QUESTIONS AND ANSWERS

from the OCTOBER 1, 2021 UFT RTC WEBINAR

POSTED OCT. 13, 2021

Speaker Kim Parker generously provided written answers to some of the questions asked of her on the Oct. 1 webinar.

Please clarify the section called **Annual Maximum Out of Pocket**. Which kinds of health care payments would be included in the calculation of this expense. With current Medicare, I have no out of pocket except if I use a non-participating provider and then have to pay the 15% above the Medicare fee that is allowed for providers in this category. If I go to a provider who does not take Medicare at all, I have to pay the whole fee. I understand that the new plan is paying the 15%. Under the new plan, what other expenses would be counted toward out of pocket expenses?	**The annual maximum out of pocket accumulates from the members out of pocket expenses that include the annual deductible of $253 and the various member copayments for Medicare covered services. The foreign travel emergency copayments do not count towards the out of pocket maximum due to the fact that these are not Medicare covered services, all other copayments apply to the Annual Maximum Out of Pocket.** **The plan will cover the additional 15% excess fee.**

Please provide COBRA information for the MAP plan. What would the current cost be to the surviving dependent?	**The 2022 COBRA rate for the MAP plan is $7.50 per member per month. The premium will be $0 for 2023 – 2027.**

For those whose doctors who are not signing up with the MAP (Medicare advantage plan), GHI's advantage plan rep Kim Parker stated numerous times that though we will have to lay out their full (Medicare dependent) fees, we will be able to be reimbursed by calling the MAP's concierge. No mention was made about nonparticipating hospitals' charges. 1. Will we be reimbursed in full for them as well? 2. How long after the procedure do we have to file a claim for reimbursement? 3. What is the process involved? 4. What forms/papers are we supposed to submit? 5. How long will it take to be reimbursed once one has submitted their request for reimbursement? 6. What conditions could cause one's claim for reimbursement to be denied? 7. If the claim is denied, what provisions are there for an appeal process, including all timelines as above?	**Out of network providers will be able to bill the plan directly to avoid members having to pay for services up front and being reimbursed. If a member does pay for services, they will be reimbursed up to the maximum Medicare billing limit less any applicable copayment. This applied to both professional providers as well as facilities. There is not a hard-set time frame for filing claims, suggested to submit as soon as possible for timely payment.** **Claim submission information will be included in the evidence of coverage and on the back of the ID card. Clean claims must be paid within the CMS time frames, no later than 30 days.** **Appeals process and timing will be included in the evidence of coverage document under members rights and appeals section.**

There is a component to the Advantage Plus plan called Live online. It is a virtual program but it may not permit access for some of us who do not have computer or smart phones at home like me. Can the UFT advocate for a telephone access to that platform to permit some of us seniors who are not tech equipped.	**The Alliance is researching the ability to access Live Health On Line providers through a telephonic option only. An update will be provided.**

Does participation in the NYC MEDICARE ADVANTAGE PLUS mean that I am no longer a participant in the federal MEDICARE program?	**Under the NYC MAP plan members Medicare benefits are administered by the new plan. Traditional Medicare will no longer be processing any of the claims.**

1) We are all aware of the continued delay in the mailing and receipt of the Empire Enrollment Guide. Combining that with the delay in the release of the Evidence of Coverage (EOC) and the listing of the procedures that	**Members will have access to all documents within the opt out period allowing time to evaluate all of the information to make an informed decision regarding their benefit plan choice. Due to the CMS timing for**

require Pre-Authorizations, members will now have much less time to review the plan details and make an informed decision. Is it possible to approve another two (2) extension of the August 31 deadline until November 15 ?	**enrollments the opt out period cannot be extended past October 31st as that will have a negative impact member enrollment materials.**

Why does the opt out form get filed with insurance company rather than city or Union, and why does it require full social security numbers twice? The application to opt out is unclear and requires important personal information that can be stolen. Also, there is no clear information on how a spouse or a child under 26 fills out the form. Will a new form be sent to us with instructions how to fill it out? 2) The Opt-Out forms that have been provided request Social Security Numbers and Medicare Numbers. Without secure transmission of these forms there is a potential fraud and identity theft issue and concern. What can be done to immediately revise these forms and/or provide secure transmission to protect member's personal information ?	**The City has requested that the Alliance manage the opt out forms to ensure all are processed correctly prior to the final enrollment file submission. The social security number is required in order to correctly identify the correct corresponding member in the City's enrollment system. There are many members with the same name within the City's system.** **The non-Medicare eligible dependents will automatically be enrolled in the corresponding companion plan, which for the NYC MAP plan and Senior Care is the GHI CBP plan. Non- Medicare eligible dependents do not need to fill out a separate form.** **Members can use the secure electronic opt out method on the NYC Medicare Advantage Plus website at https://nyc-ma-plus.empireblue.com/ Or they can call in their opt out request at 833-325-1190**

3) The Opt-Out forms include the following instructions causing some members to question which section(s) they need to complete and which section(s) a spouse or dependent should complete. Is it possible, at this late date, to revise the instructions to be more specific? This section should be completed by the Medicare-eligible participant: Complete this section with the City Retiree's information:	**Each Medicare eligible participant will need to fill out a separate opt out form.**

One member who became Medicare eligible after January 1 and is in a "look alike Drug plan" until next year. He asked what steps are being taken to ensure that the transition for members in this situation is seamless and he doesn't have trouble getting prescriptions filled in the coming year. [He had a lot of trouble during the beginning of his Medicare enrollment as the pharmacists couldn't access the look-alike plan.]	**Members on the look alike drug plan, will receive a notice in November that they will be moved to the GHI Enhanced Medicare PDP plan. 21 days after the notice has been sent, the Enrollment will be submitted to CMS for processing. Upon approval from CMS, members will be updated to the PDP plan in the EmblemHealth system and new ID cards will be mailed.**

Medicare allows you to try Medicare Advantage without losing your access to Medigap. This is known as the Medicare Advantage trial period, or the Medicare "right to try."	**These statements apply to the individual plans.**

During this time, you can buy a Medicare Advantage plan and keep it for up to 1 year. If you leave the plan during that year, you'll be able to buy a Medigap plan without medical underwriting. You won't have to worry about being denied a Medigap policy or being charged a high rate. You can also return to original Medicare and, depending on which Medicare Advantage Plan you had, may be able to purchase a Medicare Part D prescription drug plan as well. Are these statements correct?	

Re-opening periods and joining and leaving plans. I believe Medicare has its own rules on when a person can go from Medicare to Medicare Advantage. Any open periods in our new plan has to conform. What about the once in a lifetime right to switch plan plans at any time. Does that comply with Medicare's enrollment rules?	**Members can change back to original Medicare during the fall transfer period and opt into the Senior Care plan at that time, or members can utilize their once in a lifetime change to switch back at any time during the year. These rules comply with Medicare enrollment rules.**

Please clarify opt-out/opt-in guidelines. We have been told that the opt-in/opt-out option is available on a yearly basis. One of our members got a call response from the welfare fund related to this issue and was told by an actual person the following: “If you opt-out this year (2022) you can opt-in in 2023 but you cannot opt-out again in 2024.” **Please clarify what the options are.**	**Members will have the ability to switch between the NYC MAP and Senior Care on an annual basis each year during the fall transfer period.**

Members have reported receiving incorrect or confusing information from the MAP “hotline”. Please clarify. Some members report that the MAP call line has told them that if they join the MAP plan they will NOT be able to rejoin GHI Senior Care.	**The Call center representatives have been provided clear updates that outline the ability members will have to opt back into Senior Care during the fall transfer periods.**

If I have GHI SENIOR CARE now , how to opt out but join a different plan for January 1, 2022?	**Members can only opt out to stay in their current plan. If a Senior Care member opts out they can only opt out to stay with Senior Care and not enroll into another City plan.**

If one opts out choosing to remain in Emblem/GHI Senior Care, must this form (Health Benefits Program Application/Change Form) also accompany the one to be filed (found on pages 34/35 in the MA booklet) ? It has to do with making sure one would have the 365 day hospitalization high option rider.	**If a member opts out to stay on Senior Care and they do not currently have the 365 hospital rider they will need to submit the Health Benefits Application to add the rider with the OLR.**

The call center has told members that they will not get confirmation that they opted out until after the October 31 deadline. What is their recourse if OLR claims they never received the opt-out confirmation?	**We have revised this and members will received an opt out confirmation letter as the opt out request is made.**

What is the length of the contract for the GHI Senior Care Plan beginning in 2022?	**The GHI Senior Care plan renews each year.**

How will premium payments be remitted by members for both the GHI Senior Care Plan and for the drug plan?	**The premiums will be deducted from the retirees' pension check each month.**

I was told by a friend and an Advantage Care representative that under Advantage a spouse who is not a member will receive the same benefits after the death of the	**A surviving spouse will be able to continue under the MAP plan in the event the retiree passes away. The 2022 COBRA rate for the MAP plan is $7.50 per**

member. Could you please ask if this is true? I have not seen it in print. How much will the COBRA for the plan be?	**member per month. The COBRA rate for 2023 will be $0 premium.**

We are all aware of the continued delay in the mailing and receipt of the Empire Enrollment Guide. Combining that with the delay in the release of the Evidence of Coverage (EOC) and the listing of the procedures that require Pre-Authorizations, members will now have much less time to review the plan details and make an informed decision. Is it possible to approve another two (2) extension of the August 31 deadline until November 15 ?	**Members will have access to all documents within the opt out period allowing time to evaluate all of the information to make an informed decision regarding their benefit plan choice. Due to the CMS timing for enrollments the opt out period cannot be extended past October 31st as that will have a negative impact member enrollment materials.**

The Opt-Out forms that have been provided request Social Security Numbers and Medicare Numbers. Without secure transmission of these forms there is a potential fraud and identity theft issue and concern. What can be done to immediately revise these forms and/or provide secure transmission to protect member's personal information ?	**Members can log their opt out information through the secure link found on the NYC Medicare Advantage website – https://nyc-ma-plus.empireblue.com/ Or they can call in their opt out to the call center at 833-325-1190.**

The Opt-Out forms include the following instructions causing some members to question which section(s) they need to complete and which	**Both the Medicare eligible retiree and Medicare eligible spouse will each need to fill out a separate opt Out form.**

section(s) a spouse or dependent should complete. Is it possible, at this late date, to revise the instructions to be more specific ? This section should be completed by the Medicare-eligible participant: Complete this section with the City Retiree's information?	**Updated instructions will be included on the Web site.**