Agent Alert

MedicareBlue℠ Solutions

September 25, 2019

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- Pre-enrollment materials (page 2)
- October 1 Medicare marketing reminders (page 2)
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Notable 2020 plan changes

Standard plan

- Monthly premium:
  - $42.00 (+$4.10)
- Deductible:
  - $0 deductible on tiers 1 through 2, $435 on tiers 3 through 5
- Cost sharing:
  - Tier 3 is changing from a coinsurance to a copayment
  - Some copay and coinsurance amounts are changing
- Pharmacy network:
  - More than 66,000 pharmacies in the network
  - More than 32,000 preferred pharmacies

Premier plan

- Monthly premium:
  - $89.60 (-$0.10)
- Deductible:
  - $0
- Cost sharing:
  - Some changes to coverage in the coverage gap and catastrophic coverage stage
- Pharmacy network:
  - More than 66,000 pharmacies in the network
  - More than 36,000 preferred pharmacies

Look up plan details at **YourMedicareSolutions.com** on October 1.

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Pre-enrollment materials

Plans will soon begin receiving 2020 MedicareBlue Rx pre-enrollment kits. The information in the kits cannot be publicly shared until October 1. Each pre-enrollment kit contains:

- Pre-enrollment brochure and folder
- 2020 Summary of Benefits
- 2020 pre-enrollment checklist
- Enrollment form and postage-paid return envelope
- Plan ratings information for 2019 (the 2020 rating will not be available until October)

Contact your local Blue plan to order kits.

October 1 Medicare marketing reminders

Marketing for annual enrollment period (AEP) can begin October 1. Please note the following points:

- You must be certified to sell 2020 products prior to marketing those products on October 1
- You must get a signed scope of appointment (SOA) form or recorded agreement before conducting face-to-face marketing appointments with beneficiaries. Documentation must be retained for 10 years plus the current year (11 years total) and made available upon request.
- Only use marketing materials that have been approved by CMS and provided by the local Blue plan

September 25, 2019

Application guidelines for October 1 through 14

Follow the guidelines below to ensure prompt application processing, accuracy and compliance.

Some SEP enrollments can start before October 15
Enrollees may have special enrollment periods (SEPs) that allow you to accept applications before October 15. These could include SEPs for moving into the service area, moving into or out of a long-term care facility, or gaining or losing LIS status. Beneficiaries can also enroll prior to October 15 using their initial enrollment period (IEP) and employer group SEPs.

CMS guidelines prohibit plan sponsors from accepting phone or online enrollments (except for SEPs noted above) prior to October 15 for a January 1 effective date.

The 2020 online enrollment form will be available beginning October 1 at **YourMedicareSolutions.com**.

Handling paper forms from October 1 through 14
Agents may accept or solicit paper enrollment forms from beneficiaries prior to October 15 only if the enrollment is for someone with a valid election period or SEP. Enrollments using AEP should not be accepted or solicited until October 15. These enrollments have effective dates of January 1.

- Remind beneficiaries that they cannot submit enrollment forms until October 15, unless they qualify for other election periods
- If you receive a paper enrollment form from a beneficiary prior to October 15, immediately submit the form by fax or overnight mail
- If you assist beneficiaries in completing 2020 applications prior to October 15, you may be investigated for compliance with CMS guidelines

Pre-enrollment materials inform beneficiaries to wait until October 15 before submitting an application.

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Member mailing: Notification of loss of LIS status

Members who are losing eligibility for low-income subsidy (LIS), or Extra Help, for prescription drugs were sent a reminder letter informing them that they need to reapply and qualify to continue to receive the subsidy in January 2020. Members may receive this notification if any of the following scenarios apply:

- No longer qualify for Medicaid
- No longer get help from their state Medicaid program to pay Medicare Part A and Part B premiums, or
- Receive Supplemental Security Income benefits, but not Medicaid

If a member contacts you about this, instruct them to call the Social Security Administration and reapply for Extra Help. They can also call Medicare or their State Health Insurance Program (SHIP).

State	Individual members
Iowa	121
Minnesota	277
Montana	41
Nebraska	48
North Dakota	27
South Dakota	12
Wyoming	23

2020 Question and answer guide for agents

Questions and answers about the plan changes are attached to help you answer customer questions. The question and answer guide has information about the formulary, pharmacy network, cost sharing, plan changes, mail order and more.

Questions or have an enrollment? Call a Broker Help Desk
If you have questions, want to enroll an applicant by telephone or help a member make a change, please contact the appropriate agent/broker help line:

- MedicareBlue Rx pre-enrollment toll free at **1-866-464-3919**
- MedicareBlue Rx post-enrollment toll free at **1-866-849-2498**

MedicareBlue Rx coverage is separately issued by one of the following plans: Wellmark Blue Cross and Blue Shield of Iowa,* Blue Cross and Blue Shield of Minnesota,* Blue Cross and Blue Shield of Montana,* Blue Cross and Blue Shield of Nebraska,* Blue Cross Blue Shield of North Dakota,* Wellmark Blue Cross and Blue Shield of South Dakota* and Blue Cross Blue Shield of Wyoming.*
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MedicareBlue Rx question and answer guide for agents

Pre-enrollment questions	Post-enrollment customer service
1-866-434-2037 (TTY: **711**) October 1 through December 7 8 a.m. to 8 p.m., daily, Central and Mountain times December 8 through September 30 8 a.m. to 8 p.m., Monday through Friday, Central and Mountain times	**1-888-832-0075** (TTY: **711**) October 1 through March 31 8 a.m. to 8 p.m., daily, Central and Mountain times April 1 through September 30 8 a.m. to 8 p.m., Monday through Friday, Central and Mountain times
Visit **YourMedicareSolutions.com**	

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LOW-INCOME SUBSIDY PREMIUM AND COST SHARING CHARTS

2020 SHIP INFORMATION BY STATE

Appendix A: 2020 plan overview chart

1. MEDICAREBLUE RX GENERAL PLAN QUESTIONS AND 2020 PLAN CHANGES	
1.1. Where is the service area for the plan?	The service area includes Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota and Wyoming. The beneficiary's permanent residence must be in the service area for the beneficiary to be eligible for MedicareBlue Rx.
1.2. Who can join the plan?	MedicareBlue Rx is available to all Medicare beneficiaries who permanently reside in the service area and who are entitled to Medicare Part A and/or enrolled in Medicare Part B. Beneficiaries can also join if they are enrolled in any of the plans listed below that does not include Medicare prescription drug coverage: • A Medicare Supplement plan like those offered by local Blue Cross Blue Shield plans in the region • A private-fee-for-service (PFFS) plan • An MA Medical Savings Account (MSA) plan • An 1876 Cost plan If a beneficiary is enrolled in a Medicare Advantage (MA) coordinated care (HMO or PPO) plan or an MA PFFS plan with Medicare prescription drug coverage, they may not enroll in a PDP unless they disenroll from the HMO, PPO or MA PFFS plan.
1.3. What types of changes are occurring for 2020?	• The premium for the Premier plan is decreasing to $89.60. • The premium for the Standard plan is increasing to $42. • The Premier plan annual deductible remains at $0 for all tiers. • The Standard plan annual deductible is $0 on tiers 1 and 2 and $435 on tiers 3 through 5. • Some copay and coinsurance amounts are changing. Tier 3 for the Standard plan is changing from a coinsurance amount to a copay.
1.4. How can members find out more about the plan?	• Members who have questions can visit **YourMedicareSolutions.com** or call MedicareBlue Rx customer service.
1.5. Can you give me an overview of the plan?	• See Appendix 1.
1.6. How does the plan differentiate itself in the marketplace?	• MedicareBlue Rx Standard features a $0 deductible on tier 1 and 2 drugs. Members of the Standard plan have access to a nationwide pharmacy network of 66,000 pharmacies and get preferred cost sharing at more than 32,000 pharmacy locations nationwide. • MedicareBlue Rx Premier plan features a $0 deductible on all tiers, so coverage starts right away. Members of the Premier plan have access to a nationwide pharmacy network of 66,000 pharmacies and get preferred cost sharing at more than 36,000 pharmacy locations nationwide.

1. MEDICAREBLUE RX GENERAL PLAN QUESTIONS AND 2020 PLAN CHANGES	
1.7. What's the best way to determine the most suitable plan for an individual?	Beneficiaries can use the coverage and pricing tool on **YourMedicareSolutions.com**. It will calculate the beneficiary's costs for each plan option to help individuals choose the plan that's best for them. Another factor to consider is the beneficiary's comfort level with the cost sharing. Current members who want to change options this year can call our pre-enrollment Medicare Solutions specialists Agent of record information will not be changed if a member uses the call center to switch plan options this fall. You may choose to meet directly with your enrolled members to help them compare plans. Using the coverage and pricing tool will help to facilitate your discussion.
1.8. When can beneficiaries make a change?	Beneficiaries can change plan options during the annual enrollment period (AEP), October 15 to December 7. Changes made using the annual enrollment election period take effect January 1. Changes at other times of the year are allowed only if an individual is eligible for a special enrollment period (SEP).
1.9. Do members need to complete a form if they want to change to a different plan option?	Yes. Medicare requires that members complete a change form, either on paper, online or by phone, to change to a different option.
1.10. What if members don't select a new option?	They will automatically continue in their current plan option. Both plan options have benefit and premium changes for 2020.
1.11. Will all members get a new ID card for 2020?	No. Only new members and current members who enroll in a new plan option will receive new member ID cards prior to January 1.
1.12. What is the MedicareBlue Rx Star Rating?	Each year, Medicare rates how plans perform in different categories such as detecting and preventing illness, ratings from patients, patient safety and customer service. The star rating system provides consumers with information to help them choose among the Medicare plans offered in their area. MedicareBlue Rx has a Star Rating of 5 out of 5 stars for 2019. Star ratings are calculated and may change each year. Beneficiaries can find information on star ratings using the tools on **Medicare.gov** and selecting "Find health & drug plans." They will have to enter their ZIP code to compare the Star Ratings for MedicareBlue Rx and other Medicare plans in their area. Plans achieving a 5-Star Rating can offer a 5-star special enrollment period that allows individuals to enroll in a 5-star plan at any time during the year. They can enroll for the first time or change from another plan in which they are enrolled.
1.13. When will 2020 plan ratings be available?	October 2019.

1. MEDICAREBLUE RX GENERAL PLAN QUESTIONS AND 2020 PLAN CHANGES	
1.14. If a beneficiary already has health coverage through an employer or union, can they still join MedicareBlue Rx?	Beneficiaries should be aware that they could lose their employer or union health coverage if they join MedicareBlue Rx. They should be advised to read their employer or union communications. If they have questions, they should visit their employer's website, or contact the office listed in their communications. If there isn't information about whom to contact, their employer's benefits administrator or the office that answers questions about their coverage can help.
1.15. If a beneficiary has coverage under a Medicare Advantage plan, can they still join MedicareBlue Rx?	If a beneficiary's Medicare Advantage (MA) plan includes prescription drug coverage, joining MedicareBlue Rx will end their membership in the MA plan. This will affect their doctor and hospital coverage and their prescription drug coverage. They should be advised to read the information that the MA plan sends and to contact the MA plan with questions.
1.16. When should members expect to receive plan materials? What materials will they receive before they enroll?	Current members will receive a mailing with the following by September 30, 2019: • Annual Notice of Changes (ANOC) • Insert with instructions on how to access the Evidence of Coverage (EOC), formulary and pharmacy directory You can begin to discuss the changes for 2020 on October 1. Other beneficiaries who request information will receive a pre-enrollment package within 10 business days of their request. The package includes plan benefit and contact information. It also contains an application and postage-paid envelope.
1.17. What materials do members receive after they enroll?	Once a beneficiary's enrollment request is approved, member materials are mailed. These materials include a confirmation letter, member ID card and welcome kit. The confirmation letter notifies the beneficiary of CMS's response and must be mailed within 10 days of CMS's notice to MedicareBlue Rx. This letter includes the member's ID card. The welcome kit also will arrive within 10 days after CMS confirms the enrollment and includes: • Member guide • An insert that explains how to obtain a copy of the Evidence of Coverage, formulary and pharmacy directory • Electronic funds transfer (EFT) form and return envelope • Authorization to release information (ARI) form • Appointment of representative (AOR) form • CVS Caremark Mail Order form and return envelope

2. CVS CAREMARK QUESTIONS	
2.1. What does CVS Caremark[1] do as the pharmacy benefit manager?	CVS Caremark, the plan's pharmacy benefit manager (PBM), provides important services including managing the pharmacy network and drug formulary (list of covered drugs). CVS Caremark offers a wide range of services for Part D plans, including a rigorous Medication Therapy Management program and a mail order program, to help members meet their prescription drug needs.
2.2. How do members access their prescription drug information with CVS Caremark?	Members can set up an account at **Caremark.com** where they can review their claims history, order prescriptions by mail and check on the status of orders. Members can also call CVS Caremark at **1-866-412-5393** to set up an account and access their prescription information.
2.3. What is the standard one-month supply of a prescription?	A 30-day supply is the industry standard. Long-term care pharmacies fill 31-day prescriptions.
2.4. What happens if a prescription is written for 31 days or 34 days?	If the member wants to receive the extra amount above a 30-day supply, they will have to pay two copays or the additional coinsurance amount, since the copay/coinsurance is not pro-rated for the extra number of days. If the member's prescription is written for 31 or 34 days, the member can speak with their pharmacist or doctor to see about changing it to the 30-day supply.
2.5. What if a prescription is written for less than 30 days?	If the cost sharing is a copay, the amount the member pays will be based on the number of days for which the prescription is written. For example, if the cost of a 30-day supply is $30, the cost of the drug is $1 per day. If the member receives a 7-day supply, they will pay $7. If the cost sharing is coinsurance, the member will pay the same percentage regardless of whether the prescription is for a full month supply or fewer days. However, because the cost will be lower for less than a full month's supply, the coinsurance amount will also be less.
2.6. What additional services does CVS Caremark provide?	The following services are provided by CVS Caremark: • **Delivery** – Home delivery within 1-2 days nationwide and same-day within select markets, for a small fee • **Specialty Connect** – Simplifies access to specialty pharmacy by facilitating drop-off and pick-up at local CVS pharmacy, if preferred over mailing • **CVS Specialty pharmacy** – Proactively support and empower individuals with rare and chronic conditions to improve their total health and manage their multiple and complex needs • **ScriptSync –** Coordinates refill and renewal schedules for members taking multiple maintenance medications to facilitate pick-up in a single pharmacy visit

[1] CVS Caremark Part D Services is an independent company providing pharmacy benefit management services.

2. CVS CAREMARK QUESTIONS	
	• **ExtraCare® Health card** – Receive discounts on CVS branded health-related items at a CVS store • **ExtraBucks Rewards** – Pharmacy reward program • **Mobile app** – Allows members to reorder scripts, save money, order and track refills and more • **Multi-dose packs –** All a member's medications organized into packs and labeled according to the date and time they should be taken • **ScriptPath** – Prescription schedule for retail pharmacy patients who manage multiple medications, including which medications the patient takes, when to take them and how much of each medication should be taken in each dose. Patients filling at CVS may request the schedule at any time. • **Real-time benefits** – Real-time member-specific benefit information across all points of care to provide greater price transparency and access to lower-cost alternatives. Available at all CVS Pharmacy locations and directly to members through Check Drug Cost tool on Caremark.com and the CVS/Caremark app

3. PHARMACY NETWORK	
3.1. How large is the pharmacy network?	The pharmacy network includes about 66,000 pharmacies across the U.S. Major retailers, such as CVS, Costco and Walmart, are in the network. Many local and regional pharmacies, such as Albertsons, Hy-Vee and Safeway are also in the network.
3.2. Which pharmacies offer preferred cost sharing?	Within the 66,000 pharmacies in the network, there are more than 32,000 pharmacies that offer preferred cost sharing for the Standard plan and more than 36,000 that offer preferred cost sharing for the Premier plan. Members will often pay less for prescription drugs when they fill them at a pharmacy that offers preferred cost sharing. Members can go to a pharmacy that offers standard cost sharing, but they will often pay more for their prescriptions. • **Pharmacies with preferred cost sharing for the Standard plan:** More than 32,000 nationwide, including CVS, Walmart, Thrifty White and Hy-Vee. • **Pharmacies with preferred cost sharing for the Premier plan:** More than 36,000 nationwide, including CVS, Walmart, Costco, Thrifty White and Hy-Vee. • **Pharmacies with standard cost sharing:** All other network pharmacies. Members who do not live near a pharmacy that offers preferred cost sharing can take advantage of the preferred pricing by filling prescriptions through the plan's mail order service. To see all preferred pharmacies, go to **YourMedicareSolutions.com**.
3.3. Are there any pharmacies that are currently in the network that will not be in the network for 2020?	Almost all pharmacies that are currently in the network will continue to be in the network. Look up pharmacy information at **YourMedicareSolutions.com.**
3.4. Will members be notified if their current pharmacy will no longer be in the network for 2020?	No. Since most of the pharmacies our members use will continue to be in the network, we will not be sending notification if a pharmacy leaves the network. Members can find a pharmacy online or call customer service for help with pharmacy searches.
3.5. Can members get 90-day supplies at retail pharmacies?	Yes. Members can get 90-day supplies at network pharmacies at the mail order rate. Pharmacies that always offer 90-day supplies are identified by "EDS" in the pharmacy directory and the online pharmacy search tool. Non-EDS pharmacies may provide 90-day supplies if they can and these are also at the mail order rate. Some drugs may have quantity limits or other restrictions that prevent them from being available in 90-day supplies. Members can check their plan option's formulary to see if there are any other restrictions or limits on drugs.

3. PHARMACY NETWORK	
3.6. How do members access the national network when traveling?	If a member loses their prescription or it runs out while they are traveling in the U.S., they can get a refill at a network pharmacy. Members can call customer service to find a network pharmacy near them or use the online plan tools. They can also fill prescriptions at preferred pharmacies when traveling. Members should contact customer service in advance for prescription fills when traveling outside of the U.S. or its territories. MedicareBlue Rx cannot pay for any prescriptions filled outside of the U.S. or its territories. The member is subject to pay the full cost without reimbursement for each prescription filled.
3.7 If a beneficiary lives in a long-term care facility, what will they pay for their drugs?	Long-term care pharmacies are contracted separately from retail pharmacies and the preferred cost sharing will not apply, even though the retail pharmacy may provide drugs to a long-term care facility. Separate rules govern how long-term care facilities obtain prescription drugs and dispense those drugs to residents.
3.8. Who should pharmacies contact if they have questions about joining the CVS Caremark network or becoming a preferred pharmacy?	Pharmacies can call the CVS network enrollment line at **1-480-314-8457**. Pharmacies will not be able to enter the preferred network during 2020 but can start the process to become a preferred pharmacy in 2021.

4. FORMULARY QUESTIONS	
4.1. How is the formulary changing for 2020?	Notable formulary changes will be available in October 2019.
4.2. How is the formulary organized? What do the different drug tiers mean?	The formulary includes prescription drugs believed to be part of a quality treatment program. MedicareBlue Rx will generally cover the drugs listed in the plan's formulary if the drug is medically necessary, the prescription is filled at a network pharmacy and other plan rules are followed. The drugs are organized into five tiers. Each tier has a different cost-sharing amount in the form of a copay or coinsurance. The cost-sharing amount depends on which tier the drug is on.
4.3. What types of drugs are included in each tier?	• Tier 1: **Preferred generic –** This tier is the lowest tier and generally contains the lowest cost generics • Tier 2: **Generic –** Contains generics • Tier 3: **Preferred brand –** Contains preferred brand drugs and non-preferred generic drugs • Tier 4: **Non-preferred drugs –** Contains non-preferred brand drugs and non-preferred generic drugs • Tier 5: **Specialty –** Contains very high cost brand and some generic drugs, which may require special handling and/or close monitoring
4.4. Will drugs be on the same tiers for 2020?	Formularies change every year. Notable formulary changes, including tier changes, will be available in October 2019.
4.5. What are specialty drugs?	Specialty drugs are very high cost brand and some generic drugs which may require special handling and/or close monitoring.
4.6. If I have members whose drugs are not on the formulary or are in a different tier, and they choose to switch plans in 2020, what do they need to do?	If a beneficiary's drug is not included in the plan's formulary, they should first contact customer service and confirm that the drug is not covered. If the beneficiary learns that their plan option does not cover the drug, the beneficiary has two options: 1. Review the plan option's formulary with their doctor and ask to have a similar drug that is covered prescribed. 2. Ask MedicareBlue Rx to make an exception and cover the drug. See the plan option's formulary for information about how to request an exception. If a member switches to a different MedicareBlue Rx plan option, any formulary exceptions or drug utilization requirements met in 2019 will carry over for 2020. There is nothing the member needs to do until the exception expires. Members affected by 2020 formulary changes can submit coverage determinations for exceptions, prior authorization or other utilization management requests for 2020 starting on November 1.

4. FORMULARY QUESTIONS	
4.7. What process do members need to follow to submit requests for prior authorization or exceptions?	Beneficiaries can submit exception or prior authorization requests for 2020 once Medicare has approved their membership in the plan, but no earlier than November 1. Generally, an exception request will be approved only if the alternative drug on the plan's formulary would not be as effective in treating the condition or would cause adverse medical effects. The member's doctor must submit a statement supporting the exception request. If the exception involves a prior authorization, quantity limit or other limit we have placed on a drug, the doctor's statement must indicate why the prior authorization or limit would have adverse effects for the member. There are several ways to submit an exception request to CVS Caremark: • Call CVS Caremark at **1-866-412-5393** (TTY: **711**), 24 hours a day, seven days a week • Fax the request to **1-855-633-7673**. Physician fax forms are available at **YourMedicareSolutions.com** or can be requested by phone. • Submit online at: **YourMedicareSolutions.com/members/prior-authorization** • Mail the request to this address: CVS Caremark P.O. Box 52000, MC109 Phoenix, AZ 85072-2000
4.8. If a member is taking a drug that has an exception that has already been approved (formulary, prior authorization, step therapy, quantity limit), will they need to request the exception again for 2020?	Exceptions are granted for a certain period. Members receive an approval letter with an expiration date. Members can refill their prescriptions up to the expiration date. After that, they will need to complete a new exception request with CVS Caremark.

5. MAIL ORDER QUESTIONS	
5.1. How does the mail order program work?	Mail order services are provided by CVS Caremark Mail Order Pharmacy. Purchasing drugs by mail can help members save time and money when they order 90-day supplies of maintenance medications. Specialty drugs are available through mail order service in 30-day supplies. The drugs are usually delivered within 14 days after they are ordered. New members will receive information in their welcome kit. The CVS Caremark Mail Order Pharmacy phone number and website are included in the pharmacy directory. More information is available at **YourMedicareSolutions.com**.
5.2. What will the cost for a 90-day supply ordered by mail be in 2020?	For both plan options, the cost of 90-day supplies by mail will be two times the 30-day copay or the coinsurance percentage.
5.3. How can a member begin filling prescriptions by mail through CVS Caremark?	**Current members** who have not used this service before can set up an account at any time. Members will need their member ID card, address and payment information to sign up. Members who used this service in 2019 can continue to use their existing account. **New members for 2020** can set up an account on or after January 1, 2020. New members will need their member ID card, address and payment information to sign up. **How to register** Call CVS Caremark: **1-866-412-5393** Sign up online: **Caremark.com** Once a member sets up an account, either the member or their doctor can submit a prescription to be filled.
5.4. Can members order refills online?	Yes. Members will be able to go to **Caremark.com** and create an account. Once in their account, members can order refills or check the status of a current mail order. Mail order forms are available on **YourMedicareSolutions.com**. Members can also sign up for automatic mail order refills.
5.5. How does the automatic mail order refill service work?	Members can sign up to have mail order prescriptions refilled every three months through CVS Caremark's automatic mail order refill service. Members can choose which prescriptions they want automatically refilled and can drop this service at any time. Members participating in the mail order refill service receive a call or message before each shipment. They can choose to receive these alerts by phone, text or email.

6. GENERAL QUESTIONS ABOUT LOW-INCOME SUBSIDIES (LIS)	
6.1. How does CMS determine the benchmark plans?	Every year, Medicare receives bids from participating Medicare Part D plans for the coming year. From this information, they finalize premiums and set threshold pricing for plans called a benchmark. Generally, Medicare beneficiaries who receive Extra Help (subsidies) for their prescription drug coverage will pay the least amount by enrolling in a benchmark plan.
6.2. How do I find out which plans are benchmark plans?	Check **Medicare.gov** for a listing of the Medicare Part D plan sponsors that are benchmark plans.
6.3. Will MedicareBlue Rx have any auto-enrollees?	No. MedicareBlue Rx Standard's premium is above the benchmark premium.
6.4. Can an individual enroll in any MedicareBlue Rx plan option if they qualify for Extra Help (low-income subsidies) for prescription drug costs?	Yes. Individuals eligible for Extra Help can enroll in any of our prescription drug options, but neither plan option is a benchmark plan. Beneficiaries qualifying for a subsidy would pay the difference between the plan option's premium and the benchmark amount. To see what the premium will be based on the amount of Extra Help the beneficiary is receiving, refer to the 2020 Low-Income Subsidy Amounts table at the end of this Q&A. LIS beneficiaries can call customer service to evaluate their personal situation. Beneficiaries may also work with their local SHIP counselors who can help them compare benchmark plans. See the "2020 Senior Health Insurance Plan Information by State" list at the end of this document.
6.5. Can you explain what communications CMS sends to LIS beneficiaries and when they will be mailed?	Every fall, CMS reviews eligibility for LIS and notifies a beneficiary if their Extra Help will continue or change, or if they no longer qualify. CMS reassigns auto-assigned LIS beneficiaries with 100 percent premium subsidy to a different PDP if their plan is terminating, increasing above the LIS benchmark premium, or converting to an enhanced benefit plan. • **Early September** – The Social Security Administration (SSA) mails re-determination letters to certain LIS applicants • **Mid-September** – GREY LETTER mailed to those losing deemed status • **Mid-October** – ORANGE LETTER mailed to those deemed for LIS for next year, but copayment will change • **Late October** – BLUE REASSIGNMENT LETTER mailed to those receiving 100 percent subsidies being reassigned to a new LIS benchmark plan • **Early November** – TAN CHOOSERS LETTER mailed to LIS beneficiaries voluntarily enrolled in a plan that is no longer a benchmark plan; makes beneficiary aware of which plans are the new LIS benchmark plans

6. GENERAL QUESTIONS ABOUT LOW-INCOME SUBSIDIES (LIS)	
6.6. Can you explain the special enrollment periods (SEP) that apply to individuals eligible for the LIS?	Individuals who qualify for Extra Help can use the SEP to enroll in or disenroll from a Part D plan once per calendar quarter during the first nine months of the year. This election period cannot be used from October through December. If they lose Extra Help during the year, the opportunity to make a change continues for three months after they are notified that they no longer qualify. If they begin getting Extra Help or the amount of the subsidy changes, they can change plan options if they are currently enrolled in MedicareBlue Rx. If they are not enrolled, they become eligible to enroll at that time.
6.7. How does Extra Help work?	People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75 percent or more of drug costs, including monthly prescription drug plan premiums, annual deductibles, copays and coinsurance. Those who qualify will not be subject to the coverage gap or a late enrollment penalty. Individuals who qualify may enroll in, or disenroll from, a plan once per quarter during the first nine months of the year. If they gain or lose Extra Help or have a change in their LIS status during the year, the opportunity to make a change continues for three months after they are notified of the change. Individuals who are eligible and don't enroll in a prescription drug plan are automatically enrolled in a benchmark prescription drug plan by Medicare. A benchmark plan is a plan that has a monthly plan premium that is below a benchmark amount determined by Medicare. Individuals enrolled in benchmark plans pay no monthly plan premiums. If a plan's premium increases above the benchmark amount, Medicare will automatically reassign auto-assigned individuals who are eligible for Extra Help to a new prescription drug plan available in their area so that they can continue to have no monthly plan premiums.

6. GENERAL QUESTIONS ABOUT LOW-INCOME SUBSIDIES (LIS)	
6.8. What happens if a member no longer qualifies for Extra Help? What are their options?	Beneficiaries are automatically eligible if they qualify for Medicaid, get help from the state to pay their Medicare Part A or Part B premiums, or receive Supplemental Security Income (SSI) benefits. If an individual no longer meets one of these requirements, their Extra Help will end unless they apply and qualify based on their income and assets. To apply, they must provide information about their income and assets each year. If they don't provide the required information or don't meet the eligibility requirements, their subsidy may be reduced or discontinued. For questions about Extra Help or if an individual needs assistance completing the application, they can: • Call the Social Security Administration (SSA) **1-800-722-1213** (TTY: **1-800-325-0778**) 7 a.m. through 7 p.m. Monday through Friday ET. • Fill out the application online at **ssa.gov**, under the Medicare link • Complete the paper application included with the letter they received from Medicare. To get another copy of the application by mail, call **1-800-633-4227** (TTY: **1-877-486-2048**) • Call a State Health Insurance Program (SHIP) local office for free personalized health insurance counseling. See the 2020 Senior Health Insurance Plan (SHIP) Information by State list at the end of this Q&A for contact information • See the "Medicare & You" handbook If a member loses their eligibility for Extra Help, they will have a special enrollment period during which they can switch to a different plan.
6.9. What are the plan premiums, deductibles and cost-sharing amounts for those qualifying for LIS for each MedicareBlue Rx plan option?	LIS rates can be obtained from your local plan or by calling MedicareBlue Rx customer service for assistance as rates are based upon the level of Extra Help a low-income beneficiary receives. The rates are also in the *2020 Low-Income Subsidy Amounts* chart at the end of this document.

7. CHANGES IN THE COVERAGE GAP	
7.1. What is the donut hole or coverage gap and how is it affected in 2020?	Medicare prescription drug coverage has four stages: • Deductible • Initial coverage • Coverage gap • Catastrophic coverage For 2020, the coverage gap occurs after the member's total yearly drug costs reach $4,020. In the coverage gap stage, the member will receive a discount on brand-name drugs and generally pay no more than 25 percent of the plan's costs for brand drugs and 25 percent of the plan's costs for generic drugs. They pay this until they reach the catastrophic coverage stage, when their yearly out-of-pocket drug costs reach $6,350.
7.2. What happens if a member has some coverage in the coverage gap?	Members will pay the lesser of the plan's copay or 25 percent of the cost for generic drugs or 25 percent of the cost for brand-name drugs, or the actual cost if it's less.
7.3. Are all brand-name drugs discounted?	All brand-name drugs on our formularies are discounted at 70 percent of the negotiated price of the drug. CMS negotiates the agreements with drug manufacturers to offer discounts. We are required to remove any brand-name drugs from our formularies that do not have the discount agreement. Plans provide an additional 5 percent of coverage so that beneficiaries pay 25 percent.
7.4. Will the discounts change each year?	No. The manufacturer discount will remain at 70 percent, the plan will pay 5 percent and the member will pay 25 percent for brand-name drugs once the coverage gap stage is reached.
7.5. Who is eligible for the discount?	"Applicable beneficiaries" are individuals who, on the date a drug is dispensed: • Are enrolled in a prescription drug plan or MA-PD plan • Are not entitled to a low-income subsidy • Have reached or exceeded the initial coverage limit during the year
7.6. Do discounted drugs count toward the catastrophic maximum? What impact will they have?	Yes. Payments for discounted drugs count toward the catastrophic maximum if they are for a covered Part D drug. What members pay and the portion manufacturers pay will count toward their true out-of-pocket (TrOOP) cost. However, the 5 percent that the plan pays will not count toward TrOOP. This aligns with TrOOP calculations today since premiums and other plan payments do not count toward TrOOP.
7.7. Will someone with a partial subsidy receive the discounts?	No. According to current guidance, anyone who is eligible for a low-income subsidy is not eligible for the discounts.

8. ENROLLMENT PERIOD AND PREMIUM PAYMENTS	
8.1. When is the annual enrollment period (AEP)?	AEP is October 15 through December 7. Enrollments using the annual election period take effect January 1.
8.2. When does the marketing period start?	Agents can begin marketing MedicareBlue Rx on October 1.
8.3. How will a plan change affect a member's plan premium payment method?	A member's current premium payment method will automatically continue unless the member makes a change. The new premium amount will be effective on January 1. If a member currently has automatic payment deductions set up, those deductions will continue. The amount will change to reflect the new premium amount.
8.4. If a member pays plan premiums through deductions from their Social Security benefit check, will the new plan premium amount start coming out of the January Social Security check?	Depending on when the change is received, there could be a delay before the premium amount being deducted changes to reflect the 2020 premium. When the updates are processed, premiums will be retroactively adjusted to January 1. If the premium increases, the increased amount and the difference owed for the month(s) the new premium was not paid will be deducted in the month the update and premium are effective. If the premium decreases, the difference will be refunded by Social Security to the member.
8.5. How does a member sign up to have premiums deducted from their Social Security or Railroad Retirement Board (RRB) benefit checks?	Social Security or RRB requests must be submitted in writing. Members can submit their request by mail or go online and request this payment option. If a member chooses to have payments deducted from their Social Security or RRB benefit checks, the deduction may take two or more months to begin. In most cases Social Security or the RRB will accept the request for automatic deduction. If Social Security or the RRB does not approve the request, we will send paper bills. While the request is being considered, members will receive paper bills and pay the premiums directly to the plan until deduction begins. If members do not pay the paper bills, they may be disenrolled. Social Security and the RRB do not allow retroactive deductions. If a member is not approved, encourage them to sign up for EFT.

8.6. How can a member sign up for electronic funds transfer (EFT)?	Members can choose to have premium payments deducted from their checking or savings account through EFT. There are no sign-up fees or transaction charges. Members have the option to select EFT as their premium payment method on their enrollment or change form. EFT can also be submitted in writing with the proper documentation. • Sign up online at **YourMedicareSolutions.com/mbrx-change-payment-option** • Download the paper form at **YourMedicareSolutions.com** and mail to the address on the form Once the information is received, it may take up to two months for EFT to begin. Members are responsible for paying the paper bills they receive until EFT takes effect. If they don't pay all bills while EFT is being set up, any amounts owed will be included in their first EFT payment. Once EFT is active, members no longer receive a paper bill and will see payments withdrawn on their bank statements. They will receive written confirmation from the plan that they are enrolled.
8.7. Can the plan ever choose to end a beneficiary's membership?	Yes. This is called an involuntary disenrollment. There are several reasons this could happen. For example, if a member leaves the plan's service area for more than 12 months or fails to pay premiums. Refer to the Evidence of Coverage or call customer service for more information about involuntary disenrollment.
8.8. What happens if a member doesn't pay premiums or pays premiums late?	The member will receive a letter each month that the premium is not received on time. After three months, if the member has not made premium payments, the member will receive a letter notifying them that they are being disenrolled. Once the disenrollment is confirmed by Medicare, the member will receive another letter confirming the disenrollment. To ensure payments are made on time, encourage members to sign up for electronic funds transfer (EFT) or to have payments deducted from their Social Security or Railroad Retirement Board (RRB) benefit checks. It may take two or more months for automatic payments to begin. Members should continue to pay paper bills until the new payments become effective. If the member has been billed but has not paid premiums when EFT begins, any premiums due will be deducted at that time. If the member has been billed but has not paid premiums when Social Security or RRB deductions begin, the amount due will not be deducted from their benefit checks. They must pay the amount billed to bring their account up to date. Social Security and the RRB do not allow any retroactive withholding requests. Members who qualify for Extra Help (the low-income subsidy) are excluded from the delinquency process.

8.9. What can a beneficiary do during the Medicare Advantage open enrollment period (MA OEP)?	The MA OEP runs from January 1 to March 31. Beneficiaries may switch from an MA or MA-PD plan to another MA or MA-PD plan, or to Original Medicare. Individuals switching from an MA or MA-PD plan back to Original Medicare may also enroll in a stand-alone Part D plan. This enrollment period is also available for the first three months an individual has Medicare entitlement.
8.10. If a beneficiary uses MA OEP to add prescription drug coverage for the first time, will they have a late enrollment penalty (LEP)?	It depends on whether the beneficiary had other creditable drug coverage and how long they went without creditable coverage. The same LEP rules apply if a beneficiary joins a drug plan during the MA OEP.
8.11. If someone makes a change during MA OEP, when is it effective?	Changes made during the MA OEP are effective the first of the month following receipt of the enrollment request.
8.12. How does an individual disenroll from an MA-PD plan?	The individual should contact their MA-PD plan to find out how to disenroll.
8.13. If a beneficiary disenrolls from an MA-PD without getting a PDP, do they need to notify CMS that they are returning to Original Medicare?	If the beneficiary is eligible for Medicare Part A and continues to pay the Medicare Part B premium, they will automatically return to Original Medicare and do not need to notify CMS.
8.14. Can someone make other changes during the MA OEP?	No. Beneficiaries may only switch from one MA or MA-PD plan to another MA or MA-PD plan, or to Original Medicare. If switching back to Original Medicare, they may also enroll in a stand-alone Part D plan.

9. BACKGROUND INFORMATION FOR AGENTS	
9.1. How will the changes this year affect my commissions?	Please contact your local plan for details about commissions.

9.2. When should I use a scope of appointment form?	CMS requires that agents to document a scope of appointment form prior to any marketing appointment, regardless of the venue. The beneficiary must agree to the scope of the appointment and the discussion may only concern previously agreed upon topics. The requirements around documentation include:
	• The documentation can be in writing, in the form of a signed agreement by the beneficiary, or a recorded oral agreement. Agents may use a variety of means to fulfill the scope of appointment requirement, including conference calls, fax machines, designated recording line, pre-paid envelopes and email.
	• Agents are expected to include the following when documenting the scope of appointment:
	  ○ Product type (e.g., MA, PDP) that the beneficiary has agreed to discuss during the appointment
	  ○ Date of appointment
	  ○ Beneficiary contact information (e.g., name, address, telephone number)
	  ○ Signature (e.g., beneficiary or authorized representative)
	  ○ Agent information (e.g., name and contact information) and signature
	  ○ A statement that beneficiaries are not obligated to enroll in a plan; their current or future enrollment status will not be impacted and clearly explain that the beneficiary is not automatically enrolled in the plan(s) discussed
	  ○ If the scope of appointment was not signed prior to the appointment, include an explanation
	Please see section 50.3 – Personal/Individual Marketing Appointments in the 2019 *Medicare Communications & Marketing Guidelines* for additional information.

9.3. When are the forms for 2020 going to be posted online?	The enrollment form will be posted at **YourMedicareSolutions.com** on October 1. There will be online and paper versions available. Remember, we cannot process AEP enrollment forms prior to October 15.

9. BACKGROUND INFORMATION FOR AGENTS	
9.4. When can I begin submitting applications?	You may not accept or solicit paper enrollment forms from beneficiaries prior to October 15, unless the individual is eligible for a special enrollment period (SEP). • If a beneficiary personally *gives* you a form prior to October 15, submit them immediately. CMS views agents as extensions of the plan sponsor, so the acceptance of an application or change form is equivalent to acceptance by the plan, and all CMS processing timelines must be met. • If you receive a paper enrollment or change form in the *mail* between October 1 and October 14, do not return it to the beneficiary. Please immediately submit these forms. • If you help a beneficiary complete an application and it is submitted prior to October 15, you will be investigated for compliance with CMS guidelines and are subject to discipline up to and including termination.
9.5. Should I submit paper forms or use the online forms?	The online form is preferred because it can be more easily processed in the timeframe required by CMS. Complete the form at **YourMedicareSolutions.com.** The beneficiary must have checked the attestation box on the form or be present when you submit the form online. Enrollment forms have a check box beneath the beneficiary signature that the beneficiary can check to authorize agents to submit their paper application online. If you complete a paper enrollment or if the beneficiary didn't check the box authorizing you to submit their form online, you must fax it or send it by overnight delivery. Fax enrollment forms to TMG Health at **1-855-874-4702.** Each fax cover sheet must include: • Name of the beneficiary(ies) on the enrollment form(s) • Number of enrollment forms in that transmittal • Your name and contact information If you complete a paper form and want to submit it by overnight delivery, send the form(s) to: TMG Health, Inc. 25 Lakeview Drive Jessup, PA 18434
9.6. Can beneficiaries enroll or change plan options on their own? Can they mail in a paper form?	Yes. There are three ways beneficiaries can enroll or make changes: • Complete the form online at **YourMedicareSolutions.com** • Call the pre-enrollment Medicare Solutions specialists line • Complete the enrollment or change form and mail it to: MedicareBlue Rx P.O. Box 3178 Scranton, PA 18505

9. BACKGROUND INFORMATION FOR AGENTS	
9.7. What should I do if I have a beneficiary: • With limited income and their billing isn't correct? • Whose claims are not being paid correctly? • Who is experiencing difficulties accessing their benefits?	Contact the MedicareBlue Rx post-enrollment Broker Help Desk at **1-866-849-2498**.
9.8. If a prospective member is unhappy about something plan-related, where should they send their concerns?	If a *prospective member* wants to file a pre-enrollment grievance, he or she should call MedicareBlue Rx Medicare Solutions specialists. Grievance information should include any material they are complaining about in as much detail as possible. If a *member* wants to file a post-enrollment grievance, they should call MedicareBlue Rx customer service. The representative will gather or confirm the information listed above. Or members can send a written grievance to: MedicareBlue Rx Grievance Department P.O. Box 3147 Scranton, PA 18505 Fax: 1-855-874-4705 Members should refer to their Evidence of Coverage to learn more about how to submit grievances.
9.9. For which options can employers/unions contribute to the premium payments for individual prescription drug coverage?	Employers may contribute to MedicareBlue Rx premiums for either of the plan options.

2020 MEDICAREBLUE RX LOW-INCOME SUBSIDY AMOUNTS			
Monthly plan premium	**Annual deductible**	**Co-payment amount for generic/preferred multi-source drugs is no more than**	**Co-payment amount for all other drugs is no more than**
LIS amounts for: MedicareBlue Rx Standard			
Standard copay Category 1 (other full subsidy eligibles) **$6.60***	$0	$3.60 (each prescription)	$8.95 (each prescription)
Standard copay Category 2 (Full duals with income <100% FPL) **$6.60***	$0	$1.30 (each prescription)	$3.90 (each prescription)
Standard copay Category 3 (Full duals that are institutionalized) **$6.60***	$0	$0 (each prescription)	$0 (each prescription)
Standard copay Category 4 (100% subsidy eligibles) **$6.60***	$89	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (75% subsidy eligibles) **$15.50***	$89	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (50% subsidy eligibles) **$24.30***	$89	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (25% subsidy eligibles) **$33.20***	$89	15% (each prescription)	15% (each prescription)
LIS amounts for: MedicareBlue Rx Premier			
Premier copay Category 1 (other full subsidy eligibles) **$54.20***	$0	$3.60 (each prescription)	$8.95 (each prescription)
Premier copay Category 2 (Full duals with income <100% FPL) **$54.20***	$0	$1.30 (each prescription)	$3.90 (each prescription)
Premier copay Category 3 (Full duals that are institutionalized) **$54.20***	$0	$0 (each prescription)	$0 (each prescription)
Premier copay Category 4 (100% subsidy eligibles) **$54.20***	$0	15% (each prescription)	15% (each prescription)
Premier copay Category 4 (75% subsidy eligibles) **$63.10***	$0	15% (each prescription)	15% (each prescription)
Premier copay Category 4 (50% subsidy eligibles) **$71.90***	$0	15% (each prescription)	15% (each prescription)
Premier copay Category 4 (25% subsidy eligibles) **$80.80***	$0	15% (each prescription)	15% (each prescription)

2020 SENIOR HEALTH INSURANCE PLAN (SHIP) INFORMATION BY STATE	
IOWA: Iowa SHIIP – Senior Health Insurance Information Program	
CALL	1-800-351-4664
TTY	1-800-735-2942
WRITE	Iowa SHIIP 601 Locust Street, 4th Floor Des Moines, IA 50309-3738
WEBSITE	therightcalliowa.gov

MINNESOTA: Minnesota Board on Aging (Senior LinkAge Line)	
CALL	1-800-333-2433
TTY	1-800-627-3529
WRITE	Minnesota Board on Aging P.O. Box 64976 St. Paul, MN 55164-0976
WEBSITE	mnaging.org/advisor/SLL.htm

MONTANA: Montana Department of Public Health & Human Services	
CALL	1-800-551-3191
TTY	1-866-735-2968
WRITE	Senior & Long Term Care Division 111 North Sanders Street Helena, MT 59601
WEBSITE	dphhs.mt.gov/SLTC/aging/SHIP

NEBRASKA: Nebraska Senior Health Insurance Information Program	
CALL	1-800-234-7119
TTY	1-800-833-7352
WRITE	Nebraska Senior Health Insurance Information Program 1033 O Street, Suite 307 Lincoln, NE 68508
WEBSITE	doi.nebraska.gov/consumer/senior-health

2020 SENIOR HEALTH INSURANCE PLAN (SHIP) INFORMATION BY STATE	
NORTH DAKOTA: SHIC – State Health Insurance Counseling Program	
CALL	1-888-575-6611
TTY	1-800-366-6888
WRITE	North Dakota Insurance Department 600 East Boulevard Bismarck, ND 58505-0320
WEBSITE	nd.gov/ndins/shic

SOUTH DAKOTA: SHIINE – Senior Health Information and Insurance Education	
CALL	Eastern South Dakota: 1-800-536-8197 Central South Dakota: 1-877-331-4834 Western South Dakota: 1-877-286-9072
TTY	1-800-877-1113
WRITE	Senior Health Information and Insurance Education – SHIINE 700 Governors Drive Pierre, SD 57501-2291
WEBSITE	shiine.net

WYOMING: Wyoming State Health Insurance Information Program – WSHIIP	
CALL	1-800-856-4398
TTY	711
WRITE	Wyoming SHIIP P.O. Box BD Riverton, WY 82501
WEBSITE	wyomingseniors.com/WSHIIP.htm

Appendix A: 2020 plan overview chart

<table>
<tr><th colspan="5">MedicareBlue Rx 2020 plan overview</th></tr>
<tr><th></th><th colspan="2">MedicareBlue Rx Standard</th><th colspan="2">MedicareBlue Rx Premier</th></tr>
<tr><td>Monthly premium</td><td colspan="2">$42</td><td colspan="2">$89.60</td></tr>
<tr><td>Annual deductible</td><td colspan="2">$0 on tiers 1-2
$435 on tiers 3-5</td><td colspan="2">$0</td></tr>
<tr><td rowspan="5">Initial coverage

After paying the deductible, member pays the following share of the cost – either in the form of a copay or coinsurance amount – until total yearly drug costs reach $4,020</td><td colspan="4">Retail (30-day supply)</td></tr>
<tr><td>Preferred cost sharing</td><td>Standard cost sharing</td><td>Preferred cost sharing</td><td>Standard cost sharing</td></tr>
<tr><td>Tier 1: $3 copay
Tier 2: $8 copay
Tier 3: $29 copay
Tier 4: 29% coinsurance
Tier 5: 25% coinsurance</td><td>Tier 1: $15 copay
Tier 2: $20 copay
Tier 3: $46 copay
Tier 4: 35% coinsurance
Tier 5: 25% coinsurance</td><td>Tier 1: $0 copay
Tier 2: $0 copay
Tier 3: 17% coinsurance
Tier 4: 40% coinsurance
Tier 5: 33% coinsurance</td><td>Tier 1: $15 copay
Tier 2: $20 copay
Tier 3: 25% coinsurance
Tier 4: 45% coinsurance
Tier 5: 33% coinsurance</td></tr>
<tr><td colspan="4">Mail order* or extended day supply (EDS) (90-day supply)</td></tr>
<tr><td>Preferred cost sharing</td><td>Standard cost sharing</td><td>Preferred cost sharing</td><td>Standard cost sharing</td></tr>
<tr><td>Tier 1: $6 copay
Tier 2: $16 copay
Tier 3: $87 copay
Tier 4: 29% coinsurance
Tier 5: Not available</td><td>Tier 1: $30 copay
Tier 2: $40 copay
Tier 3: $138 copay
Tier 4: 35% coinsurance
Tier 5: Not available</td><td>Tier 1: $0 copay
Tier 2: $0 copay
Tier 3: 17% coinsurance
Tier 4: 40% coinsurance
Tier 5: Not available</td><td>Tier 1: $30 copay
Tier 2: $40 copay
Tier 3: 25% coinsurance
Tier 4: 45% coinsurance
Tier 5: Not available</td></tr>
<tr><td>Coverage gap</td><td colspan="4">Standard plan members will pay no more than 25% of the plan’s costs for brand-name drugs and 25% of the plan’s costs for generic drugs.
Premier plan members have tier 1 and tier 2 coverage during the coverage gap. Premier plan members will pay no more than 25% of the plan’s costs for brand-name drugs and 25% of the plan’s costs for generic drugs.</td></tr>
<tr><td>Catastrophic coverage</td><td colspan="4">Once an individual has paid $6,350 in out-of-pocket drug costs, they will pay 5% coinsurance or a $3.60 copay for generic drugs and 5% coinsurance or a $8.95 copay for brand-name drugs, whichever is greater, for a 30-day supply.</td></tr>
<tr><td colspan="5">*CVS Caremark Mail Order is currently the only mail order pharmacy service available to members. Because CVS offers preferred cost sharing, members will pay the preferred cost sharing copays/coinsurance when purchasing prescriptions by mail.</td></tr>
</table>

For agent and local plan use only. Not for use with the public.

Basic Blue Rx question and answer guide

Pre-enrollment Medicare Solutions specialists	Post-enrollment customer service
Louisiana, Pennsylvania, West Virginia: **1-888-575-7519** (TTY: **711**) North Carolina: **1-800-661-5518** (TTY: **1-800-922-3140**) October 1 through March 31 8 a.m. to 8 p.m., daily, local time April 1 through September 30 8 a.m. to 8 p.m., Monday through Friday, local time **BasicBlueRx.com**	All areas: **1-877-376-2185** (TTY: **711**) October 1 through March 31 8 a.m. to 8 p.m., daily, local time April 1 through September 30 8 a.m. to 8 p.m., Monday through Friday, local time **BasicBlueRx.com**

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2020 SHIP INFORMATION BY STATE

Appendix 1: 2020 plan options overview

1. BASIC BLUE RX GENERAL PLAN QUESTIONS	
1.1. Is Basic Blue Rx being offered in additional states?	No. In 2020, Basic Blue Rx will continue to be available to residents of Louisiana, North Carolina, Pennsylvania and West Virginia. The Basic Blue Rx Value plan will only be available in Pennsylvania and West Virginia for 2020. The Basic Blue Rx Standard plan will be available in all four service areas for 2020. Basic Blue Rx is licensed by the Blue Cross and Blue Shield Association to allow it to be Blue-branded and sold in the states listed above, but it is not a product of the participating Blue plan.
1.2. Where is the service area for the plan?	Beneficiaries must be a permanent resident in one of the following states to be eligible for Basic Blue Rx: • Louisiana (Standard plan only) • North Carolina (Standard plan only) • Pennsylvania (Value and Standard plan) • West Virginia (Value and Standard plan)
1.3. Who can join the plan?	Basic Blue Rx is available to all Medicare beneficiaries who permanently reside in the service area and are entitled to Medicare Part A and/or enrolled in Medicare Part B. Beneficiaries can also join if they are enrolled in any of the following plans that does not include Medicare prescription drug coverage: • A Medicare Supplement plan • A private-fee-for-service (PFFS) plan • An MA Medical Savings Account (MSA) plan • An 1876 Cost plan If a beneficiary is enrolled in a Medicare Advantage (MA) coordinated care (HMO or PPO) plan or an MA PFFS plan that includes prescription drug coverage, enrolling in Basic Blue Rx will automatically disenroll them from their previous prescription drug plan.
1.4. When can an individual enroll?	Members can enroll during the annual enrollment period (AEP), October 15 to December 7. Enrollment at other times of the year are allowed only if an individual is in their initial enrollment period (IEP) or is eligible for a special enrollment period (SEP). Enrollments completed using the annual election period take effect January 1, 2020.
1.5. Where can beneficiaries go to find out more information about the plan?	To find out more about Basic Blue Rx, beneficiaries can visit our website at **BasicBlueRx.com** or call: Louisiana, Pennsylvania, West Virginia: **1-888-575-7519** North Carolina: **1-800-661-5518**
1.6. Can I get a plan overview?	See Appendix 1.

1. BASIC BLUE RX GENERAL PLAN QUESTIONS	
1.7. Will all members get a new member ID card for 2020?	No. New members and current Value plan members in Louisiana and North Carolina will receive a new member ID card for 2020. Current Value plan members in Louisiana and North Carolina will be enrolled in the Standard plan for 2020 if they make no changes during AEP, and their new member ID card will reflect their enrollment in the Standard plan.
1.8. When can enrollment changes be made?	Once enrolled in the plan, members generally can only change plans during the annual enrollment period (October 15 through December 7). Changes at other times are allowed if an individual is eligible for a special enrollment period due to an event such as moving into a new service area, moving into or out of a long-term care facility or becoming eligible for Extra Help (financial assistance).
1.9. What information does the coverage and pricing tool provide?	The online coverage and pricing tool will give beneficiaries an estimate of their annual prescription drug costs and shows them if and how their prescription drugs would be covered by the plan. Visit **BasicBlueRx.com/PlanTools** to learn more.
1.10. Why are Star Ratings important? What is Basic Blue Rx's Star Rating?	Medicare rates how plans perform each year in different categories such as detecting and preventing illness, ratings from patients, patient safety and customer service. The rating system is designed to provide consumers with information to help them choose among the Medicare plans offered in their area. The Basic Blue Rx Star Rating for 2019 is 3 stars out of 5. Check the plan website in mid-October to see the 2020 rating.
1.11. What is being done to promote the plan to agents?	Most of the promotion will be through agent channels. We'll be conducting outreach to the managing and general agent or participating Blue plan (general agent) that contracts with the individual agents.
1.12. What steps do I need to take if I want to conduct a PDP sales event?	Complete and submit a sales event reporting form to your managing or general agent or participating Blue plan (general agent). CMS can request this information at any time, so it's important to submit the form in a timely manner. Sales/marketing events must include the following disclaimer on all event advertising: • For accommodation of persons with special needs at meetings, call <insert phone and TTY # here>. Please see section 50.2 – Marketing/Sales Events in the 2019 *Medicare Communications & Marketing Guidelines* for additional information.
1.13. What should I do if I need to cancel my scheduled sales event?	You should notify your general agent. You should also make a good faith effort to notify attendees of the cancellation or have someone on-site for 15 minutes to inform them of the cancellation, unless it is impractical to do so.

1. BASIC BLUE RX GENERAL PLAN QUESTIONS	

1.14. When should I use a scope of appointment form?	CMS requires that agents document a scope of appointment form prior to any personal/individual marketing appointment, regardless of the venue. The beneficiary must agree to the scope of the appointment and the discussion may only concern previously agreed-upon topics. The requirements around documentation include:
	• The documentation can be in writing, in the form of a signed agreement by the beneficiary, or a recorded oral agreement. Agents may use a variety of means to fulfill the scope of appointment requirement, including conference calls, fax machines, designated recording line, pre-paid envelopes and email.
	• Agents are expected to include the following when documenting the scope of appointment:
	  ○ Product type (e.g., MA, PDP) that the beneficiary has agreed to discuss during the appointment
	  ○ Date of appointment
	  ○ Beneficiary contact information (e.g., name, address, telephone number)
	  ○ Signature (e.g., beneficiary or authorized representative)
	  ○ Agent information (e.g., name and contact information) and signature
	  ○ A statement that beneficiaries are not obligated to enroll in a plan; their current or future enrollment status will not be impacted. Clearly explain that the beneficiary is not automatically enrolled in the plan(s) discussed
	  ○ If the scope of appointment was not signed prior to the appointment, include an explanation
	• A beneficiary may agree to a scope of appointment at a marketing/sales event for a future appointment
	
	The scope of appointment form can be found on **BasicBlueRx.com**. Please see section 50.3 – Personal/Individual Marketing Appointments in the 2019 *Medicare Communications & Marketing Guidelines* for additional information.

1.15. If a beneficiary already has health coverage through an employer or union, can they still join Basic Blue Rx?	Beneficiaries should be aware that they could lose their employer or union coverage if they join Basic Blue Rx. They should be advised to read their employer or union communications. If they have questions, they should visit their employer's website, or contact the office listed in their communications. If there isn't information on whom to contact, their employer's benefits administrator or the office that answers questions about their coverage can help.
1.16. If a beneficiary has coverage under a Medicare Advantage plan, can they still join Basic Blue Rx?	If a beneficiary's Medicare Advantage plan includes prescription drug coverage, joining Basic Blue Rx will end their membership in their Medicare Advantage plan. This will affect their doctor and hospital coverage and their prescription drug coverage. They should be advised to read the information that their Medicare Advantage plan sends them. If they have questions, they should contact their Medicare Advantage plan.

1. BASIC BLUE RX GENERAL PLAN QUESTIONS	
1.17. When should beneficiaries expect to receive plan materials? What materials will they receive before they enroll?	Beginning October 1, individuals who request information about the plan will receive a pre-enrollment package within 10 business days. The package includes plan benefit information and numbers they can call to reach a Medicare Solutions specialist. It also contains an application and postage-paid envelope.
1.18. What materials do members receive after they enroll?	Materials include a confirmation letter, member ID card and welcome kit. The confirmation letter notifies the beneficiary of CMS's response and must be mailed within 10 days of CMS's notice to Basic Blue Rx. This letter includes the member's ID card. The welcome kit will arrive within 10 days after CMS confirms the enrollment and includes: • Member guide • An insert that explains how to obtain a copy of the pharmacy directory, formulary and Evidence of Coverage (EOC) • Electronic funds transfer (EFT) form and return envelope • Authorization to release information (ARI) form • Appointment of representative (AOR) form • CVS Caremark mail order form and return envelope
1.19. If a prospective member is unhappy about something plan-related, where should they send their concerns?	If a *prospective member* wants to file a pre-enrollment grievance, they should call a Basic Blue Rx Medicare Solutions specialist. If a *member* wants to file a post-enrollment grievance, they should call Basic Blue Rx customer service. Or, members can send a written grievance to: Basic Blue Rx Grievance Department P.O. Box 3834 Scranton, PA 18505 Fax: **1-855-322-0712**

2. CVS CAREMARK QUESTIONS	
2.1. What does CVS Caremark[1] do as the pharmacy benefit manager?	CVS Caremark, the plan's pharmacy benefit manager (PBM), provides important services including managing the pharmacy network and drug formulary (list of covered drugs). CVS Caremark offers a wide range of services for Part D plans, including a rigorous Medication Therapy Management program and a mail order program, to help members meet their prescription drug needs.
2.2. How do members access their prescription drug information with CVS Caremark?	Members can set up an account at **Caremark.com** where they can review their claims history, order prescriptions by mail and check on the status of orders. Members can also call CVS Caremark at **1-888-572-0870** to set up an account and access their prescription information.
2.3. What is the standard one-month supply of a prescription?	A 30-day supply is the industry standard. Long-term care pharmacies fill 31-day prescriptions.
2.4. What happens if a prescription is written for 31 days or 34 days?	If the member wants to receive the extra amount above a 30-day supply, they will pay two copays or the additional coinsurance amount since the copay/ coinsurance is not pro-rated for the extra number of days. If the member's prescription is written for 31 or 34 days, the member can speak with their pharmacist or doctor to see about changing it to the 30-day supply.
2.5. What if a prescription is written for less than 30 days?	If the cost sharing is a copay, the amount the member pays will be based on the number of days for which the prescription is written. For example, if the cost of a 30-day supply is $30, the cost of the drug is $1 per day. If the member receives a 7-day supply, they will pay $7. If the cost sharing is coinsurance, the member will pay the same percentage regardless of whether the prescription is for a full month supply or fewer days. However, because the cost will be lower for less than a full month's supply, the coinsurance amount will also be less.

[1] CVS Caremark Part D Services is an independent company providing pharmacy benefit management services.

2. CVS CAREMARK QUESTIONS	
2.6. What additional services does CVS Caremark provide?	The following services are provided by CVS Caremark: • **Delivery** – Home delivery within 1-2 days nationwide and same-day within select markets, for a small fee • **Specialty Connect** – Simplifies access to specialty pharmacy by facilitating drop-off and pick-up at local CVS pharmacy, if preferred over mailing • **CVS Specialty pharmacy –** Proactively supports and empowers individuals with rare and chronic conditions to improve their total health and manage their multiple and complex needs • **ScriptSync –** Coordinates refill and renewal schedules for members taking multiple maintenance medications to facilitate pick-up in a single pharmacy visit • **ExtraCare® Health card –** Members receive discounts on CVS branded health-related items at a CVS store • **ExtraBucks Rewards** – Pharmacy reward program • **Mobile app** – Allows members to reorder scripts, save money, order and track refills and more • **Multi-dose packs –** All of a member's medications organized into packs and labeled according to the date and time they should be taken • **ScriptPath** – Prescription schedule for retail pharmacy patients who manage multiple medications, including which medications the patient takes, when to take them and how much of each medication should be taken in each dose. Patients filling at CVS may request the schedule at any time. • **Real-time benefits** – Real-time member-specific benefit information across all points of care to provide greater price transparency and access to lower-cost alternatives. Available at all CVS Pharmacy locations and directly to members through the Check Drug Cost tool on Caremark.com and the CVS/Caremark app.

3. PHARMACY NETWORK	
3.1. How large is the pharmacy network?	The pharmacy network for both plan options includes approximately 66,000 pharmacies across the U.S. Many major retailers such as CVS and Walmart are in the network. Many regional pharmacies such as Fry's Food and Drug and Albertsons are also in the network.
3.2. Which pharmacies offer preferred cost sharing?	Members will usually pay less when they use a preferred pharmacy. Members can go to a pharmacy that offers standard cost sharing, which is a network pharmacy, but they will often pay more for their prescription drugs than they would pay at a preferred pharmacy. For a complete list of preferred pharmacies, go to **BasicBlueRx.com**. Members who do not live near a preferred pharmacy can take advantage of the preferred pricing by filling prescriptions through the plan's mail order service.
3.3. How can beneficiaries find a network pharmacy?	Members can always call customer service for help locating a network pharmacy or to request that a pharmacy directory be mailed to them. Members can also use the pharmacy locator tool at **BasicBlueRx.com**. The pharmacy network can change at any time. Members do not have to go to the same network pharmacy every time.
3.4. Are there pharmacies currently in the network that will not be in the network in 2020?	Almost all the pharmacies that are currently in the network will continue to be in the network for 2020. Please use the pharmacy locator tool on **BasicBlueRx.com** to access up-to-date pharmacy information.
3.5. Will members be notified if their current pharmacy will no longer be in the network for 2020?	No. Since most pharmacies will continue to be in the network, we will not be providing a specific notification if a pharmacy leaves the network.
3.6. Can members get 90-day supplies at retail pharmacies?	Yes. Members can get 90-day supplies at network pharmacies at the mail order rate. Pharmacies that always offer 90-day supplies are identified by "EDS" in the pharmacy directory and the online pharmacy search tool. Non-EDS pharmacies may also provide 90-day supplies if they can and these are also at the mail order rate. Members can check their plan option's Evidence of Coverage to see if there are any other restrictions or limits on drugs.

3. PHARMACY NETWORK	
3.7. How do members access the national network when traveling?	If a member loses their prescription or it runs out while traveling in the U.S., they can get a refill or new prescription at a network pharmacy. Members can call customer service to find a network pharmacy near them or use the online pharmacy locator tool. They can also fill prescriptions at preferred pharmacies while traveling. Members should contact customer service in advance for prescription fills when traveling outside of the U.S. or its territories. Basic Blue Rx cannot pay for prescriptions filled outside of the U.S. or its territories. The member must pay the full cost without reimbursement for each prescription filled.
3.8. Who should pharmacies contact if they have questions about joining the CVS Caremark network or becoming a preferred pharmacy?	Pharmacies can call the CVS network enrollment line at **1-480-314-8457**. Pharmacies will not be able to enter the preferred network during 2020 but can start the process to become a preferred pharmacy in 2021.

4. FORMULARY/PRESCRIPTIONS	
4.1. What is the formulary?	The formulary is a list of all covered drugs. The formulary changes each year as new drugs become available, as generic versions of brand-name drugs become available, as different drugs become recognized as the recommended treatment for a condition, or as drugs are recalled or are no longer manufactured.
4.2. How is the formulary organized? What do the different drug tiers mean?	The formulary, or drug list, includes prescription drugs believed to be part of a quality treatment program. Basic Blue Rx will generally cover the drugs listed in the plan's formulary if the drug is medically necessary, the prescription is filled at a network pharmacy and other plan rules are followed. The drugs on the plan formulary are organized into five tiers. Each tier has a different cost-sharing amount in the form of a copay or coinsurance. The cost-sharing amount depends on which tier the drug is on. • Tier 1: **Preferred generic** – This tier is the lowest tier and generally contains the lowest cost generics • Tier 2: **Generic** – Contains generics • Tier 3: **Preferred brand** – Contains preferred brand drugs and non-preferred generic drugs • Tier 4: **Non-preferred drugs** – Contains non-preferred brand drugs and non-preferred generic drugs • Tier 5: **Specialty** – Contains very high cost brand and some generic drugs, which may require special handling and/or close monitoring
4.3. How is the formulary changing for 2020?	Notable formulary changes for 2020 will be released in October 2019.
4.4. Will drugs be on the same tiers for 2020?	Notable formulary changes, including tier changes, for 2020 will be released in October 2019.
4.5. How does a beneficiary find out if a drug they take is on the plan's formulary?	• Access a current list of covered drugs using the online searchable formulary at **BasicBlueRx.com** • Call customer service, or • Download a copy of the formulary for their plan option from **BasicBlueRx.com/Documents**
4.6. What are specialty drugs?	Specialty drugs are very high cost brand and some generic drugs, which may require special handling and/or close monitoring. Members pay coinsurance for specialty drugs, which are covered in tier 5. Specialty drug costs have risen significantly over the past several years with the introduction of new, high-cost drugs. This impacts premiums and can cause members to reach the catastrophic coverage level more quickly.

4. FORMULARY/PRESCRIPTIONS	
4.7. If I have members whose drugs are not on the formulary, what do they need to do?	If a beneficiary's drug is not included in their plan option's formulary, they should contact customer service to confirm that the drug is not covered. If the beneficiary learns that the plan option does not cover the drug, they have two options: 1. Review the plan option's formulary with their doctor and ask to have a similar drug that is covered prescribed. 2. Ask Basic Blue Rx to make an exception and cover the drug. See the plan option's formulary for information about how to request an exception. If a member switches to a different option, any formulary exceptions or drug utilization requirements (prior authorization, quantity limit exceptions and step therapy) met in 2019 will carry over for 2020. There is nothing the member needs to do until the exception expires. Both current and new members affected by 2020 formulary changes can submit coverage determinations for exceptions, prior authorization or other utilization management requests for 2020 starting on November 1, 2019.
4.8. What process do members need to follow to submit requests for prior authorization or exceptions?	Beneficiaries can submit exception or prior authorization requests for 2020 once Medicare has approved their membership in the plan. Generally, an exception request will be approved only if the alternative drug on the plan's formulary would not be as effective in treating the condition or would cause adverse medical effects. The member's doctor must submit a statement supporting the exception request. If the exception involves a prior authorization, quantity limit or other limit we have placed on a drug, the doctor's statement must indicate why the prior authorization or limit would have adverse effects for the member. There are several ways to submit an exception request to CVS Caremark: • Call CVS Caremark Customer Care at **1-888-572-0870** (TTY: **711**), 24 hours a day, 7 days a week • Fax the request to CVS Caremark at **1-855-633-7673**. Physician fax forms are available at **BasicBlueRx.com** or can be requested by phone. Prescribers can call **1-855-344-0930**. • Submit online at **BasicBlueRx.com/members/prior-authorization** • Mail the request to: **CVS Caremark** **P.O. Box 52000, MC 109** **Phoenix, AZ 85072-2000**

4. FORMULARY/PRESCRIPTIONS	
4.9. If a member is currently taking a drug that has an exception that has already been approved, will the member need to request the exception again for 2020?	Most exceptions are granted for a year. Members typically need to renew approved exceptions annually. Members can start this process as early as 30 days from when the previous exception is due to expire.
4.10. Does the plan cover Medicare Part B and Part D drugs?	Basic Blue Rx does not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, we only cover drugs, vaccines, biological products and medical supplies that are covered under the Medicare prescription drug benefit (Part D) and that are on our formulary. To see the most up-to-date list of drugs on each plan option's formulary, visit **BasicBlueRx.com**.
4.11. Do members have prescription drug coverage in an emergency or urgent care situation?	Prescriptions should be filled at a network pharmacy whenever possible. When filling a prescription in an emergency situation, the member may need to pay for the prescription and file a claim. The member may also be responsible for paying the difference between what the plan would have paid at a network pharmacy and what the out-of-network pharmacy charged. Members should always call customer service to see if a network pharmacy is nearby.
4.12. When do members have to show their member ID card?	When filling a prescription at a network pharmacy, members must show their member ID card. If they don't have it with them, they may have to pay the full cost and submit a claim for reimbursement. By presenting their ID card, the plan can track their purchase and they pay a consistent amount for their drugs. Whenever possible, members should show only their member ID card when purchasing drugs. If members present any other pharmacy discount card or use a pharmacy discount offer when buying prescriptions during the deductible phase, they are responsible for submitting a claim form so the plan can track their true out-of-pocket (TrOOP) and drug costs.

5. MAIL ORDER QUESTIONS	
5.1. How does the mail order program work?	Mail order services are provided by CVS Caremark Mail Order Pharmacy. Purchasing drugs by mail can help members save time and money when they order 90-day extended supplies of maintenance drugs. The drugs are usually delivered to their home within 14 days after they order. New members will receive information on the mail order service in their welcome kit. The CVS Caremark Mail Order Pharmacy phone number and website are included in the pharmacy directory. More information can also be found online at **BasicBlueRx.com**.
5.2. How can a member begin filling prescriptions by mail through CVS Caremark?	**Current members** who have not used this service before can set up an account at any time. Members will need their member ID card, address and payment information to sign up. Members who used this service in 2019 can continue to use their existing account. **New members** can set up an account on or after January 1, 2020. New members will need their member ID card, address and payment information to sign up. **How to register** Call CVS Caremark: **1-888-572-0870** Sign up online: **Caremark.com** Once a member sets up an account, either the member or their doctor can submit a prescription to be filled.
5.3. Can members order refills online?	Yes. Members can go to **Caremark.com** and create an account. Once in their account, members can order refills, check the status of a current mail order and set up automatic mail refills. Mail order forms are available on **Caremark.com** and **BasicBlueRx.com**.
5.4. How does the automatic mail order refill service work?	Members can sign up to have mail order prescriptions refilled every three months through CVS Caremark's automatic mail order refill service. Members can choose which prescriptions they want automatically refilled and can cancel this service at any time. Members participating in the mail order refill service receive a call or message before each shipment. They can choose to receive these alerts by phone, text or email. It is important for the member to confirm the order before it will be billed and shipped.

6. THE COVERAGE GAP	
6.1. What is the "donut hole" or coverage gap?	Medicare prescription drug coverage has four stages: • Deductible • Initial coverage • Coverage gap • Catastrophic coverage For 2020, the coverage gap occurs after the member's total yearly drug costs reach $4,020. In the coverage gap stage, the member will receive a discount on brand-name drugs and generally pay no more than 25 percent of the plan's costs for brand drugs and 25 percent of the plan's costs for generic drugs. They pay this until they reach the catastrophic coverage stage, when their yearly out-of-pocket drug costs reach $6,350.
6.2. Are all brand-name drugs discounted?	All brand-name drugs listed on our formularies are discounted at 70 percent of the negotiated price of the drug. CMS negotiates the agreements with drug manufacturers to offer discounts. We are required to remove any brand-name drugs that do not have the discount agreement. Plans provide an additional 5 percent of coverage so that beneficiaries pay 25 percent.
6.3. Will the discounts change each year?	No. The manufacturer discount will remain at 70 percent, the plan will pay 5 percent and the member will pay 25 percent for brand-name drugs once the coverage gap stage is reached.
6.4. What drugs will be discounted?	Manufacturers will provide discounts on "applicable drugs" for "applicable beneficiaries". An applicable drug is a covered Part D drug that is either approved under a new drug application or licensed appropriately if it is a biologic product. CMS states the Coverage Gap Discount Program (CGDP) "covers all brand-name and biologic Part D drug products needed under the Part D program." The covered drugs must be marketed under the labeler codes on the CMS labeler code list. CMS is not publishing a list of the drugs covered under the manufacturers' agreements. Each month CMS provides updated data to plans on which drugs are not covered by manufacturers' agreements and must be removed from the plan's formulary.
6.5. Who is eligible for the discount?	"Applicable beneficiaries" are individuals who, on the date a drug is dispensed: • Are enrolled in a prescription drug plan or MA-PD plan • Are not entitled to a low-income subsidy • Have reached or exceeded the initial coverage limit during the year
6.6. How will a member receive the discount?	The drug's discount will be applied at the point of sale, which is usually at the pharmacy. The pharmacy will know if the drug is eligible for a discount and how much the member must pay.

6. THE COVERAGE GAP	
6.7. Do discounted drugs count toward the catastrophic maximum? What impact will they have?	Yes. What members pay and the portion manufacturers pay will continue to count toward their true out-of-pocket (TrOOP) cost. However, the 5 percent that the plan pays will not count toward TrOOP. This aligns with TrOOP calculations today, since premiums and other plan payments do not count toward TrOOP.
6.8. Will someone who receives a partial low-income subsidy receive the discounts?	No. According to current guidance, anyone who is eligible for a low-income subsidy is not eligible for the discounts.

7. LOW-INCOME SUBSIDIES (LIS)	
7.1. How are benchmark plans determined?	Medicare receives bids from participating Medicare Part D plans for the coming year. From this information, they finalize premiums and set threshold pricing for plans called a benchmark. Generally, Medicare beneficiaries who receive Extra Help (subsidies) for their prescription drug coverage pay the least amount by enrolling in a benchmark plan.
7.2. Will Basic Blue Rx be a benchmark plan for 2020?	The Standard plan in Louisiana, North Carolina, Pennsylvania and West Virginia qualifies for low-income subsidy (LIS) auto-enrollees.
7.3. How do I find out which plans are benchmark plans?	Check **Medicare.gov** for a listing of the Medicare Part D plan sponsors that are benchmark plans.
7.4. Can an individual who is eligible for Extra Help enroll in Basic Blue Rx?	Yes, eligible individuals in Louisiana, North Carolina Pennsylvania and West Virginia can enroll in the Basic Blue Rx Standard plan. An individual in Pennsylvania or West Virginia who qualifies for LIS can enroll in the Value plan, but they will be responsible for any costs not covered by the subsidy. Look up the premium based on the amount of Extra Help a beneficiary receives in the *2020 Low-Income Subsidy Amount* chart at the end of this Q&A.
7.5. Can you explain what communications CMS sends to LIS beneficiaries and when they will be mailed?	Every fall, CMS reviews eligibility for LIS and notifies a beneficiary if their subsidy will continue or change, or if they no longer qualify. CMS reassigns auto-assigned LIS beneficiaries with 100 percent premium subsidy to a different PDP if their plan is terminating, increasing above the LIS benchmark premium or converting to an enhanced benefit plan. • **Early September** – The Social Security Administration (SSA) mails re-determination letters to certain LIS applicants • **Mid-September** – GREY LETTER mailed to those losing deemed status • **Mid-October** – ORANGE LETTER mailed to those deemed for LIS for next year, but copayment will change • **Late October** – BLUE REASSIGNMENT LETTER mailed to those receiving 100 percent subsidies being reassigned to a new LIS benchmark plan • **Early November** – TAN CHOOSERS LETTER mailed to LIS beneficiaries voluntarily enrolled in a plan that is no longer a benchmark plan; makes beneficiary aware of which plans are the new LIS benchmark plans
7.6. Can you explain the special enrollment periods (SEPs) that	Individuals who qualify for the Extra Help program can use the SEP for dual and other LIS-eligible individuals to enroll in, or disenroll from, a Part D plan once per calendar quarter during

7. LOW-INCOME SUBSIDIES (LIS)	
apply to individuals eligible for the low-income subsidy?	the first nine months of the year. This election period cannot be used from October to December. If they lose Extra Help during the year, the opportunity to make a change continues for three months after they are notified that they no longer qualify for Extra Help. If they begin getting Extra Help or the amount of assistance changes, members in Pennsylvania and West Virginia can change plan options if they are currently enrolled in Basic Blue Rx. If they are not enrolled, they become eligible to enroll at that time.
7.7. How does the Extra Help work?	People with limited incomes may qualify for Extra Help, a government financial assistance program that helps pay for Medicare Part D costs. If eligible, Medicare could pay for 75 percent or more of drug costs including monthly prescription drug plan premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Individuals who qualify may enroll in or disenroll from a plan once per calendar quarter during the first nine months of the year. If they gain or lose Extra Help or have a change in their LIS status during the year, the opportunity to make a change continues for three months after they are notified of the change. Individuals who are eligible for Extra Help who don't enroll in a prescription drug plan are automatically enrolled in a benchmark prescription drug plan by Medicare. A benchmark plan is a plan that has a monthly plan premium that is below a benchmark amount determined each year by Medicare. Low-income individuals enrolled in benchmark plans pay no monthly plan premiums. If a plan's premium increases above the benchmark, Medicare will automatically reassign auto-assigned individuals who are eligible to a new prescription drug plan available in their area so that they can continue to have no monthly plan premiums.
7.8. What happens if a member no longer qualifies for Extra Help? What are their options?	Individuals qualify in a variety of ways. They are automatically eligible if they qualify for Medicaid, get help from the state to pay their Medicare Part A or Part B premiums, or receive Supplemental Security Income (SSI) benefits. If an individual no longer meets one of these requirements, their Extra Help will end unless they apply and qualify based on their income and assets. To apply, a beneficiary must provide information about their income and assets each year. If they don't provide the required information or don't meet the eligibility requirements, their subsidy may be reduced or discontinued.

7. LOW-INCOME SUBSIDIES (LIS)	
	For questions about Extra Help for prescription drug costs, or if an individual needs assistance completing the application, they can: • Call the Social Security Administration (SSA) **1-800-722-1213** (TTY: **1-800-325-0778**) between 7 a.m. and 7 p.m. Monday through Friday ET. • Fill out the application online at **ssa.gov**, under the Medicare link • Complete the paper application included with the letter they received from Medicare. To get another copy of the application by mail, call **1-800-633-4227** (TTY: **1-877-486-2048**) • Call a State Health Insurance Program (SHIP) local office for free personalized health insurance counseling. See the *2020 Senior Health Insurance Plan (SHIP) Information by State* list at the end of this Q&A for contact information • See the "Medicare & You" handbook If a member loses their eligibility for Extra Help, they will have a special enrollment period during which they can switch to a different plan.
7.9. What are the plan premium and cost-sharing amounts for those qualifying for LIS?	Members should call customer service for assistance. Rates are based on the level of Extra Help a beneficiary receives. The *2020 Low-Income Subsidy Amounts* charts at the end of this Q&A also has this information.

8. ENROLLMENT	
8.1. When is the annual enrollment period (AEP)?	AEP is October 15 through December 7. Enrollments using the annual election period take effect January 1.
8.2. When does the 2020 marketing period start?	Agents can begin marketing Basic Blue Rx on October 1.
8.3. What are my obligations to a beneficiary when helping with the enrollment process?	When you are assisting a beneficiary with enrollment in the plan, you must: • Give the beneficiary the information needed to choose a plan that meets the beneficiary's needs • Determine if the beneficiary is enrolled in other medical or prescription drug coverage • Work with the beneficiary to determine the impact of enrollment on their other coverage • Determine if coordination of benefits with other coverage needs to be considered
8.4. When will the 2020 enrollment form be posted?	The enrollment form will be posted at **BasicBlueRx.com** on October 1. There will be online and paper versions available. We cannot process AEP enrollment forms prior to October 15.
8.5 When can I begin submitting applications?	You may not accept or solicit paper enrollment forms from beneficiaries prior to October 15, unless the individual is eligible for a special enrollment period (SEP). • If a beneficiary personally *gives* you a form prior to October 15, do not hold the form. Submit it immediately. CMS views agents as extensions of the plan sponsor, so the act of accepting an application or change form is equivalent to acceptance by the plan, and all CMS processing timelines must be met. • If you receive a paper enrollment or change form by *mail* between October 1 and October 14, do not return it to the beneficiary. Immediately submit these forms to Basic Blue Rx. • If a beneficiary completes an application and it is submitted prior to October 15, you will be investigated for compliance with CMS guidelines and subject to discipline, up to and including termination.

8. ENROLLMENT	
8.6. What are the steps in the enrollment process?	1. **Completion of enrollment form** – You have four options: • Submit an online enrollment form on **BasicBlueRx.com** • Submit an online enrollment form on **Medicare.gov** • Complete a paper enrollment form and submit it online • Complete a paper enrollment form and submit it by fax or overnight delivery 2. **Acknowledgement of enrollment form** – Basic Blue Rx must contact the beneficiary within 10 calendar days of the application date. Beneficiaries who use the online enrollment method may print a confirmation of their enrollment submission. Beneficiaries completing paper enrollments must keep a copy of the form. 3. **Submission to CMS for approval** – Basic Blue Rx must submit complete enrollment requests to CMS within seven calendar days. While CMS reviews the election request, the beneficiary can use the acknowledgement letter that verifies receipt of the complete enrollment form as proof of coverage until member materials arrive. 4. **CMS approval** – CMS reviews the enrollment request and verifies that the beneficiary meets all CMS eligibility requirements. Basic Blue Rx is then notified whether the enrollment request is approved or rejected. 5. **Member materials or rejection letter** – Once the enrollment request is approved, member materials are mailed. If CMS rejects the enrollment request, Basic Blue Rx will notify the beneficiary within 10 calendar days of the notice. The letter will describe the reason that CMS rejected the election request as well as the beneficiary's appeal rights.

8. ENROLLMENT	
8.7. What are the options for completing and submitting an enrollment form?	Determine which of the four methods for completing an enrollment form is most appropriate: • Submit an online enrollment form via **BasicBlueRx.com**. Online enrollments via an agent website are not permitted. • Submit an online enrollment form via **Medicare.gov**. • Complete a paper enrollment form and submit it online. Make sure the beneficiary has given permission for their enrollment to be submitted online by checking the authorization box on the paper enrollment form. You need to keep the paper enrollment form for 11 years. • Complete a paper enrollment form and submit it by fax or overnight delivery. If submitting a paper enrollment form by fax, you need to keep the fax confirmation and the paper enrollment form for 11 years. Telephonic enrollment is available only for a beneficiary or authorized representative. Agents must not be present during this call and may not assist in telephonic enrollments. If a beneficiary enrolls by phone, the agent will not receive commission on the enrollment and will no longer be the agent of record.
8.8. Should I submit paper forms or use the online forms?	The online form is preferred because it can be more easily processed in the timeframe required by CMS. The beneficiary must have checked the attestation box on the form or be present when you submit the form online. Paper enrollment forms have a check box beneath the beneficiary signature that the beneficiary can check to authorize agents to submit their paper application online. If you complete a paper enrollment form, you must submit it by fax or overnight mail. If the beneficiary didn't check the box authorizing you to submit it online, you must fax it or send it by overnight delivery. Fax enrollment forms to **1-855-322-0715**. Each fax cover sheet must include: • Name of the beneficiary(ies) on the enrollment form(s) • Number of enrollment forms in that transmittal • Your name and contact information Overnight mail enrollment forms to: TMG Health, Inc. 25 Lakeview Drive Jessup, PA 18434
8.9. How much time do I have to submit a beneficiary's enrollment form?	If you are unable to submit an enrollment or change form immediately, it must be submitted no later than two days after the beneficiary has signed the application. It's also important that you do not sign the application before the beneficiary has signed it.

8. ENROLLMENT	
	Applications received three or more calendar days after the agent signature date will result in corrective action. Paper enrollment or change forms received by agents must be faxed or submitted by overnight mail immediately and include documentation of application date. Paper enrollments and changes may also be entered online immediately after receipt if the beneficiary has given permission by checking the authorization box below their signature on the form.
8.10. What happens after an enrollment form is submitted?	Basic Blue Rx has 10 calendar days from the application date to provide the beneficiary with: • An acknowledgment letter verifying receipt of a complete enrollment form, which may be used as proof of coverage until member materials arrive, or • A telephonic or written request for missing or clarifying information, or • A written notice that the enrollment was denied based on a determination that the beneficiary was ineligible Within 15 calendar days of the application receipt date, the beneficiary will receive a verification letter to make sure they understand the plan rules. If an enrollment request is missing information or is incomplete, the request cannot be sent to CMS. The beneficiary must be contacted by phone or in writing within 10 calendar days of the application date to request missing information or clarifying documentation. For AEP enrollments, the beneficiary has 21 calendar days from receipt of this request or until December 7, whichever is later, to provide the requested information. If the information is not provided in that timeframe, the enrollment request is denied, and the beneficiary is notified of the denial. For all other enrollment periods, the beneficiary has 21 calendar days from receipt of the request or until the end of the month in which the request was received, whichever is later, to supply the missing information. All additional information provided by the beneficiary will be date stamped as soon as it is received. If the requested information is received within the allowable timeframe, and the enrollment request is deemed complete, the plan must forward the enrollment to CMS within seven calendar days.
8.11. What if a beneficiary wants to cancel their enrollment request?	To cancel an enrollment request during AEP, the beneficiary must call customer service by December 31. If a beneficiary cancels their enrollment request after December 7, they would need to qualify for an SEP to enroll in another plan.
8.12. When is the Medicare Advantage open enrollment period or (MA OEP)?	The MA OEP runs from January 1 through March 31. This enrollment period is also available during the first three months an individual has Medicare entitlement.

8. ENROLLMENT	
8.13. What can a beneficiary do during the MA OEP?	Beneficiaries may switch from an MA or MA-PD plan to another MA or MA-PD plan, or to Original Medicare. Individuals switching from an MA or MA-PD plan back to Original Medicare may also enroll in a stand-alone Part D plan. Beneficiaries may make this change between January 1 and March 31. It is also available during the first three months an individual has Medicare entitlement.
8.14. If a beneficiary uses the MA OEP to add prescription coverage for the first time, will they have a late enrollment penalty?	It depends on whether the beneficiary had other creditable drug coverage, for how long and how long the beneficiary was without creditable coverage. The same late enrollment penalty (LEP) rules apply if a beneficiary joins a drug plan during the MA OEP.
8.15. Is there a specific form an individual should use to disenroll from an MA-PD plan if they are enrolling in Original Medicare and a PDP?	The member should contact their MA-PD plan to find out how to disenroll.
8.16. Can someone make other changes during the MA OEP?	No. Beneficiaries may only switch from one MA or MA-PD plan to another MA or MA-PD plan, or to Original Medicare. If switching back to Original Medicare, they may also enroll in a stand-alone Part D plan.

9. PREMIUM PAYMENTS	
9.1. What is the monthly premium?	See Appendix 1.
9.2. What are the options a member has for premium payment?	Members can sign up for automatic payment deductions through electronic funds transfer (EFT), or have payments deducted from their Social Security or Railroad Retirement Board (RRB) benefit check. Visit **BasicBlueRx.com/ChangePayment**. Members can also have paper bills mailed to them.
9.3. What is the process for a member to have their plan premium deducted from their Social Security or Railroad Retirement Board (RRB) benefit check?	Social Security or RRB requests must be submitted in writing. Members can submit their request by mail or go online. If members choose to have premium payments deducted from their Social Security or Railroad Retirement Board (RRB) benefit checks, the deduction may take two or more months to begin. In most cases, Social Security or the RRB will accept the request. If Social Security or the RRB does not approve the deduction request, members will receive paper bills. While the request is being considered, members will receive paper bills and must pay the premiums directly to the plan until their deduction begins. If members do not pay the paper bills, they may be disenrolled. Social Security and the RRB do not allow retroactive deductions. If the request is not approved, members can sign up for electronic funds transfer.
9.4. If a member pays premiums through deductions from their Social Security benefit check, will the new premium amount start coming out of the January Social Security check?	Depending on when the change is received, there could be a delay before the plan premium amount being deducted changes to reflect the new 2020 premium amount. It's possible that 2019 premiums may still be deducted in the first quarter. Social Security should process the updates by the end of March. When the updates are processed, premiums will be retroactively adjusted to January 1. If the premium increases, the increased amount and the difference owed for the month(s) the new premium was not paid will be deducted in the month the update and premium are effective. If the premium decreases, the difference will be refunded to the member the month the update and new premium become effective.
9.5. What is the process for a member to set up automatic deductions through electronic funds transfer (EFT)?	Members can have premium payments deducted from their checking or savings account through EFT. • Sign up online at **BasicBlueRx.com/ChangePayment** • Download the paper form at **BasicBlueRx.com/Documents** Once the banking information is received, it may take up to two months for EFT to begin. Members are responsible for paying the paper bills they receive until EFT takes effect. If they don't pay all bills while EFT is being set up, any amounts owed will be included in their first EFT payment. Once EFT is active, members will no longer receive a paper bill and will see payments withdrawn on their bank statements. They will receive written confirmation that they are enrolled.

9.10. Can you explain the disenrollment process if a member doesn't make payments?	Plan premium invoices are mailed to members by the 15th of each month with payment due the first of the following month. If a member's premium payment is not received by the first of the month, the member is considered delinquent and will enter the disenrollment process. The member will receive a letter each month that the premium is not received on time. After three months, if the member has not made any premium payments, the member will receive a letter notifying them that they are being disenrolled. Once the disenrollment is confirmed by Medicare, the member will receive another letter confirming the disenrollment. To ensure that payments are made on time, encourage members to sign up for EFT or to sign up to have payments deducted from their monthly Social Security or Railroad Retirement Board benefit checks. Remind members that it may take two or more months for automatic payments to begin and that members should continue to pay paper bills until the new payments become effective.

2020 BASIC BLUE RX LOW-INCOME SUBSIDY AMOUNTS FOR LOUISIANA STANDARD PLAN			
Monthly plan premium	**Annual deductible**	**Copayment amount for generic/preferred multi-source drugs is no more than**	**Copayment amount for all other drugs is no more than**
Standard copay Category 1 (other full subsidy eligibles) $0.00*	$0	$3.60 (each prescription)	$8.95 (each prescription)
Standard copay Category 2 (Full duals with income <100% FPL) $0.00*	$0	$1.30 (each prescription)	$3.90 (each prescription)
Standard copay Category 3 (Full duals that are institutionalized) $0.00*	$0	$0 (each prescription)	$0 (each prescription)
Standard copay Category 4 (100% subsidy eligibles) $0.00*	$89	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (75% subsidy eligibles) $7.70*	$89	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (50% subsidy eligibles) $15.50*	$89	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (25% subsidy eligibles) $23.20*	$89	15% (each prescription)	15% (each prescription)

2020 BASIC BLUE RX LOW-INCOME SUBSIDY AMOUNTS FOR NORTH CAROLINA STANDARD PLAN			
Monthly plan premium	**Annual deductible**	**Copayment amount for generic/preferred multi-source drugs is no more than**	**Copayment amount for all other drugs is no more than**
Standard copay Category 1 (other full subsidy eligibles) $0.00*	$0	$3.60 (each prescription)	$8.95 (each prescription)
Standard copay Category 2 (Full duals with income <100% FPL) $0.00*	$0	$1.30 (each prescription)	$3.90 (each prescription)
Standard copay Category 3 (Full duals that are institutionalized) $0.00*	$0	$0 (each prescription)	$0 (each prescription)
Standard copay Category 4 (100% subsidy eligibles) $0.00*	$89	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (75% subsidy eligibles) $6.60*	$89	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (50% subsidy eligibles) $13.20*	$89	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (25% subsidy eligibles) $19.80*	$89	15% (each prescription)	15% (each prescription)

2020 BASIC BLUE RX LOW-INCOME SUBSIDY AMOUNTS FOR PENNSYLVANIA AND WEST VIRGINIA STANDARD PLAN			
Monthly plan premium	**Annual deductible**	**Copayment amount for generic/preferred multi-source drugs is no more than**	**Copayment amount for all other drugs is no more than**
Standard copay Category 1 (other full subsidy eligibles) $0.00*	$0	$3.60 (each prescription)	$8.95 (each prescription)
Standard copay Category 2 (Full duals with income <100% FPL) $0.00*	$0	$1.30 (each prescription)	$3.90 (each prescription)
Standard copay Category 3 (Full duals that are institutionalized) $0.00*	$0	$0 (each prescription)	$0 (each prescription)
Standard copay Category 4 (100% subsidy eligibles) $0.00*	$89	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (75% subsidy eligibles) $7.90*	$89	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (50% subsidy eligibles) $15.70*	$89	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (25% subsidy eligibles) $23.60*	$89	15% (each prescription)	15% (each prescription)

2020 BASIC BLUE RX LOW-INCOME SUBSIDY AMOUNTS FOR PENNSYLVANIA AND WEST VIRGINIA VALUE PLAN			
Monthly plan premium	**Annual deductible**	**Copayment amount for generic/preferred multi-source drugs is no more than**	**Copayment amount for all other drugs is no more than**
Standard copay Category 1 (other full subsidy eligibles) $12.50*	$0	$3.60 (each prescription)	$8.95 (each prescription)
Standard copay Category 2 (Full duals with income <100% FPL) $12.50*	$0	$1.30 (each prescription)	$3.90 (each prescription)
Standard copay Category 3 (Full duals that are institutionalized) $12.50*	$0	$0 (each prescription)	$0 (each prescription)
Standard copay Category 4 (100% subsidy eligibles) $12.50*	$89	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (75% subsidy eligibles) $15.60*	$89	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (50% subsidy eligibles) $18.70*	$89	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (25% subsidy eligibles) $21.90*	$89	15% (each prescription)	15% (each prescription)

2020 SENIOR HEALTH INSURANCE PLAN (SHIP) INFORMATION BY STATE	
LOUISIANA Senior Health Insurance Information Program (SHIIP)	
CALL	Toll Free: 1-800-259-5300 225-342-5900
WRITE	Louisiana Department of Insurance Senior Health Insurance Information Program (SHIIP) P.O. Box 94214 Baton Rouge, LA 70804
WEBSITE	ldi.la.gov/SHIIP

NORTH CAROLINA SHIIP Seniors' Health Insurance Information Program	
CALL	Toll Free: 1-855-408-1212
WRITE	NC Department of Insurance Seniors' Health Insurance Information Program (SHIIP) 1201 Mail Service Center Raleigh, NC 27699-1201
WEBSITE	ncdoi.com/SHIIP

PENNSYLVANIA Apprise Health Insurance Counseling Program	
CALL	Toll Free: 1-800-783-7067
WRITE	Pennsylvania Department of Aging 555 Walnut Street, 5th floor Harrisburg, PA 17101-1919
WEBSITE	aging.pa.gov

WEST VIRGINIA West Virginia State Health Insurance Assistance Program (SHIP)	
CALL	Toll Free: 1-877-987- 3646 304-558-3317
WRITE	West Virginia SHIP 1900 Kanawha Blvd. East Charleston, WV 25305
WEBSITE	wvship.org

Appendix 1

The Basic Blue Rx Value plan is only available to residents of Pennsylvania and West Virginia. The Basic Blue Rx Standard plan is available to residents of Louisiana, North Carolina, Pennsylvania and West Virginia. Refer to the Summary of Benefits for more information.

Louisiana

Standard plan	**Monthly premium:** $31.00	**Annual deductible:** $0 deductible on tiers 1 and 2; $435 deductible on tiers 3-5	
Initial coverage stage			
Pharmacy type	**Preferred retail**	**Standard retail**	**Preferred mail**
Days' supply	**30**	**30**	**90**
Tier 1: Preferred generic	$0 copay	$10 copay	$0 copay
Tier 2: Generic	$1 copay	$15 copay	$2 copay
Tier 3: Preferred brand	$30 copay	$47 copay	$90 copay
Tier 4: Non-preferred drug	30% coinsurance	36% coinsurance	30% coinsurance
Tier 5: Specialty	25% coinsurance	25% coinsurance	Not available
Coverage gap stage			
Begins when your total drug costs for the year reach $4,020[1]	Generic drugs: 25% of plan cost Brand-name drugs: 25% of plan cost		
Catastrophic coverage stage			
Amount you pay for a 30-day supply after you reach $6,350 in out-of-pocket prescription drug costs[2]	The greater of $3.60 copay for generic drugs and $8.95 copay for all other covered drugs, or 5% coinsurance		

North Carolina

Standard plan	**Monthly premium:** $26.40	**Annual deductible:** $0 deductible on tiers 1 and 2; $435 deductible on tiers 3-5	
Initial coverage stage			
Pharmacy type	**Preferred retail**	**Standard retail**	**Preferred mail**
Days' supply	**30**	**30**	**90**
Tier 1: Preferred generic	$3 copay	$10 copay	$6 copay
Tier 2: Generic	$7 copay	$15 copay	$14 copay
Tier 3: Preferred brand	$25 copay	$44 copay	$75 copay
Tier 4: Non-preferred drug	29% coinsurance	33% coinsurance	29% coinsurance
Tier 5: Specialty	25% coinsurance	25% coinsurance	Not available
Coverage gap stage			
Begins when your total drug costs for the year reach $4,020[1]	Generic drugs: 25% of plan cost Brand-name drugs: 25% of plan cost		
Catastrophic coverage stage			
Amount you pay for a 30-day supply after you reach $6,350 in out-of-pocket prescription drug costs[2]	The greater of $3.60 copay for generic drugs and $8.95 copay for all other covered drugs, or 5% coinsurance		

Pennsylvania/West Virgina

Value Plan	Monthly premium: $25.00	Annual deductible: $0 deductible on tiers 1 and 2; $435 deductible on tiers 3-5	
Initial coverage stage			
Pharmacy type	**Preferred retail**	**Standard retail**	**Preferred mail**
Days' supply	**30**	**30**	**90**
Tier 1: Preferred generic	$0 copay	$10 copay	$0 copay
Tier 2: Generic	$1 copay	$15 copay	$3 copay
Tier 3: Preferred brand	$35 copay	$47 copay	$105 copay
Tier 4: Non-preferred drug	33% coinsurance	45% coinsurance	33% coinsurance
Tier 5: Specialty	25% coinsurance	25% coinsurance	Not available

Standard Plan	Monthly premium: $31.50	Annual deductible: $435	
Initial coverage stage			
Pharmacy type	**Preferred retail**	**Standard retail**	**Preferred mail**
Days' supply	**30**	**30**	**90**
Tier 1: Preferred generic	$2 copay	$6 copay	$4 copay
Tier 2: Generic	$6 copay	$10 copay	$12 copay
Tier 3: Preferred brand	$25 copay	$47 copay	$75 copay
Tier 4: Non-preferred drug	29% coinsurance	34% coinsurance	29% coinsurance
Tier 5: Specialty	25% coinsurance	25% coinsurance	Not available
Coverage gap stage			
Begins when your total drug costs for the year reach $4,020[1]	Generic drugs: 25% of plan cost Brand-name drugs: 25% of plan cost		
Catastrophic coverage stage			
Amount you pay for a 30-day supply after you reach $6,350 in out-of-pocket prescription drug costs[2]	The greater of $3.60 copay for generic drugs and $8.95 copay for all other covered drugs, or 5% coinsurance		

[1] Your "total drug costs" include the total amount you have paid for covered drugs plus what the plan has paid for the calendar year. This does not include the plan premium you pay.

[2] Your "out-of-pocket costs" include the amount you have paid for covered drugs for the calendar year. This does not include the amount the plan has paid or the plan premium.