2015

Frequently Ask Questions
For your 2015 Medicare Enrollment

OneExchange™
from Towers Watson
Based on feedback from IBM retirees, we are sharing the following information to help you better understand certain aspects of the enrollment process that are different and more heavily regulated than the process of signing up through the IBM Employee Service Center for IBM’s group coverage. We hope that the following information will help make the transition into individual insurance plans as easy as possible.

**Enrollment**

**Q1: How long is the process to enroll with a OneExchange benefit advisor?**

**A:** Because the benefit advisors work with you personally and the actual enrollment election process is governed by law, the duration of calls varies. Allow at least one hour per person to complete your enrollment; longer if you have not completed your personal profile. If you choose not to or are unable to complete your personal profile before your call, you may be asked to confirm your personal information before a benefit advisor is able to answer your questions. Most people are able to complete their enrollment in one call.

**Q2: I have an appointment with OneExchange to complete my enrollment. What can I expect on that call?**

**A:** During your scheduled appointment, your benefit advisor will first verify your information, ask questions about your current plan and future needs, and talk to you about your Health Reimbursement Arrangement (HRA), if you are eligible for one. The benefit advisor will make recommendations based upon your needs and budget. This part of the process will take about 45 minutes because it is highly personalized.

Once you have selected a plan or plans, an application data processor (ADP), who is an enrollment specialist, will work with you to complete the process. The ADP will let you know approximately how long the applications will take to complete. The length of time is dependent upon the number of applications that need to be completed. The approximate length of time is 20 minutes per application.
The ADP is required by law to review your plan selections with you and confirm that you do want to enroll in the selected plans. For each application, you will be required to state your full name, address, Social Security Number (if applicable) and date of birth, as well as the date you would like the coverage to become effective. For the upcoming plan year, this date will be January 1, 2015. This information is required by the Centers for Medicare and Medicaid Services (CMS) for enrollment in Medicare plans, and by the insurance carriers.

**Q3: Why do I have to repeat my personal information so many times?**

**A:** In order to protect seniors, the federal government heavily regulates the advertisement and sale of individual Medicare plans and products. The rules and regulations that the ADPs and benefit advisors must follow in assisting you on the phone are quite extensive, including the requirements to follow only pre-approved verbal scripts. These scripts require the ADPs and benefit advisors to provide you with multiple disclosures, disclaimers and certain information gathering questions designed to not only assist you in making your plan choice, but also in verifying your identity. Multiple confirmations of your personal information are necessary to ensure that you are accurately enrolled, and that your application is legally compliant.

**Q4: What are voice disclaimers?**

**A:** Voice disclaimers are a series of statements for each application that we are legally required to read to you when you enroll in a Medicare plan. Disclaimers give you important information about your plan and are designed to protect you as a consumer. When you sign your application over the phone, you will be required to acknowledge that you have heard and understood the disclaimers associated with your plan. The reading of each disclaimer takes anywhere from four to seven minutes. Each type of Medicare plan—Medicare Advantage, Medicare Supplement (also known as Medigap), Medicare Part D prescription drug—as well as dental plans, has its own unique disclaimer. If you or your spouse enrolls in multiple Medicare plans, we are required to read you the disclaimers associated with each plan. For example, if you enroll in a Medicare Supplement plan and a Medicare Part D prescription drug plan, you will hear two disclaimers—one for each plan.

**Q5: Who requires the disclaimers?**

**A:** Disclaimers are required by the Centers for Medicare and Medicaid Services, your insurance company and your state’s Department of Insurance.

**Q6: Are the disclaimers recorded or will they be read by the benefit advisor?**

**A:** Voice disclaimers are pre-recorded to ensure that you hear all of the legally required statements that are associated with your Medicare plan.

**Q7: Why are the disclaimers so long?**

**A:** Voice disclaimers must provide all of the legally required statements associated with your Medicare plan. The language in each disclaimer was created by the Centers for Medicaid and Medicare Services or your state’s Department of Insurance, depending on the Medicare plan you choose.

**Q8: I’m an Access-Only participant and understand that if I don’t enroll in coverage through OneExchange, I will not be able to enroll in future years. Is this true?**

**A:** To clarify, OneExchange is available to all Medicare-eligible individuals. Therefore, you will be able to use OneExchange’s services to enroll in individual Medicare plans through our Medicare marketplace in the future, even if you do not remain continuously enrolled in coverage under OneExchange individual plans.
Q9: If I enroll in a Kaiser Permanente individual medical plan directly through Kaiser, can I enroll in a dental or vision plan through OneExchange?

A: Yes. Contact OneExchange at 1-855-359-7380 Monday through Friday, 8 a.m. to 9 p.m. Eastern Time to let them know you enrolled in a Kaiser Permanente plan and that you are interested in learning more about dental or vision plans available through OneExchange.

Q10: I currently receive my Medicare Part B premium reimbursed through the Special Health Assistance Provision (SHAP). Will this program continue?

A: Yes. You can continue to submit claims for reimbursement of the Medicare Part B premium through SHAP as you do today. IBM will continue to contribute to SHAP, which allows those who retired before December 31, 1996, as well as those under age 65 and on Medicare due to disability, to apply for 80% reimbursement of your Medicare B premium—up to $900 per family per year. If you retired as a regular part-time employee, your maximum annual reimbursement is $675.

Q11: Can I submit my Medicare Part B premium expense to both my HRA and SHAP for reimbursement?

A: Yes, but you should give careful consideration to the order in which you submit claims for reimbursement of your Medicare Part B premium expense.

Here’s how to make optimal use of the IBM Special Health Assistance Provision (SHAP) benefit:

We recommend that you first submit your Medicare Part B premium expense to SHAP, then submit the remaining premium balance against the Health Reimbursement Arrangement (HRA).

Keep in mind that you may not submit the full Part B Premium to both SHAP and your HRA because you are allowed to be reimbursed for the full amount only once. If you submit your Part B Premium to your HRA first, you risk losing eligibility to be reimbursed through your SHAP benefit for any amount your HRA does not pay. Before submitting an expense for an HRA reimbursement, you are required to certify on the claim form that the expense has not been reimbursed from any other source, and will not be submitted for future reimbursement.

Q12: Will I need to provide any sensitive or personal information to OneExchange to enroll in a plan on their Medicare marketplace?

A: Approximately 11% of Medigap plans request some sensitive or personal information, such as your height, weight or Body-Mass Index (BMI). This is required by the carrier for the health insurance plan you have chosen, not by OneExchange. The information will be securely transmitted to your health insurance carrier, and will be included in the enrollment record you complete at OneExchange.

**Prescription Profiler**

Q13: What is Prescription Profiler?

A: All Medicare Advantage plans that include prescription drug coverage and Medicare Part D prescription drug plans offer varying levels of prescription drug coverage. Prescription Profiler will help you find plan options with the lowest estimated annual out-of-pocket cost by comparing the coverage each plan offers with the medications you take. It is critical to ensure the plan you choose covers most or all of the prescription medications you need. Prescription Profiler uses information provided by Medicare and by our insurance carriers to estimate your out-of-pocket costs using the
Q14: What do I need to do to get an accurate estimate of my medication expenses using Prescription Profiler?

A: Prescription Profiler results are an estimate calculated from the prescription drug data entered in your profile. It is important to provide accurate information about medication name, dose, and frequency. Entering the information for medications in pill form is usually straightforward; however, if your prescription is a gel, cream, injection, or drop, it is essential to enter the packaging and dosage correctly to get an accurate estimate.

Q15: Do I need to include my over-the-counter (OTC) medications?

A: You do not need to enter your OTC medications. Over-the-counter medications are not covered by Medicare and are not calculated as part of the out-of-pocket cost estimate.

Q16: What are the coverage gap (donut hole) and catastrophic coverage?

A: These amounts are indexed and can change each year. In 2015, the coverage gap begins once total prescription drug costs reach $2,960 and ends after an individual’s total out-of-pocket costs exceed $4,700. In the gap, you are responsible for paying 45% of the plan’s cost for covered brand-name prescription drugs, and 65% of the plan’s cost for generic prescription drugs.

If you take numerous and/or expensive prescription medications, you may enter the prescription drug coverage gap (the donut hole) or reach catastrophic coverage levels. If your plan does not offer gap coverage you will be responsible for a larger portion of the cost until you are out of the coverage gap.

Once your out-of-pocket costs exceed $4,700 in a calendar year you enter the catastrophic coverage level. While in catastrophic coverage you pay the greater of 5% or $2.65 for generic drugs and the greater of 5% or $6.60 for all other drugs.

If you are eligible, and the Total Drug Cost for your prescription drugs exceeds the annual IBM Catastrophic Level during a calendar year, IBM will provide an additional reimbursement on top of any HRA funding you receive. Once the IBM Catastrophic Level is exceeded, the Drug Benefit will cover 100% of the actual Eligible Prescription Drug Expenses incurred by you or your eligible dependents for the remainder of the calendar year.

For 2015, the IBM Catastrophic Level is $100,000 in Total Drug Cost, and is subject to change each year. Total Drug Cost includes deductibles, coinsurance and copays that you pay, as well as payments made by the plan or other pharmaceutical manufacturers toward the cost of your prescription drugs. Your Medicare Prescription Drug (Part D) Plan will send you a monthly prescription plan summary statement that will show your Total Drug Cost. You and your eligible dependents are individually eligible for this tax-free reimbursement annually as long as you were previously enrolled in prescription drug coverage through IBM and your Total Drug Cost exceeds the IBM Catastrophic Level of $100,000 Total Drug Cost during the calendar year.

Eligible Prescription Drug Expenses are limited to prescription drug copayments and coinsurance payments incurred on or after the IBM Catastrophic Level is exceeded. Prescription drug plan premiums are not eligible for reimbursement, nor are claims reimbursed from any other source. Please see the IBM plan for details on this additional benefit.

Q17: How can I view my monthly out-of-pocket drug cost estimate?
A: To view your estimated monthly out-of-pocket costs, click the Prescription Profiler link at the top of the quote results page. On the Prescription Profiler page you can also view formulary tiers, quantity limits, prior authorization, and step therapy details for each plan.

Q18: How can I view the prescriptions in my profile?

A: Log in to your account and from the home page click the Prescription Profiler link in the Important Messages section. If a benefit advisor entered your prescriptions on the phone, the prescriptions will display in this section once you have created an account and logged in.

Q19: Can entering my medications into Prescription Profiler before my appointment save time on the phone?

A: Yes. By completing your prescription profile before your appointment, you can save a significant amount of time on the phone. During your appointment the benefit advisor will verify each medication, but will not need to enter or make changes unless information needs to be updated.

Q20: Why is Prescription Profiler not available at times?

A: Prescription Profiler is available all year except for the first couple of weeks in October. We receive data for the next year’s Medicare Advantage and Part D prescription drug plans in the first week of October. It takes a week or two to test and load the data before we can make it available to our participants.

Q21: What happens when I save my prescriptions into Prescription Profiler?

A: As a registered user who has logged in, the prescriptions you enter into the Prescription Profiler will be saved and used to calculate your estimated annual out-of-pocket cost. Your benefit advisor will also have access to this information, which will decrease the length of your enrollment call. Your prescription information is protected by HIPAA laws and is not accessible by anyone but you and your benefit advisor.

Q22: Is mail order pricing available?

A: Once you enroll in a prescription drug plan, you will have access to mail order pricing. Mail order pricing is currently available through Prescription Profiler and with your benefit advisor.

Q23: How do I know if my medication is generic or brand name?

A: When you enter the name of your prescription medication in Prescription Profiler, if a generic version is available you will see its name listed alongside the brand-name drug and be asked if you prefer to change to the generic version. When your physician prescribes a prescription medication, he will often write the prescription for a brand-name drug, but allow the pharmacy to fill it with a generic equivalent. Generic drugs are copies of brand-name drugs that have exactly the same dosage, intended use, effects, side effects, route of administration, risks, safety, and strength as the original drug, but are most often less expensive. In some cases a plan will cover generic equivalents, but not the brand name medication, which can result in higher out-of-pocket costs. If you are taking a brand-name medication or are unsure, ask your doctor or pharmacist about a generic equivalent.
Plan Availability and Costs

Q24. How do the plans available through OneExchange differ from those I can purchase on the individual market?

A: The plans available through the OneExchange Medicare marketplace are also available on the individual market and at the same price. There may be additional plans available to you on the individual market that are not available through OneExchange. If you want to enroll in a plan other than through OneExchange, you can do that and still receive your IBM-funded HRA if you enroll in a Medigap, Medicare Advantage or Prescription Drug plan through OneExchange.

NOTE: One of the reasons IBM chose OneExchange is because the company believes OneExchange delivers a value added service with expert, independent benefit advisors and tools to assist you in comparing and choosing your health plans.

Q25: Why can't I see all the plans available in my area?

A: OneExchange contracts with each insurance company that has plans listed on our web site. A few of the reasons you may not see a plan of interest to you on our exchange include:

- Some insurance companies have chosen not to participate in our Medicare marketplace.
- Some insurance companies will offer one type of plan—Medicare Supplemental, for example—but not others.
- Other insurance providers may not have the technical capabilities required to offer their plans through an online marketplace such as OneExchange.
- Occasionally, OneExchange will remove an insurer’s plans from our web site because they no longer meet our qualification criteria.

Q26: How often do you add new plans? Will there be new plans added to the exchange this season?

A: We add new insurance companies and plans to our Medicare marketplace occasionally; for 2015 we have added plans in a number of areas. We continue to work to add new plans to provide you with both national and regional plan choices. If you are satisfied with the selection you may have already made, no action is required. You can review these options on the OneExchange website at Medicare.OneExchange.com/ibm or call to set an appointment to discuss your coverage needs at 1-855-359-7380.

Q27. Why can’t I see AARP plans on the OneExchange web site?

A: OneExchange is not allowed to show plan designs or pricing for these plans on its web site. You can get information, including premiums, on AARP plans by calling a OneExchange benefit advisor at 1-855-359-7380 (TTY: 711) Monday to Friday 8 a.m. - 9 p.m. Eastern time.

Q28: Why did the OneExchange benefit advisor tell me that the rates quoted for my Medigap plan could change?

A: If a participant elects to enroll in a Medigap plan, OneExchange is legally obligated to read a statement that rates may change. Medigap carriers are not regulated by CMS, but by the state in which their plans are offered; therefore they can change their rates up to 30 days prior to the policy becoming effective. In addition, state laws allow these carriers to change their rates during the year and/or when the participant has a birthday, so long as the plans provide notice 30 days prior to the effective date of the premium change. Not all carriers do this, but because some do OneExchange is required to share the statement.
**Q29: The information I received suggested my health care costs would be lower, but I’m going to be paying more. Why?**

**A:** For most retirees, a plan is available on the OneExchange Medicare marketplace that delivers equal or better value than under the current IBM group plan options, at a lower cost. We don’t expect every retiree to duplicate exactly what they had in the IBM group plans, but to use their IBM-subsidized HRA to pick the plans that best meet their needs. In some cases, the price for similar plans on the open market will be higher than IBM plans.

If you are not satisfied with the cost of the plan you selected and other options are available to you, please call an OneExchange benefit advisor at 1-855-359-7380 Monday through Friday, 8 a.m. to 9 p.m. Eastern Time, to explore other plans that meet your budget.

**Qualifying for Your HRA**

**Q30: What is an HRA?**

**A:** A Health Reimbursement Arrangement (HRA) is an account that has been established for you and funded by IBM. You can use the funds in your HRA to receive reimbursements for eligible health care expenses up to the allocated amount. The HRA is tax-free—that is, you do not owe any taxes on the money in your HRA. IBM has established certain requirements that you must meet in order to qualify for the HRA funding, which are explained in the next answer.

**Q31: How do I qualify for the Health Reimbursement Arrangement (HRA)?**

**A:** If you’re eligible for an HRA, you must enroll in a medical plan (either a Medicare Advantage or Medicare Supplement (Medigap) plan) or prescription drug plan (PDP) through the OneExchange Medicare marketplace to receive an HRA contribution.

The following are exceptions:

- If you live outside the U.S. and territories (example, Puerto Rico)
- If you are currently enrolled in an IBM Kaiser Permanente group option and you enroll in a Kaiser Permanente individual plan
- You are a U.S. Veteran enrolled in health coverage through TRICARE for Life or eligible to obtain services from the Veterans Administration

If you meet any of the above criteria, contact OneExchange to receive the HRA, if eligible.

**Q32: I am enrolled in a medical or prescription drug plan on my own. Can I get the HRA if I only enroll in a dental or vision plan through OneExchange?**

**A:** No. IBM is providing an HRA only if you enroll through OneExchange for medical or prescription drug coverage. If you want to qualify for the HRA, please work with a OneExchange benefit advisor to find a medical or prescription drug plan option that meets your needs.

The following are exceptions:

- If you live outside the U.S. and territories (for example, Puerto Rico)
- If you are currently enrolled in an IBM Kaiser Permanente group option and you enroll in a Kaiser Permanente individual plan
You are a U.S. Veteran enrolled in health coverage through TRICARE for Life or eligible to obtain services from the Veterans Administration

If you meet any of the above three criteria, contact OneExchange to receive the HRA, if eligible.

Q33. Due to my military service, I have coverage under TRICARE or the VA. Do I still have to enroll in a plan via the OneExchange Medicare marketplace (Medigap, Medicare Advantage or prescription drug) to get my IBM HRA?

A: In recognition of your military service, IBM retirees who are eligible for health coverage under TRICARE or from the VA do not need to enroll in a plan via the OneExchange Medicare marketplace to receive access to their IBM HRA (if eligible). Please note that if you received a survivor election form, you will still need to make an election and submit the form by the deadline.

Survivor Election Options

HRA Survivor Election Options for IBM couples - current prior plan or future prior plan retirees or prior plan benefit recipients

As someone who is married to another IBM retiree/benefit recipient/active employee, please review the following questions and answers unique to your situation prior to making your HRA survivor election with Budco.

Q34: My spouse and I are both IBM prior plan retirees. Will we receive the full HRA amount of $3,000 or $3,500?

A: You will each receive an HRA with a contribution of $3,500 or $3,000, depending on date of retirement. Each of you must complete a survivor election form designating no survivor election unless you have another eligible dependent (see answer to Q35). You cannot select the survivor option for your spouse, because he/she will receive their own benefit as an IBM retiree in his/her own right and is not eligible for a survivor benefit in addition.

Q35: My spouse and I are both IBM retirees with one (or more) eligible dependent(s). Can both of us elect the survivor option to cover the dependent(s)?

A: If you have one eligible child, only one of you may elect the survivor option. If you have two or more eligible children, each of you may elect the survivor option. However, keep in mind if your children are not Medicare-eligible, only one of you has to elect survivor coverage for your children to be covered under the IBM plan for non-Medicare retirees until he or she is no longer eligible for the IBM plan (currently, the plan provides coverage for children until they reach age 19 or up to 23 if enrolled in school full-time).

Note: If you select the survivor coverage option and one of your children later becomes Medicare-eligible due to disability and is approved for continued coverage under the IBM plan after age 19 or 23, as the case may be, he or she will be eligible for the survivor HRA subsidy under the IBM plan and can enroll in individual coverage via the OneExchange Medicare marketplace.

Q36. I am on IBM Long Term Disability (LTD) and my spouse is an IBM retiree or also on IBM LTD, can we each elect survivor coverage for the other?

A: No. Because you are eligible to retire under the IBM prior retiree plan when your LTD benefit ends, each of you must complete a survivor election form designating no survivor election unless you have another eligible dependent (see answer to Q35). You cannot select the survivor option for your spouse, because he/she will receive their own benefit as an IBM retiree in his/her own right and is not eligible for a survivor benefit in addition.
Q37. My spouse and I are both IBM Medicare-eligible retirees eligible for an HRA. Why won’t IBM allow each of us to elect the survivor coverage option for our eligible child(ren)?

A: Under this approach, the retiree electing the survivor option will receive a contribution of $2,600 or $2,374, depending on retirement date, and the other will receive the full unreduced HRA contribution of $3,500 or $3,000 depending on retirement date. This approach is consistent with IBM’s approach for active and retiree health care benefits, as well as other benefits. The eligible dependent of an IBMer can only be covered by IBM once, not twice.

Q38. I am an IBM Medicare-eligible retiree and my spouse is a non-Medicare eligible retiree. Can I elect survivor coverage for my spouse?

A: No. Because your spouse is also a prior plan retiree, she or he will have an HRA in their own right when they become Medicare-eligible and transition to the OneExchange Medicare exchange for their health plan coverage.

Q39: I am an IBM Medicare-eligible retiree and my spouse is an active employee. Can I elect survivor coverage for my spouse?

A: No. Because your spouse will also be a prior plan retiree when he or she retires, they will have an HRA in their own right when they transition to the OneExchange Medicare marketplace for their health plan coverage.

As a reminder, you must complete the IBM Health Plan Survivor Election Form. If Budco does not receive the form by the due date outlined in the letter you will be considered to have elected survivor medical coverage, and your HRA will be adjusted to the lower amount even if you have no eligible dependent.

If you have questions on the election form, please call Budco at 1-888-279-7261 long distance at (313) 957-5478 between 8 a.m. - 8 p.m. Eastern Time, Monday through Friday.

Funding and Billing

Q40: What can I use my HRA for?

A: If eligible for an HRA, you can use the HRA to reimburse premiums, copays and deductibles for any tax-qualified expenses. This includes Medicare Parts B and D premiums and premiums for plans you or your spouse purchase on your own (including dental and vision) on a post-tax basis.

Q41: Why did I have to pay my new insurance company right away, even though my coverage hasn’t started yet?

A: When your first insurance premium is due varies depending upon which kind of plan you have selected. Here are some general guidelines to help you know what to expect:

- Medicare Supplement (Medigap) plans: Most Medigap applications require payment of the first premium at the time of the application. If you did not pay at the time of the application, you will receive a bill before your coverage begins.

- Medicare Advantage and prescription drug coverage (PDP) plans: Your insurance company will first need to process and approve your application. Once that has been completed, typically the first bill will arrive in December.

- Vision plans: VSP usually requires a first premium payment at the time of the application. If you did not pay at the time of the application, you will receive a bill before your coverage begins.

- Dental plans: Dental plans usually require a first premium payment at the time of the application. If you did not pay at the time of the application, you will receive a bill before your coverage begins.
Q42: If I’ve already paid my first insurance premium, can I submit a claim for reimbursement from my HRA now?

A: If you have qualified for an HRA, your 2015 account will be established on January 1, 2015. No claims for 2015 expenses can be reimbursed prior to January. When you initially qualify for an HRA you will receive an HRA Welcome Guide within two weeks of your coverage start date. This mailing will explain in detail all aspects of your funding arrangement. If you have elected auto-reimbursement for the premiums you pay to your elected health plans then your reimbursement will be automatic beginning in early 2015. Automatic reimbursement means you will not have to file claims with our funding department to be reimbursed for your premium payments for health plans you are enrolled in through OneExchange. If you elect to submit claims manually, you can do that after you receive the HRA Welcome Guide from OneExchange.

Q43: Do I have to submit a Recurring Premium Reimbursement Form each year?

A: Yes, any recurring premium reimbursement that you have submitted for 2014 will end in December 2014. You will need to submit one form for 2015 reimbursement of your Part B premium or other eligible health care premiums along with the required documentation that is described on the back of the form. Note, however, that any Automatic Reimbursement you have elected where the premium payments you make to the health plans are automatically applied to your HRA will continue with no action on your part.