

Public
Education
Employees'
Health
Insurance
Plan



For Medicare-Eligible Retirees and
Medicare-Eligible Dependents

Administered By:
Blue Cross and Blue Shield of Alabama

MEDICARE AND YOUR PUBLIC EDUCATION EMPLOYEES' HEALTH INSURANCE PLAN (PEEHIP) INSURANCE

Medicare eligible retirees and covered Medicare eligible dependents must have Medicare Part A (hospital insurance) and Part B (medical insurance). PEEHIP retirees use their Medicare Part A and Part B as primary insurance coverage and their PEEHIP Insurance as secondary coverage. With Medicare Part A and Part B as primary and PEEHIP Insurance as secondary, retirees have very good health care coverage. (See page 21 for information about Medicare Enrollment Periods. **Do NOT assume Medicare enrollment is automatic.**)

However, understanding how PEEHIP Insurance and Medicare work together can be confusing. PEEHIP and Blue Cross and Blue Shield of Alabama hope this brochure helps you understand how to make the best choices and get the care you need at the lowest cost to you. You can also refer to the regular PEEHIP benefit booklet for more information on the PEEHIP benefits. If you have questions, please refer to the "Customer Service" section at the end of this brochure for the appropriate phone number.

IMPORTANT NOTICE FROM PEEHIP ABOUT YOUR PRESCRIPTION DRUG COVERAGE

PEEHIP elected to continue providing prescription drug benefits to Medicare-eligible retirees and Medicare-eligible covered dependents even when these members are eligible for a separate Medicare Part D program. However, if a Medicare-eligible member or Medicare-eligible dependent chooses to enroll in a different Medicare Part D program, he or she will lose the PEEHIP prescription drug coverage.

Medicare-eligible members and covered Medicare-eligible dependents of retirees enrolled in PEEHIP still need and must have Medicare Part A and Part B but not a separate Part D prescription drug plan. Medicare-eligible members and dependents should not enroll in a separate Medicare Part D program if they are also enrolled in the PEEHIP Medicare Plus Coverage unless they want to lose their PEEHIP prescription drug coverage. **Beginning January 1, 2013, PEEHIP began offering a group Medicare Part D plan called Medicare GenerationRx. All Medicare-eligible members and covered Medicare-eligible dependents of retirees are automatically enrolled in the Medicare GenerationRx Part D program offered by**

PEEHIP unless they are already enrolled in a separate Medicare Part D plan or they chose not to participate by opting out.

CREDITABLE COVERAGE NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PEEHIP and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a standard Medicare drug plan or keep your PEEHIP drug coverage.

Effective January 1, 2013, the PEEHIP prescription drug benefit for Medicare retirees and Medicare covered dependents of retirees changed to the PEEHIP Employer Group Waiver Plan (EGWP) which is PEEHIP's Medicare Prescription Part D Drug Plan called Medicare GenerationRx. All PEEHIP covered Medicare eligible retirees and covered Medicare eligible dependents of retirees are automatically enrolled in Medicare GenerationRx unless you are enrolled in another Part D plan or you choose to opt-out. If you opt-out of this plan, you will have no prescription drug coverage through PEEHIP. If you are considering joining a standard Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a standard Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. PEEHIP has determined that the prescription drug coverage offered by the PEEHIP is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing PEEHIP coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a standard Medicare drug plan.

WHEN CAN YOU JOIN A STANDARD MEDICARE DRUG PLAN?

You can join a standard Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a standard Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT PEEHIP COVERAGE IF YOU DECIDE TO JOIN A STANDARD MEDICARE DRUG PLAN?

If you decide to join a standard Part D Medicare drug plan and drop your PEEHIP drug plan, your current PEEHIP drug coverage will terminate on the date that you enroll in a standard Medicare drug plan. Please be aware that you and your Medicare-eligible covered dependents will lose the PEEHIP drug coverage, and will not be able to get this coverage back until you drop the other standard Medicare Part D coverage. You cannot have PEEHIP prescription drug coverage and a standard Part D coverage at the same time. If you enroll in a standard Medicare Part D drug plan, you and your dependents will still be eligible for your current PEEHIP **health** benefits but will have no **prescription drug** coverage under PEEHIP.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A STANDARD MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with PEEHIP and don't join a standard Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE...

Contact PEEHIP at **1-877-517-0020** for further information. **NOTE:** You will receive this notice each year in the PEEHIP Advisor newsletter, and you can request a copy of this notice at any time.

Remember: Keep this Important Creditable Coverage notice. If you decide to join one of the standard Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about standard Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare and You” handbook for their telephone number) for personalized help
- Call **1-800-MEDICAR (1-800-633-4227)**. TTY users should call **1-877-486-2048**

An exception may apply to certain “low-income” individuals who may be eligible for prescription drug subsidies, and thus may be better off applying for a subsidy and Part D (two separate steps). For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1-800-772-1213** (TTY **1-800-325-0778**).

MEDICARE PART D PRESCRIPTION DRUG COVERAGE OFFERED BY PEEHIP

Effective January 1, 2013, all Medicare-eligible retirees and Medicare-eligible dependents of retirees covered under the Public Education Employees' Health Insurance Plan (PEEHIP) are automatically enrolled into the Medicare GenerationRx Part D Prescription Drug Program offered by PEEHIP. This change does **not** affect PEEHIP active members, non-Medicare eligible retired members, or members already enrolled in another Medicare Part D plan. Medicare GenerationRx (Employer PDP) is a Medicare approved Part D sponsor and is sponsored by Stonebridge Life Insurance Company. Participation in this Employer Group Waiver Plan (EGWP) is a win-win for Medicare-eligible retirees, covered Medicare-eligible dependents of retirees, and PEEHIP.

Medicare-eligible retirees and covered Medicare-eligible dependents of retirees need to use their Medicare GenerationRx ID card for prescription claims if they are enrolled in the PEEHIP Medicare GenerationRx Part D Prescription Drug Program, and use their Medicare Part A and B card for hospital medical services as primary coverage and use their current PEEHIP ID card as secondary coverage.

DEPENDENTS WHO ARE NOT YET MEDICARE-ELIGIBLE

The Medicare-eligible retiree's spouse or their other covered dependents who are not Medicare eligible will remain in the PEEHIP (non-Medicare) prescription drug plan. The non-Medicare dependent(s) should continue to use their current PEEHIP ID card and will not be enrolled in the Medicare GenerationRx program offered by PEEHIP until the dependent(s) becomes Medicare eligible.

To learn more about the Medicare Part D Prescription Drug Benefit, access the following resources:

Medicare Part D Prescription Drug Benefit Information Resources for Retirees

Telephone Number	Description
Medicare 1-800-MEDICAR (1-800-633-4227)	Medicare Help Line
Social Security Administration 1-800-772-1213	Recorded information and services are available 24 hours a day, including weekends and holidays.

Web Site	Description
Medicare www.medicare.gov	Provides access to information about Medicare and Medicare health plans.
Centers for Medicare & Medicaid Services www.cms.gov	CMS administers Medicare and Medicaid programs. A database of frequently asked questions is available.
Social Security Administration www.ssa.gov	Link to the Social Security Administration’s site for information on low-income subsidies and other resources.
AARP www.AARP.com/bulletin	Access the Medicare Benefit Drug Calculator, which illustrates what the Medicare drug benefit means to you.
Aging Parents and Elder Care www.todaysseniors.com	Senior Solutions is an independent organization providing information on issues to help seniors get the most out of retirement.
Benefits Check Up www.benefitscheckup.org	A service of the National Council on the Aging; helps find programs for people ages 55 and over that may pay some costs of prescription drugs, health care, utilities, and other essential items or services.
Destination Rx www.destinationrx.com	Provides a pharmacy discount buying service.
Medicare Rights Center www.medicarerights.org	Medicare Rights Center (MRC) is the largest independent U.S. source of health information and assistance for people with Medicare.
NeedyMeds.com www.needyMeds.com	Find information on patient assistance programs that provide no cost prescription medications to eligible participants.
Rxaminer.com www.rxaminer.com	Use this prescription drug comparison tool to find lower-cost prescription drugs.
Together Rx www.togetherrxaccess.com	Offers a prescription drug savings program.

PEEHIP, MEDICARE, AND BLUE CROSS AND BLUE SHIELD OF ALABAMA

Blue Cross and Blue Shield of Alabama works very closely with PEEHIP to administer your benefits. Under Medicare Part B (medical insurance), you can select the doctor of your choice; however, when the physician of your choice accepts Medicare assignment, Medicare and PEEHIP cover 100% of the Medicare approved physician services after you meet your annual Medicare Part B deductible for PEEHIP approved services. (You are responsible for paying your annual Part B deductible. It is not covered by PEEHIP.) Medicare pays primary and PEEHIP pays secondary. You must also pay up to a \$30 copayment for physician visits.

Under Medicare Part A (hospital insurance), Medicare pays primary and the PEEHIP plan pays secondary and will cover all **but** \$200 of the Medicare Part A inpatient hospital deductible plus a \$25 daily copay for days 2-5. You are also responsible for any special charges you incur, such as a private room or television.

A Medicare eligible retiree and/or a Medicare eligible spouse covered on a retiree plan must have both Medicare Part A and B to have adequate coverage with PEEHIP. (Most people don't pay a monthly premium for Part A but most people do pay a monthly premium for Part B. The Part B premium is paid to the Social Security Administration.) If you do not have Part B, PEEHIP will only pay 20% of the Medicare allowable fee as if you had Part B. You are responsible for the portion Part B would have paid, and you must pay up to a \$30 copayment for physician visits.

You pay less if you choose a doctor who is a Medicare participating doctor. The best way to find out is to call the physician's office and ask these two questions: "Does the doctor accept Medicare assignment? Is (s)he a participating Medicare physician?" A doctor who participates in Medicare accepts Medicare's allowable fee as full payment for his/her service.

Besides avoiding excess charges, another advantage of using physicians or suppliers who accept Medicare assignment is that they are paid directly by Medicare. Those who do not accept assignment collect the full amount of the bill from you. Medicare then reimburses you its share of the approved amount for the services or supplies received. **Regardless of whether your physician accepts assignment, (s)he must file your Medicare claim for you.**

An easy way to understand how PEEHIP works when you use a physician who accepts Medicare assignment is to remember that:

**MEDICARE PAYMENT
+ PEEHIP PAYMENT
+ VISIT COPAYMENT (when applicable)
= PAYMENT IN FULL***

* On services approved by Medicare and PEEHIP after payment of the \$200 inpatient deductible plus a \$25 daily copay for days 2-5, Part B deductible and physician visit copayment, if any, applicable at the time of service.

DEFINITIONS

MEDICARE ALLOWABLE FEE

The Medicare approved amount, also called the “Allowable Fee,” is the amount that Medicare determines to be a reasonable charge for the covered service. PEEHIP helps where Medicare leaves off, and it will pay the remainder of the “Medicare allowable fee” unless a portion is applied to the Medicare Part B deductible or there is a required physician visit copayment. If your doctor or supplier does not accept Medicare assignment and charges you more than the “Medicare allowable fee,” it is your responsibility to pay the difference.

However, if your physician is a Medicare Participating Physician, (s)he has agreed to accept Medicare’s allowable fee for services. Therefore, the services of a doctor who participates with Medicare will be covered in full for PEEHIP approved services after Medicare, your copayment and PEEHIP payments are made, and after the Medicare Part B deductible has been met.

MAXIMUM ALLOWABLE CHARGE

This is the maximum charge a physician who does not accept Medicare assignment may bill his patient. This charge is set by Medicare and is also referred to as the “Limiting Charge.”

EXPLANATION OF BENEFITS

Medicare will always notify you of any payment it makes on medical services you receive. This notice is called an “Explanation of Medicare Benefits” (EOMB).

Blue Cross will notify you of any PEEHIP payments by sending you a “Claims Report.” When a service is approved by Medicare, PEEHIP will consider the charges for payment after Medicare processes the claim.

MEDICARE PART A (HOSPITAL INSURANCE)

Medicare Part A is the portion of Medicare which covers inpatient hospital care. This includes coverage for semi-private room and board, general nursing care, and miscellaneous hospital services and supplies after the deductible. After Medicare pays primary, PEEHIP will pay secondary and all but \$200 for the Medicare Part A deductible and a \$25 daily copay for days 2-5. The PEEHIP Medicare member's cost per admission, under Medicare Part A, will be \$200 plus a \$25 daily copay for days 2-5 plus any personal items (i.e. television, telephone, etc). The following page provides more detailed information on inpatient hospital benefits.

MEDICARE PART B (MEDICAL INSURANCE)

Medicare Part B covers doctors' bills and other outpatient services which are medically necessary, such as: outpatient hospital services, certain home health care services, and various medical services and supplies. After you have met your annual Medicare Part B deductible, Medicare will pay 80% of the allowable fee and PEEHIP will pay the remaining 20% of the Medicare allowable fee for PEEHIP approved services. You are also responsible for up to a \$30 copayment on physician visits.

Medicare Part B also covers certain drugs and supplies that include but are not limited to those within the following categories: diabetes supplies (such as blood glucose test strips, lancets and blood glucose monitors); oral anti-cancer medications; respiratory medications; and immunosuppressants. Medicare Part B covered medications and supplies are excluded from coverage under the PEEHIP prescription drug benefit but will be covered under the Medicare Part B benefit. In most cases, if you choose to use a Medicare participating pharmacy or supplier, the provider will bill Medicare Part B and Medicare will pass your claim to Blue Cross Blue Shield (not MedImpact) for the secondary processing. You will not pay anything at the point of sale after you have met your annual Part B deductible when you purchase from a Medicare participating provider or pharmacy.

WHAT PEEHIP COVERS

INPATIENT HOSPITAL CARE

Medicare has a Part A (hospital) deductible for inpatient hospital care. This includes coverage for semi-private room and board, general nursing care and miscellaneous hospital services and supplies after the deductible. It also includes coverage for meals, special care units, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services that are part of the hospital

charges. Physician and other professional charges for services received in the hospital are not part of inpatient hospital care, but are covered under Medicare Part B benefits and PEEHIP (Major Medical benefits) .

BENEFIT	MEDICARE PAYS	PEEHIP PAYS	YOU PAY
Inpatient Hospital Charges	- All but the Part A deductible per admission - All but applicable coinsurance after 60 days	- All but \$200 per admission and a \$25 daily copay for days 2-5 - Applicable coinsurance after 60 days	A \$200 deductible plus a \$25 daily copay for days 2-5 and any personal charges (such as private room, telephone, TV, etc.).

If you are readmitted to the hospital for the same problem within 60 days of the original admission, you do not pay another deductible.

If you are readmitted to the hospital 60 days after discharge, Medicare requires another Part A deductible. PEEHIP will pay all but your portion of the Part A deductible (\$200) and a \$25 daily copay for days 2-5.

If you are hospitalized for more than 60 days, Medicare requires you to pay a coinsurance payment for days 61 to 90. PEEHIP will pay the coinsurance for you. If you need to use your 60 lifetime reserve days of care, Medicare requires a coinsurance payment each day and PEEHIP pays this coinsurance also.

If you have to use all your Medicare eligible hospital days, PEEHIP will pick up 100 percent of your hospital bill, except for personal items, after the \$200 deductible and the \$25 daily copay for days 2-5. The PEEHIP precertification requirements will also apply.

**AN OVERALL SUMMARY OF YOUR INPATIENT
MEDICARE + PEEHIP BENEFIT:**

When you are admitted to the hospital, you will owe a \$200 deductible plus a \$25 daily copay for day 2-5. Medicare and PEEHIP will take care of all other eligible hospital charges except personal preference items not medically necessary (private room charges, telephone, television charges, etc.).

OUTPATIENT HOSPITAL CARE AND PHYSICIAN SERVICES

Medicare Part B has a deductible for outpatient services.* Medicare and PEEHIP cover treatment received in the outpatient department of the hospital, including the facility charges for emergency room treatment, outpatient surgery, and all miscellaneous hospital supplies. The PEEHIP emergency room copayment and outpatient surgery copayment are waived for Medicare eligible retirees.

BENEFITS	MEDICARE PAYS	PEEHIP PAYS	YOU PAY
Outpatient hospital charges	80% of Medicare's approved amount after the annual Medicare Part B deductible	20% of Medicare's approved amount after the member meets Medicare Part B annual deductible and the \$30 copay for physician visits	Any charges** not covered by Medicare (including the Part B deductible) or not covered by PEEHIP*** and up to a \$30 copay for physician visits

* Your Medicare Part B annual deductible is set by Medicare and is subject to change. You are responsible for paying the annual Part B deductible.

** Including applicable copayments.

*** If your doctor does not accept Medicare assignment, (s)he may bill you at the time of service for the charges incurred. Medicare will reimburse you at 80% of the Medicare allowable fee and PEEHIP will pay the remainder of the Medicare allowable fee after the Part B deductible when the claim is filed with Blue Cross. You will be responsible for any charges not covered by Medicare or above the Medicare allowable amount on the unassigned charges or charges not approved by PEEHIP.

HERE ARE SOME EXAMPLES HOW PHYSICIAN COSTS CAN VARY*:

1) Your doctor participates in Medicare.

- The doctor bills Medicare: \$80.00
- The Medicare allowable fee for the visit is: \$60.00
- And, Medicare pays the doctor 80% of this or: \$48.00
- PEEHIP pays the doctor the other 20% of the Medicare allowable, or: \$12.00**

The physician takes Medicare assignment and accepts the Medicare allowable as full payment.

2) Your doctor does not accept Medicare assignment.

- The doctor bills: \$80.00
- Medicare pays 80% of its allowable fee, which in this case is \$60; and 80% of that is: \$48.00
- PEEHIP pays 20% of the Medicare allowable or: \$12.00**
- The doctor can balance bill you up to his Maximum Allowable Charge, which in this case is \$69, but no more, so \$9.00** you receive a bill for:

* The amounts shown are only examples and do not reflect any actual doctor's charge. Please remember PEEHIP does not pay any portion of the Part B deductible, so you will be responsible for any charges applied to the deductible in both examples.

** If the charge is for a service that requires a copayment, then you are also responsible for up to \$30 for that service.

EXAMPLES OF SERVICES COVERED BY PEEHIP (as Secondary Payer):

- Physician services.
- X-rays and lab tests.
- Home health and hospice care provided by Preferred Home Health and Hospice providers.
- Preventive care services when provided by a PPO physician (see your Medicare & You Booklet and your regular PEEHIP benefit booklet for a complete description of what is covered).
- Professional ambulance service to the closest hospital that could furnish the treatment needed for your condition. A physician must certify that the ambulance service was necessary and Blue Cross must approve it. Furthermore, the ambulance benefit does not pay for transportation from one hospital to another facility unless the condition is life-threatening AND cannot be addressed at the present facility.
- Prosthetics and orthopedic devices pre-approved by Blue Cross.
- Radiation therapy.

- Physical therapy & speech therapy (when Medicare approved and performed by a licensed provider).
- Medical supplies such as oxygen, crutches, splints, casts, trusses and braces, syringes and needles, catheters, colostomy bags and supplies and surgical dressings.
- Durable medical equipment pre-approved by Blue Cross.

In the **rare** situation that a service is not covered by Medicare but is covered by PEEHIP, such as your prescription drug charges, PEEHIP will be primary and all PEEHIP deductible and copayment amounts, precertification requirements and contract limitations will apply. In a case where Medicare covers something that PEEHIP does not cover, such as nursing home facility charges, PEEHIP will not make any payment in addition to what Medicare pays. Note: PEEHIP will not pay primary on Medicare covered services that are rejected due to your provider filing the claim incorrectly with Medicare. Please have your health care provider refile the claim correctly to Medicare for proper reimbursement.

EXAMPLES OF SERVICES NOT COVERED BY PEEHIP:

- Nursing home facility costs.
- Custodial care.
- Routine vision care (except accidental injuries, eye disease or medically necessary eye surgery).
- Occupational, recreational and educational therapy.
- Cosmetic surgery.
- Hearing aids.
- Experimental or investigational procedures.
- Services covered by Workman's Compensation laws or any other law that provides medical coverage.
- Travel, whether or not recommended by a physician.
- Charges in excess of the approved amount under Medicare Part B and/or any applicable copayments for physician visits.
- The Medicare Part B deductible.
- Dental services (unless related to an accidental injury).
- Charges for providers that are not approved by PEEHIP.
- Services for non-emergency ambulance transport not approved by Medicare and Blue Cross.
- Medications used to treat erectile dysfunction. Examples include, but are not limited to, Viagra, Ciallis, Levitra and Yohimbine.
- Experimental Drugs
- Prescription version of an Over the Counter (OTC) medication

- Over the Counter (OTC) equivalents (Items available over the counter without a prescription even when prescribed by a physician (such as vitamins and food supplements)
- Prescriptions for Medical Foods
- Other prescription drug exclusions can be found in the PEEHIP BCBS Summary Plan Document at www.rsa-al.gov/index.php/members/peehip/pubs-forms/.

PRESCRIPTION DRUG COVERAGE

The Medicare GenerationRx Prescription Drug Program administered by MedImpact gives you financial incentives to seek generic drugs and Preferred drugs when possible and to use participating pharmacies. There are no claim forms to file at participating pharmacies. Just show your PEEHIP ID card to the pharmacist so he or she will know you have this coverage. **Medicare eligible retirees and covered Medicare eligible dependents of retirees need to use their Medicare GenerationRx ID card for prescription claims if they are enrolled in the Medicare GenerationRx Part D Prescription Drug program offered by PEEHIP.** Medicare members will continue to use their Medicare Part A and B card and PEEHIP Blue Cross ID card for hospital medical coverage.

If purchased at a participating pharmacy, you pay a \$6 copay for each generic prescription, a \$40 copay for each Preferred brand name prescription and a \$60 copay for each non-Preferred brand name prescription. Approved maintenance drugs covered for a 90-day supply for a copayment of \$12 for generic, \$80 for Preferred and \$120 for non-Preferred. The drug must be on the PEEHIP approved Maintenance Drug List and must be prescribed for 90 days. First fill for a new prescription drug will be a 30-day supply. The PEEHIP Maintenance Drug List is available on the PEEHIP web page at www.rsa-al.gov/index.php/members/peehip/pharmacy/. If you use a non-participating pharmacy, you will pay the full amount of the prescription. Then you can submit a claim form to be reimbursed at the participating pharmacy rate. All PEEHIP copays and clinical utilization management programs will apply. Your out-of-pocket expenses will be higher if you use a non-participating pharmacy. Check with your pharmacist to make sure he or she participates.

A Preferred drug is a commonly prescribed drug that combines effectiveness and cost efficiency. Your physician and pharmacy should have a copy of the PEEHIP Preferred Medicare GenerationRx drug list. If a generic drug is not available, ask your physician to prescribe a Preferred prescription drug. The PEEHIP Preferred Medicare GenerationRx drug list is available on the Medicare GenerationRx website at www.medicaregenerationrx.com/PEEHIP.

You should also try to use a participating pharmacy whenever possible. For the name of a participating pharmacy in your area, you can visit the Medicare GenerationRx website at www.medicaregenerationrx.com/PEEHIP for Medicare- eligible members. If you are unable to use a participating pharmacy you will have to pay the full cost of the medication, and you can submit a manual claim form with your receipts attached. Manual claim forms can be obtained from the Medicare GenerationRx website at www.medicaregenerationrx.com/PEEHIP via the “Contact Us” link on the home page. These claims will be processed at the participating pharmacy rate less the appropriate copay. You will also owe any difference between the participating pharmacy rate and the charge. Benefits will be paid to you and not your pharmacy. If you use a participating pharmacy, you do not have to worry about filing claims or paying the difference between the pharmacy rate and the charge.

A participating pharmacy must dispense a generic medication when one is available.

Act 2002-266 Generic Equivalent Drug (Section 16-25A-18, Code of Alabama 1975)

As a condition of participation in PEEHIP, a pharmacist shall dispense a generic equivalent medication to fill a prescription for a patient covered by PEEHIP when one is available unless the physician indicates in longhand writing on the prescription “medically necessary” or “dispense as written” or “do not substitute”. The generic equivalent drug product dispensed shall be pharmaceutically and therapeutically equivalent and contain the same active ingredient or ingredients and shall be of the same dosage, form and strength.

PEEHIP ID CARD AND MEDICARE GENERATIONRX CARD

Medicare-eligible retirees and covered Medicare-eligible dependents of retirees will need to use their Medicare GenerationRx ID card for prescription claims if they are enrolled in the PEEHIP Medicare GenerationRx Part D Prescription Drug Program and use their Medicare Part A and B card and PEEHIP ID for hospital medical coverage.

WHY MEDICARE-ELIGIBLE RETIREES & MEDICARE-ELIGIBLE DEPENDENTS SHOULD PARTICIPATE IN THE PEEHIP MEDICARE GENERATIONRX PART D PRESCRIPTION DRUG PROGRAM

In past years, PEEHIP advised retirees not to sign up for an individual Medicare Part D Plan because retirees had prescription drug coverage under the PEEHIP plan. PEEHIP received subsidy money for these retirees under the Retiree Drug Subsidy (RDS) program by providing prescription drug coverage. However, in 2013, PEEHIP

moved its Medicare-eligible retirees and covered Medicare-eligible dependents of retirees to a group Medicare Part D plan which provides additional savings to PEEHIP while keeping your prescription drug benefits intact. Medicare-eligible retirees and covered Medicare-eligible dependents of retirees saw very little change in prescription benefits. In fact, as a result of this new plan, there were a number of benefits to switching to the EGWP program:

- **Significant Cost Savings** to the PEEHIP plan of an estimated \$26-\$28 million per year.
- **Minimal Disruption** to Medicare-eligible retirees and Medicare-eligible dependents with the same or lower out-of-pocket costs, using the same pharmacies, and having the option of Medication Therapy Management for qualifying members.
- **Low Income Subsidies (LIS)** that provide “extra benefits” to low income retirees who qualify.
- **E-prescribing**, which drives the best value and convenience for the retiree and PEEHIP.
- **Robust Communications Plan and Customer Call Center.**

DEPENDENTS WHO ARE NOT YET MEDICARE-ELIGIBLE

Medicare-eligible retirees and covered Medicare-eligible dependents of retirees are automatically enrolled in Medicare GenerationRx Part D Prescription Drug Program offered by PEEHIP unless they choose not to participate and officially “opt- out” of the program. The Medicare-eligible retiree’s spouse or their other covered dependents who are not Medicare eligible will remain in the PEEHIP (non-Medicare) prescription drug plan. The non-Medicare dependent(s) should continue to use their current PEEHIP ID card and will not be enrolled in the Medicare GenerationRx program offered by PEEHIP until the dependent(s) becomes Medicare eligible.

OPTING OUT OF THE MEDICARE GENERATIONRX PART D PRESCRIPTION DRUG PROGRAM

Medicare-eligible retirees and covered Medicare-eligible dependents of retirees have the choice to "Opt Out" of the Medicare GenerationRx Part D prescription drug program offered by PEEHIP. All members are mailed a pre-enrollment packet that includes a letter with opt-out instructions. Medicare-eligible retirees and covered Medicare-eligible dependents of retirees considering opting out should contact PEEHIP to discuss the impact of this important decision. PEEHIP can be reached at **1-334-517-7000** or Toll Free **1-877-517-0020**.

IMPORTANT: If you opt out of Medicare GenerationRx, you will lose your PEEHIP prescription drug coverage but can choose to keep your PEEHIP hospital

medical coverage. You can also choose to opt out of both the Medicare GenerationRx and the PEEHIP hospital medical plans altogether. If you opt out of both the Medicare GenerationRx and PEEHIP hospital medical plans, you will not be permitted to reenroll until the next PEEHIP Open Enrollment period of July 1 through August 31 for an October 1 effective date. If you have family coverage and you choose to opt out of both the Medicare GenerationRx and PEEHIP hospital medical plans, you will disenroll the entire family from both medical and prescription drug coverage.

CAN MEDICARE-ELIGIBLE RETIREES & COVERED MEDICARE- ELIGIBLE DEPENDENTS OF RETIREES ENROLLED IN PEEHIP'S MEDICARE GENERATIONRX PART D PRESCRIPTION DRUG PROGRAM BE ENROLLED IN AN INDIVIDUAL MEDICARE D PLAN?

No. Medicare does not allow a person to be enrolled in two Part D plans at the same time.

RETAIL PHARMACIES TO USE FOR THE MEDICARE GENERATIONRX PART D PRESCRIPTION DRUG PROGRAM

Medicare-eligible retirees and covered Medicare-eligible dependents of retirees can fill their prescriptions at their current pharmacy with no disruption if it is a Medicare Part D participating pharmacy. The Medicare GenerationRx national pharmacy network includes over 62,000 pharmacies. You can find the participating pharmacies in the pharmacy directory that was mailed in the pre-enrollment packet, or on line at www.medicaregenerationrx.com/PEEHIP using the Pharmacy Locator tool.

You should also try to use a participating pharmacy whenever possible. For the name of a participating pharmacy in your area, you can visit the Medicare GenerationRx website at www.medicaregenerationrx.com/PEEHIP for Medicare- eligible members. If you are unable to use a participating pharmacy, you will have to pay the full cost of the medication, and you can submit a manual claim form with your receipts attached. Manual claim forms can be obtained from the Medicare GenerationRx website at www.medicaregenerationrx.com/PEEHIP via the "Contact Us" link on the home page. These claims will be processed at the participating pharmacy rate less the appropriate copay. You will also owe the difference between the participating pharmacy rate and the charge. Benefits will be paid to you and not your pharmacy. If you use a participating pharmacy, you do not have to worry about filing claims or paying the difference between the pharmacy rate and the charge.

FORMULARY CHANGES FOR MEDICARE-ELIGIBLE RETIREES & MEDICARE-ELIGIBLE DEPENDENTS

Members enrolled with PEEHIP prior to 1/1/2013 as a Medicare-eligible retiree or covered Medicare-eligible dependent of a retiree were grandfathered in the new drug plan and are allowed to continue getting Part D-eligible drugs that they were currently taking at the same copay tier that they were currently paying, as long as they refill and take their medications as prescribed. This applied to any 30-day prescription medication filled at a retail pharmacy within 130 days prior to joining the plan and any 90-day prescription medication filled at a Choice90Rx pharmacy within 190 days of joining the plan. However, the copayments will increase to the higher tier and will lose its grandfathered status if the drug becomes non-Preferred under both the commercial and Medicare plan. This also impacted Medicare-eligible members and Medicare-eligible dependents who had obtained prior authorization (PA) for those drugs or had met a step therapy requirement. PA and step therapy history is recorded so Medicare-eligible members and Medicare-eligible dependents do not have to repeat that process. However, once the PA expires, the member is required to obtain an additional prior authorization.

Medicare-eligible members and Medicare-eligible dependents who are new enrollees with PEEHIP will be placed on Medicare GenerationRx's 4-tier national open formulary. Age-ins to Medicare coverage, who have a prescription drug claim history with PEEHIP, will be grandfathered and continue with their current formulary, as long as they refill and take their medications as prescribed. However, the copayment will increase to the higher tier and will lose its grandfathered status if the drug becomes non-Preferred under both the commercial and Medicare plan. PEEHIP has worked with the Medicare GenerationRx team to ensure that there are minimal changes within Medicare-eligible members' and Medicare-eligible dependents' benefit plan design by providing additional coverage that mirrors PEEHIP's current formulary.

The Medicare GenerationRx formulary drug list is included in the Welcome packet that all eligible Medicare-eligible retirees and Medicare-eligible dependents receive each year. The formulary is also available online at **www.medicaregenerationrx.com/PEEHIP**. Medicare-eligible retirees and covered Medicare-eligible dependents of retirees can also use the online drug search available on the website at **www.medicaregenerationrx.com/PEEHIP** to determine which drugs are covered along with the associated cost sharing, or they can call Medicare GenerationRx's Customer Service at 1-877-633-7943. TTY users dial 711. Customer Services is open 24 hours a day, 365 days a year.

If a drug is not included on Medicare GenerationRx’s list of covered drugs (formulary), Medicare-eligible retirees and covered Medicare-eligible dependents of retirees should first contact Medicare GenerationRx’s Customer Service. For a complete listing of all prescription drugs covered by Medicare GenerationRx, please visit www.medicaregenerationrx.com/PEEHIP.

PEEHIP provides enhanced prescription benefits so that members will have access to additional medications that have been excluded from Medicare Part D. These prescription drugs are not normally covered under Medicare Part D but are normally covered under PEEHIP’s commercial plan formulary. This is referred to as the wrap benefit.

PEEHIP MEDICARE GENERATIONRX PLAN COPAYS

The Medicare GenerationRx formulary (drug list) has a four-tier copayment structure:

	Preferred Pharmacies Up to 30-day Retail	Preferred Pharmacies Up to 90 day Retail (Choice90Rx) - PEEHIP Maintenance Drug List Meds Only
Tier 1: Generic	\$6	\$12
Tier 2: Preferred Brand	\$40	\$80
Tier 3: Non-Preferred Brand	\$60	\$120
Tier 4: Specialty*	\$60	\$120

*Specialty drugs are those with a cost of \$600 or more.

The Medicare GenerationRx plan includes a *Wrap* benefit, which provides full coverage if you reach the Medicare Coverage Gap, or *Donut Hole*. This allows member cost sharing to remain consistent throughout the coverage year. If members reach the catastrophic phase (\$4,700 in 2015), the benefit will either be the lesser of the corresponding tier copay or the default CMS-defined amounts as follows:

- Generic drugs – greater of 5% coinsurance or \$2.65 copay
- Brand drugs – greater of 5% coinsurance or \$6.60 copay

For more details on your prescription drug benefits, please refer to your Medicare GenerationRx benefit booklets and your regular PEEHIP benefit booklet.

HOW TO USE YOUR PEEHIP INSURANCE

1. When you go to the doctor or hospital, show them your Medicare I.D. card and your PEEHIP I.D. card.
2. Your doctor or hospital should first send the claim to Medicare in Alabama when the services are received in Alabama. See the section on the next page entitled “Out-Of-State Treatment” for instructions when services are provided outside Alabama. If Medicare approves the service and your PEEHIP identification number is on the claim, the claim will automatically be sent to Blue Cross for processing. Claims that are not approved by Medicare will not automatically be sent to Blue Cross by Medicare for consideration.

The address for Medicare is:

Medicare Claims
P.O. Box 830140
Birmingham, Alabama 35283-0140

If Medicare does not automatically send your claim to Blue Cross, you may file yourself by sending the claim form and your Explanation of Medicare Benefits (EOMB) to:

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
P.O. Box 995
Birmingham, Alabama 35298-0001

3. You will be responsible for paying any personal charges in the hospital, such as telephone, TV, and private room difference. You are also responsible for any charges in excess of the Medicare approved amount when you use a physician who does not take Medicare assignment. **Regardless of whether your physician accepts assignment, (s)he must file your Medicare claim for you.**

OUT OF STATE TREATMENT

When you receive medical treatment outside Alabama, **Medicare of that state is responsible for the payment of the claim.** In this case, the claim may not automatically be sent to Blue Cross. If the claim is not automatically sent to Blue Cross for secondary payment, you should send the EOMB from the other state to Blue Cross and Blue Shield of Alabama attached to a completed claim form, so

Blue Cross can consider the charges for payment. Use your PEEHIP identification number (from your PEEHIP ID card) and send the claim to:

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
P.O. Box 995
Birmingham, Alabama 35298-0001

If you receive medical treatment outside the United States, Medicare may not make payment. In this situation, if the services are medically necessary, PEEHIP will be primary and all PEEHIP deductible and copayment amounts and contract limitations will apply. File the claims to Blue Cross and Blue Shield of Alabama at the address listed above. The claims must be stated in U. S. dollars.

MEDICARE ENROLLMENT PERIODS

There are three times you can sign up for Medicare – Initial, Special and General Enrollment Periods. Medicare is for people aged 65 or older, under age 65 with certain disabilities, and any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or kidney transplant). **Do NOT assume Medicare enrollment is automatic.**

INITIAL MEDICARE ENROLLMENT PERIOD

You can sign up when you're first eligible for Part A and Part B. If you're eligible for Medicare when you turn 65, you can sign up during your Initial Enrollment Period. This is a 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65. Sign up early so that your Medicare is effective the first day of the month in which you turn 65. Do NOT assume you will automatically be enrolled in Medicare. If you are not drawing Social Security benefits, you will not automatically be enrolled and you must take action and sign up for Medicare.

If you enroll in Medicare the month you turn 65 or during the last 3 months of your Initial Enrollment Period, your start date will be delayed and your coverage will start one month after you sign up. Sign up early so you will have adequate coverage!

SPECIAL MEDICARE ENROLLMENT PERIOD

Once your Initial Enrollment Period ends, you may have the chance to sign up for Medicare during a Special Enrollment Period. If you are covered under a group health plan based on current employment, you have a Special Enrollment Period to sign up for Part A and/or Part B any time as long as you or your spouse (or family

member if you're disabled) are working, and you're covered by a group health plan through the employer.

You also have an 8-month Special Enrollment Period to sign up for Part A and/or Part B that starts the month after the employment ends or the group health plan insurance based on current employment ends, whichever happens first. If you enroll using a Special Enrollment Period, your Medicare coverage will begin the month after Social Security gets your completed request. If you are retiring and you (and your spouse if applicable) are Medicare eligible, make sure your Medicare Part A and Part B are effective the date of your retirement!

GENERAL MEDICARE ENROLLMENT PERIOD

If you didn't sign up for Medicare Part A or Part B during your Initial Enrollment Period when you were first eligible to enroll, or you don't qualify for Special Enrollment, you can sign up between January 1 and March 31 during the General Enrollment Period for a July 1 effective date.

Don't delay! If you are Medicare eligible and covered on a PEEHIP retired account type, you must have Medicare Part A and Part B to have adequate coverage with PEEHIP. PEEHIP will only pay secondary on your hospital and medical claims, so it is imperative that you contact your local Social Security Administration office to timely enroll in Medicare Part A and Part B. **Do NOT assume Medicare enrollment is automatic.**

NOW - some frequently asked questions from our PEEHIP retirees:

“If I have Medicare and PEEHIP, do I need to get other insurance, too?”

Probably not, especially if your physician accepts Medicare assignment. Most people, if they receive services from doctors who participate in Medicare, will have very little out-of-pocket expense, especially since many PEEHIP copayments are waived when Medicare pays primary, except the \$30 office visit copayment.

We don't want to talk you into, or out of, more insurance - we do want to help you make a good decision. And to do that:

- Calculate your out-of-pocket expenses for the last year or two.
- Figure out what part of these expenses additional insurance coverage would pay for.
- Compare your annual out-of-pocket expenses to the annual premium to decide whether you need other coverage.

“Will I receive a Claims Report telling me what PEEHIP has paid as my

Medicare supplement?"

Yes, the Claims Reports for Medicare eligible members are mailed once the claims are processed.

"How do I enroll in PEEHIP's Medicare GenerationRx group Part D Plan?"

Enrollment is automatic if you are enrolled in the PEEHIP hospital medical coverage. You DO NOT have to fill out an application or submit anything to PEEHIP.

NOTE: If you are enrolled in another standard Part D plan, PEEHIP will NOT enroll you in the PEEHIP Part D plan, and you will remain enrolled in your other Part D plan until such time that you choose to disenroll, then at that time you will automatically enroll in PEEHIP's Part D plan.

"Can I be enrolled in a Federal government health insurance plan such as Tricare, VA or other federal employee plan and have the Medicare GenerationRx plan offered by PEEHIP?"

Yes. The Federal government plans may coordinate benefits with PEEHIP and the new Medicare Part D prescription drug plan with the Medicare Part D Plan usually paying primary. More information on this topic can be found in the "Medicare and You" document at www.medicare.gov/publications.

"Will my current medications continue to be covered?"

Yes. The PEEHIP GenerationRx Prescription Drug Plan has what we call a "Wrap" benefit, which means that medications that are not normally covered under Medicare Part D that are covered by the regular PEEHIP drug plan will still be covered.

"Will my PEEHIP hospital medical premium change?"

No. There will be no increase or decrease in your PEEHIP premium due to the change in the prescription drug plan to PEEHIP's Medicare GenerationRx Part D plan.

"Will I get a new card and what about my PEEHIP Blue Cross Card?"

All Medicare eligible retired members and covered Medicare eligible dependents on a retired contract should have a PEEHIP Medicare GenerationRx Prescription Drug Plan ID card that should be shown to your pharmacy. This card has your name, your identification number and processing information for your pharmacy. If you have a Medicare eligible spouse or other Medicare eligible dependent on your PEEHIP coverage, that person will also have an individual prescription drug ID card with his/her name and personal identification number. **YOU WILL CONTINUE TO USE YOUR MEDICARE CARD AND YOUR PEEHIP BLUE CROSS AND BLUE SHIELD CARD WHEN YOU GO TO THE DOCTOR OR HOSPITAL.**

“What about my family members who are on my PEEHIP coverage, but are not Medicare-eligible?”

Family members/dependents who are on your PEEHIP hospital medical coverage, but are not Medicare-eligible will remain on the current PEEHIP Prescription Drug Plan and will not be enrolled in the Medicare GenerationRx Part D plan until they become Medicare-eligible.

ABOUT YOUR PEEHIP INSURANCE

Your PEEHIP program is FINANCIALLY RESPONSIBLE FOR PAYMENT OF YOUR BENEFITS. Blue Cross and Blue Shield of Alabama is only the **Administrator** employed by PEEHIP to process your medical claims according to the plan benefits. MedImpact is the prescription drug Administrator for PEEHIP.

YOUR BENEFITS are set by the PEEHIP Board and cannot be changed by the Administrators. Blue Cross and Blue Shield of Alabama and MedImpact are employed to better control costs while providing good service to you.

CUSTOMER SERVICE

We hope this brochure helps you understand your healthcare benefits.

BLUE CROSS BLUE SHIELD (Administrator for Hospital Medical Claims)

If you have questions regarding your health benefits, the Blue Cross Customer Service Department will be glad to help. Customer Service representatives are available from 8:00 a.m. to 5:00 p.m. Monday through Friday. The telephone number is **1-800-327-3994**. When you call about a claim, you should have the following information available:

- Your contract number
- Your group number (14000)
- The date of service
- The name of the provider (hospital, doctor, etc.)

Blue Cross also has a special 24 hour-a-day, 7 days a week, Customer Service forms request line, called Rapid Response. The number is **1-800-248-5123**. A voice activated system will ask for your name, complete mailing address, daytime phone number, what materials you are requesting, how many you need, and the contract number from your PEEHIP ID card. If you know the Blue Cross form number, you can request the item by that number. Your request is recorded and will be mailed to you the next working day if you answer all the questions completely. Allowing mailing time, you should receive your requested materials within 3 - 5 days (excluding weekends and holidays). Use Rapid Response to order materials such as:

- Alabama Preferred Provider Directories
- Claim forms
- Replacement ID cards
- Benefit booklets, brochures and other materials
- Duplicate Claims Reports

OTHER IMPORTANT BLUE CROSS PHONE NUMBERS

Fraud Hotline: **1-800-824-4391**

Preadmission Certification: **1-800-354-7412**

Blue Cross and Blue Shield of Alabama Website: **www.bcbsal.com/peehip**

MEDIMPACT (Administrator for the Core, Specialty and the Medicare GenerationRx Part D prescription drug plan)

If you have questions regarding your prescription drug benefits, You can reach MedImpact's Customer Service 24 hours a day, 7 days a week at the numbers shown below:

Medicare-Eligible Members:

Customer Service: **Medicare GenerationRx 1-877-633-7943 (Available 24 hours a day)**

Website: **www.medicaregenerationrx.com/PEEHIP**

Non-Medicare Eligible Members:

Customer Service: **1-877-606-0727 (Available 24 hours a day)**

Website: **https://mp.medimpact.com/ala**

MEDICARE

If you need to call Medicare, you can reach them at **1-800-633-4227**.

Medicare representatives are also available from 8:00 a.m. to 5:00 p.m.

Monday through Friday.

PEEHIP OFFICE

The address and phone number for the Public Education Employees' Health Insurance Plan office is:

Public Education Employees' Health Insurance Plan

P. O. Box 302150

Montgomery, Alabama 36130

Phone: **334-517-7000**

or

1-877-517-0020

Fax: **334-517-7001 or 1-877-517-0021**

NOTES

PUBLIC EDUCATION EMPLOYEES' HEALTH INSURANCE PLAN

P.O. Box 302150
Montgomery, Alabama 36130-2150

201 South Union Street
Montgomery, Alabama 36104

Phone: 334-517-7000
or 1-877-517-0020

www.rsa-al.gov



**BlueCross BlueShield
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association

450 Riverchase Parkway East
Birmingham, Alabama 35298

AlabamaBlue.com/peehip

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Rapid Response Forms Order: 1-800-248-5123

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