. It is your responsibility to complete and submit an enrollment form within the 31 day grace period or during open enrollment.**
- The reason that you cannot join the plan outside of the rules we just described is that although the City is SELF-INSURED, we do purchase a high level of insurance called STOP LOSS Insurance. If we allowed employees to join “at any time” we told you that is called “antiselection”. The STOP LOSS INSURANCE will not cover any claim for any person outside of the above set of rules. So, if, for example, we let someone into the plan “off cycle” and they had a major health event that exceeded the stop loss limit (\$750,000) the City would be on the risk and the insurance would not pay. So, there really can be no exceptions made.

Q – I looked at the instructions on the Anthem Enrollment/Change Form and under the Late Enrollee section it says I CAN apply as a Late Enrollee but a “pre-existing condition” limitation might apply and I would have to fill out a health questionnaire. That seems to contradict all of the above.

A - The application that we use is Anthem's standard application that they use for all accounts. Since we are SELF INSURED the rules are as we described above. The commercial application language is more broad and covers insured plans, ERISA plans. Municipal Government Plans are not subject to ERISA, this is not an insured plan and as described above, we cannot allow Late Applications because of the limitations under our Stop Loss Coverage. Disregard the pre-existing language and health statement language. **No one will be covered outside of the rules described above.**

Q – I tried to add a dependent and was asked for legal proof that the dependent was mine. Why do I have to bring in a birth certificate?

A - The world has changed. Divorces have split families, custody of minor children may be dictated by a court order, people adopt many more children, people live together without getting married and one partner may not have a “birth” or legal relationship with children living within that household. People remarry and each partner may have children from previous relationships, all

with different names. The Plans cover “eligible dependents” and exclude “ineligible dependents”. In order to determine if someone is eligible for coverage, we need proof in the form of a marriage certificate, birth certificate, court order or adoption papers. Your Anthem Summary Plan description defines in detail who is eligible for coverage. Please refer to that document.

Q – I am NOT covered under the Century Preferred PPO and my pharmacy benefits ran out. I want to sign up for the Century Preferred Plan now. Can I?

A – The new Health Care Reform Law required that we change the pharmacy benefits in our plans. Since things changed, you have the month of December, 2011 to change plans if you want. After that, plan changes can only be made during open enrollment, every spring.

Now, if you are in the POS plan, there are pharmacy benefits available to you through Anthem, in exactly the same way you have them through the PPO Plan so you may not want to change plans. Also, the POE Plan had a \$1,000 cap and that cap has been removed. Since expanded pharmacy benefits are now available under all three health plans, you may want to stay where you are *or* evaluate the plans in their entirety to make an informed decision.

Q – I think I should have signed up for a better plan than I did? Can I change my plan now to increase my coverage?

A – You can change plans only during the December, 2011 special enrollment. Otherwise, you must wait until the next open enrollment.

Q – I have been enrolled in and paying for the Century Preferred Plan. I talked to someone I work with who has one of the other two plans. They are paying much less than I am, what are the main differences among the plans?

A – The Anthem Century Preferred Plan pays pharmacy benefits beyond the \$1,000 Medco cap. The benefits are paid AFTER a deductible has been satisfied. You will have to pay for the drug up front and submit the claim to Anthem for reimbursement. **The Point of Service (POS) Plan has been restructured to duplicate the PPO pharmacy benefit; so if you are in the POS, the pharmacy benefit is the same as under the PPO.**

The Point of Enrollment (POE) plan has been changed so there is no longer any cap. You are responsible for copayments and all the pharmacy coverage under the POE is now through Medco; no need to file claims with Anthem!

The Century Preferred plan includes coverage for out-of-network services and non-emergency and emergency services rendered outside of Connecticut. The POS plan covers out-of-network specialists.

The POE provides no coverage out-of-network, except for emergencies. So if you are in the POE and on vacation out-of-state, then are injured; claims will be eligible for reimbursement. Anthem owns certain medical facilities in the State of New York, so if you go to one of these facilities,

services are covered. Sloane Kettering, for example, is one of the covered hospitals. Contact Anthem directly for more information.

The Century Preferred plan covers infertility treatment. The POS covers Phase I infertility treatment after a \$20 copayment and phases II and III at 50%. The POE covers Phase I infertility treatment after a \$10 copayment and phases II and III at 50%.

If you need care while traveling outside the U.S., you will need to pay for the care and submit the claim when you return to the U.S.

If you don't need the extra benefits under Century Preferred, then you should consider the POS or POE plans.

Q – My husband and I cover each other under our health care plans. We each also cover our children? Do the children get full coverage under each plan?

A – There is no “double coverage”. The rule of law that governs coordinating two benefit plans for children is called the “birthday rule”. Since the children are covered by two plans, coordination of benefits must take place. This means that one plan for the children will be designated as primary and one as secondary. The plan of the parent whose “birthday” (month and day) falls earliest in the year will be primary; the other plan will be secondary.

This means most of the benefits will be paid from the primary plan. Explanation of Benefits forms from the primary plan should then be submitted to the secondary plan along with a claim form and itemized bills. The second plan cannot pay the appropriate level of benefits until they understand what was paid by the primary plan. The birthday rule applies whether two City employees are covering children under two City plans or when one parent is a City employee and the other is covered under another employer plan.

Q – If I cover my husband and he covers me, don't we get full benefits from each plan?

A – No. Coordination of benefits will take place between the two plans for each member. The plan where each person has enrolled first and listed their spouse as a dependent is primary for the member. Claims must be submitted and paid through the primary plan first, then submitted for coordination under the secondary plan.

Q – Every year, Anthem sends us a form to fill out that asks about my spouse's employment and asks about if any other coverage is in place. I find this annoying. Why do they do this? Nothing has changed for several years.

A – Anthem needs certain information and it must be current, in order to apply Coordination of Benefit Rules. When you sign up for this health coverage, you automatically become obligated to comply with this request. Although YOU may know nothing is changed, Anthem doesn't. They have to comply with the law that governs Coordination of Benefits and can only do that if they request and receive updated and current COB information from plan participants, annually. This is explained in your Summary Plan Description.

Q – My wife and I both work for the City, but we are in two different unions. I cover her and she covers me. I need an ID Card that shows I have coverage under both programs. Will I get one card from each plan?

A – Yes, a card will be issued for each covered member under their own plan. Then, the second card issued under each plan (the one to give to each spouse, respectively) will contain the name of the primary member on both, from each plan. So you will NOT get a card with your spouse's name on it, under your plan. When you filled out your enrollment form, you listed the spouse as a covered person and he/she did the same on his/her form. So, Anthem has both records.

What is important is that when either member uses their primary and/or secondary card (which contains the Group Number and Individual Identification Number) both parties are in the computer system, under each program. **It's not the name on the card that is important; it is the enrollment information that resides with Anthem that is key.** Your doctor or pharmacist will be able to verify coverage for you.

Q – It sure seems like I pay a lot for coverage. How do I know what is taken from my paycheck is right?

A – Your deduction is based upon the Plan you elected and the number of family members you chose to cover. We publish the rates for each union group each year. Rate sheets are available for all employee groups in the City. The information is broken down by pay period, so you can check the deduction on your pay-stub against the published rates. **You should check this information regularly, to make sure you are not overpaying or underpaying.**

Q – I need to pick a doctor or a dentist. Where do I get a list of network providers? Do you have a book?

A – Go to www.Anthem.com, the website is your most current source for providers. We do not keep “paper books” because providers are added and deleted every day. The most up to date and current source for you to go to is the website. We recommend you use the website to find answers to most of your other Anthem questions as well.

Q – How much Drug coverage do I have?

A – If you are covered by one of the City health plans, you have pharmacy coverage through MEDCO. If you are in the POE, ALL pharmacy coverage is through Medco and there is no cap. If you are in the PPO or the POS, Medco provides coverage up to \$1,000 per person covered, per year. Then, you have ADDITIONAL pharmacy coverage through Anthem. The additional benefits are payable AFTER you pay a deductible and coinsurance.

In order to collect benefits from Anthem, you will have to pay for the prescription up front, then file a claim for reimbursement from Anthem. In order to get started with Anthem, YOU have to provide them with proof that you exhausted benefits under MEDCO. So, the last Explanation of

Benefits that you received from MEDCO should be submitted to Anthem along with receipts for any current prescriptions. This procedure is for the PPO and POS plans.

This additional pharmacy benefit is paid as an out-of-network benefit. See your benefit book for details and out-of-pocket maximums.

Q – Can I drop my spouse or other dependent(s) from my coverage even though my divorce is not yet final?

A –Yes, the choice to no longer cover a spouse or dependent is yours (during any open enrollment), *unless a court order is in place that governs and requires you to cover dependent children and/or your spouse*. Keep in mind, however, that if you drop the coverage for dependents and/or a spouse, they may not be eligible for COBRA if a qualifying event under COBRA has not yet taken place. For example, if a divorce is not yet final, and you drop the coverage for family members before it is, there is no eligibility for COBRA. **Please carefully consider your decision to drop coverage**, because if you drop family members from the plans during one open enrollment and they need coverage later, **you cannot add them until the next open enrollment**.

Q – If I am not working because I am on Worker’s Compensation or other leave where the payroll deduction for my health coverage is not being made because I am not receiving a paycheck. What happens to my coverage if I don’t pay my share?

A – These are contributory plans. That means if you want to continue to have your claims paid, you will need to pay the City your share of the premium that is due. The City is not obligated to pay your share. If you do not pay your share, claim payments will be suspended and coverage may be terminated.