

APS 2017 Benefit Plan Changes Frequently Asked Questions (FAQs)

Health Insurance Decisions

Q. Why do I need health insurance?

A. As medical care advances to keep people healthy, treatments and healthcare costs also increase. The purpose of health insurance is to help you pay for care. It financially protects you and your family in the event of an unexpected and expensive serious illness or injury. Health insurance is needed because you cannot predict what your medical bills will be. In some years, your costs may be low. In other years, you may have very high medical expenses. If you have health insurance, you know that you are protected from most of these fluctuating costs.

In addition, you are more likely to get routine and preventive care if you have health insurance. You should not wait until you or a family member becomes seriously ill to try enroll in a health insurance plan which only happens once a year.

Q. If my medical insurance is not going up, why should I inform myself about the benefit plan design changes?

A. It is important to be an informed decision maker regarding your health, access to healthcare and the cost of health care. You should carefully compare costs and coverage depending on your needs.

Be sure to compare:

1. Premiums.
2. Coverage/benefits.
3. Access to doctors, hospitals, and other providers.
4. Access to after hours and emergency care.
5. Out-of-Pocket costs (deductibles, coinsurance, copays, and Annual Out-of-Pocket Maximums).
6. Exclusions and limitations.

Q. Why did APS decide to offer another health plan option and a 3-Tier Option Plan for Blue Cross Blue Shield of NM and Presbyterian Health Plan?

A. In order to continue to provide affordable and easily accessible healthcare, as well as manage the 13.2% increase in healthcare costs, APS is offering more choices. A valued based narrow network health plan with New Mexico Health Connections, and the opportunity for choice within a 3-Tier Option with Blue Cross Blue Shield of NM and Presbyterian Health Plan.

Q. What are the plan design changes for Plan Year 2017?

A. A summary of plan design changes for medical, prescription drug and vision plan coverage is illustrated below:

Medical Plan	Prescription Drug Plan	Vision Plan
Moving from two medical plan carriers, Blue Cross Blue Shield of New Mexico and Presbyterian Health Plan to three carrier options	Minimum and maximum copayments will increase for both mail order and retail purchases	Eye exam copay will increase from \$10 to \$15
Introducing New Mexico Health Connections EPO (Exclusive Provider Organization) plan	- Implementing 3-tier Specialty Drug copay structure - Removing Specialty copay out-of-pocket maximum	Lenses copay will increase from \$15 to \$20
Presbyterian Health Plan and Blue Cross Blue Shield of NM will continue to be offered, however the plan designs will change	Adding Smart90 Walgreens option	No increase in premium

Q. How do I determine which type of health insurance and health plan to choose?

A. You should carefully compare costs and coverage.

Be sure to compare:

1. Premiums.
2. Coverage/benefits.
3. Access to doctors, hospitals, and other providers.
4. Access to after hours and emergency care.
5. Out-of-pocket costs (coinsurance, copays, and deductibles).
6. Exclusions and limitations.

Q. What will my cost be for each health plan?

A. [Please see below cost comparisons](#)

New Mexico Health Connections – Preferred Network – New Health Plan Option

Deductible – Individual	\$250
Deductible - 2-Party	\$500
Deductible – Family	\$750
Coinsurance	20%
Doctor Visit	\$15
Specialist Visit	\$40
Urgent Care	\$50
Emergency Room	\$150 copay then ded/coinsurance
Annual Out-of-Pocket Maximum - Individual	\$2,250
Annual Out-of-Pocket Maximum 2- Party	\$4,500
Annual Out of Pocket Maximum - Family	\$6,750

BlueCross Blue Shield of New Mexico 3 Tiered Option Plan

	Tier 1: Blue Preferred Plus Network	Tier 2: Blue Nationwide PPO Network	Tier 3: Out of Network
Deductible – Individual	\$500	\$2,000	\$4,000
Deductible - 2-Party	\$1,000	\$4,000	\$8,000
Deductible – Family	\$1,500	\$6,000	\$12,000
Coinsurance	10%	40%	50%
Doctor Visit	\$15	\$30	Deductible/coinsurance
Specialist Visit	\$40	\$75	Deductible/coinsurance
Urgent Care	\$50	\$75	\$75
Emergency Room	\$150 copay then subject to Blue Preferred Network deductible/coinsurance	\$150 copay then subject to Blue Preferred Network deductible/coinsurance	\$150 copay then subject to Blue Preferred deductible/coinsurance
Annual Out-of-Pocket Maximum - Individual	\$2,500	\$4,000	\$8,000
Annual Out-of-Pocket Maximum 2- Party	\$5,000	\$7,000	\$14,000
Annual Out of Pocket Maximum - Family	\$7,500	\$10,000	\$20,000

Presbyterian Health Plan 3 Tiered Option Plan

	Tier 1: Presbyterian Preferred Network	Tier 2: Presbyterian Nationwide PPO Network	Tier 3: Out of Network
Deductible – Individual	\$250	\$1,500	\$4,000
Deductible - 2-Party	\$500	\$3,000	\$8,000
Deductible – Family	\$750	\$4,500	\$12,000
Coinsurance	20%	30%	50%
Doctor Visit	\$15	\$25	Deductible/coinsurance
Specialist Visit	\$40	\$40	Deductible/coinsurance
Urgent Care	\$50	\$75	\$75
Emergency Room	\$150 copay then subject to Presbyterian Preferred Network deductible/coinsurance	\$150 copay then subject to Presbyterian Preferred Network deductible/coinsurance	\$150 copay then subject to Presbyterian Preferred deductible/coinsurance
Annual Out-of-Pocket Maximum - Individual	\$4,000	\$4,000	\$8,000
Annual Out-of-Pocket Maximum 2- Party	\$7,000	\$7,000	\$14,000
Annual Out of Pocket Maximum - Family	\$10,000	\$10,000	\$20,000

Q. Are my premiums increasing for my medical, dental and vision coverage in 2017?

A. There will be no increase in employee premium contributions for medical, dental and vision coverage in 2017.

Q. If I want to stay with my health plan, do I need to re-enroll?

A. If you have decided to stay with your health plan, there is no need to re-enroll.

Q. How do I enroll in a health insurance plan?

A. If you have a qualifying event contact the Employee Benefits Department, or you may come to the Bruce & Alice King Education Complex during Switch/Open Enrollment. Please also visit the benefits website at <http://www.aps.edu/human-resources/benefits>. For complete details. Click on the enrollment guidelines.

Q. When is the Switch/Open Enrollment Period?

A. The 2017 Open Enrollment begins on Friday, October 21, 2016 and ends on Friday, October 28, 2016. It will be held in the Arroyo Chico Room at the Bruce & Alice King Educational complex from 7:30 a.m. – 5:00 p.m. each day. Extended hours will be held during the Health Fair on Wednesday & Thursday, October 26th & 27th.

Q. What if I do not want to switch or make changes to my health plan?

A. If you do not want to make any changes, you do not need to do anything. You will automatically be enrolled in the same plan as you are currently enrolled in.

Q. How can I change plans, add dependents, opt out of medical?

A. To make any of the above changes to your current health plan, you will need to attend Switch/Open Enrollment.

Q. Where do I call with questions?

A. Please call the Benefits Department at 505.889.4859. Office hours are Monday through Friday from 8:00 a.m. to 4:30 p.m. For detailed information, you may also visit the benefits website at <http://www.aps.edu/human-resources/benefits>.

Glossary

Coinsurance – The amount you must pay for medical care after you have met your deductible. For example, APS may pay 80 percent of an approved amount, and your coinsurance will be 20 percent, but this may vary from plan to plan.

Copay – The flat fee you pay each time you receive medical care. For example, you may pay \$15 each time you visit the doctor. The APS medical plan pays the rest.

Deductible – The amount you must pay each year before your plan begins paying.

Exclusions – Services that are not covered by a plan. Sometimes called limitations. These exclusions and limitations must be clearly spelled out in plan literature.

Flexible spending arrangements – Employees use pre-tax dollars to set up these accounts and draw down on them to pay qualified medical expenses during the year. Unused amounts are forfeited at the end of the year.

Formulary – An insurance company's list of covered drugs.

3 Tiered Option Plan – It is a way of obtaining health care services and paying for care. The 3-Tiered Option Plan features 3 options within the Blue Cross Blue Shield of NM Health Plan, and the Presbyterian Health Plan. The 3-Tiered Option Plan is network of physicians, hospitals, and other providers who participate in the plan. In the 3-Tiered Option Plan, members have the option of choosing one of three options depending on the scale of services, access and cost to the member.

Network — A group of physicians, hospitals, and other providers who participate in a particular managed care plan.

- “Tier 1”– the option to choose providers and services that offer the lowest out of pocket cost to the member, but limited in provider choice
- “Tier 2”– the option to choose providers and services that offer a slightly higher out of pocket cost to the member, but not as limited in provider choice.
- “Tier 3”– the option to choose providers and services anywhere, but with the highest out of pocket expense to the member

Open enrollment – A set time of year when you can enroll in a health plan, change from one plan to another without benefit of a qualifying event (e.g., marriage, divorce, birth of a child/adoption, or death of a spouse). Open enrollment usually occurs in October.

Premium – The amount you pay to belong to a health plan, and are usually deducted from your pay.

Primary care physician – Usually a family practice doctor, internist, obstetrician-gynecologist, or pediatrician. He or she is your first point of contact with the health care system.

Qualifying Event – A qualifying event is a term that will allow an employee to enroll in the medical plan outside of the annual benefits switch/open enrollment opportunity. For complete details visit the benefits website at <http://www.aps.edu/human-resources/benefits>

Reasonable and customary charge – The prevailing cost of a medical service in a given geographic area.