

Retired Faculty Members – Medicare, Highmark and Prescription -- Frequently Asked Questions

- 1. What's the procedure for using the home delivery service?** You can mail in prescriptions or have your doctor fax prescriptions in to Medco using the following: **Via Mail:** Ask your doctor to write a new prescription for up to 90 days, plus refills (if appropriate) for up to one year. Then mail the new prescription(s) Home Delivery Pharmacy Service Order Form with the appropriate payment to Medco Health in the return envelope. If you are unsure of the amount due, call Highmark Member Service at 1-866-727-4935 with your prescription information and they will confirm the amount, or you can include your credit card information on the mail order envelope when you submit the prescription order. **Via fax:** Again, your doctor would need to write a new prescription for up to 90 days, plus refills (if appropriate) for up to one year. Give your doctor your member ID number. Your doctor will need to call 1-866-727-4935 for instructions on how to fax the prescriptions. The prescriptions should be delivered to your home within 10 to 14 days after you mail your order. For more information go to www.highmarkblueshield.com or www.medco.com.
- 2. My NPA – CFI card no longer works. Why? The State System awarded its Prescription Drug contract to Highmark/Medco. NPA's drug card became invalid as of July 1, 2004, along with the mail-in company CFI. 2. Will I get a new prescription card to replace the NPA card?** All faculty retirees should have received a new Highmark Blue Shield card in late June or early July. This card serves as both your medical card and your prescription card. The current Highmark medical card you should be carrying has Medco imprinted in the top right-hand corner. If you do not have the current card, please contact Highmark's customer service number (toll-free) 1-866-727-4935 or your local Human Resource Office on campus
- 3. Have my benefits been changed in anyway including prescription submission to major medical?** No. Use of the prescription discount card and mail order is still voluntary. However, if you use a participating pharmacy, presenting the discount prescription card could save you money upfront. Once you purchase your prescriptions either at the pharmacy or through the mail-in feature, you submit the receipts as you have in the past on the Member Submitted Claim Form and forward it to Highmark. The only change for the retirees was the prescription insurance company. All other benefits and filing procedures remained the same.
- 4. I am receiving a lot of materials concerning the new Medicare Part D plan – what do I need to do?** The PASSHE is retaining the retired group prescription plan. There will be no changes in your benefit structure or submissions of prescription drugs. The PASSHE is requesting that all retired members present their Highmark health/prescription insurance card each and every time a prescription is received. **Retired faculty who are enrolled with the PASSHE benefit health plan should not enroll with Medicare Part D.** Information concerning the new Medicare Part D plan has appeared in the APSCUF Newsletter and has been sent out by the PASSHE. Medicare Parts A and B are mandatory for faculty who retired on or after January 2, 1999. Those who retired prior to January 2, 1999, retain the choice to enroll with Medicare Part B but Medicare Part A is automatic in all cases.
- 5. I am getting married or remarried can I enroll my new spouse?** You must contact your Human Resources office to add your new spouse within 60 days of the marriage. It is very important to contact your Human Resources office as quickly as possible and complete and return the required enrollment application. Coverage will begin on the date of marriage; however, if eligible dependent is not added within the 60 days – enrolled will be not permitted until the next open enrollment and benefits will not take effect until July 1.
- 6. How do I handle doctor office visits or consultations under the Classic Blue plan?** Effective July 1, 2002, providers who participate with Blue Cross and Blue Shield will electronically bill the services for you. Therefore, there is no need to pay the provider on the day of your visit. Blue Shield will forward the charge to major medical. Major medical will review the information and determine whether or not you satisfied your annual deductible and out-of-pocket co-pay. If the deductible has not been satisfied, the provider will be notified and the provider will bill you for the full contract allowance. If the annual deductible has been satisfied, major medical will reimburse the doctor for 80% of the contracted allowance and you will be billed for the 20% co-insurance. If both the deductible and out-of-pocket maximum has been satisfied, the provider will be reimbursed the full amount of the contract allowance. If you use a non-participating provider, you or the patient may have to pay the provider directly for the incurred service. Obtain an itemized bill from the provider and submit the charge on Highmark Blue Shield's claim form. Highmark Blue Shield will reimburse you according to the above-referenced method. Please remember that if you seek professional

medical assistance outside of PA, Highmark Blue Shield's major medical program will reimburse at two times the in-state rate.

7. **What is the out-of-pocket maximum?**

In calculating the level of reimbursement under major medical, Highmark Blue Shield must verify that the patient satisfied the annual deductible. Faculty members who retired prior to January 2, 1999, carry an annual deductible of \$100. Those who retired prior to July 1, 2002 carry a \$250 annual deductible and those thereafter carry a \$500 annual deductible. Once the deductible has been satisfied, major medical begins to reimburse at 80% of the contracted allowance. You are responsible for the other 20% of the contract allowance or to use Highmark Blue Shield's terminology -- out-of-pocket co-insurance. Once the out-of-pocket co-insurance reaches its maximum, \$350 for those who carry a \$250 deductible or \$380 for those who carry a \$100 deductible and \$300 for those with the \$500 deductible, the reimbursement level increases from the 80% level to 100%.

8. **I am (or my spouse) is turning 65 years of age, what are we suppose to do?** If you and your spouse are currently receiving Social Security benefits, the Medicare Insurance card should be automatically sent to you with the effective date of coverage (which is the 1st day of the month in which you turn 65 or if your birthday is on the 1st of the month coverage will begin on the first day of the prior month). The Medicare card is generally sent approximately 3 months prior to the effective date of coverage. You should also receive a new Highmark card that state Medicare Compliment on the bottom within a month or so of your Medicare card. If you are not receiving Social Security benefits, you must contact the Social Security office to activate your Medicare coverage. Social Security (**not Medicare**) is now operating under a gradual increase in what is considered full retirement age, you may not qualify for that benefit until sometime after your 65th birthday. Those born before 1938 qualifies for benefits at 65, for each year thereafter add two months. Those born between 1943-54, the full retirement age is 66, for each year thereafter add two months until 1960. If born in 1960 and after, full retirement age is 67. If you are retired and covered under the PASSHE retiree health plan, you must sign up for Medicare benefits when turning 65.

9.

10. **I am a retired faculty member, I submitted a claim form as I have done in the past for my spouse. I received a "denial of benefits, coverage terminated" notice. Why?**

Highmark Blue Shield implemented a rather complicated system of submission for some retirees. Below, locate your health care coverage for the employee, spouse and dependents, and then follow the instructions on submitting claims.

Coverage	ID Card
(type of medical coverage)	(name of insured ID number, and plan name)
1 Indemnity – Single	Annuitant's name/ID – use for all
2 Indemnity – Two Party	Annuitant's name/ID – use for all
3 Indemnity – Family	Annuitant's name/ID – use for all
4 Medicare A & B – Single	Annuitant's name/ID – use for all
5 Medicare A/Basic – Single	Annuitant's name/ID – use for all
6 Medicare A & B – Two Party	Annuitant's name/ID – annuitant use for all Dependent's name/ID
7 Medicare A/Basic – Two Party	Annuitant's name/ID – annuitant use for all Dependent's name/ID
8 Indemnity – Annuitant	Annuitant's name/ID – annuitant uses for all and the dependent uses for MM only
Medicare A&B – Dependent	Dependent's name/ID – use to supplement A and B
9 Indemnity – Annuitant	Annuitant's name/ID – annuitant uses for all and the dependent uses for MM only
Medicare A only – Dependent	Dependent's name/ID-use to supplement A and B
10 Medicare A only – Annuitant	Annuitant's name/ID – use with A and Basic
Indemnity – Dependent	Annuitant's name/ID – dependent use for all and annuitant use for MM
11 Medicare A&B – Annuitant	Annuitant's name/ID – use to supplement A and B
Indemnity – Dependent	Annuitant's name/ID – dependent use for all, annuitant use for MM
12 Medicare A only – Annuitant	Annuitant's name/ID – use for all
Medicare A and B – Dependent	Dependent's name/ID – use for all
Family Coverage	
13 Medicare A and B – Annuitant	Annuitant's name/ID – use to supplement A and B
Medicare A and B – Dependent	Dependent's name/ID – use to supplement A and B
Indemnity – Dependent(s)	Annuitant's name/ID – dependent not under A and B use for all, annuitant and dependent under A and B, use for MM only

14	Medicare A only – Annuitant	Annuitant's name/ID – use to supplement A/Basic
	Medicare A only – Dependent	Dependent's name/ID – use to supplement A/Basic
	Indemnity – Dependent(s)	Annuitant's name/ID – dependent(s) not under A, use for all, annuitant and dependent under A, use for MM only
15	Medicare A and B – Annuitant	Annuitant's name/ID – use for all
	Medicare A and B – Dependent	Dependent's name/ID – use for all
16	Medicare A and B – Dependent	Annuitant's name – use for all
	Medicare A only – Annuitant	Dependent's name – use for all
	Medicare A and B – Dependent	Dependent's name– use for all
	Medicare A and B – Dependent	

Medicare Complement is imprinted on the card for those who have coverage under Medicare Parts A and B or Medicare Part A only. Indemnity is imprinted on the card(s) of those who do not have any component of Medicare.

For claims submission, where it is indicated that the dependent is to use the card for all, the dependent listed on the card is to use as the patient and the insured. Do not list the annuitant as the insured.