Full Benefit Dual Eligible (FBDE) (People who had full Medicaid benefits including drug coverage through their State Medicaid program through 12/31/05)

Audience	What If…	Answer
1. Medicare & Medicaid FBDE	A FBDE goes to a pharmacy and presents their Medicaid card	The pharmacy should check its records and determine which plan the person is enrolled in. The pharmacy staff should explain that Medicaid coverage for prescription drugs for people with Medicare stopped on December 31, and let the person know which Medicare plan will now cover their drugs. The pharmacist will fill the prescription, submit a claim to the plan and charge the person the correct copay. If the pharmacist verifies Medicare and Medicaid eligibility, and determines the person is not already enrolled in a Medicare drug plan. The pharmacist will confirm the person wants drug coverage. If the person agrees, they will be enrolled in Wellpoint (Anthem), a national prescription drug plan. The pharmacist will submit the claim to Wellpoint (Anthem), charge the $1/$3 copay amount and fill the prescription. The person may choose not to be enrolled in Wellpoint (Anthem) at that time or join another plan. If they continue to want to have their prescription filled, the person can pay the full cash price for his/her prescription. The person can also ask the pharmacy to give them only part of the prescription until he/she can join a plan. If the person wants to join a different plan, they can join a plan by calling the plan directly, or calling 1-800-MEDICARE, or using the On-Line Enrollment Center. The enrollment will be effective the first day of the month following the submission of a complete enrollment application. Note: The person will need to have sufficient proof of identity (state law). They may be required to have personal photo identification or other supporting documentation with them to substantiate their identity. If they do not have sufficient proof of identity, the person should be counseled to return with the necessary identification. **(final 12/29/05)**

Audience	What If…	Answer
2. Medicare & Medicaid FBDE	A FBDE goes to a pharmacy and they have not been assigned to a plan	If the person claims to have Medicaid and Medicare, the pharmacist will verify that the person is eligible for both Medicare and Medicaid, and that the person is not already enrolled in a Medicare drug plan. The pharmacist will confirm the person wants drug coverage. If the person agrees, they will be enrolled in Wellpoint (Anthem), a national prescription drug plan. The pharmacist will fill the prescription, submit the claim to Wellpoint (Anthem) and charge the $1/$3 copay amount. Note: The person will need to have sufficient proof of identity (state law). They may be required to have personal photo identification or other supporting documentation with them to substantiate their identity. If they do not have sufficient proof of identity, the person should be counseled to return with the necessary identification. **(final 12/29/05)**
3. Medicare & Medicaid FBDE	A FBDE opted out of their autoassigned plan, goes to a pharmacy and believes they still have Medicaid coverage	The pharmacy staff should explain that Medicaid coverage for prescription drugs for people with Medicare stopped on December 31. If they want to have their drugs paid for, they will need to join a Medicare drug plan. If they do not need a prescription filled at that time, they should be counseled that they can also join a plan by calling the plan directly, or calling 1-800-MEDICARE, or using the On-Line Enrollment Center. The enrollment will be effective the first day of the month following the submission of a complete enrollment application. If they do need their prescription filled at that time, the pharmacist will verify Medicare and Medicaid eligibility. The pharmacist will confirm the person wants drug coverage. If the person agrees, they will be enrolled in Wellpoint (Anthem), a national prescription drug plan. The pharmacist will fill the prescription, submit the claim to Wellpoint (Anthem) and charge the $1/$3 copay amount. Note: The person will need to have sufficient proof of identity (state law). They may be required to have personal photo identification or other supporting documentation with them to substantiate their identity. If they do not have sufficient proof of identity, the person should be counseled to return with the necessary identification. **(final 12/29/05)**

Audience	What If…	Answer
4. Medicare & Medicaid FBDE	A FBDE person with Medicare just qualified for Medicaid in December 2005	Medicare will automatically enroll the person into a drug plan once Medicare is notified by the State that the person has Medicaid. The pharmacy should check its records in the system and determine which plan the person is enrolled in. If there is no record of plan enrollment, the pharmacist should call the designated pharmacy enrollment/eligibility helpline or 1-800-MEDICARE to identify the plan in which the person is enrolled and the plan's telephone number. The pharmacy can then call the plan to get the information needed to send a claim to the plan. If the person needs a prescription before the enrollment record is available, the pharmacist will verify that the person has both Medicare and Medicaid coverage and is not already enrolled in a plan. The pharmacist will confirm the person wants drug coverage. If the person agrees, they will be enrolled in Wellpoint (Anthem), a national prescription drug plan. The pharmacist will submit the claim to Wellpoint (Anthem), charge the $1/$3 copay amount and fill the prescription. The person may choose not to be enrolled in Wellpoint (Anthem) at that time. If they continue to want to have their prescription filled, the person can pay the full cash price for his/her prescription. The person can also ask the pharmacy to give them only part of the prescription until he/she can join a plan. Once they receive the letter notifying them of the plan in which they have been automatically enrolled, they can contact the plan to find out how to submit a claim for reimbursement of the amount the plan (and Medicare for cost sharing under LIS) would have paid. If the person wants to join a different plan, they can join a plan by calling the plan directly, or calling 1-800-MEDICARE, or using the On-Line Enrollment Center. The enrollment will be effective the first day of the month following the submission of a complete enrollment application. Note: The person will need to have sufficient proof of identity (state law). They may be required to have personal photo identification or other supporting documentation with them to substantiate their identity. If they do not have sufficient proof of identity, the person should be counseled to return with the necessary identification. **(final 12/29/05)**

Audience	What If…	Answer
5. Medicare & Medicaid FBDE	A person just aged into Medicare this month and had Medicaid already Note: Medicare is working closely with states to get information about potential dual eligibles (both those who are within 3 months of aging into Medicare and those who are nearing Medicare eligibility because of a disability).	Medicare will automatically enroll the person into a prescription drug plan, with coverage effective as of the date the person is eligible for Medicare. The pharmacy should check its records in the system and determine which plan the person is enrolled in. If there is no record of plan enrollment, the pharmacist should call the designated pharmacy enrollment/eligibility helpline or 1-800-MEDICARE to identify the plan in which the person is enrolled and the plan's telephone number. The pharmacy can then call the plan to get the information needed to send a claim to the plan. If the person needs a prescription before the enrollment record is available, the pharmacist will verify that the person has both Medicare and Medicaid coverage and is not already enrolled in a plan. The pharmacist will confirm the person wants drug coverage. If the person agrees, they will be enrolled in Wellpoint (Anthem), a national prescription drug plan. The pharmacist will submit the claim to Wellpoint (Anthem), charge the $1/$3 copay amount and fill the prescription. The person may choose not to be enrolled in Wellpoint (Anthem) at that time. If they continue to want to have their prescription filled, the person can pay the full cash price for his/her prescription. The person can also ask the pharmacy to give them only part of the prescription until he/she can join a plan. Once they receive the letter notifying them of the plan in which they have been automatically enrolled, they can contact the plan to find out how to submit a claim for reimbursement of the amount the plan (and Medicare for cost sharing under LIS) would have paid. If the person wants to join a different plan, they can join a plan by calling the plan directly, or calling 1-800-MEDICARE, or using the On-Line Enrollment Center. The enrollment will be effective the first day of the month following the submission of a complete enrollment application. Note: The person will need to have sufficient proof of identity (state law). They may be required to have personal photo identification or other supporting documentation with them to substantiate their identity. If they do not have sufficient proof of identity, the person should be counseled to return with the necessary identification. **(final 12/29/05)**

Audience	What If…	Answer
6. Medicare & Medicaid FBDE	FBDE was not autoenrolled and shows up at pharmacy, but doesn't have appropriate proof of identification	Pharmacies are expected (and may even be required under State law) to establish certain safeguards to prevent fraud. Such safeguards are likely to include requiring a photo ID or other supporting documentation in order to verify the person's identity. If they do not have sufficient proof of identity, the person should be counseled to return with the necessary identification. **(final 12/29/05)**
7. Medicare & Medicaid FBDE	A FBDE was autoenrolled and needs a drug that's not on their plan's formulary	For auto-enrollees with coverage effective on January 1 or February 1, 2006, the pharmacist will provide a temporary "first fill" of up to 90 days of a non-formulary drug under the plan's new enrollee transition policy. The person has until March 31, 2006, to work with their doctor to switch to a prescription on the plan's formulary. Until then, the plan will allow the pharmacist to fill the current prescription through March 31, 2006. The pharmacist may also discuss switching the prescription to a generic or therapeutic alternative that is on the plans' formulary with the person or their prescribing physician. For auto-enrollees with coverage starting on March 1, 2006, or later, the plan will allow them to fill a one-time, 30-day supply of the prescription. Note: Medicare drug plans are required to cover medically necessary treatments and should offer an alternative drug that works in a very similar way and generally has the same effects. **(updated 02/17/06)**

Audience	What If…	Answer
8. Medicare & Medicaid FBDE	A FBDE gets a letter from their plan that says they are going to be charged a premium	FBDEs were enrolled by CMS into a prescription drug plan with a fully subsidized premium in November. Since then, some FBDE have exercised their right to elect a different plan. While the first plan knew the person was a FBDE because they were auto-enrolled, the second plan sees the enrollment like any other voluntary enrollment until it receives specific information from CMS concerning the individual's subsidy status. The volume of data flowing between CMS and the plans at this time is extremely high, and there are some unavoidable lag times. As a result, in the very short term, a plan may send a message to a FBDE that references premiums or cost sharing not applicable to that individual. However, once the plan has received complete information on the individual, including FBDE status, it will send out an enrollment package that includes an ID card and correct information appropriate to the individual's FBDE status. If the individual goes to a pharmacy to fill a prescription before receiving an ID card from the plan, he or she may ask the pharmacy to contact the plan and find out why the copay is higher than expected. The plan may instruct the pharmacist to collect a lower copay and resubmit the claim once systems have been updated. **(final 01/04/05)**
9. Medicare & Medicaid FBDE	A FBDE questions why there is a copay on a prescription	States may pay the Medicare copays on behalf of a FDBE and some are choosing to do so. So, the pharmacy should first check its records to see if the plan has provided information about additional (secondary) payer to bill for the copay. If a State is paying the Medicare copayment, the person should have a card from the State program (such as an SPAP). If the pharmacy cannot confirm a secondary payer, or the person does not have proof of enrollment in a State program, the pharmacist can make a case by case decision not to charge the copay (if, for example, having to pay the copayment would cause the person undue hardship or prevent him or her from obtaining the prescription. Unlike under the Medicaid program, pharmacists are not required to waive the copay. **(final 01/04/05)**

Audience	What If…	Answer
10. Medicare & Medicaid FBDE	A FBDE goes to a pharmacy that is not in their plan's network.	Most plans into which FBDE were autoenrolled include comprehensive national pharmacy networks. Thus, in most cases, a person can obtain needed drugs even from a pharmacy not located in their plan region. If the pharmacy is not in the network, in most cases there will be a network pharmacy close by. The individual should call their plans' customer service number to locate a nearby network pharmacy. In exceptional cases, e.g., where the person cannot be expected to go to a network pharmacy, Medicare will pay for the out of network coverage. (Note: The out-of-network payment process may not be automated. The person can pay the full cash price for their prescription and contact their plan to find out how to obtain reimbursement of the amount the plan or Medicare would have paid. The person can also ask the pharmacy to sell them only part of the prescription until they can locate a network pharmacy in their area, if applicable.) If the person wants to switch to a plan that includes a particular pharmacy, they can find out about plans in their area that include that pharmacy and in which they will not have to pay a premium by calling 1-800-Medicare. The enrollment will be effective the first day of the month following the submission of a complete enrollment application. The new enrollment will automatically disenroll the person from their current plan. **(final 01/04/05)**
11. Medicare & Medicaid FBDE	A FBDE goes to a pharmacy with prescriptions for drugs excluded under the Medicare drug benefit	By law, Medicare cannot pay for these drugs. Virtually all State Medicaid programs are continuing to cover the same categories of drugs through Medicaid that they have covered in the past. For example, all States except Tennessee are covering some or all benzodiazepines and barbiturates. (Other categories of excluded drugs include prescription vitamins, nonprescription drugs, or drugs used to treat certain conditions such as weight loss or gain, hair growth or fertility drugs, and drugs used for cosmetic purposes or symptomatic relief of coughs and colds that had been covered by Medicaid.) If a pharmacist is uncertain about Medicaid coverage of these drugs, he or she should call the State to check coverage and payment rules, or submit a claim to Medicaid to determine whether a drug is covered or denied. **(final 01/04/05)**

Audience	What If…	Answer
12. Medicare & Medicaid FBDE	A person has Medicare prescription drug coverage **and** Medicaid? Who pays first?	The person's Medicare drug plan will pay for the drugs covered by Medicare. Medicaid may pay for any drugs that Medicare doesn't cover. Virtually all State Medicaid programs are continuing to cover the same categories of drugs through Medicaid that they have covered in the past. For example, all States except Tennessee are covering some or all benzodiazepines and barbiturates. (Other categories of excluded drugs include prescription vitamins, nonprescription drugs, or drugs used to treat certain conditions such as weight loss or gain, hair growth or fertility drugs, and drugs used for cosmetic purposes or symptomatic relief of coughs and colds that had been covered by Medicaid.) If a pharmacist is uncertain about Medicaid coverage of these drugs, he or she should call the State to check coverage and payment rules, or submit a claim to Medicaid to determine whether a drug is covered or denied. **(final 01/04/05)**

Medicare and Low-Income Subsidy (Not including Full Benefit Dual Eligible (NFBDE))

Audience	What If…	Answer
1. LIS NFBDE	A person goes to a pharmacy and although the pharmacy cannot confirm enrollment, the individual has a plan enrollment acknowledgment letter and proof of LIS	The pharmacy should fill the prescription, submit a claim to the plan identified in the enrollment acknowledgment letter and charge the copayment amount. If a person has documentation that indicates they have qualified for extra help, but the cost sharing the pharmacy asks for is different, the person can ask the pharmacist to contact the plan to discuss the LIS documentation and to adjust the copay. Plans may not be able to determine from the documentation whether the copays should be $1/$3 or $2/$5. However, if the wrong cost sharing is charged, the plan can credit any necessary adjustment against the future copays. Note: The enrollment acknowledgement letter should include the information the pharmacy needs to send a claim to the plan. If the letter does not include this information, the pharmacy can call the plan to get the information needed to send a claim to the plan. The pharmacy can call the dedicated pharmacy enrollment/eligibility helpline or 1-800-MEDICARE to identify the plan into which the person is enrolled and obtain the plan's telephone number. **(final 12/29/05)**
2. LIS NFBDE	A person who has applied for and been approved for LIS but who has not yet enrolled in a plan shows up at a pharmacy thinking they have enrolled in a plan	The pharmacy should tell the person that they need to join a Medicare drug plan to get Medicare drug coverage. The person can call 1-800-MEDICARE to get information and to compare the plans that are available to them. Staff at 1-800-MEDICARE can also help the person join a plan of their choice. Once the plan receives a **complete** application, the person will be enrolled the first day of the following month. **(final 12/29/05)**

Audience	What If…	Answer
3. LIS NFBDE	A person with LIS joins a Medicare drug plan where they will have to pay part of the premium	When a person who is LIS eligible enrolls in a plan with a premium not covered by the full premium subsidy, the plan must send them a notice to let them know that there are plans available to them in which they would not pay a premium. They are also told that they can call 1-800-MEDICARE for a list of the prescription drug plans in their area in which they would pay no premium. The person may choose to stay in the plan and pay part of the premium. If they want to join a plan where they will not have to pay a premium, they can do so by calling the plan directly, or calling 1-800-MEDICARE, or using the On-Line Enrollment Center. Enrollment in a different plan will automatically disenroll them from the current plan. The person will be enrolled in the new plan the first day of the following month. If they need to identify plans in their area where they would not have to pay a premium, they can get a list by calling 1-800-MEDICARE or visiting www.medicare.gov. **(final 12/29/05)**
4. LIS NFBDE	A person is waiting for decision about the LIS to join a plan	The person should be counseled that they do not need to wait for a decision about their LIS application before joining a plan. They should enroll as soon as they make a choice. The person can call 1-800-MEDICARE to find out about low cost plans in their area, including plans in which they will not have to pay a premium if they qualify for LIS. If they later learn that they qualify for the extra help, the extra help will be retroactive to the date the complete application for LIS was filed. Medicare will notify the plan that the person qualifies for the subsidy and they will be charged a lower or no premium and the appropriate copays from that point forward. The plan will reimburse any cost they (or Medicare) should have paid back to the date the LIS coverage began. **(final 12/29/05)**

Audience	What If…	Answer
5. LIS NFBDE	An person that is eligible for a LIS gets a letter from their plan that says they are going to be charged a premium	The volume of data flowing between CMS and the plans at this time is extremely high, and there are some unavoidable lag times. As a result, a plan may not yet have received information from CMS confirming an individual's LIS status and may send that individual a message regarding premiums that is the same as it is sending to its other enrollees. However, once the plan has received complete information on the individual, including their LIS status, they will send out an enrollment package that includes an ID card and correct information appropriate to the individual's LIS status. If the individual goes to a pharmacy to fill a prescription before they receive their ID from the plan, they may ask the pharmacy to contact the plan and find out why the copay is higher than expected. The plan may instruct the pharmacist to collect a lower copay and resubmit the claim once systems have been updated. The individual also may pay for just a portion of the prescription out-of-pocket and then contact the plan or 1-800 Medicare for assistance. Once eligibility is confirmed, the plan will reimburse the individual for the out-of-pocket cost. **(final 12/30/05)**

Employer/Union Coverage

Audience	What If…	Answer
1. Employer/Union	A person never got creditable coverage notification	If the person didn't get a creditable coverage notification, they should contact their employer and ask for it, as they are legally entitled to receive this information. The person may have unknowingly received this notification in a newsletter or as part of some other communication piece. People who were not adequately informed that their current coverage is not creditable, and who requested a copy in writing from their employer/union, won't be faced with a penalty to join a Medicare drug plan after May 15, 2006, and they won't have to wait to join. **(final 12/28/05)**
2. Employer/Union	A person has both VA coverage and a Medicare drug plan	The person can choose on a prescription-by-prescription basis whether to get a prescription written and filled under the VA or Medicare. A prescription cannot be covered by both plans at once. **(final 12/28/05)**
3. Employer/Union	A Veteran joins a Medicare drug plan and also uses VA prescription drug benefits and wonders whether the VA payments will count towards Medicare's TROOP	VA prescription benefits are separate from Medicare drug plan requirements. These payments will not count toward Medicare's TrOOP. **(final 12/28/05)**
4. Employer/Union	A FBDE is enrolled in an employer-sponsored MA plan	People who are full benefit dual-eligible and in an employer-sponsored MA plans will be auto-enrolled following the same rules that apply to all other MA enrollees. Their auto-enrollment notice will highlight that they have employer coverage and let them know that they should contact their benefits administrator for information. **(final 12/28/05)**
5. Employer/Union	A person with existing retiree coverage tries to join a Medicare drug plan, but receives a letter from the plan asking for affirmation of intent.	The person is being asked to confirm that they want to join a Medicare drug plan, because joining may affect their current employment-related coverage both for themselves and any spouse/dependents whom may be covered by the plan. The person should make sure they understand whether joining a Medicare drug plan will affect their current coverage. Some employers may not continue to

Audience	What If…	Answer
		provide coverage for people who join a Medicare drug plan. The decision of the individual may also affect any family members covered by the plan. **(final 1/05/06)**
6. Employer/Union	FBDE wants to opt-out of auto-enrollment in order to keep their existing retiree drug coverage	The person can call 1-800-MEDICARE to permanently opt out of auto-enrollment. They should tell the Customer Service Representative that they decline Medicare drug plan enrollment. **(final 12/28/05)**
7. Employer/Union	FBDE wants to opt-out of auto-enrollment and keep retiree coverage, but enrollment in Part D is a state condition of Medicaid eligiblity (New York, others?)	Some states will recognize retiree coverage as the same as a Medicare drug plan, so the person should check with the state Medicaid office. If they must make a choice, this person should consider whether Medicaid or their retiree coverage is more valuable to them, including any related spouse/dependent coverage. If the person wants to disenroll from the Medicare drug plan, they can call 1-800-MEDICARE to permanently opt out of auto-enrollment. They should tell the Customer Service Representative that they decline Medicare drug plan enrollment. **(final 12/28/05)**
8. Employer/Union	FBDE is unknowingly auto-enrolled and loses all retiree medical coverage for himself and/or his spouse/dependents	The retiree, spouse or caregiver should contact the benefits administrator and confirm that the retiree and/or spouse must be disenrolled, and/or request reenrollment. It is possible that the employer plan will coordinate benefits for husband and wife or allow the spouse to remain covered by the employer plan. If the person must make a choice, they should review the relative value of Medicaid health coverage and Medicare prescription drug coverage compared with the health and prescription drug coverage provided by their retiree plan for themselves an/or any dependents. **(final 1/05/06)**
9. Employer/Union	A person is mistakenly informed he can't qualify for extra help if he already has employer coverage	Everyone who thinks they may qualify for extra help should apply, even if they already have employment-related prescription drug coverage. Even people with existing coverage may find that a Medicare drug plan is a better deal for them if they also qualify for extra help. **(final 12/28/05)**

Audience	What If…	Answer
10. Employer/Union	A person has Medicare prescription drug coverage **and** a retiree Group Health Plan? Who pays first?	The person's Medicare drug plan will pay first when a prescription is filled. The retiree Group Health Plan will pay second. **(final 01/04/05)**
11. Employer/Union	A person has Medicare prescription drug coverage **and** coverage under their spouse's retiree Group Health Plan? Who pays first?	The person's Medicare drug plan will pay first when a prescription is filled. The spouse's retiree Group Health Plan will pay second. **(final 01/04/05)**
12. Employer/Union	A person has Medicare prescription drug coverage **and** a retiree Group Health Plan **and** coverage under their spouse's retiree Group Health Plan? Who pays first?	The person's Medicare drug plan will pay first when a prescription is filled. Then the person's own Group Health Plan will be billed, followed by the spouse's Group Health Plan if there is any remaining balance. **(final 01/04/05)**
13. Employer/Union	A person has Medicare prescription drug coverage **and** a retiree Group Health Plan **and** a State Pharmaceutical Assistance Program (SPAP)? Who pays first?	The person's Medicare drug plan will pay first when a prescription is filled. Then the person's Group Health Plan will be billed, followed by the SPAP if there is any remaining balance. **(final 01/04/05)**
14. Employer/Union	A person has Medicare prescription drug coverage **and** a retiree Group Health Plan **and** Medicaid? Who pays first?	If the Medicare drug plan covers the drug, the person's Medicare drug plan will pay first when a prescription is filled. Then the person's Group Health Plan will be billed. Medicaid will not be billed, because it can't pay for drugs that Medicare covers. If the Medicare drug plan doesn't cover the drug, the person's Group Health Plan will be billed first, followed by Medicaid for any remaining balance. **(final 01/04/05)**

Audience	What If…	Answer
15. Employer/Union	A person who is currently working has Medicare prescription drug coverage **and** a Group Health Plan? Who pays first?	The person's Group Health Plan will generally pay first when a prescription is filled because the person is actively working (this depends on the number of actively working individuals). Generally, the Medicare drug plan will pay second. **(final 01/05/05)**
16. Employer/Union	A person has Medicare prescription drug coverage **and** coverage under the Group Health Plan for their spouse who is currently working? Who pays first?	The spouse's Group Health Plan will generally pay first when a prescription is filled because the spouse is actively working (this depends on the number of actively working individuals). Generally, the Medicare drug plan will pay second. **(final 01/05/05)**

Medicare-approved Discount Drug Card

Audience	What If…	Answer
1. Discount Card	A person has a Medicare-approved drug discount card	The person can continue to use their Medicare-approved drug discount card until they join a Medicare drug plan or until May 15, 2006, whichever comes first. If they qualified for a credit in 2005 to help pay for prescriptions, they can use any credit they have left until they join a Medicare prescription drug plan or until May 15, 2006, whichever comes first. **(final 12/29/05)**

General

Audience	What If…	Answer
1. General	A person tries to disenroll through the Plan Finder web tool	A person cannot disenroll through the web tool. A person can join a different Medicare drug plan through the web tool. The enrollment in a new plan will automatically disenroll them from their current plan. The enrollment/disenrollment is effective the first day of the following month. If a person wishes to disenroll from their current plan and not join another plan, they should contact the plan directly or call 1-800-MEDICARE. For more information, read General #10 on "enrollment rules." **(final 12/29/05)**
2. General	A person enrolled in plan and goes to the pharmacy and the pharmacy has no record of the enrollment because the person enrolled late in the month	If the person has not received his/her enrollment acknowledgement letter or other materials (including an ID card), the pharmacy should check its records and determine which plan the person is enrolled in. If there is no record of enrollment, the pharmacist should call the designated pharmacy enrollment/eligibility helpline or 1-800-MEDICARE to identify the plan in which the person is enrolled and the plan's telephone number. The pharmacy can then call the plan to get the information needed to send a claim to the plan. For more information, see 4-8 below." **(final 12/29/05)**

Audience	What If…	Answer
3. General	The person is enrolled in a plan and the pharmacy cannot confirm enrollment	If the pharmacy cannot confirm enrollment, the person can pay the full cash price for his/her prescription. The person can also ask the pharmacy to give them only part of the prescription until he/she can call their plan. The person will need to contact their plan to find out how to submit a claim for reimbursement for the amount the plan (and Medicare for cost sharing under LIS if applicable) would have paid. Note: This situation may occur when a person completes a plan enrollment application at the very end of the month and the plan does not have sufficient time to update enrollment information or for the person to receive the enrollment acknowledgment letter. The plan prescription drug coverage will be effective the first of the following month the plan receives a **complete** enrollment application (through the last day of the month). **(final 12/29/05)**
4. General	The person is enrolled in a plan and has additional (secondary) coverage. What happens if the pharmacy can't confirm enrollment in a Medicare drug plan?	If the person has additional (secondary) coverage, the pharmacy will submit the claim to the additional (secondary) insurer, who may pay the claim as a primary payer. When the Medicare drug plan enrollment is confirmed, the secondary payer may seek reimbursement from the Medicare drug plan for the amount that the plan would have paid. **(final 12/29/05)**
5. General	The person is enrolled in a plan with a deductible. How will the deductible be accounted for?	If the person is in a plan with a deductible, the pharmacy will charge him/her the plan discounted price for the covered prescriptions and that amount would be applied to the deductible. **(final 12/29/05)**
6. General	The person is enrolled in a plan without a deductible. How will this work?	If the person is in a plan with no deductible, the pharmacy will use the discounted price to charge the person whatever copay or coinsurance applies. **(final 12/29/05)**
7. General	A person filled out a paper application for drug coverage, when will the enrollment be effective?	A **complete** enrollment application must be received by the drug plan by the last day of the month to be effective the first day of the following month. In order to ensure that the enrollment application is received by the plan by the last day of the month, the person should either mail the application sooner than the last day of the month, or contact 1-800-MEDICARE or use the On-Line Enrollment Center to enroll by 11:59 p.m. (PST) on the last day of the month. An application postmarked by that date will probably not be received by the plan and therefore not be effective. **(final 12/29/05)**

Audience	What If…	Answer
8. General	A person enrolled in more than one plan prior to 01/01/06 and they think they are in a different plan than the one that is in the Medicare record.	The pharmacist should instruct the person to contact 1-800-MEDICARE to determine the plan that they have actually enrolled in. If the person wants to be in another plan, the 1-800 staff can help the person join another plan. This enrollment will automatically disenroll the person from their current plan. The enrollment in the new plan will be effective the first day of the following month. If the person needs a prescription, the pharmacist can fill it under the current plan until the new enrollment becomes effective. If a person completes a plan enrollment application at the very end of the month and the plan does not have sufficient time to update enrollment information or for the person to receive the enrollment acknowledgment letter, the pharmacy will bill the plan reflected in its system. Once the last enrollment received by the end of the month is recorded, the plans involved will reconcile the transactions. **(final 12/29/05)**
9. General	A person goes to a pharmacy that is listed in a Medicare drug plan's network, and the pharmacy has not contracted with the Medicare drug plan	The person should call the plan's customer service line to determine if there is a nearby in-network pharmacy to serve them. If they wish to continue filling their prescriptions with this particular pharmacy, they should ask the plan whether they may pay out-of-pocket and submit a paper claim for reimbursement (if applicable). Routine out-of-network claims are not permitted under the Medicare drug benefit. **(final 12/29/05)**

Audience	What If…	Answer
10. General	A person wants to join a new plan, how can they do it?	Before enrollment becomes effective, they can call their drug plan and tell them they want to cancel their enrollment or join another plan before the effective date. After the enrollment is effective, the enrollment rules are as follows: • They have one opportunity to switch Medicare drug plans through May 15, 2006. • If they are eligible for a Medicare Advantage Plan, they have an additional opportunity to join a Medicare Advantage Plan through June 30, 2006. If they are already a member of a Medicare Advantage Plan, they can join another plan or switch to the Original Medicare Plan. • Once they have used these opportunities, they are generally limited to making changes between November 15 and December 31 each year. • In certain special circumstances, such as if they move out of the plan's service area, they may have a special opportunity to make an additional change. **(final 12/29/05)**
11. General	A person already joined a Medicare drug plan, and now wants to change payment options and have their premiums withheld from their SSA check.	The person should call the plan directly to request that their payment option be changed and their premium withheld from their SSA check. **(added 1/09/06)**
12. General	A person has Medicare prescription drug coverage **and** is covered under workers' compensation (WC)? Who pays first?	If the prescription is related to the workers' compensation injury or illness, the person's workers' compensation will pay first when a prescription is filled. The Medicare drug plan will pay second. If the prescription isn't related to the workers' compensation injury or illness, the person's Medicare drug plan will pay when a prescription is filled. **(final 01/04/05)**
13. General	A person has Medicare prescription drug coverage **and** also has no-fault or liability coverage? Who pays first?	If the person was injured or fell ill and has no-fault or liability coverage (such as when you are in a car accident) **and** the prescription is related to that injury or illness, the no-fault or liability coverage will pay first. The Medicare drug plan will pay second. If the prescription isn't related to that injury or illness, the person's Medicare drug plan will pay when a prescription is filled. **(final 01/04/05)**

Audience	What If…	Answer
14. General	A person goes to the pharmacy for the first time and needs to fill a prescription that isn't covered by their Medicare drug plan, or a prescription that requires prior authorization.	If Medicare drug plan coverage was effective on January 1 or February 1, 2006, the person has until March 31, 2006, to work with their doctor to switch to a prescription on the plan's formulary. Until then, the plan will allow the pharmacist to fill the current prescription through March 31, 2006. If a person joins a Medicare drug plan with coverage starting on March 1, 2006, or later, the plan will allow them to fill a one-time, 30-day supply of the prescription. **(added 02/17/06)**

Long Term Care (LTC)

Audience	What If…	Answer
1. LTC	A FBDE enters a LTC facility and does not know what plan they are enrolled in.	The person will receive their Part D covered drugs from the LTC pharmacy according to their plan of care. All Medicare drug plans will pay for these drugs either because they are on the plan's formulary or through the plan's new enrollee transition policy. The LTC pharmacy will check its records and determine which plan the person is enrolled in. If there is no record of plan enrollment, the pharmacist should call the designated pharmacy enrollment/eligibility helpline or 1-800-Medicare to identify the plan in which the person is enrolled and to get the plan's telephone number. The pharmacy can then call the plan and get the information needed to send a claim to the plan. **(final 12/29/05)**

Audience	What If…	Answer
2. LTC	A person (NFBDE) enrolls in a Medicare drug plan very late in the month and enters a LTC facility before receiving confirmation of their enrollment in the Medicare drug plan.	The LTC pharmacy should check its records and determine which plan the person is enrolled in. If the pharmacy is not able to confirm enrollment, the person will be charged for the prescription. The person will need to contact their plan to find out how to submit a claim for reimbursement for the amount the plan (and Medicare for cost sharing under LIS if applicable) who have paid. **(final 12/29/05)**
3. LTC	A person who is not enrolled in a Medicare drug plans enters a LTC setting.	If the person entering a LTC setting is not on a Part A stay and is not enrolled in a Medicare drug plan, they will be treated as a private pay resident. They will be billed for medications. If they chose to join a Medicare drug plan, the enrollment will be effective the first day of the month following the month they enroll. **(final 12/29/05)**
4. LTC	A resident in a LTC setting is in a Medicaid spend down status and is not already enrolled in a Medicare drug plan.	If the person does not qualify for Medicaid, they are treated as a private pay resident on admission, and billed for their medications (which contributes to the "spend down"). Once the person is Medicaid eligible, Medicare will automatically enroll them in a prescription drug plan, with coverage effective the month the person is Medicaid eligible. Their low-income subsidy status will continue through the remainder of the calendar year. **(final 12/29/05)**

SPAP

Audience	What If…	Answer
1. Medicare & SPAP	A person has State Pharmaceutical Assistance Program (SPAP) **and** Medicare prescription drug coverage? Who pays first?	The person's Medicare drug plan will pay first when a prescription is filled. The SPAP will pay second. **(final 01/04/05)**