2024 Benefits Open Enrollment Webinar Q&A Summary

1.Concerning PPO plans, when we are responsible for 40% of out-of-network services after meeting the deductible, this percentage is calculated based on the 'allowed amount' rather than the full charge. This difference can often be substantial. Is there a straightforward method to determine what the 'allowed amount' is?

When you use in-network services, you pay a coinsurance percentage of the allowed amount, which is the rate that the insurance carrier has agreed upon with in-network providers. This results in a lower dollar amount for your coinsurance. However, when you go out of network, the doctor or hospital can charge whatever they choose. You will be responsible for 40% of the allowed amount, plus the difference between the allowed amount and the actual billed amount. For example, if a typical mental health visit in the area costs $250 and the allowable amount is $110, the insurance will cover 60% of $110, which is $66. Therefore, the member would be responsible for the remaining $184, calculated as follows: $250 (total cost) - $66 (insurance coverage) = $184.

To find out the allowed amount, we recommend contacting CalPERS or the insurance carrier for in-network care, as they should be able to provide that information. For out-of-network coverage, since the insurance does not have a contract with those providers, the best approach is to contact the providers directly. You can inquire about the cost of a specific procedure, such as surgery for a broken arm. If you schedule a procedure/visit at least 3 business days before the service date, the provider must give you a good faith cost estimate no later than 1 business day after scheduling. The level of detail you receive may vary by provider.

2.Could you please clarify whether individual specialists have the right to require a referral, even when using a PPO plan?

No, a referral is not required under the PPO plan. If you are being told otherwise, it is not a requirement mandated by the insurance carrier. However, please note that some specialists may have their own policies, such as not accepting new patients, which could affect your ability to schedule an appointment. These decisions are made by the provider and are not related to the insurance plan itself.

3.Could you please clarify whether the 10% coinsurance for PERS Platinum PPO inpatient services is based on the negotiated contract fee or the fee charged by the hospital, after the $250 deductible?

After you pay the $250 deductible for PPO inpatient care, you will be responsible for 10% of the remaining amount based on the negotiated, contracted fee. For example, if the total inpatient cost is $10,000 and you have a $250 deductible, the remaining amount after the deductible would be $9,750. You would then pay 10% of that $9,750.

4.Does the plan cover ambulance costs?

Generally, ambulance costs are covered in emergencies. Air or water ambulances may also be covered if they are deemed medically necessary. We recommend reviewing the plan documents to confirm the specific coverage details for each plan.

5.Could you please explain how the out-of-pocket maximum works?

The out-of-pocket maximum is essentially the most you will pay in a given plan year for services that apply toward this limit. It's important to note that not all payments contribute to the out-of-pocket maximum, and these exclusions will be specified in the plan documents.

For example, an office visit copayment, such as a $15 charge, does not count toward the out-of-pocket maximum. However, if you have an inpatient hospital stay where you pay 10% of the cost, that amount will apply toward your out-of-pocket maximum.

As you incur eligible expenses, they will accumulate until you reach the out-of-pocket maximum. Once you've hit that limit, the insurance carrier will cover 100% of the costs for any remaining covered services for the rest of the year, typically until December 31. At that point, your out-of-pocket maximum will reset on the following January 1.

The purpose of the out-of-pocket maximum is to limit your total financial liability for healthcare expenses. However, please keep in mind that some costs, such as pharmacy copayments and certain office visit charges, may not count toward this maximum. These amounts are usually smaller—often ranging from $5 to $20—and can continue to accumulate throughout the year, but they won't contribute significantly to your overall out-of-pocket costs.

6.Could you please let us know where we can find information about Stanford Coverage for the upcoming year?

Please refer to the following link.

7.I would like to find out the allowed amount and whether it is negotiable, as I have noticed that many allowable amounts do not seem to reflect current or realistic rates for providers in the Bay Area.

The allowed amounts apply to in-network care, which are established through agreements between the insurance carrier and the provider. These amounts are consistent regardless of whether you are in the Bay Area or anywhere else in the state or country, as they are based on the contract between the carrier and the provider.

If you choose to go out of network, you do have the option to negotiate with the provider. For instance, if a provider charges $10,000 for a surgery, you can inquire whether they would be willing to lower that charge. However, for in-network services, there is already a contract in place, making it much less likely that negotiation would be an option.

8.What happens if I am traveling and Kaiser is not available at my location? What coverage options are available in that case?

Kaiser operates as an in-network only plan, similar to other HMO plans. Generally, coverage is not available when you are traveling outside of the Kaiser HMO network area, except in emergencies. For example, if you are on vacation in a state where Kaiser is not available and you were to break your leg, you can visit the nearest hospital emergency room. In this case, the care you receive would be covered as if you were at a Kaiser facility.

However, for routine office visits, it’s advisable to schedule those when you are at home, where you have access to Kaiser doctors and hospitals.

9.If I do not take any action, will I automatically continue with the same plan I had last year?

If you do not take any action, your current health benefits will automatically roll over into next year. However, please note that for voluntary benefits, such as the FSA, you are required to re-enroll each year.

10.Are pharmacists available for questions regarding mail-order drugs, particularly if I experience a bad reaction to a medication?

Yes, we recommend calling the insurance hotline for the specific carrier you choose. They can refer you to a nurse line for assistance. Additionally, there are usually pharmacists on staff who can answer any questions you may have regarding the mail-order drugs.

11.If both you and your spouse are employed in PERS health care jobs, what is the best way to minimize out-of-pocket expenses if you have a dependent?

If you are in a job where PERS health care is available, there are several ways to minimize out-of-pocket expenses, especially if you have a dependent.

- In-Network Care: Whenever possible, make sure to use in-network providers.
- Preventive Care: Take advantage of your preventive care benefits, as you receive one preventive office visit for each enrolled dependent and for yourself as the employee.
- Generic Medications: If you or your dependents are prescribed medications, opt for generic drugs whenever possible to help keep co-payments lower.
- Mail-Order Pharmacy: Consider using mail-order services, which often allow you to receive a three-month supply of medications for only two months' cost. This applies to both generic and brand-name prescriptions.

Overall, using generics, mail-order services, and in-network providers are the primary strategies to save money as a family.

12.Could you please clarify whether all of our plans require deductibles?

No, only the PPO plans have deductibles in place as part of their structure. You will need to pay the first portion of your healthcare costs—either $250, $500, or whatever the specified deductible is—until you satisfy that amount.

On the other hand, HMO plans operate differently. They do not have deductibles, but instead, you pay a flat dollar amount for each type of care. For example, you may have a $15 copayment for an office visit, a $50 copayment for an emergency room visit, a $15 copayment for urgent care, and a copayment of $5, $20, or $50 for prescriptions, depending on the medication.

13.Will Stanford Medicine be covered under Blue Shield in 2025?

Blue Shield of California and Stanford Medicine — including Stanford Hospital, Lucile Packard Children's Hospital, Tri-Valley Hospital, Stanford Medicine Partners, and Packard Children's Health Alliance — have reached a new agreement. Effective September 1, 2024, all Stanford Medicine providers and hospitals are in-network for Blue Shield Commercial HMO and PPO members.

14.Could you please provide some information about the mental health facilities available to employees? Additionally, I would appreciate any details regarding chiropractic services and prescription services.

We recommend reaching out to the individual insurance provider for the plan you choose, as each carrier has different provider networks, which can vary significantly by plan. This includes coverage for chiropractic services and mental health. Additionally, some plans may offer extra benefits related to mental health. For the most accurate information, please contact the insurance carrier directly.

15.Could you please explain how the changes to PERS Platinum/Gold PPO, now administered by Blue Shield, will affect individuals in 2025?

The PPO plan administrators will be changing from Anthem Blue Cross to Blue Shield in 2025. Anthem and Blue Shield are two of the largest networks available, so there is a high degree of overlap in their provider networks. Therefore, the vast majority of individuals currently seeing in-network providers under the Anthem PPO plans are likely to find that their providers will also be in-network under Blue Shield next year.

However, there may be a small percentage—under 10%—depending on the plan you enroll in, whether it's the Platinum or Gold PPO plan, where your current in-network provider may not be in-network with Blue Shield. We encourage you to make a list of your current doctors and providers, including any mental health professionals, chiropractors, primary care physicians, or specialists you see regularly. Please check to see if they are part of the Blue Shield network. You can reach out to CalPERS or the specific insurance carrier to inquire about in-network coverage for those providers.

Please note that continuity of care coverage is available to you even if your current doctor, medical group, or hospital is not available. This means you'll continue to receive the medical and behavioral health services and medicines you need. Check with your health plan or call the Department of Managed Health Care at 1-888-466-2219 for more information about continuity of care options.

16.I turned 65 last year and already have Medicare Plan A. Do I need to call to suspend Plan B?

You do not need to sign up for Medicare Part B if you are covered under an employer's health plan. You can contact Medicare to suspend your Part B coverage if you choose to do so.

17.Is there a current outline available for employees that compares the PERS Platinum and PERS Gold plans?

Please refer to the following link.

18.Is there a document available that outlines all the changes for the new year regarding the different plans?

Please refer to the following link.

19.Could you please clarify the differences between the FSA plan options?

The district offers four FSA plans: Health Care FSA, Dependent Care FSA, Commuter Transit, and Commuter Parking, with WEX as the plan administrator. For more detailed information on these plans, please refer to the following link.

20.Could you please let me know what the maximum contribution limit for the FSA health care plan is for 2025?

The annual contribution limit for the Healthcare FSA will increase from $3,050 in 2024 to $3,200 in 2025. For the 2024 plan year, you are allowed to carry over up to $610 of unused funds from the Health Care Account into the 2025 plan year. Similarly, for the 2025 plan year, you may carry over up to $640 of unused funds from the Health Care Account into the 2026 plan year.

21.Could you please provide the list of eligible FSA expenses and the associated requirements?

Please refer to the following link.

22.Could you please clarify how an FSA works in the year you retire?

You are still eligible to sign up for an FSA. Please note that you must submit your FSA claim form within 90 days following the end of the month in which your active employment ends. All claims must be incurred before the end of that month. Your FSA Debit Card will be suspended after your coverage period ends. For more information, please refer to the following link.

23.Whom should I contact to file for FSA reimbursement?

For claim reimbursement, you have three options:

1. Submit the claim form by mail, fax, or email: fax (866-451-3245), email (forms@wexhealth.com), mail (WEX, PO Box 2926, Fargo, ND 58108-2926).
2. Submit online: Visit WEX's website to file your claim.
3. Submit via mobile app: Please refer to the video tutorial on how to use the mobile app for submitting claims.

All received claims will be processed within two business days. We also recommend setting up direct deposit with WEX, as there is no reimbursement limit for direct deposits. However, a $25 minimum reimbursement is required for paper checks.

24.Could you please let me know how much the district contributes to the FSA?

The district does not contribute to employees' FSAs; all contributions are made by the employees themselves.