

Active Faculty Members -- Health, Prescription and Health and Welfare -- Frequently Asked Questions

- 1. I am a new faculty member and need details about the PA Faculty Health and Welfare Fund benefits, where can I review these benefits?** The PA Faculty Health and Welfare Fund provide benefits as an extension or outside your medical coverage. The Fund covers a wide selection of dental and vision services plus a Wellness Exam (member/spouse), Mammogram, Hearing, Immunizations (member only), Flu and Pneumonia Vaccines (faculty only) Plans. All permanent and temporary full-time faculty are eligible for the full array of benefits and there is a separate schedule for part-part faculty members. Benefit descriptions and claim forms can be linked to off of APSCUF's home page (see right-hand side) or log in directly at www.pafac.com. If you have additional questions, please contact your campus Health and Welfare Specialist (see Health and Welfare Benefits link above for contact name) or use the E-mail link above.
- 2. Is there a separate deductible for the prescription program?** Yes. For 2004, the deductible was pro-rated at \$50 per person/ \$150 per family. Beginning on January 1, 2005, the deductible for the entire year is \$100 per person/ \$300 per family.
- 3. What does the tier structure mean?** Once a member/dependent satisfies the deductible which includes retail/mail-in purchases, the out of pocket amount or co-pay the member is responsible for is determined by whether the drug is generic, brand-preferred or brand non-preferred. The co-pays are as follows: generics \$5, brand-formulary \$10 and brand off-formulary \$20. **Members need to be aware that for both retail and mail-in prescription** that if there is a generic equivalent to any of the brand drugs being ordered, your provider must indicate on the prescription that the brand drug is medically necessary or the member will be charged the difference between the generic equivalent and the brand price.
- 4. What's the procedure for using the home delivery service?** You can mail in prescriptions or have your doctor fax prescriptions in to Medco using the following: **Via Mail:** Ask your doctor to write a new prescription for up to 90 days, plus refills (if appropriate) for up to one year. Then mail the new prescription(s) Home Delivery Pharmacy Service Order Form with the appropriate deductible/co-payment to Medco Health in the return envelope. If you are unsure of the amount due, call Highmark Member Service at 1-866-727-4935 with your prescription information and they will confirm the amount, or you can include your credit card information on the mail order envelope when you submit the prescription order. **Via fax:** Again, your doctor would need to write a new prescription for up to 90 days, plus refills (if appropriate) for up to one year. Give your doctor your member ID number. Your doctor will need to call 1-866-727-4935 for instructions on how to fax the prescriptions. The prescriptions should be delivered to your home within 10 to 14 days after you mail your order. Prescription Type Mail (up to 90-day supply) Generic \$10 co-payment Formulary (Preferred) \$20 co-payment Non Formulary (Non-Preferred) \$40 co-payment For more information go to www.highmarkblueshield or www.medco.com.
- 5. I am receiving a lot of materials concerning the new Medicare Part D plan – what do I need to do?** The PASSHE is retaining the retired group prescription plan. There will be no changes in your benefit structure or submissions of prescription drugs. The PASSHE is requesting that all retired members present their Highmark health/prescription insurance card each and every time a prescription is received. **Retired faculty who are enrolled with the PASSHE benefit health plan should not enroll with Medicare Part D.** Information concerning the new Medicare Part D plan has appeared in the APSCUF Newsletter and has been sent out by the PASSHE. Medicare Parts A and B are mandatory for faculty who retired on or after January 2, 1999. Those who retired prior to January 2, 1999, retain the choice to enroll with Medicare Part B but Medicare Part A is automatic in all cases.
- 6. I am getting married and/or had a baby or adopting a child, when and how do I enroll my new dependent?** You must contact your Human Resources office to add your new spouse within 60 days of the marriage. Your new young dependent must also be added within 60 days of the event. In all cases, it is very important to contact your Human Resources office as quickly as possible and complete and return the required enrollment application. Coverage does begin on the date of marriage as well as the date of birth/adoption – a newborn will be covered automatically for the first 31 days – however, if eligible dependents are not added within the 60 days – enrolled will be not permitted until the next open enrollment and benefits will not take effect until July 1.
- 7. How do I handle doctor office visits or consultations under the Classic Blue plan?** Effective July 1, 2002, providers who participate with Blue Cross and Blue Shield will electronically bill the services for you. Therefore, there is no need to pay the provider on the day of your visit. Blue Shield will forward the charge to major medical. Major medical will review the information and

determine whether or not you satisfied your annual deductible and out-of-pocket co-pay. If the deductible has not been satisfied, the provider will be notified and the provider will bill you for the full contract allowance. If the annual deductible has been satisfied, major medical will reimburse the doctor for 80% of the contracted allowance and you will be billed for the 20% co-insurance. If both the deductible and out-of-pocket maximum has been satisfied, the provider will be reimbursed the full amount of the contract allowance. If you use a non-participating provider, you or the patient may have to pay the provider directly for the incurred service. Obtain an itemized bill from the provider and submit the charge on Highmark Blue Shield's claim form. Highmark Blue Shield will reimburse you according to the above-referenced method. Please remember that if you seek professional medical assistance outside of PA, Highmark Blue Shield's major medical program will reimburse at two times the in-state rate.

8. **What is the out-of-pocket maximum?**

In calculating the level of reimbursement under major medical, Highmark Blue Shield must verify that the patient satisfied the annual deductible. Faculty members who retired prior to January 2, 1999, carry an annual deductible of \$100. Those who retired prior to July 1, 2002 carry a \$250 annual deductible and those thereafter carry a \$500 annual deductible. Once the deductible has been satisfied, major medical begins to reimburse at 80% of the contracted allowance. You are responsible for the other 20% of the contract allowance or to use Highmark Blue Shield's terminology -- out-of-pocket co-insurance. Once the out-of-pocket co-insurance reaches its maximum, \$350 for those who carry a \$250 deductible or \$380 for those who carry a \$100 deductible and \$300 for those with the \$500 deductible, the reimbursement level increases from the 80% level to 100%.

9. **My doctor is recommending that I obtain a colonoscopy, is it covered?** Under the Classic Blue plan, the only eligible preventive services are those that have been mandated by the Commonwealth of PA. A colonoscopy is not one of those listed services. Under the Classic Blue plan, eligibility is based on medical necessity – your provider can contact Highmark and provide the diagnostic/ procedure codes to determine eligibility. Under the PPO plan, a colonoscopy can be obtained at age 50 or after and the benefit is only eligible once every 10 years – there are certain limitations and restrictions with this and other like services, check the PPO preventive schedule and have your provider contact Highmark for approval prior to receiving any of the services.
10. **I am still an active faculty and am turning 65, what am I suppose to do?** If you are receiving Social Security benefits, you will need to notify Social Security that you are still actively working and need to waive for Medicare Part B rights until you retire. Medicare Part A automatically covers you, but as a secondary insurer until you retire. This information would apply to a spouse as well.
11. **I am thinking of retiring in the near future, what benefits will I take into retirement?** Please refer to the Pre-Retirement Check List on this site you details and check out the APSCURF page.
12. **During the annual open enrollment periods, you may have questions concerning dual health insurance coverage - TRYING TO DECIDE WHETHER OR NOT TO OPT OUT OF YOUR HEALTH BENEFIT COVERAGE AND GO WITH YOUR SPOUSE'S PLAN DUE TO THE EMPLOYEE PREMIUM CO-SHARE? The following situations were addressed by the State System. The questions disclose how the State System will handle faculty members who have dual benefit coverage and may wish to opt out of State System coverage.**

Please note: If your spouse is employed outside the State System/Commonwealth, you MUST check the governing rules on spousal coverage. Some plans contain provisions that mandate coordination of benefits with or without fully funded employer benefits. Under normal conditions, the PASSHE holds an annual open enrollment in the Spring of each year. Benefit changes become effective on July 1.

How will the following situations be handled in regard to premium co-share benefit level choices?

- a. Two married faculty employees with no children, both on separate contracts. If one enrolls as a dependent, do both employees still pay premium co-share? It was noted at one of the meetings that if premium share is taken from all employees, it is cheaper if two separate are maintained. [If one of the employees waives coverage and enrolls as a dependent, that employee will not pay a premium co-share](#)
- b. Same above situation but with children -- [See answer to a. above](#)
- c. Two employees, one management and one faculty, with or without dependents -- [See answer to a. above](#)
- d. Two employees, one AFSCME and one faculty member, with or without dependents -- [See answer to a. above](#)

e. One active faculty member and one retired faculty member without premium co-share. If the active goes on to the retiree's coverage will premium share be taken or waived until such a time as that active member would need separate coverage under the medical, e.g., spouse dies? -- See answer to a. above

f. If a retired member is covered under an active member's policy, can they both revert to the retired member's coverage with no co-share? Yes, though this would have to occur at the open enrollment period. Serious consideration should be given to what is best for the individuals since the prescription drug coverage for active employees will be significantly different than the Rx coverage for annuitants who retired prior to 7/1/04.

g. Would any of the above situations affect separation of coverage in the future? As long as the individual met the AHCP eligibility requirement, they would be eligible to enroll as an annuitant in the future. The guidelines for the AHCP are that an individual has a one-time opportunity to enroll in the AHCP, and that must occur at the time they begin receiving their annuity -- unless they are a dependent on another State System health care program contract (active or annuitant).

h. If an active faculty member goes on to a retiree's plan, does this affect the health and welfare benefits since it is a separate enrollment and contribution? No

i. If an active member chooses to opt out of the State System's coverage and instead elects coverage under their spouse's plan, will the System give that member a determined amount of money for not taking the coverage? No