Question & Answer from the November 2023 Retiree Education Session for Texas A&M University System 65 Plus Medicare Advantage Plan (PPO) Enrollees

Q: Is 2nd MD still included?
2nd MD is a separate benefit from the medical plan, and the eligibility will not be changing.

Q: Will we get new Part D Express Scripts ID cards?
A: If you are a new retiree enrolling in the 65 Plus Medicare Advantage plan, you will receive a new Part D Express Scripts drug coverage ID card just as you would for medical.

Q. Medicare has some pre-authorization requirements. Nearly ALL of the covered items in the new booklet from BCBS and TAMUS have an asterisk that says pre-authorization required. How is this not limiting access to medical services? Actually, it says "Services with an * may require Prior Authorization or a REFERRAL from your doctor -- this looks and sounds like an HMO not a PPO.
A. This is a general disclaimer informing members that a Prior Authorization may be required in certain instances. Not all services in these categories require a PA. Most Prior Authorizations mirror those required in the Texas A&M Care plan for active employees. Preventative care from a Medicare contracted provider does not generally require Prior Authorization. Ambulance transport covers a wide variety of services, some of which require a Prior Authorization.

Q: Are you dictating the brand of hearing aids?
A: No. This plan includes a preferred vendor—TruHearing—but you may use other providers.

Q. Can the hearing aid benefit be combined with the hearing aid discount under the Blue365?
A. Yes, but you must utilize your covered insurance benefits first.

Q: Do oxygen supplies for an oxygen concentrator and Inogen need preauthorization?
A: Yes, however, during the first 180 days this requirement is waived. We will work with your provider during this time to get that Prior Authorization on file.

Q: I do not live in Texas, nor do I know if I have access to TruHearing.
A: TruHearing is a preferred vendor, but you may see any provider. Call TruHearing at 1-800-334-1807 to ask about their locations or visit www.truhearing.com/how-it-works/.

Q. Will kidney transplant anti-rejection medications still be covered by Medicare?
A. Yes

Q. Will we still have Delta Dental and Superior vision?
A. Yes, Delta remains your dental carrier and Superior is your vision carrier.

Q. When will ID cards be mailed?
A. It takes approximately four weeks from the time Blue Cross and Blue Shield of Texas receives your enrollment information from your benefits office until you receive your member ID card and Welcome Kit.

Q. Is preauthorization required for MRI, CT scan, etc. ordered in an ER setting, e.g., to rule out stroke?
A. No, Prior Authorizations are not required in an ER setting.

Q. After 1/1/24, if I am over 65 but still working, will these benefits be in place for me, or do I have to retire first? For example, instead of being able to get $2,000 per ear coverage for hearing aids, I can only get the current $1,000 per ear coverage because I am still working after 1/1/24?
A. This plan and its benefits are only available to retirees who are not active or are working less than 50% effort.

Q. How much are MD Live Virtual visits?
A. There is a $10 copay for MD Live urgent care visits and $0 copay for behavioral health visits.

Q. If I'm already enrolled in 65+ do I have to enroll in this new plan? Or is it automatic?
A. No action is needed to enroll, only to decline coverage.

Q. What if a pre-auth is denied?
A. For any service that is denied, you will receive a letter that outlines all of your options to appeal that decision. Involving your provider in the process is essential.

Q. I want to know if we need to have prior approvals for specialist visits?
A. Prior Authorizations are not necessary for most Medicare Contracted specialist office visits.

Q. Are there dental and vision benefits? Will it be covered in the presentation?
A. Dental and vision benefits are not covered by this plan. They are covered separately through other carriers.

Q. Will we have two open enrollment periods now? One in July for all other insurance, and one in September for our medical?
A. The Texas A&M University System Open Enrollment period will continue to be in July. There will be no change to that process.

Q. What will the plan dates be going forward for the out-of-pocket maximums? 9/1 -8/31 or a calendar year 1/1 - 12/31?
A. Starting 1/1/2024, the plan year will be 1/1 – 12/31.

Q: Will there be an issue if the retiree's legal name with the A&M System doesn't match the name on their Medicare card—specifically the first name?
A: The legal name in Workday should match the name on file with the Social Security Administration/CMS to avoid any issues.

Q. So basically, we are to do nothing to be enrolled in the new plan, right?
A. Correct. No action is needed to enroll in the 65 Plus Medicare Advantage Plan (PPO) if you are already enrolled in the 65 Plus plan.

Q: Can we use SilverSneakers online?
A: Yes, you have access to SilverSneakers online classes, too.

Q. Can you self-refer to a dermatologist for example?
A. Because this is a PPO Plan, you do not need a referral to see a specialist.

Q. My PT provider does not file Medicare or any other insurance. Can I submit the claim myself?
A. If the provider does not accept Medicare assignment and refuses to bill BCBSTX, the member may need to pay the full billed amount of the services directly to the provider at the time of service and submit the bill to BCBSTX for reimbursement. There is no reimbursement form to complete, however the member can submit a claim for reimbursement in writing to:

Blue Cross Medicare Advantage (Claims) PO Box 4195 Scranton, PA 18505

Please include the following documentation:
- Copy of receipt showing payment was made
- Member name and complete ID listed on the card including all letters and numbers
- An invoice showing services rendered OR another form of documentation that includes
    - o Diagnosis (or DX codes if available)
    - o Procedure (or CPT codes if available)
    - o Name and address of servicing provider

NOTE: There is a difference between not accepting Medicare and a provider "opting out of Medicare." Please speak to your provider to determine if they have opted out. If the provider has opted out (which is only approximately 2% of providers nationwide), the visit will not be paid for by Medicare or the plan, due to CMS guidelines. More information can be found here: www.medicare.gov/forms-help-resources/find-providers-whove-opted-out-of-medicare.

Q. I was 57 when I retired due to a disability. Could the age requirement for SilverSneakers be waived so I could use this benefit?
A. If you are enrolled in the Medicare Advantage plan, you are eligible for SilverSneakers.

Q. A doctor may accept traditional Medicare but will not accept Medicare Advantage. Do you have a network list of those practices who actually accept Medicare Advantage? Do we have to contact each office in advance of future visits?
A. We do not have a list of practices that accept Medicare Advantage. We recommend you tell your provider that you are part of a Group Medicare Advantage Open Access Plan sponsored by the Texas A&M University System. If you have issues with a specific provider, please call the customer service number and they can help. Also, be sure to give your provider's office the "Your Providers, Your Personal Network" insert from your Enrollment or Welcome Kits to help them better understand your Open Access PPO plan.

Q. I looked for a TruHearing office; there are apparently none in Texas. How does this work?
A. TruHearing is a preferred vendor, but you may see any provider. Call TruHearing at 1-800-334-1807 to ask about their locations or visit www.truhearing.com/how-it-works/.

Q. How is this Medicare Advantage Part C plan different than all the other zero premium Medicare Advantage plans that are available from Medicare?
A. This is a custom-designed Group Medicare Advantage Open Access plan sponsored by Texas A&M University System for their retirees with unique benefits, a national network of providers and dedicated customer service support.

Q. Will TAMU offer any other options for medical insurance that are not a Medicare Advantage Part C plan?
A. No. The 65 Plus Medicare Advantage Plan (PPO) is our new retiree health care plan.

Q. The Summary of Benefits states: "hospice is covered outside of our plan." How is hospice covered and paid for?
A. Hospice is covered by original Medicare for Medicare-certified facilities. You as the member pay nothing for hospice care from a Medicare-certified hospice.

Q. Does coinsurance mean what we will pay?
A. Yes, **coinsurance** is a percentage of the total cost, and a **copay** is a set dollar amount.

Q. Does the deductible max include the Medicare deductible?
A. There is a $0 deductible (i.e., no deductible) on this plan. The out-of-pocket maximum is $750.

Q. What is the out-of-pocket maximum if I get injured out of state?
A. The out-of-pocket maximum does not change if you are out of state.

Q. Does coinsurance count toward the $750 max out of pocket expense?
A. Yes, the 5% coinsurance counts toward your out-of-pocket expenses. More information is available in your Summary of Benefits.

Q. What is CMS?
A. CMS is the Center for Medicare and Medicaid Services with the Federal Government. This department oversee Medicare.

Q. Does this New 65+ Plan mean that Medicare will no longer be our primary insurance?
A. The 65 Plus Medicare Advantage Plan (PPO) is Medicare. It is a Medicare Part C Plan which means it includes Medicare Parts A & B (Original Medicare) and includes additional benefits, like hearing, not covered by Medicare. Medicare has contracted with Blue Cross and Blue Shield of Texas to provide the plan.

Q. If someone is on Original Medicare, does this change to an Advantage plan on the BCBS portion make any change to the Original Medicare plan, or does the Original Medicare change to Medicare Advantage too?
A. If you enroll in the 65 Plus Medicare Advantage Plan (PPO), it replaces Original Medicare.

Q: If my husband retires in Dec. 2024, and he wants to join this plan with me (he is not a TAMU employee), do I have to wait until open enrollment in summer to add him, or can I add him in January because it is a life change?
A: Please contact your benefits office. This would be a qualifying life event if he is losing coverage with his current employer. Note, you have 31-days from the day he loses coverage to provide the proper documentation of the life event and enroll him in benefits through your benefits office. All changes are effective the first of the month after you complete the process with your HR office.

Q. If I have a traumatic brain injury and need to go to Herman Memorial Hospital in Texas, is that covered under my in-network benefits?
A. Yes. It's important to note that the 65 Plus Medicare Advantage Plan (PPO) is an Open Access PPO, meaning you can see any provider that accepts Medicare and is willing to bill the plan.

Q. We presently see a specialist MD that requires pre-visit lab work (blood, etc.). The same applies to our primary care doctor periodically, such as before annual Medicare Wellness visit. Will those tests now require PA under new plan?
A. It would depend on the tests. For your yearly wellness and preventative testing, a PA is not required. If the testing is diagnostic in nature, some lab testing would require a PA.

Q. Are there any annual wellness requirements?
A. No, but members are encouraged to take full advantage of their plan benefits, including preventive and health maintenance services.

Q. What can you tell me about Global Core?
A. Global Core covers urgent and emergency services when you travel internationally. You need to pay the bill at the time of service and submit a claim with an English-language bill (if your bill is in another language other than English). More information is available at www.bcbsglobalcore.com.

Q. To whom does the care coordinator owe their "fiduciary-type" trust?
A. Care Coordinators are clinicians who can help you:

- Adjust to being at home after a hospital stay
- Set up care with your doctor and other health care team members
- Better understand your health condition(s), medications and treatments
- Navigate the health care system to improve your quality of life and save money

You do not have to use them to manage your care.

Q. How are out-of-the-pocket costs calculated, or, what counts toward the out-of-pocket maximum?
A. Generally, copays, co-insurance and deductible payments count toward your out-of-pocket maximum.

Q. Some hospitals and doctors are reluctant to take Medicare Advantage (as opposed to Original Medicare) plans, especially in rural areas because "Advantage" plans (which are run by private insurance companies) are slow or reluctant to pay. How do we deal with this?
A. Medicare Advantage Plans continue to gain in popularity and so any provider resistance or confusion is lessening. Let your providers know you have Group Medicare Advantage Plan, sponsored by Texas A&M University System. These employer-sponsored Group plans generally have a better reputation than individual Medicare Advantage plans.

Q. If one opts out of this new Advantage Plan, I assume that the Express Drug plan will also be unavailable?
A. Yes, if you opt-out of the 65 Plus Medicare Advantage Plan (PPO), you will also opt out of the prescription drug plan.

Q: We are to pay 5% of "total cost" for many benefits. How is the 5% calculated? Is it 5% of total charged by provider; or is it 5% of contracted rate or Medicare allowable rate if out of network?
A: It is 5% of the allowed amount and will be clearly shown on the explanation of benefits. This allowed amount is usually less than the billed amount.

Q. If after paying 5% co-insurance I reach the $750 out of pocket maximum, then are there further costs of any kind?
A. The only costs to the member after reaching the out-of-pocket maximum would be costs over the allowance indicated for supplemental benefits like a hearing aid.

Q. My big local Health Care provider just announced they won't be accepting Medicare Advantage HMO anymore. This 65+ plan is called an Advantage PPO plan so should still be accepted?
A. We always recommend that you ask your provider about your plan but yes, the 65 Plus Medicare Advantage Plan (PPO) is a PPO, not an HMO. It is also an Open Access plan which means you can see any provider who accepts Medicare and is willing to bill the plan.

Q: May a retiree who previously opted out re-enroll in this plan?
A: Yes, during Open Enrollment in July.

Q. Do I still use my family doctor for annual physical? Am I required to have a BCBS coordinator?
A. You may see any provider, including your family doctor, if (s)he accepts Medicare and is willing to bill the plan.

Q: Do I have to enroll to this new plan every year?
A: No. This plan involves a passive open enrollment. You will automatically keep the plan you have.

Q. Do you need to bring your Medicare card if you are admitted to the hospital?
A. You shouldn't need to keep your red, white and blue Medicare card from the government with you. (Keep it in a safe place). Use your Blue Cross and Blue Shield of Texas member ID card.

Q. Will a spouse also enrolled in my 65+ plan be automatically converted to the new advantage plan too?
A. Yes, no action is needed unless your spouse wants to decline coverage.

Q. What will happen to our accumulations and deductibles met until Dec 31, 2023?
A. All accumulations and deductibles begin with this plan on January 1, 2024, and then re-set each January.

Q. I use a CPAP machine. Come Jan. 1, will I need the pulmonologist to re-authorize my continuing to get CPAP supplies?
A. All of your currently approved services will continue under the Continuity of Care benefit for 6 months. After 6 months your doctor will need to submit a Prior Authorization for CPAP supplies.

Q. When I spoke to Blue Cross/Blue Shield, they said that the pre-approvals would be initiated by the physician or hospital, not by me, the patient.
A. That is correct. Obtaining Prior Authorizations is the responsibility of the provider.

Q. Do I need a Prior Auth to see a specialist such as an orthopedic physician?
A. No. Prior Authorizations are not necessary for specialist visits. They may be necessary for some procedures.

Q. Will the premiums for this be very similar to our current plan's cost?
A. Premiums will not change.

Q. Will a Colonoscopy still be covered at 100%?
A. A routine Colonoscopy would be covered at 100% as part of your routine wellness. If a Colonoscopy is needed for diagnostic testing, it would be subject to the 5% coinsurance.

Q. Now, providers always ask who our primary insurance is. Will we now answer BCBS instead of Medicare?
A. Yes, you can say you have a Blue Cross and Blue Shield of Texas Group MAPD Open Access Plan sponsored by The Texas A&M University System.

Q. Will the EOB show what is paid by Medicare and what is paid by BCBSTX?
A. No. Claims will no longer be paid and processed by Medicare. All claims will be submitted and paid by BCBSTX.

Q. Is there any kind of comp sheet that compares all items between the current Over 65 Plan and the Medicare Advantage plan so we can see the differences?
A. A plan comparison sheet was included in your enrollment kit. This chart is also available on the website at www.bcbstx.com/tamus-retiree-medicare.

Q. Having signed up for Delta Dental and Superior Vision for 9/1/2023 coverage, do those having such have to re-register on 1/1/2024 for these same benefits??
A. No, this change only applies to the medical plan. Your dental and vision benefits will remain as is.

Q. For a surviving spouse, what will be the cost to remain in this plan?
A. There is no change to the premiums for survivors.

Q. How are physical, speech and occupational therapies handled with the deductible?
A. The member share of 5% coinsurance for these services would count toward the overall $750 out-of-pocket maximum. There is no separate deductible.

Q. Will Medicare premiums still be deducted from our Social Security payments?
A. Part B premiums are deducted from Social Security payments.

Q. Is there a list of things that Medicare covers, but this BCBSTX Advantage Plans doesn't cover?
A**.** Medicare Advantage plans are required to cover everything that Medicare covers.

Q. If I decline this plan, what happens to the state contribution toward my premium?
A. By not accepting this new plan, you would also lose any state contribution toward your medical

premiums. You'd be responsible for any Medigap premium on your own. You may qualify to apply ½ of the employer contribution to other TAMUS benefits if you certify other medical coverage. Contact your HR office for additional information.

Q. When can we expect letters of acknowledgement and confirmation?
A. You will receive an acknowledgement letter approximately a week after Blue Cross and Blue Shield of Texas receives your enrollment information from your TAMUS Benefits Office. You confirmation letter should arrive approximately a week after CMS approves your enrollment.

Q. Is there a list of hospitals that will take this plan?
A. This plan is an Open Access PPO plan. If the provider accepts Medicare and will bill the plan, you can see any provider you wish, including hospitals. If you are looking for contracted providers, please visit our Provider Finder web site. To search hospitals specifically, click the "Medical Care" category and "Hospital and Other Facilities."

Q. This new Medicare Advantage plan for retirees will go through annual enrollment each July?
A. Correct - there is no change to the annual Open Enrollment period for TAMUS.

Q. I currently wear hearing aids; do I have to be on the MA plan for 36 months before the hearing aid benefits kick in.
A. There is no waiting period for the hearing aid benefit, but the benefit does apply every 36 months.

Have additional questions? Call **1-855-476-4149 (TTY 711)**

We are open October 1 – January 31: Daily, 8:00 a.m. to 8:00 p.m. CT February 1 – September 30: Monday through Friday, 8:00 a.m. to 8:00 p.m. CT. Alternate technologies (for example, voicemail) will be used on weekends and holidays.