BLUE CROSS AND BLUE SHIELD OF MINNESOTA

Frequently Asked Questions about Group Medicare Advantage Elite with Rx (MAPD PPO)

BlueCross BlueShield Minnesota

RATE

Q: What will the plan premium be for the Group Medicare Advantage Elite with Rx?
A: The rates will remain the same for 2023. ThrivePass will mailing the rate letters. The rate is the $249.10 minus and Blue Cross retiree subsidy if there is a subsidy.

If you have any questions regarding your rate, please contact the ThrivePass Customer Service Team at 866-855-2844 option 3 during business hours (Monday through Thursday: 7:30 am to 5:30 pm CT and Friday: 7:30 am to 5:00 pm CT).

ELIGIBILITY

Q: If one leaves the retirement plan, is there an option to re-enroll at any point?
A: No, if a retiree is currently enrolled in our Retiree Medical plan offerings and leaves, they are not eligible to come back on later.

Q: I will be new retiree on 1/1/23. I understand my non-employee spouse can also get/pay for coverage under this retiree plan. If I die, can my spouse continue coverage?
A: Yes. If a retiree's spouse is already on the plan when our associate retiree passes away, they can continue their coverage.

Q: Is there a form that I must fill out?
A: The only form needed is if you are choosing to opt out of the Group Medicare Advantage Elite with Rx effective January 1, 2023. The auto enrollment packet of information was mailed out November 3, 2022, and you should arrive via standard USPS soon if not already.

You do not need to take any action unless you would like to opt out of the new plan coverage for January 1, 2023.

MEDICAL NETWORK

Q: How do I find the provider network for Arizona? Why were Maricopa and Pima counties the only highlighted counties on the map showed in the presentation.
A: Your plan gives you access to doctors and hospitals anywhere in the United States with providers who accept Medicare Assignment. The map shared in the presentation showed counties highlighted in blue to show you where Blue Cross Medicare Advantage Network is available.

Q: Why are only Maricopa & Pima counties included for out-of-state services in Arizona?
A: The Group Medicare Advantage plan includes a broad national network and allows retirees to access any Medicare contracted provider who accepts Medicare assignment. We do have Medicare Advantage PPO network in the Phoenix and Tucson areas; however, you are not limited to the Medicare Advantage Network to receive coverage at the in-network level of benefit. You can choose to access care with any Medicare contracted provider who accepts Medicare assignment.

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Q: What is the tool to confirm if my doctor is in the Group Medicare Advantage network or accepts Medicare Assignment?
A: There are a few ways to confirm if your doctor is in network.

1. Visit bluecrossmn.com/findadoctor Click on "Find a Doctor" under the Medicare plans section
Log in or select "Group Medicare Advantage Network"
Complete the search fields and click the enter button

2. Call the number on the back of your member ID card. **Group Medicare Advantage (PPO):** Call toll free at **1-800-711-9865; TTY 711**

3. The Find a Doctor tool will direct to medicare.gov if there are no providers in the Group Medicare Advantage network near you. **To find Medicare-assigned providers, visit medicare.gov and click "Providers & Services."**

Q: If your provider in the blue county is NOT in the network, you can still use a provider who accepts Medicare. Will they submit a claim for you?
A: If they accept Medicare assignment it is their responsibility to submit claims to the local Blue Plan even if they are not in the PPO network. If they are not in the PPO network and do not accept Medicare assignment, then they may or may not submit the claim for the member.

PRESCRIPTION DRUG COVERAGE QUESTIONS

Q: How are preferred generic drugs determined?
A: Preferred generic drugs are assessed as preferred where they offer a clinically appropriate benefit of helping members with adherence and/or driving costs down. Formularies change year over year, including new drugs that have become available and new generics. With that, preferred alternatives available may be different year over year.

Q: We use Walgreens for our pharmacy so do we need to use CVS?
A: No, you do not need to use CVS pharmacy as Walgreens is in the pharmacy network. Retirees have access to over 64,000 pharmacies nationwide. You can find pharmacies online:

You can find providers and pharmacies online:
1) Go to **bluecrossmn.com/medicare-documents**
2) Scroll down to **2023 Group Medicare plans**
3) Under **Doctors and pharmacies,** you can:
a. Click on the **Search online for doctors (providers)** link for providers; or
b. Click on the **Search online for pharmacies** link (via myprime.com) for pharmacies; or
c. Click on your **Provider Directory (PDF) or your Pharmacy Directory (PDF)** link to download and print

Q: If I get a 90-day supply of a medication, will I pay a lower price?
A: Yes, you can save up to a whole month copay with 90-day supplies of medication.

Q: Where is the drug formulary found? Is it different than the Medicare Blue Rx program we had in 2022?
A: A copy of the formulary is located on the retiree landing page located
https://www.bluecrossmn.com/bcbsmnemployee#retiree
The 2023 Formulary is broad and does have some differences from the 2022 formulary.

PRIOR AUTHORIZATIONS (PA)

Q: What is BCBSMN's history of approval/denial rates for prior authorization?
A: Decision to not share approval rates.

Q: Which dept will be doing the PA, Medicare, or Employee?
A: The PAs are reviewed by eviCore clinicians and MD's

Q: Which procedures require PA?
A: Please see the document located on the retiree landing page "Prior Authorizations" The providers and members should be using the PA look up tool which is a member friendly facing tool.

https://www.bluecrossmn.com/help/prior-authorization-and-medical-policy-help

Q: Do PA requirements apply to both in-network and out-of-network providers?
A: Yes, prior authorizations apply to both in-network and out-of-network providers.

Q: Are any providers exempted from PA?
A: Providers that are exempt are aware of their exemption.

Q: Are guidelines used to make PA decisions available to the public?
A: Yes, they can go to medical policy page or contact customer service at BCBSMN for a copy.

https://www.bluecrossmn.com/providers/medical-management/medical-and-behavioral-health-policies

Q: Have these been reviewed by respective medical societies?
A: Any sources for decision on medical policies for eviCore are listed in the respective policy

Q: How long does the PA process take?
A: The TAT for standard is 14 calendar days, urgent is 72 hours.

Q: Are there maximum time limits for emergent and routine procedures?
A: Emergent procedures are out of scope for Utilization Management. Routine procedures do not typically require a PA.

Q: What proportion of PA denials are appealed?
A: The decision to appeal is between the member and the provider depending on the denial rationale that is determined after the medical necessity review.

Q: What proportion of appealed decisions are reversed?
A: This also would not be member facing detail.

Q: Do PA denial letters include detailed explanations for the denial?
A: They include the denial rationale and what is needed to meet medical necessity. They often also include an alternative course of treatment if appropriate.

Q: Are there any mandatory waiting periods associated with the PA process?
A: No, there are no waiting periods.

Q: How is Blue Cross going to support the retirees who may be currently receiving services that require a prior authorization?
A: We review the impacted member's Utilization Management and claim history and built continuity of care authorizations to help them and their providers navigate the new prior authorization requirements for their first 60 days on the new plan.

Q: How can I check on the status of a prior authorization?
A: The following tools are available to check the status of a prior authorization:

- Prior authorization lookup tool | Blue Cross MN
- Call Group Medicare Advantage Customer Service

BENEFIT QUESTIONS

Q: Will SilverSneakers enrollment in the new MA Plan be automatic? Will we need to reapply for our club memberships?
A: This will happen automatically for you. There will be no need to reapply. You will need to present your new Group Medicare Advantage medical identification card to the participating facilities.

Q: Explain how the OTC benefit will work. What products are included?
A: You are entitled to a $50 allowance every quarter for the purchase of covered over-the counter (OTC) items such as vitamins, Band-Aids, allergy medications, cold remedies and much more.

The OTC benefit offers you an easy way to get generic over-the-counter health and wellness products through select CVS retail locations, by phone at 1-888-628-2770 (TTY: 711) or online at cvs.com/otchs/bcbsmn. You order from a list of approved OTC items, and OTC Health Solutions will mail them directly to your home address at no additional cost.

Q: For over-the-counter CVS-do we pay first and then submit a receipt or will we show them a card?
A: No, there is no paying up front. The benefit allows you to get up to $50 worth at no cost to you. It is managed automatically between Blue Cross and CVS Caremark.

Q: Are hearing aid batteries covered?
A: Yes, the hearing aid benefit has rechargeable hearing aids or hearing aids with batteries through TruHearing. If you utilize TruHearing, the batteries are covered.

Q: Was dental added?
A: No, the plan does not include dental coverage except for Medicare covered dental services. Medicare-covered non-routine dental care. Covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician.

Q: Are referrals required?
A: No, referrals are not required.

Q: What services go towards the annual out of pocket $3000? Drugs?
A: The annual deductible of $233 applies to the annual out-of-pocket maximum. Drug copays do not apply to this maximum.

Q: Infusion at the Oncologist covered 100%?
A: After the deductible of $233 is satisfied for Part B services, infusions are eligible to be covered at 100%.

Q: Infusion drugs where you must go into the clinic/hospital for what are they paid for (chemo)?
A: If there is an office visit billed for a clinic point of service, you are responsible for $20 copay, otherwise after the deductible of $233 is satisfied for Part B services, infusions are eligible to be covered at 100%.

Q: Would I use doctor on demand rather than urgent care?
A: Your choice, either or, it is a matter of convenience to be able to address urgent issues in the comfort of your home versus going to a clinic.

Q: Is the $20 copay a flat copay or will it work the same way it does today when the balance is less than $20?
A: The $20 copay will always apply for office visits on the Group Medicare Advantage Plan.

Q: Why do we need to re-apply for formulary exception every year when only brand is appropriate due to an allergy to all generics?
A:
Medications that are non-formulary, require Step/Prior Authorization or that are above the Plan's quantity limit are generally limited to 12-month approvals. Formularies change year over year as well as patient specific clinical information. With these changes, previous approvals may no longer be appropriate. For example, members may be able to switch to a Plan's formulary alternative that has been added to the formulary for the new year, or the Prior Authorization criteria may require new information for continued use, such as information supporting benefit of the requested medication. It would not be appropriate to allow continued use of a higher priced drug if there is an applicable formulary alternative the member could utilize for their condition. Similarly, it would not be safe to allow continued use of a medication that is not beneficial or meant to be used long term. In summary, limiting the approval time frame to 12 months ensures the most cost effective and appropriate clinical decisions are being made for our members.

Q: **I am not yet on the retiree plan. However, when educating yourself about Medicare plans, Brokers promote Medicare Supplement plans over Medicare Advantage plans. Mostly around access to Provider networks. Why is BCBSMN moving away from Medicare Supplements?**
A: Blue Cross is not moving away from Medicare Supplements; we are expanding the product portfolio to include other important types of Medicare plans like the Medicare Advantage plan. The Medicare Advantage plans include Care Management components that help our members achieve healthier outcomes as opposed to a Medicare Supplement. And the Blue Cross retiree Medicare Advantage plan provides coverage like that of a Medicare Supplement Plan.

Q: If already registered in Blue Cross online portal, do you need to register again because the plan changed?
A: No because you are remaining on BCBSMN benefits you will not need to re-register.

Q: Will I need a referral to see a specialist at Mayo?
A: The plan does not require referrals. Mayo may require one for you to make an appt there, but we do not under this plan.

Q: Are catheters covered?
A: Based on the Medicare eligibility of the catheters, yes, this is eligible to be covered 100% following the annual deductible of $233 that applies to Part B services.

Q: Are eligible services the same for the Advantage plan as they are for regular Medicare?
A: Yes, plus additional value-added coverage such as routine acupuncture and chiropractor services, over the counter benefit, eyewear. Please see your Evidence of Coverage for details.

GUARANTEE ISSUE

Q: If Blue Cross in the future reduces the benefit set or cost increases are out of line will we be given the opportunity to return to the plan N med sup without the need for underwriting?
A: No, you cannot return to the Group Plan N, however, you could enroll in the Individual Medicare Supplement Plan N without health underwriting within the first 63 days of the termination of the plan. Individual Plan N does not include coverage for routine physical, eye and hearing like the Group Plan N does today. Future guarantee Issue Rights- is based your permanent residence.

OTHER

Q: Is BCBS getting a financial subsidy? If so, has any consideration been given to lessing the cost for retirees with this transition?
A: Yes, Blue Cross does receive CMS subsidies for the Medicare Advantage Plan with Part D. The Blue Cross Retiree Group Medicare Advantage plan takes into consideration group experience and the benefit build of the plan.

Q: How is Medicare Part B premium handled?
A: There is no change with how Medicare Part B premium is handled. The premium for Medicare Part B is collected by Social Security.

Q: Will I need to pass a medical review to re-enroll in original Medicare?
A: No, you always have your Original Medicare, however, if you are considering enrollment to an Individual Medicare Supplement plan through a company other than BCBSMN you may be subject to health underwriting.

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