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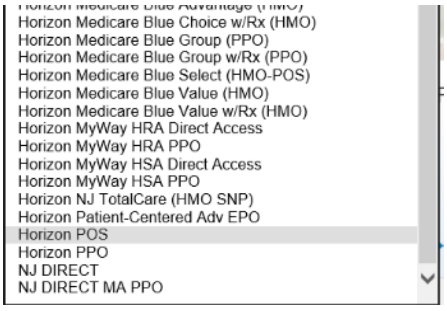
Randolph Board of Education
Horizon BCBS of NJ Open Enrollment
Frequently Asked Questions

General Carrier Change Questions:

- **New ID cards** will be mailed to your home address 7-10 business days prior to the 7/1/2019 effective date of your Horizon plan
- No changes to **Benecard Rx** and **Delta Dental** Plans
- Currently 82% of providers are In-network with Aetna, while **89% of providers are In-Network with Horizon**. 3.25% of providers currently used do no participate with Horizon
- Your **current deductible** runs on a calendar year basis and will be credited to your Horizon plan. The deductible will start anew effective 1/1/2020
- If you are **changing plans or adding dependents** to your current plan, you must complete an application
- To see if your current provider or hospital is In-Network, Out-of-Network, Tier 1 or Tier 2 visit **www.HorizonBlue.com**
- For individuals currently in any qualified **on-going treatment by a now Horizon non-participating provider**, the non-participating provider must complete a request and submit it to Horizon. This will allow members to continue their care with current physician until treatment is complete
- If a **primary care physican** that is currently being used does no participate with Horizon, the user will be notified as soon as possible

Horizon POS Design 8 & Horizon POS Design 4:

- **What do I need to do if I want to stay with my current plan?**
  - *If you are satisfied with your current plan, there is nothing you need to do in order to be enrolled in its Horizon counterpart.*
  - *Referrals from specialists and primary care physicians do not carry over, therefore on 7/1/2019 or after you must call your doctor to have your referral information submitted to Horizon. Authorizations must also be submitted in this manner*
- **How do I find a provider if I am looking for a participating provider in the POS Design 8 or POS Design 4 plan?**
  - *Visit www.HorizonBlue.com and click the "Find a Doctor" box at the top of the page. Then "Chose a Plan to Start". There will be a drop down menu of many plans. For POS Design 8 and POS Design 4, select "Horizon POS"*



Horizon Omnia Design 10 with BlueCard:

- **General Information:**
  - Horizon's answer to mitigating health costs. Doctors get paid on an outcome and experience basis of user; the better the results from users provides better compensation for healthcare professionals.
  - Every doctor in the Horizon managed care network is ranked either Tier 1 or Tier 2. If they are not ranked Tier 1 or Tier 2, they are not in the Horizon network**.**
- **Does this plan have Out-of-Network benefits*?***
  - *No, this plan does not include out-of-network benefits. It only includes In-Network benefits rated at the Tier 1 or Tier 2 level with Horizon BlueCard access to out-of-state services.*
- **Are referrals required for the Omnia plan?**

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- *There are no referrals required for the Omnia plan, unlike the POS plans offered. You also do not have to elect a primary care physician with this plan.*

- **How do I find a provider if I am looking for a provider in the OMNIA Plan?**
  - *Visit www.HorizonBlue.com and click the "Find a Doctor" box at the top of the page. Then "Chose a Plan to Start". There will be a drop down menu of many plans. For the OMNIA plan, select "OMNIA".*
- **How does BlueCard work?**
  - *When traveling out of state, Omnia members can use their Horizon BlueCard at any participating Horizon to provider for medical services. Services will be rendered and charged according to the Tier 2 benefit of the Omnia plan.*
- ***If I have the BlueCard, how do I search for providers on the Horizon website?***
  - *Visit www.HorizonBlue.com and click the "Find Doctors outside of NJ" box in the middle of the page (image to the right). Then "Choose a Plan to Start". There will be a drop down menu of many plans. For the Horizon MyWay HSA Direct Access, select "Horizon MyWay HSA Direct Access."*

- **How does this plan work if I have a medical emergency?**
  - *In the event of a medical emergency that results to a trip to the emergency room, your services will be considered Tier 1 whether you are at Tier 1 or Tier 2 hospital.*

Horizon MyWay Direct Access HSA Plan:

- **General Information:**
  - Integrated with Rx, meaning that you do will not have Prescription coverage with Benecard and will now be covered through Horizon BCBS of New Jersey
  - May not use FSA spending account, other than for dependent care
  - One deductible for both In and Out-of-Network services
  - No primary care physician or referalls required
- **What is an HSA and how does it work?**
  - *An HSA is a pre-tax health savings account that can be used to pay for qualified medical expenses determined in Section 213(d) of IRS code. You may only contribute to the HSA account if you are enrolled in this high deductible plan.*
  - *If enrolled in this plan, the user will elect a certain amount of money from their paycheck to be deducted and added directly into their health savings account. Once money is designated to this account, the user may use it via their HSA debit card.*
  - *HSA contributions from Randolph BOE are not determined at the moment and will be later this month.*
  - *Unlike an FSA, you do not lose funds with a HSA account. Any unused funds roll over from year to year, and can be taken with you if are no longer employed by Randolph BOE.*
  - *The current maximum amount that can be contributed for individual coverage is $3,500 and $7,000 for families. Users over the age of 55 can contribute an additional $1,000 to catch up. All contributions are based on the calendar year**
- ***What if I am enrolled in the MyWay HSA making monthly HSA contributions and become Medicare Eligible?***
  - *Medicare Part A eligiblity alone does not prohibit an individual from contributing to an HSA upon attaining age 65. However, if an individual is **both eligible and enrolled in Medicare** that individual cannot make HSA contributions for those months during the eligibilty/enrolled period.*
- **What can an HSA pay for?**

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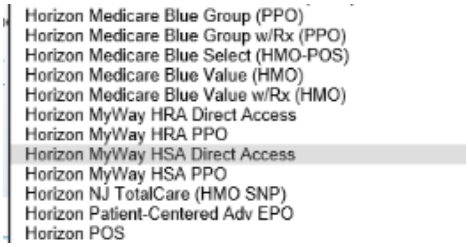
- *An HSA account can pay for any qualified medical expense determined by the IRS code Section 213(d). Expenses can include: doctor's fees, prescriptions, dental procedures, vision services including lasik, service and guide dogs and many more.*
- *An HSA account cannot be used to pay for insurance premiums, except if the user is: receiving unemployment, covered under COBRA, or for retiree medical contributions age 65 or older (Medigap premiums do not qualify*).*

- **How does my deductible work?**
  - *All services, whether In or Out-of-Network, through this HSA plan are subject to the deductible.*
  - *The HSA plan is a true family deductible, meaning that you can meet the family deductible through the summation of all services used by all members of the family receiving coverage.The difference between a HDHP deductible and a non-HDHP deductible is that the the family deductible can be met through the healthcare expenses of one family member alone, thus eliminating any individuald deductible in family HDHP coverage.*
- **How do I fina a provider if I am looking for participating provider in the Horizon MyWay HSA Direct Access plan?**
  - *Visit www.HorizonBlue.com and click the "Find a Doctor" box at the top of the page. Then "Choose a Plan to Start". There will be a drop down menu of many plans. For the Horizon MyWay HSA Direct Access, select "Horizon MyWay HSA Direct Access"*



Additional Benefit Information:

- **Do I have coverage out of state?**
  - Under the POS Design 8 and POS Design 4, non-emergency services are covered at the out of network benefit level. For any urgent and emergent services needed out of state, the services will be considered at the in-network level.
  - Under OMNIA, with the BlueCard network, any out of state services done within the Horizon network of that state will be processed at the Tier 2 level of benefits.
- **Are pre-existing conditions covered?**
  - Due to Healthcare Reform, pre-existing conditions are covered.
- **Is Vision Covered?**
  - Under the POS Design 8 plan covers a routine eye exam at 100% after a $5 copay at the in-network level. Out-of-Network is covered subject to 70% coinsurance after deductible. There is no hardware coverage.
  - Under the POS Design 4, vision eyewear is covered 100% up to $100 every 24 months. There is no hardware coverage.
  - Under the OMNIA plan, a routine eye exam is covered with a $5 copay office visit for Tier 1 providers and a $10 copay for Tier 2 providers. There is no hardware coverage.
  - Under the MyWay HSA plan, a routine eye exam is covered 100% at the in-network level. There is no hardware coverage.
- **Is my prescription plan changing?**
  - NO, your prescription plan will remain the same with Benecard if you are in the Horizon POS Design 8, Horizon POS Design 4, and Horizon OMNIA plans.
  - If you select the Horizon MyWay HSA Direct Access plan, your Rx will now be integrated and provided through Horizon
- **What Labs are considered participating with Horizon?**
  - Labcorp and Quest Diagnostics
- **Is Acupuncture covered?**
  - Acupuncture service is unlimited on all plans offered through Randolph Board of Education
- **Are Chiropractic Services covered?**
  - Under POS Design 8 and POS Design 4, unlimited visits to the chiropracter are covered

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- Under OMNIA and MyWay HAS Direct Access, chiropractic services are limited to 25 visits per calendar year

Health Insurance Glossary:

Allowed Amount- The maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal- A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing- When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider (or in-network provider) may not balance bill you for covered services.

Coinsurance- Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Copayment- A fixed amount (for example $5) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible- The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won’t pay anything until you’ve met your $1000 deductible for covered health care services subject to the deductible.

Excluded Services- Health care services that your health insurance or plan doesn’t pay for or cover.

High Deductible Health Plan- A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs yourself before the insurance company starts to pay its share (your deductible). A high deductible plan (HDHP) can be combined with a health savings account (HSA), allowing you to pay for certain medical expenses with money free from federal taxes.

The IRS defines a high deductible health plan as any plan with a deductible of at least $1,350 for an individual or $2,700 for a family. An HDHP’s total yearly out-of-pocket expenses (including deductibles, copayments, and coinsurance) can’t be more than $6,650 for an individual or $13,300 for a family. (This limit doesn't apply to out-of-network services.)]

Health Savings Account (HSA) - a type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. By using untaxed dollars in a Health Savings Account (HSA) to pay for deductibles, copayments, coinsurance and some other expenses, you can lower your overall healthcare costs. An HSA can be used only if you have a High Deductible Health Plan (HDHP)

In-network Coinsurance- The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Copayment- A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Network- The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider or Out of Network Provider- A provider who doesn’t have a contract with your health insurer or plan to provide services to you. You’ll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers.

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Out-of-Pocket Limit- The most you pay during a calendar year before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover.

UCR (Usual, Customary and Reasonable) - The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Prescription Formulary- A list of prescription drugs along with their formulas, uses, dosages and methods of preparation. In some Medicare health plans or Part D plans, doctors must order or use only drugs listed on the plan's formulary.

Generic Drug- A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs.

Point of Service (POS) - A Managed Care health plan that encourages its members to seek care from certain providers by offering them a higher level of reimbursement. Care sought outside of the network, however, is still covered but at a lower reimbursement level.

Primary Care Physician (PCP) - This is the doctor you see first for most health issues. Your PCP will coordinate your care with specialists and other health care providers to make sure you get the care you need to manage your health. In many Medicare Advantage HMO Plans, you must obtain a referral from your primary care doctor before you see any other doctor, specialist or health care provider.

Referral- A referral is a written order from your primary care doctor for you to see a specialist or get certain medical services. In many HMOs, you need to get a referral before you can receive medical care from anyone except your primary care doctor.

Preferred brand-name drugs- These are brand-name drugs that are listed on the plan's formulary (list of preferred prescription drugs).

Non-preferred brand-name drugs- These are brand-name drugs that are not included on the plan's formulary (list of preferred prescription drugs). Non-preferred brand-name drugs have higher coinsurance than preferred brand-name drugs. You **pay more** if you use non-preferred drugs than if you opt for generics and preferred brand-name drugs.