BlueCross BlueShield of Texas

September 2018

Dear Employer:

Since 2006, Medicare beneficiaries have been eligible to receive prescription drug coverage through Medicare's Part D program, enacted as part of the Medicare Modernization Act of 2003. Authoritative information for Medicare beneficiaries is available from the Centers for Medicare & Medicaid Services (CMS).

If your group health plan offers a prescription drug plan to Medicare-eligible individuals, CMS requires that you take the following actions each year:

- ✓ You must **determine** if your prescription drug plan provides coverage that is considered 'creditable' to Medicare Part D Prescription Drug Coverage (see tables 1-3).
- ✓ You must **communicate** your plan's creditable status to Medicare-eligible, actively working individuals and their dependents, Medicare-eligible COBRA individuals and their dependents, Medicare-eligible disabled individuals and any other Medicare-eligible retirees or their dependents that are covered under the group's prescription drug plan by Oct. 15, 2018. This date is the start of the annual Medicare Part D individual enrollment period. CMS requires that you disclose your prescription drug plan's status to all Medicare-eligible enrollees whether or not your plan is considered creditable or non-creditable to Medicare Part D.
- ✓ You must **disclose** to CMS whether or not your prescription drug plan is creditable to Part D (refer to page 4 in this document). The Disclosure should be completed annually no later than 60 days from the beginning of a plan year (contract year, renewal year), within 30 days after termination of a prescription drug plan, or within 30 days after any change in creditable coverage status.

Detailed descriptions of each of these requirements can be found in the following sections. For a detailed description of your obligations under the CMS creditable coverage rules, please refer to the creditable coverage information available on CMS' website at https://www.cms.gov/CreditableCoverage/. For more details on your plan's benefits, consult your prescription drug plan documents. **Please note that some of the plans that passed the gross value test last year are now considered non-creditable.**

1. Determine if your prescription drug plan is "creditable."

Coverage is considered creditable if the actuarial value of the coverage is equal to or exceeds the actuarial value of standard Medicare Part D prescription drug coverage, when using generally accepted actuarial principles in accordance with the CMS actuarial guidelines. This actuarial determination shows whether the expected amount of paid claims under the employer's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.

If your plan satisfies the requirements as creditable and you make the plan available throughout 2019, your Medicare-eligible active members and retirees are able to stay with their current plan and, in the future, be able to enroll in a Medicare prescription drug plan without a late enrollment penalty. **Please note that group health plans with multiple benefit options must apply the actuarial creditable coverage test separately for each benefit option.**

Following are two different tests you can use to determine whether or not your prescription drug plan is considered creditable:

CMS Simplified Creditable Coverage Test

If an entity is not an employer or union that is applying for the Retiree Drug Subsidy (RDS), it can use the simplified determination of creditable coverage status annually to determine whether its prescription drug plan's coverage is creditable or not. CMS has created the following simplified test for determining if a prescription drug plan is creditable to Medicare Part D.

A prescription drug plan is considered creditable if it meets the following four criteria:

1) Provides coverage for brand and generic prescriptions;
2) Provides reasonable access to retail providers;
3) Is designed to pay on average at least 60 percent of participants' prescription drug expenses; and
4) Satisfies at least one of the following:
   a) The prescription drug coverage has no annual maximum benefit or a maximum annual benefit payable by the plan of at least $25,000; or
   b) The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 per Medicare-eligible individual.
   c) For employers or entities that have integrated health coverage, the integrated health plan has no more than a $250 deductible per year, has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000 and has no less than a $1,000,000 lifetime combined benefit maximum.

Integrated Plan - An integrated plan is any plan of benefits that is offered to a Medicare-eligible individual where the prescription drug benefit is combined with other coverage offered by the entity (i.e., medical, dental, vision, etc.) and the plan has all of the following plan provisions:

1) a combined plan year deductible for all benefits under the plan,
2) a combined annual benefit maximum for all benefits under the plan, and
3) a combined lifetime benefit maximum for all benefits under the plan.

A prescription drug plan that meets the above parameters is considered an integrated plan for the purpose of using the simplified method and would have to meet steps 1, 2, 3 and 4(c) of the simplified method. If it does not meet all of the criteria, then it is not considered to be an integrated plan and would have to meet steps 1, 2, 3 and either 4(a) or 4(b).

NOTE: If the entity cannot use the simplified determination method stated above to determine the creditable coverage status of the prescription drug plan offered to Medicare-eligible individuals, then the entity must make an actuarial determination annually of whether the expected amount of paid claim under the entity's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.

Gross Value Test

Under the CMS simplified test, a plan would pay at least 60 percent of the member's total prescription drug costs. The member would pay the remaining 40 percent. However, CMS also allows you to use the gross value test to determine if your coverage is creditable. Under the gross value test, the expected amount of paid claims for your coverage must be at least equal to the expected amount of paid claims under the standard Medicare Part D benefit. When using the gross value test, our estimates indicate that the value of the Part D benefit is 65 percent of the drug costs. Therefore, any plan that is expected to pay at least 65 percent of the total drug costs would be considered creditable.

Although the final determination of whether or not your plan is creditable remains your responsibility as an employer, we have analyzed many of our Blue Cross and Blue Shield of Texas (BCBSTX) prescription drug plans using the gross value test to help you evaluate the creditability of the BCBSTX plan you have purchased.

The following tables (tables 1 – 3) can be used instead of the simplified determination method to determine creditable coverage status. If your plan is not shown on the following tables, you can use the CMS simplified test above to determine if your plan is creditable using that criteria.

2. Communicate your plan's creditable coverage status to Medicare-eligible individuals

Employers must give written notice to Medicare-eligible individuals enrolled in the group plan of the creditable status of the group's drug coverage, whether or not the coverage is creditable. CMS has created model creditable and non-creditable notices, updated for use after April 1, 2011, which can be found on CMS' website at www.cms.hhs.gov/CreditableCoverage/. Note: the employer that sponsors the group health plan is required to provide the Part D creditable coverage notice to its plan's Medicare-eligible enrollees. BCBSTX will not provide this notice to the plan's enrollees on behalf of the employer/plan sponsor.

When must the notice be provided?

1) In 2018 notice must be provided prior to the beginning of the Medicare Part D Annual Coordinated Election Period (ACEP), which runs from October 15 through December 7, 2018.
2) Notice must also be given:
   a) Prior to an individual's initial enrollment period (IEP) for Medicare Part D.
      The Part D IEP runs concurrently with the Medicare Part B IEP. This seven-month period begins three months before the month an individual meets the eligibility requirements for Part B and ends three months after the month of eligibility. For example, an individual is eligible for Medicare Part B on July 1, 2019. His or her seven-month IEP runs from April 1, 2019 through Oct. 31, 2019; or
   b) Prior to the effective date of coverage for any Medicare-eligible individual who joins the plan; or
   c) Whenever the employer no longer offers prescription drug coverage or changes the coverage offered so that it is no longer creditable or becomes creditable; or
   d) Upon a beneficiary's request.

If the creditable coverage disclosure notice is provided to all plan participants annually, CMS will consider items 1 and 2 (above) to be met. "Prior to" means the beneficiary must have been provided the disclosure notice within the past 12 months.

The following decisions are up to the employer group and not the carrier and should also be disclosed to your Part D eligible individuals:

1) Are you collecting the RDS?
   a) If yes, the employer should consider explaining in the notice the impact, if any, on the retiree's coverage if the retiree enrolls in Medicare Part D.
   b) If no, the employer should consider explaining in the notice whether the plan allows Medicare-eligible individuals to enroll in Medicare Part D.
2) Do you allow the Medicare-eligible individual and their dependents to drop coverage and then come back on later? If yes, the employer should consider explaining in the notice the impact to the enrollee if he/she attempts to re-enroll into the plan after disenrolling from the plan.

3. Disclose to CMS whether or not your prescription drug plan is creditable to Part D

When must disclosure be made to CMS?

According to CMS' June 29, 2009, instructions, at a minimum, disclosure to CMS must be submitted to CMS on an annual basis and upon any change that affects whether the drug coverage is creditable. At a minimum, the Disclosure to CMS form must be provided at the following times:

- For plan years ending in 2007 and beyond, disclosure must be provided within 60 days after the beginning of the plan year for which the entity is providing the disclosure;
- Within 30 days after the termination of the prescription drug plan; and
- Within 30 days after any change in the creditable coverage status of the prescription drug plan.

Who must make the disclosure to CMS?

- Sponsors of group health plans, including employers, unions, churches, federal, state and local governments, among others, that provide prescription drug coverage to Medicare Part D-eligible individuals must disclose creditability status to CMS.
- Though the disclosure requirement applies to prescription drug coverage provided to Medicare Part D-eligible individuals, group health plan sponsors may want to consider providing the Disclosure to CMS even if they're not aware of Part D-eligible members in their group health plan. This is because of the difficulty in determining whether employees' spouses or dependents are Medicare-eligible.
- Plan sponsors that have applied for and anticipate receiving payment for the RDS are not required to make this disclosure to CMS.

42 CFR §423.884(c)(2)(iv) requires that a Plan Sponsor provide an attestation that its prescription drug coverage is at least actuarially equivalent to the standard prescription drug coverage under Part D as part of the application for the RDS. Therefore, because the actuarial equivalence standard includes the creditable coverage standard, a sponsor that has been approved for the RDS is exempt from filing the Disclosure to CMS form with respect to those qualified covered retirees for which the sponsor is claiming the RDS. The sponsor's RDS application serves as its Disclosure to CMS under 42 CFR §423.56(e). For example, if a plan option has 100 retired beneficiaries and the plan claims RDS for 97 of them, the plan must report the 3 non-RDS participants on the Disclosure to CMS form, in addition to the non-RDS participants on other plan options.

How is the disclosure made?

Disclosure must be made electronically via the Disclosure to CMS form available on the CMS website at https://www.cms.gov/Medicare/prescription-drug-coverage/creditablecoverage/ccdisclosureform.html. For further information please visit CMS Creditable Coverage webpage at www.cms.hhs.gov/creditablecoverage/45_CCDisclosureForm.asp. **Note: the employer that sponsors the group health plan is required to provide the Part D creditable coverage notice to CMS. BCBSTX will not provide this notice to CMS on behalf of the employer/plan sponsor.**

Using the BCBSTX plan tables

To determine if your BCBSTX plan is creditable you will need to do the following:

1) Determine if your prescription drug plan is a copay plan (Table 1) or a coinsurance plan design (Table 2) or an integrated Rx and medical plan (Table 3).
2) Determine if your plan has one, two or three tiers of copays or coinsurance levels.
3) Find the mail order level, if any, (one, two or three times the retail copay) that corresponds to your plan.
4) Find the lowest deductible level applicable to your plan, if any.

5) If the copays or coinsurance amounts and the benefits of your BCBSTX plan are at or below those shown in the table, then your plan is creditable.

6) If the copays, coinsurance or deductible amounts of your BCBSTX plan are greater than those shown in the tables, then your plan may not be creditable. You can use the CMS simplified test above to determine if your plan would be creditable using that criteria.

Example 1:
If you have a three-tier copay plan with mail order at not more than three times the retail copay and no deductible, then, if the plan copays are not greater than $26 generic, $130 preferred brand and $198 non-preferred brand, the plan is creditable. See bold area on Table 1. In Table 1 under the "Three-Tier Plans" heading, see the "Ex. 1" row surrounded by a rectangle.

Example 2:
If you have a two-tier copay plan with mail order at not more than three times retail and $320 deductible, and the plan copays are not greater than $26 generic and $120 brand, then the plan is creditable. See bold area on Table 1. In Table 1 under the "Two-Tier Plans" heading, see the "Ex. 2" row surrounded by a rectangle.

Example 3:
If you have an integrated drug and medical plan (see Table 3) with 70% coinsurance, a $2,500 deductible and $3,000 out-of-pocket limit for medical/drug coverage, then the drug coverage will pass. However, if a plan has 90% coinsurance rate for drug and medical with a $10,000 deductible and $2,500 out-of-pocket limit for medical/drug coverage, then the drug coverage will fail. In Table 3 under the "90% Rx coinsurance*"* heading, see the column under $10,000.

These scenarios assume that the medical and drug coinsurance are the same. Especially in a case where the plan is on the borderline of passing, it is possible that the result could be different if the drug coinsurance stated below is lower than the medical coinsurance. Note that in all cases, the deductible must be met before the out-of-pocket maximum is reached.

ESTIMATES OF CREDITABLE COVERAGE FOR STANDARD DRUG BENEFIT
NOTE: UNDER THE GROSS VALUE TEST AS SET OUT IN TABLES 1 – 3

The purpose of this analysis of the standard BCBSTX drug benefit plans is to assist the employer/ plan sponsor in its assessment of whether its prescription drug plan coverage is creditable or non-creditable to Medicare Part D and is not fort the purposes of the retiree drug subsidy or other uses. It is the employer/plan sponsor's responsibility to review this information and make its own determinations related to the creditable coverage status of its prescription drug plan(s). BCBSTX does not assume responsibility for the accuracy/timeliness of the employer/plan sponsor's final creditable coverage determinations and the notice it sends to its enrollees and to CMS.

Drug Card Copay Plans
Table 1

One-Tier Plans

Copay	Mail Order <=	Deductible
$0 - $96	3X retail copay	$0
$0 - $70	3X retail copay	$1 - $415

Two-Tier Plans

Generic Copay	Brand Copay	Mail Order <=	Deductible
$0 - $28	$0 - $151	3X retail copay	$0
Ex. 2 **$0 - $26**	**$0 - $120**	**3X** retail copay	**$1 - $415**

Three-Tier Plans

Generic Copay	Preferred Brand Copay	Non-Preferred Brand Copay	Mail Order <=	Deductible
Ex. 1 **$0 - $26**	**$0 - $130**	**$0 - $198**	**3X** retail copay	**$0**
$0 - $26	$0 - $100	$0 - $152	3X retail copay	$1 - $415

Four-Tier Plans

Generic Copay	Preferred Brand Copay	Non-Preferred Brand Copay	Specialty	Mail Order <=	Deductible
$0 - $27	$0 - $130	$0 - $185	$0 - $220	3X retail copay	$0
$0 - $23	$0 - $48	$0 - $77	0% - 35%	3X retail copay	$0
$0 - $16	$0 - $35	$0 - $75	0% - 50%	3X retail copay	$0
$0 - $20	$0 - $117	$0 - $180	$0 - $220	3X retail copay	$1 - $415
$0 - $16	$0 - $35	$0 - $65	0% - 35%	3X retail copay	$1 - $415
$0 - $10	$0 - $25	$0 - $38	0% - 50%	3X retail copay	$1 - $415

Five-Tier Plans (no deductible)

Preferred Generic Copay	Non-Pref Generic	Preferred Brand Copay	Non-Pref Brand	Specialty	Mail Order <=
$0 - $27	$0 - $27	$0 - $130	$0 - $185	$0 - $220	3X retail copay

Six Tier Plans (no deductible)

Preferred Generic Copay	Non-Pref Generic	Preferred Brand Copay	Non-Pref Brand	Preferred Specialty	Non-Pref Specialty	Mail Order <=
$0 - $20	$0 - $20	$0 - $100	$0 - $150	$0 - $250	$0 - $500	3X retail copay
$0 - $5	$0 - $20	$0 - $30	$0 - $50	$0 - $400	$0 - $400	3X retail copay

ESTIMATES OF CREDITABLE COVERAGE FOR STANDARD DRUG BENEFIT

Drug Card Coinsurance Plans
Table 2

One-Tier Plans

Coinsurance %	Minimum Cost per RX	Deductible	Mail Order <=
0% - 36%	$0	$0	
0% - 32%	$1 - $15	$0	1X retail copay
0% - 29%	$0	$1 - $415	

Two-Tier Plans

Generic Coinsurance %	Brand Coinsurance %	Minimum Cost per RX	Deductible	Mail Order <=
0% - 31%	0% - 38%	$0	$0	
0% - 28%	0% - 32%	$1 - $15	$0	1X retail copay
0% - 24%	0% - 31%	$0	$1 - $415	

Three-Tier Plans

Generic Coinsurance %	Preferred Brand Coinsurance %	Non-Preferred Brand Coinsurance %	Minimum Cost per Rx	Deductible	Mail Order <=
0% - 28%	0% - 35%	0% - 42%	$0	$0	
0% - 24%	0% - 29%	0% - 35%	$0 - $15	$0	1X retail copay
0% - 19%	0% - 28%	0% - 35%	$0	$1 - $415	
$0 - $15	0% - 26%	0% - 35%	$0	$0	3X retail copay
$0 - $15	$0 - $90	0% - 33%	$0	$0	3X retail copay

Four-Tier Plans

Generic Copay	Preferred Brand Copay	Non-Preferred Brand	Specialty	Deductible	Mail Order <=
$0 - $15	$0 - $50	0% - 33%	0% - 42%	$0	3X retail copay

Drug Plans Integrated with Medical

The following information on creditable plans with integrated drugs and medical (Table 3) may be used for your creditable coverage notification requirements under Medicare D. Large deductibles and out of pocket amounts still qualify as creditable because much of the cost sharing is taken up by the medical benefits.

For a particular drug coinsurance level, a table is shown with deductible across the top and out-of-pocket limit down the side and whether the combination will pass or fail. For example, if a plan has 70 percent drug coinsurance with a $2,500 deductible and $3,000 out-of-pocket limit for medical coverage, then the drug coverage will pass. However, if a plan has 90 percent drug coinsurance with a $10,000 deductible and $2,500 out-of-pocket limit for medical coverage, then the drug coverage will fail.

These scenarios assume that the medical and drug coinsurance are the same. Especially in a case where the plan is on the borderline of passing, it is possible that the result could be different if the drug coinsurance stated below is lower than the medical coinsurance.

Also, if a plan's out-of-network coverage fails, it is possible that the plan is still creditable if the plan's in-network coverage is well within the range of passing.

ESTIMATES OF CREDITABLE COVERAGE FOR STANDARD DRUG BENEFIT
Integrated Drug/Medical Plans
Table 3

100% Rx coinsurance after deductible

Deductible												
500	**1000**	**1500**	**2000**	**2500**	**3000**	**3500**	**4000**	**5000**	**6000**	**7150**	**7500**	**10000**
Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail	Fail	Fail

90% Rx coinsurance 10%

OPX Limit	Deductible											
(excl. deductible)	**500**	**1000**	**1500**	**2000**	**2500**	**3000**	**3500**	**4000**	**5000**	**6000**	**7500**	**10000**
500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail
1000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail
1500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail	Fail	Fail
2000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail	Fail	Fail
2500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail	Fail	Fail
3000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail	Fail	Fail
3500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail	Fail	Fail
4000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail	Fail	Fail
5000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail	Fail	Fail
6000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail	Fail	Fail
7150	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail
7500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail
10000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail

80% Rx coinsurance

OPX Limit	Deductible											
(excl. deductible)	**500**	**1000**	**1500**	**2000**	**2500**	**3000**	**3500**	**4000**	**5000**	**6000**	**7500**	**10000**
500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail
1000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail	Fail	Fail
1500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail	Fail	Fail
2000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail
2500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail
3000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail
3500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail
4000	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail
5000	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail
6000	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail
7150	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail
7500	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail
10000	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail

70% Rx coinsurance

OPX Limit (excl. deductible)	Deductible 500	1000	1500	2000	2500	3000	3500	4000	5000	6000	7500	10000
500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail
1000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail	Fail	Fail
1500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail
2000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail
2500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail
3000	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail
3500	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail
4000	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail
5000	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail
6000	Pass	Pass	Pass	Pass	Pass	Fail	Fail	Fail	Fail	Fail	Fail	Fail
7150	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail	Fail
7500	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail	Fail
10000	Pass	Pass	Pass	Pass	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail

60% Rx coinsurance

OPX Limit (excl. deductible)	Deductible 500	1000	1500	2000	2500	3000	3500	4000	5000	6000	7500	10000
500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail
1000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail	Fail	Fail
1500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail
2000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail
2500	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail
3000	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail
3500	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail
4000	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail
5000	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail	Fail
6000	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail	Fail
7150	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail
7500	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail
10000	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail

50% Rx coinsurance

OPX Limit (excl. deductible)	Deductible 500	1000	1500	2000	2500	3000	3500	4000	5000	6000	7500	10000
500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail
1000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail	Fail	Fail
1500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail
2000	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail
2500	Pass	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail
3000	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail
3500	Pass	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail
4000	Pass	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail	Fail
5000	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail
6000	Pass	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail
7150	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail

7500	Pass	Pass	?	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail
10000	Pass	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail

Note: a cell denoted as ? is a borderline passing situation (within 1%)

The purpose of the above analysis of standard BCBSTX drug benefit plans is to help employer plan sponsors decide whether to inform their covered retirees that current coverage is creditable or non-creditable and is not for the purposes of the retiree drug subsidy or other uses.

Please note: Our analysis is based on a gross value test explained in creditable coverage guidance from CMS. Under that gross value test, the expected amount of paid claims for current coverage must be at least equal to the expected amount of paid claims under the standard Medicare Part D benefit. Our estimates indicate that the value of the standard Part D benefit is 65 percent of the total covered drug costs (the remainder is the beneficiary's share) and that a plan is therefore "creditable" if it pays at least 65 percent of the expected amount of total drug costs.

All estimates are based on the above benefits and limitations and assume a standard Medicare-eligible population. This information should not be construed as legal or actuarial advice. You are urged to consult your own independent legal, actuarial and other advisors.

If you have questions about your plan, contact your sales or account representative.

Sincerely,

Blue Cross and Blue Shield of Texas