



Your Guide to Medicare Prescription Drug Coverage

This **official government
booklet tells you:**

- How your coverage works
- How you get Extra Help if you have limited income and resources
- How prescription drug coverage works with other drug coverage you may have



“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.

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The Basics

Medicare prescription drug coverage is insurance.

Medicare prescription drug coverage (Part D) adds to your Medicare health care coverage. It helps you pay for both brand-name and generic drugs. Medicare drug plans are offered by insurance companies and other private companies approved by Medicare.

You can get coverage two ways:

- **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 Medicare Part D (prescription drug coverage) through these plans. Medicare Advantage Plans with prescription drug coverage are sometimes called “MA-PDs.”

In this booklet, the term “Medicare drug plans” means 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 to make a decision about prescription drug coverage. If you don’t use a lot of prescription drugs now, you still may think about joining a Medicare drug plan to help lower your prescription drug costs now and help protect against higher costs in the future. If you’re new to Medicare and already have other prescription drug coverage, you have new options to think about. If you aren’t new to Medicare, you may want to look over your options to find drug coverage that meets your needs. You can join or switch Medicare drug plans between October 15–December 7 each year, with your coverage beginning January 1 of the following year.

Words in red are defined on pages 77–80.

1

The Basics

Medicare prescription drug coverage is insurance (continued).

To join a **Medicare Prescription Drug Plan**, you must have Medicare Part A **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 health plan or drug plan you want to join.

Medicare drug plans may be different from each other in the prescription drugs they cover, how much you have to pay, and which pharmacies you can use. All Medicare drug plans must give at least a standard level of coverage set by Medicare. However, plans offer different combinations of coverage and cost sharing. Having more than one plan to choose from helps you get the coverage you want at a price you can afford.

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're first eligible for Medicare, and you don't have drug coverage that is expected to pay, on average, 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.

The health care law has made Medicare drug coverage more affordable with the gradual closing of the coverage gap (known as the “donut hole”). If you reach the coverage gap, you'll get a 50% discount on covered brand-name drugs and some coverage for generic drugs in the gap. See Section 2 for more information.

Words in red are defined on pages 77–80.

1

The Basics

Pick the prescription drug coverage that meets your needs.

Take time to consider all your prescription drug coverage choices before you make a decision. Look at the prescription drug coverage you may already have, like coverage from an employer or union, TRICARE, the Department of Veterans Affairs (VA), the Indian Health Service, or a Medicare Supplement Insurance (Medigap) policy. Compare your current coverage to Medicare prescription drug coverage. The prescription drug coverage you already have may change because of Medicare prescription drug coverage, so consider all 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 Web sites **aren't** prescription drug coverage and **aren't creditable prescription drug coverage**.

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

1

The Basics

Get help with your choices.

- Visit the Medicare Plan Finder at www.medicare.gov/find-a-plan to find plans in your area that cover your prescriptions and pharmacies that can fill your prescriptions.
- Call your **State Health Insurance Assistance Program (SHIP)** for free personalized health insurance counseling. Go to page 75 to get the phone number for the SHIP in your state.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Words in red are defined on pages 77–80.

How It Works

Here's what you should compare to find a plan that 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 which specific drugs are covered in each drug category.

- **Cost**

Plans have different monthly **premiums**. How much you pay for each prescription depends 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 by mail. If you spend part of the year in another state, see if the plan will cover you there.

- **Quality**

Use the Medicare Plan Finder at www.medicare.gov/find-a-plan to get plan ratings in different categories, like customer service. 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 It Works

How is this coverage different from Part B coverage for certain drugs?

Part B gives limited prescription drug coverage. It doesn't cover most drugs you get at the pharmacy. You will need to join a prescription drug plan to get Medicare coverage for prescription drugs for most chronic conditions, such as high blood pressure.

Part B covers certain drugs, such as injections you get in a doctor's office, certain oral cancer drugs, and drugs used with some types of durable medical equipment—like a nebulizer or external infusion pump. Under very limited circumstances, Part B covers certain drugs you get in a hospital outpatient setting. You pay 20% of the Medicare-approved amount for these covered drugs. It also covers the flu and pneumococcal shots. Generally, Medicare drug plans cover other vaccines (like the shingles vaccine) 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 will likely need to pay out-of-pocket for these drugs and send in a claim to your drug plan for a refund. Call your plan for more information. Also, visit www.medicare.gov/publications to get the fact sheet “How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings.”

What plans are available in my area?

Get information about specific drug plans in your area at www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For more information on how to compare plans and join one that meets your needs, see Section 5.

As you compare plans, remember that companies can mail you information but they're not allowed to call you unless you're already a plan member. Companies aren't allowed to sell plans door-to-door unless you ask them to come to your home to help you. Also, remember to keep your personal information safe. See pages 63–64.

2

How It Works

How much will my drug coverage cost?

Medicare drug plans differ in exact coverage and costs, but all must offer at least a standard level of coverage set by Medicare. How much you actually pay for Medicare prescription drug coverage depends 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're interested in to get specific cost information.

Your drug coverage costs are affected by:

- Monthly **premium**
- Yearly **deductible**
- **Copayments** or **coinsurance**
- **Coverage gap** (also called the “donut hole”)
- Catastrophic coverage

Monthly **premium**

Most drug plans charge a monthly fee that differs from plan to plan. You pay this fee 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 may include an amount for prescription drug coverage.

Note: A small group—affecting fewer than 5% of all people with Medicare—may pay a higher monthly premium based on their income.

If you reported a modified adjusted gross income of more than \$85,000 (individuals and married individuals filing separately) or \$170,000 (married individuals filing jointly) on your IRS tax return 2 years ago (the most recent tax return information provided to Social Security by the IRS), you will have to pay an extra amount for your Medicare prescription drug coverage, called the income-related monthly adjustment amount. You pay this extra amount in addition to your monthly Part D plan premium.

Social Security will send you a letter if you have to pay for the income-related monthly adjustment amount. Check the charts on the next page for the amount you will have to pay each month.

Words in red are defined on pages 77–80.

2

How It Works

If Your Yearly Income in 2010 was		You Pay
File Individual Tax Return	File Joint Tax Return	
\$85,000 or less	\$170,000 or less	Your Plan Premium
above \$85,000 up to \$107,000	above \$170,000 up to \$214,000	\$11.60 + Your Plan Premium
above \$107,000 up to \$160,000	above \$214,001 up to \$320,000	\$29.90 + Your Plan Premium
above \$160,001 up to \$214,000	above \$320,001 up to \$428,000	\$48.10 + Your Plan Premium
above \$214,000	above \$428,000	\$66.40 + Your Plan Premium

If Your Yearly Income in 2010 was	You Pay
File Married & Separate Tax Return	
above \$85,000 up to \$129,000	\$48.10 + Your Plan Premium
above \$129,000	\$66.40 + Your Plan Premium

Your adjustment amount will get taken out of your monthly Social Security, Railroad Retirement, or Office of Personnel Management check, no matter how you usually pay your plan premium. If that amount is more than what's in your check, you will get a bill from Medicare each month.

If you don't pay your entire Part D premium (including the extra amount), you may be disenrolled from your Part D plan. You must pay both the extra amount and your plan's premium each month to keep Medicare prescription drug coverage.

If you have to pay a higher amount for your Part D premium and you disagree, visit www.socialsecurity.gov or call 1-800-772-1213. TTY users should call 1-800-325-0778.

2

How It Works

Yearly deductible

The deductible is what you pay for your prescriptions before your plan begins to pay. No Medicare drug plan may have a deductible more than \$320 in 2012. 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.

Coverage gap (also called the “donut hole”)

Most Medicare drug plans have a coverage gap—after you and your plan have spent a certain amount of money for covered drugs, you pay all costs for your drugs out-of-pocket (up to a limit). **Not everyone will reach the coverage gap.** 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 or what you pay for drugs that aren't on your plan's **drug list**.

Some plans 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.

For 2012, if you reach the coverage gap in your Medicare prescription drug coverage, you will get a 50% discount on covered brand-name drugs when you buy them, until you reach the out-of-pocket limit. You will also get some coverage for covered generic drugs while in coverage gap, and this coverage will grow each year. In 2012, you will get a 14% discount on generic drugs you buy while in the coverage gap. In 2013, you will get a 21% discount. By 2020, you will get a 75% discount both for covered generic and brand-name drugs when in the gap.

Each month that you fill a prescription, your drug plan mails you an Explanation of Benefits (EOB) notice, which tells you how much you have spent on covered drugs and if you've reached the coverage gap. In 2012, your EOB notice will also show the 50% discount on brand-name drugs you buy in the coverage gap.

Words in red are defined on pages 77–80.

2

How It Works

Catastrophic coverage

What you pay for drugs and the 50% discount in the **coverage gap** both count toward your out-of-pocket limit. Once you reach your plan’s out-of-pocket limit, you come out of the coverage gap and you automatically get “catastrophic coverage.” Under catastrophic coverage, you only pay a small **coinsurance** amount or a **copayment** for the rest of the year.

Words in red are defined on pages 77–80.

Note: If you get **Extra Help** paying your drug costs, you won’t have a coverage gap and you will pay either a small copayment or no copayment once you reach catastrophic coverage.

The example below shows the costs for covered drugs in 2012 for a plan that has a coverage gap.

Ms. Smith joined the ABC Prescription Drug Plan. Her coverage began on January 1, 2012. She doesn’t get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions.

Monthly Premium—Ms. Smith pays a monthly premium throughout the year.			
1. Yearly Deductible	2. Copayment or Coinsurance	3. Coverage Gap	4. Catastrophic Coverage
Ms. Smith pays the first \$320 of her drug costs before her plan starts to pay its share.	Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their combined amount (plus the deductible) reaches \$2,930.	Once Ms. Smith and her plan have spent \$2,930 for covered drugs, she is in the coverage gap. In 2012, she gets a 50% discount on covered brand-name prescription drugs that counts as out-of-pocket spending, and helps her get out of the coverage gap. For 2012, she also gets 14% coverage on covered generic drugs while in the coverage gap.	Once Ms. Smith has spent \$4,700 out-of-pocket for the year, her coverage gap ends. Now she only pays a small copayment for each drug until the end of the year.
→	→	→	→

Visit the Medicare Plan Finder at www.medicare.gov/find-a-plan to view estimated yearly costs for each plan and your costs per prescription for each month.

2

How It Works

How can I pay my plan premium?

1. Deduct it from your checking or savings account.
2. Charge it to a credit or debit card.
3. Have your plan bill you each month directly. Some plans bill in advance for next month's coverage. Send your payment to the plan—not to Medicare. Contact your plan for their payment address.
4. Withheld funds from your Social Security payment. Contact your plan—not Social Security—to ask for this payment option. It may take up to 3 months to start, and it's likely the first 3 months of premiums will be collected at one time.

Example of Social Security Withholding: Ms. Brown's monthly drug plan premium is \$25, and her coverage begins in January. Her first premium payment of \$75 is collected in March. It includes her premium for January, February, and March. After March, only 1 month of premium payments (\$25) will be withheld from her Social Security payment each month.

If you have your premium withheld from your Social Security payment, and you have another insurer or benefit pay 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. **You may experience delays in getting your refund.**

Example: Mr. Anderson's monthly drug plan premium is \$30. His employer pays \$15 toward his premium.

- If Mr. Anderson gets his premium withheld from his Social Security payment, the full \$30 will be withheld. The drug plan will have to give him a refund of \$15 for the share of the premium paid by his employer.
- If the drug plan bills Mr. Anderson directly, he will pay his share (\$15) to his plan. His employer will pay its share (\$15) directly to his plan.

If you qualify for [Extra Help](#), some or all of your drug plan **premiums** may be covered. For more information, see Section 3.

2

How It Works

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

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

- **When you first become eligible for Medicare.** You can join during the 7-month period that begins the 3 months before you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 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. You will have another chance to join during the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.
- **Between October 15–December 7 each year.** Your coverage begins January 1 the following year, as long as the plan gets your request for enrollment by December 7.
- **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.

Note: In certain limited circumstances, you may be able to join, drop, or switch to another Medicare drug plan at other times. 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 may want to review your coverage each fall season. If you’re 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 to continue your coverage for another year. However, if you decide another plan will better meet your needs, you can switch to a different plan.

2

How It Works

How do I switch my plan?

You don't need to tell your current drug plan you are leaving or send them anything, because joining a different Medicare drug plan, at the times listed on the previous page, disenrolls you from your current drug plan. Your new Medicare drug plan should send you a letter telling you when your coverage begins.

How do I join a plan?

Contact the company that offers the plan. You may be able to join by calling, mailing, or faxing a completed enrollment form to the plan, or enrolling on the plan's Web site.

You can also enroll directly at www.medicare.gov/find-a-plan/questions/enroll-now.aspx, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Visit www.medicare.gov, or call 1-800-MEDICARE to get a list of Medicare plans in your area.

To join a Medicare drug plan, you will need to give your Medicare number and the date your Part A and/or Part B coverage started, which you'll find on your Medicare card. **Note: Medicare drug plans aren't allowed to call you to enroll you in a plan. Call 1-800-MEDICARE to report a plan that does this.**

What is the Part D late enrollment penalty?

The late enrollment **penalty** is an amount that is added to your Part D if, at any time after your initial enrollment period is over, there is a period of 63 or more days in a row when you don't have Part D or other **creditable prescription drug coverage**.

Note: If you get **Extra Help**, you don't pay a late enrollment penalty.

Words in red are defined on pages 77–80.

2

How It Works

How do I avoid paying a penalty?

- **Join a Medicare drug plan when you're first eligible**, or get other **creditable prescription drug coverage** at that time.
- **Don't go 63 days or more in a row without a Medicare drug plan or other creditable prescription drug coverage.** Creditable prescription drug coverage could include drug coverage from a former employer or union, TRICARE, the Department of Veteran Affairs (VA), or the Indian Health Service. Your plan must tell you each year if your drug coverage is creditable coverage. They may send you this information in a letter or include it in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
- **Tell your Medicare drug plan when you join if you have other creditable prescription drug coverage.** When you join a Medicare drug plan, the plan may send you a letter asking if you have creditable prescription drug coverage if the plan believes you went 63 days in a row without other creditable prescription drug coverage. Complete the form and return it to them by the deadline in the letter. If you don't tell your plan about your creditable prescription drug coverage, you may have to pay a **penalty**.

Words in red are defined on pages 77–80.



2

How It Works

How much is the late enrollment penalty?

Currently, the late enrollment **penalty** is calculated by multiplying the 1% penalty rate times the “national base beneficiary premium” (\$31.08 in 2012) times the number of full, uncovered months you were eligible to join a Medicare drug plan but didn’t and went without other **creditable prescription drug coverage**.

The final amount is rounded to the nearest \$.10 and added to your monthly premium. The “national base beneficiary premium” may go up each year, so the penalty amount may also go up every year. In addition to your premium each month, you may have to pay this penalty for as long as you have a Medicare drug plan.

Example: Mrs. Jones didn’t join when she was first eligible—by June 15, 2009. She joined a Medicare drug plan between October 15–December 7, 2011, for an effective date of January 1, 2012. Since Mrs. Jones didn’t join when she was first eligible and went without other creditable prescription drug coverage for 30 months (July 2009–December 2011), she will be charged a monthly penalty of \$9.30 in 2012 ($\$31.08 \text{ national base beneficiary premium} \times .01 \text{ penalty rate} \times 30 \text{ months} = \9.32 , rounded to nearest \$.10 = \$9.30). She pays this late enrollment penalty monthly in addition to her plan’s monthly premium.

When you join a Medicare drug plan, the plan will tell you if you owe a penalty and what your premium will be.

2

How It Works

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

- Name, birth date, and 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

You may be asked for the following information when you join a Medicare drug plan, but it's optional and not 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 (if applicable)

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. You will still use your red, white, and blue Medicare card for hospital and doctor services. If you join a **Medicare Advantage Plan** (like an HMO or PPO) or other **Medicare health plan** with prescription drug coverage, you will also get a new card to use when filling your prescriptions.

Words in red are defined on pages 77–80.



2

How It Works

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

Within 2 weeks after your plan gets your completed application, you will get a letter letting you know they got your information. Within 5 weeks, 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:

- The acknowledgement, confirmation, or welcome letter you got from the plan.
- An enrollment confirmation number you got from the plan, and the plan name and phone number.
- A temporary card you may be able to print from www.MyMedicare.gov.

Also bring your Medicare and/or **Medicaid** card and a photo ID. If you qualify for **Extra Help**, see page 37 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 costs.**

Once you choose a plan, 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 fill your prescriptions without delay.

2

How It Works

Where can I fill my prescriptions?

Each company that offers a Medicare drug plan has 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 visit www.medicare.gov, or call the plan, your pharmacy, or 1-800-MEDICARE (1-800-633-4227), 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 these pharmacies for your plan to cover your prescriptions. Medicare requires plans to have network pharmacies for you to choose from. Plans can't make you use a mail-order pharmacy, but you may have this option and want to use it. You may save money by using a mail-order pharmacy.

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

If you have End-Stage Renal Disease (ESRD) and you're in **Original Medicare**, you can join a **Medicare Prescription Drug Plan**. You generally can't join a **Medicare Advantage Plan** (like an HMO or PPO) except:

- If you're already in a Medicare Advantage Plan when you develop ESRD, you can stay in it or join another plan that includes Medicare drug coverage offered by the same company under certain circumstances.
- If you're 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 one of their Medicare Advantage Plans.
- If you've had a successful kidney transplant, you may be able to join a Medicare Advantage Plan.

Words in red are defined on pages 77–80.

2

How It Works

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, but you don't have to use this right immediately. If you go directly to **Original Medicare** after your plan leaves or stops providing coverage, you may use this right later as long as the plan accepts new members.

Also, you may be able to join a Medicare Special Needs Plan, a type of Medicare Advantage Plan for people with certain chronic diseases and conditions or who have specialized needs, if one is available in your area.

If you have ESRD and join a **Medicare Prescription Drug Plan**, Medicare Part B will pay for some of the drugs you need, such as injectable drugs and their oral forms, and biologicals, including erythropoiesis stimulating agents used for dialysis. Medicare Part D will continue to cover drugs available only in oral form.

Visit www.medicare.gov/publications to get the booklet "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services." You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



2

How It Works

What drugs are covered by Medicare drug plans?

Each plan may cover different drugs, so there's no single **drug list** that fits all plans. All Medicare drug plans must make sure the people in their plan can get **medically-necessary** drugs to treat their conditions. Drug lists (formularies), prior authorization, step therapy, and quantity limits are some of the rules plans use to make sure certain drugs are used correctly and only when medically necessary. These topics are described in the following four sections.

Drug Lists (Formularies)

Each Medicare drug plan has its own list of covered prescription, called a formulary. Plans cover both generic and brand-name prescription drugs. Medicare drug plans aren't required to cover certain drugs, such as benzodiazepines, barbiturates, drugs for weight loss or gain, and drugs for erectile dysfunction. Some plans may cover these drugs as an added benefit. Also, drug plans generally don't pay for over-the-counter drugs. Some states may cover these drugs if you have **Medicaid**.

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

If you use a drug not on your plan's drug list, you'll have to pay full price instead of a **copayment** or **coinsurance**. All Medicare drug plans have negotiated to get lower prices for the drugs on their drug lists, so using those drugs will generally save you money. Also, using generics instead of brand-name drugs may save you money.

Words in **red** are defined on pages 77–80.

2

How It Works

Generic Drugs

The Food and Drug Administration (FDA) says 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. Generic drug makers must prove to the FDA that their product performs the same way as the corresponding brand-name drug. In some cases there may not be a generic drug the same as the brand-name drug you take, but there may be a generic drug that will work as well for you. Talk to your doctor or other prescriber (a health care provider who is legally allowed to write prescriptions).

Tiers

To lower costs, many plans place drugs into different “tiers” on their **drug lists**. Each tier costs a different amount. A drug in a lower tier will cost you less than a drug in a higher tier. Each plan can divide its tiers in different ways.

Example:

- Tier 1–Generic drugs. Tier 1 drugs cost the least.
- Tier 2–Preferred brand-name drugs. Tier 2 drugs cost more than Tier 1 drugs.
- Tier 3–Non-preferred brand-name drugs. Tier 3 drugs 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, you can get a similar drug that is just as effective.

Your plan may change its drug list during the year because drug therapies change, new drugs are released, and new medical information becomes available. If a change 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 keep taking the drug until the end of the year. You can also ask for an **exception**. See page 66.

Note: A plan isn't required to tell you in advance if it removes a drug from its drug list because the FDA is taking the drug off the market for safety reasons, but it will let you know afterward.

2

How It Works

Prior Authorization

You may need drugs that require prior authorization. This means before the plan will cover a particular drug, your doctor or other prescriber must first show the plan you have a **medically-necessary** need for that particular drug. Plans also do this to be sure these drugs are used correctly. Contact your plan about its prior authorization requirements, and talk with your prescriber.

Step Therapy

Step therapy is a type of prior authorization. In most cases, you must first try a certain less-expensive drug on the plan's **drug list** that's 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 first 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 drug and it didn't work, or if your prescriber believes that because of your medical condition it's 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 prescriber's request is approved, the plan will cover the more expensive drug.

Example:

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, Dr. Smith 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.

Words in **red** are defined on pages 77–80.

2

How It Works

Quantity Limits

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

If your prescriber believes that, because of your medical condition, a quantity limit isn't medically appropriate, you or your prescriber can contact the plan to ask for an **exception**. If the plan approves your request, 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 give you a one-time, temporary supply of your current drug during your first 90 days in a plan. Plans must give you this temporary supply so that you and your prescriber have time to find another drug on the plan's **drug list** that will work as well as what you're taking now. There may be different rules for people who move into or already live in an **institution** (such as a nursing home or long-term care hospital).

However, if you already tried similar drugs on your plan's drug list and they didn't work, or if your prescriber decides you need a certain drug because of your medical condition, you or your prescriber can contact your plan to ask for an exception as soon as you get your temporary supply. You also can ask for an exception if your prescriber thinks you need to have a coverage rule waived, such as a quantity limit. If the plan agrees to your request, it will cover the drug. If your plan doesn't agree to the exception, you can appeal the plan's decision. For more information on appeals, see pages 67–70.

2

How It Works

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

Your doctor or other prescriber may need to change your prescription or prescribe a new drug. If your doctor prescribes electronically, he or she can check which drugs your drug plan covers through his or her electronic prescribing system. If your doctor doesn't prescribe electronically, give him or her a copy of your Medicare drug plan's current **drug list**.

Words in **red** are defined on pages 77–80.

If your doctor needs to prescribe a drug not 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. Keep the receipt and give a copy of it to the person deciding your appeal. 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 page 66.

Plans can change their drug list and prices for drugs. Call your plan or look on your plan's Web site to find the most up-to-date Medicare drug list and prices.

How to Get Extra Help

Ways you may qualify for Extra Help.

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

Medicare mails purple letters to people who automatically qualify for **Extra Help**. If you get one, keep it as proof that you qualify. You don't need to apply for Extra Help if you get this purple letter.

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

If you aren't already in a Medicare drug plan, you must join one to get this Extra Help. 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, then Medicare will send you a yellow letter (if you get full Medicaid coverage or SSI) or a green letter (if you belong to a Medicare Savings Program) 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 Medicare enrolls you in a plan that 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 the plan listed in the letter.

Tell them you don't want to be in a Medicare drug plan and want to opt out of enrollment. Or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

3

How to Get Extra Help

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 \$4,700**)	Your cost per prescription at the pharmacy (after \$4,700**)
Full Medicaid coverage 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 \$11,170 (single) \$15,130 (married)	\$0	\$0	Generic and certain preferred drugs: no more than \$1.10 Brand-name drugs: no more than \$3.30	\$0
Full Medicaid coverage and have a yearly income above \$11,170 (single) \$15,130 (married)	\$0	\$0	Generic and certain preferred drugs: no more than \$2.60 Brand-name drugs: no more than \$6.50	\$0
Help from Medicaid paying your Medicare Part B premiums	\$0	\$0	Generic and certain preferred drugs: no more than \$2.60 Brand-name drugs: no more than \$6.50	\$0
Supplemental Security Income (SSI)	\$0	\$0	Generic and certain preferred drugs: no more than \$2.60 Brand-name drugs: no more than \$6.50	\$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 \$4,700 per year.

The cost sharing, income levels, and resources listed are for 2012 and can increase each year. Income levels are higher 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.

3

How to Get Extra Help

Words in red are defined on pages 77–80.

2. You apply and qualify.

If you think you qualify for **Extra Help**: call Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778), or visit www.socialsecurity.gov to apply online. You can also apply at your State Medical Assistance (**Medicaid**) office. Call 1-800-MEDICARE (1-800-633-4227), and say “Medicaid” to get the phone number, or visit www.medicare.gov/contacts. TTY users should call 1-877-486-2048. 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. For more information on what income and resources count when you apply, see pages 33–34.

If you apply and qualify for Extra Help, 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 Medicare enrolls you in a plan that 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 the plan listed in the green letter. Tell them you don’t want to be in a Medicare drug plan and want to opt out of enrollment. Or call 1-800-MEDICARE.

3

How to Get Extra Help

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 \$4,700**)	Your cost per prescription at the pharmacy (after \$4,700**)
A yearly income below \$15,079.50 (single) \$20,425.50 (married) with resources of no more than \$8,440 (single) \$13,410 (married)	\$0	\$0	Generic and certain preferred drugs: no more than \$2.60 Brand-name drugs: no more than \$6.50	\$0
A yearly income below \$15,079.50 (single) \$20,425.50 (married) with resources between \$8,440 and \$13,070 (single) \$13,410 and \$26,120 (married)	\$0	\$65	up to 15% of the cost of each prescription	Generic and certain preferred drugs: no more than \$2.60 Brand-name drugs: no more than \$6.50
A yearly income between \$15,079.50 and \$15,638 (single) \$20,425.50 and \$21,182 (married) with resources up to \$13,070 (single) \$26,120 (married)	25%	\$65	up to 15% of the cost of each prescription	Generic and certain preferred drugs: no more than \$2.60 Brand-name drugs: no more than \$6.50
A yearly income between \$15,638 and \$16,196.50 (single) \$21,182 and \$21,938.50 (married) with resources up to \$13,070 (single) \$26,120 (married)	50%	\$65	up to 15% of the cost of each prescription	Generic and certain preferred drugs: no more than \$2.60 Brand-name drugs: no more than \$6.50
A yearly income between \$16,196.50 and \$16,755 (single) \$21,938.50 and \$22,695 (married) with resources up to \$13,070 (single) \$26,120 (married)	75%	\$65	up to 15% of the cost of each prescription	Generic and certain preferred drugs: no more than \$2.60 Brand-name drugs: no more than \$6.50

3

How to Get Extra Help

Applying for Extra Help.

Whose income and resources count?

- **Your** own income and resources count.
- If you're married and live with your spouse, **both** of your incomes and resources count, even if only one of you applies for **Extra Help**.
- If you're 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 (SSA-1020), available at www.socialsecurity.gov/i1020.

What income counts?

“Income” means any cash, goods, or services you can use to meet your needs for food or shelter. Examples include (but aren't limited to):

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 (such as housing assistance and disaster assistance)
- Foster care payments
- The value of expenses which a blind or disabled person needs to work
- In-kind support from family or friends, such as free rent, food or clothing
- Scholarship and education grants

Words in red are defined on pages 77–80.

3

How to Get Extra Help

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 you normally can convert to cash within 20 workdays. Examples include (but aren't limited to):

Resources counted

- Cash at home
- 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
- Real estate other than your primary residence

Resources *not* counted

- Your primary residence (the home you live in) and the land it's on
- Your personal possessions
- Your vehicle(s)
- Things you could not easily convert to cash, such as jewelry or home furnishings
- Burial expenses, burial plots, and interest earned on money you plan to use for burial expenses
- Life insurance policies
- Property of a trade or business you need for self-support
- Non-business property you need for self-support
- Certain other money you are holding is not counted for nine months, such as housing assistance
- Funds you get and save to pay for medical and/or social services

3

How to Get Extra Help

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** (in a Medicare Savings Program), or get Supplemental Security Income (SSI).

If you won't automatically qualify the next year, you'll 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'll get a notice (on orange paper) in the mail with the new copayment amounts. If you don't get a notice, you'll 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.**

Words in **red** are defined on pages 77–80.



3

How to Get Extra Help

If you apply and qualify for Extra Help

If you qualify for **Extra Help**, you'll get the Extra Help for the calendar year as long as you're enrolled in a Medicare drug plan **and** there are no changes to your income, resources, or family size.

You'll also get the Extra Help for the calendar year as long as you don't have a change in your marital status, such as:

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

If you applied to Social Security for Extra Help and you qualified, notify them if your marital status changes, because it could raise, lower, or stop the amount of Extra Help you get. The change in Extra Help you get starts the month after you report the change in your marital status.

You can report changes in your income, resources, or family size any time, and Social Security will review these changes from August to December. Any changes affecting your Extra Help start January 1 of the following year.

If you applied for Extra Help through your state, and you qualify, your state's rules may require you to tell them about changes in your circumstances.

3

How to Get Extra Help

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 that you can show to your plan as proof you qualify for **Extra Help**. If you applied for Extra Help, you can show your plan your “Notice of Award” letter from Social Security as proof 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. Each item must show you were eligible for **Medicaid** during a month after June 2010.

Words in red are defined on pages 77–80.

Proof you have Medicaid and live in an institution or get home and community-based services	Other proof you have Medicaid
<ul style="list-style-type: none">▪ A bill from an institution (like a nursing home) or a copy of a state document showing Medicaid paid for your stay for at least a month▪ A print-out from your state’s Medicaid system showing you lived in the institution for at least a month▪ A document from your state that shows you have Medicaid and are getting home and community-based services	<ul style="list-style-type: none">▪ A copy of your Medicaid card (if you have one)▪ 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

Your plan must accept any of these documents as proof you qualify for Extra Help. As soon as you have given them any one of these documents, your plan must make sure you pay no more than the right amount to fill your prescriptions.

3

How to Get Extra Help

Words in red are defined on pages 77–80.

If you qualify for **Extra Help** because you have **Medicaid**, but you don't have or can't find any of these documents, ask your plan for help. Your plan must also contact Medicare so Medicare can get proof that you qualify, if it's available. You should expect your request to take anywhere from several days to up to 2 weeks, depending on the circumstances. Be sure to tell your plan how many days of medication you have left. 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 part of what you paid. Keep your receipts, and call Medicare's Limited Income Newly Eligible Transition (NET) Program at 1-800-783-1307 for more information. TTY users should call 1-877-801-0369.

If your plan doesn't correct a problem to help you pay the right amount for your prescriptions, or 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 phone 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. Someone who wasn't involved in the first decision will decide your case.

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 form SSA-1021 ("Appeal of Determination for Help with Medicare Prescription Drug Costs") by visiting www.socialsecurity.gov/i1020.

3

How to Get Extra Help

If you want to file an appeal, keep in mind:

- 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 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 your state's appeals process. You can get the phone number for your State Medical Assistance office by visiting www.medicare.gov/contacts.**

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.

Even 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 to help you pay your prescription drug costs. Contact your State Medical Assistance (**Medicaid**) office or **State Health Insurance Assistance Program (SHIP)** for more information. See page 75 for the SHIP in your state. You can also visit www.medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227) for these phone numbers. TTY users should call 1-877-486-2048.

3

How to Get Extra Help

There are other ways you may also be able to save. Consider switching to drugs that cost less. Ask your doctor if there are generic, over-the-counter, or less-expensive brand-name drugs that could work just as well as the ones you're taking now. Switching to lower-cost drugs can save you hundreds or possibly thousands of dollars a year. Visit the Medicare Plan Finder at www.medicare.gov/find-a-plan to get information on ways to save money in your [Medicare Prescription Drug Plan](#).

You can also help lower your Medicare prescription drug costs by:

- 1. Exploring National and Community-Based Programs** (such as the National Patient Advocate Foundation or the National Organization for Rare Disorders) that may have programs that can help with your drug costs. Get information on Federal, state, and private assistance programs in your area on the BenefitsCheckUp (www.benefitscheckup.org) Web site.
- 2. Looking at State Pharmaceutical Assistance Programs (SPAP)** for which you may qualify. SPAPs in 23 states and 1 territory offer some type of coverage to help people with Medicare with paying drug plan premiums and/or cost sharing. Find out if your state has a SPAP at www.medicare.gov/pharmaceutical-assistance-program/state-programs.aspx. Go to page 56 to find more information about SPAPs.
- 3. Looking into Manufacturer's Pharmaceutical Assistance Programs** (sometimes called Patient Assistance Programs) offered by the manufacturers of the drugs you take. Many of the major drug manufacturers offer assistance programs for people enrolled in a Medicare drug plan. Find out whether the manufacturers of the drugs you take offer a Pharmaceutical Assistance Program by visiting www.medicare.gov/pap/index.asp.

Keep in mind these programs operate outside the Medicare Part D benefit, so their assistance won't move people with Medicare through the [coverage gap](#).

Your Coverage Choices

Use the list on page 43 to get information that fits your current health insurance coverage situation. 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 77–80.

If you need help with your Medicare prescription drug coverage decisions, call your **State Health Insurance Assistance Program (SHIP)**. Get their phone number on page 75. You can also visit www.medicare.gov/contacts, 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 Section 3.

4

Your Coverage Choices

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

Before you make a decision, get answers to the following questions:

- If you have drug coverage now, is it **creditable prescription drug coverage**—that is, 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 want it to?
- Does a Medicare drug plan in your area cover the drugs you take? Find out by visiting www.medicare.gov; under “Health & Drug Plans,” select “Formulary Finder—2012 Plan Data.”
- 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 a plan you wish to join requires you to use certain pharmacies.
- What are a particular Medicare drug plan’s quality ratings? Compare **Medicare Prescription Drug Plans** at www.medicare.gov/find-a-plan.

Words in red are defined on pages 77–80.

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Your Coverage Choices

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

Type of Current Health Insurance Coverage Page(s)

Original Medicare

- I have only Part A and/or Part B and no drug coverage. 44
- I have a Medigap (Medicare Supplement Insurance) policy without prescription drug coverage. 44
- I have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage. 45–46

Employer Coverage and Union Coverage, including Military

- I get drug coverage through a current or former employer or union. 46–47
- I have a Federal Employee Health Benefits plan. 48
- I have TRICARE or benefits from the Department of Veterans Affairs (VA) that include drug coverage. 49

Medicare Health Plans

- I have a Medicare health plan **without** prescription drug coverage. . 50–51
- I have a Medicare health plan **with** prescription drug coverage. 51

Medicaid and other State or Federal Programs

- I have Medicaid. 52
- I get Supplemental Security Income (SSI) benefits or help from Medicaid paying Medicare Part B premiums (a Medicare Savings Program). . 53
- I live in a nursing home or other institution. 54
- I get benefits through Programs of All-inclusive Care for the Elderly (PACE). 55
- I get help from my State Pharmacy Assistance Program (SPAP). 56
- I get help from an AIDS Drug Assistance Program (ADAP). 57
- I get prescription drug coverage from the Indian Health Service, Tribe or Tribal Health Organization, or Urban Indian Health Program. . 58

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Your Coverage Choices

Words in red are defined on pages 77–80.

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

If you have Part A and/or Part B (check your red, white, and blue Medicare card) and live in a plan’s service area, you can join that **Medicare Prescription Drug Plan**. Look in your “Medicare & You” handbook, visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) for a list of 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.

You can join a Medicare drug plan by doing one of the following:

1. Keeping your current **Medigap policy** and enrolling in a Medicare Prescription Drug Plan
2. Joining a **Medicare Advantage Plan** (like an HMO or PPO) in your area that includes prescription drug coverage. You would get all your health care benefits and prescription drug coverage from the plan.

If you join a Medicare Advantage Plan, you don’t need a Medigap policy. If you already have a Medigap policy, you can’t use it to pay for out-of-pocket costs 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 if you leave the Medicare Advantage Plan and then go back to **Original Medicare, or you may end up paying higher premiums for the Medigap policy.**

You have a legal right to keep your Medigap policy, but rights to buy a Medigap policy may vary by state. For more information about your Medigap policy, contact your Medigap insurer.

If you’re 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.

4

Your 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 their drug coverage is **creditable prescription drug coverage**. Some of your choices for prescription drug coverage include:

- Joining a **Medicare Prescription Drug Plan** and keeping your current Medigap policy without the prescription drug coverage.
- Joining a **Medicare Advantage Plan** that includes prescription drug coverage. You would get all your health care coverage including prescription drug coverage from this plan, and you wouldn't need a Medigap policy. If you join a **Medicare Medical Savings Account (MSA) Plan** (a type of Medicare Advantage Plan) you can continue to use your Medigap drug coverage, since MSAs can't offer Medicare prescription drug coverage.
- Keeping 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.

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 may have to pay this higher premium for as long as you're in a Medicare Prescription Drug Plan.

4

Your Coverage Choices

For more information about **Medigap policies**, get “Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare” at www.medicare.gov/publications, or call 1-800-MEDICARE (1-800-633-4227) to see if a copy can be mailed to you. TTY users should call 1-877-486-2048. You can also call your **State Health Insurance Assistance Program (SHIP)** for more information about Medigap. See page 75 for their phone number.

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

Medicare helps employers and unions offer high-quality prescription drug coverage. Before making a decision about whether to join a Medicare drug plan, find out how your employer or union drug coverage works with Medicare, because your coverage may change if you join a Medicare drug plan. You may want to get information from your employer or union (or the plan that administers your drug coverage) each year as to whether it’s **creditable prescription drug coverage**, and how it compares to Medicare prescription drug coverage. Read carefully and save all materials from your employer or union to know your options.

Some important questions to answer before making a decision:

- Is your employer or union prescription 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’re first eligible.
- If you join a Medicare drug plan, will you or your spouse or dependents lose all of your employer or union health coverage?
- How do out-of-pocket drug costs with your employer or union drug coverage compare to out-of-pocket drug costs with a Medicare drug plan?
- How will your costs change if you get **Extra Help** with your Medicare drug plan costs?

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

4

Your Coverage Choices

Words in red are defined on pages 77–80.

If your (or your spouse’s) employer or union tells you your current coverage IS **creditable prescription drug coverage:**

- You can keep this coverage as long as your employer or union still offers it.
- 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: Keep materials your employer or union sends you that tell you your prescription drug coverage is creditable. You may need to show it to your Medicare drug plan as proof of creditable prescription drug coverage if you decide to join a Medicare drug plan later.

If your (or your spouse’s) employer or union tells you your current coverage ISN’T **creditable prescription drug coverage:**

- If you want to join a Medicare drug plan, in most cases to avoid a late enrollment penalty, you must join when you’re first eligible.

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 get 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 prescription drug 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.

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.

4

Your Coverage Choices

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

- During the open enrollment season you will get information 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. It isn't cost effective for most people covered under a FEHB plan to join a Medicare drug plan unless they qualify for **Extra Help**. **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 do qualify for Extra Help paying Medicare prescription drug costs, see how your costs with a Medicare drug plan and any Extra Help would compare to 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**, if you join within 63 days of losing FEHB coverage.
- If you join a Medicare drug plan, you can keep your FEHB plan.



For more information, call the Office of Personnel Management at 1-888-767-6738, or visit www.opm.gov/insure/health/. TTY users should call 1-800-878-5707. You can also call your plan.

4

Your Coverage Choices

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

Words in red are defined on pages 77–80.

- As long as you still qualify, you can keep your TRICARE or VA prescription drug coverage. TRICARE or your VA provider should send you information each year about your coverage and whether it's **creditable prescription drug coverage**. Read this information carefully and save these materials.
- Before making any changes, contact your benefits administrator for information about your TRICARE or VA coverage. It's almost always to your advantage to keep your current coverage without any changes. For most people with TRICARE or VA coverage, 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, compare costs with a Medicare drug plan and any Extra Help to costs with 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**, if you join within 63 days of losing TRICARE or VA coverage.
- If you join a Medicare drug plan and have VA coverage, you can't use both types of coverage for the same prescription.
- If you have TRICARE and join a **Medicare Prescription Drug Plan**, your Medicare Prescription Drug Plan pays first, and TRICARE pays second.
- If you join a **Medicare Advantage Plan** with prescription drug coverage, you must get prescription drugs through the Medicare Advantage Plan. The MA plan is the primary payer. TRICARE may cover some or all of the claim unpaid by the Medicare Advantage plan if the MA drug plan's pharmacy is a TRICARE network pharmacy that participates in the online coordination of benefits.

For more information on 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.

Get answers to frequently asked questions on how TRICARE works with Medicare prescription drug coverage at www.tricare.mil/medicarepartd/faqs.cfm#1664 or by calling the TRICARE Pharmacy Program at 1-877-363-1303. TTY users should call 1-877-540-6261.

4

Your 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 think about other ways to get Medicare prescription drug coverage.

- See if your current Medicare Advantage Plan 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**.
- 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.
- **Medicare Medical Savings Account (MSA) Plans** **don't** offer Medicare prescription drug coverage. If you have a Medicare MSA Plan, you can join a Medicare Prescription Drug Plan to get drug 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. See pages 11–14.
 - If you don't have a Medicare Prescription Drug Plan, you can use money in your MSA account for prescription or non-prescription drugs. These expenses don't count towards the MSA Plan deductible.
- 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.

Words in red are defined on pages 77–80.

4

Your Coverage Choices

If you stay in a plan that doesn't offer 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.

Contact your plan for more information about your choices.

I have a Medicare health plan with prescription drug coverage.

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

- If you're in a Medicare Advantage Plan and you join a Medicare Prescription Drug Plan, in most cases you will be disenrolled from your Medicare Advantage Plan and returned to **Original Medicare**.
- If you're 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.

Contact your plan for more information about your choices.

4

Your Coverage Choices

Words in red are defined on pages 77–80.

I have Medicare and Medicaid.

Medicare helps pay for your prescription drugs instead of **Medicaid**. Because you have Medicaid, Medicare automatically gives you **Extra Help** with your Medicare drug plan costs. See pages 29–30 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 joined a Medicare drug plan, Medicare will enroll you in a drug plan to make sure you have drug coverage (unless you already have certain retiree drug coverage). Medicare sends you a yellow notice telling you what drug plan you're in and when your coverage starts. Check to see if the plan covers the drugs you take and includes the pharmacies you use. You can switch to a different Medicare drug plan at any time.

If you filled any covered prescriptions before your Medicare drug plan coverage started, you may be able to get back some of the money you spent. Call Medicare's Limited Income Newly Eligible Transition (NET) Program at 1-800-783-1307 for more information. TTY users should call 1-877-801-0369.

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 want to opt out of (decline) Medicare prescription drug coverage. TTY users should call 1-877-486-2048.

Caution: If you call 1-800-MEDICARE and opt out of a Medicare drug plan, you could be left without any prescription drug coverage. You can change your mind and join a Medicare drug plan at any time without **penalty** as long as you continue to qualify for Extra Help.

In limited cases, some state Medicaid programs may pay for prescriptions Medicare doesn't cover. If you continue to qualify 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 phone number, visit www.medicare.gov/contacts, or call 1-800-MEDICARE.

4

Your 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 at any time this year), Medicare will send you a purple notice letting you know you automatically qualify for **Extra Help** paying your Medicare prescription drug coverage costs. You get it automatically when you join a Medicare drug plan. See pages 29–30 for more information about your costs.

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 already have certain retiree drug coverage. Medicare sends you a yellow notice (if you have SSI) or a green notice (if you belong to a Medicare Savings Program) letting you know when your coverage begins. You can switch to a different Medicare drug plan at any time without **penalty** as long as you continue to qualify for Extra Help.

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 want to opt out of (decline) Medicare prescription drug coverage. 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 without penalty as long as you continue to qualify for Extra Help.

4

Your Coverage Choices

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

- While you're living in an **institution**, you can switch Medicare drug plans at any time.
- If you move into or 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're in a skilled nursing facility getting Medicare-covered skilled nursing care, Medicare Part A (Hospital Insurance) will generally cover your prescriptions.

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.

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.

Words in **red** are defined on pages 77–80.



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

4

Your Coverage Choices

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

PACE programs are a joint Medicare and **Medicaid** option in some states. PACE gives you your Medicare prescription drug coverage, so you don't need to join a separate Medicare drug plan.

Caution: Joining a Medicare drug plan will disenroll you from your PACE plan. Your PACE plan provides not only your prescription drug coverage, but all of your health care services. If you join a Medicare drug plan, you will become disenrolled from your PACE plan, and you will no longer get other health care benefits through PACE. 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 reduced monthly **premium** 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.

- Call Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778), or visit www.socialsecurity.gov/i1020 to apply for Extra Help online.
- You can also apply for Extra Help at your State Medical Assistance (Medicaid) office. Call 1-800-MEDICARE (1-800-633-4227), and say "Medicaid" to get the phone number. TTY users should call 1-877-486-2048. Or visit www.medicare.gov/contacts.

See pages 29–40 for more information about Extra Help.

4

Your Coverage Choices

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

Words in red are defined on pages 77–80.

Several states have programs to help certain people pay for prescription drugs. Depending on your state, the **State Pharmacy Assistance Program (SPAP)** will have different ways to help you pay 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. Find your SPAP's contact information by visiting www.medicare.gov/pharmaceutical-assistance-program/state-programs.aspx.

If you belong to an SPAP, you may have another opportunity each year to join a plan in addition to the October 15–December 7 enrollment period. You can switch one time in a calendar year to a different plan from the one your SPAP enrolled you in. If you lose your SPAP benefits, you're allowed to join a different Medicare drug plan, beginning with the month you lose your benefits and continuing for 2 more months.

Your SPAP will give you more information on how Medicare prescription drug coverage affects the help you get now.

4

Your Coverage Choices

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

Most ADAPs only cover HIV/AIDS-related medications. Since they don't cover other drugs, they aren't **creditable prescription drug coverage**. 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** to join 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.

ADAPs vary by state so contact your ADAP to learn how it will work with Medicare's drug coverage.



4

Your 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. See your Indian health provider or check with the benefits coordinator at your local Indian health pharmacy to get more information on how to join a plan.
- 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 later. Ask your Indian health care provider for a letter stating you have creditable prescription drug coverage.

Words in **red** are defined on pages 77–80.



Steps to Choosing a Medicare Drug Plan

Follow the steps below to choose and join a Medicare drug plan, whether you're joining for the first time or reviewing your plan options for coverage next year. Use the personal worksheets on pages 60–61 to help decide which plan meets your needs:

Step 1: Prepare—Take time to gather information.

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

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

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

Before choosing a Medicare drug plan, you may want to gather together 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. 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's **creditable prescription drug coverage**. Your current insurer or plan provider is required to notify you each year whether your coverage is creditable prescription drug coverage. If you haven't heard from them, call them or your benefits administrator to find out. Request a notice if your coverage is creditable prescription drug coverage and you didn't get one. Also, you may want to consider keeping your creditable prescription drug coverage rather than choosing a Medicare drug plan.

Tip: If you consider joining a Medicare drug plan, check out how any current health coverage you have could affect your coverage choices. See pages 41–58.

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 41–58.

5

Steps to Choosing a Medicare Drug Plan

Prescriptions I take:

Prescription name	Dosage (ml, mg)	Number of times a day I take my prescription	Amount I 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, look at your “Medicare & You” handbook, or use the Medicare Plan Finder at www.medicare.gov/find-a-plan. 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're interested in, use www.medicare.gov to get the information below, or call the companies that offer the plans directly.

Plan Name:

Monthly Premium \$	Yearly Deductible \$	My drugs that are covered	My drugs that aren't covered	Amount I'd pay for each drug	Could I use my pharmacy?	Is mail order available?
		1.	1.			
		2.	2.			
		3.	3.			

Plan Name:

Monthly Premium \$	Yearly Deductible \$	My drugs that are covered	My drugs that aren't covered	Amount I'd pay for each drug	Could I use my pharmacy?	Is mail order available?
		1.	1.			
		2.	2.			
		3.	3.			

Plan Name:

Monthly Premium \$	Yearly Deductible \$	My drugs that are covered	My drugs that aren't covered	Amount I'd pay for each drug	Could I use my pharmacy?	Is mail order available?
		1.	1.			
		2.	2.			
		3.	3.			

5

Steps to Choosing a Medicare Drug Plan

Refer to the worksheets on pages 60–61. Compare the Medicare drug plans based on what’s most important to your situation and your drug needs. You may want to ask yourself:

- Which plan(s) cover 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)**?
- Which plan(s) allows me to use the pharmacy I want?
- Which plan(s) allows me to get prescriptions through the mail?
- Which plan(s) 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 will 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 77–80.

If you need help with your Medicare prescription drug coverage decisions, call your **State Health Insurance Assistance Program (SHIP)**. See page 75 for their phone number. You can also visit www.medicare.gov/contacts, 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 phone, by paper application, or online. You will have to give the number on your Medicare card when you join.

Rights and Appeals

How do I protect myself from fraud and identity theft?

Help protect yourself by knowing whether **Medicare Advantage Plans** and **Medicare Prescription Drug Plans** are marketing to you properly. These plans and people who work with Medicare **aren't** allowed to:

- Charge you a fee to enroll in a plan.
- Send you unwanted emails.
- Come to your home uninvited to get you to join a Medicare plan.
- Call you, unless you're already a plan member. If you're a member, the agent who helped you join can call you.
- Offer you cash to join their plan or give you free meals while trying to sell you a plan.
- Enroll you into a drug plan over the phone unless you call them and ask to enroll.
- Ask you for payment over the phone or Internet. The plan must send you a bill.
- Sell you a non-health related product, like an annuity or life insurance policy, while trying to sell you a Medicare health or drug plan.
- Make an appointment to tell you about their plan unless you agree (in writing or through a recorded phone 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.
- Try to sell you their plans or enroll you during an educational event, like a health fair or conference.



Independent agents and brokers working for plans must be licensed by the state. The plan must tell the state which agents are selling their plans.

If you're in a **Medicare Prescription Drug Plan** and you think the plan may be breaking these rules, call the Medicare drug plan integrity contractor at 1-877-7SAFERX (1-877-772-3379).

6

Rights and Appeals

Identity theft happens when someone uses your personal information without your permission 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 if I need help applying for Extra Help, joining a Medicare drug plan, or filing a coverage determination or appeal?

You may have a representative 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. You can also appoint a family member, friend, advocate, attorney, doctor, or someone else to act as your representative.

A 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, or file a request for **coverage determination**, complaint (also called a grievance) or appeal. **A representative can't enroll you in a Medicare drug plan unless he or she is also your legal representative according to the laws of your state.**

A representative can be any of the following:

- The person who acts on your behalf if you're 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.

Words in red are defined on pages 77–80.

6

Rights and Appeals

You can appoint your representative in one of the following ways:

1. Fill out an “Appointment of Representative” form (CMS Form Number 1696) available at www.cms.gov/cmsforms/downloads/cms1696.pdf, or call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy. TTY users should call 1-877-486-2048.
2. Submit a letter that includes the following:
 - Your name, address, and phone number
 - Your Medicare number (found on your red, white, and blue Medicare card)
 - A statement appointing someone as your representative
 - The name, address, and phone number of your representative
 - The professional status of your representative or their relationship to you
 - A statement authorizing the release of your personal and identifiable health information to your representative
 - A statement explaining why you’re being represented
 - Your signature and the date you signed the letter
 - Your representative’s signature and the date they signed the letter

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.

You must send the form or letter with your appeal request. See page 67 on how to request an appeal. The person helping you must send a copy of the form or letter each time you file a **coverage determination** or appeal, so it’s a good idea to make at least one additional copy of the form or letter before you send it. If you have questions about appointing a representative, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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, regardless of the applicant’s 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.

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Rights and Appeals

Words in red are defined on pages 77–80.

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

You, your representative, or your doctor or other prescriber, may ask for a **coverage determination** if your pharmacist or plan tells you one of the following:

- A drug you believe should be covered isn't covered.
- A drug is covered at a higher cost than you think you should have to pay.
- You have to meet a plan coverage rule (such as prior authorization) before you can get the drug you requested.
- You want the plan to cover a non-preferred drug at the preferred drug price.

You may send a letter or use the “Model Coverage Determination Request” form at www.cms.hhs.gov/MedPrescriptDrugApplGriev/Downloads/ModelCoverageDeterminationRequestForm.pdf. You will need a supporting statement from your prescriber explaining why you need the drug you're asking for. Your prescriber must give a statement explaining the medical reason why the **exception** should be approved.

Depending on the situation, you might ask for a coverage determination before you pay for your prescription. If you're asking your plan to pay you back for a prescription you've already bought, you must write them to ask for a coverage determination—unless they told you they will accept a request by phone.

The plan's decision-making time period starts once your plan gets the statement. They will give you its decision within 72 hours. You or your prescriber can call or write your plan to ask that they give you an expedited (fast) decision within 24 hours. Your request will be expedited if your prescriber tells the plan or if your plan determines your life or health may be at risk by waiting for 72 hours for a decision. Your request won't be expedited if you're asking your plan to pay you back for a prescription you already bought.

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Rights and Appeals

How do I appeal?

If you ask for a **coverage determination** and then you disagree with the plan's decision, you can appeal the decision. There are **five levels** of appeal available to you, but you must follow the order listed below:

1. Request an 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 a redetermination. You must request this appeal within 60 calendar days from the date of the coverage determination notice. You, your representative, or your doctor or other prescriber can ask your plan for either a standard or an expedited redetermination. You must make your standard redetermination request in writing unless your plan allows you to file a request by phone. Your request will be expedited (sped up) if your plan determines, or your prescriber tells your plan, that your life or health may be at risk by waiting for a standard decision. You can make an expedited request in writing or by phone. Your request will **not** be expedited if you're asking to get paid back for a drug you already bought.

While your plan must accept any written request, you may want to include:

- Your name, address, and Medicare number shown on your Medicare card
- The name of the prescription drug you want your plan to cover
- Reason(s) why you're appealing, and any supporting documentation that you believe may help your case
- Your signature or the signature of your representative

The plan has 7 calendar days (for a standard request or for a request to pay you back) or 72 hours (for an expedited request) from the date it gets your appeal request to let you know its decision.

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Rights and Appeals

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). You'll get the redetermination decision by mail, and it will explain how to file a reconsideration. The plan will also send you a "Medicare Reconsideration Request Form" that you can use to make your request. If you don't get this form, call your plan or get this form at www.cms.gov/cmsforms/downloads/CMS20033.pdf. You must file your written request within 60 calendar days from the date of the plan's redetermination decision. You must send your request to the IRE at the address or fax number given in the plan's redetermination decision.

You or your representative may ask for either a standard or expedited reconsideration. Your reconsideration request will be expedited if the IRE determines, or your doctor or other prescriber tells the IRE, that your life or health may be at risk if you wait for a standard decision.

Important: If your plan didn't previously process your request as an **exception** but you're asking the IRE for an exception, as with all appeals, you need to give a supporting statement from your prescriber explaining why you need the drug you're requesting. The IRE may ask for the views of your prescribing physician either by phone or in writing, as long as the IRE has a written account in their records. The IRE's decision-making time period starts once it gets the statement.

Once you've filed your request for review (and a supporting statement from your prescriber, if needed) for a standard request for coverage or for a request to pay you back, the IRE has to tell you their decision within 7 days. They need to get back to you within 72 hours for expedited requests for coverage.

Words in red are defined on pages 77–80.

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Rights and Appeals

3. Request a hearing with an Administrative Law Judge.

The IRE will send you a reconsideration notice explaining their decision. If you disagree with the decision, you or your representative can ask for 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 and send it to the address in the IRE's reconsideration notice. 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). This amount will be listed in your reconsideration notice.

You or your representative may ask for either a standard or expedited ALJ hearing. The ALJ will expedite your request if the ALJ decides, or your doctor or other prescriber tells the ALJ, that your life or health will be put at risk if you wait for a standard decision. You can make an expedited request in writing or by phone.

Once you've filed your request for hearing, the ALJ has no later than 90 days to notify you for a standard request for coverage or for a request to pay you back. The ALJ has no later than 10 days to notify you for expedited requests for coverage.

4. Request a review by the Medicare Appeals Council.

If you disagree with the ALJ's decision or dismissal notice, you or your representative can ask for a review by the Medicare Appeals Council (MAC). You must send your request in writing to the MAC within 60 calendar days from the date of the ALJ's decision, to the location listed in the ALJ's decision or dismissal notice.

You or your representative may request either a standard or expedited MAC review. The MAC will expedite your request if the MAC decides, or your prescriber tells the MAC, that your life or health may be put at risk if you wait for a standard decision. You can make an expedited request in writing or by phone.

Once you've filed your request for review, the MAC has no later than 90 days to tell you their decision for a standard request for coverage or for a request to pay you back. The MAC has no later than 10 days for expedited requests for coverage.

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Rights and Appeals

5. Request a review by a Federal court.

If you disagree with the MAC's decision, or if your request for MAC review is denied, you or your representative can ask for a review by a Federal district court. You must file your request in writing within 60 calendar days from the date you get the MAC's decision and send it to address in the MAC's decision. To get a review by a Federal district court, the projected value of your denied coverage must meet a minimum dollar amount stated in the MAC's decision.

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

What if I don't agree with Medicare's late enrollment penalty?

If you don't join a Medicare drug plan when you're first eligible, you may have to pay a late enrollment **penalty** unless you had other **creditable prescription drug coverage**. In some cases, you have the right to ask Medicare to review your late enrollment penalty. This is called a "reconsideration."

Some reasons why you may ask for a reconsideration include:

- You think Medicare didn't count all your previous creditable prescription drug coverage.
- You didn't get a notice that clearly explained whether your previous drug coverage was creditable.

Your Medicare drug plan will give you a reconsideration request form when it sends you the letter telling you that you have to pay a late enrollment penalty. Mail the completed form to the address, or fax it to the number listed on the form within 60 days from the date on the letter. You should also send any proof that supports your case, like information about previous creditable prescription drug coverage.

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Rights and Appeals

If you need more information about requesting a reconsideration of your late enrollment **penalty**, call your Medicare drug plan. You can also visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) for help. TTY users should call 1-877-486-2048.

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 your plan. Reasons why you might file a complaint include:

- 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 you didn't ask to get and that 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 (sped up) 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 phone or in writing. You must file your complaint within 60 calendar days of the date of the event that led to your complaint.

Words in **red** are defined on pages 77–80.

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Rights and Appeals

Your plan must give you its decision generally no later than 30 days after it gets your complaint. The plan may extend the 30-day notification by up to 14 days if you (or your representative) request an extension, or if the plan can show good reason for needing additional information and that the delay is in your best interest.

If your complaint has to do with a plan's refusal to expedite a **coverage determination** or redetermination, and you haven't yet bought or didn't get the drug, you must be given 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.

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For More Information

For more information about Medicare prescription drug coverage, visit www.medicare.gov/find-a-plan to get personalized information. Enter and save your current prescription drug information to get more detailed cost information. Make sure you don't hit the back button on your keyboard or on the screen—if you do, you'll lose any personal information you entered. This feature helps keep your personal information safe.

Also, you can call **1-800-MEDICARE** (1-800-633-4227) 24 hours a day, including weekends, to get information you need. TTY users should call 1-877-486-2048.

- Speak clearly, have your Medicare card in front of you, and be ready to provide your Medicare number. This helps cut the amount of time you may wait to speak to a customer service representative. It also may help get you to a representative more quickly.
- To enter your Medicare number, speak the numbers and letters clearly one at a time. Or, enter your Medicare number on the phone keypad. Use the star key to indicate any place there may be a letter. For example, if your Medicare number is 000-00-0000A, you would enter 0-0-0-0-0-0-0-0- 0-0-*. The voice system will then ask you for that letter.
- Say “Agent” at anytime to talk to a customer service representative, or use this chart. If you need help in a language other than English or Spanish, let the customer service representative know the language so you can get free translation services.

If you're calling about...	Say...
Medicare prescription drug coverage	“Drug Coverage”
Medicare prescription drug enrollment status	“Drug Coverage” then “My Enrollment”
Help paying prescription drug costs	“Limited Income”
Phone number for your State Medical Assistance (Medicaid) office	“Medicaid”
Forms or publications	“Publications”

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For More Information

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” (CMS Form Number 10106) form at www.medicare.gov/MedicareOnlineForms, or call 1-800-MEDICARE (1-800-633-4227) to get a copy of the form. TTY users should call 1-877-486-2048.

- 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 Coverage Choices, contact your **State Health Insurance Assistance Program (SHIP)**. You can find the phone number for your state’s SHIP on the next page.

Words in red are defined on pages 77–80.

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For More Information

State Health Insurance Assistance Program (SHIP) Offices

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. Thank you.

The phone 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 phone numbers, visit www.medicare.gov/contacts. Or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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For More Information



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For More Information

Definitions

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 (72 hours for standard requests, 24 hours for expedited requests), 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.

Coverage Gap (Medicare Prescription Drug Coverage)—A period of time in which you pay higher cost sharing for prescription drugs until you spend enough to qualify for catastrophic coverage. The coverage gap (also called the “donut hole”) starts when you and your plan have paid a set dollar amount for prescription drugs during that year.

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 keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later and they do not have a gap in coverage of more than 63 days.

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For More Information

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.

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, aren't 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.

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For More Information

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're 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.

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 Plan—A plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan.

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 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.

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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 fee-for-service coverage 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 Medical Assistance Office—A state agency that's in charge of the State's Medicaid program and can give information about programs that help pay medical bills for people with limited income and resources.

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

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usuarios de TTY deberán llamar al 1-877-486-2048.