

Frequently Asked Questions for Employers and Agents



Q: What is HealthPlus HealthySolutions?

A: HealthPlus HealthySolutions is a product that helps employers encourage their employees to adopt and maintain healthy lifestyles with the goal of controlling medical costs, reducing absenteeism and increasing productivity. Members who enroll in the HealthPlus HealthySolutions product are rewarded for pursuing healthy behaviors. Members who maintain certain healthy behaviors and agree to follow their physician's treatment plan related to these healthy behaviors qualify for the Preferred benefit level and pay lower out-of-pocket costs.

Q: When will HealthPlus offer an updated version of HealthPlus HealthySolutions?

A: HealthPlus will offer an updated version beginning April 1, 2012. This version will include a third step for members who require a treatment plan in order to remain in the Preferred benefit level. HealthPlus HealthySolutions was originally launched October 1, 2008.

Q: Is HealthPlus HealthySolutions available for retirees and employees on Medicare?

A: No. HealthPlus HealthySolutions is only available to actively working employees and may not be offered to employees or retirees enrolled in Medicare.

Q: Do my premiums vary based on how many members are enrolled in the Preferred and Base benefit levels?

A: No. Employers pay the same premium regardless of how many members are in the Preferred or Base benefit levels.

Q: How do employees qualify for the Preferred benefit level in the updated version of HealthySolutions?

A: To qualify for the Preferred benefit level for the entire benefit year, members must complete the following steps:

If they are an *existing* HealthySolutions member, they will begin the benefit year in their current benefit level. In the first three calendar months of coverage the employee (and their covered spouse) must complete Steps 1 and 2 in order to qualify for the Preferred benefit level.

- 1) Visit their primary medical provider (provider), have their provider complete the HealthPlus HealthySolutions treatment plan form, return the form to HealthPlus and commit to a healthy lifestyle
- 2) Complete the HealthQuest Profile (health risk appraisal)

If they are *new* to HealthPlus HealthySolutions, they will receive the Preferred benefit level for the first three calendar months of coverage. To maintain the Preferred benefit level throughout the remainder of the contract year, the employee (and their covered spouse) must complete Steps 1 and 2 within the first three calendar months of coverage.

- 1) Visit their primary medical provider (provider), have their provider complete the HealthPlus HealthySolutions treatment plan form, return the form to HealthPlus and commit to a healthy lifestyle
- 2) Complete the HealthQuest Profile (health risk appraisal)

After the completion of the first two steps, any employee or covered spouse who committed to a treatment plan with their provider must complete Step 3 in either the 7th or 8th month of their benefit year.

Q: What is the third step?

A: If the employee or their covered spouse requires a treatment plan for any of the three health indicators listed on the treatment plan form, then they will be required to complete Step 3, a follow up visit with their primary medical provider to track progress on their treatment plan.

- Q: If the employee or covered spouse commit to a treatment plan with their primary medical provider, how will HealthPlus know that they are following the plan?**
- A: The employee or covered spouse will be required to meet with their provider a second time during either the 7th or 8th calendar month of their benefit year in order to monitor progress on their treatment plan. They must have a follow up treatment form completed and submitted to HealthPlus by the end of the 8th calendar month. This follow up form will be sent to them prior to the 7th month.
- Q: Is this the original treatment plan form that was completed in Step 1 or is it a new one?**
- A: This is a copy of the original treatment form completed in Step 1. HealthPlus will send a copy of the original treatment form to members during the 6th month of the benefit year. They will be reminded that the last two sections need to be completed by their primary medical provider and returned to HealthPlus by the end of the 8th month of the benefit year.
- Q: What if the employee or covered spouse does not meet with their provider for Step 3?**
- A: If the employee or covered spouse has a treatment plan and doesn't meet with their provider for a follow up visit, or if their provider determines that they are *not* following the treatment plan, all of the members on that contract will be moved to the Base benefit level on the first day of the 9th calendar month.
- Q: Why is the employee's covered spouse required to participate?**
- A: Studies have shown that couples working together are more likely to achieve their healthy lifestyle goals.
- Q: Do children and adult dependents complete the HealthQuest Profile and treatment plan form?**
- A: No. Children and adult dependents are automatically covered under the subscriber's plan. Only the subscriber and his/her covered spouse must complete these forms.
- Q: Does the member pay an office visit copayment for the visit with the provider to complete the treatment plan form?**
- A: There is no member copay for the completion of the treatment plan form itself. If other services, such as an office visit procedure are billed, then copays may apply. **If a member has their treatment plan form filled out prior to the effective date of their HealthPlus HealthySolutions coverage, they will be responsible for any copays that apply under their current plan.**
- Q: What healthy lifestyle commitments do employees need to make to be eligible for Preferred benefits?**
- A: The employee (and his/her covered spouse) must meet all three of the following:

SELECTION A		SELECTION B
Not use tobacco.	OR	Commit to a tobacco cessation treatment plan developed by his or her physician.
AND		
Have a healthy weight (a BMI at or below 30, unless pregnant).	OR	Commit to a weight reduction treatment plan developed by his or her physician.
AND		
Have blood pressure below 140/90 (or below 130/80 if diabetic).	OR	Commit to a blood pressure treatment plan developed by his or her physician.

The physician and member document these commitments on the HealthPlus HealthySolutions treatment plan form.

Q: What is Body Mass Index (BMI)?

A: Body Mass Index (BMI) is a number calculated from a person's weight and height. BMI provides a reliable indicator of body fatness for most people and is used to screen for weight status categories that may lead to health problems.

BMI	Weight Status
Below 18.5	Underweight
18.5-24.9	Normal
25.0-29.9	Overweight
30 and above	Obese

Q: Why are tobacco use, BMI and blood pressure chosen as the primary health measures?

A: These health measures are strongly linked to chronic illnesses (such as heart disease, diabetes and cancer) that account for a large proportion of health care costs, yet can be controlled through personal lifestyle changes such as a healthy diet and regular physical activity.

Q: If an employee or covered spouse uses tobacco, has a high Body Mass Index (BMI) or has high blood pressure, will the family automatically pay higher out-of-pocket costs?

A: No. If the employee and covered spouse commit to and continue to follow their provider-prescribed treatment plans, the family is eligible for the Preferred benefit level.

Q: How often can an employee move between the Preferred and the Base benefit level?

A: Employees can be moved between the Preferred and Base benefit levels after the first three calendar months of the benefit year. If they are in the Preferred benefit level and have a treatment plan for any of the health indicators, they must complete Step 3 or they will be moved to the Base benefit plan on the first day of the 9th calendar month. The employee will have the opportunity to re-qualify in the following year.

Q: When do coverage changes, if any, become effective?

A: Coverage changes occur on the first of the month following three calendar months from the effective date of coverage for Steps 1 and 2 and on the first of the month following eight calendar months from the effective date of coverage for Step 3, the follow up visit.

Q: What if the employee or the employee's covered spouse does not complete the HealthQuest Profile within three calendar months or does not want to work on improving his/her health behaviors?

A: Both the employee and covered spouse on a contract must qualify for the Preferred benefit level. If both employee and covered spouse qualify, everyone on the contract, including dependent children, receives the Preferred benefit level. If **either the employee or covered spouse** does not qualify for the Preferred benefit level because he or she does not make the required physician visit, does not commit to the required healthy behaviors and/or does not complete the HealthQuest Profile within the first three calendar months, everyone on the contract is moved to the Base benefit level.

Q: How does an employee complete the HealthQuest Profile?

A: The HealthQuest Profile (health risk appraisal) is available on the HealthPlus website at www.healthplus.org. The employee must create a user name and password to enter the secure portion of the site. If the member does not have access to the Internet, the member may call 1-800-332-9161 and obtain a paper copy.

For optimal results, employees should have the following information when filling out the questionnaire: Blood pressure

- Dates and results of recent blood tests, such as cholesterol and blood sugar
- Dates of recent health screenings, such as a mammogram or colonoscopy

- Q: What happens if an employee can't get an appointment with his/her doctor within three calendar months or the seventh or eighth months?**
- A: This should not be a problem. Filling out the treatment plan form does not require a physical and can be completed during a brief visit. We encourage members to call their doctor as soon as possible following enrollment to schedule an appointment. If members call early, there should be no problem securing an appointment. If a member has a problem scheduling an appointment, he/she should contact HealthPlus Customer Service at 1-800-332-9161. There will be no extension of the required deadlines. If the member (or covered spouse) fails to complete any of their required three steps they will be moved to the Base benefit level.
- Q: What happens after the physician fills out the treatment plan form?**
- A: The physician will submit the form to HealthPlus. It will take up to 10 business days to process the form. The employee will be able to view confirmation that HealthPlus received the form by logging in to www.healthplus.org, going to "Your Wellness Program" and selecting "Track Wellness Credits".
- Q: What if the employee can't go online to check and see if the treatment plan form has been received or if a message doesn't show up?**
- A: They can call the HealthPlus Customer Service Department at 1-800-332-9161 to verify that the treatment plan form has been received.
- Q: What programs are available through HealthPlus to help my employees achieve their health behavior goals?**
- A: HealthPlus offers many resources and services free-of-charge to assist members in achieving their goals. Visit the HealthPlus website at www.healthplus.org, to learn more about tobacco cessation, weight management, physical activity and disease management programs. Or call HealthPlus at 1-800-345-9956, ext. 1943.
- Q: What happens when a new employee joins the company in the middle of the contract year?**
- A: New employees are initially placed in the Preferred benefit level and have three calendar months to complete the requirements to maintain their Preferred benefit level for the remainder of the contract year. New employees whose qualification period would end in the fourth quarter of the contract year will not have to complete the requirements and will remain in the Preferred benefit level until the end of the contract year. All new employees will then have to qualify (as described above) at the next renewal date to maintain or regain their Preferred benefit level.
- Q: Will new employees added to HealthySolutions in the middle of the contract year be required to do Step 3, the follow up visit if they require a treatment plan?**
- A: New employees who are added to the plan after the 4th month of the contract year will not be required to do Step 3, the follow up visit in that year.
- Q: What is the reinstatement policy if an employee leaves the plan and subsequently comes back?**
- A: If a member leaves the plan and comes back in less than or equal to 180 days, he or she will be placed in the former benefit level. If a member leaves and comes back to the plan after the 180 day period, he or she will be treated as a new hire.
- Q: What happens when an employee adds a covered spouse to his/her contract mid-year?**
- A: Newly covered spouses are assigned the benefit level of the subscriber when added to the contract, but will be asked to qualify (as described above) at the next renewal date.
- Q: What happens when an employee adds a dependent to his/her contract mid-year?**
- A: The dependent is added at the benefit level of the subscriber's contract.
- Q: What happens when an employee elects to participate in COBRA?**
- A: If a member and/or covered spouse elect to participate in COBRA, they must complete all forms and requirements of the HealthPlus HealthySolutions plan. If the member and/or covered spouse have fulfilled the requirements prior to going on COBRA, they will remain at the benefit level that they qualified for originally. At the beginning of the next contract year, they must complete all forms and requirements to maintain the Preferred benefit level.

Q: What happens if the employee's covered spouse is eligible for Medicare?

A: HealthPlus HealthySolutions is not available to individuals who are enrolled in Medicare. If a covered spouse is enrolled in Medicare, the covered spouse need not comply with the spousal rules of HealthPlus HealthySolutions (i.e. completing Steps 1, 2 or 3).

Q: If a member is added retroactively, is the timeline to complete the treatment plan form within three calendar months affected?

A: The member must complete all forms and steps within their required timelines. **Retroactive contract additions after the effective date reduce the time available to the member to complete the necessary forms and requirements.**

Q: What happens if the employee's covered spouse has secondary HealthPlus coverage?

A: Both the subscriber and covered spouse must complete all forms and requirements, regardless of whether the spouse has primary or secondary coverage.

Q: How is the deductible handled if an employee moves from one benefit level to the other benefit level?

A: The costs an employee incurs against the deductible are recognized regardless of changes in the benefit level. For example, if an employee incurs \$400 in costs against the deductible during the first three (3) calendar months under the Base benefit level, the employee will continue to be credited with \$400 in costs toward the deductible when the employee moves to the Preferred benefit level at the end of the three calendar months.