PEBC Frequently Asked Questions
Medicare and Open Access Medicare Advantage

For retirees transitioning to a new Medicare plan:

Q. I am already enrolled in a Medicare plan. Will it continue?

A. You can only be enrolled in one Medicare plan at a time. While Medicare usually cancels your previous Medicare Insurance plan coverage automatically when you enroll in a new plan, we recommend that you contact your current carrier to cancel your coverage. Be sure to continue coverage until the new plan's effective date to avoid any gaps in coverage.

Q. I am already on a care plan. Will it continue?

A. As you move to your new Medicare Advantage plan, a team of Care Coordinators works to make sure you don't have any gaps in care or coverage. This is called Continuity of Care. It applies if you are being treated now or have treatments planned. The goal is to make sure the services you receive now or have scheduled will continue by Medicare contracted providers for Medicare covered services for 90 days from your enrollment date.

Care Coordinators help by working with you to document and communicate established and scheduled services. They determine if a transition of care plan is necessary after 90 days and keep an active Care Management Plan that was already set up by a Health Advocate.

Care Coordinators also work closely with the medical, mental health and pharmacy teams to support you as you receive needed care for sensitive health issues (e.g., cancer, heart disease, depression, etc.), even if your Medicare contracted providers are not in the network.

To ask about care coordination, or if you have questions about your benefits, call the customer service number on the back of your new member ID card.

Q. What do I need to know about switching insurance carriers?

A. Your previous carrier will likely share claims and care information with BCBSTX, so there will be no gap in understanding about your needs. You will receive new plan documents and member ID card. Be sure to share the card with your providers and pharmacy so they have the right information for filing your claims. If you choose the HMO plan, confirm that your PCP accepts the plan or select a new provider. If you choose the Open Access PPO, be sure to share the 'Your Provider, Your Personal Network' flyer with your providers. It explains how the plan works and how to submit claims. If you have a previous carrier's customer service number or website links on your phone or tablet, be sure to update them. Register for Blue Access for Members and get the BCBSTX mobile app for easy access to plan documents and your member ID card. You'll also be able to link directly to the provider finder tool as well as the online pharmacy and formulary tools.

Q. Does my plan cover any prescription drugs?

A. This group retiree Medicare Advantage Prescription Drug (MAPD) plan covers drugs or services that are normally covered by Medicare Part B and Part D.

Q. Can I continue to use manufacturer coupons and/or discount cards with this plan?
A. Federal law forbids people who have Medicare from using coupons or other discounts with their Part D plan. These may only be used outside of your Part D benefit.

Q. How do I know if a pharmacy is in-network or if my drug is covered?
A. Go to https://www.myprime.com/. You can check to see if your chosen pharmacy is in-network or if a drug you take is listed in the formulary.

Q. What type of formulary does PEBC offer to its retirees?
A. 5 Tier Premier Formulary

Q. When will I get my new Medicare Advantage member ID card?
A. You should receive it within 10-14 days after Medicare approves your enrollment. You will receive three separate mailings: an acknowledgment letter followed by a confirmation letter and then your new card.

Q. When will my group retiree Medicare Advantage plan start?
A. As PEBC transitions to the new coverage under BCBSTX, the effective date will be 1/1/2025. For people aging into Medicare throughout the year, coverage is effective on the first day of the month following the date your application was processed or your Medicare Part A and Part B effective date, whichever is later.

For people becoming eligible for Medicare:

Medicare Basics

Q. What is Medicare?
A. Medicare is the Federal government health care program designed for people ages 65 and over. Most U.S. citizens earn the right to enroll in Medicare by working and paying their taxes for a minimum of 10 years. The earliest someone who is turning age 65 can sign up for Original Medicare Parts A and B is three months before the month they will turn age 65. Under certain circumstances, people under 65 may be eligible for Medicare.

There are four parts of Medicare related to specific services:

Part A — Hospital coverage

Part B — Medical coverage

Part C — Medicare Advantage Plans (private insurers like BCBSTX that contract with the government to provide Medicare coverage through a variety of insurance products).

Part D — Prescription drug coverage

IMPORTANT: To participate in a group retiree Medicare plan, you will need to enroll in both Parts A and B. If you do not enroll in Medicare Parts A, B and D when you are first eligible, you may be subject to late enrollment penalties.

Q. Where can I find additional Medicare resources?

A. The following web sites may be helpful: **www.medicare.gov**; **www.ssa.gov**; **www.cms.gov**.

Q. How do I enroll in Medicare?

A. Medicare enrollment is done through the Social Security Administration. It takes time to process. If you plan to retire at 65, we recommend enrolling three months prior to your 65th birthday.

Most people should enroll in Medicare Part A (hospital coverage) during the Initial Enrollment Period (IEP). This is the period during which you can enroll in Medicare for the first time. It is a 7-month period that begins three months before the month you turn 65, includes the month you turn 65, and runs for three months after the month you turned 65. For example, if you were born in June, your window to enroll is March 1 through September 30. SSA will send you enrollment instructions at the beginning of your IEP.

If you're already receiving Social Security benefits, you will be automatically enrolled in Medicare Part A at the start of your Initial Enrollment Period. However, you will need to contact SSA to sign up for Part B. If you do not receive instructions from the SSA, please call **1-800-772-1213** (**TTY 1-800-325-0778**) or go to **www.ssa.gov** to enroll in Medicare.

Q. What happens if I do not have, or cannot enroll in, Medicare Parts A and/or B?

A. Medicare Advantage requires you have both Medicare Parts A and B before you can enroll in Part C. You will need both to enroll in either the Open Access PPO or HMO plan.

Medicare Advantage (Part C)

Q. What are the advantages of a group Medicare plan like the plan over an individual Medicare plan?

A. As a rule, group Medicare plans have better benefits than individual plans. And, because many employers or unions offer a defined contribution plan or subsidy (paying part of the cost you would pay wholly on your own with an individual plan), the cost is likely less as well.

Q. Do I need to enroll in both Original Medicare and this Medicare Advantage plan?

A. You have two separate enrollments: Original Medicare and this plan. Enrollment in Medicare Part A and Part B through the Federal government is required to be eligible for any Medicare plans, including this group retiree plan. To have full coverage, you must sign up for Medicare Parts A and B and continue to pay any required Part A or Part B premiums. You will need to do this first and get your 11-character Medicare Beneficiary Identifier before you can enroll in your group retiree plan. When enrolling in your Medicare Advantage plan, you will provide your MBI located on your red, white and blue Medicare card, along with your effective date.

Q. What is a Medicare Advantage Plan? How does it work with Original Medicare?

A. Medicare Advantage plans bundle your Part A, Part B, and usually Part D coverage into one plan. Medicare Advantage, also known as 'Medicare Part C', must cover all emergency and urgent care, and almost all medically necessary services Original Medicare covers. Your rights and protections are the same.

Medicare Advantage plans like this one may offer some extra benefits such as a fitness membership, 24-hour nurse advice line, or discount program. Plans also coordinate care and offer disease prevention and management resources. The plan takes care of all claims and coordinates Original Medicare benefits for you. You won't need your Medicare card to receive services [or prescription drugs], just your BCBSTX member ID card. Costs for monthly premiums and the services you receive vary depending on your group retiree plan. You must continue to pay your Part B premium.

For more information about Medicare Advantage plans, visit **Medicare.gov** or refer to your Medicare & You handbook mailed annually by the Federal government.

Q. What is an RFI or Request for Information?

A. An RFI, or Request for Information, is a CMS-directed request regarding a prospective member's enrollment. It means either their application is missing information or more context is needed regarding their individual situation. A prospective member has 21 days to respond to the RFI.

Q. I am already on a care plan. Will it continue?

A. As you move to your new Medicare Advantage plan, a team of Care Coordinators works to make sure you don't have any gaps in care or coverage. This is called Continuity of Care. It applies if you are being treated now or have treatments planned. The goal is to make sure the services you receive now or have scheduled will continue by Medicare contracted providers for Medicare covered services for 90 days from your enrollment date.

Care Coordinators help by working with you to document and communicate established and scheduled services. They determine if a transition of care plan is necessary after 90 days and keep an active Care Management Plan that was already set up by a Health Advocate.

Care Coordinators also work closely with the medical, mental health and pharmacy teams to support you as you receive needed care for sensitive health issues (e.g., cancer, heart disease, depression, etc.), even if your Medicare contracted providers are not in the network.

To ask about care coordination, or if you have questions about your benefits, call the customer service number on the back of your new member ID card.

Q. What happens if I have a pre-existing condition?

A. If you have a pre-existing condition, you cannot be refused coverage, your coverage cannot be canceled, and your claims for covered services cannot be denied.

Medicare Prescription Drug Plan (Part D)

Q. Does my plan cover any prescription drugs?

A. This group retiree Medicare Advantage Prescription Drug (MAPD) plan covers drugs or services that are normally covered by Medicare Part B and Part D.

Q. Can I continue to use manufacturer coupons and/or discount cards with this plan?

A. Federal law forbids people who have Medicare from using coupons or other discounts with their Part D plan. These may only be used outside of your Part D benefit.

Q. How do I know if a pharmacy is in-network or if my drug is covered?

A. Go to https://www.myprime.com/. You can check to see if your chosen pharmacy is in-network or if a drug you take is listed in the formulary.

Q. What type of formulary does PEBC offer to its retirees?

A. 5 Tier Premier Formulary

Dates and Timing

Q. When will my Medicare Parts A and B coverage be effective?

A. Coverage is effective on the first day of the month following the date the application was processed or the Medicare Parts A and B effective date, whichever is later.

Q. When will I get my new Medicare Advantage member ID card?

A. You should receive it within 10-14 days after Medicare approves your enrollment. You will receive three separate mailings: an acknowledgment letter followed by a confirmation letter and then your new card.

Q. When will my group retiree Medicare Advantage plan start?

A. As PEBC transitions to the new coverage under BCBSTX, the effective date will be 1/1/2025. For people aging into Medicare throughout the year, coverage is effective on the first day of the month following the date your application was processed or your Medicare Part A and Part B effective date, whichever is later.

Costs

Q. What are the costs of Medicare outside my group retiree plan?

A. **Part A** will not cost you anything if you or your spouse paid into Social Security for a minimum of 10 years. You pay a premium each month for **Part B**. Most people will pay the standard premium amount. Your Part B premium will be automatically deducted from your benefit payment if you get benefits from one of these:

- Social Security
- Railroad Retirement Board
- Office of Personnel Management

If you don't get these benefit payments, you will receive a Part B premium bill.

Part B and Part D monthly premiums change each year. And, if your income is above a certain limit, you'll pay a surcharge to the government in addition to your premium. This is called **IRMAA**: Income-Related Monthly Adjustment Amount. Any Part B and Part D IRMAA surcharge is based on the modified adjusted gross income reported on your IRS tax return from two years ago. A notice from Medicare will be mailed to those who will pay the IRMAA surcharge(s).

If you've had a life-changing event that reduced your household income, you can ask Social Security to lower the additional amount you'll pay.

Q. What happens if I do not pay my Part B premiums?

A. Non-payment of Part B premiums and/or IRMAA surcharges will result in termination of coverage.

Q. What is an LEP or Late Enrollment Penalty?

A. A Late Enrollment Penalty is a monetary penalty incurred if the prospective member does not enroll within three months of turning 65.

Spouse and Dependent Eligibility

Q. Can my spouse or partner be on a different plan?

A. Retirees and Medicare-eligible dependents will be enrolled in the same plan option.

Q. Are my dependents eligible?

A. Dependents are defined as a spouse, a child under the age of 26, or an eligible, incapacitated dependent over the age of 26 who is included under the retiree's medical coverage through PEBC. Check with your employer about your dependent needs. Different plan scenarios apply depending on Medicare eligibility:

- If the retiree and dependents are all eligible for Medicare, then all can be enrolled in the plan.
- If a spouse or dependent is not eligible for Medicare, then the retiree is enrolled in the Medicare plan. The dependents are enrolled in the PEBC PPO plan.
- If the retiree is not eligible for Medicare but dependents are, then all will remain on the PEBC PPO plan until all are eligible for Medicare.
- If neither the retiree nor dependents are eligible for Medicare, then all will remain on the PEBC PPO plan until all are eligible for Medicare.

Providers

Q. Will I be able to see my current providers?

A. Under the Medicare Advantage Open Access PPO plan, which is a 'non-differentiated' or 'passive' PPO, you can go to any providers who: 1) accept Medicare; 2) agree to see you as a patient; and 3) will send claims the plan. Providers do not need to be part of any Blue Cross and Blue Shield network.

Members' coverage levels are the same inside and outside their plan service area nationwide for covered benefits. Referrals aren't required for office visits. Prior authorization may be required for certain services from providers who are Medicare Advantage-contracted with BCBSTX.

Under the Medicare Advantage HMO plan, you can only continue to see your current providers if they are in our network. If you choose a PCP or use providers outside the network, you may pay full cost for your care. If your current PCP is not in the network but would like to join, they can call the customer service number on the back of your ID card.

Please note: Even providers who accept Medicare can decide which patients they want to see, except in an emergency. We recommend that you confirm that yours will accept and submit claims to this Open Access plan. Share the enclosed 'Your Providers, Your Personal Network' flyer with your providers. It explains your plan and how to submit claims.

Q. Will my provider be able to submit claims easily to the plan?

A. We make the claims process simple. We take care of any interactions with Medicare. Instead of submitting claims to Medicare, your providers will send them directly to the plan. If you choose the Open Access PPO plan, providers outside of Texas will file claims with their local BCBS plan. They are familiar with how to do this. If you choose the HMO plan, your providers will follow their normal process when filing claims with BCBSTX. The customer service number listed on the back of your member ID card is for you or your provider to call with any questions.

Q. How do I find out if my provider is in-network?

A. You can go to Provider Finder on our website at www.bcbstx.com/retiree-medicare-tools and select the plan in which you want to enroll. The Provider Finder will open in a new window. Follow the prompts (you can search as a guest, without signing in) or call customer service.

The pre-enrollment Education Helpline can be reached at **1-877-842-7564 TTY 711**.

Post-enrollment Customer Service can be reached at **1-877-299-1008 TTY 711**.

Prior Authorizations

Q. Which medical services need prior authorization?

A. Prior Authorization (PA) is when a contracted provider needs to get approval from the health plan to deliver a service. The goal is to make sure the treatment or service is covered by Medicare, the best for the member, medically necessary and safe. PA is needed for:

- Advanced Imaging (MRI, MRA, CT scans and PET scans),
- Lab Management Solutions – molecular and genomic lab testing,
- Musculoskeletal – pain/joint/spine services – excludes exams, physical therapy, and occupational therapy,
- Inpatient stay that is not the result of an emergency,
- Outpatient medical oncology, radiation therapy, sleep study, and specialty drugs,
- Select Durable Medical Equipment,
- And some procedures that are performed as part of an inpatient stay.

Twenty-three (23) hour observation and emergency room visits do not need PA. Your provider will work with the plan to get any PA you may need and may talk with you about other options, if necessary.

Q. What happens if a PA is not completed?
A. Your provider is responsible for getting a PA for you. If they fail to get a PA before providing a service, the plan may not pay the claim and the provider would have to absorb the cost of the service. You are not required to pay for the service if the provider fails to get a required PA. Providers can request a PA by calling the customer service number listed on your member ID card, or via fax. They may also use our provider service through Availity® Essentials.*

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Low-Income Subsidy for Part D

Q. Are there resources to help with the high cost of drugs?
A. Financial assistance to help with the costs of prescription drugs, like deductibles and copays, may be available through the government's Low Income Subsidy program, also called Extra Help. You can apply for it any time. Visit the Social Security web site at **www.ssa.gov** and click "Medicare," then "Apply for Part D Extra Help."

Q. What is a Low-Income Subsidy?
A. A low-income subsidy is a CMS-initiated program to help those with lower incomes pay their premiums. You are not automatically enrolled for a low-income subsidy.

International Travel

Q. Will I be covered if I travel internationally?
A. The Blue Cross and Blue Shield Global Core program gives members traveling outside of the United States and its territories access to urgent and emergency medical assistance services and doctors and hospitals in more than 200 countries around the world.

Communications

Q. Will I receive a periodic Medicare statement based on the plan I select?
A. You will receive your Explanation of Benefits (EOB) from Blue Cross and Blue Shield of Texas. How often you receive one depends on how often you see a provider or fill a prescription. The EOB is a statement, not a bill. It simply details what you have paid and indicates the level of benefits you've used.

Q. What is the Blue Cross and Blue Shield of Texas group retiree website?
A. Please visit **www.bcbstx.com/retiree-medicare-pebc.**

Q. What is the Blue Cross and Blue Shield of Texas Customer Service number?
A. The pre-enrollment Education Helpline can be reached at **1-877-842-7564 TTY 711**.

Post-enrollment Customer Service can be reached at **1-877-299-1008 TTY 711**.