

# Frequently Asked Questions

The following are frequently asked questions about the Cypress-Fairbanks ISD Health Reimbursement Arrangement (HRA) Plan or the Cypress-Fairbanks ISD KelseyCare plan. If you review these questions and answers and still require assistance to understand your plan choices, you should contact the CIGNA Pre-enrollment Information Line at (800) 401-4041 or CIGNA Customer Service at (800) 244-6224.

The following questions and answers apply to both plans offered by the district.

**1. Will our social security numbers appear on our member identification cards?**

No, several years ago the district opted not to utilize social security numbers as a means of identification for our health plan. Your medical plan Identification Card will have a number assigned by CIGNA.

**2. If husband and wife are both employees of the district, must they enroll separately?**

Yes. A full-time employee cannot be enrolled as a dependent of another employee. Spouses that are both full-time employees of the district must enroll in coverage independently of each other.

**3. Both my spouse and I are employees of the district, is it advantageous to cover our children separately or group them together as dependents under one employee?**

It is generally more common to group dependent children under one employee's coverage. However, let's consider the impact of separating their coverage between the two employees under the HRA plan. Let's compare the premiums for these two scenarios. If you and your spouse each cover one child your individual premium would be \$230 a month for a monthly family expense of \$460 or \$5,520 a year. If you cover both children under one employee at a monthly premium of \$230 and your spouse enrolls as employee only for a monthly premium of \$104, your monthly family expense will be \$334 or \$4,008 a year. The difference is \$1,512.

Now let's compare the HRA benefit for these scenarios. In the first scenario where the children are each covered by a different parent, the HRA benefit is \$1,500 for each parent. In the second scenario the HRA benefit is \$750 for the parent enrolled as an employee only and \$1,500 for the parent covering both children. The difference in the HRA benefit is \$750.

Lastly, let's consider the impact on the deductible portion of the benefits. In the first scenario where each employee has a dependent child, each parent would have a \$5,000 annual deductible to satisfy for a total potential deductible of \$10,000 for the entire family. In the second scenario, where both children are covered by one parent, the individual deductible of \$2,500 would apply to one employee and the family deductible of \$5,000 would apply to the other employee for a total potential deductible of \$7,500 for the entire family.

Now, let's consider the impact of separating their coverage between the two employees under the "KelseyCare" plan. If you and your spouse each cover one child your individual premium would be \$350 a month for a monthly family expense of \$700 or \$8,400 a year. If you cover both children under one employee at a monthly premium of \$350 and your spouse enrolls as employee only for a monthly premium of \$150, your monthly family expense will be \$500 or \$6,000 a year. The difference is \$2,400.

Therefore it is advisable to consolidate your dependent coverage under one employee's coverage.

**4. I have a college student attending school outside of Houston, which of the two plans will work best for my student?**

The two plans operate differently and therefore you must consider certain factors to ascertain which will work best for your student's health needs.

The "KelseyCare" plan is a geographically based network of physicians with a service area oriented around the Houston metropolitan area. Consequently, any services required outside of this geographic area must be handled in a special manner. The first consideration is that emergency services are always covered anywhere inside or outside the service area. The second consideration is the availability of "Guest Privileges" at the location outside of Houston where your student is attending school. If "Guest Privileges" are available in the city where your student is attending school, then you can apply for "Guest Privileges" and be assured that your student will have access to care whenever necessary. If "Guest Privileges" are not available in the city where your student is attending school, then any services other than emergency services will not be covered by the "KelseyCare" plan.

The HRA plan contracts with the CIGNA Open Access Plus national network and has both in-network and out-of-network benefits, so regardless of where your student is attending school he/she will be covered by plan benefits. We strongly encourage all of our members to utilize participating providers in order to receive the greatest amount of benefit from the plan.

**5. How long may I keep my children enrolled in the plan?**

Generally, your dependent children, including qualified grandchildren, are eligible to be on the plan until they turn 25 years old. Eligible dependent children include: your unmarried, dependent child or grandchild from birth to age 25, and children of your covered dependent children. A child is: your biological child, your stepchild, your foster child, your adopted child, or a child placed for adoption with you; or any child who is related to you by blood or marriage who is primarily dependent on you for care and support, and lives with you in a parent/child relationship.

You must show evidence that the child is a dependent on your federal income tax return. Therefore, you should review the IRS rules concerning dependency to determine if your child may be claimed as your dependent.

Recently the IRS began requiring employers to tax benefits for children participating in a group health plan as a dependent of an employee when the child does not satisfy the criteria to be claimed as a dependent of the employee on their tax return.

**6. If I must go to an emergency room for treatment, how much will I pay?**

If you are enrolled in the HRA you will pay the actual fees after negotiation between the CIGNA Open Access Plus provider and CIGNA subject to your applicable deductible & co-insurance. If the hospital emergency room is not a participating CIGNA Open Access Plus provider benefits will be provided at in-network levels if it meets the "prudent layperson" definition of an emergency. Otherwise benefits will be provided at 50% of charges, additionally out-of-network services are subject to the contract year deductible and maximum reimbursable charge limitations. Providers may bill the member the difference between their billed charge and the maximum reimbursable charge as determined by the benefit plan.

If you are enrolled in the KelseyCare plan you will pay the emergency room co-payment of \$100. This co-payment will be waived if you are admitted into the hospital. Then the Hospital Inpatient Admission co-payment of \$500 would apply.

**7. If I enroll in either the HRA or “KelseyCare” plans, can I withdraw from the plan before the next annual enrollment period?**

No. Your enrollment election is a one-time annual election and may not be changed during the plan year. The only exception to this restriction occurs if you experience a “qualifying event”. Qualifying events include, but are not limited to; Marriage, birth of a child, or a change in employment status.

**8. How do either of the plans coordinate with Medicare for members that are 65 years old or older?**

If you are enrolled, as an employee or a dependent of an employee, in either of the plans offered by the district and eligible for Medicare benefits, the district plan benefits will be considered your primary coverage and Medicare will be secondary. If you are eligible for both district and Medicare it is important for you to inform your medical provider that you have benefits under both plans.

**9. Can I keep seeing my current doctor?**

If you enroll in the HRA plan you may see any provider you select. If your doctor is a participating CIGNA Open Access Plus provider then your claim will be processed according to the in-network schedule of benefits. If your doctor is not a participating provider, then your claim will be processed according to the out-of-network schedule of benefits.

If you enroll in the KelseyCare plan. You may only utilize providers affiliated with the KelseyCare. If you seek treatment from a non-participating provider no benefits will be payable except in a emergency situation.

**10. Can I still use M. D. Anderson Cancer Center under the new plans?**

Under the HRA plan M.D. Anderson Cancer Center is a participating hospital in the Open Access Plus network and therefore would be eligible for in-network benefits. However, you should always verify that your treating physician is a participating provider and that he/she refers you to the participating facilities for treatment that cannot be performed in his/her office.

The “KelseyCare” Plan has a nationally recognized cancer treatment program. The Kelsey-Seybold Cancer Center is the first freestanding cancer program in the nation to receive the seal of excellence from the American College of Surgeons' Commission on Cancer. The “KelseyCare” Plan out-sources some, but not all, of their patient services through the M.D. Anderson Cancer Center. For additional information regarding KelseyCare resources for treating cancer you may visit their website;

[http://www.kelsey-seybold.com/MS\\_Oncology/Patient\\_Resources.cfm](http://www.kelsey-seybold.com/MS_Oncology/Patient_Resources.cfm)

The following questions and answers apply to the Health Reimbursement Arrangement (HRA) plan offered by the district beginning September 1, 2009.

**11. How does the Cypress-Fairbanks ISD Health Reimbursement Arrangement (HRA) Plan pay claims?**

- a. When you see your doctor, you do not have to pay anything at the time of the office visit. Instead, your doctor sends your claim directly to CIGNA HealthCare. CIGNA HealthCare processes the claim and sends you an Explanation of Benefits (EOB) that tells you:
  - i. if your plan covers the services you received; and
  - ii. if so, what portion of the covered services your plan pays; and
  - iii. if not, how much you owe;
  - iv. if you have met/not met your deductible and whether there is a balance due toward satisfying your remaining deductible or co-insurance.
- b. If there is money in your HRA, your doctor is paid directly from the fund. You and your doctor receive EOBs explaining that payment has been made from your fund. Your EOB also tells you how much money is left in your fund.
- c. If there is no money in your HRA, or if the expense is not eligible for payment from the fund, you receive an EOB letting you know that the payment cannot be made from the fund. If it is a qualified expense it will be applied to your deductible and that you are responsible for paying the bill.
- d. If you receive a bill from your doctor, you should always make sure it has been sent to CIGNA HealthCare for processing before you pay it. You can check by:
  - i. reviewing your fund activity on myCIGNA;
  - ii. determining whether you've received an EOB;
  - iii. calling the toll-free number on your CIGNA HealthCare ID Card.

**12. How are fees charged to patients determined?**

Fees charged for medical services rendered by participating Open Access Plus providers are negotiated between the provider and CIGNA.

**13. Will my doctor accept the HRA benefits?**

Yes, if your doctor, or medical provider, is a participating CIGNA Open Access Plus provider. If you elect to use a non-participating provider your benefits will be processed according to the out-of-network schedule of benefits.

**14. Do all participating providers charge the same negotiated rate for their services?**

No. Each participating provider contracts with CIGNA independently of other providers. The fee charged by a provider for a specific service will vary from one provider to another.

**15. What is the difference between in-network coverage and out-of-network coverage?**

When you visit an Open Access Plus participating doctor, you will have lower out-of-pocket costs. That's because these providers have agreed to charge lower fees, and your plan's benefits cover a larger share of the charges.

With out-of-network benefits, you can see any doctor you wish and still be covered for treatment of any illness or injury. Keep in mind, however, that your out-of-pocket costs will be higher if you choose a doctor, or other medical provider, who doesn't participate in the Open Access Plus network.

**16. If the \$750 or \$1,500 HRA funds are not utilized in a plan year, will these funds rollover to the next plan year?**

No, any funds not utilized in a given plan year will be forfeited. However, at the beginning of each plan year the district will replenish the HRA funds so that the account balance is the annual amount established by the district for the employee only tier or the annual amount established by the district for the employee plus one or more dependents tier. You will have a brief grace period following the end of the plan year to submit claims that were incurred during the plan year but not processed.

**17. Please provide examples of Preventive Care benefits?**

A list of preventive care services is available online through the District Insurance Department webpage. This is the link to get to the list;

<http://www.cfisd.net/dept2/insur/Preventive%20Quick%20Reference%20Guide%207.1.09.pdf>

This list may be printed and used to discuss your preventive care needs with you physician.

**18. Are Preventive Care Services covered at 100%?**

Yes, preventive care services are covered at 100%. Refer to the link above for a list of covered preventive care services under the HRA Plan.

**19. Do fees for preventive care services reduce the HRA balance?**

No. Fees for preventive care services are covered at 100% and will not reduce your HRA balance.

**20. Are Kelsey-Seybold physicians “participating providers” in the HRA plan?**

Yes, many Kelsey-Seybold physicians are “participating providers” in the CIGNA Open Access Plus network which is the network for the HRA plan.

**21. Will my current plan deductible be applied to the new plan?**

If you are currently in the Open Access Plus (OAP) plan and you transition to the Health Reimbursement Arrangement (HRA) plan, the amount of your individual in-network deductible you have satisfied through August 31, 2009, to the maximum of \$500, will be credited to your individual deductible in the Health Reimbursement Arrangement (HRA) plan beginning September 1, 2009.

**22. Does the entire employee plus one or more deductible of \$5,000 have to be satisfied if one person requires care that costs more than \$2,500?**

No, family members meet only their individual deductible and then their claims will be covered under the plan coinsurance. If the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.

**23. Are there any limitations on how the HRA funds may be used?**

The HRA is administered by CIGNA through their processing of claims. Payments from the HRA will occur only when a claim is accepted as covered under the terms of the plan. Expenses for medications dispensed by PTRX are not eligible to be paid by the HRA.

**24. If only one person in a family requires treatment, will that individual be required to satisfy the entire family deductible and out-of-pocket maximum?**

No. Each member of a family has an individual deductible of \$2,500 and out-of-pocket maximum of \$3,500.

**25. Is the HRA amount of \$1,500 for an employee plus one or more dependents allocated to each member of the family?**

No. The HRA is available as one lump sum used to pay claims as they are processed. One family member may use all available HRA funds before another family member has an opportunity to use the HRA benefit. This will be determined by the order claims are submitted for processing.

**26. When does the annual deductible reset each year?**

The new HRA plan deductible begins September 1, 2009 and accumulates through August 31, 2010 and resets each year thereafter. Also, the annual out-of-pocket maximum accumulates from September 1, 2009 through August 31, 2010 and resets each year thereafter.

The following questions and answers apply to the “KelseyCare” plan offered by the district beginning September 1, 2009.

**27. I am currently enrolled in the Network Plan, will I be able to continue to see my current doctors?**

The network plan is changing and as of September 1, 2009 will become the “KelseyCare” plan. If you currently utilize Kelsey-Seybold physicians you may continue to see your current doctors. However, if your current doctors are not part of the KelseyCare network of physicians you will be required to select new providers from the KelseyCare network of physicians.

**28. Does the KelseyCare plan have a dedicated clinic for cancer patients?**

Yes, Kelsey-Seybold has a nationally recognized cancer treatment program. The Kelsey-Seybold Cancer Center is the first freestanding cancer program in the nation to receive the seal of excellence from the American College of Surgeons' Commission on Cancer. For additional information regarding KelseyCare resources for treating cancer visit their website;

[http://www.kelsey-seybold.com/MS\\_Oncology/Patient\\_Resources.cfm](http://www.kelsey-seybold.com/MS_Oncology/Patient_Resources.cfm)

**29. What if the KelseyCare plan does not have a specialist provider that I need?**

Your medical treatment needs will be coordinated by your primary care physician through the KelseyCare network of physicians. If a specialist referral is required for your specific condition and KelseyCare does not have that specific specialty represented on their panel of physicians, KelseyCare will arrange for you to see an appropriately qualified physician to treat your medical condition.

**30. What is “Transition of Care” benefits and how long do they last?**

Transition of Care benefits are temporary benefits intended to provide coverage for members who meet all of the following criteria:

- a. They have one of several specified medical conditions.
- b. They require ongoing treatment for a certain period of time.
- c. They are receiving services with providers (doctors, other health professionals, hospitals or other facilities) who are not part of the CIGNA “KelseyCare” HealthCare network (non-participating).
- d. They are receiving these services at the time they become eligible for the CIGNA KelseyCare plan.

If a new member meets all of these criteria, CIGNA HealthCare will contact the provider and attempt to arrange for the provision of covered services. If the provider does not agree to CIGNA HealthCare's contractual terms and conditions, CIGNA HealthCare may deny or only provide limited Transition of Care benefits.

**31. What are some examples of medical conditions or other situations that may qualify for Transition of Care benefits?**

Examples of acute medical conditions that may qualify for Transition of Care benefits include, but are not limited to:

- ◆ Pregnancy in the second or third trimester at the time of the effective date of coverage.
- ◆ Newly diagnosed or relapsed cancer in the midst of chemotherapy, radiation therapy or reconstruction.
- ◆ Trauma.
- ◆ Transplant candidates, unstable recipients or recipients in need of ongoing care due to complications associated with a transplant.
- ◆ Recent major surgeries still in the global follow-up period (generally six to eight weeks).
- ◆ Acute conditions in active treatment such as heart attacks, strokes or unstable chronic conditions, etc. For the purpose of this policy, "active treatment" is defined as a provider visit or hospitalization with documented changes in a therapeutic regimen within 21 days prior to eligibility.
- ◆ Hospital confinement on the plan effective date (only for those plans that do not have extension of benefit provisions).
- ◆ Behavioral health conditions during active treatment.