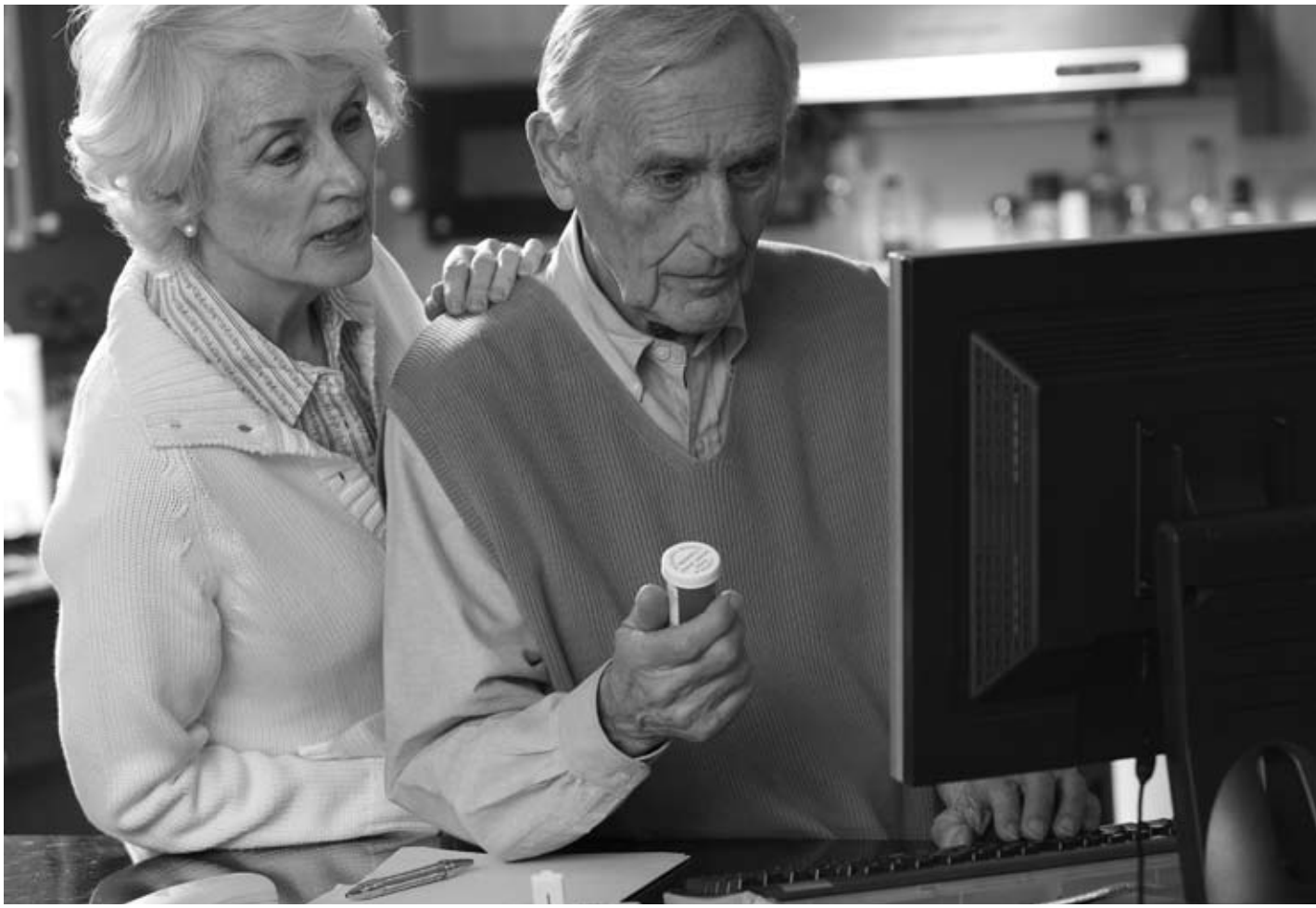
CENTERS FOR MEDICARE & MEDICAID SERVICES

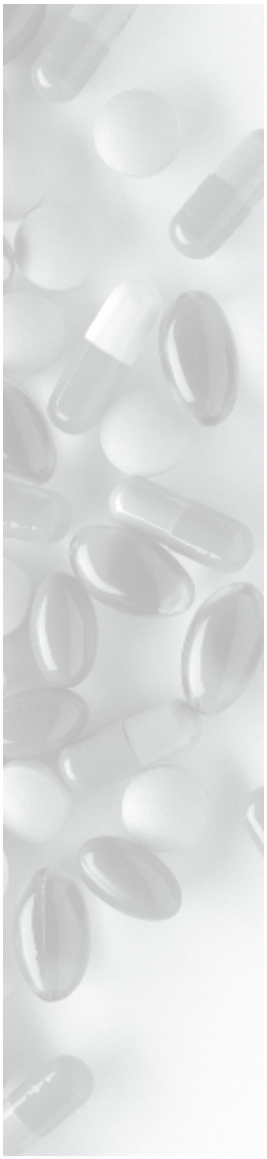


Your Guide to Medicare
Prescription Drug Coverage

This official government booklet 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

Table of Contents



"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) is coverage that adds to, or is included with, your Medicare health care coverage. It helps you pay for both the brand-name and generic drugs you need. Medicare drug plans are offered by insurance companies and other private companies approved by Medicare.

There are two ways to get Medicare prescription drug coverage:

- Medicare Prescription Drug Plans (sometimes called PDPs) add prescription drug coverage to Original Medicare, some Medicare Private Fee-for-Service (PFFS) Plans, some Medicare Cost Plans, and Medicare Medical Savings Account (MSA) Plans.
- Medicare Advantage Plans (like an HMO or PPO) or other Medicare health plans that offer prescription drug coverage. You generally get all of your Medicare Part A (Hospital Insurance), Medicare Part B (Medical Insurance), and Part D coverage through these plans. Medicare Advantage Plans with prescription drug coverage are sometimes called "MA-PDs."

Words in red are defined on pages 69–72.

We use the term "Medicare drug plans" throughout this booklet to mean all plans that provide Medicare prescription drug coverage. 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 between November 15–December 31 each year.

1 Medicare Prescription Drug Coverage Basics

To join a Medicare Prescription Drug Plan, you must be entitled to Medicare Part A (Hospital Insurance) and/or have Medicare 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.

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 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 may have to pay a late enrollment penalty if you join later. The penalty is in addition to your premium each month for as long as you have a Medicare drug plan.

Words in red are defined on pages 69–72.

1 Medicare Prescription Drug Coverage Basics

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 drugs, such as certain injectable, cancer, and immunosuppressive drugs. You pay coinsurance, and the Part B deductible applies. Part B also covers the flu and pneumococcal vaccines. Generally, Medicare drug plans cover vaccines (like the shingles vaccine) 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, observation unit, surgery center, or pain clinic) 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 contact your plan to get back some of the cost. 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 can 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.

Words in red are defined on pages 69–72.

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 Veterans Affairs, the Indian Health Service, or a Medigap (Medicare Supplement Insurance) 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. Doctor samples, discount cards, free clinics, or drug discount websites **aren't** prescription drug coverage and **aren't** creditable 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 to get personalized information. Select "Compare Medicare Prescription Drug Plans" or "Compare 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 68 for your state's SHIP telephone number.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

section

2 How Medicare Prescription Drug Coverage Works

Medicare drug plans vary in which drugs they cover, what your out-of-pocket costs will be, and which pharmacies you can use. Comparing plans based on coverage, cost, convenience, and quality 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 how much 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.

- **Quality**

The web tools on www.medicare.gov offer plan ratings to help you choose a plan that performs well in different categories like customer service. Select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the quality of Medicare drug plans in your area. You can also call 1-800-MEDICARE (1-800-633-4227) for plan rating information. TTY users should call 1-877-486-2048.

2 How Medicare Prescription Drug Coverage Works

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 or 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.

As you consider the plans available to you, remember that companies are allowed to mail you information, but plans can't call you unless you are already a member of the plan. Companies aren't allowed to sell plans door-to-door unless you ask them to come to your home to help you. Remember to keep your personal information safe. See pages 60–61.

How much will my drug coverage cost?

Exact coverage and costs are different for each plan, but all Medicare drug plans must provide at least a standard level of coverage set by Medicare. Your actual costs for Medicare prescription drug coverage will vary depending on which drugs you use, which Medicare drug plan you join, whether you go to a pharmacy in your plan's network, and whether you get extra help paying for your drug costs. 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:

- **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 (like an HMO or PPO) or a Medicare Cost Plan that includes Medicare prescription drug coverage, the monthly premium for that plan may include an amount for prescription drug coverage.
- **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 you pay the deductible. You pay your share and your plan pays its share for covered drugs.

Words in red are defined on pages 69–72.

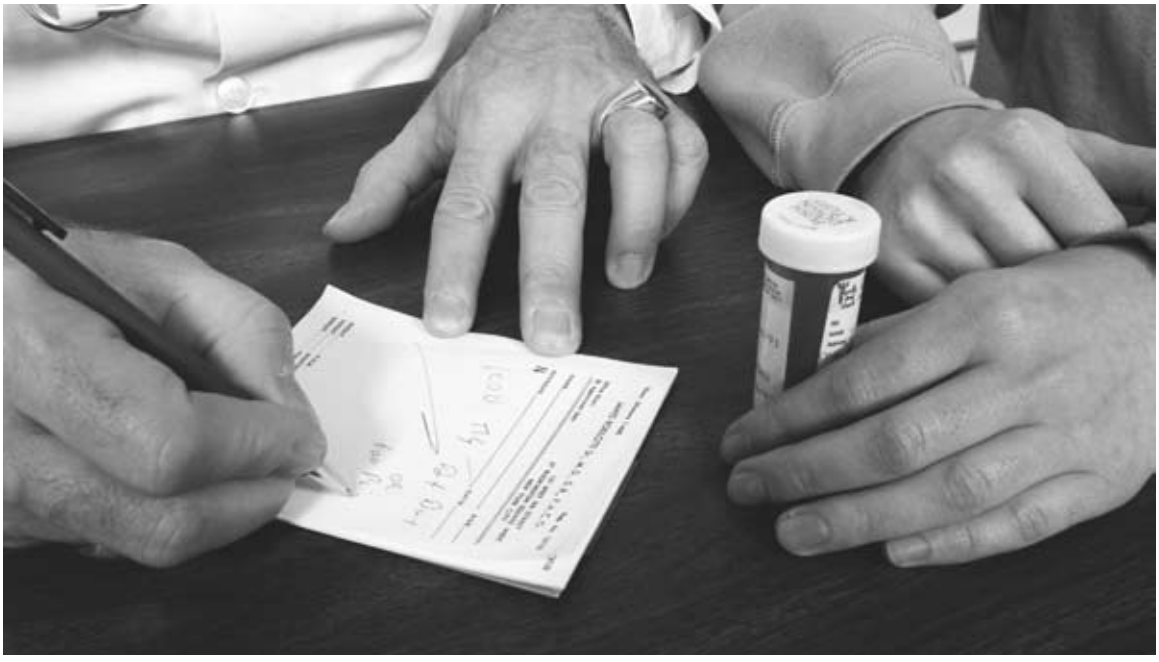
2 How Medicare Prescription Drug Coverage Works

- **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 out-of-pocket for your drugs (up to a limit). Your yearly deductible, coinsurance or copayments, and what you pay in the coverage gap all count toward this out-of-pocket limit. The limit doesn't include the drug plan's premium.

  There are plans that offer some coverage during the gap, like for generic drugs. However, plans with gap coverage may charge a higher monthly premium. Check with the plan first to see if your drugs would be covered during the gap.

- **Catastrophic coverage**— Once you reach your plan's out-of-pocket limit during the coverage gap, you automatically get "catastrophic coverage." Catastrophic coverage assures that once you have spent up to your plan's out-of-pocket limit for covered drugs, you only pay a small coinsurance amount or a copayment for the rest of the year.

Note: If you get extra help paying your drug costs, you won't have a coverage gap and will pay a small or no copayment once you reach catastrophic coverage.



2 How Medicare Prescription Drug Coverage Works

The example below shows the costs for covered drugs in 2009 for a plan that has a coverage gap.

Mr. Jones joins the ABC Prescription Drug Plan. His coverage begins on January 1, 2009. 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 when he buys prescriptions.

Monthly Premium— Mr. Jones pays a monthly premium throughout the year.			
1. Yearly Deductible	**2. Copayment or Coinsurance**	**3. Coverage Gap**	**4. Catastrophic Coverage**
Mr. Jones pays the first $295 of his drug costs before his plan starts to pay its share.	Mr. Jones pays a copayment for each prescription, and his plan pays its share for each covered drug until what **they** pay (plus the deductible) reaches $2,700.	Once Mr. Jones and his plan have spent $2,700 for covered drugs, he is in the coverage gap. He will have to pay **all of his drug costs until he has spent $4,350**.	Once Mr. Jones has spent $4,350 out-of-pocket for the year, his coverage gap ends. Now he only pays a small coinsurance amount or copayment (like $6) for each drug until the end of the year.

Visit www.medicare.gov and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to view estimated annual costs for each plan and your costs per prescription for each month.

2 How Medicare Prescription Drug Coverage Works

How can I pay my Medicare drug plan premium?

In general, there are four 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.

Words in red are defined on pages 69–72.

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.

2 How Medicare Prescription Drug Coverage Works

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 25–36.

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 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.
- Between November 15–December 31 each year. Your coverage will begin on January 1 of the following year as long as the plan gets your request for enrollment by December 31.
- 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, and those who apply and qualify.

Words in red are defined on pages 69–72.

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, lose creditable prescription drug coverage, 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 on the previous page 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 to find out how you can join. Depending on the company, you may be able to join by calling the plan, mailing or faxing a completed enrollment form, or enrolling online.

Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) for a list of the Medicare plans in your area. TTY users should call 1-877-486-2048.

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. The late enrollment penalty is an amount that is added to your Medicare drug plan premium (for as long as you have Medicare drug coverage) if all of the following are true:

- You don't join a Medicare drug plan when you're first eligible.
- You don't have other creditable prescription drug coverage.
- You later decide to join a Medicare drug plan.
- You don't qualify for extra help.

2 How Medicare Prescription Drug Coverage Works

How do I avoid paying a penalty?

- **Join a Medicare drug plan when you're first eligible.** You won't have to pay a penalty, even if you've never had prescription drug coverage before.
- **Don't go for more than 63 days without a Medicare drug plan or other creditable coverage.** Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the VA. You should get a notice every year telling you whether the drug coverage you have is creditable coverage. Keep this notice, because you may need it if you join a Medicare drug plan later.
- **Let your Medicare drug plan know when you join if you have other creditable coverage.** You may get a letter from your plan asking if you have creditable coverage. Complete the form they give you if you do. If you don't tell your plan about your creditable coverage, you may have to pay a penalty.

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. When you join a Medicare drug plan, the plan will tell you if you owe a penalty, and what your premium will be. To estimate your penalty amount, count the number of full months that you didn't have creditable coverage after you were eligible to join a Medicare drug plan. If you multiply this number by 30 cents (in 2009), you can estimate the amount that will be added each month to your Medicare drug plan's premium for the current year. This penalty amount may increase every year.

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 number)
- How you want to pay your plan premiums
- Other insurance information and any creditable coverage notices

2 How Medicare Prescription Drug Coverage Works

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 information for an emergency contact
- Name, address, and phone number of nursing home or institution where you live

Words in red are defined on pages 69–72.

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.

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

When you join a Medicare Prescription Drug Plan that works with Original Medicare, 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?

About a week after you join a plan, you will get a letter from the plan letting you know they got your information. Three to 5 weeks later, you should get a welcome package with your membership card. If you need to go to the pharmacy before your membership card arrives, you can use any of the following as proof of membership in your Medicare drug plan:

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

2 How Medicare Prescription Drug Coverage Works

You should also bring your Medicare and/or Medicaid card and a photo ID. If you qualify for extra help, see page 33 for more information about what you can use as proof of extra help. 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—you may be able to get back some of the cost or have the amount credited toward your out-of-pocket expenses.**

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.

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, 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 to see if your pharmacy works with the plan you want to join. TTY users should call 1-877-486-2048.

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 network 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. Using mail-order pharmacies can save you money.

2 How Medicare Prescription Drug Coverage Works

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

Words in red are defined on pages 69–72.

If you have ESRD (permanent kidney failure requiring dialysis or a kidney transplant) and you are in Original Medicare, you can join a Medicare Prescription Drug Plan. You generally can't join a Medicare Advantage Plan except as follows:

- If you are already in a Medicare Advantage Plan, you can stay in it or join another plan that includes Medicare drug coverage offered by the same company in the same state.
- 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 Original Medicare after your plan leaves or stops providing coverage, you will still have a one-time right to join a Medicare Advantage Plan later 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.

For more information about ESRD and Medicare Advantage Plans, visit www.medicare.gov/Publications/Pubs/pdf/10128.pdf 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.

2 How Medicare Prescription Drug Coverage Works

What drugs are covered by Medicare drug plans?

Words in red are defined on pages 69–72.

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 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 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 don't provide 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 generally must 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.

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

2 How Medicare Prescription Drug Coverage Works

Generic drugs

According to the Food and Drug Administration (FDA), a generic drug is the same as its brand-name counterpart 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 corresponding 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. Each tier costs a different amount. 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 the least.
- Tier 2–Preferred brand-name drugs. Tier 2 drugs will cost more than Tier 1 drugs.
- Tier 3–Non-preferred brand-name drugs. Tier 3 drugs will cost more than Tier 1 and Tier 2 drugs.

Your plan's drug list might 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 62.

Note: 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, but it will let you know afterward.

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 that 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 and 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 on their drug list, before you can get a similar, more expensive brand-name drug covered.

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 more expensive drug will be 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 then cover the brand-name drug.

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 one 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 69–72.

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 or already live in 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 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 63–65.

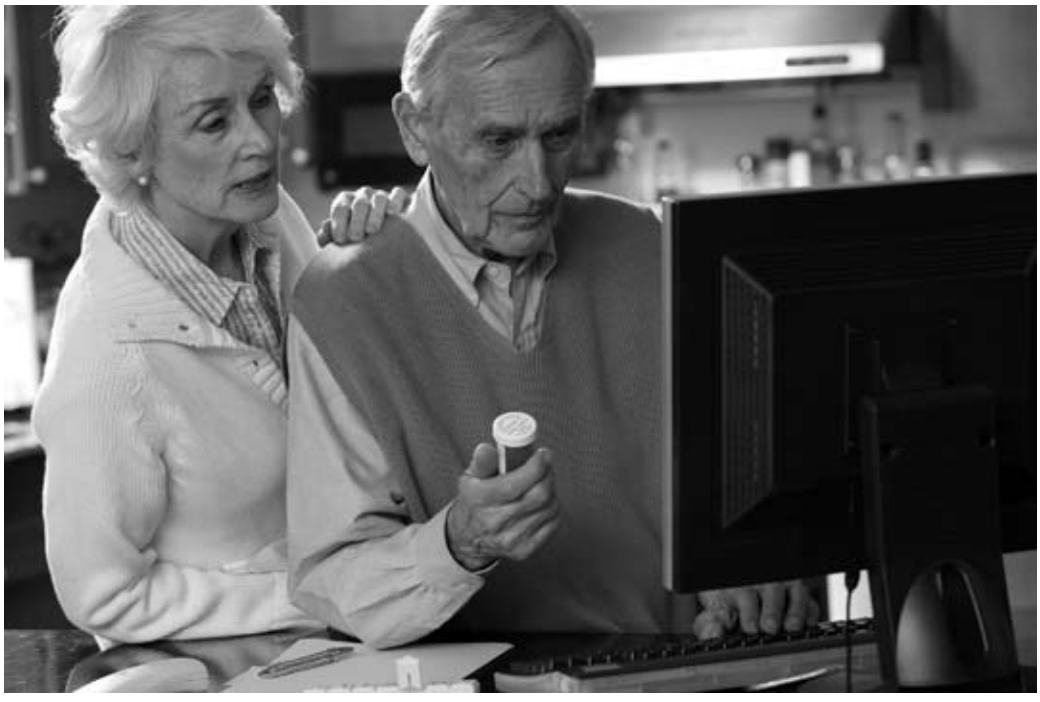
What if I join a plan and then my doctor changes my prescription?

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 prescribes electronically (also known as "e-prescribing"), he or she can check which drugs your insurance covers electronically through his or her e-prescribing system.

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 61–62.

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.



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.

Words in red are defined on pages 69–72.

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 27 and 29 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.

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

Ways you may qualify for extra help

Words in red are defined on pages 69–72.

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 any of the following are true:

- You get full coverage from a state Medicaid program.
- You get help from Medicaid paying your Medicare Part B premiums (a Medicare Savings Program).
- You get Supplemental Security Income (SSI) benefits.

If you don't join a Medicare drug plan on your own, Medicare will enroll you in a plan so you get help paying for your prescription drugs, unless you have certain retiree drug coverage from a former employer or union. 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, and your new plan will begin the first day of the next month. 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 $4,350**)	Your cost per prescription at the pharmacy (after $4,350**)
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 $10,830 (single) $14,570 (married)	$0	$0	**Generic and certain preferred drugs:** no more than $1.10 **Brand-name drugs:** no more than $3.20	$0
full Medicaid coverage and have a yearly income above $10,830 (single) $14,570 (married)	$0	$0	**Generic and certain preferred drugs:** no more than $2.40 **Brand-name drugs:** no more than $6	$0
help from Medicaid paying your Medicare Part B premiums	$0	$0	**Generic and certain preferred drugs:** no more than $2.40 **Brand-name drugs:** no more than $6	$0
Supplemental Security Income (SSI)	$0	$0	**Generic and certain preferred drugs:** no more than $2.40 **Brand-name drugs:** no more than $6	$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 $4,350 per year.

The cost sharing, income levels, and resources listed are for 2009 and can increase each year. If you live in Alaska or Hawaii, or you or your spouse pays at least half of the living expenses of dependent family members who live with you, or you work, income levels are higher.

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

Words in red are defined on pages 69–72.

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, 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, and your new plan will begin the first day of the next month.

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 $4,350**)	Your cost per prescription at the pharmacy (after $4,350**)
a yearly income below $14,620.50 (single) $19,669.50 (married) with resources of no more than $8,100 (single) $12,910 (married)	$0	$0	**Generic and certain preferred drugs:** no more than $2.40 **Brand-name drugs:** no more than $6	$0
a yearly income below $14,620.50 (single) $19,669.50 (married) with resources between $8,100 and $12,510 (single) $12,910 and $25,010 (married)	$0	$60	up to 15% of the cost of each prescription	**Generic and certain preferred drugs:** no more than $2.40 **Brand-name drugs:** no more than $6
a yearly income between $14,620.50 and $15,162 (single) $19,669.50 and $20,398 (married) with resources up to $12,510 (single) $25,010 (married)	25%	$60	up to 15% of the cost of each prescription	**Generic and certain preferred drugs:** no more than $2.40 **Brand-name drugs:** no more than $6
a yearly income between $15,162 and $15,703.50 (single) $20,398 and $21,126.50 (married) with resources up to $12,510 (single) $25,010 (married)	50%	$60	up to 15% of the cost of each prescription	**Generic and certain preferred drugs:** no more than $2.40 **Brand-name drugs:** no more than $6
a yearly income between $15,703.50 and $16,245 (single) $21,126.50 and $21,855 (married) with resources up to $12,510 (single) $25,010 (married)	75%	$60	up to 15% of the cost of each prescription	**Generic and certain preferred drugs:** no more than $2.40 **Brand-name drugs:** no more than $6

Please see the notes below the table on page 27 for more information.

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

Applying for Extra Help

Words in red are defined on pages 69–72.

Whose income and resources count?

- Your income and resources count.
- If you are married and live with your spouse, both of your incomes and resources count 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 count.

Note: Married couples living together who both 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 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

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 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 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 (single) or less or $3,000 (married)
- 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 you need for self-support
- Non-business property you need for self-support
- Funds you get and save to pay for medical and/or social services

How long will I get extra help if I qualify?

If you automatically qualify for extra help

To automatically qualify for extra help for the coming year, you must continue to 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).

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

If you apply and qualify for extra help

If you qualify for extra help, you will get the extra help 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 any time, and Social Security will review them from August to December. 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.

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

If I qualify for extra help, what can I do to make sure I pay the right amount?

If you automatically qualify, you should get a purple, yellow, or green letter from Medicare you can show to your plan as proof that you qualify. If you applied for extra help, you can show your "Notice of Award" letter from Social Security as proof that you qualify. If you have Supplemental Security Income (SSI), you can use your award letter from Social Security as proof you have SSI.

You can also give your plan any of the following documents as proof that you qualify for extra help. Each item listed below must show that you were eligible for Medicaid during a month after June of 2008.

Other Proof You Have Medicaid	Proof You Have Medicaid and Live in an Institution
▪ A copy of your Medicaid card ▪ A copy of a state document that shows you have Medicaid ▪ A print-out from a state electronic enrollment file or screen print from your state's Medicaid systems that shows you have Medicaid ▪ Any other document from your state that shows you have Medicaid	▪ A bill from the institution (like a nursing home) or a copy of a state document showing Medicaid payment to the institution for at least a month ▪ A screen print from your state's Medicaid systems showing that you lived in the institution for at least a month

Words in red are defined on pages 69–72.

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

Words in red are defined on pages 69–72.

Your plan must accept any of these documents as proof that you qualify for extra help. As soon as you have provided any one of these documents, your plan must make sure that you pay the right amount.

If you qualify for extra help because you have Medicaid, but you don't have or can't find any of these documents, and you ask for help, your plan must also contact Medicare so that Medicare can get proof that you qualify, if it's available. You can expect your request to take anywhere from several days to up to 2 weeks to process, depending on the circumstances. Be sure to tell your plan how many days of medication you have remaining. Your plan and Medicare will work to process your request before you run out of medication, if possible.

If you paid for prescriptions since you qualified for extra help, you may be able to get back some of these costs. Keep the receipts, and call your plan for more information.

If your plan doesn't correct a problem to help you pay the right amount for your prescriptions, doesn't respond to your request for help, or takes longer than expected to get back to you, call 1-800-MEDICARE (1-800-633-4227) to file a complaint. TTY users should call 1-877-486-2048.

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. TTY users should call 1-800-325-0778. 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.

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, and 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?

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 help pay your prescription drug costs. Contact your State Medical Assistance (Medicaid) office or State Health Insurance Assistance Program (SHIP) for more information. See page 68 for the SHIP in your state. You can also call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov for these telephone numbers. TTY users should call 1-877-486-2048.

section

4 Your Prescription Drug Coverage Choices

Find the information that fits your current health insurance coverage situation in the list on page 39. 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

Words in red are defined on pages 69–72.

If you need help with your Medicare prescription drug coverage decisions, call your State Health Insurance Assistance Program (SHIP). See page 68 for their telephone number. You can also visit www.medicare.gov, 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 25–36.

4 Your Prescription Drug Coverage Choices

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

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.
- What are a particular Medicare drug plan's quality ratings?

Words in red are defined on pages 69–72.

4 Your Prescription Drug Coverage Choices

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

Type of Current Health Insurance Coverage Page(s)

4 Your Prescription Drug Coverage Choices

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

Words in red are defined on pages 69–72.

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 Prescription 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, 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.
- If you are joining a Medicare Advantage Plan for the first time, you may get a 12-month trial period during which you can disenroll from the Medicare Advantage Plan and get back your Medigap policy, or if it isn't available, buy another Medigap policy.

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 stating 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 isn't creditable prescription drug coverage.** You will pay this higher premium for as long as you are in a Medicare Prescription Drug Plan.

For more information about Medigap policies, read "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" by visiting www.medicare.gov/Publications/Pubs/pdf/02110.pdf. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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.

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

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 health 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

Words in red are defined on pages 69–72.

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 if your current coverage isn't creditable.
- 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.

- If you are covered under a FEHB plan, you will get information during the open season about your prescription drug coverage and whether it's 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.

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:

Words in red are defined on pages 69–72.

- 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.

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

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 Original Medicare 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.
- 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, you can join a Medicare Prescription Drug Plan to get this coverage.
- No Medicare Medical Savings Account (MSA) Plans offer Medicare prescription drug coverage. If you have a Medicare MSA Plan, you can join a Medicare Prescription Drug Plan to get this coverage.
    - 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 counts toward your drug plan out-of-pocket costs described on pages 10–12.
    - If you don't have a Medicare Prescription Drug Plan, MSA account dollars can be used for prescription or non-prescription drugs since they are "qualified medical expenses" and aren't taxed. However, those expenses wouldn't count towards the MSA Plan deductible since only Medicare Part A and Part B expenses count towards the MSA Plan's deductible.

Words in red are defined on pages 69–72.

4 Your Prescription Drug Coverage Choices

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.

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.

- 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 Original Medicare.
- 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.
- With a Medicare Cost Plan, you can either get your Medicare prescription drug coverage from the plan (if offered), or you can join a separate Medicare Prescription Drug Plan to add prescription drug coverage.

For more information about your choices, contact your plan.

4 Your Prescription Drug Coverage Choices

I have Medicare and Medicaid

Words in red are defined on pages 69–72.

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 26–27 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 will enroll you in a drug plan to make sure you have drug coverage, unless you have certain retiree drug coverage from a former employer or union. 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 without penalty as long as you continue to qualify for extra help.

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 (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.

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, and select "Find Helpful Phone Numbers and Websites," or call 1-800-MEDICARE.

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 belong to a Medicare Savings Program (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 26–27 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, unless you have certain retiree drug coverage from a former employer or union. 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 without penalty as long as you continue to qualify for extra help.

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.

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.

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

- While you are living in an institution, you can switch Medicare drug plans at any time.
- If you move into or move out of a nursing home or other institution, you can switch Medicare drug plans at that time.
- If you aren't able to join on your own, your appointed 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.

Words in red are defined on pages 69–72.

Unless you choose a Medicare Advantage Plan with drug coverage or a Medicare Prescription Drug Plan on your own, 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.

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 health care services. Therefore, if you disenroll from your PACE plan by joining a Medicare drug plan, you will no longer get 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. However, 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, 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 25–26.

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

Words in red are defined on pages 69–72.

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 another 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. If you lose your SPAP benefits, you will have the opportunity to join a different Medicare drug plan, beginning with the month you lose your benefits plus 2 additional months.

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

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

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.

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 56–57 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, convenience, and quality.

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

Tip: Before considering which Medicare drug plan to join, check out how any current health coverage you have could affect your prescription drug coverage choices. See pages 40–54.

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 notices you get 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. If your coverage is creditable and you didn't get a notice saying so, request one from your insurer, plan provider, or benefits administrator.

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:_____

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 www.medicare.gov and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area," or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

5

Steps to Choosing a Medicare Drug Plan

When you find some plans you are interested in, use the tools at www.medicare.gov 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.			
		2.			
		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.			
		2.			
		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.			
		2.			
		3.			

5

Steps to Choosing a Medicare Drug Plan

Refer to the worksheets on pages 56–57. 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 are the plans' quality ratings?
- 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 already have a plan)?

Words in red are defined on pages 69–72.

If you need help with your Medicare prescription drug coverage decisions, call your State Health Insurance Assistance Program (SHIP). See page 68 for their telephone number. You can also visit www.medicare.gov 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 online. You will have to provide the number on your Medicare card when you join.

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.

An appointed 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 appointed 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.

An appointed 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. **An appointed representative can't enroll you in a Medicare drug plan unless he or she is also your legal representative.**

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.

An appointed 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.

6 Your Medicare Drug Plan Rights and Appeals

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 why. You may contact the plan for more information about your options.

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. TTY users should call 1-877-486-2048. 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:

Words in red are defined on pages 69–72.

- Charge you a fee to enroll in a plan.
- Send you unwanted emails.
- Come to your home uninvited to sell or endorse any Medicare-related products.
- Call you unless you are already a member of the plan. If you are a member, the agent who helped you join can call you.
- Offer you cash to join their plan or give you free meals while marketing a plan to you.
- Enroll you into a drug plan, in general, over the telephone unless you call them and ask to enroll.
- Ask you for payment over the telephone or web. The plan must send you a bill.
- Sell you a non-health related product, like an annuity or life insurance policy, during a sales pitch for a Medicare health or drug plan.
- Make an appointment to tell you about their plan unless you agree in writing or through a recorded telephone discussion to the products being discussed. During the appointment, they can only try to sell you the products you agreed to hear about.
- Talk to you about their plan in areas where you get health care, like an exam room, hospital patient room, or at a pharmacy counter.
- Market their plans or enroll you during an educational event, like a health fair or conference.

6 Your Medicare Drug Plan Rights and Appeals

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 (1-877-723-3379).

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 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 or to file a complaint online, visit www.consumer.gov/idtheft.

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 get a written explanation (called a coverage determination) from your plan. You can do either of the following:

- 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.

You, your prescriber (such as a 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.

6 Your Medicare Drug Plan Rights and Appeals

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 must 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. You can also appoint a representative with a letter signed and dated by you and the person helping you. Your letter must include the same information that is requested on the Appointment of Representative form. The form or letter must be sent with your coverage determination or appeal request.

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 gets 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.

Words in red are defined on pages 69–72.

Important: For some types of coverage determinations called exceptions, you will need a supporting statement from your prescriber 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 prescriber 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 gets the statement.

Once your plan gets 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.

6 Your Medicare Drug Plan Rights and Appeals

How to Appeal

If you ask for a coverage determination and you disagree with the plan's decision, you can appeal the decision. There are **five 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." Any unfavorable coverage determination decision you get from your plan will tell you how to file this appeal. You must request this appeal within 60 calendar days from the date of the coverage determination notice. You, your representative, or your prescriber, 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 representative, or your prescriber 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 prescriber tells your plan, that your life or health may be seriously jeopardized by waiting for a standard decision.

A written appeal request should include the following:

- Your name, address, and Medicare 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 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 representative can request a review (called a "reconsideration") by an Independent Review Entity (IRE). The redetermination decision will be mailed to you and will 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. You can also get this form by visiting www.cms.hhs.gov/MedPrescriptDrugApplGriev/13_Forms.asp. 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.

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.

Words in red are defined on pages 69–72.

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 prescriber 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 up to 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 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 reconsideration 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 get the MAC's decision. You must send your request to the location specified in the MAC's decision. To get 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 also 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 didn't make a decision about a coverage determination or redetermination within the required timeframe and didn't send your case to the Independent Review Entity (IRE). You can file a complaint, and also appeal the decision.
- 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 gets 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 didn't get the drug, you must be notified of the decision no later than 24 hours after the plan gets 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.

section

7 For More Information

For more information about Medicare prescription drug coverage, use the following resources:

- Visit www.medicare.gov, and get personalized information. Select "Compare Medicare Prescription Drug Plans" or "Compare 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. Please have your Medicare number available.

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"

Note: If you want Medicare to give your personal health information to someone other than you, you need to let Medicare know in writing. You can fill out a "Medicare Authorization to Disclose Personal Health Information" form. You can do this online by visiting www.medicare.gov, or call 1-800-MEDICARE to get a copy of the form.

- For more information about your current drug coverage, contact your benefits administrator, insurer, or plan.
- 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. 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 next page.

Tip: Call your State Health Insurance Assistance Program (SHIP) for free personalized counseling on your prescription drug coverage choices. See page 68.

7 For More Information

This page has been intentionally left blank. The printed version contains phone number information. For the most recent phone number information, please visit www.medicare.gov/contacts/home.asp. 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, 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 Original Medicare, your prescription drug plan, or your other insurance begins to pay.

For More Information

Drug List—A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. 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 prescriber must send a supporting statement explaining the medical reason for the exception.

Extra Help—A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Institution—For the purposes of this publication, an institution is a facility that provides short-term or long-term care, such as a nursing home, skilled nursing facility (SNF), or rehabilitation hospital. Private residences, such as an assisted living facility or group home, are not considered institutions for this purpose.

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. 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 Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

For More Information

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 Original Medicare (your Cost Plan pays for emergency services or urgently-needed services).

Medicare Health Maintenance Organization—A type of Medicare Advantage Plan (Part C) available in some areas of the country. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Most HMOs also require you to get a referral from your primary care physician.

Medicare Medical Savings Account (MSA) Plan—MSA Plans combine a high deductible Medicare Advantage Plan and a bank account. The plan deposits money from Medicare into the account. You can use the money in this account to pay for your health care costs, but only Medicare-covered expenses count toward your deductible. The amount deposited is usually less than your deductible amount so you generally will have to pay out-of-pocket before your coverage begins.

Medicare Preferred Provider Organization (PPO) Plan—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 Original Medicare, 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 follows the same rules as Medicare Prescription Drug Plans.

7 For More Information

Medicare Private Fee-for-Service (PFFS) Plan—A type of Medicare Advantage Plan (Part C) in which you can generally go to any doctor or hospital you could go to if you had Original Medicare, if the doctor or hospital agrees to treat you. The plan determines how much it will pay doctors and hospitals, and how much you must pay when you get care. A Private Fee-For-Service Plan is very different than Original Medicare, and you must follow the plan rules carefully when you go for health care services. When you're in a Private Fee-For-Service Plan, you may pay more, or less, for Medicare-covered benefits than in Original Medicare.

Medigap Policy—Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage. Some Medigap policies sold before January 1, 2006, have prescription drug coverage. Policies sold on or after January 1, 2006, don't have prescription drug coverage.

Original Medicare—Original Medicare 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.

Index

Index

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Official Business
Penalty for Private Use, $300

CMS Publication No. 11109
Revised May 2009

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

My Health.
My Medicare.

To get this booklet in Spanish, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

¿Necesita usted una copia de esta guía en Español?
Llame GRATIS al 1-800 MEDICARE (1-800-633-4227).
Los usuarios de TTY deberán llamar al 1-877-486-2048.