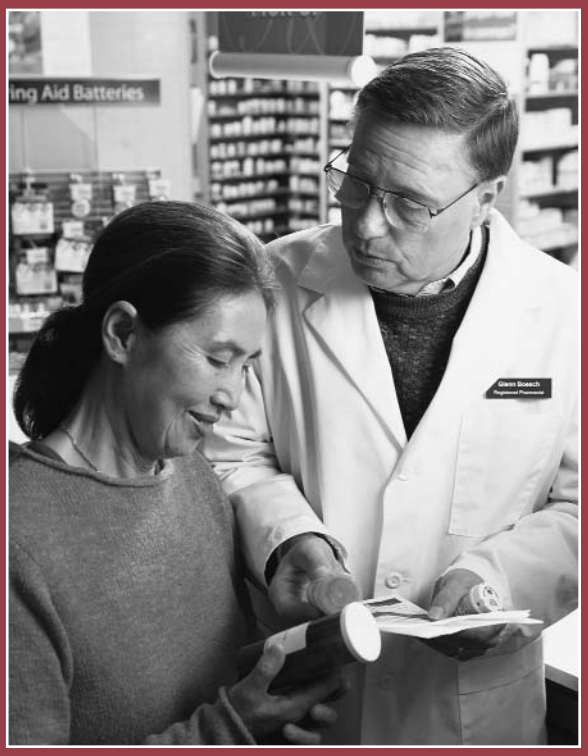
CENTERS FOR MEDICARE & MEDICAID SERVICES

Your Guide to Medicare

Prescription Drug Coverage



This official government booklet about Medicare Prescription Drug Coverage tells you the following:

- How it works
- How to get extra help paying for drug coverage if you have limited income and resources
- How it may affect any current drug coverage

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"Your Guide to Medicare Prescription Drug Coverage" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

Section

1 Medicare Prescription Drug Coverage Basics

Medicare prescription drug coverage is insurance.

Medicare prescription drug coverage (Part D) helps you pay for both the brand-name and generic drugs you need. It is coverage that adds to, or is included with, your Medicare health care coverage depending on the type of Medicare plan you join. You must choose and join a Medicare drug plan to get Medicare prescription drug coverage.

Everyone with Medicare has a decision to make about prescription drug coverage. If you don't use a lot of prescription drugs now, you still should consider joining a Medicare drug plan. This coverage may help lower your prescription drug costs and help protect against higher costs in the future. If you are new to Medicare and have prescription drug coverage now, you have new choices to consider. If you aren't new to Medicare, you have the opportunity to review your options for drug coverage and join or switch Medicare drug plans from November 15–December 31 each year.

Medicare drug plans are offered by insurance companies and other private companies approved by Medicare. There are 2 ways to get Medicare prescription drug coverage:

Words in red are defined on pages 65–68.

- Medicare Prescription Drug Plans (sometimes called PDPs) add prescription drug coverage to the Original Medicare Plan, some Medicare Private Fee-for-Service (PFFS) Plans, some Medicare Cost Plans, and Medicare Medical Savings Account Plans.
- Most Medicare Health Plans, including Medicare Advantage Plans (like an HMO or PPO), have prescription drug coverage. You generally get all of your Medicare health care and prescription drug coverage through these plans.

We use the term "Medicare drug plans" throughout this booklet to mean all plans that provide Medicare prescription drug coverage.

To join a Medicare Prescription Drug Plan, you must have Medicare Part A (Hospital Insurance) and/or Part B (Medical Insurance). To join a Medicare Advantage Plan or other Medicare Health Plan with prescription drug coverage, you must have Medicare Part A **and** Part B. You must also live in the service area of the Medicare drug plan you want to join.

1 Medicare Prescription Drug Coverage Basics

Medicare prescription drug coverage is insurance. (continued)

Medicare drug plans vary in what prescription drugs they cover, how much you have to pay, and which pharmacies you can use. All Medicare drug plans must provide at least a standard level of coverage set by Medicare. However, plans offer different combinations of coverage and cost sharing. Having a variety of plans to choose from gives you the chance to pick a plan that meets your unique needs. Choosing a plan that fits your situation allows you to get the coverage you want at the best price possible.

If you decide to join a Medicare drug plan, compare plans in your area and choose one that meets your needs. If you don't join a Medicare drug plan when you are first eligible for Medicare, and you don't have drug coverage that is, on average, expected to pay at least as much as standard Medicare prescription drug coverage (called creditable prescription drug coverage), you will have to pay a late enrollment penalty if you join later. You will pay the penalty in addition to your premium each month for as long as you have a Medicare drug plan.

Words in red are defined on pages 65–68.

How is Medicare prescription drug coverage different from the coverage Part B provides for certain drugs?

Part B provides limited prescription drug coverage. Part B covers certain injectable, cancer, and/or immunosuppressive drugs. You pay coinsurance, and the Part B deductible applies. Part B also covers vaccines such as the flu or pneumococcal shot. Generally, Medicare drug plans cover vaccines that aren't covered under Part B when the vaccine is needed to prevent illness.

Note: Generally, self-administered drugs you get in an outpatient setting like an emergency room or observation unit aren't covered by Medicare Part A or Part B. Your Medicare drug plan may cover these drugs under certain circumstances. You may need to pay out-of-pocket for these drugs and submit a claim to your plan. Call your plan for more information.

For more information on what Medicare drug plans cover, see Section 2.

Extra help is available for those who need it most.

If you have limited income and resources, you may get extra help paying your Medicare drug plan costs. See Section 3.

1 Medicare Prescription Drug Coverage Basics

Pick the prescription drug coverage that meets your needs.

Take time to consider all of your choices for prescription drug coverage before making a decision. This may include looking at the prescription drug coverage you already have, like coverage from an employer or union, TRICARE, the Department of Veteran's Affairs, the Indian Health Service, or a Medigap policy. Compare it to Medicare prescription drug coverage. The prescription drug coverage you already have may change as a result of Medicare prescription drug coverage, so it is important to consider all of your coverage options.

If you have (or are eligible for) other types of prescription coverage, read all the materials you get from your insurer or plan provider. Talk to your benefits administrator, insurer, or plan provider before you make any changes to your current coverage.

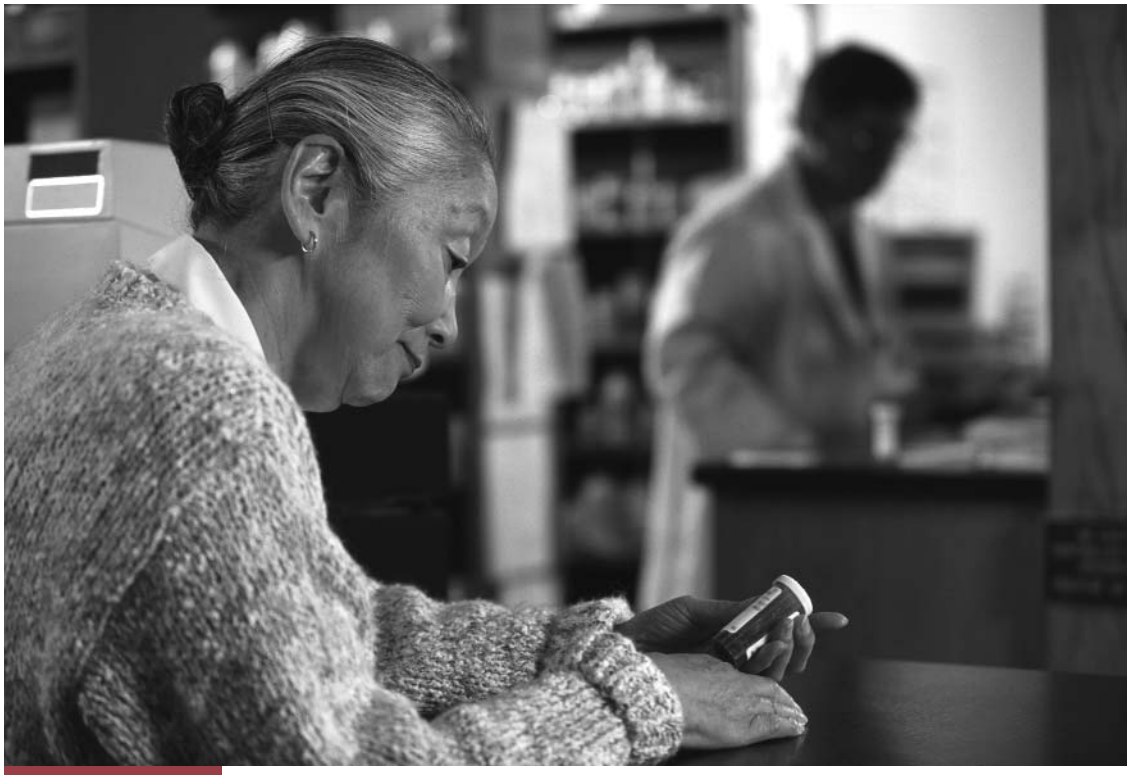
Note: Prescription drug coverage is insurance. Using doctor samples, discount cards, free clinics, or drug discount websites aren't the same as having prescription drug coverage.

For details about how Medicare prescription drug coverage may affect other coverage, see Section 4.

Get help with your choices.

You can get help comparing or joining Medicare drug plans:

- Visit www.medicare.gov on the web and get personalized information. Under "Search Tools," select "Compare Medicare Prescription Drug Plans" or "Compare Medicare Health Plans and Medigap Policies in Your Area." These tools can help you find which plans in your area cover your prescriptions and which pharmacies you can use to fill prescriptions.
- Call your State Health Insurance Assistance Program (SHIP) for free personalized health insurance counseling. See page 64 for your state's SHIP telephone number.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



Tip:

Even if you don't use a lot of prescription drugs now, joining a Medicare drug plan helps make sure you have coverage for your future needs.

Section 2

How Medicare Prescription Drug Coverage Works

Medicare drug plans vary in which drugs are covered, what your out-of-pocket costs will be, and which pharmacies you can use. Comparing plans based on coverage, cost, and convenience can help you decide which plan meets your needs.

- **Coverage**

Medicare drug plans cover generic and brand-name drugs. All plans must cover the same categories of drugs, but plans can choose what specific drugs are covered in each drug category.

- **Cost**

Plans have different monthly premiums, and what you pay for each prescription varies depending on which plan you choose. If you have limited income and resources, you may qualify for extra help from Medicare paying your drug plan costs.

- **Convenience**

Check with the plan to make sure the pharmacies in the plan are convenient to you. Some plans also allow you to get your prescriptions through the mail. If you spend part of the year in another state, see if the plan will cover you there.

What Medicare drug plans are available in my area?

You can get information about the specific drug plans in your area by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. See Section 5 for information on how to compare plans and join one that meets your needs.

Companies are allowed to mail you information and to call you, but plans must comply with the Do Not Call law. They aren't allowed to sell plans door-to-door unless you invite them to your home to help you. Remember to keep your personal information safe. See page 56.

2 How Medicare Prescription Drug Coverage Works

How much will my drug coverage cost?

Your costs for Medicare prescription drug coverage will vary depending on which drugs you use, which Medicare drug plan you join, and whether you get extra help paying for your drug costs. Medicare drug plans may design their plans with different coverage and costs, as long as what their plan offers is at least as good as the standard coverage described on the next page. **Contact the plan(s) you are interested in to get specific cost information.**

Payments you may make in a Medicare drug plan include the following:

Words in red are defined on pages 65–68.

- **Monthly premium**—Most drug plans charge a monthly fee that varies by plan. You pay this in addition to the Part B premium. If you belong to a Medicare Advantage Plan or Medicare Cost Plan that includes Medicare drug coverage, the monthly premium you pay includes an amount for prescription drug coverage. Some drug plans charge no premium.
- **Yearly deductible**—This is the amount you pay for your prescriptions before your plan begins to pay. Some plans charge no deductible.
- **Copayments or coinsurance**—You pay these amounts for your prescriptions after the deductible. You pay your share and your plan pays its share for covered drugs.
- **Coverage gap**—Most Medicare drug plans have a coverage gap. This means that after you and your plan have spent a certain amount of money for covered drugs, you have to pay all costs for your drugs while you are in the coverage gap. You must also continue to pay your plan's monthly premium while you are in the coverage gap.

  Each state offers at least one plan with some type of coverage during the gap. However, it's important to note the following:
  - Plans with gap coverage may charge a higher monthly premium.
  - Some plans may offer only generic drug coverage during the gap.
  - Even if a plan offers gap coverage, check with the plan first to see if your drugs would be covered in the gap.
- **Catastrophic coverage**—If you have extremely high drug costs, Medicare drug plans provide coverage called "catastrophic coverage." This means that once you have paid up to a certain limit for covered drugs in 2008, you only pay a coinsurance amount (like 5% of the drug cost) or a copayment (like $2.25 or $5.60 for each prescription) for the rest of the calendar year.

Note: If you get extra help paying your drug costs, some or all of your monthly premium may be covered, and you won't have a coverage gap. However, you will probably have to pay a small copayment or coinsurance amount for each prescription.

2 How Medicare Prescription Drug Coverage Works

How much will my drug coverage cost? (continued)

The example below shows calendar year costs for covered drugs in a plan that meets Medicare's standards in 2008:

Mr. Jones joins the ABC Prescription Drug Plan. His coverage begins on January 1, 2008. He pays the plan a monthly premium throughout the year, even during his coverage gap. He doesn't get extra help and uses his Medicare drug plan membership card.

1. Yearly Deductible	2. Copayment/ Coinsurance	3. Coverage Gap	4. Catastrophic Coverage
Mr. Jones pays the first $275 of his drug costs.	Mr. Jones pays a copayment or coinsurance amount for each prescription, and his plan pays its share for each drug until his total drug costs (including his deductible) reach $2,510.	Mr. Jones pays **everything** until he has spent $4,050 out-of-pocket. This amount includes his yearly deductible, his coinsurance or copays, and what he pays while in the coverage gap. This doesn't include the drug plan's premium.	Once Mr. Jones has spent $4,050 out-of-pocket for the year, his coverage gap ends. Now he only pays a small coinsurance (like 5%) or a small copayment (like $2.25 or $5.60) for each prescription until the end of the year.

2 How Medicare Prescription Drug Coverage Works

How can I pay my Medicare drug plan premium?

In general, there are 4 ways you can pay your Medicare drug plan premiums:

1. Deducted from your checking or savings account
2. Charged to a credit or debit card
3. Billed to you each month directly by the plan. (Some plans bill in advance for coverage the next month.)
4. Withheld from your Social Security payment. Contact your plan (not Social Security) to ask for this payment option. If you choose this option, your first 2 months of premiums will be combined.

Example of Social Security Withholding: Ms. Brown's monthly drug plan premium is $25 and her coverage begins in January. Her first premium payment is collected in February for $50. It includes her premium for January and February. After February, only 1 month of premium payments ($25) will be withheld from her Social Security payment.

If you choose to have your premium withheld from your Social Security payment, and you have another insurer or benefit that pays part of your drug plan premium (such as an employer health plan or a State Pharmacy Assistance Program (SPAP)), Social Security will withhold your entire monthly premium. Your drug plan will need to give you a refund for the amount your employer health plan or SPAP paid. **Caution:** You may experience delays in getting your refund.

Example: Mr. Anderson's monthly drug plan premium is $20. His SPAP or employer pays $10 toward his premium.

- If Mr. Anderson gets his premium withheld from his Social Security payment, the full $20 will be withheld. The drug plan will have to give him a refund of $10 for the share of the premium paid by his SPAP or employer.
- If the drug plan bills Mr. Anderson directly, he will pay his share ($10) to his plan. His SPAP or employer will pay its share ($10) directly to his plan.

For more information about your Medicare drug plan premium or ways to pay it, contact your plan.

If you qualify for extra help, some or all of your drug plan premiums may be covered. For more information, see pages 19–28.

2 How Medicare Prescription Drug Coverage Works

When can I join, switch, or drop a drug plan?

You can join, switch, or drop a Medicare drug plan at these times:

- When you first become eligible for Medicare. You can join the 3 months before you turn age 65 to 3 months after the month you turn age 65.
- If you get Medicare due to a disability, you can join during the 3 months before to 3 months after your 25th month of disability.
- From November 15–December 31 each year. Your coverage will begin on January 1 of the following year.
- At any time if you qualify for extra help. This includes people who have Medicare and Medicaid, belong to a Medicare Savings Program, get Supplemental Security Income (SSI) benefits (but not Medicaid), and those who apply and qualify.

Note: In certain limited circumstances, you may be able to switch to another Medicare drug plan. For example, you may be able to switch at other times if you permanently move out of your drug plan's service area or if you enter, live in, or leave a nursing home.

If you currently have Medicare prescription drug coverage, you should review your coverage each year in the fall. If you are happy with your coverage, cost, and customer service, and your Medicare drug plan is still offered in your area, you don't have to do anything for your coverage to continue for another year. However, if you decide another plan will better meet your needs, you can switch to a different plan.

How do I switch my plan?

You can switch from your current plan at the times listed above by joining a different plan. Joining a different Medicare drug plan will disenroll you from your current plan. You don't need to tell your current Medicare drug plan you are leaving or send them anything. You should get a letter from your new Medicare drug plan telling you when your coverage begins.

How do I join a plan?

Contact the company that offers the plan you want to join, and ask how to join the plan. Depending on the company, you may be able to join by calling the plan, by mailing or faxing a completed enrollment form to the company, or by enrolling through the company's website. You may also be able to join through the Medicare Prescription Drug Plan Finder tool by visiting www.medicare.gov on the web. Under "Search Tools," select "Compare Medicare Prescription Drug Plans."

2 How Medicare Prescription Drug Coverage Works

What happens if I don't join a Medicare drug plan when I am first eligible?

In most cases, you will pay a late enrollment penalty if you don't join when you are first eligible for Medicare, and you have been without creditable prescription drug coverage for 63 continuous days or more. Also, if you have a break of 63 continuous days or more in creditable prescription drug coverage at any time you are eligible for Medicare prescription drug coverage, you will have to pay a late enrollment penalty if you later join a Medicare drug plan.

Words in red are defined on pages 65–68.

How much is the late enrollment penalty?

The cost of the late enrollment penalty depends on how long you waited to join a Medicare drug plan. Your exact late enrollment penalty will be calculated when you join a Medicare drug plan. To estimate your penalty amount, multiply 1% of the national base beneficiary premium for the current year ($27.93 for 2008) by the number of full months you were eligible to join a Medicare drug plan but didn't. Round this to the nearest 10 cents. This penalty amount is added each month to your Medicare drug plan's premium for as long as you have the plan.

What information do I need to join a Medicare drug plan?

You will need the following information to complete your enrollment in a Medicare drug plan:

- Name and birth date
- Permanent street address
- Information found on your Medicare card (Medicare Claim Number)
- How you want to pay your plan premiums
- Other insurance information

You may be asked for the following information when you join a Medicare drug plan, but it is optional and isn't required to process your enrollment:

- Social Security number
- E-mail address
- Name and contact information of an emergency contact
- Name, address, and phone number of nursing home or institution where you live

Once you join a plan, the company will send you specific materials you will need like a membership card, member handbook, drug list, pharmacy provider directory, and complaint and appeal procedures.

2 How Medicare Prescription Drug Coverage Works

Will I get a separate card for my Medicare drug plan?

Yes, when you join a Medicare Prescription Drug Plan that works with the Original Medicare Plan, the plan will mail you a separate card to use when you fill your prescriptions. Your red, white, and blue Medicare card won't change. You will still use your red, white, and blue Medicare card for hospital and doctor services. If you join a Medicare Advantage Plan or other Medicare Health Plan with prescription drug coverage, you may or may not get a new card depending on the plan.

What if I need to fill a prescription before I get a membership card?

If you need to fill a prescription and you haven't received a membership card yet, call the plan you joined for help. You can take any of the following to the pharmacy as proof of membership in your Medicare drug plan:

- An acknowledgement, confirmation, or welcome letter from the plan
- An enrollment confirmation number that you got from the plan, and the name and telephone number of the plan

You should also bring your Medicare and/or Medicaid card and a photo ID. If you don't have any of the items above, and your pharmacist can't get your drug plan information any other way, you may have to pay out-of-pocket for your prescriptions. If you do, save the receipts and contact your plan to get back some of the cost.

Enroll early in the month. This gives the Medicare drug plan time to mail you important information, like your membership card, before your coverage becomes effective. This way, even if you go to the pharmacy on your first day of coverage, you can get your prescriptions filled without delay.

2 How Medicare Prescription Drug Coverage Works

Where can I get my prescriptions filled?

Each company offering a Medicare drug plan will have a list of pharmacies you can use. If you want to continue filling prescriptions at the same pharmacy you use now, you should check to see if the pharmacy is on the plan's list. You can call the plan, your pharmacy, or 1-800-MEDICARE (1-800-633-4227), or visit www.medicare.gov on the web to see if your pharmacy works with the plan you want to join.

Once you join a Medicare drug plan, the company will send you a pharmacy provider directory. Generally, you must go to one of the pharmacies listed in this directory for your plan to cover your prescriptions. Medicare requires plans to have pharmacies for you to choose from. Plans can't require you to use a mail order pharmacy, but you may have the option to do so.

What are the special rules for people with End-Stage Renal Disease (ESRD)?

If you have ESRD (permanent kidney failure requiring dialysis or a kidney transplant) and you are in the Original Medicare Plan, you can join a Medicare Prescription Drug Plan. You generally can't join a Medicare Advantage Plan. However, if you are already in a Medicare Advantage Plan, you can stay in it or join another plan offered by the same company in the same state that includes Medicare drug coverage. Also, if you are a member of a health plan (like through a former employer or union) offered by the same company that offers one or more Medicare Advantage Plans, you may be able to join a Medicare Advantage Plan offered by that company. If you've had a successful kidney transplant, you may be able to join a Medicare Advantage Plan.

If you have ESRD and are in a Medicare Advantage Plan and the plan leaves Medicare or no longer provides coverage in your area, you have a one-time right to join another Medicare Advantage Plan. You don't have to use your one-time right to join a new plan immediately. If you change directly to the Original Medicare Plan after your plan leaves or stops providing coverage, you will still have a one-time right to join a Medicare Advantage Plan at a later date as long as the plan is accepting new members.

You may also be able to join a Medicare Advantage Plan called a Medicare Special Needs Plan for people with ESRD if one is available in your area.

2 How Medicare Prescription Drug Coverage Works

What are the special rules for people with End-Stage Renal Disease (ESRD)? (continued)

Visit www.medicare.gov on the web for more information about ESRD and Medicare Advantage Plans. Under "Search Tools," select "Find a Medicare Publication" to view the booklet "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services." You can also call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048.

What drugs are covered by Medicare drug plans?

Words in red are defined on pages 65–68.

The drugs covered by each plan vary, so there is no single drug list that applies to all plans. All Medicare drug plans must make sure that the people in their plan can get medically-necessary drugs to treat their conditions. Listed below and described on the following pages are some of the coverage rules plans use to make sure that certain drugs are used correctly and only when necessary. Becoming familiar with these terms will help you make choices about your coverage:

- Drug Lists (Formularies)
- Prior Authorization
- Quantity Limits

Drug Lists (Formularies)

Each Medicare drug plan has a list of prescription drugs that it covers. Plans may cover both generic and brand-name prescription drugs.

There are certain drugs that Medicare drug plans aren't required to cover, such as benzodiazepines, barbiturates, drugs for weight loss or gain, and drugs for erectile dysfunction. Some plans may choose to cover these drugs as an added benefit. In addition, drug plans generally aren't allowed to cover over-the-counter drugs. Some states may cover these drugs if you have Medicaid.

The drug lists for each plan must include a range of drugs in each prescribed category. This makes sure that people with different medical conditions can get the treatment they need. All Medicare drug plans must generally cover at least two drugs in each category of drugs, but plans can choose which specific drugs are covered in each category. Plans are required to cover almost all drugs in six classes: anti-psychotics, anti-depressants, anti-convulsants, immunosuppressants, cancer, and HIV/AIDS drugs.

2 How Medicare Prescription Drug Coverage Works

Drug Lists (Formularies) (continued)

All Medicare drug plans have negotiated to get lower prices for the drugs they cover. This means using drugs on your plan's list will generally save you money. Using generics instead of brand-name drugs can also save you money.

Tip: A plan isn't required to tell you in advance if it removes a drug from its drug list because the FDA takes the drug off the market for safety reasons.

Generic drugs

According to the Food and Drug Administration (FDA), a generic drug is the same as a brand-name drug in safety, strength, quality, the way it works, how it's taken, and the way it should be used. Generic drugs use the same active ingredients as brand-name drugs and work the same way. Generic drug makers must prove to the FDA that their product performs in the same way as the brand-name drug. Today, almost half of all prescriptions are filled with generics. In some cases, there may not be a generic drug available for the brand-name drug you take. Talk to your doctor.

Tiers

To have lower costs, many plans place drugs into different "tiers" on their lists, which cost different amounts. Each plan can divide its tiers in different ways. Below is an example of how a plan might divide its tiers. A drug in a lower tier will cost you less than a drug in a higher tier.

Example:

- Tier 1–Generic drugs. Tier 1 drugs will cost you the least amount.
- Tier 2–Preferred brand-name drugs. Tier 2 drugs will cost you more than Tier 1 drugs.
- Tier 3–Non-preferred brand-name drugs. Tier 3 drugs will cost you more than Tier 1 and Tier 2 drugs.

Your plan's drug list may not include a drug you take. However, in most cases, a similar drug that is safe and effective will be available.

Your plan's drug list may change during the year because drug therapies change, new drugs are released, and new medical information becomes available. If there is a change that affects a drug you take, your plan must notify you at least 60 days in advance. You may have to change the drug you use or pay more for it. In some cases, you can continue taking the drug you were on until the end of the year. You can also ask for an exception. See page 57.

2 How Medicare Prescription Drug Coverage Works

Prior Authorization

Plans may have drugs that require prior authorization. Prior authorization means before the plan will cover a particular drug, your doctor must first show the plan that there is a medically-necessary reason why you must use that particular drug. Plans do this to be sure these drugs are used correctly and only when medically necessary. Contact your plan about its prior authorization requirements before you talk with your doctor.

Step Therapy

Step therapy is a type of prior authorization. With step therapy, in most cases you must first try a certain less-expensive drug on the plan's list that has been proven effective for most people with your condition, before you can move up a "step" to a more expensive drug. For instance, some plans may require you to try a generic drug (if available), then a less expensive brand-name drug that is on their drug list, before you can get a similar, more expensive brand-name drug covered.

Example of step therapy:

Step 1–Dr. Smith wants to prescribe an ACE inhibitor to treat Mr. Mason's heart failure. There is more than one type of ACE inhibitor. Some of the drugs Dr. Smith considers prescribing are brand-name drugs covered by Mr. Mason's Medicare drug plan. The plan rules require Mr. Mason to use the generic drug lisinopril first. For most people, lisinopril works as well as brand-name drugs.

Step 2–If Mr. Mason takes lisinopril but has side effects or limited improvement, his doctor can provide that information to the plan to get approval to prescribe a brand-name drug. If approved, Mr. Mason's Medicare drug plan will now cover this drug.

However, if you have already tried the similar, less-expensive drugs and they didn't work, or if your doctor believes that because of your medical condition it is medically necessary for you to be on a more expensive step-therapy drug, he or she can contact the plan to request an exception. If your doctor's request is approved, the step-therapy drug will be covered.

Words in red are defined on pages 65–68.

2 How Medicare Prescription Drug Coverage Works

Quantity Limits

For safety and cost reasons, plans may limit the amount of drugs that they cover over a certain period of time. For example, most people who are prescribed heartburn medication take 1 tablet per day for 4 weeks. Therefore, a plan may cover only an initial 30-day supply of heartburn medication. Should you need more medication, you may need your doctor's help in providing more information for a refill.

Words in red are defined on pages 65–68.

If your doctor believes that because of your medical condition a quantity limit isn't medically appropriate for you, you or your doctor can contact the plan to request an exception. If the request is approved, the quantity limit won't apply to your drug.

What if I'm taking a drug that isn't on my plan's drug list when my drug plan coverage begins?

Your drug plan will provide a one-time, temporary 30-day supply of your current drug during your first 90 days in a plan. Plans are required to give you this temporary supply so that you and your doctor have time (30 days) to find another drug on the plan's drug list that will work as well as the drug you are taking now. Different rules may apply for people who move into an institution (such as a nursing home or long-term care hospital).

However, if you have already tried similar drugs on your plan's drug list and they didn't work, or if your doctor determines that you need a certain drug because of your medical condition, you or your doctor can contact your plan to request an exception as soon as you get your temporary 30-day supply. You can also request an exception if your doctor thinks you need to have a coverage rule waived, such as a dose or quantity limit. If you or your doctor's request is approved, the plan will cover the drug. If your plan doesn't approve the exception, you can appeal the plan's decision. For more information on appeals, see pages 58–60.

2 How Medicare Prescription Drug Coverage Works

What if I join a plan and then my doctor changes my prescription?

If your doctor needs to change your prescription or prescribe a new drug, give your doctor a copy of your Medicare drug plan's current drug list.

If your doctor needs to prescribe a drug that isn't on your Medicare drug plan's drug list and you don't have any other health insurance that covers outpatient prescription drugs, you or your doctor can ask the plan for an exception.

If your plan still won't cover a specific drug you need, you can appeal. If you want to get the drug before your appeal is decided, you may have to pay out-of-pocket for the prescription. If you win the appeal, the plan will pay you back. For more information about what to do if a plan won't cover a drug you need, see pages 57–58.

The drug list and the prices for drugs can change. To get information about these changes, call your plan or look on your plan's website to find the most up-to-date Medicare drug list and prices.

Tip:

If you have limited income and resources, apply for extra help with drug plan costs.

Section

3

How to Get Extra Help With Your Medicare Drug Plan Costs

If you have limited income and resources, you may qualify for extra help paying your Medicare drug plan costs.

If you qualify, you will get help paying for your Medicare drug plan's monthly premium, deductible, and copayments. The amount of extra help you get is based on your income and resources. You have to join a Medicare drug plan to get extra help paying your drug costs. The charts on pages 20 and 22 show what you would pay with extra help from Medicare based on your income and resources.

Note: The U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of Puerto Rico, and the Commonwealth of Northern Mariana Islands provide help for their residents with their Medicare drug costs. In general, this help is for residents in these areas who qualify for Medicaid. The help isn't the same as the extra help provided elsewhere in the United States. To find out more about the rules for these territories, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Ways you may qualify for extra help

1. You automatically qualify and don't need to apply.

Medicare mails purple letters to people who automatically qualify for extra help. If you get one, keep this letter as proof that you qualify.

You automatically qualify for extra help if you have any one of the following:

- You have full coverage from a state Medicaid program.
- You get help from Medicaid paying your Medicare Part B premiums (belong to a Medicare Savings Program).
- You get Supplemental Security Income (SSI) benefits but not Medicaid.

If you don't join a plan on your own, Medicare will enroll you in a plan so you get help paying for your prescription drugs. If Medicare enrolls you in a plan, Medicare will send you a yellow or green letter letting you know when your coverage begins. Check to see if the plan covers the drugs you use and if you can go to the pharmacies you want. If the plan Medicare enrolls you in doesn't meet your needs, you can switch plans at any time. If you don't want Medicare to enroll you in a Medicare drug plan (for example, because you want to keep your employer or union coverage), call 1-800-MEDICARE (1-800-633-4227) or the plan listed in the letter and tell them you don't want to be in a Medicare drug plan and want to "opt out" of enrollment. TTY users should call 1-877-486-2048.

3 How to Get Extra Help With Your Medicare Drug Plan Costs

Medicare Drug Plan Costs if You **Automatically Qualify** for Extra Help

If you have Medicare and	Your monthly premium*	Your yearly deductible	Your cost per prescription at the pharmacy (until $4,050**)	Your cost per prescription at the pharmacy (after $4,050**)
full Medicaid coverage and for each full month you live in an institution, like a nursing home	$0	$0	$0	$0
full Medicaid coverage and have a yearly income at or below $10,400–single $14,000–married	$0	$0	**Generic and certain preferred drugs:** no more than $1.05 **Brand-name drugs:** no more than $3.10	$0
full Medicaid coverage and have a yearly income above $10,400–single $14,000–married	$0	$0	**Generic and certain preferred drugs:** no more than $2.25 **Brand-name drugs:** no more than $5.60	$0
get help from Medicaid paying your Medicare Part B premiums	$0	$0	**Generic and certain preferred drugs:** no more than $2.25 **Brand-name drugs:** no more than $5.60	$0
get Supplemental Security Income (SSI) but not Medicaid	$0	$0	**Generic and certain preferred drugs:** no more than $2.25 **Brand-name drugs:** no more than $5.60	$0

Notes: *There are plans you can join and pay no premium. There are other plans where you will have to pay part of the premium even when you automatically qualify for extra help. Tell your plan you qualify for extra help and ask how much you will pay for your monthly premium.

** Your cost per prescription generally decreases once the amount you pay and Medicare pays as the extra help reach $4,050 per year.

The income levels and resources listed are for 2008 and can increase each year. If you live in Alaska or Hawaii, or you or your spouse pay at least half of the living expenses of dependent family members who live with you, or you work, income limits are higher. Costs listed are for 2008 and can change each year.

3 How to Get Extra Help With Your Medicare Drug Plan Costs

Ways you may qualify for extra help (continued)

2. You apply and qualify

If you think you may qualify for extra help, call Social Security at 1-800-772-1213, visit www.socialsecurity.gov on the web, or apply at your State Medical Assistance (Medicaid) office. There is no risk or cost to apply. Remember, even if you qualify, you still need to join a Medicare drug plan to get the extra help.

If you apply and qualify, Medicare will enroll you in a Medicare drug plan if you don't join one on your own. This makes sure you get help paying for your prescription drug costs. Medicare will mail you a green letter letting you know when your coverage begins. Check to see if the plan covers the drugs you use and if you can go to the pharmacies you want. If not, you can change plans. If the plan Medicare enrolls you in doesn't meet your needs, you can switch plans at any time.

If you don't want Medicare to enroll you in a Medicare drug plan (for example, because you want to keep your employer or union coverage), call 1-800-MEDICARE (1-800-633-4227) or the plan listed in the green letter and tell them you don't want to be in a Medicare drug plan and want to "opt out" of enrollment. TTY users should call 1-877-486-2048.

3 How to Get Extra Help With Your Medicare Drug Plan Costs

Medicare Drug Plan Costs if You **Apply and Qualify** for Extra Help

If you have Medicare and	Your monthly premium*	Your yearly deductible	Your cost per prescription at the pharmacy (until $4,050**)	Your cost per prescription at the pharmacy (after $4,050**)
a yearly income below $14,040–single $18,900–married with resources of no more than $7,790–single $12,440–married	$0	$0	**Generic and certain preferred drugs:** no more than $2.25 **Brand-name drugs:** no more than $5.60	$0
a yearly income below $14,040–single $18,900–married with resources between $7,790 and $11,990–single $12,440 and $23,970–married	$0	$56	up to 15% of the cost of each prescription	**Generic and certain preferred drugs:** no more than $2.25 **Brand-name drugs:** no more than $5.60
a yearly income between $14,040 and $14,560–single $18,900 and $19,600–married with resources up to $11,990–single $23,970–married	25%	$56	up to 15% of the cost of each prescription	**Generic and certain preferred drugs:** no more than $2.25 **Brand-name drugs:** no more than $5.60
a yearly income between $14,560 and $15,080–single $19,600 and $20,300–married with resources up to $11,990–single $23,970–married	50%	$56	up to 15% of the cost of each prescription	**Generic and certain preferred drugs:** no more than $2.25 **Brand-name drugs:** no more than $5.60
a yearly income between $15,080 and $15,600–single $20,300 and $21,000–married with resources up to $11,990–single $23,970–married	75%	$56	up to 15% of the cost of each prescription	**Generic and certain preferred drugs:** no more than $2.25 **Brand-name drugs:** no more than $5.60

Please see the notes below the table on page 20 for more information.

3 How to Get Extra Help With Your Medicare Drug Plan Costs

Applying for Extra Help

Whose income and resources count?

- Your income and resources are counted.
- If you are married and live with your spouse, both of your incomes and resources are counted even if only one of you is applying for extra help.
- If you are married and don't live with your spouse when you apply, only your income and resources are counted.

Note: Married couples living together who apply for extra help through Social Security can use the same application form to apply (SSA-1020).

What income counts?

"Income" means any cash, goods, or services that can be used to meet your needs for food or shelter. Examples of income that is and isn't counted by Social Security or your state to decide if you qualify include (but aren't limited to) the following:

Income counted

- Wages
- Earnings from self-employment
- Social Security benefits
- Railroad Retirement benefits
- Veterans benefits
- Pensions
- Annuities
- Alimony
- Rental income
- Worker's Compensation

Income not counted

- Income tax refunds
- Assistance based on need, funded by a state or local government
- Foster care payments
- The value of expenses which a blind or disabled person needs to work

3 How to Get Extra Help With Your Medicare Drug Plan Costs

Applying for Extra Help (continued)

What resources count?

Social Security or your state must count your resources to decide if you qualify for extra help. Your resources include cash and other things that you normally can convert to cash within 20 workdays. Examples of resources that are and aren't counted when deciding if you qualify include (but aren't limited to) the following:

Resources counted

- Accounts at financial institutions (like savings; checking; money market; time deposits or certificates of deposit; and retirement, such as individual retirement accounts (IRA) or 401(k) accounts)
- Stocks
- Bonds
- Savings bonds
- Mutual fund shares
- Promissory notes
- The value of property that isn't connected to your home

Resources not counted

- Life insurance policies you own with a combined face value of $1,500 or less ($3,000 or less for you and your spouse)
- The home you live in and the land it's on
- Resources such as family heirlooms and wedding/engagement rings
- Property of a trade or business which is essential to your means of self-support
- Non-business property which is essential to your means of self-support
- Funds received and saved to pay for medical and/or social services

What happens after I apply for extra help?

If you file a paper application for extra help, Social Security will send you a notice in the mail to let you know they got your application. If you apply online, you will get a receipt online. If your online or paper application isn't complete, Social Security will send you a letter or call you asking for the missing information. Once Social Security or your state makes a decision about your application, you will get a letter in the mail telling you if you qualify, how much extra help you will get if you qualify, and what to do next.

3 How to Get Extra Help With Your Medicare Drug Plan Costs

How long will I get extra help if I qualify?

If you apply and qualify for extra help

If you qualify for extra help, the decision remains in effect for the calendar year as long as you are enrolled in a Medicare drug plan **and** there are no changes to your income, resources or family size, **or** you don't have a change in your marital status.

Changes in marital status include the following:

- Marriage
- Divorce
- Annulment
- Separation (not temporary)
- You and your spouse resume living together after separating
- Death of spouse

Any of these changes could cause the amount of your extra help to increase, decrease, or end.

If you applied with Social Security and qualified for extra help, you should notify Social Security of any changes in your marital status. If the change in your marital status affects your extra help, the change in extra help will be effective the month after you report the change in your marital status. Changes to your income, resources, or family size can be reported from August–December, and any changes that affect your extra help will be effective January 1 of the following year.

If you applied for extra help through your state and your state determined that you qualify, your state may have rules that require you to report changes in your circumstances to your state.

If you automatically qualify for extra help

You won't automatically qualify for extra help for the coming year if you no longer qualify for Medicaid, get help from your state Medicaid program to pay Medicare Part B premiums (belong to a Medicare Savings Program), or get Supplemental Security Income (SSI) but not Medicaid.

If you won't automatically qualify the next year, you will get a notice (on grey paper) in the mail by early fall. If the amount of extra help you get is changing so that your copayment amounts change for next year, you will get a notice (on orange paper) in the mail with the new copayment amounts. If you don't get a notice, you will get the same level of extra help next year that you have this year.

Even if you get the notice on grey paper because you don't automatically qualify, you may still be able to save on your Medicare prescription drug coverage costs. **You need to apply for extra help to find out.**

3 How to Get Extra Help With Your Medicare Drug Plan Costs

What if my application for extra help is denied?

You have the right to appeal the decision. If you applied with Social Security, they will give you a hearing by telephone unless you choose a case review. Either way, Social Security will review those parts of the decision which you believe are wrong and will look at any new facts you provide. Social Security may also review those parts which you believe are correct. The person who will decide your case will be someone who wasn't involved in the first decision.

To request an appeal, call Social Security at 1-800-772-1213. You can also get a copy of the form SSA-1021, "Appeal of Determination for Help with Medicare Prescription Drug Costs" by visiting www.socialsecurity.gov on the web.

If you want to file an appeal, remember the following:

- You have 60 days to ask for an appeal.
- The 60 days start the day after you get a letter from Social Security denying your application. Social Security will assume you got the letter 5 days after the date on it unless you show them that you didn't get it within the 5-day period.
- You can have a lawyer, friend, or someone else help you. Call Social Security at 1-800-772-1213 for a list of groups that can help you with your appeal. To find your local Social Security office, visit www.socialsecurity.gov on the web. Select "Find a Social Security office."

If you apply for extra help with your state, your decision letter should include appeal rights and procedures. Call your State Medical Assistance (Medicaid) office for information on the appeals process for your state.

3 How to Get Extra Help With Your Medicare Drug Plan Costs

What if I don't qualify for extra help?

Words in red are defined on pages 65–68.

You can still choose and join a Medicare drug plan that meets your needs. You will have to pay the monthly premium, yearly deductible (some plans have no deductible), and a share of the cost of your prescriptions.

If you don't qualify for extra help now, you can apply or reapply later if your income and resources change.

Your state may have programs that provide help paying your prescription drug costs. Contact your State Medical Assistance (Medicaid) office or State Health Insurance Assistance Program (SHIP) for more information. See page 64 for the SHIP in your state. You can also call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web for these telephone numbers. TTY users should call 1-877-486-2048.

Tip:

Compare Medicare drug plans to find one that meets your needs. Help is available.

Section

4 Your Prescription Drug Coverage Choices

Find the information that fits your current health insurance coverage situation in the list on page 31. Read what you need to know about the choices you have with Medicare prescription drug coverage. More than one situation may apply to you.

Get help with prescription drug coverage decisions

If you need help with your Medicare prescription drug coverage decisions, call your State Health Insurance Assistance Program (SHIP). See page 64 for their telephone number. You can also visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Medicare is working with other government representatives, community and faith-based groups, employers and unions, doctors, pharmacies, and other people and organizations in your community. Look for information about events in your local newspaper or listen for information on the radio.

If you have limited income and resources, you may qualify for extra help paying the costs of Medicare prescription drug coverage (see pages 19–28).

Tip: Prescription drug coverage is insurance. Using doctor samples, discount cards, free clinics, or drug discount websites aren't the same as having prescription drug coverage.

4 Your Prescription Drug Coverage Choices

What else do I need to think about before I decide to get Medicare prescription drug coverage?

Words in red are defined on pages 65–68.

Before you make a decision, you need to answer the following questions:

- If you have drug coverage now, is it creditable prescription drug coverage (is it expected to pay, on average, at least as much as standard Medicare prescription drug coverage)? Your current plan can tell you.
- If you have drug coverage now, should you keep it?
- If you join a Medicare drug plan and keep your current drug coverage, how will it affect your current coverage? Your current plan can tell you.
- How would a particular Medicare drug plan affect your out-of-pocket costs?
- If you wait to join a Medicare drug plan, would your premium be higher later because you have to pay a late enrollment penalty? Would your coverage start when you wanted it to?
- Does a Medicare drug plan in your area cover the drugs you take?
- Can you get extra help paying for your prescription drug costs if you join a Medicare drug plan?
- Is there a particular pharmacy you want to use?
- Do you spend part of each year in another state? This may be important if the plan requires you to use certain pharmacies.

4 Your Prescription Drug Coverage Choices

Find your personal situation below, and turn to those pages.

Type of Current Health Insurance Coverage — Page(s)

Original Medicare Plan

I have only Part A and/or Part B and no drug coverage 32

I have a Medigap (Medicare Supplement Insurance) policy without prescription drug coverage 32

I have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage 33–34

Employer Coverage and Union Coverage, including Military

I get drug coverage through a current or former employer or union . . . 35–36

I have a Federal Employee Health Benefits plan 37

I have TRICARE or benefits from the Department of Veterans Affairs (VA) that include drug coverage 38

Medicare Health Plans

I have a Medicare Health Plan without prescription drug coverage 39

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Medicaid and other State or Federal Programs

I have Medicaid 41

I get Supplemental Security Income (SSI) benefits or help from Medicaid paying Medicare Part B premiums (belong to a Medicare Savings Program) 42

I live in a nursing home or other institution 43

I get benefits through Programs of All-inclusive Care for the Elderly (PACE) 44

I get help from my State Pharmacy Assistance Program (SPAP) 45

I get help from an AIDS Drug Assistance Program (ADAP) 46

I get prescription drug coverage from the Indian Health Service, Tribe or Tribal Health Organization, or Urban Indian Health Program 47

4 Your Prescription Drug Coverage Choices

Words in red are defined on pages 65–68.

I have only Part A and/or Part B (the Original Medicare Plan) and no drug coverage

If you have Part A and/or Part B (check your red, white, and blue Medicare card) and live in a plan service area, you can join a Medicare drug plan to help with the costs of your prescription drugs. You can choose and join a drug plan that meets your needs. Look in your "Medicare & You" handbook, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) for a list of Medicare Prescription Drug Plans in your area. TTY users should call 1-877-486-2048.

I have Medicare and a Medigap (Medicare Supplement Insurance) policy without prescription drug coverage

If you currently have Medicare and a Medigap policy that doesn't provide prescription drug coverage, you can join a Medicare drug plan to help with the costs of your prescription drugs. Your choices are listed below:

- You can keep your current Medigap policy and enroll in a Medicare Prescription Drug Plan available in your area to get prescription drug coverage.
- You can join a Medicare Advantage Plan in your area that includes prescription drug coverage, and get all your health care benefits and prescription drug coverage from the plan. **If you join, your Medigap policy won't pay any deductibles, copayments, or other cost sharing under your Medicare Advantage Plan. Therefore, you may want to drop your Medigap policy if you join a Medicare Advantage Plan. However, you might not be able to get the same Medigap policy back.** In some cases, you might not be able to buy any policy if you leave the Medicare Advantage Plan. You have a legal right to keep the Medigap policy. Your rights to buy a Medigap policy may vary by state.

For information about your Medigap policy, contact your Medigap insurer.

4 Your Prescription Drug Coverage Choices

I have Medicare and a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage

Before 2006, some Medigap policies included prescription drug coverage. If you still have a Medigap policy with prescription drug coverage, your Medigap insurer must send you a detailed notice each year describing your choices for prescription drug coverage and whether the drug coverage under your Medigap policy is creditable prescription drug coverage. Read the notice carefully for more information. Some of your choices for prescription drug coverage are listed below:

- You can join a Medicare Prescription Drug Plan and keep your current Medigap policy without the prescription drug coverage.
- You can join a Medicare Advantage Plan that includes prescription drug coverage. You will get all your health care coverage including prescription drug coverage from this plan, and you won't need a Medigap policy. However, you can continue to use your Medigap drug coverage if you join a Medicare Medical Savings Account (MSA) Plan since MSAs can't offer Medicare prescription drug coverage.
- You can keep your current Medigap policy with the prescription drug coverage included.

Tip: Contact your Medigap insurer before you make any changes to your prescription drug coverage.

The information you get from your Medigap insurer describes these choices in detail. You can also check with your state insurance department to find out what other options you may have for prescription drug coverage.

If you decide to join a Medicare Prescription Drug Plan, you can keep your current Medigap policy without the prescription drug coverage. You will need to tell your Medigap insurer when your Medicare prescription drug coverage starts. They must remove the prescription drug coverage from your Medigap policy and adjust your premium based on this change. Also, you may have to pay a late enrollment penalty to join a Medicare Prescription Drug Plan if the prescription drug coverage you have had under your Medigap policy doesn't expect to pay, on average, at least as much as standard Medicare drug coverage. You will pay this higher premium for as long as you are in a Medicare Prescription Drug Plan.

4 Your Prescription Drug Coverage Choices

I have Medicare and a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage (continued)

For more information about Medigap policies, read the "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" booklet. You can view or download this booklet by visiting www.medicare.gov on the web. Under "Search Tools," select "Find a Medicare Publication." You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

4 Your Prescription Drug Coverage Choices

I have Medicare and get drug coverage from a current or former employer or union

Medicare helps employers and unions continue to offer high quality prescription drug coverage. Before you make a decision about whether to join a Medicare drug plan, it's important for you to understand how your employer or union drug coverage works with Medicare. Your employer or union drug coverage may change if you join a Medicare drug plan. You should get information from your employer or union (or the plan that administers your drug coverage) annually about how your drug coverage compares to Medicare prescription drug coverage (whether it is creditable drug coverage). Read carefully and save all materials from your employer or union. They will help you understand your options and make your decision much easier.

Words in red are defined on pages 65–68.

Here are some important questions to answer before making a decision:

- Is your employer or union drug coverage creditable (on average, does it expect to pay at least as much as standard Medicare prescription drug coverage)? If not, in most cases, you will have to pay a late enrollment penalty if you don't join a Medicare drug plan when you are first eligible.
- Will you or your spouse or dependents lose all of your employer or union coverage if you join a Medicare drug plan?
- How do your out-of-pocket drug costs with your employer or union drug coverage compare to your out-of-pocket drug costs with a Medicare drug plan?
- If you qualify for extra help with your Medicare drug plan costs, how does this change how your costs compare?

4 Your Prescription Drug Coverage Choices

I have Medicare and get drug coverage from a current or former employer or union (continued)

Tip: Talk with your employer or union benefits administrator before making any changes to your health care coverage.

Your (or your spouse's) employer or union tells you that your current coverage **IS** creditable prescription drug coverage.

- You can keep this coverage as long as it is still offered by your employer or union.
- You won't have to pay a late enrollment penalty if your employer or union stops offering prescription drug coverage as long as you join a Medicare drug plan within 63 days after the coverage ends.

Note: You should keep any materials your employer or union sends you that tell you your prescription drug coverage is creditable. You may need to provide it to your Medicare drug plan as proof of creditable prescription drug coverage if you decide to join a Medicare drug plan later.

Your (or your spouse's) employer or union tells you that your current coverage **ISN'T** creditable prescription drug coverage. If you want to join a Medicare drug plan, you must join when you are first eligible to avoid a late enrollment penalty.

Caution: If you drop your employer or union coverage, you may not be able to get it back. You also may not be able to drop your employer or union **drug** coverage without also dropping your employer or union **health** coverage. If you drop coverage for yourself, you may also have to drop coverage for your spouse and dependents.

Find out about your options from your benefits administrator. You may be able to do one of the following:

- Keep your current employer or union drug coverage and join a Medicare drug plan to give you more complete prescription drug coverage.
- Keep only your current employer or union drug coverage. If you join a Medicare drug plan later, you may have to pay a late enrollment penalty.
- Drop your current coverage and join a Medicare Prescription Drug Plan, or join a Medicare Health Plan that covers prescription drugs.

4 Your Prescription Drug Coverage Choices

I have Medicare and a Federal Employee Health Benefits (FEHB) plan

The FEHB Program offers health coverage for current and retired federal employees.

Words in red are defined on pages 65–68.

- If you are covered under a FEHB plan, you will get information during the open season about your prescription drug coverage and whether it is creditable prescription drug coverage. Read this information carefully.
- Contact your FEHB insurer before making any changes. It will almost always be to your advantage to keep your current coverage without any changes. For most people, unless you qualify for extra help, it isn't cost effective to join a Medicare drug plan. **Caution:** You can't drop FEHB drug coverage without also dropping FEHB plan coverage for hospital and medical services, which may mean higher costs for these services.
- If you qualify for extra help paying Medicare prescription drug costs, see how your costs compare with a Medicare drug plan and any extra help versus your FEHB plan prescription drug coverage.
- If you ever lose your FEHB coverage and need to join a Medicare drug plan, in most cases, you won't have to pay a late enrollment penalty, as long as you join within 63 days of losing FEHB coverage.

For more information, contact the Office of Personnel Management or visit www.opm.gov/insure/health on the web.

4 Your Prescription Drug Coverage Choices

I have Medicare and TRICARE or benefits from the Department of Veterans Affairs (VA) that include drug coverage

If you get health care benefits from TRICARE or the VA, you need to know the following:

- As long as you still qualify, you can keep your TRICARE or VA prescription drug coverage. You should get information each year from TRICARE or your VA provider about your coverage and whether it is creditable prescription drug coverage. Read this information carefully.
- Contact your benefits administrator for information about your TRICARE or VA coverage before making any changes. It will almost always be to your advantage to keep your current coverage without any changes. For most people, unless you qualify for extra help, it isn't cost effective to join a Medicare drug plan.
- If you qualify for extra help paying Medicare prescription drug costs, see how your costs compare with a Medicare drug plan and any extra help versus your TRICARE or VA prescription drug coverage.
- If you ever lose your TRICARE or VA coverage and need to join a Medicare drug plan, in most cases, you won't have to pay a late enrollment penalty, as long as you join within 63 days of losing TRICARE or VA coverage.

For more information about your VA benefits, call the VA Health Benefits Service Center at 1-877-222-VETS (8387), visit your local VA medical facility, or visit www.va.gov/healtheligibility on the web.

For more information about TRICARE, call 1-888-363-5433 or visit www.tricare.osd.mil on the web.

4 Your Prescription Drug Coverage Choices

I have a Medicare Health Plan without prescription drug coverage

If you have a Medicare Advantage Plan (like an HMO or PPO) or another Medicare Health Plan that doesn't include prescription drug coverage, you may want to consider other ways to get Medicare prescription drug coverage.

- Check with your current Medicare Advantage Plan to see if it offers a Medicare prescription drug option. If so, you can switch to that option.
- If your current plan doesn't offer Medicare prescription drug coverage, you can switch to another Medicare Health Plan in your area that offers it.
- If your current plan doesn't offer Medicare prescription drug coverage, you can switch to the Original Medicare Plan and join a Medicare Prescription Drug Plan.
- If your Medicare Cost Plan doesn't offer Medicare prescription drug coverage, you can join a separate Medicare Prescription Drug Plan to add prescription drug coverage.
- No Medicare Medical Savings Account (MSA) Plans and only some Medicare Private Fee-for-Service (PFFS) Plans offer Medicare prescription drug coverage. If your Medicare PFFS Plan doesn't offer Medicare prescription drug coverage, or if you have a Medicare MSA Plan, you can join a Medicare Prescription Drug Plan to get this coverage. Note that if you have a Medicare MSA Plan and a Medicare Prescription Drug Plan, any money you use from your MSA plan account on Medicare drug plan deductibles or cost sharing count towards your drug plan out-of-pocket costs described on page 7.

Words in red are defined on pages 65–68.

If you stay in your current plan that isn't offering drug coverage and you don't join a Medicare Prescription Drug Plan or have other creditable prescription drug coverage, you may have to pay a late enrollment penalty if you want Medicare prescription drug coverage later.

For more information about your choices, contact your plan.

4 Your Prescription Drug Coverage Choices

I have a Medicare Health Plan with prescription drug coverage

If you have prescription drug coverage from a Medicare Advantage Plan (like an HMO or PPO) or other Medicare Health Plan, in most cases you will need to get your Medicare prescription drug coverage from your plan.

Words in red are defined on pages 65–68.

- In most cases, if you are in a Medicare Advantage Plan and you join a Medicare Prescription Drug Plan, you will be disenrolled from your Medicare Advantage Plan and returned to the Original Medicare Plan.
- If you are in a Medicare Private Fee-for-Service (PFFS) Plan that doesn't offer Medicare prescription drug coverage, you can join a separate Medicare Prescription Drug Plan to add prescription drug coverage.
- If you are in a Medicare Cost Plan that includes Medicare prescription drug coverage, you can still join a separate Medicare Prescription Drug Plan to add prescription drug coverage. So you will need to decide if you want to get your Medicare prescription drug coverage from the Medicare Cost Plan or from a separate Medicare Prescription Drug Plan.

For more information about your choices, contact your plan.

4 Your Prescription Drug Coverage Choices

I have Medicare and Medicaid

Medicare helps pay for your prescription drugs instead of Medicaid. Because you have Medicaid, Medicare automatically gives you extra help with your Medicare drug plan costs. See pages 19–20 for information about your costs. If you live in an institution (like a nursing home), in most cases you pay nothing for your covered prescriptions.

If you haven't yet joined a Medicare drug plan, Medicare enrolls you in a drug plan to make sure you have drug coverage. Medicare sends you a yellow letter letting you know what plan you are in and when your coverage begins or began. Check to see if the plan covers the drugs you use and if you can go to the pharmacies you want. If you decide to switch to a different Medicare drug plan, you can do so at any time.

The yellow letter also tells you that if you (or anyone on your behalf) have filled prescriptions since the date that your Medicare drug plan coverage began, you may be able to get back some of these costs. Contact your Medicare drug plan for more information.

If you don't want Medicare prescription drug coverage, and you don't want Medicare to enroll you in a Medicare drug plan (for example, because you have other creditable prescription drug coverage), call 1-800-MEDICARE and tell them you don't want to join ("opt out"). **Caution:** If you call 1-800-MEDICARE and tell them you don't want to join a Medicare drug plan, you could be left without prescription drug coverage. You can change your mind and join a Medicare drug plan at any time, but you may have to pay a late enrollment penalty if you join later.

In limited cases, some state Medicaid programs may pay for prescriptions not covered by Medicare. If you continue to be eligible for Medicaid, Medicaid will still cover the other health care costs that Medicare doesn't cover. If you aren't sure whether you still qualify for Medicaid, call your State Medical Assistance (Medicaid) office. To get the telephone number of the office in your state, visit www.medicare.gov on the web. Under "Search Tools," select "Find Helpful Phone Numbers and Websites," or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

4 Your Prescription Drug Coverage Choices

I have Medicare and get Supplemental Security Income (SSI) benefits or help from Medicaid paying Medicare Part B premiums (belong to a Medicare Savings Program)

If you have Medicare and get SSI or get help from Medicaid paying your Medicare Part B premiums (or were eligible for either in all or part of this year), you automatically qualify for extra help paying Medicare prescription drug coverage costs. Medicare will send you a purple letter letting you know that you automatically qualify. Because you get SSI benefits or belong to a Medicare Savings Program, Medicare gives you extra help to pay your Medicare prescription drug coverage. You get it automatically when you join a Medicare drug plan. See pages 19–20 for more information about your costs. You should choose a plan that meets your prescription drug needs.

If you don't join a Medicare drug plan on your own, Medicare will enroll you in a Medicare Prescription Drug Plan, to make sure you have coverage. Medicare sends you a green letter letting you know when your coverage will begin. You can switch to a different Medicare drug plan at any time.

The green letter also tells you that if you (or anyone on your behalf) have filled prescriptions since the date that your Medicare drug plan coverage began, you may be able to get back some of these costs. Contact your Medicare drug plan for more information.

Words in red are defined on pages 65–68.

If you don't want Medicare prescription drug coverage, and you don't want Medicare to enroll you in a Medicare drug plan (for example, because you have other creditable prescription drug coverage), call 1-800-MEDICARE (1-800-633-4227) and tell them you don't want to join ("opt out"). TTY users should call 1-877-486-2048. **Caution:** If you call 1-800-MEDICARE and tell them you don't want to join a Medicare drug plan, you could be left without prescription drug coverage. You can change your mind and join a Medicare drug plan at any time, but you may have to pay a late enrollment penalty if you join later.

4 Your Prescription Drug Coverage Choices

I have Medicare and live in a nursing home or other institution

- If you move into or move out of a nursing home or other institution, you can switch Medicare drug plans at that time. You can switch Medicare drug plans at any time while you are living in the institution.
- If you aren't able to join on your own, your authorized representative can enroll you in a plan that meets your needs.
- If you are in a skilled nursing facility getting Medicare-covered skilled nursing care, your prescriptions generally will be covered by Medicare Part A (Hospital Insurance).

If you live in a nursing home or other institution, you will get your covered prescriptions from a long-term care pharmacy that works with your plan. This long-term care pharmacy usually contracts with (or is owned and operated by) your institution.

Medicare automatically enrolls people with both Medicare and full Medicaid coverage living in institutions into Medicare Prescription Drug Plans. If you live in a nursing home and have full Medicaid coverage, you pay nothing for your covered prescriptions after Medicaid has paid for your stay for at least 1 full calendar month.

Note: Institutions don't include assisted living or adult living facilities or residential homes, or any kind of nursing home not identified by Medicare.

4 Your Prescription Drug Coverage Choices

I have Medicare and benefits through Programs of All-inclusive Care for the Elderly (PACE)

PACE combines medical, social, and long-term care services for frail people who live and get health care in the community. These programs are a joint Medicare and Medicaid option in some states.

You don't need to join a separate Medicare drug plan because you get Medicare prescription drug coverage through PACE.

Caution: If you join a Medicare drug plan, you will be disenrolled from your PACE plan. Your PACE plan provides not only your prescription drug coverage, but all of your heath care services. Therefore, if you disenroll from your PACE plan by joining a Medicare drug plan, you will no longer receive other health care benefits from your PACE plan. Contact your PACE plan for more information.

If you also have full Medicaid coverage, you get prescription drugs at no cost to you through your PACE plan.

If you have Medicare only, you get all of your health care benefits, including prescription drug coverage, through your PACE plan. You pay a monthly premium that is reduced because it doesn't include prescription drugs. You will also pay a separate Medicare prescription drug premium to cover the cost of your prescription drugs.

If you don't have Medicaid coverage, you may still qualify for extra help paying for Medicare prescription drug coverage. If you think you may qualify, call Social Security at 1-800-772-1213, visit www.socialsecurity.gov on the web, or go to your State Medical Assistance (Medicaid) office and fill out an application for extra help. For more information about this extra help, see pages 19–28.

4 Your Prescription Drug Coverage Choices

I have Medicare and get help from my State Pharmacy Assistance Program (SPAP) paying prescription drug costs

Words in red are defined on pages 65–68.

Several states have programs to help certain people pay for prescription drugs. Each state makes its own rules on how to provide drug coverage to its members. Depending on your state, the State Pharmacy Assistance Program (SPAP) will have different ways of providing you with help paying your prescription drug costs. Some SPAPs may require you to join a Medicare drug plan, and then they will cover the costs that Medicare doesn't cover.

If you belong to an SPAP, you may have one additional opportunity each year to join a plan in addition to November 15–December 31. You can join a Medicare drug plan for the first time, one that works specifically with your SPAP, **or** you can switch to a different plan from the one your SPAP enrolled you in.

You will get more information from your SPAP about how Medicare prescription drug coverage affects the help you get now.

4 Your Prescription Drug Coverage Choices

I get help from an AIDS Drug Assistance Program (ADAP)

Words in red are defined on pages 65–68.

Most ADAPs only cover HIV/AIDS-related medications. Since these ADAPs don't cover other drugs, it's not creditable prescription drug coverage. ADAPs vary by state so you should contact your ADAP to learn how it will work with Medicare's drug coverage.

Note: If you don't have creditable prescription drug coverage and delay joining a Medicare drug plan, you may have to pay a late enrollment penalty later.

All Medicare drug plans will cover all antiretroviral medications. Your ADAP may require you to join a Medicare drug plan to get ADAP benefits. An ADAP can cover Medicare drug plan premiums, deductibles, coinsurance, and/or copayments to help with your drug costs. Check with your ADAP to see if they require you to join or if they will help pay for these costs.

4 Your Prescription Drug Coverage Choices

I have Medicare and get prescription drug coverage from the Indian Health Service, Tribe or Tribal Health Organization, or Urban Indian Health Program

- You and your community may benefit if you join a Medicare drug plan. Ask your health provider or benefits coordinator if joining a plan is right for you. If you decide to join, they can help you find a plan.
- If you get prescription drugs through an Indian health pharmacy, you pay nothing and your coverage won't be interrupted.
- Joining a Medicare drug plan may be helpful to your Indian health provider because the drug plan pays part of the cost of your prescriptions. This helps the Indian health provider with the cost of services.
- If you have full coverage from Medicaid and live in a nursing home, you pay nothing for your Medicare prescription drug coverage. For more information on how to join a plan, see your Indian health provider or check with the benefits coordinator at your local Indian health pharmacy.
- If you get health care from the Indian Health Service, Tribal Health Program, or Urban Indian Health Program, you have creditable prescription drug coverage. You won't have to pay a penalty to join a Medicare drug plan at a later date. Ask your Indian health care provider for a letter stating you have creditable coverage.

Tip:

Before considering which Medicare drug plan to join, check out how any current health coverage you may have could affect your prescription drug coverage choices.
See page 31.

Section

5

Steps to Choosing a Medicare Drug Plan

The steps below can help you choose a Medicare drug plan. You may wish to use the personal worksheets on pages 50–51 to help you decide which plan meets your needs. These sheets can help you organize your information. Whether you are joining for the first time or reviewing your plan options for coverage next year, follow these three important steps:

Step 1: Prepare—Take time to gather the information.

Step 2: Compare—Compare plans in your area based on cost, coverage, and customer service.

Step 3: Decide—Decide which plan is best for you, and join.

Step 1: Gather information about your current prescription drug coverage and needs.

Before you choose a Medicare drug plan, it is helpful to gather some information about yourself. You need information about any prescription drug coverage you may currently have as well as a list of the prescription drugs and doses you currently take. You should also gather any notice you received from Medicare, Social Security, or your current Medicare drug plan about changes to your plan.

If you have prescription drug coverage, you need to find out whether it is creditable prescription drug coverage. Your current insurer or plan provider will let you know. If you haven't heard from them, call your insurer, plan provider, or benefits administrator to find out.

Words in red are defined on pages 65–68.

5 Steps to Choosing a Medicare Drug Plan

List the prescriptions you take.

Prescription name	Dosage of prescription (ml, mg)	Number of times a day you take your prescription	Amount you pay each month

Today's date: _____

Steps to Choosing a Medicare Drug Plan

Step 2: Compare Medicare drug plans based on costs, coverage, and customer service.

For lists of the specific drug plans available in your area, read the "Medicare & You" handbook, visit the Medicare Prescription Drug Plan Finder or Medicare Options Compare (to compare Medicare Health Plans) tools by visiting www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

When you find some plans you are interested in, use the tools at www.medicare.gov on the web to find the information below, or, call the companies that offer the plans and fill in information about these plans.

Plan Name:

Monthly Premium $	Yearly Deductible $	My drugs that are covered	Amount I'd pay for each drug	Could I use my pharmacy?	Is mail order available?
		1.	1. $		
		2.	2. $		
		3.	3. $		

Plan Name:

Monthly Premium $	Yearly Deductible $	My drugs that are covered	Amount I'd pay for each drug	Could I use my pharmacy?	Is mail order available?
		1.	1. $		
		2.	2. $		
		3.	3. $		

Plan Name:

Monthly Premium $	Yearly Deductible $	My drugs that are covered	Amount I'd pay for each drug	Could I use my pharmacy?	Is mail order available?
		1.	1. $		
		2.	2. $		
		3.	3. $		

5 Steps to Choosing a Medicare Drug Plan

Step 2: Compare Medicare drug plans based on costs, coverage, and customer service. (continued)

Refer to the worksheets on pages 50–51. Compare the Medicare drug plans based on what is most important to you, depending on your situation and drug needs. You may want to ask yourself some of these questions:

- Which plan covers the prescriptions I take?
- Which plan gives me the best overall price on all of my prescriptions?
- What is the monthly premium, yearly deductible, and the coinsurance or copayment(s)?
- Can I use the plan in addition to my current prescription drug coverage?
- Which plan allows me to use the pharmacy I want?
- Which plan allows me to get prescriptions through the mail?
- Which plan provides me with coverage in multiple states (if I need it)?
- How do the plans rate on quality?
- Will I have to pay a penalty because I waited to join?
- Can my coverage start when I want it to?
- Is it likely that I'll need protection against unexpected drug costs in the future?
- Am I satisfied with my Medicare drug plan's service (if I'm already enrolled but reviewing my plan options)?

Words in red are defined on pages 65–68.

If you need help with your Medicare prescription drug coverage decisions, call your State Health Insurance Assistance Program (SHIP). See page 64 for their telephone number. You can also visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Step 3: Decide which plan is best for you, and join.

After you pick a plan that meets your needs, call the company offering it, and ask how to join. You may be able to join by telephone, by paper application, or on the web. You will have to provide the number on your Medicare card when you join.

5 Notes

Tip: Keep your personal information safe. Don't give your information to anyone who comes to your home (or calls you) uninvited selling Medicare-related products.

Section 6

Your Medicare Drug Plan Rights and Appeals

What if I need help applying for extra help or joining a Medicare drug plan?

Some people can help, or act on your behalf, to enroll you in a Medicare drug plan and/or to apply for extra help paying Medicare prescription drug coverage costs.

A legal or authorized representative is someone who, by state or Federal law, has the legal right (such as through a Power of Attorney or a court order) to act on your behalf.

Your legal or authorized representative can help you, or on your behalf, do the following:

- Apply to see if you qualify for extra help paying Medicare prescription drug coverage costs
- Join a Medicare drug plan that meets your needs.

A personal representative can help you, or act on your behalf, to apply to see if you qualify for extra help paying for Medicare prescription drug coverage. **A personal representative can't enroll you in a Medicare drug plan unless he or she is also your legal representative.**

A personal representative can be any of the following:

- The person who acts on your behalf if you are incapacitated or can't make decisions for yourself
- Anyone you choose to act as your representative (such as your spouse, your child, or a caregiver)
- Your "representative payee" (sometimes called a rep. payee). This is a person, agency, organization, or institution that Social Security selects to act on your behalf.

What if my enrollment in a Medicare drug plan is denied?

Medicare drug plans generally have to accept all eligible applicants who live in their service area, no matter what your age or health status. If your enrollment form is denied, the company will send you a letter explaining the reason why. You may contact the plan for more information about your options.

6 Your Medicare Drug Plan Rights and Appeals

How do I protect myself from fraud and identity theft?

Call 1-800-MEDICARE (1-800-633-4227) if you aren't sure if a plan is approved by Medicare. Knowing how Medicare Advantage Plans and Medicare Prescription Drug Plans can market to you can help you protect yourself. Medicare Advantage Plans, Medicare Prescription Drug Plans, and people who work with Medicare **aren't** allowed to do the following:

- Ask for your Social Security number, bank account number, or credit card information over the telephone. (However, if you filled out an application for extra help paying for Medicare prescription drug coverage and there is missing information, someone from the plan may contact you to ask for the missing information. They will only ask you for the information that's missing from the application.)
- Come to your home uninvited to sell or endorse any Medicare-related product, but they can call you. However, they can't call you if you have placed your telephone number on the National Do Not Call Registry.
- Offer you cash to join their plan
- Enroll you in a drug plan over the telephone unless you call them
- Ask you for payment over the telephone or web. The plan must send you a bill.

If you are in a Medicare Prescription Drug Plan and you think the plan may be breaking these rules, call the Medicare drug integrity contractor at 1-877-SAFERX (1-877-772-3379).

Identity theft happens when someone uses your personal information without your consent to commit fraud or other crimes. Personal information includes things like your name, or your Social Security, Medicare, bank account, or credit card numbers.

If you think someone is misusing your personal information, call any of the following:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- The Fraud Hotline of the HHS Office of the Inspector General at 1-800-447-8477. TTY users should call 1-800-377-4950.
- The Federal Trade Commission's ID Theft Hotline at 1-877-438-4338 to make a report. (TTY users should call 1-866-653-4261.)

For more information about identity theft, visit www.consumer.gov/idtheft on the web.

6 Your Medicare Drug Plan Rights and Appeals

What do I do if my plan won't cover a drug I need?

If your pharmacist tells you that your Medicare drug plan won't cover a drug you think should be covered, or it will cover the drug at a higher cost than you think you are required to pay, you have the right to the following:

- Request a coverage determination from your plan.
- Pay for the prescription, save your receipt, and ask the plan to pay you back by requesting a coverage determination.
- Request a coverage determination if your plan requires you to try another drug before it pays for the drug prescribed for you, or there is a limit on the quantity or dose of the drug prescribed for you, and you disagree with the requirement or limit.

Words in red are defined on pages 65–68.

Tip: Any person you appoint, such as a family member or your physician, may help you request a coverage determination or an appeal.

You, your doctor, or your appointed representative can ask the plan to cover the prescription you need by calling your plan or writing them a letter. If you write to the plan, you can write a letter or use the "Model Coverage Determination Request" form. You can get a copy of this form by visiting www.cms.hhs.gov/MedPrescriptDrugApplGriev/13_Forms.asp on the web.

If you want to appoint a representative to help you with a coverage determination or appeal, you and the person you want to help you should complete the "Appointment of Representative" form (Form CMS-1696) and send it with your coverage determination or appeal request. You can get a copy of this form by visiting www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf on the web.

You may file either a standard or an expedited (fast) coverage determination request. Your request will be expedited if your plan determines, or your doctor tells your plan, that your life or health may be seriously jeopardized by waiting for a standard request. Once your plan has received the request, it has 72 hours (for a standard request for coverage or for a request to pay you back) or 24 hours (for an expedited request for coverage) to notify you of its decision.

6 Your Medicare Drug Plan Rights and Appeals

What do I do if my plan won't cover a drug I need? (continued)

Words in red are defined on pages 65–68.

Important: For some types of coverage determinations called exceptions, you will need a supporting statement from your doctor explaining why you need the drug you are requesting. You may need this statement for any of the following:

- You are asking the plan to cover a drug that isn't on its drug list (formulary).
- You want the plan to cover a non-preferred drug at the preferred drug price.
- Your doctor believes that you can't meet one of your plan's coverage rules, such as a prior authorization, quantity limit, or dose limit.

Check with your plan to find out if the supporting statement is required, and if it must be in writing. If a supporting statement is required, the plan's decision-making time period begins once your plan receives the statement.

Once your plan has received your request (and supporting statement if required), it has 72 hours (for a standard request for coverage or for a request to pay you back) or 24 hours (for an expedited request for coverage) to notify you of its decision.

How to Appeal

If you ask for a coverage determination and the plan decides against you, you can appeal the decision. There are **5 levels** of appeal available to you. You must follow the order listed below:

1. Appeal through your plan.
The first level of appeal is called a "redetermination." You must request this appeal within 60 calendar days from the date of the coverage determination notice. Only you or your appointed representative can file a standard request. Standard requests must be made in writing unless your plan allows you to file a request by telephone. You, your appointed representative, or your doctor can ask your plan for an expedited redetermination. Expedited requests can be made in writing or by telephone. Your request will be expedited if your plan determines, or your doctor tells your plan, that your life or health may be seriously jeopardized by waiting for a standard decision. Any unfavorable coverage determination decision you get from your plan will tell you how to file this appeal. Once your plan gets your request for an appeal, the plan has 7 calendar days (for a standard request for coverage or for a request to pay you back) or 72 hours (for an expedited request for coverage) to notify you of its decision.

How to Appeal (continued)

A written appeal request should include the following:

- Your name, address, and the health insurance claim (HIC) number shown on your Medicare card
- The name of the prescription drug you want your plan to cover
- Reasons why you are appealing and any supporting documentation that you believe may help your case
- Your signature or the signature of your appointed representative

Once your plan gets your request for an appeal, the plan has 7 calendar days (for a standard request for coverage or for a request to pay you back) or 72 hours (for an expedited request for coverage) to notify you of its decision.

2. Review by an Independent Review Entity
If you disagree with the plan's redetermination, you or your appointed representative can request a review by an Independent Review Entity (IRE) called a "reconsideration." The request must be filed in writing within 60 calendar days from the date of the plan's redetermination decision. Your request must be sent to the IRE at the address or fax number listed in the plan's redetermination decision. This decision letter will be mailed to you and will fully explain how to file this appeal. The plan will also send you a "Request for Reconsideration" form that you can use to request a reconsideration. If you don't get this form, call your plan and ask for it. You can also get this form by visiting www.cms.hhs.gov/MedPrescriptDrugApplGriev/13_Forms.asp on the web.

You or your appointed representative may request either a standard or expedited reconsideration. Your reconsideration request will be expedited if the IRE determines, or your doctor tells the IRE, that your life or health may be seriously jeopardized by waiting for a standard decision.

How to Appeal (continued)

Important: If you are asking the IRE for an exception and the plan didn't previously process your request as an exception, you will need a supporting statement from your doctor explaining why you need the drug you are requesting. Check with the IRE to find out if the supporting statement is required, and if it must be in writing. If a supporting statement is required, the IRE's decision-making time period begins once it gets the statement.

Once the request for review (and the supporting statement, if required) has been filed, the IRE has 7 days (for a standard request for coverage or for a request to pay you back) or 72 hours (for expedited requests for coverage) to notify you of its decision.

3. Hearing with an Administrative Law Judge
If you disagree with the IRE's decision (reconsideration notice), you or your appointed representative can request an Administrative Law Judge (ALJ) hearing. You or your appointed representative must make the request in writing within 60 calendar days from the date of the IRE's reconsideration notice. The request must be sent to the location listed in the IRE's reconsideration notice that is mailed to you. To get an ALJ hearing, the projected value of your denied coverage must meet a minimum dollar amount (you may be able to combine claims to meet the minimum dollar amount). The IRE's notice will include this amount.

4. Review by the Medicare Appeals Council
If you disagree with the ALJ's decision, you or your appointed representative can request a review by the Medicare Appeals Council (MAC). The request must be sent to the MAC in writing within 60 calendar days from the date of the ALJ's decision. You must send your request to the location listed in the ALJ's decision that is mailed to you.

5. Review by a Federal court
If you disagree with the MAC's decision, you or your appointed representative can request a review by a Federal court. The request must be filed in writing within 60 calendar days from the date you received the MAC's decision. You must send your request to the location specified in the MAC's decision. To receive a review by a Federal court, the projected value of your denied coverage must meet a minimum dollar amount. The MAC's decision will include the amount.

When you join a Medicare drug plan, the plan will send you information about the plan's appeal procedures. Read the information carefully and keep it where you can find it when you need it. Call your plan if you have questions.

6 Your Medicare Drug Plan Rights and Appeals

What can I do if I have a complaint (also called a grievance) about my plan?

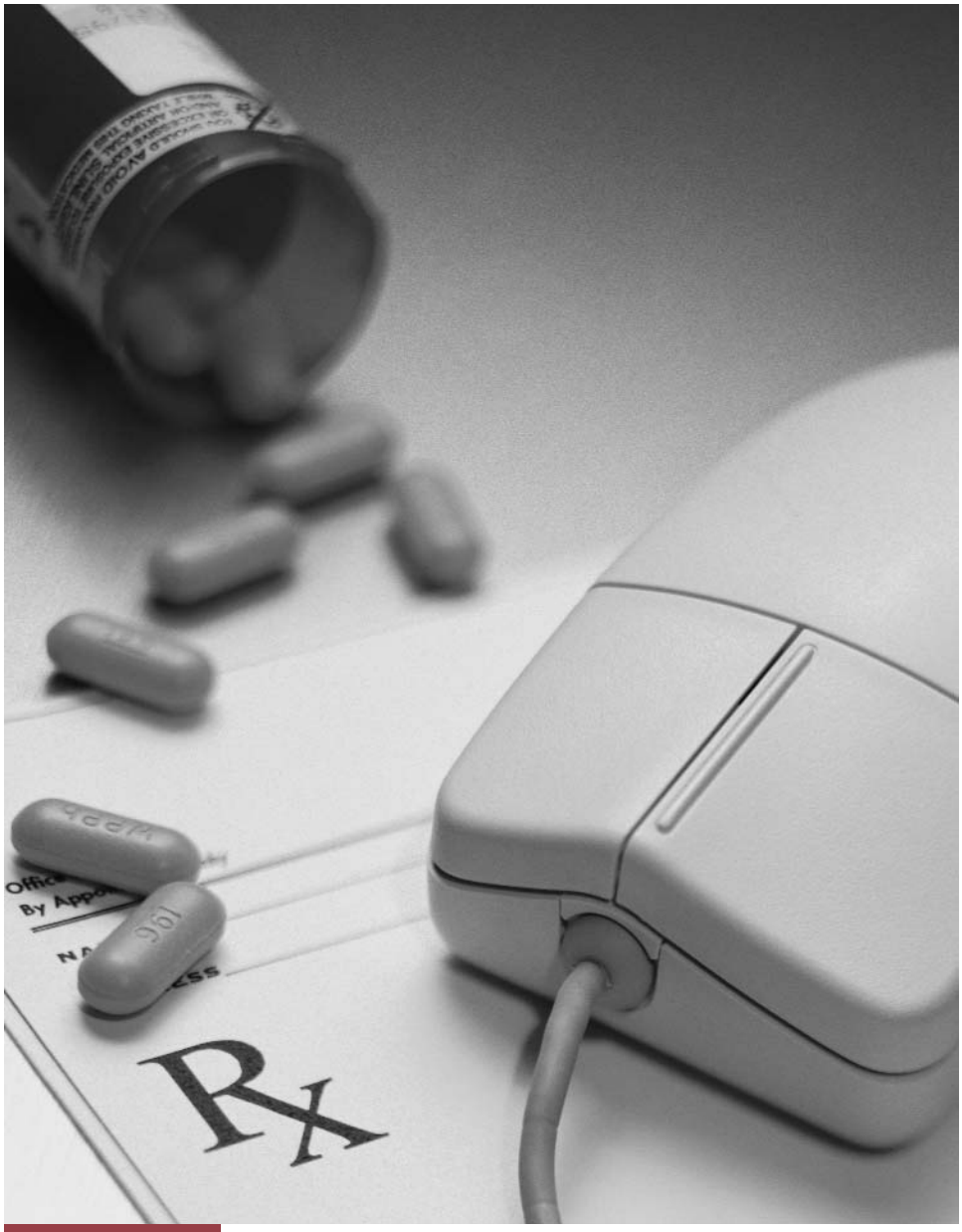
You have the right to file a complaint with the plan.

Some examples of why you might file a complaint include the following:

- You believe your plan's customer service hours of operation should be different.
- You have to wait too long for your prescription.
- The pharmacy is charging you more than you think you should have to pay. You can file a complaint and ask for a coverage determination.
- The company offering your plan is sending you materials that you didn't ask to get and aren't related to the drug plan.
- The plan doesn't give you a decision about a coverage determination or redetermination within the required timeframe.
- The plan didn't make a decision about a coverage determination or first-level appeal within the required timeframe and didn't send your case to the Independent Review Entity (IRE).
- You disagree with the plan's decision not to grant your request for an expedited coverage determination or redetermination.
- The plan didn't provide the required notices.
- The plan's notices don't follow Medicare rules.

You can file your complaint with the plan over the telephone or in writing. You must file your complaint within 60 calendar days of the date of the event that led to your complaint. Your plan must notify you of its decision generally no later than 30 days after the plan receives the complaint. If the complaint relates to a plan's refusal to expedite a coverage determination or redetermination and you haven't yet purchased or received the drug, you must be notified of the decision no later than 24 hours after the plan receives the complaint.

If you think you were charged too much for a prescription, call the company offering your plan to get the most up-to-date price. If the plan doesn't take care of your complaint, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



Tip: Your State Health Insurance Assistance Program (SHIP) can provide you with free personalized counseling on your prescription drug coverage choices. See page 64.

Section 7

For More Information

- For more information about Medicare prescription drug coverage, use the following resources:
  - Visit **www.medicare.gov** on the web and get personalized information. Under "Search Tools," select "Compare Medicare Prescription Drug Plans" or "Compare Medicare Health Plans and Medigap Policies in Your Area." Enter and save your current prescription drug information to get more detailed cost information. Any personal information you enter when using these tools will be erased if you hit the back button on your keyboard. This feature helps to keep your personal information safe.
  - Call **1-800-MEDICARE** (1-800-633-4227). Call to get the information you need 24 hours a day, including weekends. TTY users should call 1-877-486-2048.

    A speech-automated system will ask you questions that you answer with your voice to direct your call automatically. Please have your Medicare number available when you call.

For…	**Just say…**
Medicare prescription drug coverage	"Drug Coverage"
Medicare prescription drug enrollment status	"Drug Coverage" then "My Enrollment"
Telephone number for your State Medical Assistance (Medicaid) office	"Medicaid"
Medicare publications	"Publications"
A customer service representative	"Agent"

Words in red are defined on pages 65–68.

- For more information about your current drug coverage, contact your benefits administrator, insurer, or plan provider.
- For more information about applying for extra help with your Medicare drug plan costs, call Social Security at 1-800-772-1213 or visit www.socialsecurity.gov on the web. TTY users should call 1-800-325-0778.
- For free personalized counseling on your prescription drug coverage choices, contact your State Health Insurance Assistance Program (SHIP). To find the telephone number for your state's SHIP, see the list on page 64.

7 For More Information

State Health Insurance Assistance Programs (SHIPs)

This page has been intentionally left blank. It contains phone number information. For the most recent phone number information, please visit the Helpful Contacts section of our web site. Thank you.

The telephone numbers and web addresses in this booklet were correct at the time of printing. Sometimes this information changes. To get the most up-to-date Medicare telephone numbers, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

7 For More Information

Words to Know

Coinsurance—An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit or prescription. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.

Coverage Determination—The first decision made by your Medicare drug plan (not the pharmacy) about your drug benefits, including the following:

- Whether a particular drug is covered
- Whether you have met all the requirements for getting a requested drug
- How much you're required to pay for a drug
- Whether to make an exception to a plan rule when you request it

If the drug plan doesn't give you a prompt decision, and you can show that the delay would affect your health, the plan's failure to act is considered to be a coverage determination. If you disagree with the coverage determination, the next step is an appeal.

Creditable Prescription Drug Coverage—Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Deductible—The amount you must pay for health care or prescriptions, before the Original Medicare Plan, your prescription drug plan, or your other insurance begins to pay.

Drug List—A list of drugs covered by a plan. This list is also called a formulary.

Exception—A type of Medicare prescription drug coverage determination. A formulary exception is a drug plan's decision to cover a drug that's not on its formulary or to waive a coverage rule. A tiering exception is a drug plan's decision to charge a lower amount for a drug that is on its non-preferred drug tier. You must request an exception, and your doctor must send a supporting statement explaining the medical reason for the exception.

Extra Help—A program to help people with limited income and resources pay prescription drug costs. Also called the "low-income subsidy."

Institution—A facility that meets Medicare's definition of a long-term care facility, such as a nursing facility or skilled nursing facility, not including assisted or adult living facilities or residential homes.

Medicaid—A joint Federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary—Services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

Medicare Advantage Plan (Part C)—A type of Medicare Health Plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Also called "Part C," Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and aren't paid for under the Original Medicare Plan. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Cost Plan—A type of Medicare health plan available in some areas. In a Medicare Cost Plan, if you get services outside of the plan's network without a referral, your Medicare-covered services will be paid for under the Original Medicare Plan (your Cost Plan pays for emergency services, or urgently needed services).

7 For More Information

Medicare Health Maintenance Organization (HMO)—A type of Medicare Advantage Plan (Part C) available in some areas of the country. Many HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Your costs may be lower than in the Original Medicare Plan.

Medicare Medical Savings Account (MSA) Plan—A high deductible Medicare Advantage Plan that works with a special kind of bank account, called a Medicare Medical Savings Account or MSA. The high deductible plan deposits money from Medicare into the savings account. You can use the money to pay your medical expenses until your plan deductible is met. After the deductible is met, the high deductible plan covers your Medicare-covered services.

Medicare Preferred Provider Organization Plan (PPO)—A type of Medicare Advantage Plan (Part C) available in some areas of the country in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Prescription Drug Plan (Part D)—A stand-alone drug plan that adds prescription drug coverage to the Original Medicare Plan, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that must follow the same rules as Medicare Prescription Drug Plans.

Medicare Private Fee-for-Service (PFFS) Plan—A type of Medicare Advantage Plan (Part C) in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare Program, decides how much it will pay and what you pay for the services you get. You may pay more or less for Medicare-covered benefits than in the Original Medicare Plan.

Medigap Policy—Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage.

7 For More Information

Original Medicare Plan—The Original Medicare Plan is the fee-for-service plan under which the government pays your health care providers directly for your Part A and/or Part B benefits.

Penalty—An amount added to your monthly premium for Medicare Part B or a Medicare drug plan (Part D), if you don't join when you're first eligible. You pay this higher amount as long as you have Medicare. There are some exceptions.

Premium—The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

State Health Insurance Assistance Program (SHIP)—A state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

State Pharmacy Assistance Program (SPAP)—A state program that provides help paying for drug coverage based on financial need, age, or medical condition.

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