BlueMedicare Group Plans - Questions & Answers

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BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Product Overview

BlueMedicare Group HMO

- Available in certain counties (Broward, Hillsborough, Miami-Dade, Palm Beach, Pinellas and Polk). Members must receive care by participating providers within their service area, unless otherwise authorized or the care is urgent or emergency care.
- BCBSF network.
- No referrals needed for visits to participating specialists.
- Preventive care benefits.

BlueMedicare Group PPO

- Statewide service area. Members must have a permanent address in the state of Florida.
- Open access to participating specialists in the state of Florida.
- Access to any non-network Medicare provider nationwide using out-of-network benefits.
- Predictable costs with limits on out-of-pocket expenses.
- Network is a footprint of NetworkBlue.

BlueMedicare Group PFFS (Effective 1/1/08)

- BlueMedicare Group Private Fee-For-Service (PFFS) gives members the ability to select any health care provider; however, not all providers may accept this plan, and even Medicare providers may not accept this plan. If a member chooses this plan, it is very important that all the providers they want to see know, before providing services to them, that they have BlueMedicare Group PFFS coverage in place of Medicare. This gives the provider the right to choose whether or not to accept BlueMedicare Group PFFS terms and conditions of payment for treating. Providers have the right to decide if they will accept BlueMedicare PFFS each time they see a member. This is why a member must show their BlueMedicare Group PFFS ID card every time they visit a health care provider.

- A Medicare Advantage Private-Fee-for-Service Plan works differently than a Medicare Supplement Plan. Your doctor or hospital must agree to accept the plan's terms and conditions prior to providing healthcare services to you, with the exceptions of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, the physician may not provide healthcare services to the member, except in emergencies. Providers can find the plan's terms and conditions on our website at: http://www.bcbsfl.com/pffsterms.

- Nationwide service area allows members who reside outside of Florida to select this product.

BlueMedicare Group Rx

- Options 1 and 2 provide generic and brand drug coverage through the coverage gap.
- Four tiers with fixed copayments or coinsurance. Mail order available for a 90-day supply for an amount equal to two monthly copayments.
- Service area is nationwide and our pharmacy network is also available nationwide.
- Each option is available with our HMO, PPO and PFFS plans or as a Part D only product.

1 = Q&A for All (employees, employers, agents, providers, BCBSF internal, etc)
2 = Q&A for Employer Group & BCBSF Internal Only
3 = Q&A for all excluding Providers

	QUESTION	ANSWER
1	What is CMS?	CMS is the Centers for Medicare & Medicaid Services. CMS is a division of the Department of Health and Human Services (HHS) responsible for administering the Medicare, Medicaid and several other health-related programs.
1	What is Medicare?	Medicare is a federal health insurance program for people age 65 and older, people of any age with permanent kidney failure, and certain disabled people under age 65. Medicare is managed by the Centers for Medicare & Medicaid Services (CMS), which is part of the Department of Health and Human Services. Medicare has two parts: Part A (Hospital coverage) and Part B (Medical coverage).
1	What is Medicare Part A?	Part A (Hospital Insurance) helps pay for care in hospitals and skilled nursing facilities, and for home health and hospice care. If you are eligible, Part A will be premium free that is, you don't pay a premium because you (or your spouse) paid Medicare taxes while working. Part A is also available for a monthly premium to individuals who never paid Medicare taxes while working.
1	What is Medicare Part B?	Part B (Medical Insurance) helps pay for doctors, outpatient hospital care and some other medical services that Part A doesn't cover, such as the services of physical and occupational therapists. Part B is voluntary. If you choose to have Part B, the monthly premium is deducted from your Social Security, Railroad Retirement, or Civil Service Retirement payment. If an individual does not receive any of the above payments, Medicare will bill the individual. The Part B premium changes on a yearly basis and can vary by individual based on certain criteria. The minimum Part B premium for 2008 is $96.40 per month. Some people may pay more depending on yearly income and whether or not they are assessed any late enrollment penalties.
1	When is an individual assessed late enrollment penalty when joining Medicare Part B?	If an individual fails to enroll in Medicare Part B during the initial or a special enrollment period, premiums may be higher depending on the reason enrollment in Part B did not occur. The cost of Part B may be increased 10% for each 12-month period that a beneficiary did not have Part B. Beneficiaries will have to pay this extra cost as long as they remain enrolled in Medicare Part B. Individuals should contact the Social Security Administration (SSA) for assistance at 1-800-772-1213, 7 a.m.

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		to 7 p.m. ET, Monday through Friday. TTY/TDD users should call 1-800-325-0778.
1	Why is Medicare sometimes referred to as "original" Medicare?	Individuals who receive Medicare benefits from Parts A and B are receiving benefits through the federal government and accordingly are enrolled in original Medicare. Original Medicare was designed in the 1960s and many people still elect to receive benefits based on this design. As an alternative, Medicare also offers beneficiaries the option to receive care through private insurance carriers instead of the federal government. These plans are called Medicare Advantage plans or Part C. BCBSF's EGWP (BlueMedicare Group retiree) plans are Medicare Advantage plans. Medicare Advantage plans are referred to as a "replacement to original Medicare" and are required to provide the full range of Medicare benefits to each enrolled individual.
1	What are Medicare Advantage Plans? (Also referred to as Medicare Replacement, Medicare + Choice or Part C plans)	**Medicare Advantage plans** are health plan options that are part of the Medicare program offered by private carriers (such as BCBSF). There are several different types of Medicare Advantage plans that a carrier may offer within a given state or area of a state, such as: • Medicare Health Maintenance Organization (HMO) • Medicare Preferred Provider Organization (PPO) • Medicare Private Fee-for-Service Plans (PFFS) • Medicare Special Needs Plans (SNP) • Medicare Medical Savings Accounts (MSA) To join a Medicare Advantage plan an individual must be enrolled in Medicare Part A and Part B. **The individual will continue to pay their monthly Medicare Part B premium to CMS (Medicare)**. In addition, the Medicare Advantage plan they select may have a monthly premium. When an individual joins a Medicare Advantage plan, they use the health insurance card(s) provided by the insurance carrier (such as BCBSF) instead of the original red, white and blue Medicare card. Most Medicare Advantage plans generally provide extra benefits and lower out-of-pocket expenses than "original" Medicare and many include prescription drug coverage. Please remember when you move to a BlueMedicare

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		Group plan you do not lose your Medicare coverage it is just replaced by the BlueMedicare Group plan
1	What are Employer Group Waiver Plans (EGWP)?	EGWP's (also known as Group retiree or Group Medicare plans) are employer-sponsored Medicare Advantage plans offered to the group's Medicare-eligible retirees and their Medicare eligible dependents as an option to "original" Medicare or the employer group's retiree commercial plan. BCBSF's EGWP plans are called "BlueMedicare Group" such as BlueMedicare Group PPO.
1	In what counties are the BlueMedicare Group plans available?	1**. BlueMedicare Group HMO** is available in certain counties (Broward, Hillsborough, Miami-Dade, Palm Beach, Pinellas and Polk). Members must receive care by participating providers within their service area, unless otherwise authorized or the care is urgent or emergency care. 2**. BlueMedicare Group PPO** is available to Medicare-eligible retirees who have a permanent address in the state of Florida. Members can access our statewide network or use their out-of-network benefits, not only in the state of Florida, but nationwide. Members can travel for up to six months at a time. 3. **BlueMedicare Group PFFS** plans are statewide and nationwide so members can reside out of the state of Florida for their coverage. 4. **Bluemedicare Group Rx** is also available nationwide
1	What is a Private Fee-for-Service plan?	Private Fee-for-Service (PFFS), like other Medicare Advantage/replacement plans, was developed as an alternative to "original" Medicare. Unlike other Medicare Advantage plans (PPO and HMO), the PFFS plans do not have provider network requirements. A PFFS member can receive care from any provider willing to treat a PFFS customer. Providers are entitled to reimbursement from the private carrier (such as BCBSF) that would be equivalent to the payment the provider would have received from "original" Medicare. Of course, the patient would be responsible for their defined copayment/co-insurance applicable to their PFFS plan; and, the carrier (BCBSF) would be responsible for the remaining payment to equal Medicare reimbursement.

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		A Medicare Advantage Private-Fee-for-Service Plan works differently than a Medicare Supplement Plan. Your doctor or hospital must agree to accept the plan's terms and conditions prior to providing healthcare services to you, with the exceptions of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may not provide healthcare services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at: http://www.bcbsfl.com/pffsterms.
1	If I am currently enrolled in a Medicare Part D prescription drug plan, what happens if I join a Medicare Advantage plan?	If the Medicare Advantage plan includes prescription drug coverage then automatic dis-enrollment from a Part D prescription drug plan will occur. You have the ability to enroll in our Group Medicare plans during your employers enrollment period. Your application to join this plan will automatically disenroll you from your past Part D plan.
1	When can a retiree or dependent enroll in the plan?	Members can enroll during the group's open enrollment period. If a member has a Special Election Period (age in, retiree etc) they can join the plan the 1st of the following month,
1	When can a retiree or dependent disenroll in the plan? How do I notify you of a member seeking to disenroll?	CMS has guidelines for when members can disenroll from a Medicare Advantage Plan. In most cases members can disenroll during the group's open enrollment period, the Medicare open enrollment period 11/15-12/31 or if they permanently move from a covered service area. Groups must notify BCBSF in writing (email) of their request to disenroll a member. It is helpful we have a signed letter from the retiree as well. Please do not mark your invoice to capture a disenrollment because CMS guidelines require us to have a formal request in writing.
1	If a retiree is unhappy with the plan can they disenroll prior to our next enrollment period	Yes, CMS has allowed special rules for group retirees and if the group allows changes for all retirees prior to next enrollment period BCBSF can disenroll the member the 1st of the following month upon notice from the group of member. **Example** A member joined the plan January 1 and on January 20 decided they wanted to go back to their old plan. BCBSF can process the disenrollment on Febuary 1 (1st of the following month)

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1	Is a Medicare Supplement policy needed if I enroll in a Medicare Advantage plan?	Medicare Supplement policies (Medigap plans) are not valid with a Medicare Advantage plan. Therefore, an individual who enrolls in a Medicare Advantage plan may want to drop their Medigap policy. It is important to understand that the individual has a legal right to keep the Medigap policy but it will offer no coverage as long as an individual remains enrolled in a Medicare Advantage plan.
2	How are the employer group premiums developed for the BlueMedicare Group plans?	The BlueMedicare Group rate is developed using several factors from specific employer group's claims history and census data. The actuaries will utilize this information along with the pre-determined formula based on expected CMS reimbursement to develop the rates.
2	Is there a limit to the premium increases from year to year under the BlueMedicare Group plans?	No, premiums are determined based on the experience of the Group's retiree segment. If utilization increases over the benefit period, it would be reasonable to expect the rates to also increase for the next benefit year. The CMS subsides will also help determine the rates for the following years Please note a retiree's premium may be lower or higher then what was quoted to the employer. Retirees who are eligible for Low Income Subsidy may have their premium reduced and retirees who do not have prior Part D creditable coverage may have a late Part D enrollment penalty. Medicare will notify BCBSF if one of these circumstances happens and the invoice to the employer will note this change.

	QUESTION	ANSWER
2	Can an individual enroll in a BlueMedicare Group plan (PPO, HMO, PFFS, Rx) if they do not have permanent residence in Florida?	For the BlueMedicare Group PPO plans, the service area is the state of Florida; therefore, individuals must have a permanent residence in Florida. For the BlueMedicare Group HMO plan, members must have a permanent residence in the approved counties within Florida. For the BlueMedicare Group PFFS or BlueMedicare Group Rx plans, the member can live anywhere in the United States since these products have a nationwide service. In addition, if a BlueMedicare member moves outside of the required service areas, their coverage expires. The individual must switch to "original" Medicare or elect another option available through their employer group or carrier within their new state or residency.
2	If an individual joins a BlueMedicare Group plan how will the premium be determined for dependents (spouse, children) remaining on the Group's commercial plan?	At this time, the premium rates for dependents remaining under the employer commercial group coverage will be the determined using the dependent portion of the current commercial rates. Commercial rates are currently labeled as follows: EE (Employee Only) EE + Spouse EE + Children EE + Family For example, to determine the commercial premium for a spouse remaining on the commercial plan: EE+Spouse rate (-) EE only rate (=) Spouse only rate Please note due to Split Contracts the tiering structure will change (see below): **01 = Single** **02 = Family** **04 = Employee / 1 Child** **06 = Employee / Children** **07 = Employee / Spouse** **10 = Child Only)** **18 = Spouse** **20 = Spouse Child**
2	As a Group Administrator, how	The BlueMedicare Product will bill a separate monthly premium

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	will my bill from BCBSF capture the retirees who select this product. Will there be just one bill?	to the group. The invoice is sent out roughly 15 days prior to the due date. Please note your 1st bill, which may not capture all of your retirees because it was produced prior to the effective date and BCBSF will wait for the CMS confirmation of enrollment prior to billing the group. Although the invoice may not list your retirees it does not stop them from getting their ID card and accessing their health and pharmacy benefits
2	As a Group Administrator, how can I follow the self-billing process when CMS may delay eligibility of the member until a following month?	As a Medicare replacement product, the BlueMedicare Group PPO must follow CMS enrollment and billing regulations. The due date on billing cannot be until after the sponsor organization is notified by CMS of the beneficiary's premium and notifies the member of the amount due.
2	How can this CMS delay in notification be made to work for self-billing?	We are implementing a process to work as effectively as possible for a self-billing group. We recommend that invoices should be paid as billed to ensure no disruption in the enrollment process.
2	How will a self-billing group know who's approved or not?	Only enrollees who have been confirmed by CMS will appear on the invoice. Once the member is confirmed they will appear on your invoice. Members not approved by CMS would be allowed to return to their commercial product.
2	Why is there an approval process for enrollment?	CMS requires that enrollees in a Medicare Advantage product be entitled to Medicare Part A and Part B and live in the participating geographic area. Enrollment must be validated by CMS to assure claims are paid correctly and that Part D TrOOP be monitored and administered correctly. The timeliness of enrollment varies with CMS, but is handled on a first in / first-out (FIFO) basis.
2	If an enrollee is not approved by CMS, are they without coverage?	No. We would allow denied enrollees to return to the commercial product with no lapse in coverage.
2	Our group members are receiving penalty letters for not enrolling in Part D, when the group has evidence of Creditable Coverage for that member.	A small number of retirees may have received a Medicare Late Enrollment Penalty letter due to a keying error by BCBSF. Please advise them not to be concerned. This issue has been worked with CMS for all impacted BlueMedicare enrollees. Preventive processes have been deployed to eliminate this in the future.
1	Are Medicare-eligible individuals	No, the BlueMedicare Group plan is only offered to Medicare-

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	that work full time or part time (actives), that are eligible for the Group's commercial plan as an "active" employee, eligible to join the BlueMedicare Group plan?	eligible retirees and their Medicare eligible dependents. Note: If the employee works at all (even part time for the group), he/she is not eligible for the plan.
1	Can an individual that is retired and "close to" turning 65 go ahead and enroll in the BlueMedicare Group plan?	No. However, once the member is 65 years of age and enrolled in Medicare Part A and Part B, they are eligible to switch to the BlueMedicare Group plan without waiting for the employer group's annual open enrollment. You must first enroll several months prior to your 65th birthday to insure your Medicare Part A or Part B will be effective timely.
3	If I am an under 65 active employee, but my spouse is over 65 and Medicare A eligible and enrolled in Part B, can my spouse enroll in the BlueMedicare Group plan while I remain on the active employee commercial plan?	CMS guidance 11/5/07 Yes, Medicare-eligible dependants of an active can enroll in the EGWP plan. The active would need to select the commercial product and this would then be considered a Split Contract.
3	If I am a Medicare-eligible retiree, but my spouse is under 65 and not Medicare eligible, can I join the BlueMedicare Group plan while my spouse remains on the group's retiree commercial plan?	Yes, this is considered a "Split Contract." Also if the employee is retired and non-Medicare eligible, the Medicare-eligible spouse can select the BlueMedicare Group plans.
3	If I am a Medicare-eligible retiree, can my Medicare-eligible spouse or dependent elect to join the BlueMedicare Group plan even if I elect to remain in the Group's retiree commercial plan?	No, if the Medicare-eligible retiree elects to remain in the Group's retiree commercial plan or other plan such as "original" Medicare; then, the Medicare-eligible spouse or dependent(s) cannot join the BlueMedicare Group plan without the retiree.
3	If the retiree has dependents (such as children) that are Medicare-eligible (such as on Medicare Disability) are they eligible to enroll in the BlueMedicare Group plan?	Yes, age does not matter as long as the dependent is Medicare eligible (enrolled in Medicare Part A and Part B).
3	What is included in the	• Welcome Letter

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	BlueMedicare Group plan enrollment kit?	• Summary of Benefits • Member Product Brochure • BlueComplements Brochure • Enrollment/Application • Formulary • Appointment of Representative Form • Provider Directory
3	Can the HIPAA Authorization of Representative Form that was completed as part of the individual's current health coverage apply to the BlueMedicare Group plan?	No. A new Authorization of Representative Form must be completed. The form is included in the BlueMedicare Group pre-enrollment package.
3	What enrollment paperwork must be completed to enroll in a BlueMedicare Group plan?	• A BlueMedicare Group Enrollment/Application Form must be completed by each Medicare-eligible family member electing the BlueMedicare Group plan. • Authorization of Representative Form (if applicable). • A Group Health & Financial Change Application Form must be completed to remove individuals currently enrolled in the Group's commercial plan if at least one family member will remain on the commercial plan. Note: If the family will have at least one family member enrolled in the BlueMedicare Group plan and at least one other family member enrolled in the Group's commercial plan then the family is considered to have a "SPLIT CONTRACT/ENROLLMENT", which means the verbiage "SPLIT CONTRACT" should be written across the top of each individual's BlueMedicare Group application and the Group Health & Financial Change Application Form.
3	Why does the application ask if an applicant has End Stage Renal Disease (ESRD)?	CMS imposes enrollment limitations under certain situations for applicants with ESRD. To be eligible to enroll in an EGWP plan, one of the following must apply: • An individual with ESRD who is already enrolled in any of our BCBSF plans is eligible to switch to our BlueMedicare Group plan. • The individual no longer needs dialysis or has had a successful kidney transplant.

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		Note: Individuals who have had a successful kidney transplant and no longer require dialysis to maintain life are not considered to have ESRD for purposes of eligibility.
3	What should an individual do with their completed BlueMedicare Group Enrollment forms?	Individuals should return their completed Enrollment/Application paperwork to their Group's Benefit Administrator/Human Resource representative.
3	What should the employer group do with the completed/collected BlueMedicare Group enrollment forms?	The BCBSF Account Management Specialist should not take possession of the BlueMedicare Group applications from the employer group, nor should the employer group mail the BlueMedicare Group applications to BCBSF, until the Account Management Specialist confirms that the employer group has been "set up" in the BCBSF system (MHS) to accept the applications. This is because CMS guidelines require that BCBSF provide each applicant with an "Acknowledgement Letter" within seven (7) calendar days of receipt of the application. The Acknowledgement Letter cannot be generated unless the employer group is set up in MHS to process the application. The completed applications need to be sent to the following address Blue Cross and Blue Shield Of Florida Attn: Enrollment and Billing Department Building 1, 2nd Floor 8928 Freedom Commerce Parkway Jacksonville, Fl 32256
1	What will be sent to the applicant once the BlueMedicare enrollment paperwork is received by BCBSF?	BCBSF will send the applicant an "Acknowledgement Letter" within 7 days of the receipt of the application indicating the application has been sent to CMS for review/approval. The "Acknowledgement Letter" contains information that can be utilized as a temporary ID card if necessary. **They will also be sent the following information** 1. Attestation of Creditable Prescription Drug Coverage. This is required by Medicare and each member must complete the section for employers and unions, sign and return. They can either complete the dates or send copies of the creditable coverage form. Medicare is looking to

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		make sure each member had creditable Rx coverage starting 1/1/2006 2. Each year they will also be asked to complete a Coordination of Benefits survey that will ask each member if they have any other insurance besides one of our BlueMedicare Group plans. If they do not have any other insurance they need to check No, sign and return.
1	When will a BlueMedicare plan applicant/enrollee receive the contract and ID card package?	Post-enrollment packages (containing the BlueMedicare Group Evidence of Coverage, ID Card, etc) will be mailed to the new members as soon as possible. BlueMedicare Group members who have not received their ID card should contact 1-800-926-6565 for customer assistance. Hours of operation are 8 a.m. to 9 p.m. ET, 7 days a week. TTY users should call 711. Or visit www.bcbsfl.com
1	How many ID cards will BlueMedicare Group plan members have?	Each BlueMedicare Group member (even if in same family) will receive two ID cards, one card for medical coverage and a separate card for prescription drug coverage. Members may also be sent a Blue Script ID card that will offer pharmacy discounts for them and their family members.
1	What is the BlueMedicare Group Member Customer Service Contact Phone Number?	BlueMedicare Group members should contact 1-800-926-6565 for customer assistance, between 8 a.m. and 9 p.m., seven days a week. TTY users should dial 711.
3	If an individual switches to a BlueMedicare Group plan, what happens to any out-of-pocket costs already met by that individual under their commercial plan year to date?	Out-of-pocket amounts met under the commercial plan cannot be applied to the individual's new BlueMedicare Group plan. However, if the individual has family members that will remain on the Group's commercial plan then any amounts obtained for the current calendar year will be transferred to the remaining family member(s). Members of BlueMedicare Group PPO and BlueMedicare Group PFFS will have out-of-pocket maximums. Please see your Summary of Benefits or Evidence of Coverage for the applicable amount.
1	Is there a calendar year out-of-	All BCBSF PPO and PFFS BlueMedicare Group plans include a

	QUESTION	ANSWER
	pocket (OOP) maximum under the BlueMedicare Group plan? If yes, what accumulates toward calendar year OOP maximum? And, is there a separate calendar year OOP maximum for in- and out-of-network benefits?	calendar year OOP maximum. All health related copayments and co-insurance cost-sharing charges for covered health services accumulate toward the calendar year OOP maximum. Their OOP maximum is combined for both in- and out-of-network cost-sharing charges. Once a member reaches their annual OOP maximum, the plan will pay 100% for covered health services. NOTE: The following items do not count toward calendar year out of pocket maximums: Calendar Year Deductibles and Rx Costs
1	How can I find out how much of my annual out-of-pocket maximum I have met?	BlueMedicare Group members who would like to know their up-to-date information on their OOP maximum should contact 1-800-926-6565 for customer assistance. Hours of operation are 8:00 a.m. to 9:00 p.m. ET, 7 days a week. TTY users should call 711. Or visit www.bcbsfl.com.
1	What is Creditable Prescription Drug Coverage?	A prescription drug plan that provides at least the same coverage an individual would receive if enrolled in a CMS standard Part D Prescription Drug plan. NOTE: As of January 1, 2006, CMS requested that all Medicare-eligible individuals obtain some type of “Creditable Prescription Drug Coverage,” either through their own means (such as a retiree plan) or by enrolling in a CMS Part D Prescription Drug Plan. If the individual does not currently have prescription drug coverage or their coverage is not considered “Creditable” by CMS, then the individual may have to pay a late enrollment penalty (LEP) when/if they join a Medicare Part D prescription drug plan, such as the one included in the BlueMedicare Group plans.
3	Is any assistance available to help members with their prescription copayments?	Medicare provides “extra help” to pay prescription drug costs for people who meet specific income and resources limits. If a BlueMedicare Group member qualifies then Medicare will help pay for the member’s prescription drug plan copayments. The amount of “extra help” provided depends on the member’s income and resources.

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		Member's automatically qualify for extra help and do not need to apply if they are receiving: • Full coverage for the state Medicaid program; • Help from Medicaid to pay Medicare premiums; and • Supplemental Security Income benefits. Member's can apply for extra help if their yearly income and resources meet the requirements specified by the Social Security Administration (SSA). The SSA will notify the member if approved and how to obtain "extra help." A qualified member will be re-certified by the SSA annually. Individuals should contact the Social Security Administration (SSA) for assistance 1-800-772-1213, 7 a.m. to 7 p.m. ET, Monday through Friday. TTY/TDD users should call 1-800-325-0778.
2	What phone number can a Benefit Administrator or prospective member call to obtain answers for questions pertaining to BlueMedicare Group plans?	There is a Membership and Billing Benefit Administrator Contact Center and the phone number is 1-866-946-2583 ext. 68154. This is a new department and they may not be able to answer all questions. In that event, the benefit administrator can call Gregg Kunemund or Smith Coffey. The toll free number is 1-800-477-3736 and the operator can transfer the call**. Prospective members or Benefit Administrators can also call WEBSO at 1-800-967-8938 for further information on the BlueMedicare Group plans, Monday – Thursday 8am-9pm, and Friday 9am-9pm.**
2	What phone number can agents or brokers call for assistance with BlueMedicare Group plans?	The Agent Service Center phone number is 1-800-267-3156.
1	What is an "Annual Notice of Change" (ANOC)?	The ANOC explains all benefit changes for the upcoming benefit year. BlueMedicare Group members will receive an ANOC (from BCBSF) prior to the employer group's annual open enrollment period.
1	How can a BlueMedicare Group	Members should only be billed for the portion of the service,

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	member resolve provider billing concerns, such as if the member believes they are receiving bills for amounts they do not owe?	which is their responsibility, such as copayments, deductible, co-insurance amounts, or charges for non-covered services. If a member has any questions about billed amounts they should contact Member Services at 1-800-926-6565 for assistance, between 8 a.m. and 9 p.m. ET, seven days a week. TTY/TDD users should dial 711.
1	Are BlueMedicare Group plans effective at any time of the month?	No, they are always effective on the 1st of the month.
1	Are BlueMedicare Group members covered when outside the United States?	For all BlueMedicare Group plans emergency and urgent care is covered worldwide. Members may be requested by the rendering provider to pay for the service up front and file a claim for reimbursement. Effective January 1, 2008, BlueMedicare Group HMO is available in certain counties (Broward, Hillsborough, Miami-Dade, Palm Beach, Pinellas and Polk). Members must receive care by participating providers within their service area, unless otherwise authorized or the care is urgent or emergency care. BlueMedicare Group PPO is available statewide with nationwide coverage (members must have a permanent address in Florida; however, they can travel for up to 6 months at a time). BlueMedicare Group PFFS has a nationwide service area. You can reside in all 50 states.
1	Will BCBSF cover hospital charges outside of the United States?	BCBSF provides coverage for emergency and out-of-the-area urgently needed services, as defined in the Evidence of Coverage. You or your designee should notify Member Services of the emergency as quickly as possible at 1-800-926-6565, between 8 a.m. and 9 p.m. ET, seven days a week. TTY/TDD users should dial 711. Most medical providers in foreign countries will not bill an insurance carrier and you may have to pay out-of-pocket. You will need to provide us with an itemized bill within 90 days or as soon as reasonably possible (no later than 1 year) for reimbursement consideration.
1	If care is rendered at an	Prescription medications can be filled at any of our participating

	QUESTION	ANSWER
	emergency room or emergency clinic outside of the BCBSF service area, and prescription medication is needed, where can the drug(s) be obtained?	pharmacies nationwide. As long as it is a covered medication, all applicable limitations and copayments will apply. If there is no participating pharmacy in the area, BCBSF will reimburse members for the prescription medication purchased outside the service area, as long as the prescription is related to the emergency condition. Members should submit receipts to **BCBSF Member Services** **8400 NW 33rd Street Suite 100** **Miami, Florida 33122-1932** Members should include an explanation as to why the prescription was purchased outside the service area.
1	Does BCBSF cover ambulance services and/or air transportation?	Yes. For emergencies, ambulance service including air ambulance transportation to the nearest hospital appropriately equipped and staffed to treat the condition is a covered benefit. Non-emergency transport is not covered unless pre-authorized by BCBSF. Please refer to your Evidence of Coverage for a complete list of covered benefits.
1	If the member's BlueMedicare Group plan becomes effective the first of the month and the member has an appointment on the 2nd, will there be any difficulty verifying coverage if the ID card has not been received?	If you have not received your ID membership card before your appointment, please present the "Acknowledgement Letter" you received from BCBSF, as it contains information validating your health and pharmacy coverage. Or, have the provider contact the BCBSF Member Service Department at 1-800-926-6565 for verification, between 8 a.m. and 9 p.m. ET, seven days a week. TTY/TDD users should dial 711.
1	In more rural areas of Florida, where can a BlueMedicare member have a mammogram?	A BlueMedicare Group PPO member's can go anywhere to obtain a mammogram; however, utilizing an in-network provider will result in less out-of-pocket expense. A BlueMedicare Group HMO must use in-network providers for their mammogram. A BlueMedicare Group PFFS member can go to any provider who accepts our plans terms and conditions for payment.
1	Are there any participating	Two of BCBSF's BlueMedicare Group statewide providers are

	QUESTION	ANSWER
	Diabetic Supply providers in the BlueMedicare Group PPO?	listed below and provide home shipping: Byram Healthcare can be reached by calling 1-877-902-9726 (1-877-Go Byram) for service anywhere in Florida. EdgePark Medical Supplies can be reached at 1-800-321-0591 for service anywhere in Florida. * Subject to change Refer to online Provider Directory for a complete listing of DME providers that may be available in your area at www.bcbsfl.com or contact Member Services at 1-800-926-6565, between 8 a.m. and 9 p.m. ET, seven days a week. TTY users should dial 711.
3	How does a member obtain a pharmacy directory?	A list of all BlueMedicare Group participating providers can be found in the online Provider Directory on our website at www.bcbsfl.com. Or, if you have questions or would like to obtain a printed version of pharmacy or medical providers, please call BCBSF Member Services 1-800-926-6565, between 8 a.m. and 9 p.m. ET, seven days a week. TTY users should dial 711.
	What should a BlueMedicare Group member do if they will be on vacation for several weeks and will run out of their medication before returning home?	BCBSF has a pharmacy network in the United States and Puerto Rico at the following pharmacies: Publix, CVS, Walgreens, Winn Dixie, Target, Long's and Genovese. Members may fill/refill prescriptions at one of the above pharmacies while on vacation. Additionally, a prescription for a 60 or 90-day supply may be obtained prior to leaving, subject to physician approval. This may be more convenient and would eliminate the need to find a pharmacy while traveling.
3	Do all BlueMedicare Group plans require selection of a Primary Care Physician?	No, only BlueMedicare Group HMO requires selection of a primary care physician.
3	If a member has a BlueMedicare Group HMO plan and would like to change their primary care physician. What is the process?	To change your primary care physician, you simply need to contact BCBSF Member Services at 1-800-926-6565, between 8 a.m. and 9 p.m. ET, seven days a week.
3	Why is a physician listed in the	A physician's panel status might change periodically. One of

	QUESTION	ANSWER
	Provider Directory as participating in the BlueMedicare Group plan but not available for selection?	BCBSF's goals is to assure accessible quality of care to our members. At times, adjustments to a provider's panel will be necessary. The decision to change a physician's panel status might be made by the physician directly and/or BCBSF. The final decision is always undertaken with the member's interest in mind. If you need assistance selecting a physician, please call BCBSF's Member Services Department at 1-800-926-6565, between 8 a.m. and 9 p.m. ET, seven days a week. TTY users should dial 711. The panel status notations are as follows: • Open Panel: Physicians will accept new patients. • Established Panel: Physician is only accepting patients currently under his/her care, such as a patient that switched from their one health plan to the BlueMedicare Group plan. • Closed Panel: Physician is not accepting any new BCBSF members, even if the member is a current patient and just switched their health coverage to the BlueMedicare Group plan.
1	Are authorizations required for physician appointments, including specialist appointments?	No. However, if you have BlueMedicare Group HMO then the physician may be required to obtain prior approval to render certain procedures.
1	If surgery is needed, is authorization required? How can a member verify that BCBSF has approved the authorization?	Depending on your plan type (BlueMedicare Group HMO, PPO, PFFS etc.) you may not need an authorization for surgical procedures. Please refer to your Evidence of Coverage for a complete list of covered benefits. For the convenience of our members, a toll-free number is available for members to confirm that their provider has obtained an authorization for services by calling 1-800-926-6565, between 8 a.m. and 9 p.m. ET, seven days a week. TTY users should dial 711.
1	What is Home Health Care?	Home Health Care offers medical services to a member who is homebound and does not require confinement in a hospital or other health care facility. Depending on your plan, prior authorization may be required. Home Health Care services may include, but are not limited to, the services of professional visiting nurses and other health care personnel for services covered under your contract, such as physical, occupational and speech therapy.

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	QUESTION	ANSWER
		Long-term care is mostly custodial care and is usually an exclusion; it offers a variety of services that help people with personal needs and activities of daily living over a period of time. Some long-term care can be provided in the home or in various types of faculties, including nursing homes and assisted living facilities. Please refer to the Evidence of Coverage for a complete list of covered benefits.
1	What is the difference between a physical exam and a periodic checkup? Does BCBSF cover both?	Physical exams technically refer to a complete examination of the entire body. A periodic check-up is a term that refers to the need for specific evaluations (like colorectal exams and pap smears). Period check-ups are recommended at various intervals, sometimes yearly. BCBSF covers physical exams and periodic checkups. Please refer to your Evidence of Coverage for a complete list of covered benefits and applicable copayments.
1	If a physician has requested a particular prescription medication for a member that requires a special exception for coverage by BCBSF, how is this handled?	The physician will submit the request to BCBSF. Then, BCBSF will notify the physician when the request has been processed. The member may contact their physician or BCBSF Member Services at 1-800-926-6565, between 8 a.m. and 9 p.m. ET, seven days a week to confirm processing/approval. TTY users should dial 711.
1	Should a BlueMedicare Group member go to the hospital in an emergency situation? Is there a copayment for emergency services.	In an emergency situation, BCBSF members may seek health care services at a hospital, health care provider or Urgent Care Center. Emergency services are covered for inpatient and outpatient services that are needed immediately because of an injury or sudden illness, which could reasonably be expected to result in death or risk permanent damage to your health. Member liability (usually copayment) is usually lower when care is rendered at a health care provider office or Urgent Care Center. Please refer to your Evidence of Coverage for a complete list of covered benefits.
1	What is the difference between	**Emergency room** services are for immediate injury or sudden

	QUESTION	ANSWER
	an urgent care center and an emergency room?	illness, which could be expected to result in death or risk of permanent damage to your health or loss of limbs such as chest pain, deep open wound, hemorrhages or multiple injuries. **Urgent Care Centers** are usually equipped to handle minor injuries and illness, such as fever, sore throats, and small cuts or bruises. In most cases, out-of-pocket cost for care received at an urgent care center is less than an emergency room.
3	What does it mean when a physician is Board Certified?	Board Certification means that the physician has completed the requirements set forth by the Specialty Board. This generally includes graduation from an approved medical school, completion of a residency program accredited by the American Board of Medical Specialties, and completion of comprehensive written and oral examinations in that field. BCBSF considers Board Certification a significant credential in evaluating physicians.
1	If the BlueMedicare Group plan has a yearly deductible and a member is having a procedure that will require payment of the deductible amount, such as a hospital stay, can the provider (such as the hospital) require payment of the deductible upfront or is the provider required to bill the member later?	The member is financially responsible for copayments, deductible, co-insurance, and any other applicable amounts. Normally, these charges are due upon receipt of the service or at the time of pre-admission to a facility. BCBSF encourages participating providers and members to discuss financial plans before services are rendered, whenever possible.
3	Will BCBSF replace prescription drugs that are lost or stolen?	BCBSF will not reimburse a member for lost or stolen medications. However, the member should contact their pharmacy or provider to obtain a replacement prescription.
3	How can a member determine if a prescription medication is covered under their BlueMedicare Group pharmacies benefits?	Members can refer to the comprehensive formulary for a complete list of covered drugs and applicable charges. A paper copy of the formulary was provided in the member post enrollment package. However, if a member is in need of one, they can access the online version at www.bcbsfl.com. Or, they can contact Member Services at 1-800-926-6565, between 8 a.m. and 9 p.m. ET, seven days a week. TTY users should dial 711.

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	QUESTION	ANSWER
3	Will BCBSF allow BlueMedicare Group members to fill prescriptions early in the event of a hurricane?	Yes, BCBSF will authorize early refills during disasters in the state of Florida (when the governor has declared a state of emergency). Contact Member Services at 1-800-926-6565, between 8 a.m. and 9 p.m. ET, seven days a week, for more information. TTY users should dial 711.
1	Are their participating Skilled Nursing Facilities (SNF) in the BlueMedicare Group PPO plans? And, is the 100 days limitation per plan year?	There is an extensive network of SNF's located throughout the state. Manor Care, with 12 facilities, is a preferred provider. BCBSF members have priority admissions. There is a 100-day limit per benefit period; however, unlike original Medicare, a 3-day hospital stay is not required prior to admission.
3	How can a BlueMedicare Group member determine their co-insurance amounts?	Co-insurance amounts vary, depending on the BlueMedicare Group plan and service rendered. If the type of service is known, the provider's office can usually provide the patient with the co-insurance amount prior to their visit date if requested. However, if a member is unsure of the co-insurance amount they have paid to a provider or an amount quoted from a provider, the member should contact Member Services at 1-800-926-6565, between 8 a.m. and 9 p.m. ET, seven days a week. TTY users should dial 711.
1	What is a benefit period?	A benefit period only applies to skilled nursing care. It is defined as the period that begins when admitted and ends 60 days after discharge. For instance, if admitted on July 1st and discharged on September 15th, the benefit period would run from July 1st to November 15th. If the patient is readmitted before the benefit period runs out, the original period is extended.
1	Is Home Health Services paid at 100% if care is rendered in network? And, are there medical policy guidelines such as a limit on days or a dollar limit?	Yes, covered Home Health Services are paid at 100% if care is rendered in network. The number of days that an individual gets is determined by Medicare and can vary based on the condition of the patient. Medicare does not assign a dollar limit nor limits the number of days. Medical necessity would determine when the services would end.
1	Do all BlueMedicare Group members have the same effective/expiration dates?	No, effective dates are based on the employer group's annual enrollment period. The majority of groups are effective on July 1, October 1 or January 1 each year. In addition, individuals can "age in" when they turn 65 and join during the plan year.

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	QUESTION	ANSWER
1	How can providers identify BlueMedicare Group members?	Providers should always request a copy of the member's current ID card. The ID card shows the plan name (e.g., BlueMedicare Group PPO, BlueMedicare Group HMO, etc). If a provider is unsure they can contact Member Services at 1-800-926-6565, between 8 a.m. and 9 p.m. ET, seven days a week. TTY users should dial 711.
1	How should a provider verify eligibility and benefits for BlueMedicare Group members?	Check eligibility and benefits electronically through the Availity® Health Information Network or by calling the Provider Contact Center at 1-800-727-2227.
1	Where should a provider call if they have questions about BlueMedicare Group plans?	Providers should contact the Provider Contact Center at 1-800-727-2227.
1	Are authorizations required for advanced imaging services for BlueMedicare Group plans?	Currently, authorization is only required for BlueMedicare Group HMO members. Provider should call NIA toll free at 1-866-326-6302 to authorize CT Scans, MRIs, MRAs, PET Scans, and Nuclear Medicine – Cardiovascular System Procedures when performed and billed in an outpatient or office location. Providers should verify authorization has been obtained before performing these services. Authorization for advanced imaging services is not required for other BlueMedicare Group products (such as PPO, PFFS) at this time.

Copy of a recent bulletin sent to all Florida Providers that explains claims submissions and member cost-share

November 2007

Determining BlueMedicare Group PPO Member Cost-Share Amounts

BlueMedicare[SM] Group PPO is a Blue Cross and Blue Shield of Florida, Inc. (BCBSF) Medicare Advantage plan sponsored by employers. Employer groups select BlueMedicare Group PPO plans for Medicare-eligible retirees and their Medicare-eligible dependants. BlueMedicare Group PPO provides prescription drug coverage and allows members to choose their health care providers with no referrals needed. Members also have the option to obtain services from out-of-network providers.

This communication provides helpful tips for determining and collecting appropriate member cost-share amounts.

How to Determine and Collect Member Cost-Share Amounts

If you are an in-network provider for BlueMedicare PPO*:

Bill BlueMedicare Group PPO members for the applicable in-network copay, coinsurance and/or deductible amounts for the service(s) rendered up to the contracted allowance. If the charge amount is greater than the BCBSF contracted allowance, the provider cannot balance bill the member or BCBSF for this portion.

Example:

- Your charge $200
- BCBSF allowance $100
- Member copay $15
- BCBSF payment $85
- Do not balance bill $100 (difference between charge and allowance)

BCBSF payment will be mailed to the provider.

* If you participate in BlueMedicare PPO, you are an in-network provider for both BlueMedicare PPO (for individuals) and BlueMedicare Group PPO. Samples of member ID cards can be found on our website at www.bcbsfl.com.

If you are not a BlueMedicare PPO provider but you do participate in Medicare OR you agree to accept Medicare assignment:

Bill BlueMedicare Group PPO members for the applicable out-of-network copay, coinsurance and/or deductible for the service rendered up to the Medicare allowance. If the charge amount is greater than the Medicare allowance, the provider cannot balance bill the member or BCBSF for this portion.

Example:

- Your charge $200
- Medicare allowance $100
- Member coinsurance $20 (20% of Medicare allowance)
- BCBSF payment $80 (80% of Medicare allowance)
- Do not balance bill $100 (difference between charge and allowance)

BCBSF payment will be mailed to the provider.

If you are not a BlueMedicare PPO provider and you are not a Medicare provider and you will not accept Medicare assignment:

Bill BlueMedicare Group PPO members for the applicable out-of-network copay, coinsurance and/or deductible amount for the service rendered up to the Medicare Limiting Charge for providers that do not participate with Medicare. A non-Medicare provider can collect an additional 15 percent of the Medicare allowance for the service(s) rendered (referred to as the "Limiting Charge Amount"). Any remaining amount above the defined Medicare allowance and the additional 15 percent cannot be billed to the member or BCBSF.

Example:

• Your charge	$200.00	
• Medicare allowance	$95.00	(Allowance is 95% of contracted rate)
• Medicare approved (Limiting Charge)	$109.25	(Additional15% of allowance ($95 + $14.25)
• Member coinsurance	$19.00	(20% of the $95 Medicare allowance)
• BCBSF payment	$76.00	(80% of the $95 Medicare allowance)
• Additional member liability	$14.25	(Additional 15% of the allowance)
• Do not balance bill	$90.75	(Your charge (-) Limiting Charge ($200 - $109.25)

BCBSF payment will be mailed to the member.

Important Filing Requirements per Federal Law

Any provider, regardless of participation status with Medicare or BlueMedicare Group PPO that renders care to a Medicare-eligible, MUST file the claim(s) on the patient's behalf (even though the patient is a member of a Medicare Advantage Plan). In addition, out-of-network providers that do not accept assignment cannot charge members more than 15% above the Medicare allowance, per federal law.

Verify Eligibility and Benefits through the Availity®[1] Health Information Network

You can verify eligibility and benefits and identify member responsibility through Availity at *www.availity.com*. You may also call the Provider Contact Center at (800) 727-2227.

Filing Claims

We encourage providers to submit claims electronically through the Availity® Health Information Network. Paper claims should be mailed to BCBSF at the following address:

Blue Cross and Blue Shield of Florida, Inc.
P.O. Box 1798
Jacksonville, FL 32231

Network Questions

If you would like information about joining BCBSF's BlueMedicare PPO network, call the Network Management Service Unit at (800) 727-2227, say "More Choices," then "Network Management."

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