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**	

Topic index

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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>