Agent Alert

Basic Blue® Rx (PDP)
A Medicare Prescription Drug Plan

September 20, 2017

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NOTE: 2018 PLAN INFORMATION CANNOT BE SHARED PUBLICALLY UNTIL OCTOBER 1, 2017

September formulary changes

The formulary changes effective September 1 have been incorporated into the formulary posted online. An updated PDF of the formulary is available on **BasicBlueRx.com.** The changes have been incorporated into the online search tools, as well.

Name	Basic Blue Rx 5-Tier	Change Description	Therapeutic Category	Therapeutic Class
ARISTADA INJ 1064MG - new strength	Add tier 4, QL	Add	CENTRAL NERVOUS SYSTEM	ANTIPSYCHOTICS
CLINDMYC/NAC INJ 300/50ML - new formulation	Add tier 4	Add	ANTI-INFECTIVES	ANTI-INFECTIVES - MISCELLANEOUS
CLINDMYC/NAC INJ 600/50ML - new formulation	Add tier 4	Add	ANTI-INFECTIVES	ANTI-INFECTIVES - MISCELLANEOUS
CLINDMYC/NAC INJ 900/50ML - new formulation	Add tier 4	Add	ANTI-INFECTIVES	ANTI-INFECTIVES - MISCELLANEOUS
DIASTAT ACDL GEL 12.5-20 - brand only covered	Add tier 4	Add	CENTRAL NERVOUS SYSTEM	ANTICONVULSANTS
DIASTAT ACDL GEL 5-10MG - brand only covered	Add tier 4	Add	CENTRAL NERVOUS SYSTEM	ANTICONVULSANTS

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DIASTAT PED GEL 2.5M GEL - brand only covered	Add tier 4	Add	CENTRAL NERVOUS SYSTEM	ANTICONVULSANTS
DOXORUBICIN INJ 10MG - new strength	-	Add	ANTINEOPLASTIC AGENTS	ANTHRACYCLINES
ISENTRESS HD TAB 600MG - new formulation	Add tier 5	Add	ANTI-INFECTIVES	ANTIRETROVIRAL AGENTS
LORTAB TAB 10-325MG - Product discontinued	Delete	Delete	ANALGESICS	OPIOID ANALGESICS, CII
LORTAB TAB 5-325MG - Product discontinued	Delete	Delete	ANALGESICS	OPIOID ANALGESICS, CII
LORTAB TAB 7.5-325 - Product discontinued	Delete	Delete	ANALGESICS	OPIOID ANALGESICS, CII
MOXIFLOXACIN HCL OPHTH SOLN 0.5% (BASE EQUIV) - generic available	Add tier 3	Add	OPHTHALMIC	ANTI-INFECTIVES
PICATO GEL 0.015% - Tier change	Add tier 3	Add/Tier	TOPICAL	DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE
PICATO GEL 0.05% - Tier change	Add tier 3	Add/Tier	TOPICAL	DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE
Restasis Multidose Ophthalmic Emulsion 0.05 % - new package size	Add tier 3, QL	Add	OPHTHALMIC	MISCELLANEOUS
SELZENTRY SOL 20MG/ML - new formulation	Add tier 5	Add	ANTI-INFECTIVES	ANTIRETROVIRAL AGENTS
TESTOSTERONE TD SOLN 30 MG/ACT - generic available	Add tier 3, PA, QL	Add	ENDOCRINE AND METABOLIC	ANDROGENS
ZAZOLE CRE 0.8% - Product discontinued	Delete	Delete	GENITOURINARY	VAGINAL ANTI-INFECTIVES

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2018 plan changes

Every year, we review our Medicare plans and make changes to ensure that our plans offer value to our members while remaining competitive and affordable. Notable changes for 2018 include:

Standard

- A decrease in monthly premium, from $28.60 to $24.90
- A $0 deductible on Tier 1 and Tier 2 (in 2017, only Tier 1 had $0 deductible), with a full $405 deductible on Tier 3, Tier 4 and Tier 5 drugs
- No 60- or 90-day supply available for Tier 5 Specialty drugs

Formulary

The formulary will continue to have a five-tier structure.

Pharmacy network

The pharmacy network will continue to include more than 67,000 pharmacies nationwide in 2018. The numbers of pharmacies that offer preferred cost sharing in Michigan and nationally will be reduced to 23,000 pharmacies nationally.

For the most recent network pharmacy information, use the 2018 pharmacy locator tool that will be available in October on **BasicBlueRx.com/pharmacy**.

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2018 Basic Blue Rx Benefits

Basic Blue Rx Benefits				
	2018		**2017**	
Monthly premium	$24.90		$28.60	
Annual deductible	$0 deductible on Tier 1 and Tier 2; $405 deductible on Tiers 3, 4 and 5		$0 deductible on Tier 1; $400 deductible on Tiers 2, 3, 4 and 5	
Monthly day supply	30 days		30 days	
Initial coverage	**Preferred**	**Standard**	**Preferred**	**Standard**
Retail pharmacy				
Tier 1: Preferred Generic	$4 copay	$16 copay	$0 copay	$15 copay
Tier 2: Generic	$9 copay	$20 copay	$2 copay	$20 copay
Tier 3: Preferred Brand	15% coinsurance	21% coinsurance	15% coinsurance	22% coinsurance
Tier 4: Non-Preferred drug	30% coinsurance	46% coinsurance	40% coinsurance	45% coinsurance
Tier 5: Specialty	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Initial coverage Mail order and Extended Days' Supply (90-day supply)				
Tier 1: Preferred Generic	$10 copay	$40 copay	$0 copay	$30 copay
Tier 2: Generic	$23 copay	$50 copay	$4 copay	$40 copay
Tier 3: Preferred Brand	15% coinsurance	21% coinsurance	15% coinsurance	22% coinsurance

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Basic Blue Rx Benefits				
	2018		2017	
Tier 4: Non-Preferred drug	30% coinsurance	46% coinsurance	40% coinsurance	45% coinsurance
Tier 5: Specialty	NA	NA	25% coinsurance	25% coinsurance
Coverage gap Once total yearly covered drug costs reach $3,750 ($3,700 in 2017), cost-sharing defined in health care reform begins	Member pays no more than 35% of the plan's costs for brand-name drugs and 44% of the plan's costs for generic drugs		Member pays no more than 40% of the plan's costs for brand-name drugs and 51% of the plan's costs for generic drugs	
Catastrophic coverage Once total out-of-pocket drug costs reach $5,000 ($4,950 in 2017), member reaches this stage of coverage	Member pays the greater of 5% coinsurance OR a $3.35 copay for generic drugs and $8.35 copay for all other covered drugs		Member pays the greater of 5% coinsurance OR a $3.30 copay for generic drugs and $8.25 copay for all other covered drugs	

The Coverage Gap and Catastrophic Coverage

Medicare sets the amounts for the coverage gap and catastrophic coverage each year. These amounts are changing in 2018. Once members pay $3,750 ($3,700 in 2017), they have reached the coverage gap.

Members will then receive a discount on brand-name drugs and in 2018 generally pay no more than 35% of the plan's costs for brand drugs and 44% of the plan's costs for generic drugs. Any brand-name drugs for which there is not a discount agreement cannot be on the formulary per the Centers for Medicare & Medicaid Services (CMS).

Once an individual has paid $5,000 ($4,950 in 2017) in out-of-pocket prescription drug costs, catastrophic coverage begins. Members will pay the greater of 5 percent coinsurance OR a $3.35 copay ($3.30 in 2017) for generic drugs and a $8.35 copay ($8.25 in 2017) for all other covered drugs.

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ANOCs and EOCs mailings

Annual Notice of Changes (ANOC) and Evidence of Coverage (EOC) documents began mailing September 15 to individual members. Individual members must receive the ANOC and EOC by September 30, per the Centers for Medicare and Medicaid (CMS) guidance.

The mailing includes:

- **ANOC:** Describes premium and plan changes that take effect January 1, 2018
- **2018 EOC**: Details plan benefits
- **2018 Formulary:** Lists drugs covered by the plan
- **Pharmacy insert:** Explains how members can ask for a current directory or search for network pharmacies online
- **Low-income subsidy (LIS) Rider**: Explains how much help members receive towards their premium, deductible and copayments.

By law, the distribution of the ANOC is the responsibility of the health plan sponsor and distribution of the wrong documents to a member could create compliance issues for the plan. Therefore, the distribution of these documents by agents is prohibited.

Please see attached zip file for samples of some of these materials.

2018 Pre-enrollment materials ready

The 2018 pre-enrollment booklets for prospective members will be ready soon. **The information in the booklets cannot be publicly shared until October 1, 2017.** Each pre-enrollment booklet contains:

- Pre-enrollment brochure
- 2018 Summary of Benefits
- 2018 Individual Enrollment Form and postage-paid return envelope

Please see attached zip file for samples.

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Important reminders for October 1 Medicare product marketing

The marketing for the Annual Enrollment Period (AEP) begins October 1, 2017. Please remember the following important points:

- Agents must be certified to sell 2018 products prior to marketing those products beginning October 1, 2017.
- Agents must acquire a signed Scope of Appointment form or a recorded agreement prior to any face-to-face marketing appointment with any beneficiary**.** Both types of documentation must be retained for 10 years plus the current year (11 total) and must be made available to the plan upon request.
- Agents may only use marketing materials (including letters and ads) that have been CMS approved and provided by your local plan.
- Marketing materials that mention plan specific benefits must be submitted by the plan to CMS for approval. Generic marketing materials do not need to be submitted to CMS for approval; however, agents are encouraged to submit generic marketing materials to their local plan for review.
- All 2017 enrollment materials and other product brochures must be recycled on December 1, 2017, as the enrollment period for 2017 products expires.

Application guidelines for October 1-14, 2017

Although marketing for the 2018 Basic Blue Rx plan may begin October 1, 2017, the Annual Enrollment Period (AEP) officially starts October 15, 2017, and runs through December 7, 2017. The guidelines below must be followed regarding when applications may be accepted and/or solicited by agents and brokers of Medicare Advantage and Part D organizations between October 1 and October 14.

Certain SEP enrollments can start before October 15

Enrollees may have special enrollment periods (SEPs) that allow you to accept applications prior to October 15. These could include SEPs for moving into the service area, moving into or out of a nursing home, or gaining or losing “Extra Help” (the low-income subsidy). In the “Enrollment Period Determination” section, select the appropriate situation. Beneficiaries can also enroll prior to October 15 using their Initial Enrollment Period (IEP) for Part D enrollments), and employer group SEPs.

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All other enrollments start October 15

The CMS guidelines prohibit Part D plan sponsors from accepting telephone or online enrollments (except for the SEPs noted above) prior to the beginning of the AEP on October 15, 2017, for a January 1, 2018, effective date.

The 2018 online enrollment form for Basic Blue Rx will be available beginning October 1, 2017, and can be found on **BasicBlueRx.com**. The 2018 telephone applications will not be accepted by Customer Service prior to October 15, 2017.

Handling paper forms October 1-October 14

Agents and brokers under contract to sell Basic Blue Rx may accept or solicit paper enrollment forms from individual enrollees prior to October 15, 2017, only if the enrollment is for someone with a qualifying election period/SEP. Enrollments using the AEP should not be accepted or solicited until October 15. These enrollments have effective dates of January 1, 2018. Keep in mind:

- When marketing, remind beneficiaries that they cannot submit enrollment forms until October 15, unless they qualify for other election periods.
- Should an enrollee personally *give* you a form prior to October 15, do not hold these forms but submit them immediately by fax or overnight mail. Because CMS views agents and brokers as extensions of the plan sponsor, the act of accepting an application is equivalent to acceptance by Basic Blue Rx. All CMS required processing timelines must be met. If you hold an enrollment form, we cannot meet these timelines, which places the plan out of compliance with CMS.
- If you receive a paper enrollment form in the mail between October 1 and October 14, do not return it to the beneficiary. Instead, please immediately submit.
- If you as an agent help a beneficiary complete a 2018 application and it is submitted prior to October 15, you will be investigated for compliance with CMS guidelines.

We realize the difficult nature of this guidance given the opportunity and intent to begin marketing Basic Blue Rx beginning October 1. To help minimize the number of early applications you may receive, instructions are included in pre-enrollment materials that tell enrollees to wait until October 15, the start of AEP, before submitting an application.

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2018 enrollment form updates

There were changes to the 2018 enrollment form. The year was updated, and the following changes were made:

- The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, requires that CMS remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on new Medicare cards, which will be issued to beneficiaries no earlier than April 2018. Beneficiaries may use either the HICN or MBI when completing an enrollment request during this transition period. To account for either number being used in the enrollment process during the transition period, the language in the model enrollment form exhibit has been modified to change the term from "Medicare Claim Number," to "Medicare number" to refer to the number assigned to the beneficiary. In addition, the design of the Medicare card will be changing and will be effective when CMS begins to mail new MBI cards in 2018. To address this change, CMS is removing the picture of the Medicare card from the model enrollment form exhibit and replacing it with text to capture only the needed information from the Medicare card: the name as printed on the card (in order to make a positive match in CMS's systems), the Medicare Number, and the Medicare coverage effective dates. Gender is also no longer being requested in this section, as it is already requested earlier in the form.

- In the "Paying your plan premium" section of the forms, a new option has been added: Electronic funds transfer (EFT). CMS has modified guidance to provide plan sponsors with the ability to collect financial information at the time the telephonic enrollment request occurs for the purpose of obtaining the beneficiary's preferred method to pay their premiums.

The form will be available on **BasicBlueRx.com** on October 1. Unless the prospect or member has a special enrollment period, 2018 enrollment forms cannot be submitted for the annual enrollment period (AEP) until October 15, 2017. AEP enrollments have an effective date of January 1, 2018.

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2018 Part D IRMAA amounts

The Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA) is an amount in addition to the monthly Part D premium for individuals whose modified gross income exceeds certain thresholds. Individuals with Part D-IRMAA, who may be members of individual or group plans, must pay this additional amount to the government and not to their plan.

The additional amounts a member may have to pay in 2018 based on income are on the next page and also listed in Chapter 1 in a member's *Evidence of Coverage.*

Beneficiaries who file individual tax returns with income:	Beneficiaries who are married but file separate tax returns from their spouses, with income:	Beneficiaries who file joint tax returns with income:	Part D income-related monthly adjustment amount
Equal to or less than $85,000	Equal to or less than $85,000	Equal to or less than $170,000	$0
Greater than $85,000 and less than or equal to $107,000		Greater than $170,000 and less than or equal to $214,000	$13.00
Greater than $107,000 and less than or equal to $133,500		Greater than $214,000 and less than or equal to $267,000	$33.60
Greater than $133,500 and less than or equal to $160,000		Greater than $267,000 and less than or equal to $320,000	$54.20
Greater than $160,000	Greater than $85,000	Greater than $320,000	$74.80

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