



# Frequently Asked Questions

Medicare Eligible Retiree Medical Coverage

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## General Questions about the Retiree Medical Plan for Members Age 65 & Over

### (1) I am over 65 and covered by the Retiree Medical Plan. What is my insurance coverage for 2020?

If you and/or your covered dependents are age 65 or over and enrolled in Medicare, you will now have a choice between a Medicare Advantage Plan or a Medicare Supplement Plan both administered by Aetna. The Aetna is one of the top carriers in the Medicare space and has a strong national network.

If you and/or your covered dependents are under 65 and not eligible for Medicare, or if you are living outside of the United States, your insurance coverage is afforded by a Preferred Provider Organization (PPO) plan administered by Blue Cross Blue Shield of Illinois (BCBSIL) (“BCBSIL PPO”), which uses the BCBSIL network of doctors and hospitals. The BCBSIL PPO is not a Medicare plan.

### (2) What is the difference between a Medicare Advantage Plan and a Medicare Supplement Plan?

A **Medicare Advantage Plan** is a plan offered by a private company that is approved by Medicare. Medicare Advantage Plans are also sometimes called “Medicare Part C” because they include both Medicare Part A (hospital insurance) and Part B (medical insurance). Coverage under a Medicare Advantage Plan means you still have Medicare, but your insurance coverage is managed and paid for by the Medicare-approved private company—in this case, Aetna.

With the Aetna Medicare Advantage Plan, you no longer interact with Medicare for coordination of benefits. Rather, Aetna coordinates directly with your providers and Medicare. If you have the Aetna Medicare Advantage Plan through the Retiree Medical Plan, you are still part of the federal Medicare program. Your medical services must be provided by a doctor who accepts Medicare, even though Medicare pays Aetna for your care instead of paying your doctor directly. The plan also offers benefits beyond traditional Medicare coverage, including routine hearing services, hearing aid coverage, membership in the Silver Sneakers fitness program, and vision discounts.

A **Medicare Supplement Plan** (also called a Medigap Plan) is a plan offered by a private company that coordinates payments with Medicare Part A and B. Medicare provides your primary medical coverage, and Aetna will process your claim under the terms of the Retiree Medical Plan once it knows the amount that Medicare has covered and paid. In Medicare Supplement plans, patients can go to any doctor or hospital in the United States that accepts Medicare. Traditional Medicare does not have a “network.” Referrals are not needed to see specialists and there is no prior authorization required to obtain services.

### (3) What if I am 65 or over and Medicare-eligible, but my covered dependent is under 65 (or vice versa), and we’re both enrolled in the Retiree Medical Plan?

You and your eligible dependents may be enrolled in different medical plans based on your Medicare eligibility. For 2020, the family member who is eligible for Medicare will be covered by one of the Aetna plans and the family member who is not eligible for Medicare will be covered by the current BCBSIL PPO. Note: If you and your dependent are both over 65, you must enroll in the same Aetna plan.

**(4) Will I be able to change my Aetna plan later?**

Yes, each year during Open Enrollment you will be able to switch plans.

**(5) How is prescription drug coverage affected as a result of the transition to the Aetna Medicare Plans?**

Your Medicare Part D prescription drug program continues to be administered by Express Scripts. The Aetna Medicare Plans do not include Medicare Part D prescription drug coverage. For information on your prescriptions, or to find an Express Scripts participating retail network pharmacy in your area, visit [express-scripts.com](http://express-scripts.com). You can also call Express Scripts Customer Service at 1-866-838-3979 (age 65 or over) or 1-800-935-7189 (under age 65).

**(6) I'm not familiar with some of the terms used in the Aetna Medicare Plan documents I received. How do I find out more?**

Please see the [Glossary of Terms](#) at the end of this FAQ for definitions of common terms.

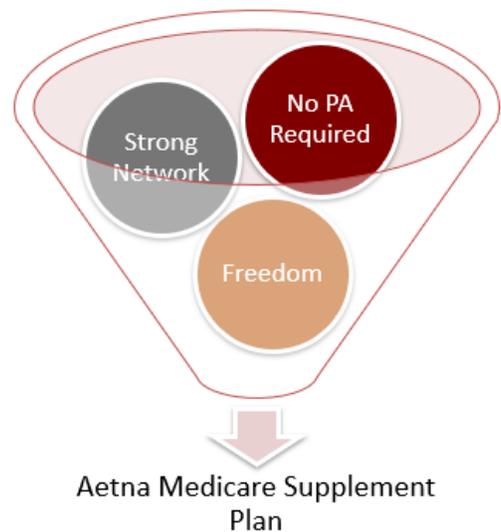
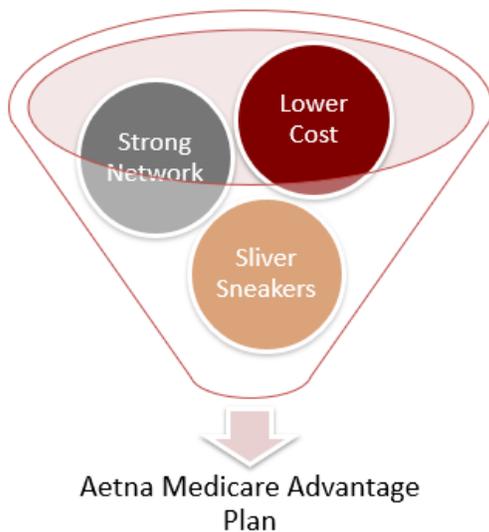
**(7) How do I reach someone at UChicago about my questions or concerns about the Retiree Medical Plan?**

The University benefits team is also available Monday through Friday, 8:30am-4:30pm CST at 1-855-822-8901 / [retiree@uchicago.edu](mailto:retiree@uchicago.edu).

**(8) How do I know which plan is best for me?**

You should ask yourself what is most important to you:

- ✓ Low out-of-pocket costs
- ✓ Low premiums
- ✓ Freedom to see any doctor
- ✓ Silver Sneakers and [additional benefits](#)
- ✓ [Strong Provider Network](#)
- ✓ No Prior Authorization (PA) required



## Questions about the Aetna Medicare Plans

### Providers, Networks, and Coverage

#### (9) I have an Aetna Medicare PPO plan ID card and my original Medicare card – do I need both?

If you are in the **Medicare Advantage Plan**, when you go to a regular medical appointment, **you must show your Aetna Medicare Advantage Plan ID card**. Do not use your Medicare card to obtain this care. (If you provide your Medicare card instead of the Aetna Medicare Advantage card, you may end up having to pay the full cost of the services you receive while using it).

You should retain your Medicare card in case you plan to participate in hospital-based research studies or want or need to obtain hospice services, as either may ask for a Medicare card. Your provider may also ask to see your Medicare card to verify that you are enrolled in Medicare.

If you are in the **Medicare Supplement Plan**, you will need to show your Medicare card and your Aetna Card. Aetna's Medicare Direct Program electronically links Medicare as the primary payer with Aetna as the secondary eliminating the need for you to file a claim to Aetna for secondary consideration. Retirees who are enrolled in Medicare Direct will know that the expenses have been submitted to Aetna by the notation on the Explanation of Medicare Benefits (Unpaid charges have been forwarded to your complementary insurer).

#### (10) What providers can I see under the Aetna Medicare Plans?

The **Medicare Advantage Plan** uses the Aetna Medicare Plan (PPO) with Extended Service Area (ESA). As a member of the Aetna Medicare Advantage Plan (PPO) with an Extended Service Area (ESA), you can receive services from any provider that is eligible to receive Medicare payment and is willing to treat you. Your cost share will be the same as in-network care. Out-of-network providers are under no obligation to treat Aetna members, except in emergency situations.

If your doctor accepts Medicare but is not part of the Aetna Medicare PPO network, they may ask you to pay upfront for services. If you decide to pay upfront, you can submit a request for reimbursement to Aetna which will reimburse you for the Medicare-allowable rates for covered services, minus your cost share (see question **18**).

You are not required to get a prior authorization to see an out-of-network provider, but you may want to make sure that your out-of-network doctor gets prior authorization for any services listed in the schedule of cost sharing.

The **Medicare Supplement Plan** has an open network with the same benefits in and out of network so you can see any provider that accepts Medicare and is willing to treat you.

#### (11) How do I check if my provider accepts Medicare?

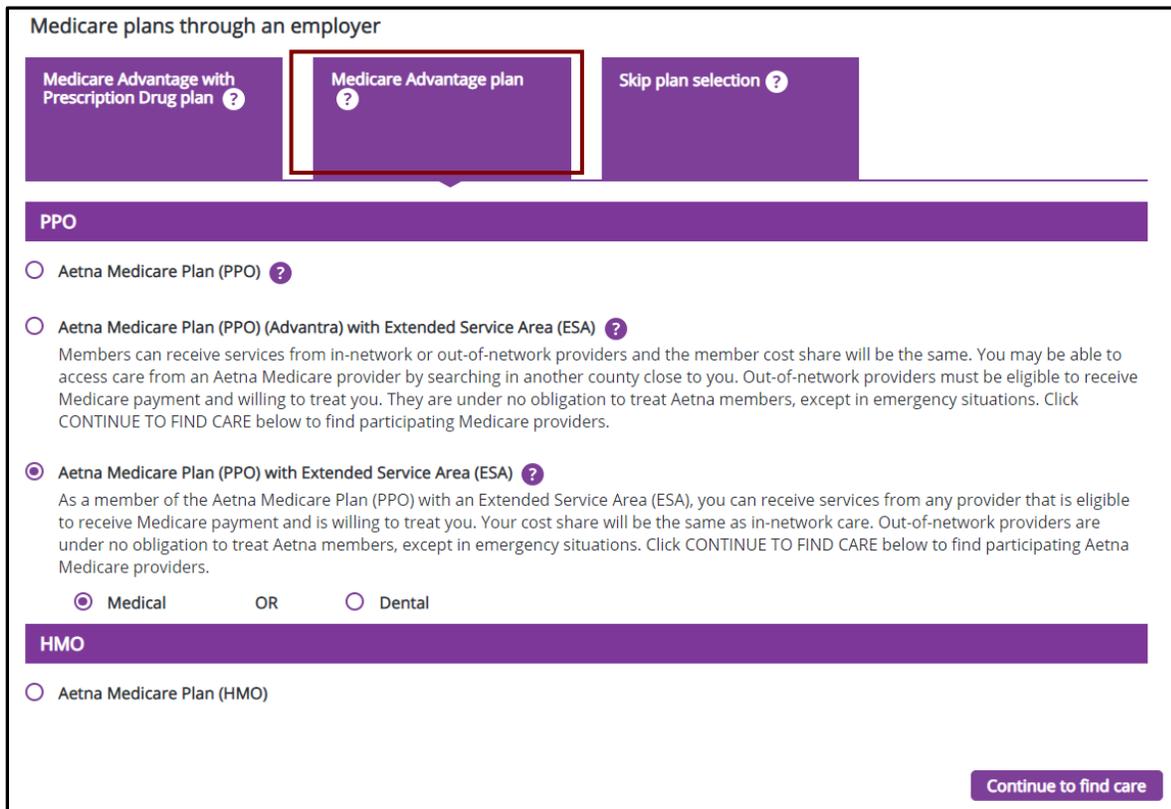
You may call your provider's office to verify. A list of all Medicare-contracted providers can also be found online at <https://www.medicare.gov/physiciancompare/>.

**(12) How do I check if my provider is in the Aetna Medicare PPO network?**

You may call Aetna’s Member Services for this information. Aetna representatives are available Monday through Friday from 8:00am-6:00pm local time at 1-888-267-2637. Prior to January 1<sup>st</sup>, call the pre-enrollment number 1-800-307-4830.

For the Aetna Medicare Advantage plan, you may also confirm online by visiting <http://aetnaretireplans.com>. For detailed instructions on how to search for a provider, review the [Step by Step Aetna Provider Search Instructions](#) on the Benefits website in the 2020 Retiree Medical section.

In brief, select *Medicare Advantage* on the Aetna website and then select *Aetna Medicare Plan (PPO) with Extended Service Area (ESA)*. Then select the “Medical” button. Click “CONTINUE TO FIND CARE” below to find participating Aetna Medicare providers. **Note: Our plan does not cover dental.**



Medicare plans through an employer

Medicare Advantage with Prescription Drug plan ?
  Medicare Advantage plan ?
  Skip plan selection ?

**PPO**

Aetna Medicare Plan (PPO) ?

Aetna Medicare Plan (PPO) (Advantra) with Extended Service Area (ESA) ?

Members can receive services from in-network or out-of-network providers and the member cost share will be the same. You may be able to access care from an Aetna Medicare provider by searching in another county close to you. Out-of-network providers must be eligible to receive Medicare payment and willing to treat you. They are under no obligation to treat Aetna members, except in emergency situations. Click CONTINUE TO FIND CARE below to find participating Medicare providers.

Aetna Medicare Plan (PPO) with Extended Service Area (ESA) ?

As a member of the Aetna Medicare Plan (PPO) with an Extended Service Area (ESA), you can receive services from any provider that is eligible to receive Medicare payment and is willing to treat you. Your cost share will be the same as in-network care. Out-of-network providers are under no obligation to treat Aetna members, except in emergency situations. Click CONTINUE TO FIND CARE below to find participating Aetna Medicare providers.

Medical    OR     Dental

**HMO**

Aetna Medicare Plan (HMO)

[Continue to find care](#)

**(13) What do I do if my doctor says they don’t accept the Aetna Medicare Advantage Plan?**

In some cases, doctors may say they don’t accept the Aetna Medicare PPO plan due to a misunderstanding of what your insurance plan really is. It is important that your doctor understand that you still have Medicare, and that the Aetna Medicare PPO is a Medicare Advantage Plan. You can provide them with the flyer available [here](#) to help educate them on the Aetna Medicare Advantage Plan.

As long as your provider accepts Medicare and have agreed to provide you with medically

necessary services, they can bill the Aetna Medicare Advantage Plan for your treatment even if they don't participate in the Aetna Medicare PPO network.

Note: The Medicare Supplement plan does not use the Aetna Medicare PPO Network because the doctor is billing Medicare directly. However, you can use the Aetna Medicare network as a guide to identify doctors that will accept Medicare.

**(14) What happens when you are an in-patient and your doctor or surgeon at the hospital takes the plan but other specialists that you need don't?**

If a member has a scheduled hospitalization, the scheduling provider would normally pre-certify the scheduled procedure/stay and all services would be covered under the hospital copay of \$250. Doctors are not allowed to balance bill members.

**(15) Will the Aetna Medicare Plans continue cover me if I move to another part of the country?**

Yes. You can go to any doctor or facility that accepts Medicare anywhere in the United States, Washington D.C, Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, and Northern Mariana Islands. The doctor or facility does not have to be in the Aetna network, though all of the same in-network/out-of-network differences will still apply. If you move to another part of the country, remember to update your contact information with the UChicago benefits team.

**(16) Will I have insurance when I travel abroad?**

The Retiree Medical Plan provides coverage outside of the United States for emergencies and urgent services only, through the Aetna Medicare Plan. This coverage is good for temporary travel up to six months at a time.

A medical emergency is when you believe that you have medical symptoms that require immediate medical attention. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

In an emergency, go directly to the nearest hospital. Call Aetna Member Services at 1-888-237-2637 when you need to locate a doctor or hospital or need in-patient care. Representatives are available 8am to 9pm EST.

If you anticipate extended travel abroad longer than six months, please contact the UChicago benefits team to ensure you and your covered dependents have routine coverage abroad: 1-773-702-9634 / [retiree@uchicago.edu](mailto:retiree@uchicago.edu).

**(17) Are there any pharmacy charges that are paid under Aetna and not Express Scripts?**

Vaccines covered under your Aetna medical plan include Medicare Part B Immunizations such as the Pneumonia Vaccine, Flu Shots and Hepatitis B Vaccine. There is no copay, coinsurance or deductible for these Medicare Part B covered vaccines.

Vaccines reimbursed under your Express Scripts prescription plan include Medicare Part D Immunizations such as Shingles, Diphtheria and Tetanus Vaccine. Members are required to pay the full charge out-of-pocket and get reimbursed from Express Scripts. Please note, in some instances a provider may charge more than Express Scripts allowable charge.

## Costs and Billing

**(18) Will I have to pay upfront for any services?**

In-network providers do not require payment upfront. See questions **10** and **12** for more information on in-network and out-of-network providers.

Providers that accept Medicare but are out-of-network may require payment upfront from you. Aetna will reimburse you for the Medicare-allowable rates for all covered services, minus your cost share (see question **10**). However, out-of-network providers are encouraged to contact Aetna directly at 1-800-624-0756 for information about how they can bill and receive Medicare-allowable rates for covered services without charging you upfront.

**(19) Where can I/my provider find instructions for how to bill the Aetna Medicare PPO?**

Basic billing instructions for providers are included on the back of your Aetna Medicare PPO ID card. You may refer your provider to these instructions if questions arise when you go for care. Providers are encouraged to contact Aetna directly at 1-800-624-0756 for information about how to bill and receive payment at the Medicare-allowable rates for covered services.

**(20) What are the key plan design changes for 2020?**

In the **Medicare Advantage Plan**, we reduced your out-of-pocket costs by reducing the deductible from \$300 to \$150 per individual and the out-of-pocket maximum from \$1,750 to \$1,000 per individual. The **Medicare Supplement Plan** looks very similar to the 2019 Medicare Advantage plan design, but that design is an enhancement over the 2018 Plan (see question **21**).

This side by side summary illustrates how the two plans compare. Anything indicated in **red** would be a lesser benefit than what we have now and anything in **blue** would be a benefit enhancement over the current Anthem plan. Please note that Part D prescription copayments and routine hearing services do not count toward your out-of-pocket maximum.

	Aetna Medicare Advantage	Aetna Medicare Supplement
<b>Deductible per Individual</b>	<b>\$150</b>	\$300
<b>Out-of-Pocket Max per Individual</b>	<b>\$1,000</b> <b>(Includes deductible, copays &amp; coinsurance)</b>	\$1,750 (Includes deductible & coinsurance)
<b>Office Visits</b>	Deductible, then <b>\$10/\$35</b> Copay	<b>Deductible, then 10% Coinsurance</b>
<b>Preventive Care</b>	100% Covered	100% Covered
<b>Lab Work</b>	Deductible, then 100% Covered	Deductible, then 100% Covered
<b>X-Rays</b>	<b>Deductible, then \$35 Copay</b>	<b>Deductible, then 10% Coinsurance</b>
<b>Durable Medical Equipment</b>	Deductible, then 10% Coinsurance	<b>Deductible, then 10% Coinsurance</b>
<b>Inpatient Hospital</b>	Deductible, then \$250 per admission	\$250 copay, then <b>10% coinsurance</b> after deductible
<b>Outpatient Hospital</b>	<b>Deductible, then \$50 Copay</b>	<b>Deductible, then 10% Coinsurance</b>
<b>Urgent Care</b>	\$65 Copay	<b>10% to max copay of \$65</b>
<b>Emergency Room</b>	\$100 Copay	Deductible, then 10% Coinsurance



**(21) What are the key differences between the old 2018 supplement plan and the new Aetna Medicare Supplement Plan?**

This side by side summary illustrates how the two plans compare. Anything indicated in **red** would be a lesser benefit than the 2018 plan and anything in **blue** would be a benefit enhancement over the 2018 plan.

	<b>BCBS 2018 Supplement</b>	<b>Aetna Medicare Supplement</b>
<b>Deductible per Individual</b>	\$300	\$300
<b>Annual Out-of-Pocket Max</b>	\$1,750 (per family) (Excludes deductible)	\$1,750 ( <b>per individual</b> ) <b>(Includes deductible &amp; coinsurance)</b>
<b>Office Visits</b>	Deductible, then 50%	<b>Deductible, then 10% Coinsurance</b>
<b>Preventive Care</b>	100% Covered	100% Covered
<b>Lab Work</b>	Deductible, then 50%	<b>Deductible, then 100% Coinsurance</b>
<b>X-Rays</b>	Deductible, then 50%	<b>Deductible, then 10% Coinsurance</b>
<b>Durable Medical Equipment</b>	Deductible, then 50%	<b>Deductible, then 10% Coinsurance</b>
<b>Inpatient Hospital</b>	Deductible, then 20%	<b>Deductible, then \$250 per admission &amp; 10% Coinsurance</b>
<b>Outpatient Hospital</b>	Deductible, then 50%	<b>Deductible, then 10% Coinsurance</b>
<b>Urgent Care</b>	50% Coinsurance	<b>10% to max copay of \$65</b>
<b>Emergency Room</b>	50% Coinsurance	<b>Deductible, then 10% Coinsurance</b>

**(22) Do out-of-pocket payments to an out-of-network provider count toward the annual deductible and out-of-pocket maximum?**

Yes, if the out-of-network provider accepts Medicare. Payments to a provider who does not accept Medicare are not covered and will not count toward your deductible or out-of-pocket maximum.

## Medicare Advantage Prior Authorization

### **(23) Am I required to get Prior Authorizations with Aetna?**

If you are enrolled in the Aetna Medicare Advantage plan, you may need to get a prior authorization for some services (see question **24**). If you are enrolled in the Aetna Medicare Supplement Plan, you are not required to get a Prior Authorization for services.

### **(24) Some of my Aetna Medicare Advantage Plan documents refer to “prior authorization” for certain services. What is Aetna’s prior authorization process?**

In some cases, your doctor may need to get approval in advance from the Medical Management Department for certain types of services or tests. (This is called getting “prior authorization’.) If you are using an in-network provider, the doctor is responsible for getting prior authorization. Services and items requiring prior authorization are listed in the Schedule of Cost Sharing included in the Evidence of Coverage. The provider would need to call 1-800-624-0756 option 3 to request a prior authorization.

You are not required to get a prior authorization to see an out-of-network provider, but you may want to make sure that your out-of-network doctor gets prior authorization for any services listed in the schedule of cost sharing.

### **(25) What is the turnaround time for prior authorization requests?**

Standard turnaround time for processing a prior authorization request is up to 14 calendar days. If your health requires it, you can request a “fast coverage decision” or “expedited determination.” If Aetna agrees to provide a fast coverage decision, turnaround time is up to 72 hours. Aetna will automatically agree to a fast coverage decision if your provider requests it for you.

Requesting prior authorization does not necessarily mean your services will be authorized. If your request is denied, Aetna will send you a written statement explaining their decision, and you can pursue an appeals process.

#### **For high tech radiology or other services handled through the Enhanced Clinical Review (ECR) Process**

In many cases, especially when the provider requesting the review has sufficient clinical documentation, the request can be preauthorized during the initial contact with the ECR -- either web-based, by phone call or fax. In general, approximately 60-65 percent of all requests are being approved during the initial request contact.

If additional information is requested or a peer-to-peer review (see question **26**) is required, Aetna generally require two business days after receipt of sufficient clinical information to review a request for medical necessity on non-urgent cases.

**(26) My provider has done “Peer-to-Peer” conversations with my insurance in the past when claims were denied. Can they do this with Aetna?**

Yes, Aetna offers peer-to-peer reviews right away when notifying providers of the intent to deny an expedited pre-service organization determination. They get this information when Patient Management calls to issue pre-denial notices.

Aetna offers peer-to-peer reviews, to practitioners, within 48 hours of the notification of the intent to deny a standard pre-service organization determination. This 48-hour period is the standard but Aetna may shorten or extend it for a particular case based on the available period for decision-making. Peer-to-peer reviews for imminent post-acute admissions (transfer to SNF/rehab/LTAC) are only available on the day Aetna notifies treating practitioners of the Medical Director’s intent to deny determination.

For Medicare Advantage, Aetna accepts a peer-to-peer request for any pre-service coverage decision that Patient Management makes, not just those on the prior authorization list.

**(27) What if I have a medical emergency?**

If you have an emergency, you should seek care immediately – you do not need to get prior authorization. You may get covered emergency medical care whenever you need it, anywhere in and out of the United States. (A medical emergency is when you believe that you have medical symptoms that require immediate medical attention. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse).

The Aetna Medicare Plans cover ambulance services in situations where getting to the emergency room in any other way could endanger your health. The doctors who are providing you with emergency care will decide when your condition is stable and the medical emergency is over.

It’s important that someone notifies Aetna Member Services (1-888-267-2637) of your medical emergency as soon as possible.

*Please note: This document is intended to provide general information regarding the Retiree Medical Plan for its Medicare-eligible population. In the event of a discrepancy between this document and the legal plan document, which governs the operation of the Retiree Medical Plan, the Plan document will take precedence. Contact the Benefits Office ([retiree@uchicago.edu](mailto:retiree@uchicago.edu)) for a copy of the Plan document.*

## Glossary of Terms

<b>Aetna</b>	The administrator of the Aetna Medicare Advantage and the Aetna Medicare Supplement plans members age 65 or over and enrolled in Medicare.
<b>Aetna Medicare Advantage PPO</b>	The Medicare Advantage plan provided by the Retiree Medical Plan for retirees and/or dependents who are age 65 or over and enrolled in Medicare. It is administered by Aetna.
<b>Aetna Medicare Supplement PPO</b>	The Medicare Supplement plan provided by the Retiree Medical Plan for retirees and/or dependents who are age 65 or over and enrolled in Medicare. It is administered by Aetna.
<b>Aetna Medicare PPO with Extended Service Network</b>	The in-network providers are in the Aetna Medicare PPO with Extended Service Network.
<b>Blue Cross Blue Shield Global Core</b>	The international travel or permanent residency healthcare program associated with the Retiree Medical Plan. It provides access to doctors and hospitals around the world through Blue Cross Blue Shield for retirees and/or eligible dependents who are age 65 or under and not enrolled in Medicare or who are living outside of the United States for more than six months, regardless of age.
<b>Blue Cross Blue Shield (of Illinois)</b>	The administrator for the insurance available to plan members who are under age 65 and not enrolled in Medicare. Though it mentions Illinois, the Blue Cross Blue Shield of Illinois network extends across the U.S.
<b>Coinsurance</b>	The percentage of the total cost of certain medical services that you pay.
<b>Copayment (copay)</b>	The fixed amount you pay each time you receive certain medical services.
<b>Deductible</b>	The amount you pay for medical services before your plan begins to pay its share.
<b>Extended Service Area (ESA)</b>	The ESA allows you to receive services from any provider that is eligible to receive Medicare payment and is willing to treat you. Your cost share will be the same as in-network care.
<b>In-Network Providers</b>	The facilities, providers and suppliers your health insurer or plan has contracted with to provide healthcare services.
<b>Medicare Advantage Plan</b>	A plan offered by a private company that is approved by Medicare. Medicare Advantage Plans are also sometimes called “Medicare Part C” because they include both Medicare Part A (hospital insurance) and Part B (medical insurance). If you have a Medicare Advantage Plan, you still have Medicare but your insurance is managed and paid for by the Medicare-approved private company (for UChicago, this is Aetna).



<b>Medical Necessity</b>	Services or supplies needed for the prevention, diagnosis, or treatment of a medical condition. This is typically determined by a Medical Director on behalf of your plan administrator (e.g., Aetna).
<b>Medicare Supplement Plan</b>	Also called a Medigap Plan. It is a plan offered by a private company that coordinates payments with Medicare Part A and B. While Medicare provides your primary medical coverage, it does not pay your claims in full. Aetna will process your claim under the terms of the Retiree Medical Plan once it knows the amount that Medicare has covered and paid.
<b>Out-of-Network Providers</b>	Doctors or other healthcare professionals or facilities that have not arranged to coordinate or provide covered services to members except in emergency situations. These providers are not employed, owned, or operated by the plan administrator and/or are not under contract with the plan administrator to deliver covered services to members.
<b>Peer-to-Peer</b>	The peer-to-peer process facilitates a conversation between your provider and a medical representative of your plan administrator (e.g. the Aetna Medical Director). These conversations can be requested following an adverse determination notice (claim denial) and are usually used to clarify information that your clinical record cannot convey to the insurance administrator.
<b>PPO</b>	Stands for Preferred Provider Organization, which is a medical care arrangement in which medical professionals and facilities provide services to subscribed clients at reduced rates. It is also sometimes used to stand for Preferred Provider Option and Participating Provider Organization, all of which refer to the same concept.
<b>Prior Authorization</b>	An advance approval from the Aetna Medicare PPO plans to receive covered services from in-network providers.
<b>Provider</b>	The general term used for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by the State to provide healthcare services.