ARBenefits News Monthly

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Office Visit Coverage 2015

ARBenefits

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Effective January 1, 2015, the copay on the Premium plan is $25 for a Primary Care Physician and $50 for a Specialist. There is also a $250 copay for an emergency room visit. Please refer to your schedule of benefits for a full listing of copays.

All plan levels have a copay of $50 for hearing and vision screenings.

For members on the Classic or Basic plans, services are subject to the deductible and coinsurance (with the exception to vision and hearing screenings)

The plan does cover one wellness visit for each member per year at 100% for all plan levels. The visit must be coded as a wellness visit, and members should not have to pay a copay.

Please refer to the schedule of benefits for your plan to see what services apply towards your deductible.

A full list of what is covered for each plan can be found in the ARBenefits Summary Plan Description.

The Summary Plan Description can be accessed online at ARBenefits.org, and you can request a copy be mailed to you.

Please keep in mind that the Summary Plan Description is a living document and will have changes throughout the year. An updated Summary Plan Description can be accessed at ARBenefits.org.

Retirees on the Primary Plan

QualChoice is the new carrier for Medicare Primary members on the ARBenefits plan, taking over for Health Advantage.

In addition, once a member on a plan is Medicare eligible, every member moves to the Primary plan through QualChoice.

Members on the Primary plan who are not Medicare eligible will be covered at the Premium plan level. Please refer to the schedule of benefits for Premium members on the state employee side or public school employee side to see the benefits for your plan.

Medicare primary members should not see a change in their benefits due to the change in carrier. They do not have to use the QualChoice network, just a provider that accepts Medicare. Medicare is still their primary insurance carrier with ARBenefits as the secondary through QualChoice.

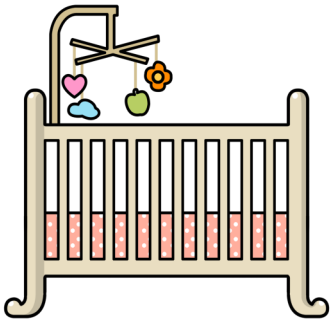
A schedule of benefits for Medicare Primary retirees can be found at ARBenefits.org in the Forms & Publications section, and also the Summary Plan Description.

Members on the Primary plan who are not Medicare eligible will have to use the QualChoice network of providers to obtain in-network benefits. A searchable database for QualChoice providers in your area can be found at ARBenefits.org by clicking contact us at the bottom of the homepage.

You have the option to terminate coverage on your spouse when he/she becomes Medicare eligible, and not be moved to the Medicare Primary Plan. If you wish to remain on the Classic or Basic plan, you must submit an election form to EBD requesting termination of your spouse 60 days prior to the Medicare eligibility date of the spouse. If you wait until after the plan change has been made, you cannot change back to your original plan until Open Enrollment for the next January effective date.

Please note, If a member decides to terminate their spouse from their policy, that spouse can never come back to the plan.

Maternity Program Changes



Changes have gone into effect for the Maternity Program as of January 1, 2015.

If you or your spouse are pregnant, you can take advantage of one-to-one support from a Registered Nurse who will help you achieve a healthy pregnancy. Even if you aren't a first-time mom, your nurse can help you through the changes that come with each unique pregnancy. The program is available to you at no cost and you may register up to 20 weeks gestation. A $250.00 check will be mailed to you once completion of the program has been verified.

To enroll, call 1-866-458-0408 and select option 3.

Bariatric Surgery Program Enrollment Resumes

Enrollment into the Bariatric Surgery Program was suspended last spring, but has now reopened as of January 1, 2015.

For members accepted into the program, ARBenefits will provide coverage for bariatric surgery to include:

A) Gastric bypass surgery

B) Adjustable gastric banding surgery

C) Sleeve gastrectomy surgery

D) Duodenal switch biliopancreatic diversion

The Arkansas State and Public School Life and Health Insurance board must approve additional procedures. The surgical procedure must be pre-certified by your surgeon and supported as medically necessary by your primary care physician prior to surgery.

The eligibility criteria are as follows:

1. Only Arkansas State and Public School Employees, ages 25-55, with a BMI greater than 35 will be considered for bariatric surgery (no dependents or spouses).

2. If the Employee's BMI is between 35 and 40, candidates must have co-morbid conditions, such as cardiopulmonary disease, sleep apnea, hypertension or diabetes. (If you are followed by your physician for, or are on medications to treat a condition, you must enroll in a Disease Management Program.)

3. The Employee under the plan must have been a plan participant for a minimum of one plan year prior to enrollment in the bariatric program.

A full list of participation criteria can be found on ARBenefits.org along with a link for frequently asked questions. Just click on Resources and Links in the Health Enhancement section of the EBD homepage.

Please note that This program will only cover the first Bariatric procedure per lifetime. (Employees who have had previous bariatric procedures are ineligible.)

Any member who enrolled prior to the suspension of the pilot program are subject to the former requirements.

Any requirements are subject to change. Members must call EBD at 501-682-9656 or 1-877-815-1017 to enroll.

ASK EBD

Q: I am on the Premium plan. If I am referred by the 24/7 Nurse Hotline to the ER, how is the waiving of the copay handled?

A: If you are referred to the Emergency Room by the 24/7 Nurse Hotline, please go directly to the ER. American Health Holding (AHH) administers the 24/7 Nurse Hotline. They receive a report each week which details if a member has been referred to the ER. AHH will then contact Health Advantage to get the claim adjusted, or to reimburse if the copay was already paid by the member.

Please remember that the 24/7 Nurse Hotline is not a substitute for 911. Please contact 911 if you are having a health emergency.

New Year, New Resolutions

The start of a new year is a time where people set new resolutions for themselves for the upcoming year. If you have a resolution to improve your health, GuidanceResources®, your EAP provider is available to assist you reach your goals.

Guidance Resources® through their HealthyGuidance® program offers wellness programs in these areas at no charge to you and your dependents:

- Tobacco cessation
- Weight management
- Stress reduction
- Healthy Eating
- Diabetes Prevention
- Cardiovascular Maintenance
- Exercise
- Health Risk Assessments (HRA)
- Sleep Health

Tobacco Cessation Program

Smoking and related health complications are the single largest cause of preventable premature illness and death. Certified tobacco counselors provide:

- One-on-one telephone counseling
- A customized assistance plan
- Helpful ideas and resources
- Behavior modification techniques
- Strategies to help you quit smoking permanently

If you participate in the Tobacco Cessation Program, you can receive nicotine replacement patches, bupropion or Chantix at no cost if enrolled and approved by the program.

Weight Management Program

Look better, feel better and reduce your risk of illness with coaching and support from your HealthyGuidance® Weight Management Program. Work one-on-one with a certified health coach by phone to create a weight management program just for you.

- Address health issues
- Learn exercise and diet techniques
- Online learning modules support your new, healthier lifestyle

Lifestyle Coaching

Work with a wellness coach to create goals that reduce your risk for disease. The certified coaches are trained experts in nutrition, exercise and behavior change. Work on:

- Diabetes prevention
- Cardiovascular disease prevention
- Stress management

Health Risk Assessment (HRA) and Online Health Portal

Determine the state of your health and learn ways to improve it by completing a confidential HRA. Answer questions on a wide range of health and lifestyle topics, and you will receive a comprehensive personal health report that includes your risk factors for disease and the specific steps you can take to improve your health. Helpful meal planning, exerciser trackers and six-week self-study learning modules are available online to help support your goals.

HealthyGuidance® Kids

Are you worried about your overweight child? Work one-on-one with a health coach to understand the causes and risks of having an overweight child. The experts will help you to:

- Create family goals for a healthier lifestyle
- Deal with the social and emotional aspects of being overweight

Start Today!

To enroll in the Tobacco Cessation Program contact Member Services at 877.815.1017.

To participate in any of the other programs contact:

GuidanceResources® at 877.247.4621 or TDD: 800.697.0353.

You can also contact GuidanceResources® for assistance with these topics:

- Confidential Counseling
- Financial Information and Resources
- Legal Support and Resources
- Work-Life Solutions
- GuidanceResources® Online

Keeping in the Loop

It is important to have your mailing address up-to-date to receive important information from EBD about your health plan, including your insurance cards. Also, it is important that EBD has an up-to-date phone number in the system for you. If you need to update your contact information, please contact your agency or school district health insurance representative.

What Do I Need to Know About My Flexible Spending Account (FSA)

—This article affects Arkansas State Employees with a State of Arkansas Cafeteria Plan (ARCAP) Flexible Spending Account through FBMC/Wage Works. Please note that a full FSA is only available on the Premium Plan. Only a Limited FSA is available on the Classic and Basic plans. A Limited FSA is for dental and vision only.

Flexible Spending Accounts (FSA) are a good tool to help pay for needed medical expenses that are not covered by your traditional health insurance policy – especially since all plans now have a deductible. The fact that your FSA contributions are pre-tax can also help your paycheck by increasing your amount of take home pay.

After you enroll in the FSA and have decided on your contribution amount, you are provided a debit card that is loaded with the amount of contributions that you are expected to contribute during the plan year. Many different businesses and medical providers accept these debit cards for payment of services. However, there are rules and regulations that accompany the use of the funds in your FSA. Not understanding these rules and regulations can cause you problems when the plan year ends. You do not want to find yourself in a situation where you have to pay back any of these funds.

MYTHS ABOUT FSA DEBIT CARDS

Myth #1: "If the debit card is used for an eligible service or expense, I never have to provide receipts or documentation to support the expense."

Myth #2: "Any claim at a doctor, dentist, pharmacy, or vision provider will not require receipts."

Both of the statements are just that – MYTHS! Since not all services from these vendors are eligible FSA medical expenses, receipts are sometimes required to verify eligibility. As an example: A dentist may perform teeth whitening, which is not an eligible expense under FSA rules.

If there is a question on whether or not the expense is an eligible expenditure under FSA rules, Fringe Benefits Management Company (FBMC), a Division of WageWorks, may contact you and ask for substantiation of your claim. FBMC sends monthly notices to those who do not participate in the paperless option. If you see a claim transaction in red that means the claim/ expenditure needs substantiation. There will also be a notice in that document that tells you to submit documentation for that claim/ expenditure. If you selected the paperless option you may log on to your FBMC account at any time to review the transactions and determine if there are any claims that need substantiation.

HOW DO I SUBSTANTIATE MY CLAIMS?

The first thing is: KEEP YOUR RECEIPTS! Most purchases of eligible expenses made with your debit card will be auto-substantiated at the point of sale at certified vendors. If the claim cannot be auto-substantiated, the IRS requires that the employee submit documentation to support the claim.

There are two ways purchases may be substantiated in compliance with IRS requirements:

AUTO-SUBSTANTIATION: Substantiation may be made automatically through electronic evidence. An example of this could be the co-pay established by your health plan. The established co-pay for a primary care doctor visit is $25 with our current Premium plan. This could be auto-substantiated because it matches the co-pay established by our health plan. Charges that exactly match the dollar amount, or up to 5 times the dollar amount may be auto-substantiated. For example multiples of $25 ($50, $75, $100, and $125) may also be auto-substantiated. Auto-substantiation works as a real-time substantiation process. Charges are verified as eligible expenses by the merchant or service provider. For example, a store may automatically approve qualified purchases using an Inventory Information Approval System (IIAS). IRS rules state that health account debit cards may not be used at retail outlets like pharmacies, department stores, etc., unless the merchant retailer has an IIAS system. This technology must be able to separate eligible purchases from ineligible purchases. For example, you want to use your FSA debit card to pay for a refill on your prescription but you also want to buy a candy bar. If you try to use the debit card to pay for both, the IIAS system will not accept the candy bar payment because it is an ineligible expense. The debit card cannot be used for the candy bar, but it will allow the purchase of the prescription. The merchant will ask you to pay with another payment method for ineligible charges that are identified.

MANUAL SUBSTANTIATION: All purchases that do not qualify for auto-substantiation must be manually substantiated with receipts or other documentation submitted to FBMC. Download a claim form from the FBMC website at www.FBMC.com. Documentation must contain the date of service, type of service, the service provider and the amount of the service. For example, a receipt that only shows the debit card transaction would not be acceptable documentation because it does not show the date of service (it may show the payment date, but that is not the service date) or the type of service. Attach your receipts or other documentation and either mail them or fax them to FBMC. Mail claim forms and documentation to FBMC, PO Box 1820, Tallahassee, FL 32302 or fax them to 1-888-800-5217.

WHAT HAPPENS IF I DON'T SUBSTANTIATE MY CLAIMS?

There is a period of time called the "run-out" period which is 90 days after the end of the plan year. For Plan Year 2014, that means you have until March 31, 2015 to substantiate any claims for 2014.

In March FBMC will send a letter to all members with unsubstantiated claims for 2014 and will accept receipts and documentation until March 31, 2015. If you fail to substantiate your claims by the deadline, FBMC will send a list to EBD of unsubstantiated claims and EBD will deduct the amount of these claims from your paycheck in April, if you receive your pay through AASIS. If this amount is not collected through AASIS payroll, then EBD will initiate a collections process to recoup the money from the member. If EBD is unsuccessful in recouping the money from the member, then the member's debt is placed in the State's Tax Setoff Program and the amount can be withheld from your state income tax refund.

Bottom line: If you have unsubstantiated claims make sure to take the necessary steps to substantiate your claims. This is especially important if you have unsubstantiated claims for 2014. You still have a limited time to get your claims substantiated. Don't find yourself in the situation of having money deducted from your paycheck all year for your FSA, but then having to pay additional money back into the FSA because you didn't substantiate all your claims. The IRS rules governing the substantiation requirements can be found in Revenue Ruling 2003-43 and Notice 2006-69.