

## Questions and Answers Regarding Retiree Health Care Benefit Effective August 1, 2012

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- 1. How will the 90-day prescription order co-payments be done? Do you pay double when you get it? If that is the case, maybe a new category needs to be done - 10/40/80 and double.**

The two copays will be charged at the time the prescription is picked up at the pharmacy or mailed. This will apply to any prescription filled for 31-90 days. This only applies for medications written for a 84 to 90 day supply. Supplies of medication that are 31 to 83 days are not covered.

- 2. Mandatory generics - What is the difference in this and what we currently have with generics?**

**Mandatory Maximum Allowable Cost (MAC)** When a generic equivalent is available for a brand-name drug and the brand-name drug is dispensed, the member is responsible for the difference in cost between the brand-name drug and the MAC price, in addition to the applicable brand-name co-pay, regardless of whether the doctor indicates “DAW” (Dispense as Written) or not. This applies to both retail and mail-order. Medical necessity authorization may be available; if approved by BCBSM, product selection fee only is waived. If you are being charged more than the applicable co-pay for a brand-name drug, contact your physician and give them the BCBSM help desk phone number 1-800-437-3803 option 1. You can also ask the pharmacy to contact your physician as well. Your physician can either change your prescription to the generic or contact BCBSM to request authorization. If the authorization is approved, the pharmacy can reprocess the claim and fill the entire prescription. If the authorization is approved, you are still responsible for your applicable brand name co-pay. If the authorization is denied and you fill the prescription, you will be responsible for the brand-name co-pay plus the cost difference between the brand and generic drug.

- 3. Step Therapy - What is this?**

**Prior Authorization:** A process requiring the physician to obtain approval from BCBSM before prescribing select prescription drugs. The program targets high-cost brand-name drugs that have suitable lower-cost alternatives, or drugs with specific FDA-approved indications. Current users are grandfathered as long as they have a claim in the system within the last 180 days.

**Step Therapy:** An automated process that requires one or more drugs be used before coverage is extended to other drugs. Step therapy directs participants to effective, lower-cost drug treatments before moving toward more expensive therapies. Current users are grandfathered as long as they have a claim in the system within the last 180 days.

If a claim rejects at the pharmacy, contact your physician and give them the BCBSM help desk phone number 1-800-437-3803 option 1. You can also ask the pharmacy to contact your physician as well. Your physician can either change the prescription to a covered alternative or contact BCBSM and request authorization. If the authorization is approved, the pharmacy can reprocess the claim and fill the entire prescription. If the authorization is approved, you are still responsible for your applicable brand co-payment. If the authorization is denied and you fill the prescription, you will be responsible for 100% of the cost

**4. How does one know if they need prior authorization for new and/or certain other drugs?**

The BCBS custom formulary quick guide lists the most common prescribed drugs by class and tier. Any drugs with a (ST) or (PA) listed are subject to prior authorization or step therapy. A copy of this can be obtained at [bcbsm.com](http://bcbsm.com) or by contacting Human Resources. You can also log into the BCBSM website at [bcbsm.com](http://bcbsm.com) and use the On-line benefit tool to look up specific medications. You can also call the BCBS customer service number on the back of your BCBS card.

**5. If my dosage changes on the same drug that I have already been using will it need to be pre-authorized?**

This will not affect any prior authorizations approved by Blue Cross.

**6. Every time that I am prescribed a new drug will it have to be pre-authorized?**

It depends if the medication under the step therapy/prior authorization program or has a generic equivalent. Please see question #2 and 3 for more information.

**7. Will new prescriptions have to be generic?**

No but you may have to pay additional copays if you do not try the generic medication or your physician does not contact BCBSM in advance to request authorization. Please see question #2 for more information.

**8. What about the current drugs that I take that are not generic? Will I have to do something different prior to my next re-fill?**

It depends if the medication under the step therapy/prior authorization program or has a generic equivalent. Please see question #2 and 3 for more information.

**9. Can retirees get a list of those drugs covered under the \$40 and \$80?**

Please see question #4.

**10. How will the new deductibles and co-insurance work?**

Deductibles will work the same under the PPO2 and the PPO 4. Deductibles are paid on services rendered outside of fixed dollar copays (such as doctor's office visit copays, chiropractic visit copays, urgent care copays, emergency room copays, pharmacy copays) and preventive care services. Once the deductible is satisfied for the member, the member's services are subject to the percent copay. Deductibles start over every calendar year on January 1<sup>st</sup>. The PPO4 has a \$500 single/\$1,000 family deductible.

**11. Will we be starting over with a new deductibles and co-insurance on August 1<sup>st</sup>?**

All deductibles paid by a member under the PPO 2 from January 1 to July 31, 2012 will follow a member to the PPO 4 plan. You will have to meet any additional deductible amounts required by the PPO 4 starting on August 1, 2012.

**12. Using a Family Deductible of \$1,000, we are showing a max co-pay of \$3,000 thus \$4,000. Is this the same as the Family Out of Pocket (OOP) or is the Family Out of Pocket (OOP) something different and if so - what is it?**

The Family Out of Pocket Maximum (OOP) is the total of the deductible plus the maximum percent copay.

**13. Why limit the chiropractic visits if we are paying a \$20 co-pay? Is it 24 per year or no more than 2 every 30 days?**

24 visits per person per calendar year is the standard BCBSM benefit.

**14. What is covered under Preventive Care Maximum for retirees?**

Please see the chart below.

	In-network	Out-of-network
<b>Preventive care services</b> – *Payment for preventive services is limited to a combined maximum of \$250 per member per calendar year		
Health maintenance exam – includes chest x-ray, EKG and select lab procedures	Covered – 100%*, one per calendar year	Not covered
Gynecological exam	Covered – 100%*, one per calendar year	Not covered
Pap smear screening – laboratory and pathology services	Covered – 100%*, one per calendar year	Not covered
Well-baby and child care	Covered – 100%* <ul style="list-style-type: none"> <li>• 6 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 2 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> <li>• 1 visit per birth year, 48 months through age 15</li> </ul>	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunization Practices and the American Academy of Pediatrics	Covered – 100%*	Not covered
Fecal occult blood screening	Covered – 100%*, one per calendar year	Not covered
Flexible sigmoidoscopy exam	Covered – 100%*, one per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered – 100%*, one per calendar year	Not covered

**15. Will I be receiving a new Blue Cross card in the mail?**

New cards will not be issued for the August 1 benefit change.

**16. Please explain “the elimination of duplicate County health care and dental coverage”.**

Duplicate coverage for both retirees and employees of St. Clair County is being eliminated. If a retiree has a spouse who is working for or is retired from the County then they will need to choose which coverage they want to participate in OR they can each elect their own coverage. They may not be both a dependent and a participant on each other’s St. Clair County policy. If the retiree or their spouse has coverage through a separate employer then they may continue to be covered under both policies.

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