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Region 25 – MedicareBlue Rx
(Revised 9/28/16)

Questions & Answers for 2017 AEP
AGENTS & AGENCIES

Contents – Press CTRL and Click to access each topic.

See the Topic Index on the next page to quickly locate information.

Get your individual questions answered about MedicareBlue Rx:

Pre-Enrollment Questions	Post-Enrollment Customer Service
1-866-434-2037 TTY: **711** **Hours:** From 10/1-2/14, call daily from 8 a.m. to 8 p.m., Central and Mountain times. For the rest of the year, hours are Monday through Friday from 8 a.m. to 8 p.m., Central and Mountain times. **YourMedicareSolutions.com**	**1-888-832-0075** TTY: **711** **Hours:** From 10/1-2/14, call daily from 8 a.m. to 8 p.m., Central and Mountain times. For the rest of the year, hours are Monday through Friday from 8 a.m. to 8 p.m., Central and Mountain times. **YourMedicareSolutions.com**

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Use this Topic Index to quickly locate questions on specific topics.

1. MEDICAREBLUE RX GENERAL PLAN QUESTIONS AND 2017 PLAN CHANGES	
1.1. Where is the service area for the plan?	The service area for the plan is a seven-state region in the Upper Midwest and Northern Plains consisting of Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota and Wyoming. The beneficiary's permanent residence must be in the service area to be eligible for MedicareBlue Rx.
1.2. Who can join the plan?	MedicareBlue Rx is a stand-alone Part D Prescription Drug Plan available to all Medicare beneficiaries who permanently reside in the seven-state region service area *(Note: See Q&A 1.1.)* and who are entitled to Medicare Part A and/or enrolled in Medicare Part B. Beneficiaries can also join MedicareBlue Rx if they are enrolled in a plan such as these 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 that includes Medicare prescription drug coverage, he or she may not enroll in a Prescription Drug Plan (PDP) unless he or she disenrolls from the HMO, PPO or MA PFFS plan. Note: Group MedicareBlue Rx beneficiaries do not need to reside in the service area to join a group plan. These beneficiaries should contact their group administrator for additional information regarding eligibility.
1.3. What types of changes are occurring in MedicareBlue Rx for 2017?	• The premium for the Premier plan option is decreasing from $111.20 to $92.00 while the premium for the Standard plan option is staying the same. • The Standard plan will have a $0 deductible for Tier 1 (Preferred Generic) drugs and a $400 deductible for Tier 2 (Generic), Tier 3 (Preferred Brand), Tier 4 (Non-Preferred drug) and Tier 5 (Specialty) drugs. The Premier deductible remains $0. • Some of the copay and coinsurance amounts are changing to provide greater cost savings at preferred pharmacies. *(Note: See Q&A 3.3. for more information about how preferred cost sharing works.)* • Both plan options will have the same drug formulary for 2017, and some drugs may move to a different tier as a result of formulary changes.

1. MEDICAREBLUE RX GENERAL PLAN QUESTIONS AND 2017 PLAN CHANGES	
	• The 5-tier structure will remain the same, but the name of Tier 4 will change from Non-Preferred Brand drugs to Non-Preferred drugs based on direction from the Centers for Medicare & Medicaid Services (CMS).
1.4. Why does the plan change each year?	We set prices for our plans based on the claims experience from the previous year and the claims we expect in 2017. Each year, Medicare requires us to review our claims and set prices for the following year based on each plan's actual claims for the previous year. If claims are higher or lower than expected, we must change the plan premiums or adjust the benefits for the following year.
1.5. If I have beneficiaries who need more information, where can they call?	Beneficiaries who have questions can visit **YourMedicareSolutions.com** or call MedicareBlue Rx Customer Service at **1-888-832-0075**.
1.6. Can you give me an overview of the plan?	See the table that follows.

<table>
<tr><th colspan="5">MedicareBlue Rx 2017 Plan Overview</th></tr>
<tr><td></td><td colspan="2">MedicareBlue Rx Standard</td><td colspan="2">MedicareBlue Rx Premier</td></tr>
<tr><td>Monthly Premium</td><td colspan="2">$35.10</td><td colspan="2">$92.00</td></tr>
<tr><td>Annual Deductible</td><td colspan="2">$0 for Tier 1 Preferred Generic drugs; $400 for Tier 2 (Generic), Tier 3 (Preferred Brand), Tier 4 (Non-Preferred drugs) and Tier 5 (Specialty) drugs</td><td colspan="2">$0</td></tr>
<tr><td rowspan="6">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 $3,700

(Note: See Q&A 4.3. for names of drug tiers.)</td><td colspan="2">Retail (30-day supply)</td><td colspan="2">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 Preferred Generic:
$1 copay
Tier 2 Generic:
$6 copay
Tier 3 Preferred Brand:
18% coinsurance
Tier 4 Non-Preferred drug:
35% coinsurance
Tier 5 Specialty:
25% coinsurance</td><td>Tier 1 Preferred Generic:
$13 copay
Tier 2 Generic:
$19 copay
Tier 3 Preferred Brand:
25% coinsurance
Tier 4 Non-Preferred drug:
50% coinsurance
Tier 5 Specialty:
25% coinsurance</td><td>Tier 1 Preferred Generic:
$0 copay
Tier 2 Generic:
$0 copay
Tier 3 Preferred Brand:
18%coinsurance
Tier 4 Non-Preferred drug:
45% coinsurance
Tier 5 Specialty:
33% coinsurance</td><td>Tier 1 Preferred Generic:
$15 copay
Tier 2 Generic:
$20 copay
Tier 3 Preferred Brand:
25% coinsurance
Tier 4 Non-Preferred drug:
50% coinsurance
Tier 5 Specialty:
33% coinsurance</td></tr>
<tr><td colspan="2">Mail Order or Extended Day Supply (EDS) (90-day supply)</td><td colspan="2">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>
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$2 copay
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$12 copay
Tier 3 Preferred Brand:
18% coinsurance
Tier 4 Non-Preferred drug:
35% coinsurance
Tier 5 Specialty:
25% coinsurance</td><td>Tier 1 Preferred Generic:
$26 copay
Tier 2 Generic:
$38 copay
Tier 3 Preferred Brand:
25% coinsurance
Tier 4 Non-Preferred drug:
50% coinsurance
Tier 5 Specialty:
25% coinsurance</td><td>Tier 1 Preferred Generic:
$0 copay
Tier 2 Generic:
$0 copay
Tier 3 Preferred Brand:
18% coinsurance
Tier 4 Non-Preferred drug:
45% coinsurance
Tier 5 Specialty:
33% coinsurance</td><td>Tier 1 Preferred Generic:
$30 copay
Tier 2 Generic:
$40 copay
Tier 3 Preferred Brand:
25% coinsurance
Tier 4 Non-Preferred drug:
50% coinsurance
Tier 5 Specialty:
33% coinsurance</td></tr>
</table>

MedicareBlue Rx 2017 Plan Overview		
	MedicareBlue Rx Standard	**MedicareBlue Rx Premier**
	Long Term Care Pharmacy (31-day supply)	**Long Term Care Pharmacy (31-day supply)**
	Tier 1 Preferred Generic: $13 copay **Tier 2 Generic:** $19 copay **Tier 3 Preferred Brand:** 25% coinsurance **Tier 4 Non-Preferred drug:** 50% coinsurance **Tier 5 Specialty:** 25% coinsurance	**Tier 1 Preferred Generic:** $15 copay **Tier 2 Generic:** $20 copay **Tier 3 Preferred Brand:** 25% coinsurance **Tier 4 Non-Preferred drug:** 50% coinsurance **Tier 5 Specialty:** 33% coinsurance

MedicareBlue Rx 2017 Plan Overview	
Coverage Gap	Once members pay $3,700 in 2017, they have reached the coverage gap. Standard members will pay no more than 40 percent of the plan's costs for brand-name drugs and 51 percent of the plan's costs for generic drugs. Premier members will pay these amounts in the coverage gap: • Preferred Cost Sharing: $0 copay for Tier 1: Preferred Generic Drugs, $0 copay for Tier 2: Generic Drugs • Standard Cost Sharing: $15 copay for Tier 1: Preferred Generic Drugs; $20 copay for Tier 2: Generic drugs They will also pay no more than 40 percent of the plan's costs for brand-name drugs and 51 percent of the plan's costs for generic drugs.
Catastrophic Coverage	Medicare sets the amounts for catastrophic coverage each year. These amounts are changing in 2017. Once an individual has paid $4,950 in out-of-pocket prescription drug costs, they will pay the greater of 5 percent coinsurance OR a $3.30 copay for generic drugs and an $8.25 copay for all other covered drugs.

1. MEDICAREBLUE RX GENERAL PLAN QUESTIONS AND 2017 PLAN CHANGES	
1.7. How does the plan differentiate itself in the marketplace?	The Northern Plains Alliance has worked with Medicare for many years. We know what it takes to work with government processes and succeed. Both MedicareBlue Rx plan options have features that beneficiaries may find attractive for different reasons. The Standard plan option has a low monthly premium and features a $1 copay with no deductible on Tier 1 Preferred Generic drugs at pharmacies that offer preferred cost sharing. The Premier option has no annual deductible, so members can begin receiving prescription drug benefit coverage with their first prescription purchase. The plan features Tier 1 Preferred Generic drugs and Tier 2 Generic drugs for $0 when purchased at a pharmacy that offers preferred cost sharing. Members can appreciate how easy the plans are to use. Both plans have the same pharmacy network that includes the major chains across the United States and many independent pharmacies. Both plans also include pharmacies with preferred cost sharing where costs may be lower. The cost-sharing structure of the plans is set up so members can easily budget their prescription drug expenses.
1.8. What's the best way to determine the most suitable plan for an individual?	Selecting the most suitable plan that best meets a person's personal situation depends on several factors: premium amounts, deductible amounts, drugs covered and cost-sharing amounts. Beneficiaries can use the 2017 Pricing Tool that will be available on **YourMedicareSolutions.com** on October 1. It will calculate the beneficiary's financial liability for each of our plan options and provide information to help individuals choose the plan that's best for them. Other factors to consider are the beneficiary's comfort level with the cost sharing. Some individuals prefer a lower premium plan with a deductible for most drugs. Others may want coverage right away with no deductible and be willing to pay a higher premium for it. The choice is theirs. Current members who may want to change options this year can call our Medicare Solutions specialists at **1-866-434-2037** for help with the Pricing Tool. Agent of record information will not be changed if a member uses the call center to switch plan options this fall.

1. MEDICAREBLUE RX GENERAL PLAN QUESTIONS AND 2017 PLAN CHANGES	
	Beneficiaries with Internet access can use the drug cost calculator on the Pricing Tool by going to **YourMedicareSolutions.com**. This comparison tool will be available starting October 1, 2016. You may choose to meet directly with your enrolled members to help them compare plans. Using the online cost calculator will help to facilitate your discussion with them.
1.9. I have trouble printing from the Pricing Tool. What should I do?	If the Pricing Tool charts are not displaying properly on your web browser when you attempt to print, it may be the result of an outdated web browser. To ensure compatibility for all web functions, especially for printing charts or pages from the Pricing Tool, please use one of the following web browsers: • Firefox (preferred). Only download from the official website: https://www.mozilla.org/en-US/firefox/desktop/ • Chrome (preferred). Only download from the official website: https://www.google.com/chrome/browser/desktop/index.html • Internet Explorer 9 or newer (acceptable). Earlier versions may result in unpredictable results. ○ From your browser menu select *Help* > *About* to determine browser version • You may try updating Internet Explorer using the following links as a reference: http://windows.microsoft.com/en-US/internet-explorer/download-ie http://www.wikihow.com/Update-Microsoft-Internet-Explorer • **TIP**: use your browser's print preview feature available from the print menu to see how your printed document will appear. You can modify page margins or switch from portrait to landscape to ensure all content on the page appears as desired on your final printed document.
1.10. When can beneficiaries make a change?	Beneficiaries can change plan options during the annual enrollment period (AEP), October 15 to December 7, 2016. Changes made using the annual enrollment election period take effect January 1, 2017. Changes at other times of the year are allowed only if an individual is eligible for a Special Enrollment Period as a result of

1. MEDICAREBLUE RX GENERAL PLAN QUESTIONS AND 2017 PLAN CHANGES	
	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.

1. MEDICAREBLUE RX GENERAL PLAN QUESTIONS AND 2017 PLAN CHANGES	
1.11. Do members need to complete a form if they want to change to a different MedicareBlue Rx plan option?	Yes. Medicare requires that members complete a change form, either paper, online or by phone, to change to a different option. We cannot automatically move members from one plan option to another without the member completing a form.
1.12. What happens if members don't select a new option?	If members don't make a change, they will automatically continue in their current plan option. Both plan options have benefit changes for 2017, and the Premier option also has a premium decrease.
1.13. Will all members get a new ID card for 2017?	Premier plan members and anyone who enrolls in a new plan option for 2017 will receive new ID cards prior to their coverage effective date. Other members should continue using their current card.
1.14. I've heard about Medicare plans having star ratings. 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 is designed to provide consumers with additional information to help them choose among the Medicare plans offered in their area. In 2016, MedicareBlue Rx received a four out of five star rating. Medicare evaluates plans based on a 5-star rating system. Star Ratings are calculated each year and may change from one year to the next. Beneficiaries can find information on star ratings on the Internet 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.
1.15. When will 2017 plan ratings be available?	We expect the 2017 plan ratings for MedicareBlue Rx to be released sometime in October. Once they are released, we have 21 days to replace all 2016 plan ratings in the 2017 pre-enrollment kits. If you order a quantity of kits, be aware that you will have to replace the 2016 plan ratings with the 2017 version within 21 days, too.

1. MEDICAREBLUE RX GENERAL PLAN QUESTIONS AND 2017 PLAN CHANGES	
1.16. How do the Marketplaces/Exchanges in each state affect Medicare beneficiaries?	Available since 2014, the Marketplace is a way for uninsured individuals to purchase individual health insurance. The policies sold through the Marketplace are not intended for people eligible for Medicare. Individuals eligible for Medicare can continue to participate in Medicare and buy Medicare Advantage, Prescription Drug and Medicare Supplement policies directly from insurance companies as they do today.
1.17. 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 is no information on whom to contact, their employer's benefits administrator or the office that answers questions about their coverage can help.
1.18. If a beneficiary has coverage under a Medicare Advantage plan, can they still join MedicareBlue Rx?	Beneficiaries may already have prescription drug coverage from a Medicare Advantage plan that will meet their needs. By joining MedicareBlue Rx, their membership in their Medicare Advantage plan may end. This will affect both 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 and if they have questions, they should contact their Medicare Advantage plan.
1.19. When should members expect to receive plan materials? What materials will they receive before they enroll?	Current members received their Annual Notice of Changes and Evidence of Coverage, as well as a new formulary, by September 30, 2016. You can begin to discuss the changes for 2017 on October 1, 2016, so members can understand the changes and decide if a different plan would better suit their needs. Other beneficiaries, such as non-members, who request information about any of the plan options, will receive a pre-enrollment package within 7 to 10 business days of their request. The package includes plan benefit information and numbers they can call to reach a Medicare Solutions specialist if they have additional questions (numbers can also be found on the first page of this document). It also contains an application and postage-paid envelope should they choose to enroll by mail.

1. MEDICAREBLUE RX GENERAL PLAN QUESTIONS AND 2017 PLAN CHANGES	
1.20. 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 issued by the plan notifies the beneficiary of CMS' response and must be mailed within 10 days of CMS' 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: • Welcome Flyer • Member Handbook • Evidence of Coverage booklet • Formulary • An insert that explains how to obtain a copy of the Pharmacy directory • Electronic Funds Transfer (EFT) form and return envelope • Authorization to Release Information (ARI) form • Authorization of Representative (AOR) form and instructions • CVS Caremark Mail Order information 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). As one of the largest independent prescription drug management companies in the country, 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 beneficiaries 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 mail orders. Members can also call CVS Caremark at **1-866-412-5393** to set up an account and access their prescription drug information. *(Note: See Q&A 5.3. for details on setting up a mail order account with CVS Caremark.)*
2.3. What is the standard one-month supply of a prescription?	A 30-day supply is the industry standard. Note: To meet CMS requirements, 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, he or she would 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 talk with their pharmacist or doctor about changing it to a 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, he/she 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.

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

2. CVS CAREMARK QUESTIONS	
	However, because the cost will be lower for less than a full months' supply, the coinsurance amount will also be less.
2.6. What additional services does CVS Caremark provide?	After they enroll, members will receive a CVS Caremark ExtraCare® Health Card that they can use to receive a 20% discount on regularly priced CVS/pharmacy brand health-related products. Each member will receive two key tags that they and their family members can use to save money on products such as non-prescription allergy and pain medications, cough and cold products, vitamins, first aid supplies and skin care products. Another service that CVS Caremark offers is its automatic mail order refill service, ReadyFill at Mail®. *(Note: See Q&A 5.5. for more information on ReadyFill at Mail®.)*

3. PHARMACY NETWORK QUESTIONS	
3.1. How large is the pharmacy network?	Both plan options offer the same pharmacy network. Nationwide, the pharmacy network includes about 67,000 pharmacies. A number of major pharmacy chains such as CVS/pharmacy (including former Target pharmacies), Walgreens, Wal-Mart, and Costco are in the network. Many local and regional pharmacies such as Hy-Vee, White Drug, Albertsons, Safeway and Osco are also in the network.
3.2. Will both plan options continue to have pharmacies with preferred cost sharing in 2017?	Yes. Offering preferred cost sharing at certain pharmacies is one way to manage prescription drug costs. It's also competitive with other Part D plans and allows members to save money by choosing where they fill their prescriptions. About 80% of members in the region currently use preferred pharmacies.
3.3. Which pharmacies offer preferred cost sharing?	Within the 67,000 pharmacies in the network, there are more than 36,000 pharmacies that offer preferred cost sharing. The plan has negotiated lower cost-sharing amounts for prescription drugs at these pharmacies. That means 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, which is still a network pharmacy, but they will often pay more for their prescription drugs. • Pharmacies with preferred cost sharing: More than 36,000 nationwide, including CVS/pharmacy (including former Target pharmacies), Wal-Mart, White Drug 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. *(Note: See Section 5. Mail Order for more information on mail order.)* Note: The terms "preferred" and "standard" cost sharing are from CMS.

3. PHARMACY NETWORK QUESTIONS	
	Following is the complete list of 2017 preferred pharmacies: CVS/pharmacy (including former Target pharmacies) Hy-Vee Kroger Medicine Shoppe/ Medicap Safeway/Albertson's Shopko SuperValu Thrifty White Wal-Mart/Sam's Club AccessHealth Ahold APNS Bartell Drugs Cardinal Health Discount Drug Mart Good Neighbor Kinney Drugs LeaderNet Navarro Discount Pharmacies PPOK Preferred pharmacies are identified by a "P" in the pharmacy directories.
3.4. Are there any pharmacies that are currently in the network that will not be in the network for 2017?	Almost all of the pharmacies that are currently in the network will continue to be in the network for 2017. PDFs of the 2017 pharmacy directories are posted on **YourMedicareSolutions.com**. The lists in these directories are current as of July 2016. For the most up-to-date information, always check the online pharmacy search tool or call the Broker Help Desk.
3.5. Will members be notified if their current pharmacy will no longer be in the network for 2017?	No. Since the majority of pharmacies our members use will continue to be in the network, we will not be providing a specific notification if a pharmacy leaves the network. Members can review the pharmacy directory or use the online pharmacy search tool at any time to confirm that the pharmacy they want to use is still in the network. They can also call Customer Service for help with pharmacy searches.
3.6. Can members get 90-day supplies at retail pharmacies?	Yes. Members will be able to a get 90-day supply at all retail pharmacies in the network for the mail order rate. For Preferred Generic and Generic drugs, they will pay the mail order rate of 2 monthly copays. For other drugs, the appropriate coinsurance level will apply. The cost may be lower at a preferred pharmacy.

3. PHARMACY NETWORK QUESTIONS	
3.7. How do members access the national network when traveling?	Members can locate a network pharmacy anywhere in the U.S. by calling Customer Service or using the online pharmacy search tool. They can fill prescriptions at any network pharmacy nationwide by showing their ID card. They can also fill prescriptions at preferred pharmacies when traveling.
3.8 If I have a relative in a nursing home and the nursing home uses a preferred pharmacy, what will my relative pay for 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.
3.9. 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: **1-480-314-8457**. Pharmacies will NOT be able to enter the preferred network during 2017, but can start the process to become a preferred pharmacy in 2018.
3.10. For members who had coverage in 2014, how long will they be able to submit 2014 claims to Prime Therapeutics?	While most claims are processed at the pharmacy in real time, members who need to submit claim forms for 2014 claims will be able to submit those claims for payment for three years (through the end of 2017). Mailing address: Pharmacy Claims P.O. Box 14429 Lexington, KY 40512-4429

4. FORMULARY QUESTIONS	
4.1. How is the formulary changing for 2017?	The formulary is a list of all covered drugs. Both plan options will have the same formulary for 2017. For 2017, both plan options will have a formulary with slightly fewer drugs than last year. 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. There are some formulary changes for 2017. The number of changes for 2017 is similar to the amount of changes that typically happen from one year to the next.
4.2. If there is a formulary change related to a drug a current member is taking, will the member be notified?	No. There will not be significant changes to the formulary for 2017.
4.3. 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 as long as the drug is medically necessary, the prescription is filled at a network pharmacy and other plan rules are followed. The drugs on the plan's formulary are organized into five tiers. Each tier has a different cost-sharing amount in the form of either a copay or coinsurance. The cost-sharing amount depends on which tier the drug is on. The name for Tier 4 is changing from Non-Preferred Brand drugs to Non-Preferred drugs based on direction from CMS. • Tier 1: **Preferred Generic drugs** • Tier 2: **Generic drugs** • Tier 3: **Preferred Brand drugs** • Tier 4: **Non-Preferred drugs** • Tier 5: **Specialty drugs**
4.4. What types of drugs are included in each tier?	Here are the types of drugs included in each tier: • Tier 1: **Preferred Generic drugs –** This tier is the lowest tier and includes some preferred brands. • Tier 2: **Generic drugs –** This tier includes generics and some low-cost preferred brands. • Tier 3: **Preferred Brand drugs –** This tier includes preferred brand drugs and non-preferred generic drugs.

4. FORMULARY QUESTIONS	
	• Tier 4: **Non-Preferred drugs –** This tier includes non-preferred brand drugs and non-preferred generic drugs. • Tier 5: **Specialty drugs –** This tier includes very high cost brand and some generic drugs, which may require special handling and/or close monitoring.
4.5. Will drugs be on the same tiers for 2017?	Formularies change every year. Drugs move from one tier to another, new drugs are added and drugs are removed if generics become available or new drugs are recommended to treat specific conditions. Some drugs are moving to different tiers for 2017. For some drugs, this will result in lower costs, while for others it may result in a cost increase. Members should review the 2017 formulary once they receive it to confirm the amount they will pay for their drugs in 2017.
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. Specialty drugs are covered in Tier 5, and members pay coinsurance for Specialty drugs. The cost of specialty drugs has risen significantly over the past several years with the introduction of new drugs, such as drugs to treat Hepatitis C. These new high cost drugs impact premiums and can cause members to reach the catastrophic coverage level more quickly.
4.7. If I have members whose drugs are not on the formulary or are in a different tier, and they choose to switch plans in 2017, what do they need to do?	If a member switches to a different option within MedicareBlue Rx, any formulary exceptions or drug utilization requirements (prior authorization, quantity limit exceptions and step therapy) met in 2016 will carry over for 2017. There is nothing the member needs to do until the exception expires. Both current and new members affected by 2017 formulary changes can submit coverage determinations for exceptions, prior authorization or other utilization management requests for 2017 starting on December 1, 2016.

4. FORMULARY QUESTIONS	
4.8. What process do members need to follow to submit requests for prior authorization or exceptions?	Either a member or a doctor can submit an exception request, although if the member submits the request, a doctor's statement will most likely be required as well. The doctor must submit a statement indicating that the exception is necessary because none of the drugs on the formulary would be as effective in treating the member's condition or because taking a different drug would have adverse effects for the member. If the exception involves a prior authorization, quantity limit or other limit we have placed on a drug, the doctor's statement must indicate that the prior authorization or limit would not be as effective for treating the condition or 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**. Representatives are available seven days a week, 24/7. TTY users call **711**. • Fax the request to **1-855-633-7673**. Physician fax forms are available at **YourMedicareSolutions.com** or can be requested by phone. • Mail the request to this address: CVS Caremark P.O. Box 52000, MC109 Phoenix, AZ 85072-2000
4.9. If a member is currently taking a drug that has some type of exception that has already been approved (formulary, prior authorization, step therapy, quantity limit), will the member need to request the exception again for 2017?	Exceptions are granted for a certain period of time. 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 MedicareBlue Rx members save time and money when they order 90-day extended supplies of maintenance medications. The drugs are usually delivered to their home within 10-14 days after they order. Prescriptions are available by mail through CVS Caremark Mail Order Pharmacy. New members will receive information on the mail order service in their Welcome Kit when they enroll in the plan. The CVS Caremark Mail Order Pharmacy phone number and website are included in the pharmacy directory. More information can also be found online at **YourMedicareSolutions.com**.
5.2. What will the cost for 90-day supplies ordered by mail be in 2017?	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?	**Members who were enrolled in one of the MedicareBlue Rx plans in 2016, but did NOT use CVS Caremark mail order in 2016** can call CVS Caremark at **1-866-412-5393** to set up a mail order account or set up an account online at **Caremark.com**. Information needed to set up an account includes address and payment information. **New members joining a MedicareBlue Rx plan in 2017** can call CVS Caremark at **1-866-412-5393** on or after January 1, 2017 to set up an account, or they can set up an account online by going to **Caremark.com** after January 1, 2017. Once an account is created, either the member or his/her doctor can submit prescriptions to be filled. If a member has previously used CVS Caremark mail order in 2016 with MedicareBlue Rx, there is already an account set up. The member can continue to use that account to fill future prescriptions. Any refills that exist at the end of 2016 that are still valid will be available for them to refill in 2017.

5. MAIL ORDER QUESTIONS	
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 **Caremark.com** and **YourMedicareSolutions.com**. While on the site, members can also sign up for ReadyFill at Mail®.
5.5. What is ReadyFill at Mail® and how does it work?	ReadyFill at Mail® is an automatic mail order refill service offered by CVS Caremark. Members can sign up to have their mail order prescriptions automatically refilled every three months. Members can choose which prescriptions they want ReadyFill to apply to and can add or drop this service at any time. Members participating in ReadyFill receive a call or message prior to each shipment. They can choose to receive these alerts by phone, text message or email. It is important for the member to confirm the order and verify that they still want the prescription before it is billed and shipped.

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. Some Part D plans fall above the benchmark and some fall below. Generally, Medicare beneficiaries who receive Extra Help (subsidies) for their prescription drug coverage will pay the least amount by enrolling in a benchmark plan. The national base beneficiary premium for 2017 is $35.63 and the regional benchmark amount for 2017 is $34.02. MedicareBlue Rx Standard's premium ($35.10) is above the benchmark premium, so it will not qualify for low-income subsidy (LIS) auto-enrollees. However, LIS members who choose MedicareBlue Rx Standard as their prescription drug plan will not have to pay a premium *(see next Q&A for more information)*.
6.2. Which plans are benchmark plans?	Check **Medicare.gov** for a listing of the Medicare Part D plan sponsors that are benchmark plans in 2017.
6.3. Will MedicareBlue Rx have any auto-enrollees?	No. Since MedicareBlue Rx is not a benchmark plan in 2017, no beneficiaries will be auto-enrolled. LIS individuals auto-assigned to a plan in 2016 that is no longer a benchmark plan in 2017 will receive a letter in the fall stating that they will be reassigned to a new benchmark plan effective January 1, 2017, unless they enroll in a new plan on their own by December 31, 2016. On the back of the letter *(referenced in Q&A 6.5. as the Blue Reassignment Letter)* is a list of 2017 benchmark plan options. Eligible beneficiaries can change plans in early December if they choose or will be auto-assigned to a new benchmark plan.
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 of the MedicareBlue Rx plan options are benchmark plans for 2017. It is important that they understand their financial liability for each plan.

6. GENERAL QUESTIONS ABOUT LOW-INCOME SUBSIDIES (LIS)	
	The premiums for the Premier plan is greater than the benchmark premium so beneficiaries qualifying for a subsidy would pay the difference between the Premier premium and the benchmark amount. Health care reform included a provision that allows plans whose premium is within a certain dollar amount of the benchmark to waive the difference. In 2017, this amount is $2. MedicareBlue Rx Standard's premium is within this amount so we will waive the difference for LIS beneficiaries. However, MedicareBlue Rx Premier's premium is not within this amount so we cannot waive the difference for LIS beneficiaries in the Premier plan. To see what the premium will be based on the amount of Extra Help the beneficiary is receiving, refer to the 2017 Low-Income Subsidy Amounts table at the end of this Q&A. LIS beneficiaries can call Customer Service at **1-888-832-0075** to evaluate their personal situation. Beneficiaries may also work with their local SHIP counselors who will be able to help them compare benchmark plans for 2017. See the "2017 Senior Health Insurance Plan Information by State" list at the end of this document to find your local SHIP.
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. In addition, 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. Here's a list of the mailings and when they are received by the beneficiary. **Early September** 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.

6. GENERAL QUESTIONS ABOUT LOW-INCOME SUBSIDIES (LIS)	
	Early November TAN CHOOSERS letter mailed to LIS beneficiaries that voluntarily enrolled in a plan that is no longer a benchmark plan; makes beneficiary aware of who the new LIS benchmark plans are.
6.6. Can you explain the Special Enrollment Periods (SEP) that apply to individuals eligible for the LIS?	• Individuals who qualify for Extra Help with prescription drug costs have a continuous SEP; they may enroll in, disenroll from, or change plan options month to month. • If they lose this Extra Help during the year, the opportunity to make a change continues for two months after they are notified that they no longer qualify for Extra Help. • If they begin getting Extra Help or the amount of the Extra Help 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. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Individuals who qualify for Extra Help with prescription drug costs may enroll in, or disenroll from, a plan at any time. If they lose their Extra Help during the year, the opportunity to make a change continues for two months after they are notified that they no longer qualify for Extra Help. 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 amount, Medicare will automatically reassign auto-assigned individuals who are eligible for Extra Help to a

6. GENERAL QUESTIONS ABOUT LOW-INCOME SUBSIDIES (LIS)	
	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 (low income subsidies)? What are their options?	Individuals qualify for Extra Help in a variety of ways. They are automatically eligible for Extra Help if they qualify for Medicaid, get help from the state to pay their Medicare Part A or Part B plan 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 again based on their income and assets. If an individual needs 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 Extra Help may be reduced or discontinued. For questions about Extra Help (low-income subsidies) for prescription drug costs, or if an individual needs assistance completing the application, they can: • Call the Social Security Administration (SSA) at **1-800-722-1213** (TTY users call **1-800-325-0778**) between 7 a.m. and 7 p.m. Monday through Friday ET. • Or, fill out the application online at **socialsecurity.gov**, under the Medicare link. • Or, complete the paper application included with the letter they received from Medicare. To get another copy of the application by mail, call **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. • Call a State Health Insurance Program (SHIP) local office for free personalized health insurance counseling. See the "Medicare & You" handbook or call **1-800-MEDICARE (1-800-633-4227)** for their telephone number. If a beneficiary loses their eligibility for Extra Help, they will have a Special Enrollment Period during which they can switch to a different plan. *(Note: For more information, see Q&A 6.6.)*
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. Call **1-888-832-0075**. The rates are also in the 2017 LIS low-income subsidy table at the end of this document.

6. GENERAL QUESTIONS ABOUT LOW-INCOME SUBSIDIES (LIS)	
6.10. How are low-income subsidy amounts calculated?	In establishing the Part D program, CMS defined four benefit types in regulation — defined standard (DS) benefits, actuarially equivalent (AE) standard benefits, basic alternative (BA) benefits, and enhanced alternative (EA) coverage — in order to describe permissible benefit variations. These terms were intended to provide explicit guidance on permissible benefit design parameters for plan sponsors and actuaries. The first three benefit types are considered basic prescription drug coverage, and are actuarially equivalent to the defined standard benefit established in statute. The Standard plan was filed for bid approval as an actuarially equivalent (AE) plan meeting basic prescription drug coverage, and thus was evaluated when CMS established the benchmark for 2017. The Premier plan option is filed/submitted as an EA (enhanced alternative) plan and is not included in the establishment of the LIS benchmark. The premium amount for full or partial subsidy LIS beneficiaries is calculated from the basic prescription drug coverage established by CMS. In 2017, the base beneficiary premium is $35.63 and the regional benchmark subsidy amount is $34.02. However, plan designs are not limited to the Medicare basic benefits and can include enhanced or supplemental benefits. The overall premium for a plan is made up of a combination of the basic premium plus an enhanced premium. The basic portion of the premium is covered by government subsidies (either full or partial) for LIS beneficiaries, but the enhanced portion of the premium is not.

7. CHANGES IN THE COVERAGE GAP	
7.1. What is the donut hole or coverage gap and how is it affected in 2017?	Medicare prescription drug coverage has four stages: the deductible, initial coverage, the coverage gap and catastrophic coverage. For 2017, the coverage gap occurs once a member's total yearly drug costs reach $3,700. At that point the member will receive a discount on brand-name drugs and generally pay no more than 40 percent of the plan's costs for brand drugs and 51 percent of the plan's costs for generic drugs. Members pay this until their out-of-pocket drug costs reach $4,950. This period is called the coverage gap or donut hole. Due to health care reform legislation, the donut hole will gradually close each year so that by 2020 beneficiaries will pay the same amount from the initial coverage stage to the catastrophic coverage stage in the basic Medicare drug plan. In 2017 beneficiaries will pay 51 percent of the cost for generics and plans will pay 49 percent of the cost. Health care reform legislation mandated at least a 50 percent discount on brand-name drugs in 2012. In 2017, beneficiaries will pay 40 percent of the plan's cost for brand-name drugs in the coverage gap. The rest is covered by the manufacturer discount of 50 percent and an additional 10 percent payment provided by the plan. This percentage will increase each year until 2020 when beneficiaries will pay 25 percent of the cost for brand-name drugs.
7.2. What happens if a member has some coverage in the coverage gap, such as in MedicareBlue Rx Premier?	Members will pay the lesser of the plan's copay or 51 percent of the cost for generic drugs or 40 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 listed on our formularies are discounted at 50 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 10 percent of coverage so that beneficiaries pay 40 percent in 2017.

7. CHANGES IN THE COVERAGE GAP	
7.4. Will the discounts change each year?	Yes, the percentage the beneficiary pays for generic drugs will gradually decrease each year until 2020 when beneficiaries pay 25 percent of the cost for drugs. The 50 percent manufacturers discount for brand-name drugs that applies today will not change but the amount plans will pay for these drugs will gradually increase until beneficiaries pay 25 percent of the cost for brand-name drugs.
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 ($3,700 in 2017) during the year Members of employer group plans and waiver plans are eligible to participate in the discount program since they qualify based on the above criteria.
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 as long as they are for a covered Part D drug. What beneficiaries pay and the portion manufacturers pay will continue to count toward their true out-of-pocket cost (TrOOP). However, the 10 percent that the plan will pay in 2017 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 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.

8. ENROLLMENT PERIOD AND PREMIUM PAYMENTS	
8.1. Are enrollment periods changing?	No. The AEP continues to be October 15 to December 7. Any enrollments or changes using the annual election period take effect the following January 1.
8.2. When does the marketing period start?	The marketing period for 2017 begins on October 1, 2016, the same date as in previous years.
8.3. How will a plan change affect a member's plan premium payment method?	A member's current plan premium payment method will automatically continue unless the member contacts Customer Service to change it. The new plan premium amount will be effective on January 1, 2017. If a member currently has payments deducted from a bank account through Electronic Funds Transfer or deducted from their Social Security or Railroad Retirement Benefit (RRB) benefit check, those deductions will continue. The amount will change to reflect the new premium amount for 2017.
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 plan premium amount being deducted from the member's Social Security benefit check changes to reflect the new 2017 plan premium amount. It's possible that 2016 premiums may still be deducted in the first quarter. When the updates are processed, premiums will be retroactively adjusted (the increased or decreased amount) back 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. If the total additional payment needed to catch up is more than $200, Social Security deductions will stop and we will send the member a paper bill.
8.5. If a member is paying plan premiums through Electronic Funds Transfer from a bank account, will the new plan premium amount be deducted in January?	Depending on when the change is received, there could be a delay of one or two months before the plan premium amount being withdrawn from the member's bank account changes to reflect the new 2017 plan premium amount. If the delay results in a larger withdrawal than the new plan premium, we will send the member a refund check for the difference. If the delay results in a smaller withdrawal than the new plan premium, we will send the member a paper bill for the outstanding balance. If a member signs up for EFT and has been billed for but not

8. ENROLLMENT PERIOD AND PREMIUM PAYMENTS	
	paid premiums, the amount of premiums due will also be deducted from the account.
8.6. How does a member sign up to have premiums deducted from their Social Security or Railroad Retirement Board (RRB) benefit checks?	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 deduction request, we will send paper bills and resubmit the request. While the request is being considered, members will receive paper bills and must pay the premiums directly to the plan until premium 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 Electronic Funds Transfer.
8.7. How can a member sign up for Electronic Funds Transfer (EFT)?	Members can choose EFT as a payment option on the paper enrollment form at the time they enroll. This option is not available with online or phone enrollments since the plan needs a voided check to process EFT. The EFT form will be in pre-enrollment kits and can be mailed back with the enrollment application or separately.
8.8. Can the plan ever choose to end a beneficiary's membership?	Yes. If the plan ends a beneficiary's membership, this is called an involuntary disenrollment. There are a number of reasons this could happen. For example, if a member leaves the plan's service area for more than 12 months or fails to pay plan premiums. Refer to the Evidence of Coverage, the plan's member handbook or call Customer Service for more reasons for involuntary disenrollment.
8.9. 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 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 Electronic Funds Transfer from a bank account or sign up to have payments deducted from their monthly Social Security or Railroad Retirement Board benefit checks. Remember 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. If the member has been

8. ENROLLMENT PERIOD AND PREMIUM PAYMENTS	
	billed but not paid premiums when Electronic Funds Transfer begins, any premiums due will be deducted at that time. If the member has been billed but 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. If they don't pay the billed premiums, they may be disenrolled from the plan.
8.10. What can a beneficiary do during Medicare Advantage Disenrollment Period (MADP)?	The MADP occurs from January 1 to February 14 of each year. Beneficiaries can disenroll from their current Medicare Advantage (MA) plan or Medicare Advantage Prescription Drug (MA-PD) plan and return to Original Medicare only or return to Original Medicare and enroll in a stand-alone prescription drug plan (PDP).
8.11. If a beneficiary uses the MADP to add prescription drug coverage for the first time, will he/she have a late-enrollment penalty?	It depends on whether the beneficiary had other creditable drug coverage, for how long and how long he/she was without creditable coverage. The same LEP rules apply if a beneficiary joins a drug plan during the MADP.
8.12. If someone makes a change during MADP, when is it effective?	Changes made in January during the disenrollment period are effective February 1 and changes made in February are effective March 1.
8.13. Is there a specific form an individual should use to disenroll from an MA-PD plan if they are returning to Original Medicare and a PDP?	The individual should contact their MA-PD plan to find out how to disenroll.
8.14. If a beneficiary chooses to disenroll from an MA-PD without purchasing a PDP, do they need to notify CMS that they are returning to Original Medicare or is this automatic?	As long as 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.
8.15. Can someone make other changes during the MADP?	Yes, if the other plans permit it. You may be able to offer beneficiaries who want to leave their MA or MA-PD plan enrollment in a Medicare Supplement or Cost plan (if the plan allows it) as well as a prescription drug 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, prior to any personal/individual sales/marketing appointment, the beneficiary must agree to the scope of appointment. This agreement must be documented. 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. Plan Sponsors are encouraged to use a variety of technological means to fulfill the scope of appointment requirement, including conference calls, fax machines, designated recording line, pre-paid envelopes and email.
	• Plan Sponsors 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)
	  ○ Method of contact (e.g., walk-in)
	  ○ 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 why it was not completed
	• A beneficiary may set a scope of appointment at a marketing/sales event for the future appointment.

9.3. When are the forms for 2017 going to be posted online?	The 2017 MedicareBlue Rx enrollment and change forms will be posted at **YourMedicareSolutions.com** on October 15, 2016. Remember, we cannot process AEP enrollment or change forms prior to October 15.
9.4 When can I begin submitting applications?	You may not accept or solicit paper enrollment forms from beneficiaries prior to October 15, 2016 unless the individual is eligible for a Special Enrollment Period (SEP).

9. BACKGROUND INFORMATION FOR AGENTS	
	• Should a beneficiary personally *give* you an enrollment or change form prior to October 15, do not hold these forms but submit them immediately. Because CMS views agents and brokers as extensions of the plan sponsor, the act of accepting an application or change form is equivalent to acceptance by MedicareBlue Rx, and all CMS required 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. Instead, please immediately submit these forms to MedicareBlue Rx. • If you as an agent help a beneficiary complete an application and it is submitted prior to October 15, you will be investigated for compliance with CMS guidelines.
9.5. Should I submit paper forms or use the online forms?	Use of the online forms is preferred because they can be more easily processed in the timeframe required by CMS. You may complete the forms **online** at **YourMedicareSolutions.com**. The beneficiary must have checked the attestation box on the form in order for you to submit the form online. All individual product 2017 forms have a check box beneath the beneficiary signature that the beneficiary can check to authorize agents to submit their paper application online. This is the same paper-to-online authorization that has been in place for the last several years. If you complete a paper form, you cannot submit it by regular mail. If the beneficiary didn't check the box authorizing you to submit it online, you must either fax it or send it by overnight delivery. See the instructions that follow.
Overnight delivery	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 When using overnight delivery, make sure you have the correct street address (overnight deliveries cannot be made to a P.O. Box).

9. BACKGROUND INFORMATION FOR AGENTS	
	You can also call the MedicareBlue Rx Broker Help Desk at **1-866-464-3919** if you have enrollment questions.
Faxing	**Fax** paper enrollment forms to: • MedicareBlue Rx – **1-855-874-4702** Each fax cover sheet must include the following information: • Name of the beneficiary(ies) on the enrollment form(s) • Number of enrollment forms in that transmittal • Your name and contact information should the plan need to contact you with questions Plans may provide fax cover sheets you can use when submitting. Check with your plan to see if one is available. The fax cover sheet for Iowa and South Dakota is located on the plan's Sales Toolkit, form number: 00C134. It's called the "2017 MedicareBlue Rx Application Fax Cover Sheet- IA/SD." You can also call the pre-enrollment Broker Help Desk at **1-866-464-3919** if you have enrollment questions.
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 on their own: • Complete and submit the form online at **YourMedicareSolutions.com** • Call MedicareBlue Rx at **1-866-434-2037** and enroll or make the change over the phone. • Complete the MedicareBlue Rx 2017 enrollment or change form and mail it to the plan at: MedicareBlue Rx P.O. Box 3178 Scranton, PA 18505
9.7. What should I do if I have a beneficiary: • **With very limited income and their billing isn't correct?** • **Whose claims are not being paid correctly?** • **Who does not have access to claims when they need them?**	Contact the MedicareBlue Rx post-enrollment Broker Help Desk at **1-866-849-2498**.

9. BACKGROUND INFORMATION FOR AGENTS	
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 at **1-866-434-2037**. The representative will gather or confirm the following information: full name, phone number, address and grievance information. Grievance information should include any material they are complaining about in as much detail as possible, for example, down to the detail of the page and paragraph or an exact statement by a broker. They will then document the information in the system and it will be reported to the plan. If a *member* wants to file a post-enrollment grievance, he or she should call MedicareBlue Rx Customer Service at **1-888-832-0075**. 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 3178 Scranton, PA 18505 Fax: 1-855-874-4705 Members can also use the Medicare grievance process. A link to this process is on the **YourMedicareSolutions.com** website. You can find it in Coverage Determinations under the Members tab from the Home page.
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.

2017 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) **$0**	$0	$3.30 (each prescription)	$8.25 (each prescription)
Standard copay Category 2 (Full duals with income <100% FPL) **$0**	$0	$1.20 (each prescription)	$3.70 (each prescription)
Standard copay Category 3 (Full duals that are institutionalized) **$0**	$0	$0 (each prescription)	$0 (each prescription)
Standard copay Category 4 (100% subsidy eligibles) **$0**	$82	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (75% subsidy eligibles) **$9.60**	$82	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (50% subsidy eligibles) **$18.10**	$82	15% (each prescription)	15% (each prescription)
Standard copay Category 4 (25% subsidy eligibles) **$26.60**	$82	15% (each prescription)	15% (each prescription)

2017 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 Premier			
Premier copay Category 1 (other full subsidy eligibles) **$58.00**	$0	$3.30 (each prescription)	$8.25 (each prescription)
Premier copay Category 2 (Full duals with income <100% FPL) **$58.00**	$0	$1.20 (each prescription)	$3.70 (each prescription)
Premier copay Category 3 (Full duals that are institutionalized) **$58.00**	$0	$0 (each prescription)	$0 (each prescription)
Premier copay Category 4 (100% subsidy eligibles) **$58.00**	$0	15% (each prescription)	15% (each prescription)
Premier copay Category 4 (75% subsidy eligibles) **$66.50**	$0	15% (each prescription)	15% (each prescription)
Premier copay Category 4 (50% subsidy eligibles) **$75.00**	$0	15% (each prescription)	15% (each prescription)
Premier copay Category 4 (25% subsidy eligibles) **$83.50**	$0	15% (each prescription)	15% (each prescription)

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2017 SENIOR HEALTH INSURANCE PLAN (SHIP) INFORMATION BY STATE	
IOWA: Iowa SHIIP – Senior Health Insurance Information Program	
CALL	1-800-351-4664
TTY/TDD	1-800-735-2942
WRITE	Iowa SHIIP 601 Locust Street, 4th Floor Des Moines, IA 50309-3788
WEBSITE	shiip.state.ia.us

MINNESOTA: Minnesota Board on Aging (Senior LinkAge Line)	
CALL	1-800-333-2433
TTY/TDD	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/TDD	1-866-735-2968
WRITE	Senior & Long Term Care Division 111 North Sanders Street Helena, MT 59604
WEBSITE	dphhs.mt.gov/sltc/index.shtml

NEBRASKA: Nebraska Senior Health Insurance Information Program	
CALL	1-800-234-7119
TTY/TDD	1-800-833-7352
WRITE	Nebraska Department of Insurance 941 O Street, Suite 400 Lincoln, NE 68508-3690
WEBSITE	doi.ne.gov/shiip/

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2017 SENIOR HEALTH INSURANCE PLAN (SHIP) INFORMATION BY STATE	
NORTH DAKOTA: SHIC – State Health Insurance Counseling Program	
CALL	1-800-247-0560
TTY/TDD	1-800-366-6888
WRITE	North Dakota Insurance Department State Capitol, Fifth Floor 600 East Boulevard Bismarck, ND 58505-0320
WEBSITE	nd.gov/ndins/shic

SOUTH DAKOTA: South Dakota Office of Adult Services and Aging Department of Social Services	
CALL	1-800-536-8197
TTY/TDD	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/TDD	711
WRITE	Wyoming SHIIP P.O. Box BD Riverton, WY 82501
WEBSITE	wyomingseniors.com/WSHIIP.htm