Your Pharmacy Benefit: Make it Work for You!

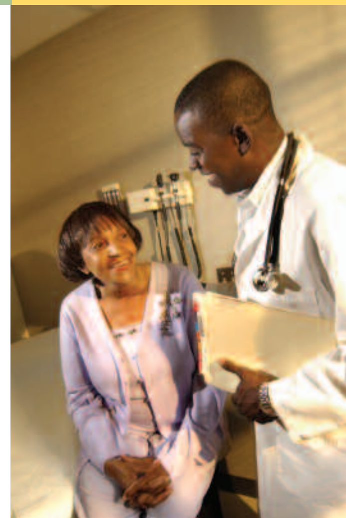
www.YourPharmacyBenefit.org

Table of Contents

Choose Your Plan 2
Steps in Choosing Your Pharmacy Benefits 3
Chart: Comparing Your Plan Options 4
Use Your Plan 6
What to Do When Your Prescription Can't Be Filled 6
Writing a Letter of Appeal 7
Sample Appeal Letter 9
More Options for People Who are Eligible for Medicare 10
Resources for Additional Information 12
If You Have Private Insurance 12
If You Have Medicare Coverage 13

Index of Definitions

Co-payment (or co-pay) 3
Co-payment tiers 3
Contraindication 7
Formulary 3
Medicare Advantage Plan 10
Medicare Prescription Drug Plan (PDP) 10
Pharmacy Benefit Manager (PBM) 6
Prior authorization 4
Step therapy 4



Almost half of all Americans use some sort of prescription medication each month, and many people use more than one. This isn't surprising since many conditions that used to be treated in the hospital can now be treated at home with medicines. But it means that making sure your prescriptions are covered by your insurance is just as important as knowing that your doctor is available through the plan.

Figuring out how to choose and join in a health insurance plan can be challenging enough. But for many people that's just the beginning. It's also important to learn how to effectively use your benefits to pay for the medicines you need to stay healthy. This booklet provides tips on choosing and using your pharmacy benefits, whether you have private insurance through your employer or union, or you are eligible for Medicare Prescription Drug Coverage.

The first section, *Choose Your Plan*, walks you through the steps in comparing the benefit options you have for prescriptions and picking the one that meets your needs. The second section, *Use Your Plan*, helps you know what to do if you've joined a plan for the year and then run into problems – such as a prescription that the pharmacist tells you can't be filled. This section also explains how to file an appeal to try and get the insurance company to pay for a medicine they wouldn't normally cover, but that your doctor feels is medically necessary for you to have. The third section tells you about additional coverage options for people who are eligible for Medicare. And finally, the last section gives you a list of resources for more information about your benefits.

Throughout this guide, you'll see words in **bold letters** that you may not know. These words are often used in health insurance materials, so learning them will help you understand information you get from your plan. We've included definitions of these terms for you on the edge of the page where they are first used.

Read on to learn how to make your pharmacy benefit work for you!

Choose Your Plan: Make an Informed Decision

Key Questions:

1) Are there any other health insurance plans available to me?
2) Does my current plan provide the best coverage for my needs?

You may have access to insurance coverage for your medicines through a number of sources. One of the most common ways to get coverage for your prescription medicines is through the health insurance plan you join through your employer or union. If you're retired, you may still receive benefits through your former employer's plan. If you're self-employed, you may buy an individual health insurance policy directly from an insurance company or through a professional association to which you belong. Or, you may be covered under your spouse's plan. But regardless of which options are available to you, there are two basic questions you should always ask when you have the opportunity to make changes to your insurance coverage once each year:

If you are eligible for Medicare, see also:
"*Things to Think About When You Compare Plans*" (Publication 11163) from the Centers for Medicare & Medicaid Services. Available at http://www.medicare.gov/publications/pubs/pdf/11163.pdf.

1) Are there any other health insurance plans available to me?

2) If so, does the plan I am currently enrolled in meet my needs or would a different plan be better for me medically and financially?

Most people have a hard time answering the second question. It's important to note that most health insurance plans are all-in-one plans covering doctor visits, hospital stays, lab work, and prescription medicines. You usually can't pick and choose to have certain services covered and not others. (The exception is that vision and dental coverage are sometimes separate plans.) You need to look at the whole health insurance plan and choose the one that gives you the best combination of benefits for your specific health care needs.

The information in this section is designed to help you evaluate the pharmacy part of your benefits to figure out which plan gives you the best coverage of the prescription medicines you—and anyone else in your family who is covered by the same plan—are currently taking. You should weigh this information along with factors such as access to your preferred doctors and hospitals, and the types of medical services that are covered, to find a plan that meets your needs.

Key Questions:

1) Is there a list of prescription medicines the plan will cover?

2) What is the process for filing an appeal and how long does it take?

3) How much must you pay when you fill a prescription?

4) Must the plan approve some prescriptions before it will pay?

5) Will you have to use a mail order service or can you fill prescriptions at a local pharmacy if you prefer?

Steps in Choosing Your Pharmacy Benefits

- Step 1: Ask if the plan has a list of prescription medicines that will be covered. This is known as a **formulary**. If you regularly take medications for an illness, such as high blood pressure, asthma, or diabetes, be sure those medicines are on the formulary before you select that plan. If they aren't, you will be expected to switch to different medications or pay the full cost yourself.

- Step 2: Ask about the process for filing an appeal if the plan will not pay for the medicine you need. If a medicine you need is not on the formulary, you have the right to file an appeal with the plan to ask that they pay for it anyway. You might not be told about your right to appeal when you are told that the plan will not pay, so it is important to know how to appeal on your own and how long you can expect it to take. A plan is only likely to grant your appeal if your doctor convinces them that the medicine you were prescribed is absolutely medically necessary for you or that no other medicine that is on the formulary will work as well for you.

- Step 3: Ask how much you have to pay when you fill a prescription. Most plans require a **co-payment** for each prescription. Many plans have three or even four levels of co-payments that apply to different medicines. These are often called **co-payment tiers** or preferred drug levels. To find out what co-payment level applies to each of your medications, call the plan or look at their Web site. If it is more than you can afford, you may want to ask your doctor if there is a generic version of your medicine or if there are other medicines at a lower cost that would be appropriate for you.

Formulary: A list established by a plan to indicate which medicines they cover and at what level of co-payment.

Co-payment (or co-pay): A fixed amount, for example $10, that an insured individual pays for health services or medicines, regardless of the actual cost of that service or medicine. See also "Co-payment tiers."

Co-payment tiers: A co-payment that varies depending on the medication, rather than a fixed amount. Usually, each medicine is assigned to a tier by the plan. There are usually 2, 3, or 4 tiers, each with a different co-payment amount. This design is intended to encourage the use of medicines that are in the less expensive tiers.

Comparing Your Plan Options

	Plan 1			
Name of Plan				
Considerations	Medicine 1	Medicine 2	Medicine 3	Medicine 1
Is the medicine on the plan's formulary? (yes/no)				
How long can I expect the appeal process to take?				
How much will I have to pay monthly for this medicine?				
Does this medicine require prior authorization? (yes/no)				
Must I use mail order for this medicine? (yes/no)				

Prior authorization: A requirement that a doctor get approval from the insurance company before the plan will pay for the medicine.

Step therapy: A requirement to try a less expensive medicine first to see if it works before the plan will pay for a more expensive medication.

Step 4: Ask if the plan has to pre-approve certain medications before you can fill the prescription. Some plans require your doctor to get **prior authorization** for certain medicines before it will pay for them. That means your doctor or pharmacist must call the plan for permission to prescribe these medications. Some plans require you to try a less expensive medicine before they will pay for the one your doctor might otherwise recommend. This is called **step therapy**. The less expensive medicine will likely be a different medication that is used to treat the same medical condition, and for which the insurance company negotiated a lower price. Also, some plans will only pay for a limited number of doses of a certain medicine per month, regardless of how many you really need. For example, they may only cover six doses of a medicine for a migraine headache. If you need a certain medication for a valid medical reason, you may be able to get it covered by asking for an exception to the rule or filing an appeal (see Step 2). If you can't wait for

Plan 2		Plan 3		
Medicine 2	Medicine 3	Medicine 1	Medicine 2	Medicine 3

the appeal process to finish, you may need to pay for the medicine yourself and then file an appeal to be paid back by the plan.

- Step 5: Ask if you must use a mail order service. Many plans have a mail order option for medicines, but some may require you to use it for medicines that you take regularly rather than getting them from a local pharmacy.

Most people with private insurance can choose a different plan (if one is offered) once a year. Your benefits administrator at work or at your union can tell you when you can change and give you information about other plan options. Fill in the chart above to help you compare the pharmacy benefits offered by the plans you're considering.

Use Your Plan: Troubleshoot Problems Filling Your Prescriptions

Pharmacy Benefit Manager (PBM): A company that manages pharmacy benefits. They aren't insurance companies, but they are often subcontracted by health insurers or employers to manage the prescription drug portion of the health insurance plan.

Once you join a plan, you may not be able to change to a different plan until the next, year so it's important to know how to make best use of the benefits offered by the plan you have. This is especially important for people who can only get coverage through one plan. You need to know the rules!

Each plan is different. You can learn more about your specific plan by reading the materials your employer and health insurance plan provide. If you don't already have a copy, ask your employer or health insurance plan for one. Use your brochure, handbook, plan Web site or other information provided to answer important questions about your pharmacy benefits. If you still have questions, don't give up; call the member services department of your health plan or **pharmacy benefit manager**. The best telephone number for you to call should be on the back of the pharmacy benefit ID card that was sent to you when you joined the plan.

Why can't my prescription be filled?

- Incorrect Information
- Timing
- Drug Interactions
- Prior Approval
- Not Covered

What to Do When Your Prescription Can't Be Filled

When you're told there's a problem filling your prescription, ask why. There are several common explanations and a number of actions you can take to try to fix the problem.

- Incorrect Information: The information the pharmacy has about your plan may not match what is on your pharmacy benefit ID card. It may appear to the pharmacist that you are not covered by the plan because the ID number has been entered incorrectly, or because you have changed to a different plan. A quick double-check of the information on your pharmacy benefit ID card may allow you to find and fix the problem. If correcting a mistake in the ID number doesn't fix the problem, call the member services phone number on the back of your pharmacy benefit ID card.

- Timing: It may be too soon to refill the prescription. Most plans don't allow refills too soon—a prescription for a month's worth of pills can't be refilled after only two weeks, for example. Sometimes, however, plans make allowances for people who are about to go on a long trip or have other reasons they need an early refill. You can find out about your early refill options by calling the member services number on your pharmacy benefit ID card.

- Drug Interactions: The medicine may be flagged because it may react badly with another medication you're taking or because of another medical condition you have. This is called a **contraindication**. If this is the reason your plan won't pay for the medicine, don't pay for it yourself! If the pharmacist hasn't already done so, contact your doctor immediately to make sure that he or she knows about the potential contraindication. Your doctor may want you to take that medicine anyway, but it's best to double check. If your doctor does want you to take that medicine anyway, you should ask what side effects the medicine will have. If it doesn't do what your doctor tells you it should do, or if there are different side effects you weren't expecting, contact your doctor's office immediately.

Contraindication: Also called "drug interaction" or "adverse event." A warning that a medicine may react badly with another medication you're taking or because of another medical condition you have.

- Prior Approval: Prior authorization may be required. Sometimes a pharmacist may only fill a prescription if your doctor has already gotten approval from your plan. If this is the problem, you can get approval if the pharmacist contacts the doctor who prescribed the medicine and then submits the necessary information to the plan.

- Not Covered: The medicine prescribed by your doctor may not be on the formulary, so it is not covered by the plan. If this is the problem, ask your doctor if a different medicine—one your plan will pay for—will work for you. If not, you and your doctor can appeal to try to get the prescribed medicine covered. (See "Steps in Choosing Your Pharmacy Benefits: Step 2" on page 3.)

If you are eligible for Medicare, see also: "*Your Medicare Rights and Protections*" (Publication 10112) from the Centers for Medicare & Medicaid Services. Available at http://www.medicare.gov/publications/pubs/pdf/10112.pdf.

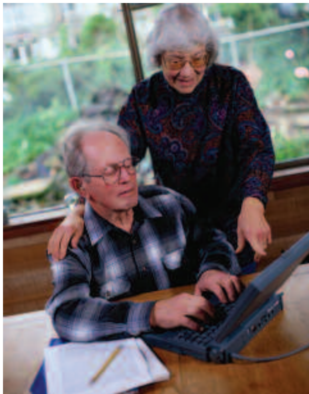
Writing a Letter of Appeal

If your insurance company will not pay for a medicine that your doctor feels is medically necessary for you, you have a right to appeal. If you have coverage through an individual policy or a plan you joined through your employer or union, you can find out about your appeal rights and how to file an appeal by contacting your health plan or your state department of insurance. You can find contact information for your state's department of insurance at www.naic.org/state_web_map.htm, or in the blue pages of your phone book. If you join a Medicare Prescription Drug Plan, the plan will send you materials about complaint and appeal procedures.

Generally, your doctor or pharmacist can ask the plan to pay for a medication your insurance would not normally cover by making a phone call or sending a fax to the plan explaining why your prescription is medically necessary. The plan will respond within a few days at the most, to let you know if they will cover the medication. If your request for an exception is denied, then you can pursue a formal appeal. It's best to submit your appeal in writing. This way you also have a written record of the actions you took and the dates on which you took them. Be sure to keep a copy for yourself.

Regardless of whether you or your doctor's office files the appeal, you are responsible for following it through.

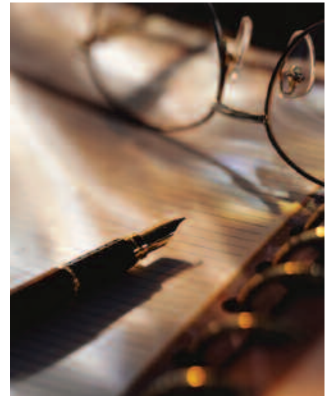
It is best to ask your doctor's office to take the first step in filing an appeal, or to give you a written explanation of the problem that you can include in your letter. But it's important to remember that regardless of whether you or your doctor's office files the appeal, *you* are responsible for following it through. The pharmacy may not tell your doctor's office that the medication isn't covered, so if you need help from your doctor's office to solve the problem, you must ask them directly. Be sure to follow up at each step of the process because the insurance company may not send your doctor's office copies of letters that you receive regarding your appeal.



Here are some suggestions on what to include in your appeal letter:

- Your name
- Your address
- Your phone number
- Your health plan and/or Medicare ID number
- The date you are writing the letter
- The date you sought to fill the prescription
- The name and address of the pharmacy where you tried to fill the prescription
- The name, address, and phone number of the doctor who wrote the prescription

Sample Appeal Letter*



[Your Name]
[Your Address]
[City, State ZIP]
[Your Phone Number]
[Your ID Number]
DOB: [Your Date of Birth]

Date

Health Plan or Pharmacy Benefit Management Plan Name
Plan Address
City, State ZIP

To Whom It May Concern:

I am writing to formally appeal denial of drug coverage. I am covered under your plan and my ID number is [ID number]. On [date], I attempted to fill a prescription for [name of medicine] at the [pharmacy name] Pharmacy located at [pharmacy address]. I was told by the pharmacist that [reason for denial]. I decided to [action taken].

My contact information is above, and contact information for Dr. [name of physician who wrote prescription], is listed below.

[Name of Doctor Who Wrote Prescription]
[Doctor's Address]
[City, State ZIP]
[Doctor's Phone Number]

Dr. [name of physician] wrote the prescription, and you may contact him/her if medical information is needed for consideration of my appeal. I have included a copy of the [prescription or receipt] for your consideration.

Please provide me with a written explanation of any additional steps I must take for you to process my appeal, as well as a written explanation of the basis for your decision about my claim.

Sincerely,
[Your Name]

You can find this information on the back of your pharmacy benefit ID card - the one you use when you pick up your prescriptions.

Your ID number is on the front of your pharmacy benefit ID card.

For example, did you pay for the medicine yourself? Did you decide not to fill the prescription?

If you don't have a copy of the written prescription or the pharmacy receipt, list the name of the medication and the dose that you were prescribed. Double check with your pharmacist to make sure that you have spelled everything correctly since the names of many medications are similar.

* This sample appeal letter is provided for informational purposes only. Every plan has different rules and procedures for appeals, and this sample letter may not meet the requirements of your plan. DO NOT USE THIS LETTER WITHOUT FIRST CHECKING THE SPECIFIC PROCEDURES OF YOUR PLAN FOR APPEAL LETTERS.

More Options for People Who are Eligible for Medicare

Medicare Prescription Drug Plan (PDP): Stand-alone drug plan, offered by insurance and other private companies to add prescription drug coverage to the Original Medicare Plan, Medicare Private Fee-for-Service Plans without prescription drug coverage, and Medicare Cost Plans.

Medicare Advantage Plan: Medicare is working with Medicare Advantage and other Medicare Health Plans to help them provide even more coverage and/or lower costs. Your plan will let you know about the prescription drug options they will offer.

Beginning January 1, 2006, Medicare will offer prescription drug coverage to people with Medicare. For the first time, you can choose coverage for this important health need, and Medicare will help pay for it. Medicare prescription drug coverage is insurance that covers both brand-name and generic prescription drugs at participating pharmacies in your area. A typical person with Medicare and no drug coverage could see total drug costs drop by about 50%. Should prescription drug costs dramatically increase, Medicare will pay up to 95% of these costs after you spend $3,600 out-of-pocket in a year. Extra help is available for people with limited income and resources. To get Medicare prescription drug coverage, you must choose and join a Medicare drug plan.

Joining a Medicare plan that covers prescription drugs is your choice. If you want coverage, you must choose to join a plan to receive it. You can join as early as November 15, 2005 for coverage starting January 1, 2006. Just like other insurance, if you choose not to join when you are first eligible and later change your mind, you may have to pay a late enrollment penalty.

If you have Original Medicare only, or Original Medicare and a Medigap ('Supplement') Policy *without* drug coverage, you can join a **Medicare Prescription Drug Plan** that covers prescription drugs only and keep your Original Medicare coverage the way it is. Or you can join a **Medicare Advantage Plan** or other Medicare Health Plan that covers doctor and hospital care as well as prescriptions. If you do not opt for prescription drug coverage by May 15, 2006, you will have to pay a late enrollment penalty to get drug coverage later.

If you have Original Medicare and a Medigap ('Supplement') Policy *with* drug coverage, you will need to decide between keeping your Medigap policy with drug coverage or joining a Medicare plan that offers prescription coverage. Look for more information from Medicare and the plans offering drug coverage in your area in the fall, and compare the drug coverage from your Medigap plan to the new Medicare coverage. Unlike Medigap, most of the cost of Medicare drug coverage is paid by Medicare, and will never run out if you have high drug costs. Also, if you do not join a Medicare Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage by May 15, 2006, you will have to pay a late enrollment penalty to get drug coverage later.

See also: "*What Medicare Prescription Drug Coverage Means to You: A Guide to Getting Started*" (Publication 11146) from the Centers for Medicare & Medicaid Services. Available at http://www.medicare.gov/publications/pubs/pdf/11146.pdf.

If you are a retiree and have drug coverage through your (or your spouse's) former employer or union, look for information coming from your former employer or union this fall. This information will explain how they will work with Medicare on prescription drug coverage and what decisions you will have to make. If you do not hear from them, visit their Web site or call your benefits administrator.

If you have a Medicare Advantage Plan (like an HMO or PPO) or other Medicare Health Plan, look for information in the mail in October explaining any additional prescription drug coverage your plan will offer.

If you have Medicare and Medicaid, and currently get your drug coverage from Medicaid, starting January 1, 2006, you will get your prescription drug coverage from Medicare instead of Medicaid. That means that in the fall, you will need to decide which Medicare plan that offers prescription drug coverage you would like. If you do not sign up for a plan, Medicare will sign you up for one to make sure you do not miss a day of coverage. You can switch to a different plan if you choose.

Resources for Additional Information

If You Have Private Insurance

Many people have insurance through their employer or union. Some people may also purchase this kind of insurance individually for themselves. If you have questions about how to use this kind of insurance:

- Contact membership services. You can find this number by looking at your insurance card and finding the phone number (typically a toll-free number) that will take you to a member support person who can answer your questions about how to use your benefits.

- Contact your state department of insurance for information on your rights and how to file a complaint. You can find contact information for your state's department of insurance at www.naic.org/state_web_map.htm, or in the blue pages of your phone book.

- Go to www.YourPharmacyBenefit.org for information to help answer your questions about how to choose coverage that is right for your family's needs and how to make the best use of the coverage you have. This Web site is sponsored by a group of health care organizations, working together to provide tips and tools to help consumers make the best personal decisions about their pharmacy benefits.

- Contact your local Area Agency on Aging. You can find contact information for your local Area Agency on Aging at www.eldercare.gov, or in the blue pages of your phone book.

- Contact the Administration on Aging (AoA) at www.aoa.gov or call 1-202-619-0724. The AoA serves as the Federal focal point and advocate agency for older persons and their concerns. The AoA's mission is to promote the dignity and independence of older persons and to help society prepare for an aging population.

If You Have Medicare Coverage

This is a program designed for people 65 or older, some people under 65 with permanent disabilities, and people with End-Stage Renal Disease requiring dialysis or a kidney transplant. To learn more about how to use your Medicare benefits:

- For more information on Medicare prescription drug coverage, read the "Medicare & You 2006" handbook mailed to you in October 2005. It lists the specific plans available in your area. After October 2005, if you need help visit www.medicare.gov and get personalized information, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

- Call your State Health Insurance Assistance Program (SHIP) for free, personalized health insurance counseling. See page 86 of the "Medicare & You 2006" handbook for your state's SHIP telephone number, or visit www.medicare.gov/contacts/static/allStateContacts.asp.

- Go to www.YourPharmacyBenefit.org for information to help answer your questions about how to choose coverage that is right for your family's needs and how to make the best use of the coverage you have. This Web site is sponsored by a group of health care organizations, working together to provide tips and tools to help consumers make the best personal decisions about their pharmacy benefits.

- Check for local events for help enrolling in a drug plan. Contact your local Area Agency on Aging. You can find contact information for your local Area Agency on Aging at www.eldercare.gov, or in the blue pages of your phone book.

- Contact the Administration on Aging (AoA) at www.aoa.gov or call 1-202-619-0724. The AoA serves as the Federal focal point and advocate agency for older persons and their concerns. The AoA's mission is to promote the dignity and independence of older persons and to help society prepare for an aging population.

The U.S. Department of Health and Human Services' Administration on Aging has reviewed this publication, which is produced by the National Pharmaceutical Council (NPC). The U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services has reviewed the information regarding the Medicare program. NPC is a nonprofit, research-based association that advances the appropriate use of pharmaceuticals for the betterment of human health. This publication may be reprinted for educational and nonprofit purposes.

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