CONTINENTAL
Benefits

Welcome to Continental Benefits!

Who is Continental Benefits?

- ✓ Continental Benefits is the Claims Administrator for your Medical Benefits Plan:
  - We process medical claims submitted by you or your provider(s) for the payment of covered expenses under your Medical Benefit Plan, and
  - Our Customer Service team will answer coverage and claim status inquiries from you or your provider(s).

- ✓ Our Continental Benefits Service Team also includes employees from "WellSystems," our affiliate company. This means you could receive email communications from both Continental Benefits and WellSystems, depending on the information being provided to you.

What do I need to do different on or after 1/1/16?

- ➢ Please present your new health benefit ID card to your health care provider(s) at your next visit, so your provider has the correct claims submission information on file.
- ➢ Your provider should contact Continental Benefits for any verification of coverage they may need.
- ➢ The Continental Benefits member services phone number displayed on the top of your ID card. Our service hours are 8:00 AM EDT to 8:00 PM EDT.

What if I didn't receive or lost my benefit ID card, and my dependent or I need to see my doctor or pick up a prescription before I can get a card?

- ➢ Provide your doctor or pharmacy with the information below so that they can verify your coverage:
  - ✓ Medical Plan Administered by Continental Benefits, www.continentalbenefits.com
    - Medical Group # CB170
    - For Eligibility & Claims Call: (866) 805-2542
    - For Pre-Certification Call: (800) 432-8421
    - Submit Claims to: Continental Benefits, PO Box 3610, Brandon, FL 33509-3610
    - Provider EDI Claims to: Envoy Payer ID #35245
    - For issue regarding balance billing by facilities call AMPS (800) 425-9373

    - For Prescription Drugs call: WellDyneRX, www.mywdrx.com
      - Members: (888) 479-2000
      - Providers: (888) 886-5822
      - RX BIN #: 008878
      - RX Group #: CB170L (La Feria ISD) or CB170R (Rio Hondo ISD)

We invite you to use Continental Benefits *24/7* Web Portal to:

- ✓ View your eligibility & benefit plan information
- ✓ Search for a provider
- ✓ View claim status & print explanations of benefits (EOBs)
- ✓ Download forms and member materials
- ✓ Print and order ID cards

24/7 WEB PORTAL ACCESS INSTRUCTIONS

1. Go to: http://www.continentalbenefits.com.
2. Click on the blue "Members Portal Login" button on the top right of the home page.
3. When the Continental Benefits Web Portal page appears, click on the words "Sign Up Now."
4. On the New User Registration page, select the radio button next to "Employee," enter your email address, and click on the "Continue" button.
5. Enter your Social Security Number (without dashes), First Name, Last Name, and Date of Birth, and click on the "Continue" button.
6. On the New User Registration – Matching Records page, click on the radio button next to your record, and click on the "Continue" button. (If your name does not appear, click on the "Search Again" button. If it still does not appear, call the customer service number on your card.)
7. Complete the information on the New User Registration – Security page. After entering your First and Last name, enter a Username and Password that you will remember, and select and answer a "Security Question" for future password assistance. Then click on the "Continue" button.
8. Verify your information on the New User Registration – Summary page, and add an Electronic Authorization Signature by typing your full name and the current date below the "Disclaimer." Then click on the "Continue" button.
9. Click the "Go To Login Page" button on the Confirmation page, and then enter the UserID (Username) and Password you created in Step 7 above to gain access to your information.

Click on the tabs:
Home, Accumulators, Benefits, Claims, Eligibility, and Resources to navigate through the web portal,
or click on any of the blue text links for shortcuts to your health information.

Frequently Asked Benefit Plan Questions and Answers

Q1. Who can I contact if I have questions about my claims/benefits?

- ✓ Call Continental Benefits 866-805-2542
- ✓ Call or Email Jessica at 956-428-7006 or sotxhc@gmail.com

Q2. What is a deductible?

- ✓ A deductible is specified dollar amount of covered expenses which must be incurred during a calendar year before any other covered expenses can be considered for payment according to the applicable benefit percentage.
- ✓ "Deductible" also means that dollar amount of the expense of a particular procedure or covered expense for which it is indicated in the schedule of benefits that a special deductible will apply.
- ✓ The plan administrator reserves the right to allocate and apportion the deductible and benefits to any covered persons and assignees.

Q3. What does co-insurance mean?

- ✓ Co-insurance means the portion of covered expenses that is shared by the plan and the covered person in a specific ratio (i.e. 70%/30%) after the calendar year deductible has been satisfied.
- ✓ The amount of co-insurance paid by or on behalf of the covered person is applied towards the covered person's or family's annual out-of-pocket maximum.

Q4. What is an annual out-of-pocket maximum?

- ✓ The annual out-of-pocket maximum is the maximum dollar amount a covered person will pay for covered medical expenses, in addition to the calendar year deductible, other deductibles, copayments, and any covered charges already paid at 100% in any one calendar year period, unless otherwise specified in the schedule of benefits.

Q5. How do I know if my doctor is contracted?

- ✓ STHC has contracted with many physicians in the area. Please review the provider listing to determine if your provider is contracted.
- ✓ You may also contact Continental Benefits or Jessica to confirm if your provider is contracted.

Q6. Am I responsible for the Contracted-Discount?

- ✓ No, you are not responsible for the Contracted-Discount amount.

Q7. Do my co-pays apply towards my deductible?

- ✓ No, your co-pays do not apply towards your deductible?

Q8. Is my deductible calendar year?

- ✓ Yes, your deductible is for expenses incurred between January 1st and December 31st.

Q9. How do I know if my prescriptions are applying towards my deductible?

- ✓ You will receive an explanation for benefits from Continental Benefits

Q10. Do I need to provide proof of full time student status for my dependents over the age of 19?

- ✓ No, your dependent will be covered up to the day before their 26th birthday

Q11. Can I add a dependent at any time during the year?

- ✓ No, you can only enroll a dependent during the year if there is a change of status, such as a new baby, marriage, or loss of your spouse's insurance coverage; if you elect to do so within 30 days of that status change event.

Q12. Can I change my plan election at any time during the year?

- ✓ No, you can only change your plan election during the annual open enrollment period.

Q13. When does my insurance become effective?

- ✓ Your insurance becomes effective the first of the following month of your date of hire.

Q14. Who can I add to my health coverage?

- ✓ You can add your legal spouse and/or your child(ren) to your health coverage.

Q15. Do my benefits change if I see a doctor that is not contracted?

- ✓ Yes, out of contract provider expenses get applied to your deductible and coinsurance,
- ✓ No copays apply, and
- ✓ You may be billed for any amount over the plan's allowable amount for non-contracted doctors.

Q16. Are Contracted and Non Contracted deductibles combined?

- ✓ Yes, Contracted and Non Contracted deductibles are combined.

Q17. What does my office visit copay cover?

- ✓ Your office visit copay includes office visit, examination, treatment, diagnostic tests, lab, x-ray, tests and supplies provided by and billed by Physician at the time of the office visit, except surgery, chemotherapy/radiation therapy, infusion therapy, physical therapy, occupational therapy and speech therapy.

Q18. What is an Explanation of Benefits (EOB)?

- ✓ An Explanation of Benefits (EOB) is a statement sent from the claims administrator to a member listing services that were billed by a healthcare provider, how those charges were processed, and the total amount of patient responsibility for the claim.

Q19. What is Protected Health Information (PHI)?

- ✓ PHI is individually identifiable health information that is created or received by a Covered Entity (the Plan) and relates to:
  - (a) a person's past, present or future physical or mental health or condition;
  - (b) provision of health care to that person; or
  - (c) past, present, or future payment for that person's health care.

  This term shall be constructed in accordance with the Privacy Regulation.

Q20. Who can call and inquire about my claims, benefits, or other information?

- ✓ Should you need a designated person to call and inquire about claims, benefits, or other information on your behalf, a written authorization must be submitted to our office.
- ✓ The written authorization must include the date, the name and relationship of designee, and your signature.

Q21. What is the "Health Insurance Portability and Accountability Act of 1996" (HIPAA)?

- ✓ The Health Insurance Portability and Accountability Act of 1996 (HIPAA) implemented the portability of health insurance set standards for Pre-existing Condition exclusion periods and change health status eligibility provisions for employee health plans.

Q22. What is a pre-existing condition?

- ✓ Any physical, mental illness, or injury for which the covered person received medical care, advice, diagnosis or treatment, or
- ✓ for which a physician was consulted or
- ✓ for which medical expenses were incurred or
- ✓ for which a covered person has taken prescribed drugs or medicines during the six months immediately prior to the covered person's enrollment date in the Plan.
- ✓ The pre-existing provision can be waived if a Certificate of Coverage is provided that shows you had prior coverage of at least 12 months with no more than a 63-day break in coverage.
- ✓ Pre-existing does not apply to dependents under the age of 19.

PLAN OPTION SUMMARY

Plan Option		Facility / Contracted / Non-Contracted	RX Retail* Generic / Brand	RX Mail* Generic / Brand
☐ LF BASE	PCP	n/a / $35 copay / 80% after ded.	$10 Copay / $100 RX Deductible; then $35 copay or 50% copay up to $200 whichever is greater	$20 copay / $100 RX Deductible; then $70 copay or 50% copay up to $400 whichever is greater
	Specialist	n/a / $65 copay / 80% after ded.		
	Urgent Care	n/a / $50 copay / 80% after ded.		
	ER	(Ded waived): $250 copay, 80%/80%/80%		
☐ LF Buy Up	PCP	n/a / $25 copay / 80% after ded.		
	Specialist	n/a / $50 copay / 80% after ded.		
	Urgent Care	n/a / $50 copay / 80% after ded.		
	ER	(ded. waived on all): $250 copay, 80% / 80% / 80%.		
☐ LF Alternate	While confined in a hospital benefits are $250/day. (1 day = 1 room & board charge.) 30 days max per hospital admission. Benefits are not coordinated, but paid in addition to other medical coverage.		No RX Coverage	No RX Coverage
☐ RH BASE	PCP, Specialist, & Urgent Care	n/a / 90% after ded. / 90% after ded.	90% after ded. / 90% after ded.	90% after ded. / 90% after ded.
	ER	90% after ded/90% after ded/90% after ded		
☐ RH Buy Up 1	PCP	n/a / $35 copay / 80% after ded.	$10 Copay / $100 RX Deductible; then $35 copay or 50% copay up to $200 whichever is greater	$20 copay / $100 RX Deductible; then $70 copay or 50% copay up to $400 whichever is greater
	Specialist	n/a / $65 copay / 80% after ded.		
	Urgent Care	n/a / $50 copay / 80% after ded.		
	ER	(ded. waived on all): $250 copay, 80% / 80% / 80%.		
☐ RH Buy Up 2	PCP	n/a / $25 copay / 80% after ded.		
	Specialist	n/a / $50 copay / 80% after ded.		
	Urgent Care	n/a / $50 copay / 80% after ded.		
	ER	(Ded waived): $250 copay, 80%/80%/80%		
☐ RH Alternate	While confined in a hospital benefits are $250/day. (1 day = 1 room & board charge.) 30 days max per hospital admission. Benefits are not coordinated, but paid in addition to other medical coverage.		No RX Coverage	No RX Coverage