FREQUENTLY ASKED QUESTIONS

Learn more about the prescription drug plan offered to you by the State of Iowa. If you choose the Program N or Program F health plan, you may also choose the prescription drug plan option.

1. **How is the new plan different from the previous year?**
   Below are the main differences:
   - There is no supplemental drug coverage.
   - You pay either a copay (Tiers 1 and 2) or coinsurance (Tiers 3, 4 and 5) for drug coverage.
   - This new plan has a five-tier formulary; the previous year's plan had a four-tier formulary.

2. **I already have Program N or Program F and a Group MedicareBlue Rx prescription drug plan in 2019. Do I have to fill out an application to get the new $5/$10/20%/45%/33% plan for 2020?**
   No. If you want to continue with group coverage with the new $5/$10/20%/45%/33% plan for 2020, you do not need to fill out an application to have a prescription drug plan.

3. **I already have Program N or Program F, but I do not want the new $5/$10/20%/45%/33% plan for 2020. What do I need to do?**
   To find other prescription drug plans that fit your needs, you can contact a member of the Senior Health Insurance Information Program (SHIIP). Across Iowa there is a network of trained volunteers who can help you compare and analyze health and drug policies you are considering. These volunteers have been trained by people from the State of Iowa Division of Insurance. This free service is available through SHIIP. You may reach out to them for more information at 800-351-4664, 800-735-2942 (TTY), or shiip@iid.iowa.gov.

4. **I already have Program N or Program F, but I want to change my health plan option for 2019. What do I need to do?**
   You can switch to the other health plan by completing an application form by Dec. 7, 2019, and submitting it to:

   Department of Administrative Services
   Human Resources Enterprise
   Hoover Building, Level A
   1305 E. Walnut Street
   Des Moines, IA 50319-0150

5. **How do the Group MedicareBlue Rx plans work — especially in the coverage gap?**
   Medicare Part D drug plans have several phases of coverage: the initial coverage stage, the coverage gap stage and the catastrophic coverage stage.

   During the initial coverage stage, you will pay copays (or coinsurance) for your drugs based on the plan design and tier on which your drug resides. Once your Total Yearly Drug Cost equals $4,020, you will enter the coverage gap stage.

   In the coverage gap stage you pay for a 30-day supply:
   - $5 copayment for Tier 1 drugs and $10 copayment for Tier 2 drugs.
   - You will generally pay no more than 25% of the plan's costs for all other generic and brand-name drugs on Tier 3, Tier 4 and Tier 5.

After your yearly out-of-pocket drug costs (including drugs you purchased through your retail pharmacy and through mail order) reach $6,350, you enter the catastrophic coverage stage.

In the catastrophic coverage stage you pay the greater of:

- 5% of the total cost, or
- $3.60 copay for generic drugs (including brand-name drugs treated as generic) and $8.95 copay for all other drugs.

6. What is the difference between total yearly drug costs and total out-of-pocket costs?

Medicare Part D drug plans have several phases of coverage: the initial coverage stage, the coverage gap stage and the catastrophic coverage stage. Members' drug costs are tracked by the plan to determine when they move from one benefit stage to the next.

Total yearly drug costs are the amounts that you — the member — and your prescription drug plan have paid for covered drugs in that calendar year. This does not include any premiums.

Total out-of-pocket costs are the amounts you — the member — have paid for covered drugs in a calendar year. This does **not** include the amount that your prescription drug plan has paid, costs related to supplemental drugs or premiums. If you should change prescription drug plans in the middle of the year, to another Medicare Part D plan, your total out-of-pocket costs "follow" you, and you will receive credit for amounts already paid under the prior plan.

When you add up your out-of-pocket costs, you can include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 3 of your Evidence of Coverage (EOC) booklet):

- The amount you (or those paying on your behalf) pay for drugs when you are in any of the following drug payment stages:
    - The initial coverage stage
    - The coverage gap stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

7. Who do I contact if I still have questions?

Please contact Group MedicareBlue Rx at 877-838-3827 from 8 a.m.–8 p.m., daily, Central Time (TTY 711).

Program N and Program F are underwritten by Wellmark Blue Cross and Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association.

Group MedicareBlue[SM] Rx (PDP) is a Medicare-approved Part D sponsor. Enrollment in Group MedicareBlue Rx depends on renewal of the plan sponsor's contract with Medicare. This information is not a complete description of benefits. Contact 877-838-3827, 8 a.m.–8 p.m., daily, Central Time (TTY 711) for more information.

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