

WHAT YOU NEED TO KNOW ABOUT CHOOSING AND USING YOUR NEW MEDICARE PRESCRIPTION DRUG COVERAGE

The new Medicare prescription drug coverage offers you the opportunity to choose from a number of prescription drug plans. This gives you more control to make sure that your drug plan meets your needs. If it doesn't, you can select a different plan in your next enrollment period. It is important to compare plans before selecting one, and to understand how the plan you choose works, so that you can use your benefits wisely.

CHOOSING A PRESCRIPTION DRUG PLAN

Your choices may include: new Medicare Prescription Drug Plans; existing coverage that you may have through your former employer; or your State's Pharmacy Assistance Program.

- If you have a Medicare Advantage plan, you will only be able to get drug coverage from the drug plan that is offered by your Medicare Advantage plan. This will help your Medicare Advantage plan to coordinate your health care and pharmacy benefits.
- If you have traditional Medicare – not a Medicare Advantage plan – you will have at least two prescription drug plan choices. Medicare will send you information about your choices before the open enrollment period that starts in November. You should contact the plan you choose when you're ready to join.
- Everyone who already has Medicare will be able to get the new prescription drug coverage for the first time in November, 2005 and this enrollment period will last until May, 2006. If you become eligible for Medicare in the future, you will have an open enrollment period of seven (7) months: three months before your birth month, your birth month, and three months after your birth month. But in all later years, enrollment will only be in November and December.
- If your retiree health insurance from your former employer includes drug benefits, you may choose to continue receiving your coverage through that employer.
- If you already have drug coverage through your Medicare supplement plan (Medigap), you may be able to continue to purchase this drug coverage without joining a Medicare Prescription Drug Plan. However, Medigap prescription drug coverage is not, on average, as good as a Medicare Prescription Drug Plan.
- If you are enrolled in your State's Pharmacy Assistance Program (each has its own name, such as EPIC, ConnPACE, PAAD, etc) then you will receive a letter from the State about whether it will continue to offer coverage. In some states, you may choose to join only the state program, but others may require you to also join a Medicare prescription drug plan.

You must join a Medicare prescription drug plan or another "creditable plan" in order to avoid a future late penalty.

- A "creditable plan" is a plan that provides coverage that is, on average, at least as good as the coverage Medicare provides. In some cases, your coverage through your former employer may be considered a "creditable plan."
 - You will get a letter from any plan you are enrolled in to let you know whether or not it is "creditable."
 - If you do not join a Medicare drug plan or other "creditable plan" within six (6) months of becoming eligible, your premium will be higher if you join in the future because a late penalty will be added to it. Just like life insurance, it will cost more if you wait.
 - However, if you are already enrolled in another "creditable plan" then you do not need to join a Medicare plan in order to avoid the late penalty.
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- Your Medicare supplement (Medigap) plan, if it includes drug coverage, is also required to send you a letter about whether or not the plan's coverage is creditable. It is probably not creditable.
- Your State's Pharmacy Assistance Program may offer creditable coverage, depending on the benefits it offers. The state is required to send you a letter about whether or not the program's coverage is creditable.

Generally, if you are unhappy with your Medicare Prescription Drug Plan, you may switch to a new plan once each year during the enrollment period, but under certain circumstances, you may be able to switch more often.

- If you are eligible for both full Medicaid benefits and also Medicare, you can switch monthly.
- If you move out of the service area of your Medicare Prescription Drug Plan, you may switch to a new plan that covers you in your new location. For example, if you live in Ohio and move to Florida, you can switch plans when you move.
- If your Medicare Prescription Drug Plan misled you about their benefits or rules, or failed to provide timely benefits, you may be able to switch to a different plan before the next enrollment period.
- If you do not take action to switch to a new Medicare Prescription Drug Plan during the annual enrollment period, then you will automatically be re-enrolled in the same plan for the next year.

When choosing a Medicare Prescription Drug Plan, compare the plan's "formulary" with the list of medicines you take to make sure your current medicines are covered.

- Medicare Prescription Drug Plans are allowed to have a list of medicines that they will cover, called a "formulary." It must cover at least two medications for every health problem, but does not have to cover every medication available to treat your health problem.
- If you take several different medications and not all of them are covered by the Medicare Prescription Drug Plan, talk with your doctor about your medicines and find out which ones you should not change.
- If the medicines you need are not on plan's list of covered drugs, you will be expected to switch to a medicine that is on the formulary. However, you and your doctor may appeal to try and get your non-formulary medicine covered.

When choosing a Medicare Prescription Drug Plan, compare the "copayments." Prescription drug plans may have different levels of copayments for different drugs.

- A "copayment" or "copay" is an amount that you are responsible for paying toward the total cost of your medicine.
- Private sector drug plans often charge lower copayments for generic medicines than brand name medicines. The Medicare Prescription Drug Plans are likely to follow a similar pattern, or have even more levels than this.
- Medicare Prescription Drug Plans may charge you an even higher copayment if you do not use a pharmacy they prefer, or if you choose to use a local pharmacy when the plan has offered you the opportunity to order your chronic medication through the mail.
- Copayments can be very high. Be sure you compare your Medicare Prescription Drug Plan choices, based not only on what medicines are on the formulary, but also on what the copayments are for the medicines you use.

USING YOUR PRESCRIPTION DRUG PLAN

Be sure you understand your Medicare drug benefit. Medicare requires prescription drug plans to meet certain standards, including “deductibles” and more generous benefits if you have very high drug costs.

- Unless you qualify for extra help as a person with limited income, you will be responsible for paying an amount up to the first \$250 of your medication costs each year. This is called your “deductible.” After you’ve paid your deductible, Medicare starts paying about 75% of the cost of your medicines. The rest is paid by you as a copayment.
- After the Medicare Prescription Drug Plan has paid about \$1,500 in benefits in a year, there is a second deductible period, in which the plan again pays nothing and you are responsible for the full cost of your medications. This period is also known as the “coverage gap” or “donut hole.”
- Once your deductibles and copayments add up to \$3,600, you receive more generous coverage for the rest of the year. Under these benefits, your copayments are limited to either \$5 or 5% of the cost of the medicine, whichever is greater.
- Medicare Prescription Drug Plans can customize their coverage within the rules so the coverage will not be exactly alike under each plan. The point at which you start receiving more generous benefits – when your deductibles and copayments add up to \$3,600 - is the same across all plans.
- People with limited income, who receive extra help, have lower deductibles (in some cases, no deductible at all) and much lower copayments.
- All of these dollar amounts will be adjusted each year for inflation.

Medicare Prescription Drug Plans may have rules you must follow before they will pay. Get to know what these rules are.

- The Medicare Prescription Drug Plan may require your doctor or pharmacist to get approval from the plan for a medication before they will pay for it. This is called “prior authorization.”
- The Medicare Prescription Drug Plan may require that you try a less expensive medication before they will agree to pay for a more expensive medication. This is called “step therapy.”
- The Medicare Prescription Drug Plan may limit the number of doses of a particular medication it will cover in a month.
- If a medication you need is not covered (denied) for any of these reasons, you have the right to appeal for coverage.

Any time your medication is not paid for, when you expected that it would be, you have a right to appeal.

- Remember that the Medicare Prescription Drug Plan cannot pay for your medications during the deductible periods.
- If your medicine is not paid for because it is not on the formulary, or if your doctor or pharmacist has tried to get prior authorization of a medicine and has been turned down, then you may appeal.
- You may appeal first and wait for the plan to pay for your medication, or you can pay for the medication yourself and appeal to be paid back.

- To start the appeal process, you, your doctor or your pharmacist need to contact your Medicare Prescription Drug Plan and ask for an “exception.” If the plan does not grant your exception, there are steps you can take to appeal further. Any time the Medicare Prescription Drug Plan denies your request for an exception or a step in the appeal process, they will send you a letter with instructions on how to take the next step in the appeal process.
- Medicare requires prescription drug plans to allow you to appeal for a lower copayment. Your doctor must send in a statement telling the plan that the medicine you take with a high copayment is the only one that works for you and that other medicines with lower copayments do not work for you. The appeal process works the same way as when the plan doesn’t pay for a medication at all.

A Medicare Prescription Drug Plan can change the list of medicines (formulary) it covers during the year.

- A Medicare Prescription Drug Plan can delete a medicine from its formulary during the year.
- If the Medicare Prescription Drug Plan does take a medication off its formulary, it must send you and your doctor a letter 60 days in advance so that you have time to talk to your doctor and decide whether you should switch to a different medicine on the formulary or appeal to continue coverage for the medicine you are already taking.

Medicare is always there to answer your questions, and there are other resources.

- To learn more about Medicare prescription drug coverage, call Medicare at 1-800-633-4227. The phone lines are staffed 24 hours a day, seven (7) days a week.
- You can also visit www.medicare.gov on the Internet.
- You will also receive material in the mail from Medicare, which you should read carefully.
- If you have problems with your Medicare Prescription Drug Plan, call the Medicare Ombudsman, Dan Schreiner, who can be reached at 1-800-MEDICARE (1-800-633-4227).
- Each state has a State Health Insurance Assistance Program which can help you. You can find a list of these agencies’ Web sites and phone numbers at <http://www.medicare.gov/contacts/static/allStateContacts.asp>.
- There is a Web site at www.YourPharmacyBenefit.org that gives you more information about your rights and how to appeal, including a sample appeal letter.