BlueCross BlueShield of Illinois

Your Future — Our Focus

Frequently Asked Questions about Medicare and Medicare Advantage plans.

Table of Contents

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Enrolling in Medicare

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. 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 Blue Cross and Blue Shield of Illinois that contract with the government to provide Medicare coverage through a variety of insurance products).
Part D — Prescription drug coverage.

Q. Do I need to enroll in Medicare with the government or just with this plan?
A. Enrollment in Medicare Part A and Part B through the federal government is required for retirees to be eligible for any retiree Medicare plans, including this MAPD Open Access PPO. To have full coverage, you must sign up for Medicare Parts A & B and continue to pay your Part B premium. Call the Mid-America Carpenters support line at 1-855-824-7313 to learn how your retiree plan will work with Medicare.

Q. I am enrolling in Medicare for the first time. When will 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 & B effective date, whichever is later. When enrolling in the MAPD Open Access PPO Plan, you will need to provide your 11-character Medicare Beneficiary Identifier (MBI), located on your red, white and blue Medicare card along with your effective date. The earliest someone who is turning age 65 can sign up for Parts A & B is three months before the month they will turn age 65.

Q. I'm not 65 yet. When do I enroll in Medicare Part A and B?
A. You have an Initial Enrollment Period (IEP) of 7 months to sign up: the 3 months leading up to the month you turn age 65, the month you turn 65, and 3 months following the month you turn 65. We strongly encourage you to **start the enrollment process 3 months prior to turning age 65** so that there will be less chance of any gaps in coverage.

Q. How do I enroll in Medicare Part A and B?
A. Enrollment is done through the Social Security Administration (SSA). If you are 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. Contact the Social Security Administration:

Visit SSA online at www.ssa.gov, or
Visit in person at your local SSA office, or
Call SSA at 1-800-772-1213 (TTY 1-800-325-0778)

Frequently Asked Questions about Medicare and Medicare Advantage plans.

Most people should enroll during the Initial Enrollment Period (IEP), and SSA will send you enrollment instructions at the beginning of your IEP. This is the period during which you can enroll in Medicare for the first time. It is a seven-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.

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. Because enrollment takes time to process, we recommend enrolling three months prior to your 65th birthday.

IMPORTANT: If you plan to enroll in an employer-sponsored Medicare plan, you will need to enroll in both Parts A and B. And if you do not enroll in Medicare Parts A and B when you are first eligible, you can be subject to late enrollment penalties.

Q. Are there costs to Medicare outside of my plan?
A. Part A will not cost you anything if you or your spouse paid into Social Security for a minimum of 10 years. But signing up for Part A and/or Part B means you can no longer add funds to a health savings account. You pay a premium each month for Part B. 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.

Q. What happens if I do not pay my Part B premiums?
A. Non-payment of Part B and/or IRMAA premiums will result in termination of coverage.

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

Medicare Advantage Plans

Q. What is a Medicare Advantage Plan? How is it different from my traditional coverage?
A. Medicare Advantage plans are government-authorized plans offered by private health insurance companies like Blue Cross and Blue Shield of Illinois that expand upon the benefits offered by Medicare Parts A and B. Also known as 'Medicare Part C' plans, they include some medical benefits not traditionally covered by Original Medicare Parts A and B. For example, this MAPD Open Access PPO includes non-Medicare covered benefits such as dental, hearing, physical therapy, mental health services, the SilverSneakers® fitness program, a 24-hour nurse line, and virtual visits.

Frequently Asked Questions about Medicare and Medicare Advantage plans.

Q. Are Medicare Advantage plans joint? Can my spouse or partner be on a different plan?
A. Retirees and their eligible dependents are enrolled in Medicare as individual members; however sponsored plans determine their own eligibility and enrollment policies. See below for enrollment information specific to your MAPD Open Access PPO.

Q. Can I be refused coverage due to a pre-existing condition? Can my policy be canceled once I am enrolled because of my condition?
A. You cannot be refused coverage because of a pre-existing condition. Your coverage cannot be canceled and your claims for covered services cannot be denied because of a pre-existing condition.

The Medicare Advantage Open Access PPO

Q. What are the advantages of a group Medicare plan like this compared to an individual Medicare plan?
A. As a rule, group Medicare plans have better benefits than individual plans. And, because the Fund offers a subsidy (paying part of the cost you would pay on your own with an individual plan), the cost is likely less as well.

Q. Regarding Part C, will coverage through a supplemental plan be included?
A. The Medicare Advantage Open Access Plan (PPO) is a Part C Medicare Advantage plan, not to be confused with a Medicare Supplement Insurance plan. Unlike a Medicare Supplement Insurance plan, this Medicare Advantage PPO has additional benefits that Medicare does not cover.

This new plan covers all the services that Medicare Parts A and B cover and includes additional benefits not covered by Original Medicare (Parts A and B). Plan specifics and details are covered in enrollment materials, including a chart that compares this plan with your current plan. You can also call the Mid-America Carpenters support line at 1-855-824-7313 for help understanding how the plans compare.

Q. Are my dependents eligible?
A. Yes, if they are at least age 65 and/or meet both Medicare and Fund eligibility rules regarding dependents.

Q. Am I covered by this Medicare Advantage PPO plan if I travel outside the U.S.?
A. If you require medical treatment while out of the country, you are only covered in an emergency per Medicare rules. 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. If you have questions about what medical care is covered when you travel, please call the Mid-America Carpenters support line at 1-855-824-7313, or access information at www.bcbsglobalcore.com.

Q. Can I enroll in this plan if I live abroad?
A. This Medicare Advantage plan is available to retirees who live in the United States and its territories. If you reside full time outside of the country, you are not eligible for the plan.

BlueCross BlueShield of Illinois

Your Future — Our Focus

Frequently Asked Questions about Medicare and Medicare Advantage plans.

Q. Will the Blue Cross Medicare Advantage PPO cover everything that is covered by my current plan?
A. Your MAPD Open Access PPO was designed to mirror the benefits of your current plan in a managed care plan. Based on the specific procedure or service, there could be some differences, but those are rare. In many cases, the Medicare Advantage Open Access plan has additional benefits outside of what Medicare allows. Please see the benefit comparison chart and summary of benefits for coverage details. You can also call the Mid-America Carpenters support line at 1-855-824-7313.

Q. Which "high-cost medical services" need prior authorization?
A. Some examples of higher cost services are diagnostic procedures such as MRI, MRA, CT scans and PET scans (Advanced Imaging). Prior Authorization (PA) is also needed for:

- ✓ Musculoskeletal – Pain/Joint/Spine
- ✓ Outpatient Medical Oncology
- ✓ Outpatient Radiation Therapy
- ✓ Outpatient Sleep Study
- ✓ Outpatient Specialty Drugs
- ✓ Lab Management Solutions – Molecular and Genomic Lab Testing

Services that are performed as part of an inpatient stay, 23-hour observation or emergency room visit 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. If you have a PA in place when you enroll in this Medicare Advantage Open Access PPO, that PA continues for the first six months of coverage.

Q. Do I have to choose a plan offered by Mid America Carpenters Regional Council Health Fund?
A. No, but if you opt out of the plan (cancel coverage), you will no longer have medical or prescription drug coverage through the Fund. You will need to contact the Fund Office to complete a form to opt out of the plan. If you are the retiree and you have a spouse and/or dependent child covered under your account, their coverage will *automatically* cancel if you opt out of coverage.

Q. How do I enroll in the Medicare Advantage?
A. As long as you are enrolled in Medicare Parts A and B, you will be automatically enrolled in the Medicare Advantage Plan (PPO). **There is no form to complete, and no action is needed on your part.**

Q. How do I opt out of (cancel) the Medicare Advantage Plan (PPO)?
A. You must complete a form—available through the Fund Office—to opt out of this plan (cancel coverage). If you take action to cancel coverage, you will not have any medical or prescription drug coverage through the Fund. If you are the retiree and you have a spouse and/or dependent child covered under your account, their coverage will *automatically* cancel if you opt out of coverage.

Frequently Asked Questions about Medicare and Medicare Advantage plans.

Q. If I decline participation in this Group plan now, can I sign up later?
A. Yes. You will be able to sign up to this Medicare Advantage Open Access PPO at a later date for coverage post-January 1, 2024. Medicare and the Plan rules require you to prove you have had "creditable coverage" (coverage that is at least as good as what Medicare provides) during the time you were not enrolled in this plan in order to enroll at a later date.

Medicare may apply a late enrollment penalty (also called the "LEP" or "penalty") if you cannot prove you have had prescription drug coverage during the time you have not been enrolled in this plan.

Q. When will my new plan coverage be effective?
A. Coverage for this plan is effective January 1, 2024. Remember to utilize your new member I.D. card and number beginning January 1, and to dispose of your old card. You will have one card for your medical, pharmacy and dental benefits. While you should keep your red, white and blue Medicare card that you receive from the Federal Government, you will not need it for provider appointments to prove your coverage.

Q. How do I pay my monthly premium?
A. Your premium will continue to be deducted from your monthly pension payment. In rare cases where the pension amount has been insufficient to cover the monthly premium, you will continue to make monthly payments directly to the Fund Office. For questions regarding your premium or payment information, contact the Retirement Benefits Department Monday–Friday from 8:00 a.m. to 4:30 p.m. (CT) at 312-787-9455, menu option 4.

Providers

Q. Will I be able to see my current providers?
A. Most likely, yes. Under the Medicare Advantage Plan (PPO), which is an 'open access' or 'passive' PPO, you can go to any providers who: 1) accept Medicare; 2) agree to see you as a patient; and 3) agree to submit claims to Blue Cross and Blue Shield of Illinois or their local Blue Cross plan. They do not need to be part of any Blue Cross and Blue Shield network.

Q. How will my provider know my plan has changed?
A. Please inform your providers that your plan has changed when you call for an appointment and when you arrive for your visit. As an MAPD Open Access PPO member, you have a new member number and ID card. Be sure to show your new card to your providers or their office staff. Remind them that your old ID is no longer valid. If your provider does not use your new number, care may be delayed. Your enrollment and welcome kits will also have a notice to bring with you when you see your provider.

Frequently Asked Questions about Medicare and Medicare Advantage plans.

Q. Will my provider be able to submit claims easily to this Open Access plan?
A. Yes. In fact, we simplified the claims process for providers. Instead of submitting claims to Medicare, providers can now submit directly to Blue Cross and Blue Shield of Illinois. We take care of any interactions with Medicare on behalf of the provider and you.

Q. Will most providers agree to bill the new program?
A. 98% of providers across the country accept Medicare. Open Access PPO plans like yours cover everything covered by Medicare Part A and B. For most Medicare Advantage PPO patients, providers will file claims with their local BCBS plan and are familiar with this process. If your providers accept Medicare, we've made it easy for them to submit claims for your care.

Q. Help me understand how the provider network works if I do not need to see a network provider.
A. This is an Open Access PPO plan. Any provider who accepts Medicare assignment and agrees to bill BCBS or their local Blue Cross and Blue Shield plan, will be paid. Providers who have contracted to be in the BCBS network will be paid their contracted rate. Providers who are not in the BCBS network will be paid the Medicare allowable rate for your care. You can see providers inside and outside of the BCBS network who agree to the rules stated above. Providers outside of Illinois can file claims with their local BCBS plan and are familiar with this process.

Q. The plan requires that providers accept Medicare patients and must also "agree to submit claims to BCBSIL." What does this claim process entail? Does it differ from the current billing procedures?
A. There is no difference in the submission of claims for providers accepting assignment and willing to submit claims to BCBS. With this process there will be no member intervention needed. Providers will not need to submit claims directly to Medicare. The claims will process seamlessly according to benefits allowed and based on medical necessity. Providers outside of Illinois can file claims with their local BCBS plan and should be familiar with this process.

Q. If a provider is not on the PPO list, is it possible to continue to be treated by this healthcare provider without incurring significant copays and/or deductibles?
A. This is an Open Access PPO plan. Any provider who accepts Medicare assignment and agrees to bill BCBS will be paid. Providers who have contracted to be in the BCBS network will be paid their contracted rate. Providers who are not in the BCBS network will be paid the Medicare allowable rate for your care. Providers outside of Illinois can file claims with their local BCBS plan and are familiar with this process.

Q. We live outside of Illinois and our providers are not part of the BCBS network. Will they know what this plan is? What documents will we have to share with the provider to explain how to submit claims?
A. This is an Open Access PPO plan. Any provider who accepts Medicare assignment and agrees to bill BCBS will be paid. Providers who are not in the BCBS network will be paid the Medicare allowable rate for your care.

Frequently Asked Questions about Medicare and Medicare Advantage plans.

You will receive a notice in both your enrollment and welcome kits to share with your provider. Providers outside of Illinois can file claims with their local BCBS plan and are familiar with this process. 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. One of the joys of retirement is that retirees can travel to visit family and places outside of their home bases. If we become ill or are involved in an accident while traveling, will we be able to find care and how will the provider submit the claim?
A. This is an Open Access PPO plan. You can see any out-of-state provider who accepts Medicare assignment and agrees to bill BCBS.

If you require medical treatment while out of the country, you are only covered in an emergency or urgent situation. 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 as well as doctors and hospitals in more than two hundred countries around the world. If you have questions about what medical care is covered when you travel, please call customer service or access information at www.bcbsglobalcore.com.

Claim Forms for care received abroad can be obtained at www.bcbsglobalcore.com or by calling 800-810-BLUE. You will need to provide a bill translated into English if you receive care in a non-English speaking country.

Submit claims to:

BCBS Global Core Service Center
P.O Box 2048
Southeastern, PA 19399

Q. What is the appeal process?
A. To request an appeal, you, your representative, or your doctor can mail or fax a written request as well as contact customer service. Appeals must be submitted within 60 days of receiving your Explanation of Benefits (EOB) for the visit in question.

If you submit a written request for appeal, you must include the following information:

Your name, member number, address, reasons for appealing, and any evidence you want us to review such as medical records, doctor's letters or other information that explains why you need the item or service.

Requests can be mailed to:

Blue Cross Medicare Advantage
Attention: Appeals & Grievance Department
P.O. Box 4288
Scranton, PA 18505

For a standard appeal we will provide a written decision within 60 days.

Frequently Asked Questions about Medicare and Medicare Advantage plans.

Q. Can I see a provider who doesn't accept Medicare assignment?
A. Yes. If a member goes to a provider who does NOT accept Medicare assignment and is not in the national BCBS Medicare Advantage PPO network, the member may be expected to pay the billed amount directly to the provider at the time of service. The member can submit the claim to BCBSIL. We would then pay the claim to the member at the Medicare limiting charge of 115% of the Medicare fee schedule for professional providers. If the provider has charged more than the 115% limiting charge, the member would not be reimbursed the difference of the billed amount they paid to the provider for services and 115% Medicare rates paid. The member would need to pursue a refund from the provider directly**.**

Example: Robert sees Dr. Smith, a non-participating provider and pays him $200 after the visit. The Medicare allowed amount for the visit is $80. Because Medicare limits what the provider can charge for covered services to 115% of the allowed amount for the service, Robert will be reimbursed $92. The remaining $108 will not be reimbursed.

$ 80 Medicare allowed amount for the service
$ 92 115% of the allowed amount

$200 Robert pays Dr. Smith
$ 92 Robert is reimbursed this amount by BCBS
$108 Robert would need to seek this refund from the provider on his own

Q: Can I see a provider who has opted out of Medicare?
A. Less than 2% of providers opt out of Medicare. Providers who have opted out are unable to be reimbursed for services rendered. A member may see a provider who has opted out of Medicare; however, the visit will not be paid for by the Plan or Medicare. A listing of providers that have opted out of Medicare can be found on the CMS website.

Q: How do I file a claim after seeing a provider who doesn't accept Medicare assignment?
A. If the provider does not accept Medicare assignment and refuses to bill BCBS, the member may need to pay the billed amount of the services directly to the provider at the time of service and submit the bill to BCBSIL for reimbursement. There is no reimbursement form to complete, however you 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 ID number including the alpha prefix listed on ID card, and
- An invoice showing services rendered OR another form of documentation that includes:
    - Diagnosis (or DX codes if available)
    - Procedure (or CPT codes if available)
    - Name and address of servicing provider

Prescription Drug Coverage

Q. Does my plan cover any prescription drugs?
A. Yes, your plan includes Part D prescription drug coverage with a $0 deductible and $1,500 out-of-pocket maximum. Your co-payments have not changed. The plan includes 30-, 60-, and 90-day retail pharmacy coverage at more than 62,000 pharmacies nationwide. This includes most national, regional and local pharmacy chains and independent operators.

Q. Does this plan have a mail order requirement?
A. No, there is no mail order requirement with the MAPD Open Access PPO, but you may continue to use mail order through Express Scripts, AllianceRX Walgreens, and Amazon Pharmacy.

Q. Are specialty drugs covered?
A. Yes, specialty pharmacies include Accredo and AllianceRX Walgreens as well as retail pharmacies.

Q. Are there utilization requirements for some prescription drugs?
A. Some covered drugs may have additional requirements or limits on coverage including Prior Authorization (your provider submits a request to the plan for approval), quantity limits (a pre-determined quantity limit or duration), or Step Therapy (trying a "first-line" drug before coverage is provided for a different drug).

Supplemental Benefits

Q. Will I have access to dental, hearing or other benefits?
A. The MAPD Open Access PPO covers both preventive and comprehensive dental services, a significant increase. This plan also includes a $5,000 hearing aid allowance for both ears over 5 years, as well as the SilverSneakers fitness program, 24/7 Nurseline, and virtual visits through MDLIVE.

Frequently Asked Questions about Medicare and Medicare Advantage plans.

Q. How does the hearing benefit work?
A. You can see your own audiologist or other provider, and your coverage includes hearing aid repairs. The $5,000 hearing aid allowance accumulates over 5 years starting with your first use of the benefit—and resets to $5,000 after five years from that first use date.

For example:

Year One – starts with $5,000 balance, member uses $2,000
Year Three – member has a $3,000 balance, uses $1,000
Year Five – member has $2,000 left to use
Year Six – balance resets to $5,000 at beginning of the year

There is no rollover of any balance from a previous plan to this MAPD Open Access Plan.

Q. Are mental health benefits covered by the Medicare Advantage Open Access PPO?
A. Yes, outpatient psychiatric and mental health specialty services have a $0 copay. You can also utilize MDLIVE for mental health services and request the same provider for your virtual visits.

Q. What are all my supplemental benefits?
A. Your supplemental benefits include:

- Hearing Care
- Preventive and Comprehensive Dental Care
- SilverSneakers® Fitness Program*
- 24/7 Nurseline
- Virtual Visits

* Classes and amenities vary by location.

Plan Effective Date and Communications

Q. When will my MAPD Open Access Plan (PPO) ID card arrive?
A. ID cards for effective date 1/1/2024 will be mailed in December.

Here are the items you can expect, in order: You will receive an acknowledgment letter stating that your Medicare application has been received, followed by a confirmation letter explaining that you have been enrolled, and then your new member ID card (mid-December for 1/1/2024 effective date). You may use your confirmation letter as proof of insurance until your card arrives. Your card is for use with hospital, medical and dental providers, and prescription drugs—all with the same member support phone number of 1-855-824-7313. You do not need to use your red, white and blue Medicare card from the Federal Government for any appointments.

Frequently Asked Questions about Medicare and Medicare Advantage plans.

As a MAPD Open Access Plan (PPO) member, you have new member number ID cards. Be sure to show your new cards to your providers or their office staff. Remind them that your old ID card is no longer valid. If the provider does not use your new ID number, your benefits cannot be confirmed and there may be delays processing your claims.

Q. Will I receive a periodic Medicare statement?

A. You will receive your Explanation of Benefits (EOB) from Blue Cross and Blue Shield of Illinois. How often you receive it depends on how often you see your provider. This statement is not a bill. It simply details what you have paid and indicates the level of benefits you have used.

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Frequently Asked Questions about Medicare and Medicare Advantage plans.

The relationship between these vendors and Blue Cross and Blue Shield of Illinois (BCBSIL) is that of independent contractors. BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by the above-mentioned vendors.

Blue365 is a discount program only for BCBSIL members. This is NOT insurance. Some of the services offered through this program may be covered under your health plan. Employees should check their benefit booklet or call the Customer Service number on the back of their ID card for specific benefit facts. Use of Blue365 does not change monthly payments, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors that take part in this program. BCBSIL does not guarantee or make any claims or recommendations about the program's services or products. Members should consult their doctor before using these services and products. BCBSIL reserves the right to stop or change this program at any time without notice. Hearing services are provided by American Hearing Benefits, Beltone ™, HearUSA and TruHearing ®. Vision services are provided by ContactsDirect ®, Croakies, Davis Vision℠, EyeMed Vision Care, Glasses.com, Jonathan Paul Fitovers and LasikPlus ®.

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