April 2018 Newsletter

Insurance/Health --- Joe Polce

EGWP + Wrap Issues

It's been three years since the Medicare retirees were moved into the Medicare Part D prescription drug program (EGWP + Wrap). For review, the Employee Group Waiver Program (EGWP) has been working very well. The Wrap part of the program insures the Medicare retirees continue to have the same prescription benefits in place prior to the change.

On occasion, CVS reps fail to recognize the Wrap part of the plan. This was a problem in the beginning but as time passes, new reps are employed and may not fully understand the plan. This is where an informed consumer is very important. If information is provided that indicates that a drug is not covered, the first question should be related to the Wrap part of the plan. If this does not provide an adequate remedy, a call should be made to Doris Toms (301 644 5052). Again, the Wrap part of the plan should be part of the discussion.

The covered drug list changes quite often. On occasion a drug may be reclassified from a Tier 2 to a Tier 3 category. This would mean that the drug is now a Non-Preferred Brand instead of a Preferred Brand drug. CVS is required to notify the member if negatively affected by tier changes or drug exclusions 30-45 days prior to the effective date. This simply changes the co-pay. This should not change the availability of the drug. Please remember that co-pays have not changed. If the co-pay is more than the Tier allows, there is a problem, so ask questions. There are many times that that cost of the drug is less than the prescribed co-pay. This deals mainly with Generics. A brief outline of the prescription drug plan can be viewed at fcps.silverscript.com.

Medicare Payments

The Medicare explanation of benefits will indicate the maximum amount that you may be billed. This amount is paid by United Health Care after the $183.00 deductible has been met. There have been occasions where a provider has billed a Medicare patient for the amount not paid by either of the insurers. This is called balanced billing and is prohibited by the Medicare contract. Always refer to the maximum amount that you may be billed line on the Medicare EOB if there are problems with billing. Medicare EOB's are available at www.mymedicare .gov.

Non-Medicare members are subject to balanced billing if the provider is not in the plan network. UHC only covers 80% of the eligible expenses. The remainder may be billed to the patient.