

Retiree Health Benefits 2013 Frequently Asked Questions

- 1. I received a letter from Aetna telling me that CMS needs me to verify if I have other prescription drug coverage. Do I have to complete this form and return it?**

No you should disregard the letter and the form. The City has confirmed that your coverage is now through the Aetna Prescription Drug Plan (PDP) and approved by Centers of Medicare and Medicaid Services (CMS). Please call the Aetna on-site representative at 817-392-7780 if you have additional questions.

- 2. I have not received my Prescription I.D. card.**

If you have not received a card please call the Aetna on-site representative at 817-392-7780.

- 3. I am an active City employee who covers my spouse on my insurance plan. My spouse is also a City retiree. Is my spouse covered under the Medicare Prescription Drug Plan (PDP) or my plan?**

If you cover your spouse under your plan as an active employee, your spouse is covered on the same prescription plan as you. Your plan is the primary plan for both of you. If your spouse is also covered as a retiree, the City retiree plan (PDP) would be your spouse's secondary plan.

- 4. Why did my prescription copay cost more this year?**

There have been no change to the copays for the Traditional Choice Plan prescription coverage for 2013; however there is a \$50 per person deductible that must be satisfied each year before the copays are taken. Generally your first prescription of the year will include this \$50 deductible. However, since we moved to a group Medicare Part D prescription drug plan (PDP), the Medicare formulary for certain prescriptions may be in a different "tier" than they were under the prescription drug plan last year which could be a different copay. If you think you have been charged incorrectly, please call the Aetna on-site representative at 817-392-7780.

- 5. I received a book that included pharmacies and drug lists. Are these the only drugs and pharmacies I can use?**

No, the book you received is only a partial listing. You should be able to use the pharmacies and obtain the same drugs you have always used in the past. The book is a requirement from the Centers for Medicare and Medicaid Services (CMS); it does not list all 60,000 pharmacies

or drugs – the listing would be too cumbersome, however they are available on line at www.Aetna.com.

6. Can I still get my covered medications through mail order?

Yes, the mail order program has not changed. You can access Aetna Rx Home Delivery® for pharmacy mail-order services and Aetna Specialty Pharmacy® for hard-to-fill medications. With Aetna Rx Home Delivery® Service, you can order up to a 90-day supply of medications you use regularly delivered to your home or another location of your choice with no additional cost for standard shipping.

If you use Aetna’s Navigator system to order/re-order your prescriptions you will need to update your account information with your ***new prescription ID Card number***.

7. How do I re-order medications if I use mail-order services?

Mail order is still through Aetna. You can visit www.aetnarxhomedelivery.com to track and/or refill orders. You can also use the handy re-order form that is included in your first shipment. Another option for Aetna members is to re-order medications over the phone by calling 1-866-612-3862 (TDD 1-800-201-9457).

If you had refills available before January 1, they are still available. Remember the deductible does start over in January so you will have the \$50 deductible to pay.

8. What are prior authorization, step therapy and quantity limits?

Prior authorization is a program that is used to ensure the appropriate use of medications. Medications that require prior authorization require that you or your physician receive pre-approval from Aetna before the medications will be covered.

Step therapy is a program that is used to encourage the use of safe, cost-effective medications first. Medications that require step therapy require you to try a different drug for your condition before the drug your doctor initially prescribed will be covered.

Quantity limits are used to help ensure safe use and reduce costs. A quantity limit is the maximum quantity of a drug that will be covered within a certain period of time.

If the medication that your doctor prescribes for you has one of these restrictions (prior authorization, step therapy or a quantity limit), you are entitled to receive a 31-day supply of the Part D drug within the first 90 days of your enrollment. The period of time in which you are entitled to receive the transition supply is called your “transition period”. Upon filling of your transition supply of the medication, Aetna will send a notification to you and your prescribing doctor to explain the transition fill and what action you and your doctor need to

take. You should speak to your doctor about whether you should change the drug you are currently taking or request an exception before the transition supply ends. Your doctor can help you determine if there's a different drug on the formulary that would be equally effective for your condition. Or, your doctor may believe it's medically necessary for you to continue taking your current medication. In that case, you will need to ask for an exception to receive coverage for the drug. You can make the request for a formulary exception or your doctor can make the request on your behalf. However, it may be easier to have your doctor submit the request for you with all the required information needed for the authorization. If Aetna provides approval for you to continue on your current drug, Aetna will provide a medical exception and you will not have to make any changes.

9. Did the formulary change? Can I get the same drugs as last year?

Yes, it especially changed this year for participants in the Traditional Choice Plan because you went to a Medicare Part D approved formulary from a commercial prescription formulary. However, most drug formularies Medicare and/or commercial change each year. Aetna revises their formulary (commercial) listing so drugs may change tiers or come on or off the formulary each year. Medicare has its own formulary which may contain some differences from the one used by the City. The MAPD PPO and MAPD HMO use the same approved Medicare formulary.

You should be able to get the same drugs as last year unless they are on the Step Therapy listing and your doctor did not present the proper authorization. When you present your Aetna RX card at the pharmacy, the Medicare formulary will apply first and then default to the Aetna formulary if the drug is not on the Medicare formulary.

10. I have heard that PDP plans have “donut holes” or gaps in coverage. Does this apply to us?

No, the plan design (deductibles and copays) did not change. There is no donut hole or gaps in coverage with the City's Medicare prescription drug plans under the Traditional Choice Plan, MAPD PPO Plan, or MAPD HMO Plan.

11. I received a letter telling me I will be dropped from the plan. Why and what does that mean?

The Centers for Medicare and Medicaid Services (CMS) requires people to be enrolled in only one prescription drug plan (PDP). CMS considers the last enrollment received to be the one true enrollment. People who have double coverage through other employers or through an individual plan are affected by this relatively new CMS rule. If you have double coverage of a PDP plan you will need to decide which plan you prefer to be on. The City plan is a bundled plan meaning you have both medical and prescription coverage together. You cannot drop

just medical coverage or just prescription coverage. If you decide to drop the City plan, you will be dropping coverage for both medical and prescriptions and will not be allowed to re-enroll in the City plan. If you have received a letter about being dropped from the plan, please call the Retiree Hot Line 817-392-8644 if you would like to speak to someone about your options.

12. My doctor has suggested I enroll in a Medicare plan called Plus – should I consider this?

You should discuss this with your doctor. Plus is a new program called an Accountable Care Organization (ACO). An ACO is a group of doctors, hospitals, and other health care providers who work together to provide you with better, more coordinated care. Doctors and hospitals in an ACO communicate with you and with each other to make sure that you get the care you need when you are sick, and the support you need to stay healthy and well. An ACO isn't an HMO, managed care or insurance company. Unlike HMOs, managed care, or some insurance plans, an ACO can't tell you which health care providers to see and can't change your Medicare benefits. If your doctor participates in a Medicare ACO, you always have the right to choose any doctor or hospital who accepts Medicare at any time. If your doctor chooses to participate in an ACO, you will be notified. This notification might be a letter, written information provided to you when you see your doctor, a sign posted in a hospital, or it might be a conversation with your doctor the next time you go to see him or her.

If you aren't sure if your doctor or healthcare provider is participating in a Medicare ACO, ask him or her. For general information on ACOs, call 1-800-MEDICARE (1-800-633-4227) 24 hours a day 7/days a week. TTY users should call 1-877-486-2048.

Your participation in an ACO does not affect your coverage through the City of Fort Worth for medical or prescription coverage.

13. I tried to get my prescriptions from my normal pharmacy and they could not get my card to work. Why did my card not work at the pharmacy?

Occasionally a pharmacy will have new employees who are unfamiliar with the process or may be experiencing other technical difficulties. If you should have this happen please call the Aetna on-site representative at 817-392-7780 who will work with the pharmacy to process your prescription.

14. I tried using the Aetna navigator website. It was difficult to find what I needed on it. Who should I call for help?

The Aetna websites are always under review to make them more “user friendly” so changes may occur in the future. If you have any difficulties using the website or accessing information, please call the Aetna on-site representative at 817-392-7780.

15. I usually get my diabetic supplies from the pharmacy – will there be any changes?

Yes, there is an enhanced program that allows certain diabetic supplies such as strips, lancets or glucose meters to be covered at no cost to you. You will need to show the pharmacist your medical ID card along with your prescription ID card. You can also use the mail order program for these supplies and have them delivered to your home.

16. I received a letter telling me I may owe a late penalty premium – what is this and why did I get this letter?

This is the standard PDP acceptance letter sent to all new enrollees. You do not need to be concerned about owing a late penalty. You do not owe any late penalties as you have had continuous creditable coverage through the City’s prescription coverage since the inception of Medicare Part D. The City has provided CMS all the necessary information to confirm you had creditable coverage and do not have any late penalties. Please call the Retiree Hot-Line at 817-392-8644 if you have any questions.

17. I received a letter telling me I now have to pay extra premium to Social Security for Medicare Part D. Why did this happen?

Effective January 1, 2013, the City of Fort Worth bundled its Medicare Traditional Choice Plan with a Group Medicare Part D plan which enrolled all participants into Medicare Part D. The Affordable Care Act of 2010 mandated all Medicare beneficiaries enrolled in Part D who have a modified adjusted gross income of more than \$85,000 for individuals or \$170,000 for married couples filing jointly, pay an additional Medicare Part D Income-Related Monthly Adjustment Amount (IRMAA) based on their income. This became effective January 1, 2011 and the extra premium is paid directly to the Federal government.

18. Where can I find the phone numbers for help in understanding my benefits or getting help with any other issue related to my health coverage?

You may call:

- Aetna pharmacy management: 800-594-9390
- Aetna Rx Home Delivery: 866-612-3862
- Aetna On-site Representative 817-392-7780
- City Retiree Hot Line 817-392-8644

19. For retirees eligible for city-paid health insurance (i.e., hired before 10/5/1988), and specifically for those who don't have 40 quarters, what happens at age 65?

Retirees, age 65 or over, hired before 4/1/1986 and neither they nor their spouse have earned the 40 credits (quarters) to meet Medicare eligibility would enroll in the City's non-Medicare plans.

Retirees hired before 10/5/1988, but on or after 4/1/1986, and worked 10 years for the City have earned their necessary 40 credits for Medicare eligibility.

20. If the spouse of a retiree has 40 quarters, but is younger than the retiree, what happens when retiree's spouse turns 65?

If the retiree turns 65 before their spouse (or vice versa), their retirement health coverage under the City will become a Split Coverage (one on Medicare and one or more non-Medicare). The Medicare recipient would be placed on the Traditional Choice Plan and the non-Medicare member(s) would remain on the current non-Medicare plan.

The Split Coverage will remain until **both** retiree and spouse become Medicare eligible; when this occurs they will both be enrolled in the same Medicare plan. The retiree and/or retiree's spouse upon reaching age 65 and eligible for Medicare should send a copy of their Medicare ID Card to the Benefits Office and they will be contacted for their choice of Medicare plan. Or they can call (currently) Debby Smith at 817.392.2897 to discuss their choice of plans.

Please mail a copy of the card to: City of Fort Worth, Attn: Debby Smith HR/Benefits, 1000 Throckmorton Street, Fort Worth, TX 76102.

21. Does the retiree hired before 10/5/1988 always retain city-paid health insurance and not Medicare?

The City's Retirement Health Plan covers non-Medicare and Medicare retirees.

- a) Retirees, age 65 or older, hired prior to 4/1/1986 who will never acquire Medicare eligibility due to their employment with the City or through their spouse's eligibility are enrolled under the City's non-Medicare plans, i.e., Basic, Basic Plus, and Consumer Choice. Currently, the City pays 100% of the retiree's premium who is enrolled in the Basic Plan.

Retirees hired prior to 10/5/1988 and eligible for Medicare are enrolled in the City's Retirement Health Plan for Medicare Retirees, i.e., Traditional Choice Plan, MAPD PPO, MAPD HMO. These plans are offered by the City and coordinated with Medicare. Currently, the City pays 100% of retiree premiums for those enrolled in one of the City's Medicare plans.

- b) Explain how this relates to Part B.

The Medicare-eligible retiree can gain the most benefit from the City's Medicare plans if they are enrolled in Part B. Under the Traditional Choice Plan, Medicare pays primary. Under Part B, Medicare pays 80% and the Traditional Choice Plan pays the remaining balance of 20%, plus most uncovered expenses that Part B do not cover. With Medicare Part B, retirees generally have 99.5% of medical services paid for under the Traditional Choice Plan. Retirees enrolled in Part A only do not get the full benefit of the coordination of benefits between Medicare and the Traditional Choice Plan because the retiree assumes the cost that Medicare would have paid. To enroll in the City's MAPD plans you must be enrolled in Part A and Part B.

22. Is the retiree hired before 10/5/1988 and those on or after 10/5/1988 forced on Medicare, with the city covering the supplementary?

No. If you have earned the required 40 credits and receive Social Security payments, Social Security will automatically send you a Medicare ID card showing an effective enrollment date for Part A and Part B. You will be given the choice to keep or deny Part B enrollment. If you do not receive Social Security payments, you will need to initial your enrollment into Medicare by calling Social Security at least three months prior to your reaching age 65, you would also let them know if you want to enroll in Part B.

Once you are covered under Medicare Part A and incur medical claims, the City is notified of your enrollment into Medicare and will transfer you from the non-Medicare category to the Medicare Traditional Choice Plan. If you chose not to enroll in Part B, any Part B medical services will be processed as if you were enrolled in Part B and the City's Traditional Choice Plan pays 20% of the Medicare Allowable Amount. The retiree would be responsible for the 80% that would have been paid by Medicare.

23. Who should I call if I have questions about my Medicare eligibility?

For questions about Medicare eligibility contact the Social Security office. You may be penalized for not enrolling in Part B and/or Part D. Especially if you fall in one of the following categories:

- I have not earned 40 credits; my spouse has 40 credits and is younger than me
- I am a widow/widower
- I am divorced from a spouse I was married to for more than 10 years

Contact Social Security at 800.772.1213 or www.socialsecurity.gov

24. Why are health insurance premiums for retirees who cover their family not offered in rates for spouse only, then other eligible family members on a per person added? It seems unfair to charge the same for retiree and family with one dependent (other than spouse) the same as for a retiree with multiple eligible dependents.

The City, similar to other employers, uses the standard 4 tier rating [Employee, Employee & Spouse, Employee and Child(ren) and Family (employee, spouse and 1 or more children)] due to employee/retiree impact (changing results in more children, the higher the premium). Many employers have considered or actually moved to "unitized" pricing in recent years, where there is an incremental cost for each additional dependent, but it's still relatively rare. The City will consider the impact of "unitized" pricing on its health plan in future strategies.

25. Is there any truth in the rumors the City is going to quit paying the insurance premium for employees hired prior to 10/5/1988?

No, at the present time no request or proposal exists to eliminate the premium. This does not preclude any future changes may not occur.

26. What has been proposed to the City?

Karen Marshall, Human Resources Director, presented a Healthcare Strategy to the Council on April 3, 2012, on ways to slow down trend cost. You can go the City's Internet www.fortworthtexas.gov and click on the Fort Worth Video On-Line; Video Archive and pull her presentation plus the Informal Report that went to Council.