OOWA

BENEFITS

FREQUENTLY ASKED QUESTIONS

Q: Who is Eligible?

A: Member companies in good standing (per bylaws) may join the Health Program. The benefits are offered to you, your employees and their dependents.

Q: Why is the association offering this?

A: We are always seeking to improve our member benefits. We saw an opportunity to offer our membership a quality healthcare solution built EXCLUSIVELY for members.

Q: What are the benefits?

A: This health insurance program was built EXCLUSIVELY for members and offers you, your employees, and their dependents quality healthcare with affordable monthly premiums, discounted group rates, and long term rate stability.

Q: What is the process? How does this work?

A: This health insurance program was built EXCLUSIVELY for members and offers you, your employees, and their dependents quality healthcare with affordable monthly premiums, discounted group rates, and long term rate stability.

Q: What does it cost?

A: The cost is to be determined after the census gathering portion of the process. There is no way to determine exact rates until the stop loss carrier can see a sample of the groups. But, we have traditionally seen rates anywhere from 10% - 25% lower than the marketplace for comparable products. We also implement a tiered rating system for the plan that helps reach a majority of the groups.

Q: How long are the plans and rates offered by the Health Program valid? Can my coverage be canceled at any time?

A: Options and rates are good for one year from the initial offering date. One launched, the Health Program cannot cancel coverage during the plan year. Groups will receive advance notice of changes or terminations upon renewal, as state and federal laws require. When a group sets up a plan it is technically the plan sponsor of that plan for purposes of ERISA.

Q: What networks are available to plan members?

A: Currently, the plan offers Cigna PPO, PHCS, and Anthem. Please select any of the links to review doctor participation.

Q: What if there is an emergency and I go to a hospital outside of the network?

A: If you are experiencing a true medical emergency then you can go to any hospital's emergency room. If it is not a true emergency, some restrictions may apply.

Q: How does the Reference Base Pricing / PHCS network work?

A: The Reference Based Pricing (RBP) option is an "open network" program allowing members to see any provider they wish. The RBP program provides medical providers with reimbursement ranging between 110%-150% of Medicare reimbursement.

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Q: Is there an open enrollment period?

A: Generally, an initial open enrollment is held for staff who wish to participate at inception of the plan. Those who are newly hired or experience a Qualifying Life Event (QLE) can join throughout the plan year.

Q: Is there a minimum number of employees that need to be enrolled?

A: There is no minimum. The plan can enroll groups of one.

Q: How does the Pharmacy discount card work?*

A: On the $7350 deductible plan there is an integrated Rx/Pharmacy card. This allows members access to discounted pharmaceutical pricing that will seamlessly accumulate toward a member's annual deductible. Discount cards are integrated with the pharmacy benefit manager so members are not required to keep track of separate benefit cards. Show your ID card at the pharmacy counter, and let the Health Program do the rest. This is exclusive to the $7350 Plan as drug copays are generally cheaper on lower deductible plans.

Q: Are these plans subject to the Employee Retirement Income Security Act (ERISA)?

A: Yes, these plans are subject to ERISA.

Q: Can members utilize their local broker to obtain this coverage?

A: That is not an available option at this time.

CONTACT BONA VITA BENEFITS GROUP AND START SAVING!

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