Benefits Redesign 2013

FREQUENTLY ASKED QUESTIONS

**Why and When Are We Doing This?**

- **Why are we going to a two-tiered medical plan?**
  - We’ve spent a great deal of time determining how we can address rising healthcare costs. To lower the cost of our healthcare, we found we had two options: 1) Increase the cost for everyone OR 2) reduce the number and severity of our claims. We feel that the best way to reduce the number and severity of claims is through encouraging healthier lifestyles among our members by being more proactive in their healthcare.

- **When does all of this start?**
  - Although there will be two plans in place July 1, 2013, for the first plan year, July 1, 2013 to June 30, 2014, EVERYONE will be in the Preferred Plan. Beginning July 1, 2014 the plan in which you are placed will be determined by the Health Risk Assessment (HRA) process.

**About the HRA Process**

- **What is a HRA?**
  - An HRA is a personalized health analysis with interpretations and trends. An HRA allows a physician to explain conditions and treatments by analyzing lab results generated from a clinical blood draw and a questionnaire. Both the blood draw and questionnaire are strictly confidential. Your employer will never have access to this information.

- **What are the HRA Dates and what is my deadline for completing my HRA?**
  - You must have an HRA between February 1, 2013 and July 1, 2013. CareHere will hold on-site events at several Sumner County locations. See the HRA Schedule on: www.sumnerschools.org/benefits
  http://finance.sumnertn.org/services/Employee_insurance_benefits_(1)
carehere.com
  - Note: If you do not have an HRA, you will automatically be placed in the Standard Plan effective July 1, 2014.

- **Are my dependent children required to have an HRA?**
  - No. Only you and your dependent spouse (if applicable) will be required to have an HRA.

**TERMS:**

**Rising healthcare costs:** Between 2010-2011 and 2011-2012 the County’s medical and drug costs rose $1,203,324 on total claims of $17,770,151. During the same period enrollment dropped 3.24%. These claim dollars were paid out of Sumner County Trust Funds.

**Preferred Plan:** The health insurance program that will include all participants who are actively working on personalized health plan.

**HRA:** “Health Risk Assessment” a measure of an individual’s health through lab processed blood samples, weight and body measurements, blood pressure readings and a confidential questionnaire.

**Standard Plan:** The health insurance program that will include all people choosing not to participate in the personalized health plan, beginning July 1, 2014. Out of Pocket expenses will be much greater under this plan.
**Who sees my HRA results?**
- Only you, CareHere and/or your healthcare provider will have access to your HRA results.

**How much will it cost me?**
- All blood draws must be completed at a remote CareHere Non-clinic site. You may have the HRA process completed at a clinic location, if you have scheduled a visit to the clinic for an unrelated event. These services are free. It is assumed that the patient will also use a CareHere provider for the analysis. If so, that service is also free. If the patient chooses to use their own doctor there may be out of pocket expense for the analysis and follow up visits. See below.

**How do I schedule an HRA Blood Draw?**
- Schedule online at [www.carehere.com](http://www.carehere.com) or via the toll free number 877.423.1330. You may schedule for one of the off-site HRA appointments. You must have your HRA between February 1, 2013 and July 1, 2013 for consideration in the Preferred Plan designation.

**Can I see my own physician for the HRA Review?**
- Yes; however, you must have the blood draw through CareHere. If you choose to see your physician to review your results, he/she must follow the guidelines set forth by CareHere and it is your responsibility to provide the proper HRA forms to CareHere by March 1, 2014. You will need to notify CareHere that you are going to follow-up with your own primary care physician.

**If I choose to go to my primary care physician for my HRA review, will I be responsible for payment of the visit?**
- Yes. This will occur just as any other visit. You would be responsible for any deductibles, co-pays, and out of pockets as set forth in your corresponding plan. The County’s Insurance Trust will be paying the balance as is normally the case with all in and out of network claims.

**What happens if I fail to have the required HRA completed?**
- You will automatically be placed in the Standard Plan on the effective date of the next policy year, as well as any of your dependents on the plan.

**I recently had a HRA. Will I need to have another during the months of February through June 2013?**
- It depends on when it was performed. If you had an HRA performed through CareHere On February 1, 2013, or after, that procedure can be used, otherwise, you must have the procedure completed within the dates outlined above.

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**TERMS:**

**Plan Designation:** This is the certification by your chosen physician of your adherence to the personalized health plan. These decisions happen only once per year and can only be changed at that time.

**HRA FORMS:** These forms can be obtained from the CareHere Clinic at the time of HRA.

**Effective Date:** The annual date that marks the first day of each new year of coverage. You are currently on a July 1 annual effective date.

**Policy Year:** The span of time which marks the beginning and ending of a coverage year. Since your effective date is July 1, your policy year is July 1 through June 30.
• **What if I don’t meet all the benchmarks in my HRA? Does that automatically put me in the Standard Plan?**
  - The ONLY at-risk category that automatically will put you into the Standard Plan is the use of tobacco products. You will, however, have the opportunity to stop using tobacco prior to your plan designation. Aside from tobacco use, benchmarks are goals. You only have to be working towards them to be on the Preferred Plan, as certified by your physician.

• **What if an issue is found in my HRA? Does that automatically put me in the Standard Plan?**
  - No. For the first plan year (July 1, 2013 to June 30, 2014), EVERYONE will be in the Preferred Plan.
  - For the next plan year (July 2014 to June 30, 2015), the ONLY at-risk category that automatically puts you into the Standard Plan is the use of tobacco products. However, you will have an opportunity to stop using tobacco prior to your plan designation.
  - For example, you discover you have high blood pressure during your HRA, and your blood pressure remains high the following year. As long as you have followed your individual plan of care to address this issue, you would still be placed in the Preferred Plan, even if your BP remains high. There is no “magic number” in any category that places you in one plan or the other. Working with your physician, or on-site personnel, addressing the condition(s) is the only determining factor in your placement.

• **Will I be on my own to work on the plan developed between my provider and myself? Will I have any tools available to me and at what cost?**
  - You will not be on your own. First, the provider is there to assist you and answer your questions and concerns. Second, if your HRA results identifies a concern, your CareHere representative will enroll you in CareHere Connect. Within this system you will have access to various health coaches by email or by phone. These are professionals that can meet with you personally. This is NOT a web service or “800“ number. You will have access to your own personal site that is populated with the data that was gained from the HRA event. You will be assigned tasks each week that can help you stay on course and educate you regarding your own condition. **THIS SERVICE IS FREE.**

• **If my spouse is covered on my plan and does not cease tobacco use or follow his/her action plan during the year, does that mean I will be enrolled in the Standard Plan too?**
  - Yes. Both the employee and the spouse must comply with all criteria to qualify for the Preferred Plan. Family coverage cannot be split between Standard and Preferred. This boosts the sense of team and will help increase success rates, making a healthier population.

**TERMS:**

**Benchmarks:** Goals set by physician, based on HRAs, that plan participants have to be actively working towards in order to remain on the preferred plan. These do not have to be met; only working towards.

**Individual Plan of Care:** This is your personalized health plan derived from the aforementioned HRA. This plan will be developed between you and your physician.

**CareHere Connect:** This is an online place where an individual can go to access all of the information and personal assistance they need to change and improve their health behavior and condition. It is confidential and includes a social networking piece if the patient chooses to use it.
How will I be notified as to which plan I will be enrolled in?
- You will be notified by the employer.

**Plan Designation Can Change Year to Year**

If I am on the Standard Plan one year, is it possible for me to move to the Preferred Plan the following year?
- Yes. If your CareHere provider (or your physician) determines that you are following your plan of action, as defined, you will qualify for the Preferred Plan the following year if that determination can be made prior to the March 1st deadline prior to the upcoming plan effective date of July 1st of that year.

**Other Plan Changes**

Can I go to an out-of-network provider on either plan?
- The first year of the plan (July 1, 2013 through June 30, 2014), you may use in-network and out-of-network providers (see plan summary for deductible amounts). However, beginning July 1, 2014, the Preferred Plan will NOT include out-of-network benefits. This means if you are on the Preferred Plan, you will have to pay 100% of the cost for out-of-network providers. In addition, effective July 1, 2014 if you are on the Standard Plan and use out-of-network Provider, there is no cap on what you can be responsible for after you satisfy your deductible.

I noticed that the prescription drug plan has changed quite a bit. I take a drug that is VERY expensive and is not available from the clinic. I may not be able to afford the new retail percentage. What can I do?
- Check with your doctor and see if there is an alternate drug or generic available that is less expensive.
- Some drug manufacturers offer special programs for those who cannot afford certain drugs. Speak with your doctor or druggist.

How will my deductibles be figured with the plan year change?
- Currently, all annual deductibles are figured from January 1 through December 31 of each calendar year. Beginning July 1, 2013 deductible and out of pocket expenses will be calculated on a plan year from July 1 through June 30. In order not to penalize someone who has accumulated deductible and out of pocket expenses during the first half of 2013, there will be a one-time opportunity to accumulate deductible and out of pocket expenses for an 18-month period from January 1, 2013 to June 30, 2014. Please note this is a one-time added benefit.
• **What happens if I miss a scheduled CareHere Clinic appointment?**
  
  • Effective February 1, 2013, after an Employee or Spouse misses ONE scheduled appointment each year without an attempt to notify the clinic to cancel or reschedule the appointment at least 12 hours prior to the scheduled appointment; the employee will be charged $50 as a "No Show" fee beginning with the 2nd "No Show.” Arriving more than 10 minutes late for the appointment will also count as a no show. Payment of the fee can be made only at the Shafer Clinic with any form of payment other than cash. Failure to pay the fee will suspend clinic privileges until the fee is submitted. Suspended clinic privileges could place your preferred plan status at risk. Unlike retail doctors, CareHere doctors do not see multiple patients at one time. When there is a “No Show” all of the fixed costs, including salaries for that twenty-minute time slot, are covered by all of the other employees of the County, out of the Trust. Last year there were over 1,200 missed appointments.

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**Wellness Programs**

• **Does Sumner County offer tobacco cessation programs?**
  
  • Yes. Programs are offered through CareHere. Contact CareHere for more information on this and other great programs that are available to you.

• **Are there any other additional costs if my spouse or I do not stop using tobacco products?**
  
  • In addition to remaining in the Standard Plan a tobacco product user will be charged $50 per month effective 7-1-2014. This amount will be assessed as part of your health insurance premiums and collected bimonthly (24 times a year.) If an employee has Family Coverage, and the employee and spouse use tobacco products, then the additional charge will be for the employee and spouse or a total of $100 per month. It must be clear that both the employee and the spouse have to be free of tobacco use to be covered under the preferred plan.

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**TERMS:**

**Tobacco Cessation:** These are programs that use personal counseling, group meetings, and certain prescription drugs to overcome the habit of using tobacco products.
Helpful Tips

- **To help reduce pharmacy cost**
  - Always ask your doctor if a generic drug is available. Helpful information about generic products:
    - Many times the difference between name brand and generic has to do with time release agents determining how often you must take the medicine.
    - The ingredients of a generic drug are tested under the same FDA regulations as name brand. Many times they have the same ingredients. You should have your pharmacist explain the difference to you. If they do not know or do not have time to speak with you, consider changing pharmacies.
    - Most generics are manufactured by the same companies that manufacture name brands and often in the same facility.

- **Why are prescriptions given away at the on-site clinic?**
  - Although drugs are given to the patient, they are not free to the Trust. CareHere checks their purchase price against the cost to the plan through BCBS/Medco.
  - CareHere will only stock a drug that they can purchase for the County at a price below the BCBS/Medco product price. If they cannot save Sumner County money, CareHere does not stock the item and will instead write the patient a prescription.
  - Many times the drug you get at a large retailer or drug store for $4.00 might cost the County $1.00.
  - CareHere does not mark up the cost of the drugs given out in the clinic. The Trust is charged exactly what CareHere pays for the drug.
  - Drugs must be pre-packaged (sealed) to be dispensed in the clinic without a pharmacist.
  - NO NARCOTIC DRUGS ARE EVER STORED OR DISPENSED THROUGH THE CLINIC.

- **My doctor is not in the network or has dropped out of the network. Why?**
  - Three of the common reasons a doctor, hospital, other provider is not in a network are:
    - Networks require that a provider agree to reduce their charges by a certain percentage. Some providers have all the patients they need and do not want to receive less for their services.
    - Networks conduct extensive credentialing (checking a providers history, outcomes, complaints, etc) and some do not measure up to the standards of the network.
Some networks have multiple payment centers while others have one or two. Providers spend a great deal of resources in dealing with insurance companies and trying to receive payment for the larger portion of your expense.

- **How can I get my doctor in our network?**
  - Ask the provider to join and let them know that if they do not you will have to change doctors or hospitals.

- **My doctor has always been in our network. Can I assume that they are in the network the next time I go to the doctor?**
  - No. You should ask at the front desk EVERY time you go in; before you are seen by the staff.
  - A doctor group may be in a network but an individual doctor in that group may not be. So, you should ask.

- **If I go into the hospital for surgery can I assume that everyone who works on me will be in the network just because the hospital is in my network?**
  - No. There are doctors who are employees of the hospital called “hospitalists.” These doctors will be in the network. Other hospital based-meaning their practice is primarily run at the hospital—are considered “in-network” by Blue Cross Blue Shield. Examples are pathologists, radiologists emergency room and anesthesiologists. However surgeons and other specialties may not be in the network.
  - You should make it clear in the business office, when you schedule your stay, that you expect everyone who works on you will be in the network. Let them know that you will not be responsible for any extra charge for the use of a non-network provider working within their facility. Ask for it in writing.

- **What do I do if I cannot physically travel to one of the HRA blood draw sites?**
  - Contact CareHere at www.carehere.com or via the toll free number 877.423.1330.

- **If I already know that I have a serious chronic condition will that automatically place me in the Standard Plan?**
  - No. You should work with your doctor or the on-site clinic physician to monitor the condition and review and change any current plan of care, as appropriate. As long as you are working toward managing your disease it is likely that the physician will certify you for the Preferred Plan. Note that every case is based on its own merit and this statement does not override the opinion and knowledge of your attending physician.
**Tobacco Cessation**

**TERMS:**

- **Will there be a tobacco test—blood, hair, saliva, etc.**?
  - Not at this time. The tobacco affidavit will be the only source of information about a participant’s use of tobacco. There are however serious consequences for not telling the truth on this form.

- **If the $50 smoking charge isn’t paid, will that put me in the Standard Plan?**
  - If you do not have the non-smoking affidavit(s) on file for yourself and your spouse (if your spouse is covered), you will be assessed the applicable smoking surcharges through payroll and you will default to the standard plan.

- **If both spouses are non-smokers, but only one doesn’t comply with benchmarks, do we both go into Standard Plan?**
  - Yes, the system is not capable of placing individuals within a family in different plans. All family members including the employee will be placed in the same plan. Being a smoker may or may not be a consideration.

- **How is the smoker’s charge paid?**
  - The charge will be through payroll deduction. A separate deduction code will be set up to accommodate the process.

- **If I get Cancer, but don’t smoke, how do I convince The Trust that I wasn’t a smoker?**
  - That decision will be left up to the medical community and the research that was performed to come to that diagnosis.

- **What is this tobacco affidavit?**
  - The tobacco affidavit is an on-line form, included in the health risk assessment process that asks if you have used tobacco products within the past thirty days. This document also outlines the penalties for use of tobacco and falsifying your answer. If you are tobacco free you must sign this document electronically by March 1st of each year and have been tobacco free 30 days prior to signing the document.

- **Is the tobacco surcharge only charged to the smoker, even if both spouses are on the Standard Plan?**
  - Yes, the only individuals that will be charged are those that answered the affidavit saying that they have NOT been tobacco free for the past thirty days or has not completed the required affidavit. Both however will still be in the Standard Plan.
• Does the tobacco surcharge only relate to smoking, or to all forms of tobacco?
  • All forms of tobacco use.

• Are things like electronic cigarettes, nicotine patches, nicotine gums, etc. subject to the tobacco surcharge and the Standard Plan?
  • If the product uses tobacco in any way you will be considered to be using a tobacco product. You should check with a physician before using any product that replaces the use of tobacco products.

• If my spouse won’t quit using tobacco, can I remove them from the plan entirely and not have to worry about non-compliance?
  • Only if they are removed during open enrollment or by a qualifying event (as defined by your section-125 agreement).

• If the spouse on the plan uses tobacco, are we automatically put on the Standard Plan?
  • Yes.

• If the spouse is not on the plan and uses tobacco, are we automatically put on the Standard Plan?
  • No.

• What if an employee or spouse starts smoking in 2014?
  • They must be tobacco free for 30 days prior to March 1st 2015 or they will either remain in the Standard Plan or be transferred to it.

• What if quitting smoking or using tobacco products is too hard for me?
  • You will be placed in the Standard Plan and any dependents as well, if on your plan. Also, you will be assessed the smoking surcharge.

• Why is this plan focused on tobacco users while saying nothing about drugs or alcohol?
  • The federal government does not allow the employer discretion concerning other health behaviors other than tobacco products at this time.

• What is stopping me from just quitting smoking one month a year?
  • Your conscience and your fellow Trust participants who will be paying for your behavior. – (The trust may consider amending the affidavit to cover such occurrences.)
• **What if a dependent child, 26 or under, is a smoker?** Does that put my family on the Standard Plan? Is there any surcharge for them?
  - First, dependents must come off of your plan when they turn 26. They would however be offered Cobra and could stay on the plan if the proper premium were paid. However, under no circumstances would a dependent child be penalized for using tobacco products. It is anticipated that by the time the use of tobacco takes a toll on their body that they will no longer be on the plan as a dependent.

• **What happens if I quit smoking halfway through the year?** Do I have to pay the smoking surcharge all year in addition to being on the Standard Plan until the new plan year starts?
  - Yes, the affidavits will only be certified during the annual enrollment process.

• **Will the blood work show Nicotine?**
  - No, we are not currently testing for nicotine however; the SIB Trust can choose to proceed with this additional testing at some point in the future.

• **What keeps me from lying on the affidavit?**
  - Your conscience, the language in the document, and your fellow Trust participants who will be paying for your behavior. If it is discovered that you did and you are on the preferred plan you will be transferred to the Standard plan and charged appropriate surcharges back to the effective date.

• **What happens if I am a healthy non-smoker and don’t do anything?**
  - You, and if any dependents, will be placed on the Standard Plan. Additionally, if the affidavits are not completed when required the applicable smoking surcharges will apply.

• **If I start smoking halfway through the year, when does my $50 surcharge start?**
  - If you are still smoking 30 days before March 1st of the year you mentioned you will be placed on the Standard Plan the following July 1st and will begin paying the surcharge at that time.

• **Why am I being charged $50 for smoking?**
  - There is overwhelming medical and scientific evidence that using tobacco products results in serious health problems and decreases productivity. If you insist on using tobacco products, it is not fair to the rest of the members on the Trust who are not using tobacco or stopped using tobacco. You should pay more for your health benefits than your non-tobacco fellow employees and their dependents.

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**TERMS:**

**Language in the document:**
“By clicking the button below I am confirming that I am tobacco free. I also understand that if I confirm I am tobacco free but am using any tobacco product that this will constitute Fraud.”

**Overwhelming medical and scientific evidence:**
Over 440,000 people in the USA and 100,000 in the UK die because of smoking each year. According the US Centers for Disease Control and Prevention, $92 billion are lost each year from lost productivity resulting from smoking-related deaths.
**TERMS:**

No Lifetime Max Rule: As part of the 2012 Health Reform legislation lifetime caps were removed over a period of time into 2014 for certain medical treatment.

- What programs and or medications are available to the members to aid with quitting tobacco?
  - The clinic has Wellbutrin in-stock at each clinic location. We offer Chantix through the Tobacco Cessation program. **At what cost?** The Wellbutrin is available in clinic at no charge to the patient.

- Will Chantix be available to bus drivers and operators of heavy machinery?
  - Chantix will be available to any employee or dependent spouse that participates in the Tobacco Cessation program and the clinic provider deems use is appropriate. **If so, does the taking of this medication prohibit driving a commercial vehicle in any way?** The clinic provider will assess Chantix recommendations on a case by case basis, taking into account the mental health of the employee and dependent spouse as well as the type of job the individual performs.

- Will I have to have a Psychological evaluation before beginning a Chantix regimen?
  - Yes, a psychological assessment by the clinic providers prior to Chantix being prescribed.

**Plan Design**

- Is Dental and Vision still covered, and are there any benchmarks to meet with them?
  - Yes, both are covered with no benchmarks. These coverages are the same regardless of plan assignment. The deductible change to a fiscal year will also apply to these coverages. Benefits that are stated within these coverages on an annual basis will be spread over eighteen months.

- Does the lack of a cap on the Standard Plan violate the “No Lifetime Max” rule?
  - This rule does not currently apply to large group/self-funded plans like the Sumner County SIB Trust. The proposed rule applies the out-of-pocket maximums to in-network services only. The group will not be required to have an out-of-pocket max on their out-of-network services. If requirements change when final rules are issued the Trust will adjust accordingly.
  - Below is the current rule concerning this matter about compliance with the Affordable Care Act.

  § 156.130 Cost-sharing requirements.
  (c) *Special rule for network plans.* In the case of a plan using a network of providers, cost-sharing paid by, or on behalf of, an enrollee for benefits provided outside of such network shall not
count towards the annual limitation on cost sharing (as defined in paragraph (a) of this section), or the annual limitation on deductibles (as defined in paragraph (b) of this section).

- **Why do we not have an HSA option?**
  - These plans require a large deductible and there cannot be any copays. That means that you would have to pay 100% of the cost of your drugs until you reach your deductible.

- **Will our insurance company change between the Preferred and the Standard plans?**
  - No. Your coverage will be through the Sumner County SIB Trust with either plan.

- **Why is this plan only for classified employees?**
  - Several years ago the certified teachers voted to leave the Trust and buy a fully insured plan through the state of Tennessee. That plan continues to run out of control and the state will increase their premiums again next year 10%. There will also likely be additional reductions in benefits and further restriction on plan participation.

- **What is a Pre-Approval code?**
  - Certain medical procedures require the provider to call and get approval. This approval determines if the procedure is medically necessary. It is important to note that the determination that a procedure is medically necessary does not authorize the procedure as a covered procedure under your plan.

- **If something has been covered, will it continue to be?**
  - Yes.

- **What happens to our plan when we retire?**
  - If you have met the retirement eligibility requirements, you may continue on the plan until you reach age 65, at which time the plan terminates. Alternatively, you will qualify for COBRA.

- **Why are the deductibles on the Standard Plan so high?**
  - To create enough difference to cause an individual to seriously consider participating in becoming involved in their health.

- **Is the Preferred Plan what we have now?**
  - Yes.
- Do children up to 26 years of age have to comply, or is it just employees and spouses?
  - Just employees and spouses.

- This has always been a family plan. Will this force some to seek coverage elsewhere?
  - It may cause individuals to determine if there is a better alternative.

- Will my paycheck change if I am on either the Standard or Preferred plans?
  - If you use tobacco products there will be an additional surcharge.

- Why does my card say Blue Cross Blue Shield if they aren’t my insurance company?
  - It says Blue Cross Blue Shield so the provider will know that you have the Blue Cross Blue Shield network. This alerts them to how much they will have to discount their services.

- How does Blue Cross Blue Shield make any money if they don’t get any premiums?
  - They are being paid a fee to process claims. It is assumed that there is a profit margin built into those costs. In addition the Trust pays them an access fee to use their network to receive discounts. That, too, likely has a profit included in the fee. Even so, all costs to run the plan, including Blue Cross are less than 4% of the total expense. Fully insured plans run a maximum administrative cost of 15%.

- Why isn’t Sumner County giving us gym memberships if it wants us to get healthy?
  - There is a 10% discount off the cost at the Hendersonville YMCA. However, studies show that when gym memberships are given, that the ones who use them are the ones who were already going to the gym. These should be incentives to use the services by the majority of the participants, not discounts for a few. Early on the Trust gave a $100 gift card for those who had an HRA. Many received the HRA, received the gift card and then did very little with the information they received from the HRA. Incentives must be used for the greater good.

- When will the first person be put on the Standard Plan?
  - July 1, 2014
Who decides that a claim is to be denied?
- Blue Cross Blue Shield, the claims payer using the plan developed by Sumner County.

Who decides grievances?
- Blue Cross Blue Shield handles the grievance procedure for the Trust. It is part of their administrative charge.

Do I have to log-in to CareHere connect to remain on the Preferred Plan?
- No, but you must stay in touch with your provider and complete the plan developed by your provider and yourself.

Can I come back to the Preferred Plan if put on the Standard? Yes. How might I accomplish this?
- By having an HRA, meeting with your provider to discuss the results, working with the provider to develop a plan to address one of the five areas identified by this program, if one occurs, and then participating in that plan of care.

How do we return forms from an outside provider?
- Either by the fax number listed on the forms or physically returning the forms to a CareHere clinic.

How is my information kept private?
- All records are kept electronically by CareHere in their on-line electronic medical records (EMR) system. Everything is HIPAA compliant. CareHere has a full-time HIPAA Compliance Officer who oversees this operation. Does the County see it? Not without your permission and other HIPAA standards.

How much does the CareHere program cost?
- Administrative costs, provider fees, supplies, drugs and all other expenses are estimated to run $2.5 million for 2012-2013. If the clinic were to be pulled out those costs would go back into the Blue Cross administered program at an additional cost of $1 million dollars. Is it less expensive than what traditional doctors’ offices charge? Yes, approximately 40% less. Plus, the patient gets more quality time with the provider and in some cases drugs at no cost to the patient.

How long before The County sees any return on its investment in this wellness program?
- The average is three years.

Is the 18 month deductible in effect right now?
- Yes, January 1, 2013 to July 1, 2014.
Do I have to wait a whole year to get back on the Preferred Plan?
- Until the next July 1st renewal after you were placed in the Standard plan, assuming you meet the requirements to enter the Preferred Plan by March 1st prior to the next July 1st renewal date.

What happens if I don’t do anything?
- You will automatically be placed in the Standard Plan and you will be charged the smoking surcharge for you and your spouse, if applicable.

Why doesn’t the County just give us money to go buy individual plans that we want?
- First, that money would have to be taxed, which effectively lowers what you would receive. Second, a similar plan would cost much more.

If my spouse and I are both County employees, do we have to pay the Dependent surcharge?
- No.

Do I need to remove my spouse who won’t comply at this year’s open enrollment or next year’s?
- Next year’s open enrollment. No one will be placed in the Standard Plan effective July 1, 2013. However, you will need to discuss this with the benefits department at least 30 days prior to the 2014 open enrollment.

In and Out of Network

How do I determine if a provider is “In-Network?”
- The safest way is to ask the provider. The riskiest way is to look in a publication. Providers can drop out of a network quickly. Ask when you make an appointment. Ask when you get to the appointment. Also, be sure to ask about lab tests. The lab must also be in-network.

If I go to an In-network hospital, but someone works on me and isn’t In-network, will I be penalized?
- Not if it is considered a “hospital-based” provider.
Does the network stretch across state lines?
- Yes. There is not a national Blue Cross insurance company. Each state has a self-contained version of Blue Cross. They do have a national association. There is a program called the “Blue Card.” If you are out of state you should ask if the provider is a member of that state’s Blue Cross program. There are special differences in some states. For example California has a Blue Cross company and a separate Blue Shield company. As long as the out of state provider is in that state’s version of Blue Cross Blue Shield you should be okay. However, it is your responsibility to have the out-of-state Blue Cross provider authorize the work that they will perform, before it is performed. As before, in an emergency, you should not be penalized for something over which you have no control. Again, ask, ask, ask.

Is the P Network available to both Preferred and Standard Plans?
- Yes, the “P” network will be used for both. This is the broadest network available in Tennessee. It will be difficult to find a provider that is not in the P Network. Providers cannot afford to refuse to be in the network. They would lose too many patients. Even though, ask.

If I am unconscious, am I responsible for checking In-network status of my providers?
- You will not be penalized for circumstances that you cannot control. That doesn’t mean that the billing department of the out of network provider will get it right. You may have to do some damage control after you recover, but you should not be penalized.

Why does the Veterans Administration hospital want my insurance card if it isn’t in network?
- They ask for the member’s ID card in case services rendered are not covered under VA benefits then they can file them under BCBST.

If I have lab work performed in my in-network doctor’s office, does that mean that the lab in which it is processed will be in-network?
- No. You should ask. Lab work is an income source to any provider that orders tests of any kind, including lab tests. Some doctors have their own labs so they can control the quality and cost of the procedure. This does not insure that the quality of cost is best for you. Some providers will use private labs and even labs out of state. Many times these facilities are not in your network. If not, you could be responsible for all of, or a large portion of the cost. Again, you should ask.
What if the doctor prescribes medication, but you do not like, or are allergic to medications, can we try other Holistic or Natural remedies?

- You should talk to your provider any time you deviate from their recommendations. If you have an issue taking medications you should speak with your provider concerning those issues. If the provider cannot accommodate, you should ask for a referral.

### HRA Process

- If I have never used CareHere before, how do I set up my account online?
  - You Log on to [www.carehere.com](http://www.carehere.com) and check register for the first time. Use ACCESS CODE SC327 and complete the information.

- Aren’t we already getting HRAs?
  - Some are. Everyone has always been eligible.

- Do I need to make an appointment for the HRA event?
  - Yes.

- Will HRA events be at all schools?
  - Almost. Please see the schedule on-line.

- Is there an HRA event schedule posted?
  - Yes. It is on-line at [www.carehere.com](http://www.carehere.com) and both the county and BOE benefit sections of their websites.

- Can I use the blood work my own doctor has already measured?
  - No. For uniformity all of the blood draws must be done through the CareHere off-site events.

- Do I need to bring any paperwork to the CareHere clinic or HRA events?
  - Your County Health Insurance Card.

- Do I need to tell the clinic to add an HRA if I am going for something else?
  - Yes, and remember it is a 12 hour fasting blood draw.
Will a blood draw I had in September – January suffice for my HRA?
- No, you will have to have another. You can wait until later in the year however. You have until June of 2013.

A member of my family has a chronic condition which can bring about emergency situations. Do I have to get Prior Authorization for these situations?
- This does not appear to be related to the wellness program. Under any circumstance when there is a true emergency you should immediately seek medical attention. Details can be discussed when things are stabilized.

What if work prevents my spouse from attending an HRA event?
- You should call CareHere to discuss at 1-877-423-1330. Please note that special approval will need to be granted by CareHere for HRA blood draws in clinic other than two (2) Saturday morning events that are being planned. These should be on the schedule by March the 8th. When scheduled, one will be at the Portland Clinic in March and one at the Shafer Clinic in April. This restriction is to ensure that acute and routine needs are able to access the clinics. Please be advised that all HRA blood draws scheduled in clinic without approval will be rescheduled for an HRA event.

Do I have to have my blood drawn at a CareHere clinic/HRA event?
- Yes. Visit www.carehere.com

Why is my blood being drawn?
- It is a consistent way to determine your health status regarding several things that directly affect your health and wellbeing.

Can I get my blood drawn elsewhere? Why or why not?
- Your blood must be drawn through CareHere for consistency. Otherwise there could be a question regarding these issues. CareHere uses Lab Corp, one of the largest laboratories in the USA. Most doctors use this same vendor, but the results must all come back through CareHere as a single repository.

What if my doctor tells me I am fine, but CareHere says I am not?
- You may wish to get another opinion. That opinion will be at your own cost through the medical plan. Or, you might ask the two physicians to collaborate and discuss the issue and where they differ on the diagnosis. This is done often and the CareHere electronic medical records make that process very easy.

**TERMS:**

**Chronic condition:** A health condition that demands continuous care by a medical professional, for example a diabetic or someone with high blood pressure or high cholesterol.
• What if my Doctor’s lab results conflict with CareHere’s lab results?
  • You may wish to get another opinion. That opinion will be at your own cost through the medical plan. Or, you might ask the two physicians to collaborate and discuss the issue and where they differ on the diagnosis. This is done often and the CareHere electronic medical records make that process very easy.

• How can my doctor give to and receive from CareHere important information on my health?
  • You must give permission to CareHere and they can transmit that information electronically to your doctor. Much of this information is on line through CareHere Connect and is within your reach without requesting anything.

• Can spouses come alone to the HRA blood draw?
  • Yes.

• Will a doctor or nurse decide on my plan of care, or is this dictated by the County?
  • Be assured that the county is not involved in this decision in any way. This decision will be made between you and your physician.

• How long does an HRA last?
  • Health Risk Assessment (HRA) will qualify the employee and dependent spouse for 1 plan year. The actual blood draw event will take about 5 minutes.

• If I am already scheduled for a quarterly blood draw, can I just have my HRA at that time?
  • Yes, the HRA blood test can be added to an existing patient’s quarterly lab work.

• What is a Fasting Blood draw?
  • A fasting blood draw means to be without food for at least 12 hours prior to HRA appointment. You are able to drink water and black coffee prior to your HRA blood draw appointment.
• Do I have to go to the HRA event?
  • Yes, all employees and dependent spouses need to attend an HRA event unless:
    ✓ Are routinely scheduled for quarterly lab draws
    ✓ Have a medical condition that makes them unable to attend an HRA event.
    Determination will be made by CareHere. For consideration contact help@carehere.com or 1-877-423-1330.

• What’s different between an HRA event and a clinic visit?
  • An HRA event is an onsite event held at locations throughout Sumner County. Please visit www.carehere.com and login to view the HRA schedule in your area. A clinic visit is an appointment scheduled at one of the five clinics in Sumner County.

• What does the blood draw test for?
  • The HRA blood test consists of a lipid panel, electrolyte panel, CMP, Glucose.

• Is “Step 3” a second follow up?
  • Yes, step 3 is a second follow-up that is needed if all Benchmarks were unmet at the initial HRA follow-up appointment. This appointment is to determine if employee or dependent spouse has complied with the Plan of Care and to determine compliance status for health plan.

• Should we not be looking at A1C instead of Glucose as it pertains to Diabetes prevention?
  • We will not be drawing for a hemoglobin A1c unless it is ordered by your provider. We draw a glucose level as opposed to a hemoglobin A1c as employees or spouses without diabetes would not need this additional testing. By drawing glucose this enables testing to be performed more efficiently for the majority of participants. The glucose testing is also less expensive therefore saving the SIB Trust additional cost for testing that is unnecessary.

• Who are the HRA providers?
  • The HRA providers in the CareHere system are the same providers currently working in the Sumner County CareHere Clinics.

• Do I have to keep up with any paperwork if I do everything at the CareHere clinic?
  • No.
What is the 60 day rule, blood work follow-ups?

- The requirement for the HRA Wellness Initiative is to have your HRA performed by CareHere and to follow-up with a CareHere clinic provider or your external PCP within 60 days of your HRA blood draw. The 60 day requirement is to ensure that if benchmarks are not met that you have adequate time to participate in a Plan of care for compliance.

Do I have to do anything online for the HRA?

- Yes, we have the HRA schedule available online at www.carehere.com for your convenience.

Are these Fasting blood draws?

- Yes, you must fast 12 hours prior to your HRA appointment. Why can’t I eat? We request that you fast 12 hours prior to blood draw due to the impact on inaccurate lab results with non-fasting lab test. Can I drink anything at all? Yes, you may drink water or black coffee within the 12 hours prior to your HRA event. You may also take medications as long as medications do not require to be taken with food.

If I can’t get a hold of my Health Coach, who do I call?

- Please contact help@carehere.com and a member of our Wellness Team will reach out to you to address your need.

If I have a problem with the CareHere clinic or HRA event, who do I call?

- You can submit your question or concern to help@carehere.com or call 1-877-423-1330.

**Benchmarks**: Goals set by physician, based on HRAs, that plan participants have to be actively working towards in order to remain on the preferred plan. These do not have to be met; only working towards.

**BMI**: Body Mass Index. This determines if your height and weight are within a healthy range.
Why aren’t we using more precise measurements for calculating BMI and body fat percentage?
• We choose to utilize this measurement for BMI due to the need to assess at multiple HRA locations as well as prevent additional cost to the SIB Trust.

Will The Trust assist us in meeting benchmarks?
• The SIB Trust has designed this HRA Wellness Initiative as a participation based wellness program not, outcome based. Compliance will be based on participation in Plan of Care determined by the CareHere clinic providers or your external provider.

Will The Trust pay for any costs associated with meeting benchmarks?
• No, however there will be counseling and other resources available through CareHere at no cost to the patient. As always, if there is a drug that is part of the plan of care that is normally stocked in the clinic, that drug will also be at no cost to the patient.

Who determines that a member is “Trying hard enough?”
• You and your physician.

If I am 30 pounds overweight, by when do I have to lose it?
• You may not have to lose it, rather, your physician will determine if you are following the prescribed plan of care to lose it. That decision will be made on March 1st of each year for the upcoming July 1st effective date.

If I go onto Medicare, do I have to continue meeting benchmarks?
• Only if you remain on the Trust plan.

Will we be penalized if we are working on a goal, but falling short?
• That decision will be made by your physician.

What are the benchmarks?
• Blood Pressure 140/90 or less, cholesterol 220 or less, Body Mass Index 30 or less, fasting glucose below 100mg/dl, use of tobacco products.

If I am already a Diabetic, how do my benchmarks work?
• If you already have a chronic condition such as diabetes then, you will work with either a CareHere provider or your external PCP to determine a Plan of Care that best fits your health condition.
Childhood obesity is a growing problem. Why aren’t the children subject to these benchmarks as well?
- It is anticipated that they will be off the plan before their condition creates serious claims.

If the employee or spouse fails to meet any of the 5 benchmarks, are we automatically on the Standard Plan?
- No. That is determined by your willingness to work with your physician and participate in the plan of care agreed upon by you and the physician.

Are the benchmarks checked monthly or annually?
- The benchmarks are checked annually through HRA blood draw.

If someone is terminally ill, will they have to meet all of these benchmarks and get HRAs every year?
- This will need to be determined by the SIB Trust. Traditionally, terminally ill patients have been exempt from participating in the HRA Wellness Initiative.

No Show Fee

A fee for not canceling an appointment at a CareHere clinic within a certain timeframe.

If the $50 No-show fee isn’t paid, will that put me in the Standard Plan?
- No. But it will suspend your clinic privileges and jeopardize your ability to remain in the Preferred Plan at the next renewal.

How quickly is an appointment canceled when I click Cancel Appointment?
- Immediately.

Do the employees get paid if the Provider is ten minutes late?
- No, but if the doctor is backed up with another patient perhaps you will understand the next time you need more of the doctors time. If the doctor is not on premises on time you should call CareHere and make them aware of the situation.

How much notice is needed to prevent a No-show?
- Twelve hours.
What if traffic causes me to miss an appointment? Will I be penalized?
- You should speak with CareHere and explain your circumstances. Remember there is one no show without penalty each year. If traffic is a problem more than once you might need to schedule your visit at another clinic or at a different time of day.

Who decides if a No-show is justifiable?
- CareHere will determine No Show appointments and will investigate any concerns regarding a No Show appointment and advise the patient of outcome decision.

How is the No-show charge paid?
- The No Show fee will be collected at the Shafer clinic through Debit, Credit or Check. NO cash will be accepted. Also, if you have 2 No Show appointments your privileges to the CareHere Clinics will be suspended until your No Show fee is paid in full.

If I choose Generic over Name Brand, does it save money?
- Almost always.

Without scheduling an appointment, how do I determine if my medications are available at the CareHere clinic?
- Please contact CareHere at 1-877-423-1330 or help@carehere.com for a clinic staff member to address your prescription inquiries.

If I was getting my prescriptions through the Pharmacy, can I now get them at the clinic?
- The majority of generic medications will be available at the Sumner County Clinic locations. If you were on a brand name medication then, you will need to have your medication filled at a retail pharmacy as the clinics do not carry brand name medications.

What is the county looking at in terms of financial aid for the purchase of Insulin?
- This was addressed at the January 2013 Trust Board meeting and the decision was made to leave the deductible as it currently reads. The Trust cannot discriminate in favor of one particular class of drug.
• **Will this plan force people to take meds, even if they don’t want to?**
  • There should be a reason that someone doesn’t want to take medication. That should be discussed with your provider. If you just don’t want to participate you are not complying with your plan of care and the provider will likely not certify you for the Preferred Plan.

**Reminder!**

• **You must get your HRA blood draw**
  • You must have an HRA between February 1, 2013 and June 30, 2013.
  • After having your HRA completed, you must review the results with a provider and develop a plan to address any identified issues.
  • You must work any program developed by you and your physician for 180 days.
  • Your progress must be certified by your physician and submitted to CareHere for processing and ultimate notification to the employer for plan placement by March 1, 2014.