Darien Public Schools

High Deductible Health Plan/Health Savings Account

General Presentation

$2,500/$5,000 Deductible

Please refer to your benefit summary for details regarding your insurance coverage.

What is a High Deductible Health Plan?

- A health insurance plan with a high deductible and lower premium
- The insured pays the initial medical/prescription expenses before satisfying the deductible
- Once the deductible is met, Anthem begins to cover the claims

What is the Deductible?

Your plan has a $2,500 deductible for Single coverage and a $5,000 deductible for Two Person and Family coverage

The deductible is an aggregate deductible; therefore, all in-network medical and pharmacy charges, for you and your dependent(s), are applied toward the deductible.

The Darien BOE will contribute 50% of the deductible into a Health Savings Account on your behalf each plan year, as per union contract.

What does that mean?

While you work toward reaching your $2,500 or $5,000 deductible, you pay the NEGOTIATED medical and pharmacy charges that are associated with the services/prescriptions you receive by in-network healthcare providers, facilities and/or pharmacies.

What are Negotiated Charges?

The $ amount that Anthem has negotiated to pay the provider for services rendered under the plan. This means the provider is an "In-Network" provider.

Example – Office Visit

Sick office visit with your primary care provider
Normal charge - $160
Anthem's Negotiated Charge - $120
$120 is applied toward your $2,500 or $5,000 deductible
You owe $120 to the provider

Example – Prescription

Cost of medication - $200 for 30 day supply
Anthem's **Negotiated** Charge - $150
$150 is applied toward your $2,500 or $5,000 deductible
You owe $150 to the pharmacy

How do you know how much money has been applied toward your deductible and when you have met your deductible?

After you receive medical services performed by your provider, the provider submits a claim to Anthem. Anthem will process the claim, per your plan, and you will be mailed an Explanation of Benefits, also referred to as an EOB.

The EOB shows the date of service, the provider's name, the provider's charge for the services, the Anthem negotiated rate, the $ amount applied toward your deductible, your deductible $ balance, and the $ you owe to the provider. This applies to doctor's visits, lab work, x-rays, therapy, etc.

You can also view your EOB on-line via the Anthem website or the Sidney App.

Once your deductible has been satisfied, you will see the balance of either $2,500 or $5,000 in the deductible column.

Anthem will pay your claims directly to the providers and you will not incur out-of-pocket costs for the remainder of the plan year, for in-network, covered services under the plan, with the exception of prescription expenses.

Example of Rx Copays
$5 Generic
$35 Formulary Brand-name
$40 Non-Formulary Brand-name
(Please refer to your Benefit Summary for your plan's Rx Copays)

A maximum limit is set for annual out-of-pocket medical expenses

Coverage	In-and-Out-of-Network Deductible	Out-of-Pocket Maximum
Individual	$2,500	$5,000
Two-Person & Family	$5,000	$10,000

How does the Out-of-pocket maximum work?

Note: Out-of-pocket maximum includes a combination of deductible, copayments and coinsurance for medical/pharmacy services. Out-of-pocket is combined for in and out-of-network.

In-network

- Once member's $5,000 family deductible is met, the plan will pay 100% of in-network covered charges, **excluding** pharmacy copays, illustration below.

Member Responsibility

Deductible:	**$5,000**
Pharmacy copays:	$5,000 Applies **ONLY** after deductible satisfied (Example -$5/$35/$40)
Total out-of-pocket:	$10,000

Out-of-network

- Once member's $5,000 deductible is met (combined in and out-of-network) the plan will pay 70% of the maximum reimbursable dollars for out-of-network covered charges. In-network pharmacy copays are included in the $10,000 maximum, illustration below.

Member Responsibility

Deductible:	$5,000
Out-of-network covered charges paid at 30% and pharmacy copays:	$5,000
Total Out-of-pocket:	$10,000*

*Does not include balance billed charges or health care charges not covered under the health plan.

Preventive Care Services Covered at 100%

Under the Affordable Care Act, the insured and their families are eligible for preventive services to help avoid illness and improve general health.

These services are covered at 100%, no cost to the members, and do not apply to the HDHP's deductible.

Depending upon your age, you may have access to preventive services such as:

- Annual physicals, including women's visits
- Blood pressure, diabetes and cholesterol tests
- Many cancer screenings, including mammograms and colonoscopies
- Routine vaccinations against diseases such as measles, polio or meningitis
- Flu and pneumonia shots
- Counseling, screening, and vaccines to ensure healthy pregnancies
- Regular well-baby and well-child visits

Diagnostic testing is not considered preventive

For example, at a routine physical:

- Doctor performs regular exam (well-exam) and orders blood work
- Preventive exam would be paid in full (100% covered)
- Blood work that does not meet the preventive services criteria under healthcare reform, is considered diagnostic and would apply toward the deductible

What is a Health Savings Account?

- Tax-advantage medical savings account available to high deductible health plan enrollees only
- The account can be employer and member funded
- The account is designed to pay for qualified medical expenses – Refer to IRS Publication 502 (found on IRS website)
- Provides future savings
- You use funds in your HSA to pay toward your deductible for qualified expenses
- Money in the account can be used either during the plan year or accumulated from year to year

HSA Eligibility – as per IRS

- Must be covered by a qualified High Deductible Health Plan (HDHP)

- **Account holder** cannot be covered by another type of health plan (i.e., HMO, PPO or POS)

- Dependents/spouse may be covered under other plans - Dependents must meet tax criteria as per IRS guidelines

- May not participate in both Section 125 FSA & HSA Members may have dependent care

- Members cannot be enrolled in any part of Medicare while contributing to an HSA account

- Members receiving VA benefits (medical or pharmacy) must wait three months after receiving benefits to contribute to HSA

How Much will the IRS allow me to Contribute to my HSA per Calendar Year?

The IRS determines the annual contribution limits for HSA. Regardless of plan year, the maximum is based on **calendar year**

January 1st through December 31st

	Annual Contribution Maximum	The Darien Public School provides 50% Deductible Contribution Example	Allowable Maximum For Employee
Individual	2024 @ $4,150 2025 @ $4,300	$1,250	$2,900 $3,050
Two-Person & Family	2024 @ $8,300 2025 @ $8,550	$2,500	$5,800 $6050

Individuals age 55 and older can make an additional "catch-up" contributions up to $1,000 more per year

The IRS allows the use of HSA funds for eligible expenses of:

- The HSA owner and his/her spouse
- All dependents you claim on your tax return
  - If divorced, children are still eligible even if you don't claim them on taxes.
- Any person you could have claimed as a dependent on your return except that:
  - The person filed a joint return
  - The person had gross income of $4,700 or more, or
  - You, or a spouse if filing jointly, could be claimed as a dependent on someone else's 2023 return

Source – Refer to IRS Publication 969 for further details

Note – You may want to consult your tax advisor for questions regarding dependent eligibility

What Happens When I Go to the Doctor?

At the Visit

Show Medical Plan ID Card; **No copayment fee**

After a Visit (2 - 3 Weeks) You Will Receive

Explanation of Benefits (EOB) from Anthem showing:

- Discounted rate applied
- Amount applied to deductible
- Amount you are responsible to pay directly to physician

Doctor's Office Bill

- Total amount owed (at discounted rate)

Prior to Meeting your Deductible

Submit payment to the doctor's office based upon information reflected on the EOB using:

- Bank HSA Debit Card provide account information on statement
- On-line Payment Tool via the member portal
- On-line check request via the member portal or call member services

What Happens When I Go to the Pharmacy?

At an in-network pharmacy, show medical plan ID card.

The Pharmacist will determine the discounted rate based on information provided by your insurance plan in **real time**

Prior to Meeting your Deductible

Pay the pharmacist the discounted rate using your Bank HSA Debit Card

After Meeting your Deductible

You will pay a pharmacy copayment:
Example - $5/$35/$40

Sample of Anthem ID Card