Frequently Asked Questions (FAQ) for the Anthem Webinar for Aerospace Retirees/Survivors

2017 Anthem Medicare Preferred (PPO) Plan with Senior Rx Plus (Medicare Advantage PPO Plan)

Disclaimer: The Evidence of Coverage (EOC) for the Anthem Medicare Preferred (PPO) Plan overrides any answers in the FAQ. The EOC will be mailed to participants by Anthem. The EOC is also available on the Aerospace retiree website (retirees.aerospace.org).

1. **Q – Is the Anthem webinar presentation available for printing?**
   A – Yes, the presentation is available for download and printing from the Aerospace retiree website (retirees.aerospace.org).

2. **Q - Will Anthem be issuing new ID cards?**
   A – Yes, new ID cards will be issued to all members. The ID cards will be sent to the address that The Aerospace Corporation has on file for you. If you have moved, please ensure that you update your address with Aerospace Employee Benefits at 310.336.5107 or 800.458.3892.

3. **Q - When should we expect to receive our cards?**
   A - Everyone should receive their new ID cards in late December. If you have recently changed your address, please notify Aerospace Employee Benefits at 310.336.5107 or 800.458.3892 so that Anthem can update the mailing address on file for the member.

4. **Q - Will retirees receive a new Evidence of Coverage document for the new plan?**
   A – Yes. The Evidence of Coverage will be included in your Welcome Packet which you should be receiving soon.

5. **Q – Do you have a list of things that are not covered?**
   A – Your plan will cover all of the same services that original Medicare does. There will be a list of exclusions in the Evidence of Coverage that you will receive within your Welcome Packet from Anthem.

6. **Q - Is the enrollment process automatic for transition retirees?**
   A - Enrollment is automatic. If you do not want to join the plan, there is an Opt Out form in the Anthem Pre-enrollment booklet that was mailed to you earlier in October.

7. **Q – Does the Medicare Advantage PPO Plan mean we will no longer have unlimited copayment for the Medicare portion of the coverage, but no limit for Anthem Medicare Advantage PPO Plan?**
   A – Your new Medicare Advantage plan for 2017 has an annual out of pocket maximum of $2,500. All copays, coinsurance, and deductibles listed in the benefit chart are accrued toward the medical plan out-of-pocket maximum with the exception of routine hearing and foreign travel emergency and urgent care copay or coinsurance amounts. Medicare Part D prescription drug deductibles and copays do not apply to the medical plan out-of-pocket maximum.

8. **Q – What is the coinsurance amount on the plan?**
   A – The Medicare Advantage PPO plan has straight copays for most services. For example, if a member goes to see a specialist, they will pay a $20 copay. There are a few benefits in which the member will pay a co-insurance amount. An example would be Part B drugs. Members that receive Part B drugs will pay 20% co-insurance for those drugs.

9. **Q - How do I handle bills from providers that do not participate in Medicare? For non-Medicare providers will the plan reimburse me if I pay the doctor's bill directly?**
   A - The Medicare Advantage PPO plan cannot reimburse the member if the provider does not participate with Medicare. The doctor has to be a Medicare participating provider. You can contact First Impressions at 1.877.411.1647 to verify if your doctor is a Medicare participating provider and also for assistance to find other providers that do participate with Medicare.

10. **Q - Is there a significant difference in cost if we go to an out-of-network provider if that provider takes Medicare?**
    A – Your new Medicare Advantage PPO plan for 2017 is a "Passive" plan which means you have the same benefits for both In and Out-of-Network providers (as long as the out-of-network provider accepts Medicare patients).

11. **Q – Do retirees need to complete a Health Survey to remain in the program?**
    A – No, it is not a requirement to complete the Health Survey in order to remain on the plan. However, it is beneficial to complete the survey as it helps Anthem identify areas that we may be able assist with you with your health care needs.

12. **Q – Does the plan cover custom braces?**
    A – Custom orthotics (braces) are covered if considered medically necessary and meets all of original Medicare's guidelines for coverage. You must get a prior-authorization before you order/purchase an item to ensure all guidelines have been met. The plan will pay 90% of Medicare allowed amount and you will be responsible to pay 10% of Medicare allowed amount.

13. **Q – Are retirees required to use the 24/7 NurseLine for health?**
    A – Retirees are not required to use the 24/7 NurseLine. 24/7 NurseLine is program provided to you at no extra cost that allows you to speak directly to a registered nurse any time of the day or night and they will help answer your health-related questions in non-life threatening situations. There is no copay for using this service.

14. **Q – If you require a prescription that is not on the Medicare formulary, but has been traditionally required by your primary care physician, how do members obtain it? Can an exception be obtained?**
    A – An exception can be requested by your physician. They should contact Express Scripts to provide additional information as to why you are not able to substitute another drug that is already on the formulary.

15. **Q – Who determines the drug formulary – Medicare or Anthem?**
A – Medicare determines what classes of drugs are covered by Part D. Anthem determines which drugs from each class are part of the formulary.

16. **Q - Do I need to re-enroll with Express Scripts or will they continue with my ongoing prescriptions?**
A – You do not need to re-enroll with Express Scripts because your ID number will remain the same as your Part D ID number you had in 2016.

17. **Q - Will our existing Express Scripts prescriptions continue or do we need to obtain new scripts for our prescriptions from our doctors?**
A – You will not need to obtain new scripts. The existing Express Scripts prescriptions will be transferred to your new plan for 2017. Please keep in mind though that all prescriptions are typically written by your prescribing doctor for no more than one year at a time so a new one may be required. You might want to ensure you allow extra time during the refill process since your doctor will need to approve the refill.

18. **Q - With the My Health Advantage, if I receive a medication issue alert will that medication be unavailable until issue resolved by seeing PCP?**
A - If there is a critical alert for My Health Advantage, Anthem will call your provider directly to warn them of a potential medication issue.

19. **Q - Currently certain diabetic supplies are covered by Medicare, like strips for blood tests. How is this going to be handled now?**
A - Supplies to monitor your blood glucose such as test strips, lancets devices and lancets, and glucose control solutions are covered under the medical plan with a $30 copay for a 30 day supply at a retail pharmacy or a $60 copay through the mail order pharmacy. Original Medicare covers Diabetic Supplies at 80% and then your 2016 plan covered the remaining 20% at 80%. You still paid for part of these supplies under the 2016 plan.

20. **Q - Where do we go to get supplementary health insurance coverage, similar to what Aerospace retirees used to have?**
A – The 2017 Anthem Medicare Advantage PPO plan is replacing the current 2016 Anthem Blue Cross PPO with Part D plan offered by The Aerospace Corporation.

21. **Q – Does this plan include coverage for inpatient rehabilitation?**
A – Yes, inpatient rehabilitation is covered. It is covered under the Regular Inpatient Hospital Care benefit. There is no limit to the number of days covered by the plan. Treatment must be medically necessary and meet Medicare guidelines.

22. **Q – Does this plan cover skilled nursing facility services and is custodial care covered?**
A – Skilled Nursing Facilities are covered for Skilled Care medically necessary care. There is a $125 copay per admission with no prior hospital stay required. Custodial care is not covered.

23. **Q - How does the in-network doctor determine if services provided are Primary Care or Specialty Care?**
A – A Primary Care Physician (PCP) is a General Practice Doctor, or an Internal Medicine Doctor and any service provided by them will apply the PCP copay of $5. All other providers are considered specialists and will apply the specialist copay of $20.

24. **Q – Please explain how you calculate our maximum payments for copayments, our share of the services, etc.**
A - For medical services, this plan has an Out-of-Pocket Maximum of $2,500 per calendar year. All copays, coinsurance, and deductibles listed in the benefit chart are accrued toward the medical plan out-of-pocket maximum with the exception of the routine hearing services and the foreign travel emergency and urgently needed care copay or coinsurance amounts. Part D Prescription drug deductibles and copays do not apply to the medical plan out-of-pocket maximum.

25. **Q – What have been the chief complaints from other clients who have switched from regular Anthem Blue Cross Blue Shield to the Anthem Medicare Advantage PPO Plan?**
A – Most issues are related to members failing to provide their new ID card to their provider.

26. **Q – Under this plan who pays Anthem?**
A – Medicare contracts with private insurance companies to provide coverage under Medicare Advantage plans. Medicare pays a monthly amount to Anthem per member. Aerospace and the member each also pay a portion of the premium that is paid to Anthem.

27. **Q - Does a specialist providing on-going treatment for a 2016 issue have to communicate with Anthem again?**
A – While it may not be necessary, if you are unsure, you should contact First Impressions (1.877.411.1647) or Customer Service (1.877.411.1640) with your specific treatment information to see if a new prior authorization is needed. Preauthorization guidelines may differ from plan to plan.

28. **Q - Will LabCorp still be in network for lab work?**
A – Yes

29. **Q - What needs to be done about HIPAA forms and POA forms? Do they need to be resubmitted? How do we find out how to do that?**
A - You should not need to resubmit these forms because your ID number will be the same as your current Part D ID number. Any document that is on file for the Part D plan will transfer over to the new 2017 LPPO Medicare Advantage plan.

30. **Q – Do members need to select a PCP?**
A – You do not need to choose a PCP for the 2017 Anthem Medicare Advantage PPO plan.

31. **Q - I live in Colorado. Do I use www.anthem.com/ca or co?**
A – You should use www.anthem.com/ca

32. **Q - Are routine eye exams covered for everyone in the Anthem Medicare Advantage PPO plan?**
A - Yes - there is $0 copay limited to a $50 maximum per calendar year.

33. **Q – Does the Medicare Advantage PPO plan provide exercise gym programs similar to what Kaiser provides with gym helpers?**
A – Yes, the Medicare Advantage PPO offers the Silver Sneakers program. The Silver Sneakers program provides a free gym membership to gyms that participate in the Silver Sneakers program. The gym helpers would be dependent on the services provided by the gym.

34. **Q - Can I check for Silver Sneakers providers before January 2017 when the new plan takes effect?**
A – Yes. Contact Silver Sneakers at 1.888.423.4632 (TTY: 711) or visit www.SilverSneakers.com to find participating providers. You can start using services on January 1, 2017.

35. **Q - Is durable medical equipment covered, in particular CPAP?**
A - Yes. CPAP's are covered along with any other medically necessary durable medical equipment covered by Original Medicare. The plan will pay 90% of Medicare allowed amount and the member is responsible to pay 10% of Medicare allowed amount.

36. **Q – Does the plan cover acupuncture, chiropractic, or physical therapy?**
A – Acupuncture is not a covered benefit. Chiropractic services are limited to only covering manual manipulation of the spine to correct subluxation. A $20 copay applies per visit. Outpatient rehabilitation such as Physical, Occupational and Speech therapy is covered as long as medically necessary. There is a $10 copay per visit. Prior-authorization applies.

37. **Q - What about physical therapy that might be ordered by a doctor. How is that handled?**
A - Outpatient rehabilitation therapies including Physical, Occupational and Speech therapies are covered. There is a $10 copay per visit. The Medicare Advantage PPO plan covers all of the same services that original Medicare covers. Anthem uses Medicare guidelines to determine medical necessity.

38. **Q - Will we continue to receive Anthem and Medicare information on our health care, such as amounts paid, etc.? We have used this information in the past to make sure our billing from providers is correct.**
A - You will only receive an explanations of benefits (EOB) from Anthem. The provider no longer needs to submit the claim to Medicare. You keep your Medicare card in a safe place and only present your Anthem card to your providers starting January 1, 2017.

39. **Q - What about the monthly updates from Medicare which describe what is covered and how much they paid and what remains**.
A - Anthem will now be sending you the monthly summaries for both medical claims and Part D claims.

40. **Q - How are appeals handled?**
A - You can contact Anthem customer service to request a grievance or an appeal. The customer service number will be listed on your new ID card (1.877.411.1640). You can also submit a written request to Anthem at the address on your ID card. Anthem follows Medicare guidelines for processing grievances and appeals.

41. **Q - Does the Medicare Advantage PPO plan cover foreign travel?**
A - Foreign travel is a covered benefit for urgent and emergency services. There is a $50 copay for emergency care, a $10 copay for urgent care and a $100 copay per admission for emergency inpatient care.

42. **Q - The Los Angeles Times reported this morning that Anthem is being sued for renewing a group of Obamacare PPO customers into an EPO plan (which does not pay for out-of-network services). Could this happen to Aerospace retirees in 2018?**
A – No. Obamacare plans have no impact on Aerospace group plans. That was the annual notification alerting plan members that that their plan was changing and if they wanted to move to another plan, they needed to do that during open enrollment.

43. **Q – Question regarding slide 33. What does it mean that, if we opt out, we may not be able to re-enroll? What conditions determine that?**
A – Survivors of Retirees or Survivors of Deceased Employees: If the survivor opt outs of the plan, the survivor cannot re-enroll into the Aerospace Retiree Medical Plan.

Retiree**:** If the retiree opt outs (waives out of medical coverage), the current plan allows the retiree to re-enroll into the Aerospace Retiree Medical Plan during the next open enrollment period which is usually held in early November of each year with an effective date of January 1st. However, the retiree will need to contact Aerospace Employee Benefits at 310.336.5107 or 800.458.3892 to request a retiree open enrollment package. They may also view the open enrollment information on the retiree website: retirees.aerospace.org

44. **Q - Do you consider Survivors as dependents?**
A – Survivors of Retirees or Survivors of Deceased Employees are enrolled in the Aerospace Retiree Medical Plan under their own SSNs if they meet eligibility requirements for survivor medical. If a Survivor opts out/cancels their enrollment in the Aerospace Retiree Medical Plan, the survivor cannot re-enroll later. Also, if a Survivor remarries, they must notify Aerospace Employee Benefits to cancel their medical plan at the end of the remarriage month and cannot re-enroll later.